ENHANCING GLOBAL HEALTH AND WELL-BEING:
THE BOTSWANA GLOBAL HEALTH INITIATIVE

2022

PROGRAM REPORT

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ACKNOWLEDGMENTS

Promoting health and well-being for all is undeniably one of the most pressing challenges our world faces today. Effectively tackling this imperative goal requires a concerted effort that unites researchers, community stakeholders, donors, non-government actors, and governments in a collaborative, interdisciplinary endeavor. By forging sustainable partnerships and empowering all stakeholders, we can foster innovative solutions and drive positive outcomes in the global health landscape.

The Botswana Global Health Initiative (BGHI) stands at the forefront of this endeavor, striving to develop sustainable solutions to the health and social challenges facing families and communities in Botswana and beyond. Through the transformation of excellence and impact, we prioritize exceptional research, discovery, innovation, and engagement to create a lasting effect.

At the core of BGHI's mission lies active engagement in exploring, developing, and sharing concrete solutions that communities, government organizations, and civil society groups can implement to address practical problems faced by vulnerable populations in Botswana and globally.

Supported by the Robert & Sara Rothschild Endowment Fund, BGHI embodies a collaborative effort involving Oregon State University's College of Health, the Ministry of Health (MOH), and the Ministry of Youth, Gender, Sport, and Culture. Together, we are dedicated to identifying and implementing locally relevant and sustainable community-based efforts that aim to:

1. Improve Health Infrastructure: By investing in and upgrading health infrastructure, BGHI aims to provide accessible and quality healthcare services to all needy individuals.
2. Strengthen Health Care Services and Systems: Through research and innovation, we seek to bolster healthcare services and enhance the efficiency and effectiveness of healthcare systems to better respond to the evolving health needs of communities.
3. Empower Youth: BGHI is committed to empowering youth through various employment, engagement, and skill-building activities, equipping them with the tools they need to shape their futures positively.
4. Address Health Disparities: Our collaborative efforts target the reduction of health disparities and the promotion of health equity, ensuring that vulnerable populations receive the care and attention they deserve.
5. Foster Sustainable Solutions: We understand the importance of sustainable solutions that can withstand the test of time. BGHI actively promotes initiatives that will have a lasting impact on health and well-being in Botswana and beyond.

The BGHI endeavors to create meaningful change in the lives of individuals and communities through a multi-faceted approach that combines research, engagement, and innovation. Working hand-in-hand with local stakeholders ensures that our efforts are practical, culturally sensitive, and community-centric. With a shared vision and determination, the Botswana Global Health Initiative continues to make strides towards a healthier, more equitable world where every individual has the opportunity to lead a prosperous and fulfilling life. Together, we can turn our challenges into opportunities for growth, progress, and lasting change.

Key Partners

- ♦ **Ministry of Health, Government of Botswana**
- ♦ **Ministry of Youth, Gender, Sport, and Culture, Government of Botswana**
- ♦ **College of Health, Oregon State University**
- ♦ **Oregon State University Foundation**
- ♦ **Robert and Sara Rothschild Endowment Fund**
- ♦ **The Robert & Sara Rothschild Family Foundation: Building Libraries Empowering Communities**

Our work in 2022 took place in Maunatlala – a village in the Central District of Botswana – situated at the foot of the Tswapong hills near the Lotsane River. It is located approximately 221 miles from Gaborone, the capital city of Botswana. Maunatlala's population is around 5,000 individuals. The community has three schools (two primary and one junior secondary), a community health clinic, and the Maunatlala Community Library. The Maunatlala community has partnered with us since 2017, offering us a vibrant learning opportunity from community members, leaders, and diverse local and regional stakeholders. We focused on four overlapping health and social concerns identified by the Maunatlala community and our government partners. These concerns included underrepresentation and lack of resources for individuals with disabilities in Maunatlala; the need for improving the knowledge and awareness of sexual and reproductive health issues among youth; reducing gender-based violence and promoting gender equity; and identifying locally engaging and sustainable strategies to address alcohol/substance abuse, especially by youth, in the community. The interns collaboratively worked with community members and key stakeholders, including youth group leaders, schoolteachers, and library and clinic staff, to promote community awareness and involvement to find appropriate solutions to address these issues.

In addition to collecting data through interviews, we gathered data through observation, resource mapping, analysis of records, and visual documentation—both data collection and initial data analysis simultaneously while we were in Maunatlala. We focused on concept saturation and triangulation of information. We became familiar with the data by reading and re-reading our field notes, noting impressions, looking for meanings, and identifying overlapping and recurring themes. We categorized data into broad themes and identified relationships (patterns, connections, contradictions, etc.) between and across themes. Specifically, we focused on content analysis, narrative analysis, conversation analysis, and grounded theory.

This report represents the perspectives of various stakeholder groups and highlights the experiences and aspirations of Maunatlala residents and leaders. In our roles as collaborators, we endeavored to summarize diverse yet complementary perspectives on critical priorities as shared with us by people living and working in Maunatlala. We have made key recommendations based on rigorous data analyses to foster positive change in the village and help the Maunatlala community and our government partners identify key priorities to improve health services and everyday life.

Our work in Botswana represents an unconventional multisectoral collaboration driven by the passion and commitment to discovering sustainable, culturally appropriate, locally feasible, and economically empowering solutions. We have designed a Sustainable Community Partnership and Empowerment (SCOPE) strategy to find community-driven answers to problems identified by the community. The best solutions come from people who know their community best and have good ideas about removing barriers. With diverse expertise and a value-driven approach, SCOPE collaborators ensure that the proposed community-driven programs are successful. Our SCOPE strategy embodies an innovative

approach to sustainably improving health and well-being across all stakeholders. SCOPE harnesses science and data to foster high-functioning collaboration across academia, community, civil society sectors, and regional and national government stakeholders. Ultimately, SCOPE outlines a vision for upscaling and long-term success with deepened engagement from all participating partners.

INTRODUCTION

According to the World Health Organization (WHO), nearly 15% of the world's population lives with a physical, intellectual, or mental disability that affects daily living. Additionally, those living with disabilities may face unequal access to life-altering resources, such as education, health care, rehabilitation, and employment (World Health Organization 2011, Cameron, 2005) (Mitra et al., 2013; Mukhopadhyay & Moswela, 2020). People with disabilities are considerably limited by preexisting social, cultural, and economic constraints rather than by their individualized disabilities. For people with disabilities, social and environmental barriers, like historical stigma, physical inaccessibility, and lack of adaptive learning opportunities, can affect access to education, thus reducing opportunities to enhance overall well-being and social inclusion (Omotoye, 2018). Stigma, discrimination, and lack of autonomy experienced by people with disabilities globally have signaled disability as a human rights concern (World Health Organization, 2011).

The lack of research on cultural underpinnings and contextual factors adversely affects the representation of this population in low-income, low-resource regions. Limited research is available on the cultural underpinnings and contextual factors that affect an individual perception and attitude toward persons experiencing disability in Botswana, specifically in rural communities. (Mukhopadhyay & Moswela, 2020; The World Bank, 202. The global dimensions of disability – the interaction between the individual and personal, social, and environmental factors in each cultural setting – remain understudied and often overlooked in program formulation and implementation. We aim to examine such interactions impacting the experiences of persons with disabilities in rural Botswana through the implementation of Disability Awareness Training.

The objective of this project was to establish and evaluate a community-driven Disability Awareness Training grounded in theoretical tenets of community-based participatory research (CBPR) in Maunatlala, Botswana, to increase community-inclusive practices. We used a mixed-methods approach to address cultural and contextual factors that impact the inclusive practices of educators and healthcare workers of all ages in Maunatlala, Botswana. Specific aims for this project are below:

- Aim 1: To understand cultural, contextual perceptions and barriers to disabilities through community-based interviews and group discussions.
- Aim 2: To identify strategies to address barriers to inclusion.
- Aim 3: To assess participants' change in knowledge, attitude, and behavior related to disability because of the comprehensive Disability Awareness Training.

METHODS:

PROGRAM DEVELOPMENT

The Disability Awareness Training used a mixed-methods approach to address cultural and contextual factors that impact inclusive practices of educators and health care workers of all ages in Maunatlala, Botswana. The program was designed to reflect the medical and social understanding of disability to teach best, communicate, and interact with people of all abilities. This eight-domain program

incorporates distinctive content areas specific to the needs of local community members with disabilities (Table 1). The program was developed using community goals collected in 2019 (Khanna et al., 2019) in collaboration with critical stakeholders experiencing disability. Moreover, the outline for our Disability Awareness Training was loosely modeled after the Disability Awareness Toolkit (Plan International, 2016) and the Disability-inclusive Health Services Toolkit (World Health Organization & Regional Office for the Western Pacific, 2020).

PARTICIPANTS

Forty-three individuals participated in stakeholder interviews and focus group discussions (Table 2). Participants were representative of persons with disabilities (20.9%) and without disabilities (79.1%). At this phase, we emphasized the involvement of persons with disabilities and their caregivers to prioritize the voices of people with disabilities to understand better the barriers this population faces in the village. The purpose of the stakeholder interviews and focus group discussions was to understand cultural and contextual perceptions and barriers to disabilities and to identify strategies to address the obstacles to inclusion (Aims 1 & 2).

An additional nineteen individuals participated in the pilot Disability Awareness Training (Table 3). All nineteen participants completed the 8-module program, a post-then-pre-survey, and focus group discussion. Of the nineteen participants, fourteen were educators at a local primary school (73.7%), and five were healthcare workers at a local clinic (26.3%). Participants represented persons with disabilities (10.5%) and without disabilities (89.5%). This pilot phase of the study aimed to assess participants' change in knowledge, attitude, and behavior related to disability due to the comprehensive Disability Awareness Training (specific aim 3).

To accurately represent people with disabilities, we developed a community working group of Oregon State University researchers and Maunatlala community members who self-identified as having a disability. We presented our proposed program to the group, received their input, and planned to adjust it based on their feedback. We are excited to build this partnership, as we believe it will expand the Disability Awareness Training's reach.

DATA COLLECTION AND ANALYSIS

Data were collected between June and August 2022 using a convergent parallel mixed methods design (Creswell, 2014). Upon completion of the Disability Awareness Training, each participant completed a retrospective, post-then-pre-survey to measure whether the Disability Awareness Training significantly changed participants' self-reported knowledge and attitudes related to disability. This method was selected over the more common pre-then-post method as it allows for a more reliable assessment of change in participants' knowledge and skills as a direct result of the given program (Khanna et al., 2009; Marshall et al., 2007). Responses for knowledge-based and skill-related questions were scored on a 5-point Likert scale ranging from "strongly disagree" to "strongly agree." This data was then tabulated and grouped into two categories: (1) after completion of the program and (2) before completion of the program. Data were systematically analyzed using descriptive statistics to examine the distribution of participants' responses. Percent distribution and mean values for all reactions were reviewed to assess self-reported changes in knowledge, attitude, and behavior related to disability. A nonparametric Wilcoxon signed-rank test was used to determine if the differences between the two groups were significantly different from 0, indicating a change in self-perceived knowledge, attitude, and skill.

Additional data was collected through the completion of in-depth interviews and focus group discussions to gain a shared understanding of the program and perceived self-change in attitudes from participants. Semi-structured interview guides were used for in-depth interviews and focus group discussions to gain narrative interpretations of the participant experience and perspectives on the topics discussed in the comprehensive training. Before each interview or focus group discussion, all participants were informed of the purpose of the interview, how it might be used in the research process, and that their participation was voluntary, permitting them to stop at any point. Informed consent was received through a verbal agreement. All interviews were recorded after obtaining the participant's permission. Data were collected until no new patterns or themes emerged, indicating successful concept saturation.

Upon completion of qualitative data collection, all interviews and focus group discussions were transcribed and prepared for an inductive thematic analysis. Raw data transcriptions were reviewed and validated by at least two researchers, following a cyclical coding process that increases inter-coder agreement (Saldana, 2021). We then classified and categorized the data repeatedly, allowing provisional codes to be formed and reformed until the research team reached an inter-coder agreement. Lastly, the data was themed categorically, providing detail about patterns observed and expanding upon central ideas (Saldana, 2021). Systematic observations were also analyzed to understand the participants' level of engagement and as an iterative learning process to improve the program's quality. Quantitative data was combined with qualitative data during the interpretation of results.

RESULTS

QUANTITATIVE RESULTS

Of the 25 participants who attended the Disability Awareness Training, 19 completed the post-then-pre-survey in July of 2022 (response rate of 76%). Upon completing the program, preliminary testing revealed that participants experienced a positive shift in their knowledge and skills about providing inclusive classroom practices. For all but one item in the survey, the "after training" (post) mean scores are higher than the "before training" (pre) mean scores (Table 4). These changes suggest a positive shift in participant knowledge and understanding of inclusive practices to better include persons with disabilities in their classrooms. However, for item 6 ("When you have difficulty communicating with someone with a disability, you should make decisions for them"), the "after training" (post) mean value is lower than the "before training" (pre) mean value. This difference suggests that by attending the Disability Awareness Training, participants understood the importance of promoting individual independence and self-determination regardless of an individual's perceived ability. All items recorded statistically significant changes between the "after training" (post) mean scores and the "before training" (pre) mean scores.

The most noticeable shift in participants' self-reported responses is observed in participant self-efficacy in implementing universal design (item 16), adapting teaching tools and techniques (item 14), working with students who have intellectual disabilities (item 15a), and recognizing personal attitudes and biases towards persons with disabilities (item 17). On a 5-point scale, the positive shifts in the differences between "after training" (post) and "before training" (pre) mean scores for the four items are 1.95, 1.89, 1.85, and 1.78, respectively. First, these changes suggest that involvement with the Disability Awareness Training increased participants' awareness of the importance of learning about inclusion and reflecting on the medical and social understanding of disability to teach best, communicate, and interact with students of all abilities. Second, the changes reflect an increase in participants' self-reported knowledge

of the inclusive practices discussed during the Disability Awareness Training and their self-reported skills for implementing principles of universal design that will assist in creating inclusive environments for students of all abilities.

QUALITATIVE RESULTS

Upon analysis of interview and focus group transcripts, concept saturation led to the emergence of three themes: 1) shifts in knowledge-based understanding, 2) shifts in skill-based practice, and 3) advocacy. The themes are described below and illustrated by representative quotes from study participants in Table 5.

SHIFTS IN KNOWLEDGE-BASED UNDERSTANDING

Participants repeatedly acknowledged a shift in their knowledge of disability and attitudes towards persons with disabilities. Participants who had both proximity to people with disabilities (i.e., direct family members) and robust familial support systems were more inclined to use positive connotations when discussing disability compared to those who had no preexisting relationship or had a weakened social support system (Table 5 – 1.1). People who did not have close contact or fractured interpersonal relationships with someone with a disability were more likely to use negative terms that focused on the physical or mental impairment when describing the individual. Moreover, these individuals who lacked intergroup interactions often spoke of fear-based thoughts when telling people with disabilities, such as "inability" and "afraid" (Table 5 – 1.1).

Most participants agreed that a universal lack of awareness caused this disparity in the local perception of disability regarding this population's needs and inaccessible resources. Participants highlighted that before their involvement in this program, they relied on the community's perception of disability, which was driven by negative stereotypes and emphasized overprotection.

Participants acknowledged that a change in attitude is needed to dispel stigma and increase awareness of people with disabilities. Moreover, they felt that their involvement with this program increased their self-efficacy in recognizing and managing personal implicit and explicit biases related to disability. Such acknowledgment allowed participants to reflect internally on where they identified positive behavior shifts and their plans when interacting with people with disabilities. In particular, the equity of human rights and the validity of human emotion among all people with and without disabilities were discussed (Table 5 – 1.2).

Learning about the importance of promoting independence, self-determination, and respecting personal autonomy were critical features highlighted by participants. Lack of cultural discussion and awareness surrounding disability led participants to explain that before their participation, they felt the responsibility to make decisions for persons with disabilities. Participants expressed that they often assumed the needs of this community as they were not equipped with the necessary information to effectively communicate with and include persons of all abilities in decision-making processes. A significant shift was observed in participant understanding of the importance of promoting self-determination and independence among people with and without disabilities (Table 5 – 1.3).

Participants indicated that accepting and including people with disabilities were necessary, especially for long-term advocacy of their peers living with disabilities. Moreover, participants recognized that disability is a condition or event any individual can acquire at any given time; thus, it is essential to shift

community attitudes towards acceptance and acknowledge disability as human diversity to benefit all community members (Table 5 – 1.3).

SHIFTS IN SKILL-BASED BEHAVIORS

In addition to increasing knowledge-based understanding of disability issues, participants also exhibited an increased awareness of skill-based behaviors to improve the environment and tools for inclusive practice. Before interaction with the Disability Awareness Training, participants defaulted to the medical model of disability when addressing disability issues, that disability is an n impairment within the individual. However, participants who completed the program shifted their language to address disability from the lens of the social model to disability as a result of environmental and social barriers (Table 5 – 2.1).

Participants recognized that barriers to inclusion resulted primarily from systematic practices led by the community. They began to acknowledge the importance of working in partnership to reflect on changes the community can make to create a more inclusive, welcoming environment rather than expecting persons with disabilities to adapt to the inaccessible structure already in place (Table 5 – 2.1).

Teachers and healthcare workers discussed how they planned to adapt their classroom environment to be more conducive to learners and patients of all abilities. They highlighted these adaptions, incorporating universal design principles in three separate ways. First, they would use perceptible information, such as utilizing contrasting colors and universal symbols for posters and incorporating visual support tools. Second, flexibility would be incorporated by providing students and patients with different options to complete a given task, like simple and intuitive use or simplifying instruction. Third, the size and space of classrooms and office environments would be adapted to create space for people using wheelchairs.

Before participating in the Disability Awareness Training, participants explained that they received minimal training to work with students or patients with disabilities. Those who did receive training, like special educators, received basic training that excluded students with severe intellectual disabilities and autism spectrum disorders. Participants explained that their interaction with the Disability Awareness Training expanded their understanding of intellectual disability and tools that can be implemented in the education and medical setting to improve communication among persons with and without disabilities (i.e., visual schedule boards, choice boards, and picture communication cards). Participants expressed that such tools increased their comfort and self-efficacy when working with people of all abilities. They noted that the most significant self-perceived change in skill-based behavior was their interactions with persons with intellectual disabilities and autism spectrum disorders (Table 5 – 2.2).

The following shifts signal participants' acknowledgment of the need to respect and support community members living with disabilities, highlighting the diversity of their peers in Maunatlala. Moreover, participants began to discuss how they could adapt to the social environment to mitigate disabling features, analyzing their actions instead of focusing exclusively on the individual's impairment. This shift in language from the medical to the social model of disability was coded frequently, indicating a significant change in participants' short-term knowledge regarding inclusion and disability awareness.

ADVOCACY
Upon completion of the Disability Awareness Training, additional group discussions and interviews were conducted to gain participant feedback. Unprompted, participants indicated the desire to use the

information acquired to raise awareness of disability issues further and advocate for improved community inclusion (Table 5 – 3.1). This suggests that information regarding the inclusion of persons with disabilities and the adaptation of resources learned during this Disability Awareness program may have positive impacts that expand beyond the training. Comments from participants post-involvement suggest that this program has the potential to reach not only those directly involved but offers participants the tools and confidence to extend the information to the general community. Participants expanded on their desire to spread awareness by proposing action items, including the implementation of additional workshops and campaigns which focused on topics comprising of the use of appropriate language (i.e., person-first vs. identity-first), acknowledgment of community stereotypes, and accessibility. Participants explained that they are now responsible for further educating the Maunatlala community about inclusion practices and how to better welcome persons with disabilities across all community sectors (Table 5 – 3.1).

In collaboration, participants with and without disabilities expressed the importance of centering experiences of people living with disabilities and their caregivers in the Disability Awareness Training and future advocacy work (Table 5 – 3.2). Participants indicated the desire to mobilize the larger community to increase the sustainability of inclusive practices locally. Participants expressed the importance of mobilization in partnership with community members with disabilities and those without disabilities. People with disabilities and their caretakers were adamant about building working groups in the community to promote awareness of disability issues and to initiate change towards more positive community inclusivity. Such information would be based on the personal experiences of members in these working groups (Table 5 – 3.2).

In supplemental to implementing the Disability Awareness Training, we conducted a focus group discussion with community members living with disabilities and their caregivers. This gathering sparked discussion about the importance surrounding intergroup support, which is the support between people who identify as having a disability and people that do not have a disability. Awareness between these two groups is also vital to developing future inclusive action (Table 5 – 3.3).

Moreover, this discussion highlighted the importance of support within a group sharing a common identity. Participants with disabilities expressed that they often feel defeated, unable to participate in society due to limitations placed upon them by society, stemming primarily from preexisting stigma and stereotypes. However, elders in the village living with disabilities shared their experiences to support youth with disabilities and young caregivers. This decisive moment of shared understanding gave these individuals a sense of community, which we hope to continue to build in the upcoming years (Table 5 – 3.3).

The desire to magnify awareness of disability issues exuded by participants with and without disabilities suggests that this Disability Awareness Training is a multifaceted tool to shift knowledge, attitudes, and beliefs surrounding disability positively. Additionally, this tool may promote intergroup contact, dispelling stigma and associated cultural fear of diverse abilities (Allport, 1954; Pettigrew, 1998; Pettigrew et al., 2007).

Both quantitative and qualitative data suggest that positive shifts in participants' attitudes, knowledge, and skill related to working with individuals with disabilities were reinforced by participation in Disability Awareness Training. As a result of the program, participants self-reported an enhanced understanding of disability issues and inclusion practices and improved skills necessary to work effectively and include persons with varying disabilities in the educational and medical settings.

The Disability Awareness Training aimed to establish a sustainable community-based training program encompassing the knowledge, experiences, history, and culture related to persons with disabilities in Maunatlala, Botswana. Through surveys, in-depth interviews, and focus group discussions, we were able to gather recommendations from the community on how to better the program and increase the inclusion of persons with disabilities in the rural village.

1.   Support the Maunatlala Committee for People Living with Disabilities:

A group discussion with local persons with disabilities, caregivers, and the Women's Group showed the need for an outreach group for people with disabilities and their caregivers. This discussion led to the establishment of a local committee. Thanks to local partnerships made with community members who identify as having a disability, this organization will provide support for caregivers and persons with disabilities. The committee will be a collection of people with disabilities and their allies who plan to work together under a common goal to advocate and raise awareness of disability issues and barriers. Consequently, the voices of people who identify with having a disability will be centered, and local representation and understanding will be increased, overall, increasing integration in the community and access to resources for all abilities. As they grow, this committee must have the Maunatlala community's support and the government Ministries' help. This committee will not only benefit persons experiencing disability but also support people who have experienced gender-based violence and other marginalizing actions within the village.

We propose that this group be actively involved in developing and implementing the Disability Awareness program moving forward. Disability awareness training programs that include positive, quality intergroup contact have proven to promote positive attitudes toward people with disabilities (Giuliano et al., 2019; Magnusson et al., 2017). Implementing this committee of members with disabilities can promote advocacy for disabled community members. Still, it may also lead to more significant long-term changes in the community's attitudes, behaviors, and knowledge regarding disability. Shifts in long-term attitudes towards positive perceptions of disability may lead to increased intention to change behaviors surrounding intergroup interactions. This is supported by Hayward et al. (2021), who explains that intention is influenced by attitude, social norms, and perceived behavior control, which is an antecedent to behavior change and should be considered when developing awareness-type programs. By focusing on attitude and perception changes within this Disability Awareness Training, we may be able to address community behavior change. While current data is representative only of short-term shifts, we anticipate that in supporting this working group, comprised of locals living with disabilities, community members will be more likely to advocate for the rights of persons with disabilities. Such advocacy could signal a long-term shift in community awareness and understanding of disability.

2.   Expand the Disability Awareness Training to surrounding schools and clinics:

The compelling discussion with the Committee for People Living with Disabilities and the Disability Awareness Training implementation led to the suggestion of expanding foundational awareness of disability to others within the rural community. We propose to extend the Disability Awareness Training to other schools and clinics in Maunatlala and surrounding villages. Most participants agreed that a universal lack of awareness caused this disparity in the local perception of disability regarding this population's needs and inaccessible resources. Only those who were well connected in the village and could (personally, socially, and economically) navigate complex governmental systems could learn about

resources available for people with disabilities and the importance of inclusion, which impacted their perceptions and definitions of disability. This highlights the importance of expanding the Disability Awareness Program. By improving the accessibility of such information, the disparity gap between people with disabilities and those without begins to lessen. The spread of misinformation and stigma regarding people living with disabilities can be addressed, allowing the community to tackle issues related to inclusion. Moreover, partnerships with local persons with disabilities will allow us to expand the program and center their voices around the core of the training in the future. Community members encouraged the continuation of the program and its expansion to other rural villages to help increase the inclusion of people with disabilities and combat the preexisting barriers this community faces.

3. Employ a community health worker to work exclusively with persons with disabilities:

After piloting the Disability Awareness Training at the local clinic, participants noted that they would benefit significantly from having a community health worker trained and hired to work specifically with populations of people with disabilities. This role would be vital in assuring proper resources were readily accessible regardless of disability type. Consistently, healthcare workers acknowledged an expectation to provide quality care for this population without adequate training. It is recommended to expand the Disability Awareness Training to all healthcare workers in the clinic and other health posts and establish a permanent position to work directly with people with disabilities. This will ensure that community members of all abilities receive equal access to quality care.

After the implementation of the Disability Awareness Training, we received significant feedback in terms of the delivery and content of the program. The participants suggested bolstering the training by including videos, role-playing, skits, and other interactive activities. An emphasis on group activities, including discussions, also came up in the focus group feedback. As one participant mentioned, "[We] understand best when [we] are in a group discussion, and [we] are engaging." In addition, one healthcare worker mentioned the need for additional policy information and education in medical settings; to both provide further context as to the existing policy for people with disabilities and also to empower healthcare workers to create and change local policy within their clinic. Therefore, to increase inclusive practices beyond training sessions, the researchers will consider this feedback when adjusting the current curriculum to meet community needs better.

We hope to continue the implementation of Disability Awareness Training in Maunatlala, Botswana, by partnering with local community members and persons with disabilities. Further investigation of the program's long-term effects and sustainability is necessary. We hope to maintain these foundational relationships and continue to obtain feedback from local community members on how to include better and bring about awareness of disability.

Table 1. The eight domains of disability awareness training and their key topics

DOMAIN	KEY TOPICS
1. INTRODUCTION	Health and well-being of people with disabilities; the magnitude and relevance of disability; defining disability and how it can be measured; challenges faced by persons with disabilities; disability and social life; disability prevalence and disability awareness (e.g., invisible vs. visible disabilities).
2. INCLUSION AND UNIVERSAL DESIGN	Community-based inclusive development for improving lives of individuals with disabilities; and principles of universal design – equitable use, flexibility of use, simple and intuitive use, perceptible information; tolerance for error; low physical effort; size and space for use.
3. ACCESSIBILITY (PHYSICAL & SOCIAL)	Enabling access to the physical, social, and economic environment; building an accessible physical, social, and economic environment
4. EFFECTIVE COMMUNICATION	The use of person-first language; avoiding negative connotations and assumption; age-appropriate language; and direct communication with individuals with disabilities
5. ETHICAL CONSIDERATIONS	Safeguarding public confidence; promoting principles of self-determination; non-discrimination; promoting progression
6. POLICY	Prevalence of disability in Botswana, the rural community, neighboring communities/region, etc.; assessing existing policies (community, health, education, etc.)
7. ETIQUETTE	Identifying disability-specific characteristics and adapting communication and the environment to meet the individual's needs (e.g., how to present health information to a person with a visual impairment, hearing loss, or developmental disability)
8. BARRIERS & FACILITATORS	Vocational specific examples that can be used to guide behavior and action to ensure facilitators are maximized and barriers are minimized.

Table 2. Demographic characteristics of qualitative FGD and interview participants (N = 43)

I. Demographic characteristics	N (%)
Gender	
Male	16 (37.2%)
Female	27 (62.8%)
Profession	
Community development officer	1 (2.3%)
Educators	7 (16.3%)
Health care workers	11 (25.6%)
Other community members	24 (55.8%)
Self-identified disability status	
Has a disability	9 (20.9%)
Does not have a disability	34 (79.1%)
TOTAL	N = 43

Table 3. Demographic characteristics of pilot program participants (N = 19)

I. Demographic characteristics	N (%)
Gender	
Female	13 (68.4%)
Male	6 (31.6%)
Profession	
Educators	14 (73.7%)
Health care workers	5 (26.3%)
Self-identified disability status	

Has a disability	2 (10.5%)
Does not have a disability	17 (89.5%)
Age of participant (years)	
Mean (SD)	41.1 (10.4)
Median [Min, Max]	44.0 [23.0, 58.0]
Years in profession	
Mean (SD)	14.2 (10.8)
Median [Min, Max]	11.0 [1.0, 35.0]
TOTAL	N = 19

Table 4. Differences Between Participants' Self-Reported Responses After (Post) and Before (Pre) Attending the Disability Awareness Training (N = 19)

Survey Item	After training (post) Mean (SD)	Before Training (Pre) Mean (SD)	Mean Difference (Post-Pre)	Wilcoxon Rank Test (p)
II. Knowledge				
1	4.74 (0.452)	3.26 (1.24)	1.48	0.001*
2	4.68 (0.478)	3.68 (1.06)	1.00	0.002*
3	4.89 (0.315)	3.68 (0.885)	1.21	0.001*
4	4.74 (0.452)	3.37 (1.01)	1.37	0.001*
5	4.58 (0.507)	3.95 (0.848)	0.63	0.003*
6	1.63 (0.955)	3.00 (1.25)	-1.37	0.001*
7	4.79 (0.419)	3.53 (1.22)	1.26	0.002*
8	4.68 (0.582)	3.63 (1.01)	1.05	0.001*
9a	4.32 (0.946)	3.68 (1.20)	0.64	0.025*
9b	4.68 (0.582)	3.26 (1.05)	1.42	0.001*
9c	4.63 (0.597)	3.84 (1.01)	0.79	0.003*
9e	4.68 (0.582)	3.53 (1.22)	1.15	0.002*
9f	4.63 (0.761)	3.74 (0.933)	0.89	0.008*
9g	4.89 (0.315)	3.42 (1.22)	1.47	0.001*
9h	4.84 (0.501)	3.95 (1.08)	0.89	0.005*
III. Skill				
10	4.63 (0.496)	3.32 (1.16)	1.31	0.001*
11	4.58 (0.507)	3.47 (1.07)	1.11	0.000*
12	4.74 (0.452)	3.26 (0.991)	1.48	0.000*

13	4.05 (1.03)	2.89 (1.15)	1.16	0.001*
14	4.89 (0.315)	3.00 (1.20)	1.89	0.000*
15a	4.53 (0.612)	2.68 (1.45)	1.85	0.001*
15b	4.63 (0.496)	2.95 (1.31)	1.68	0.001*
15c	4.63 (0.496)	2.95 (1.31)	1.68	0.000*
15d	4.05 (1.03)	3.11 (1.24)	0.94	0.003*
15e	4.11 (0.937)	2.84 (1.38)	1.27	0.002*
15f	3.84 (0.958)	2.79 (1.27)	1.05	0.002*
15g	3.84 (0.958)	2.47 (1.31)	1.37	0.005*
16	4.74 (0.452)	2.79 (1.23)	1.95	0.000*
17	4.89 (0.459)	3.11 (1.56)	1.78	0.001*
18	4.68 (0.478)	2.95 (1.35)	1.73	0.000*

*Statistically significant at alpha 0.05

Table 5. Participant quotes representative of study themes (N = 43)

Theme	Representative Quote
1) Shift in knowledge-based understanding	
1.1) Proximity to disability influences perception	"I was there for her [sibling with a disability]. So, no one is going to discriminate or stigmatize my sister, no no no no no. Even my other family members have accepted her. It depends on the caretaker. If you allow some other members to stigmatize her or him, then you open a gate for each and every negativity. But if you close this, at the end they accept the child or the sister." [Educator 7] "Before the workshop, I was afraid. I didn't know any [people with disabilities] and was afraid of some of them… I also thought they were not okay. They couldn't think. They couldn't do anything for themselves… We now know how to handle them. Now we are in the position to deal with special students." [Educator 3]
1.2) Acknowledgement of personal bias	"I learned they are right…to know that they [people with disabilities] are humans; they too have rights, they need to be respected, they too have views that need to be respected. They too have emotions. They can get angry, they can get frustrated, they can get impatient. So, they need to be respected and taken into consideration. They are humans. They shouldn't be treated differently from us. I think from here, we'll be able to treat them well. Love them more. Yeah. And respect them." [Health care worker 2]
1.3) Promotion of independence	"I like the fact that it opened my eyes to know the views and emotions of the patient you treat…you cannot assume what they are thinking or that they are ok just because I might not understand the way they talk. Whatever procedure, whatever care that they are receiving, you need to get feedback from them. Get to know how they are feeling. And the results about the care that they are receiving, you need to hear from them…not doing everything because I think its best. And also, just because they are disabled…it doesn't mean that

they are unable. They still can-do things for themselves." [Health care worker 2]

"This workshop has really changed us. We are going to have maybe a positive attitude towards them [people with disabilities] because we interact with them daily, so we are going to have positive attitude. We are not going to discriminate them." [Educator 7]

2) Shift in skill-based behaviors	
2.1) Adapting the environment	"There are… the adaptations to the environment. I learned you cannot modify the person, but you can modify the environment. So that they can suit the person. Maybe the way that they are writing… The environment can be especially divisive. Perhaps you modify the environment to suit those especially that are using the wheelchairs… You cannot change the person. You can only change the environment, that's what I liked most about this program." [Educator 6] "Let me change the environment…to adapt to them rather than expecting them to adapt to us. To, to get help in a system that is rigid. Adjusting to us is not appropriate. We can make changes to the setting to improve accessibility. I now know how." [Health care worker 1]
2.2) Adapting tools and strategies	"It is going to be easier for us to interact with and use these strategies with our students. Strategies like universal design and visual supports. I now feel good about using them in my class." [Educator 4]
3) Advocacy	
1.1) Action to spread awareness	"I will change my attitudes toward the students with disabilities and I will even give up positive information to other community members. I want to help others learn too." [Educator 1] "You see the setup of the village, it's still behind in terms of development… and education about the disabilities… so to see… this workshop, it can help us talk about disabilities and help develop the community understanding." [Educator 2] "As teachers, we have a lot to do. We have to sensitize the community about disability because we find that there are some parents who still look down upon this, learners with disability. They don't have support, so it is hard for them to care and they are treated poorly. They call them names. They believe in curse. They don't love them. So, through this workshop we just have to work very hard in order to sensitize the community so that they accept them, and they are just members like us. We are all members, and we have some disabilities one way or the other." [Educator
1.2) Centering the experiences of people with disabilities	"If we have, maybe, an ambassador or…somebody living with disability as an ambassador. It will motivate others who are disabled too to stand up and have a voice." [Health care worker 2]

"The bottom line is awareness. We can sing, we can jump, we can come up with ideas, but as long as people are not aware of what we are capable of there won't be anything tangible to hold onto. We need to speak our minds and let the community know of our experiences. Inclusion simply means living harmoniously with people with disabilities, people without disabilities in one place, one community, one love… Through awareness anything is possible, but without awareness nothing will be achieved. We can actually break all of the barriers that people living with a disability are experiencing. Through awareness they can stop abusing him. They can stop abusing her….They can stop discriminating us. They can stop name calling us. Just through awareness we can break everything. My experience can help start change." [Community member 10]

1.3)	Intergroup support	"We can include them [people with disabilities] in games, engage them, let them play outside. Children alone, let them play outside. Let them understand with him having a disability doesn't mean that he can't play with other kids. They can throw to him while he sits in the wheelchair. Include him in that play and engage him in the conversation. Make them [people with disabilities] aware that we [people without disabilities] value them. We can better understand them, just through awareness we can actually live." [Community member 9] "An individual [with a disability] must be very perseverant, be very bold. If you are not, you will not make it. I was bold enough to say I will go far, despite the fact that physically I have troubles… and here I am right now. I made it. I just want everyone to realize that you can make it. Also encourage other people with disabilities to do something to. Tell them you are doing it your own way and that you are not different from any other. Your own way is just as good as any other way. I know it's not easy, but we can make it together." [Community member 19]

SECTION II: SEXUAL AND REPRODUCTIVE HEALTH (SRH) – DIVYA REDDY

INTRODUCTION

Globally, youth between the ages of 13 to 18 years old are highly vulnerable to adverse sexual and reproductive health (SRH) outcomes. These adverse health outcomes are unintended pregnancies, maternal morbidity and mortality, gender-based violence (GBV), and sexually transmitted infections (STIs), including HIV/AIDS (UNFPA, 2016; Morris & Rushwan, 2015). Botswana has a population of 2.3 million people. It has an HIV prevalence of 20.3%, the fourth highest globally, despite providing universal free antiretroviral treatment (ART) for people living with HIV (WHO, 2019; UNFPA, 2008). Botswana's youth face a lack of access to knowledge about SRH issues. Literature provides numerous cases of comprehensive SRH knowledge; that is, comprehensive SRH moves youth from a state of vulnerability to a state of empowerment that helps promote an STI-free generation and improve their overall health (Morris & Rushwan, 2015; Barchi et al., 2021). Comprehensive SRH education would be an effective strategy to empower youth by providing scientifically accurate and realistic information. Youth present an optimum point for comprehensive SRH education to ensure their well-being, reverse the HIV/AIDS epidemic, and improve general health and well-being.

Studies have shown a strong association between the caregiver's communication with the adolescent about the SRH topics and the adolescent's attitude and behavior towards delayed sexual debut, using condoms/other contraceptives, having fewer partners, and their ability to discuss SRH topics with their partners (Duby et al., 2022; Eshete & Shewasinad, 2020; Wudineh et al., 2021). However, due to cultural and social barriers, a gap has always been seen in the caregivers' open conversation with their adolescents (Mbachu et al., 2020; Wudineh et al., 2021). It was found that providing better SRH knowledge to the caregivers can initiate an open conversation between caregivers and their adolescents, hence supporting them in making better SRH-related decisions (Wudineh et al., 2021; Ewnetu et al., 2021; Eshete & Shewasinad, 2020b).

Based on our engagement with the key stakeholders in 2019, we narrowed the community's requirements to three major themes: knowledge about SRH topics and issues, gender-based violence knowledge, and social issues related to intimate relationships (Khanna, 2019). The student researcher developed two separate curricula focusing on these themes, including the adolescents (13-17 years) and their caregivers (18+; this category included their parents, grandparents, or legal guardians). While developing the SRH curriculum, the student researcher considered including the cultural and social aspects to help better understand and provide more relevance to the participants.

METHODS:

We expanded upon our efforts from the 2019 summer to introduce the sexual and reproductive health education programs at the Masupe Primary School. A separate curriculum was taught to adolescents between 13-17 years of age and their caregivers at different times. Finally, both groups were brought together for the final session to observe the understanding of the curriculum and to establish rules between the caregiver-adolescent dyad for maintaining healthier and open communication about different SRH topics. The caregivers were asked to provide consent for the adolescent's participation. The caregivers who returned unsigned documents or opted out of the sessions were excluded. For pilot testing of the SRH curriculum, we received consent from 29 adolescents. Eight caregivers participated in the pilot study. However, only 5 participants completed the study.
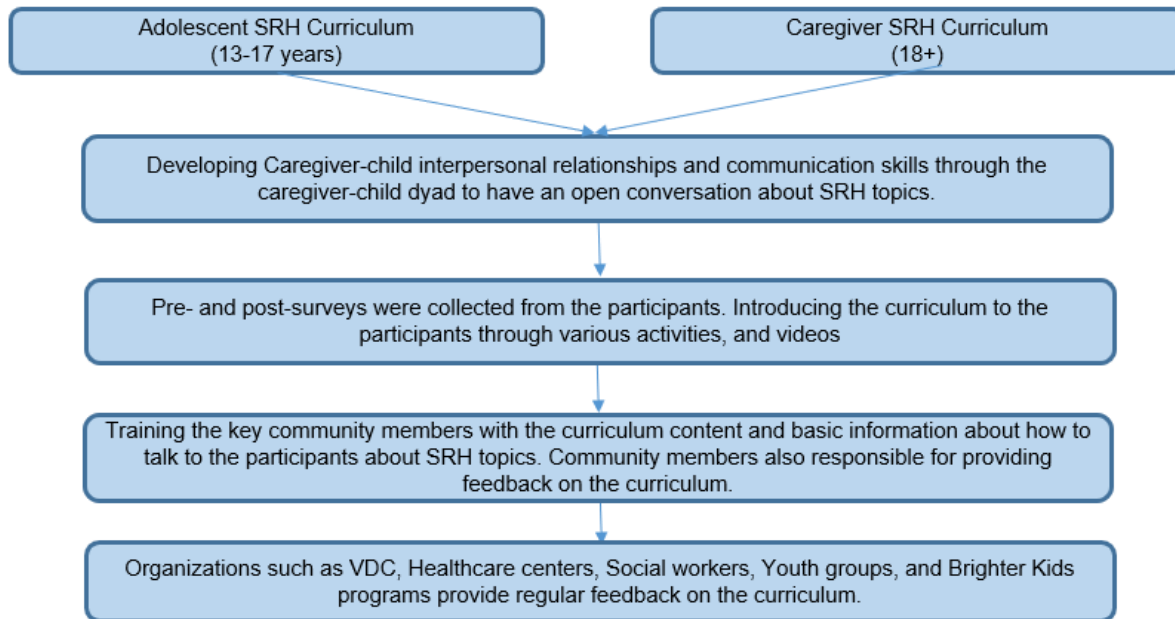
Figure 1: SRH Education Program

A mixed-methods approach was incorporated for data collection. For the qualitative data collection, the curriculum was presented to the key stakeholders in the community-clinic nurses, women's groups, home-based care groups, social workers, and youth group members. These interviews provided information about the communication barriers that led to the lack of communication between caregivers, schools, and adolescents. In addition, the groups were interviewed to provide feedback on the content quality, the sessions' length, and understanding of the language used in the planned activities, videos, and props used for the session. The feedback received will be used to make changes in the curriculum before implementing it with a larger group of participants.

For the quantitative data collection, the participants were given a paper-based questionnaire before and immediately after the SRH curriculum implementation. The questions for the adolescent-based questionnaire were acquired from the WHO's Illustrative Questionnaire for Interview survey. The survey is divided into subsections: sexual health norms, sexual health knowledge, understanding, STI awareness, and source of SRH information.

For the caregiver session, a questionnaire based on the Parent-Adolescent Relationship Survey (PARS) was developed, using questions related to the caregiver-adolescent relationship quality, the caregiver monitoring scale, and caregiver-adolescent sexual communication. This questionnaire has been previously utilized to check the relationship between caregiver interaction and the adolescent's risk of getting exposed to HIV sexually transmitted infections (STIs) in Botswana (C. Sun et al., 2020).

A paper-based survey was delivered in English, and a translator was available for the questions the participants needed help understanding. All identifiers were removed, and each participant was assigned a code. The data was entered in Excel manually, and missing data was provided a value "0". The data was checked and analyzed using RStudio.

QUALITATIVE ANALYSIS

While conducting the FGDs with various groups in the community, most groups emphasized caregivers having stronger interpersonal and communication skills to provide better knowledge to their children. Specific barriers were identified that limited conversation between the caregiver and the children, between the caregivers and the schools, and between the health care professional and the adolescents.

One of the caregivers said that even if they wanted to talk to their children about SRH topics, their adolescents were not interested in discussing these topics with their caregiver:

"So sometimes the parents try to talk to the kids or the youth, they turn out to be not understanding or not listening to what the caregiver is trying to protect them from. So, they choose to go their way than listen to their caregivers."

Another caregiver thought that since the children are getting SRH information at school, they believe that they know more than what their caregivers want to tell them:

"These kids, when they are just 4,5,6,7, they are being taught about menstrual health hygiene, and they will be taught that once you reach the stage if you meet with a man or a boy, a high chance of you to conceive a child. And after they have been taught this, now they think that they know more than the caregivers."

Culture also plays a vital role in creating a barrier between the caregiver and their children, as it is thought inappropriate for a father to talk about SRH topics to his daughter. In the absence of the mother, the father feels awkward talking to his daughter:

"Maybe, there will be a single-parent family, where is a father and there are kids, but his kids mostly are daughters. And in our culture, it is difficult for me as a father to address issues of SRH with my daughter. So, they need to be taught how to handle those issues as a man while they have a single parent, and that parent is a man, and he is raising kids of young females in his family. And also, if a mother is raising his sons without a father, some of the issues the mother will not discuss with his sons."

While discussing the curriculum with the clinic nurse, the adolescents do not visit the clinic for SRH consultation or testing. Most adolescents get screened for STIs during their regular visits to the clinic, and the treatment is provided after that. The school provided SRH sessions by the health care workers to occur only once a year to the graduating students. Hence other students are deprived of the information before they become sexually active:

"But we go there rarely, sometimes when the schools are closing just to go and give them some health education even when the school, even when some of them are graduating like the primary schools that are graduating to junior secondary schools and those graduating from the junior secondary schools to the senior secondary schools, we go there and talk to them about those SRH issues."

The government provided a school-based comprehensive SRH curriculum to the healthcare workers that was implemented regularly. However, this program was discontinued from the schools; since then, none of the programs developed by the clinic staff were adequate for the school students:

"I don't have, we used to have a program two years ago, but now we don't have any program."

The qualitative data provided information about the lack of an SRH program in the community, resulting in reduced knowledge and attitude towards SRH knowledge and increased indulgence in risky sexual behavior. Key stakeholders provided a better understanding of the community's cultural context, the healthcare workers working with the limited resources available to them, and the caregivers unable to have an open conversation with their children due to a lack of knowledge and cultural barriers. During the curriculum feedback sessions, the community stakeholders provided the research team with effective feedback to help provide an effective SRH curriculum to the community members and their children.

QUANTITATIVE ANALYSIS:

The SRH program was implemented with 29 adolescent participants and eight caregivers over four days. A total of 5 caregiver-adolescent dyads participated in the caregiver-adolescent session. Slightly more than three-fourths (75.9%) of the adolescent participants lived with their parents (both or either of the parents). On average, 44.8% of the participants lived with both their parents, while the remaining 31% lived with either of their parents. It was found that 31% of the adolescent participants lived with their grandparents, and 3.4% lived with a legal caregiver. The average of the adolescents was 13.5 years; 93.1% of the participants were between the ages of 13-15 years, and the remainder 6.9% were between the ages of 16-18. 79.3% of the participants claimed to have previous SRH education at school, while the remaining 20.7% did not have any SRH education.

The average age of the caregiver was 33.1 years. Most of the caregivers are unemployed, though the source of income was not mentioned. All the caregivers care for multiple biological and relatives' children. All the caregivers were females, identified as heterosexual, unmarried with/without partners. The caregiver pilot testing started with eight participants. Two caregivers were lost to follow-up; one of the participants was the niece of the participant enrolled in the pre-survey. Hence, post-curriculum data could be collected from only five of the participants.

ADOLESCENT DATA ANALYSIS:

A satisfactory amount of change was seen in the post-survey compared to the pre-survey in the adolescent session. The general changes in the participants were their perspective on sexual health norms, their sexual health knowledge, and their perspectives on teenage pregnancies, peer pressure, and practicing safer sex. The adolescent's belief in having multiple partners reduced significantly from 90% pre-survey to 78% post-survey. Additionally, boys responsible for deciding whether to use a condom during sexual intercourse reduced from 97% to 86%, i.e., the participants accepted that it is both males' and females' responsibility to decide to have safer sexual intercourse. The adolescents also agreed that unsafe abortions lead to maternal mortality. However, there was not much change in the participant's perspective about the questions related to the physical, mental, and emotional changes during puberty. We also found a higher level of change in SRH knowledge and attitude among males than females.

CAREGIVER DATA ANALYSIS:

The overall results from the survey showed a positive change in the caregivers' knowledge and attitude levels. However, the percentage of caregivers who believed in having multiple sexual partners increased from 62% to 100%. Most parents also believed that men should be the primary decision-makers in the

family. 60% of the caregivers thought that there was nothing wrong with adolescents having sex if both agreed to it. On the other hand, the number of caregivers who believed in using condoms for safer sexual practices increased from 62% to 80%. Most parents thought talking to their children about the SRH issues would help them indulge less in risky sexual behaviors.

RECOMMENDATIONS

Recommendations:

1. Qualitative data:

It was evident from the interviews with the community stakeholders that an SRH curriculum is required for the adolescents at school that help them get the proper knowledge and protect themselves from STIs and HIV/AIDS. Based on the feedback from the community stakeholders, the curriculum length will be reduced to 2 sessions from the current four sessions. The videos will include subtitles for a better understanding of the adolescents. Instead of providing information through PowerPoint presentations, the adolescents and the caregivers will also be provided a copy of the curriculum to allow the participants to go through the curriculum more often.

2. During the session:

The sessions were conducted in English with a translator available during the session, who was responsible for translating the section that the participants needed help understanding. However, having the curriculum and questionnaires in simplified language and being translated into Setswana would be helpful for the future implementation of the program to the community members. Providing the participants with a copy of the curriculum, which contains content in both English and Setswana, beforehand would be helpful. This would allow the participants to go through the content before the session and understand more during the session the examples and videos shown by the researcher.

3. Curriculum Content:

The curriculum contains videos, activities, and other props to make the participant better understand the content. However, the videos were available to the participants in English. Adding subtitles for all the videos would be helpful. Also, adding more interactive activities would provide a better understanding to the younger participants.

4. Duration of the curriculum:

The curriculum at the Masupe Primary School was conducted over five days. Even though the school did an excellent job of providing the research team with the time to complete the session during school hours, it took much work for the students to be seated for so long and listen to the session. Hence, reducing the time the participants spend during the session by developing a self-learning module would help the participants learn by themselves at their own pace.

5. Caregiver curriculum:

The SRH sessions for the adolescents and the caregivers were conducted during school hours. Most caregivers could not attend these sessions due to their job commitments. This led to low enrollment of caregivers. The involvement of more caregivers would have provided better information on how the

caregiver curriculum could be modified for better results. The caregiver's session had 100% female participants enrolled. Having the male participants enroll for this session would have provided information on whether the curriculum worked similarly with the male caregivers. Hence implementing the caregiver session during the evening, if possible, at the library could increase caregiver enrollment.

6. Caregiver enrollment:

The consent form was sent to the caregivers beforehand to get their approval for their and their child's participation in the sessions. However, most caregivers have a traveling job, live in a different city, and care for multiple children. This also reduces the enrollment of caregivers for the session. Providing an itinerary of the program beforehand would help the caregivers in better planning to attend the sessions. The help of the community's key stakeholders to spread the word about the program early would be helpful.

7. The appropriate time for implementation:

The pilot testing of the program was conducted during the month of July. In Botswana, during this time, the students have midterms followed by winter break. This hindered running the program since the school needed more time for the researchers to conduct the session. Conducting the program during regular school hours other than before winter and summer breaks would be beneficial.

SECTION III: PREVENTING GENDER-BASED VIOLENCE – MIKALA KOWAL

INTRODUCTION

Gender-Based Violence (GBV) is a significant public health problem and a violation of human rights, often stemming from gender inequality, abuse of power, and harmful norms (Gender-Based Violence, 2021). Gender inequality and sociocultural factors, especially around employment and income, increase the risk of GBV (Keller et al., 2017). Experiencing GBV can result in critical and lifelong health consequences, including poor school attendance and achievement, poor physical and mental health, poor self-esteem, as well as increased risk for chronic pain, physical disability, drug and alcohol abuse, depression, and issues with employment and lifetime productivity (Ellsberg & Heise, 2005; Keller et al., 2017).

Gender-Based Violence (GBV) is endemic in Botswana, with around 67% of women experiencing this violation of human rights (Violence against Women and Girls (VAWG) Helpdesk, 2019). Known as an issue masked by a culture of silence, this number is likely an underrepresentation of the population experiencing GBV. Under-reporting is expected due to cultural constructions of gender that include gender roles, stigma, and a lack of access to resources and support.

Considered an intergenerational cycle of abuse, experiencing or witnessing abuse as a child is associated with future experiences and perpetrations of GBV as an adult. A harrowing statistic found that 56% of women GBV survivors and 26% of male GBV perpetrators reported witnessing their mothers being abused (Violence against Women and Girls (VAWG) Helpdesk, 2019). In Botswana, 88% of women and 66% of men reported being abused as children. Due to the intersecting nature of GBV between men/boys, women/girls, and families, a program must be developed addressing GBV for children, parents and caregivers, and the community. These programs must address the knowledge, attitudes, and social norms resulting in GBV. Teaching communities to be proactive when witnessing GBV behaviors could increase comfort with intervening with GBV and reduce apathetic and tolerant views (Keller et al., 2017). Women and girls will benefit from empowerment by protecting themselves, raising awareness, and learning to identify risks and discover solutions (Jordan River Foundation et al., 2020). Social and cultural norms that focus on the roles of men and women and their relationships must be addressed.

Therefore, a GBV prevention/education program must address the attitudes, norms, and behaviors associated with GBV through school and community education. This project aimed to pilot test and evaluate a GBV prevention/education program for adolescents and their caregivers. This GBV prevention/education program had the following aims 1) end violence, 2) empower women and girls, and 3) promote equitable, respectful relationships and communication skills.

METHODS

Mixed methods were used to assess changes in gender attitudes and beliefs, knowledge, and perceptions of GBV from adolescents and caregivers through a pilot test of a GBV knowledge and prevention program. Workbooks and activities were adapted from existing programs, including UNESCO's Connect with Respect program and programs made by The African Population and Health Research Center (APHRC), The World Health Organization (WHO), and International Women and Children's Health (IWCH). In addition to the GBV prevention/education program, in-depth interviews

and focus groups were held with several community stakeholders to understand 1) the cultural underpinnings of intimate partner violence in Maunatlala, 2) the resources available to individuals who experience or perpetrate GBV and 3) how the GBV is perceived in the community.

PARTICIPANTS

For this study, caregivers are defined as parents, aunts/uncles, grandparents, or any person who gives primary direct care to a child. Twenty-nine adolescents enrolled in standard 7 participated in person for the pilot GBV knowledge and prevention program. School administrators allowed us to work with this specific class because they met the following inclusion criteria 1) the adolescent is 13 years of age or older, 2) the adolescent has a free period where they are not taking exams, and 3) the adolescent has a caregiver living in Maunatlala. Convenience sampling was used because the standard 7 class were the only adolescents to meet these criteria. Adolescent participants' ages ranged from 13 – 16 years old. Of these participants, 55% were male and 45% female. Eight female caregivers were present at the start of the program. However, caregivers expressed discomfort working through the content as a group and could take their workbooks home to work independently. Loss to follow-up resulted in only four caregivers remaining, one of which was the niece of one of the initial 8 participants. This participant was allowed to stay in the study as she had an adolescent enrolled in the program and independently completed the GBV workbook.

Twenty-five adolescents enrolled in forms 1 and 2 participated in an at-home option of the pilot GBV knowledge and prevention program. School administrators randomly selected these participants from forms 1 and 2 with the inclusion criteria of 1) the adolescent is over 13, and 2) the adolescent has a caregiver living in Maunatlala. The at-home option tested the feasibility of a program where adolescents and their caregivers are given the workbooks to complete at their own pace with a deadline to discuss answers in the workbook and evaluate the workbook content. Adolescent participants' ages ranged from 13 – 17 years old. Of these participants, 21% were male and 79% female. Seven caregivers, which included one male caregiver, were also given workbooks. Caregivers were told they might complete the workbooks independently, with each other/friends, or with their children.

In addition to pilot testing the GBV education and prevention program, 32 individuals participated in stakeholder interviews and focus group discussions. Participants included individuals involved in healthcare, social work, education, caregivers, and women who have previously experienced GBV. The purpose of these interviews and focus groups was to understand GBV in the community, how it is perceived, and how reported cases of GBV are handled. Information on the referral system and the acceptability of this system was also assessed. Individuals who participated in stakeholder interviews and focus groups were also introduced to the program and its content. Input on the feasibility and scope of the program was gained and thus will be used to improve the program for further use.

DATA COLLECTION AND ANALYSIS

From June – August 2022, data was collected using mixed methods. Pre- and post-test surveys were completed by participants to analyze the school climate (adolescents only), changes in gender attitudes and beliefs, as well as GBV knowledge. Responses for assessing school climate as well as gender attitudes and beliefs were scored on a 5-point Likert scale, using the ranges "never" to "always" for school climate questions and "strongly disagree" to "strongly agree" for gender attitudes and beliefs. Percent distribution for responses was analyzed, and the difference between changes in responses pre- and post-test were analyzed. GBV knowledge assessments were given as a single-answer multiple choice

quiz, answering options A through D or T/F. The percentage of students who responded correctly pre- and post-program were analyzed to determine knowledge gained from the program.

Semi-structured stakeholder interviews and focus groups were conducted using prepared interview guides to understand GBV in the community, the referral system, and how various community members and stakeholders view GBV and the referral system. Before interviews and focus groups, informed consent was read to participants. Interviews and focus groups were recorded after obtaining verbal consent from all participants. All interviews and focus groups were transcribed verbatim, with participant observation notes recorded. Transcripts were then coded for thematic analysis.

RESULTS

IN-PERSON PILOT

Of the 29 original participants for the in-person session, 24 students completed a pre-and post-test survey (83% response rate). The portion of the survey assessing the school climate indicates that students feel that relationships between students could be improved, with about 33% of the students responding that "students treat each other well" rarely or never. Around 50% of students reported that they are sometimes or constantly worried about students hurting them. Students also indicated that 41.35% rarely report incidents of sexual harassment or violence, and 58.62% of students reported that violence is always a problem. However, students generally view teachers as good resources if they are experiencing issues since 65.52% of students indicated that teachers always listen when students have problems, and 51.72% indicated that teachers/school officials always act if violence is reported. In general, students responded positively about their experiences in school, suggesting that they are always happy to be at school and that students usually feel comfortable when attending school (62.09% and 65.52%, respectively). (See Table 1).

The portion of the survey assessing gender attitudes and beliefs resulted in some positive shifts in beliefs. Overall, 13 out of 27 prompts showed positive changes in gender attitudes (see Table 2). The four prompts showing the most difference are "A mother should tolerate violence from the father" (strongly disagree/disagree pre – 44.82%, strongly disagree/disagree post – 76%), "It is acceptable for a girl to act or dress more like a boy" (strongly agree/agree pre – 6.9%, strongly agree/agree post – 40%), "It is acceptable for a woman to disagree with her husband" (strongly agree/agree pre – 24.14%, strongly agree/agree post – 52%), and "If a boy and a girl have been intimate, then it is okay for a boy to force a girl to have sex even if she wants him to stop" (strongly disagree/disagree pre – 43.59%, strongly disagree/disagree post – 75%). Interestingly, a positive shift was found in the gender attitude of "It is acceptable for a girl to act or dress more like a boy" (strongly agree/agree pre – 6.9%, strongly agree/agree post – 40%). However, a negative shift was found in the gender attitude that "It is acceptable for a boy to act or dress more like a girl" (strongly agree/agree pre – 6.9%, strongly agree/agree post – 40%), and that "Boys sometimes deserve to be hit by the girls they are dating" (strongly agree/agree pre – 13.8%, strongly agree/agree on post – 29.16%). This could be due to an emphasis on women's and girls' empowerment in the workbook and sessions, indicating that adaptations of the program must stress equity and include more examples of female-to-male GBV scenarios. The knowledge assessment slightly increased participants' knowledge of all questions (see Table 3).

Caregivers showed positive shifts in 5 out of 27 prompts for gender attitudes and beliefs (see Table 4). However, the small sample size and changes in attendance are a limitation of this data and may not

apply to the larger population of caregivers in this community. More significant shifts in gender attitudes included the prompts "It is acceptable for a woman to disagree with her husband" (strongly agree/agree pre – 12.50%, strongly agree/agree post – 75%) and "Girls should continue in school even if they get pregnant" (strongly agree/agree pre – 75%, strongly agree/agree post – 100%). Caregivers showed negative shifts in gender attitudes and beliefs, with 12.50% responding that they strongly agree that girls deserve to be hit by the boys they are dating, 50% agreeing with this statement post-test, as well as 25% indicating that they strongly agree that it is acceptable for a girl to hit her boyfriend who was 0% pre-test. This may be due to shifts in attendance of caregivers pre-and post-test.

Additionally, the knowledge assessment for caregivers showed improvement in all but two prompts (see Table 5). Caregivers had particular difficulty answering what gender is both pre-and post-test, with no caregivers answering correctly. The four caregivers that remained for the entirety of the program expressed excitement over the project and a desire to move forward and potentially deliver the program to other caregivers in the future. Caregivers were also frustrated that more caregivers did not attend the sessions, as they viewed this as necessary for all caregivers.

TAKE-HOME PILOT

The school climate assessment identified threatening and name calling (always - 52%), fights between students (sometimes - 44%, always 48%), and violence being a problem (always 84%) as issues occurring at school. Gender differences appear to be associated with the issues listed above, as students reported that boys and girls are not often friendly to each other (rarely – 25%, never – 20.93%). However, students indicated that they typically like school (sometimes – 24%, always – 64%) and are happy to be there (sometimes – 20%, always – 56%). Students also denoted that school officials and teachers often act when students report violence (always – 76%), report problems (sometimes – 28%, always – 60%), and when students hurt other students (sometimes – 16%, always – 76%) Climates between schools were fairly similar. However, violence and negative student interactions were slightly higher in this school (See Table 6).

Assessing gender attitudes and beliefs did not show significant shifts like the in-person pilot did, likely due to few students finishing the workbook on time. However, three positive changes in attitudes were still observed, including: "Girls should continue in school even if they get pregnant" (strongly agree/agree pre – 40.91%, strongly agree/agree on post – 52%), it is acceptable for boys and men to make sexual comments to girls at school/when walking to school" (strongly disagree pre – 69.57%, strongly disagree post – 73.91%), and "it is acceptable for a boy to hit his girlfriend (strongly disagree/disagree pre – 6.9%, strongly agree/agree post – 40%). Responses for "it is acceptable for a boy to hit his girlfriend had 41.67% of students strongly disagree pre-test, while 69.57% strongly disagreed post-test. Similarly, to the in-person pilot test, these students had a negative shift in attitudes towards the inverse of girls hitting boyfriends, with 4.17% of students agreeing that it is acceptable for a girl to hit their boyfriend, and post-test 21.74% of students agreeing (see Table 7).

The most noticeable change in students who participated in the take-home pilot was their knowledge assessment, showing an increase in knowledge in all but two questions (see Table 8). Twice the number of students answered correctly what biological sex is (44.83% correctly answered pre-test, 88.33% correct post-test). Additionally, students showed an increased ability to accurately identify and distinguish between physical, verbal, sexual, and psychological GBV (see Table 8).

Data is still being collected for the caregivers of this segment of the pilot test. Therefore, only pre-test data will be analyzed in this section. Similar to the in-person pilot, caregivers were more accepting of

girls acting/dressing like boys but less accepting of boys acting/dressing like girls (57.14% and 14.29% agreed, respectively). Most caregivers felt women should not disagree with their husbands (33.33% strongly disagree, and 33.33% disagree). Additionally, 42.86% of caregivers indicated that mothers should tolerate violence from their spouses, 28.57% indicated they agreed that boys and men making sexual comments to girls at school/on their way to school was acceptable, and 28.57% agreed that only men should work for pay (see table 9). Interestingly, caregivers in this segment scored significantly higher on almost all knowledge assessment questions, even though their attitudes were similar to those in the other part of the study (see Tables 10 and 5).

QUALITATIVE RESULTS:

Analysis of interviews and focus group transcripts resulted in four themes: 1) resources for people experiencing GBV, 2) Cultural norms related to GBV, 3) causes of GBV, and 4) community-identified solutions to GBV. All participants in interviews and focus groups showed interest in a GBV education and promotion program and expressed the importance of such a program. Respondents had high variability in the age group that individuals should first receive such a program (ages 8 – 19), the concern over the lack of male community members who would be involved, and the lack of information on male experiences of GBV.

RESOURCES FOR PEOPLE EXPERIENCING GBV

Participants were asked to discuss the referral system which exists in the community. Stakeholders and community members outlined specific challenges to this system. Stakeholders discussed how individuals wanting to report GBV would often withdraw cases due to "fear," "solving matters on their own," or the perpetrator apologizing. Additionally, victims were described as "disappointed" officials when they did not follow the steps necessary for reporting. Officials also claimed that community members would request that officials talk to their abusers but refuse to open an official case. Community members discussed how the referral system is a "long process" and "tiring" yet "necessary." Participants believed counseling must also extend to the perpetrators who may not get counseling in jail and the family members who may have witnessed the abuse.

CULTURAL NORMS RELATED TO GBV

Participants repeatedly noted a culture of silence for those experiencing GBV in the community. Several interviewees said that individuals would keep their experiences of GBV a secret, and depending on situations of support, individuals may be encouraged by others not to report or discuss the abuse ("say nothing to him because he is a man"). If men are the victims of abuse, they will be "ashamed" to report and called names like "coward" and "lazy" for saying such things. Participants described instances of othering for those who have experienced GBV: "People look at you as someone else" they will tell men experiencing GBV, "You don't act like a person." These interactions and experiences promote non-disclosure of GBV, even when individuals can report the abuse at places like the health clinic. Several participants were aware of the intergenerational cycle of abuse that GBV perpetuates, noting that "…others will believe that GBV is not good, but others believe it's nothing because they have seen what their parents have been through."

CAUSES OF GBV IN THE COMMUNITY

Participants described confusion between the line of "exercising authority and being abusive" as one of

the causes of GBV, in addition to a barrier for reporting. Other community-identified causes for GBV included a lack of education and economic opportunities for women, leaving them to rely on men for support. This also affects their children, who can then be easily "lured" into situations of abuse by a small amount of money for essentials they cannot purchase otherwise. Many participants noted that drinking, a lack of education, having a disability, power dynamics, and lack of decision-making authority in relationships can all lead to increased cases of GBV.

COMMUNITY-IDENTIFIED SOLUTIONS TO GBV

Several participants, during interviews, identified solutions they believed would help the community. These solutions included 1) community-wide education on the issues of GBV and the common causes/triggers, 2) an active group educating on GBV issues and providing resources, 3) increasing parent involvement in children's school and caretaking skills/abilities, 4) a shelter for old age women, individuals experiencing GBV, and orphaned children that will provide individuals with counseling and other resources.

RECOMMENDATIONS

Based on the mixed-methods data collected from June – August 2022 in Maunatlala on GBV in the community, we propose the following recommendations to reduce GBV in this community.

1. Widespread public awareness of the differences between preexposure prophylaxis (PrEP) and postexposure prophylaxis (PEP).

Caregivers in our program indicated confusion over the differences between PEP and PrEP. These participants were in the 30-40-year-old age range, which is considered high risk for HIV infections in Botswana (UNICEF, 2022). Our participants were aware of PEP as an option for women who have experienced rape. However, the women we interviewed were unaware of PrEP as an option for protection against HIV/AIDS. Once these women understood the difference between the medications, half said they would go to the health clinic the following day to obtain the medication, and the other half indicated that this type of medication would "promote prostitution." Effective informative campaigns on a highly effective preventative measure readily available in the local health clinics could significantly reduce HIV prevalence, not just in Maunatlala but throughout Botswana. This awareness should include the benefits and effectiveness of PrEP and dispel misinformation about the medication, including the promotion of prostitution.

2. Support the Maunatlala Women's Group shelter.

The Women's group in Maunatlala has purchased a plot of land and plans to build a shelter for the elderly, individuals experiencing GBV, and orphans. The goal of this shelter is to provide a home for individuals in need and counseling services. As the shelter develops, the women's group plans to work with the social worker to counsel the individuals staying there. However, many of the women are also interested in offering counseling services to others and have expressed interest in being trained in offering counseling to others. Providing these women with grant funding to build their shelters and initial and ongoing training on how to counsel, refer, and provide other services to the elderly, individuals experiencing GBV, and orphans could greatly benefit the community. This could provide additional services to the community while reducing some of the burden on the social worker who oversees several villages, including Maunatlala.

3. Improve the referral system to increase reporting and support individuals through a trauma-informed approach.

Community members indicated that the referral system makes individuals feel as though they are passed from person to person while repeating the events of what happened several times. A trauma-informed approach would involve interviews being conducted in a way that assists survivors in retrieving information from their experiences. Survivors should never be blamed for the situations they describe, nor should they be required to make the same complaint multiple times. No matter where the person who experienced GBV reports, the person taking the report should take detailed notes to be shared with other necessary personnel for the person's case (social worker, police officer, healthcare worker). Professionals involved with the referral system should be trained in interviewing techniques that promote individualized approaches to each case. Train interviewers on active listening, allowing interviewees to tell their stories uninterrupted without preconceived notions of the individuals involved (DiBenedetto, 2022). This may be particularly difficult for officials living in rural villages like Maunatlala, where most community members know each other well. Lastly, male experiences of GBV should be normalized, and reporting should be encouraged for both men and women. Community members should be encouraged to make complete reports of their experiences of GBV and be discouraged from withdrawing cases.

Table 1: Adolescent Participants' Perceptions of School Climate (In-Person Pilot)

Survey Item:	Proportion of student responses (%)				
School Climate	Never	Rarely	Not sure	Sometimes	Always
1	24.14	10.34	0	44.83	20.68
2	3.45	20.69	0	34.48	41.38
3	0	3.45	0	20.69	75.86
4	3.45	10.35	3.45	41.38	41.38
5	20.69	24.14	0	20.69	17.24
6	34.48	27.59	0	20.69	17.24
7	13.79	6.90	10.34	17.24	51.72
8	6.90	3.45	6.90	17.24	65.52
9	17.24	6.90	24.14	10.34	41.38
10	0	13.79	0	13.79	72.41
11	3.45	10.34	3.45	17.24	65.52
12	6.90	24.14	3.45	3.45	62.09
13	41.38	6.90	13.79	10.34	27.59
14	6.90	3.45	6.90	34.48	48.28
15	31.03	17.24	24.14	17.24	10.34
16	3.45	34.48	13.79	24.14	24.14
17	3.45	10.34	24.14	3.45	58.62
18	20.69	10.34	31.03	37.93	0
19	17.24	17.24	6.90	41.38	17.24
20	3.45	20.69	3.45	6.90	65.52
21	20.69	13.79	17.24	20.69	27.59

Table 2: Differences in Adolescent Participants' Gender Attitudes and Beliefs Before and After attending the GBV Program (In Person Pilot).

Survey Item	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	post
	Strongly Disagree	Strongly Disagree	Disagree	Disagree	Don't know/ NA	Don't know/N A	Agree	Agree	Strongly Agree	Strongly Agree
1. Only men should work for pay	34.48	20.00	41.38	32.00	10.34	16.00	10.24	24	3.44	8.00
2. Girls are smarter than boys	24.14	4.00	24.14	28.00	31.03	24.00	13.79	32.00	6.90	12.00
3. Boys are smarter than girls	24.14	8.00	24.14	32.00	20.69	40.00	24.14	16.00	6.90	4.00
4. A mother should tolerate violence from the father	20.69	36.00	24.13	40.00	34.38	12.00	0.00	8.00	20.69	4.00
5. Boys who act like girls deserve to be called names	27.59	24.00	20.69	16.00	13.79	24.00	34.48	24.00	3.45	12.00
6. It is acceptable for a girl to act or dress more like a boy	41.38	24.00	24.14	20.00	27.59	16.00	3.45	20.00	3.45	20.00
10. It is acceptable for a boy to act or dress more like a girl	27.59	24.00	24.14	36.00	24.14	32.00	17.24	4.00	6.90	4.00
7. It is more important for boys than girls to perform well in school	13.79	8.00	48.28	56.00	13.79	24.00	17.24	8.00	6.90	4.00
8. It is acceptable for a woman to disagree with her husband	17.24	16.00	27.59	12.00	31.03	20.00	20.69	36.00	3.45	16.00
9. Girls should continue in school even if they get pregnant	24.14	24.00	17.24	40.00	44.83	20.00	10.34	12.00	3.45	4.00

11. Boys are better at mathematics and science than girls	6.90	28.00	31.03	16.00	41.39	28.00	13.79	12.00	6.90	16.00
12. Girls are better at mathematics and science than boys	10.34	12.00	37.93	36.00	27.59	24.00	10.34	20.00	13.79	8.00
13. It is better for girls to be quiet and shy	20.69	16.67	27.59	33.33	20.69	12.50	20.69	20.83	10.34	16.67
14. It is acceptable for boys to cry	20.69	8.33	37.93	3.33	10.34	8.33	17.24	37.50	13.79	12.50
15. It is acceptable for boys and men to make sexual comments to girls at school or when the girls are walking to school	31.03	62.50	34.48	8.33	20.69	12.50	6.90	4.17	6.90	12.50
16. When girls and boys are dating, it is important that the girl does what the boy wants her to do	24.14	29.17	48.29	37.50	6.90	16.67	17.24	0.00	3.45	16.67
17. In order for a boy to be accepted by his teenage friends, he should have sex with his girlfriend	41.38	37.60	37.93	25.00	13.79	16.67	3.44	4.17	3.44	16.67
18. It is acceptable for girls to take things such as a cell phone, money, or jewelry in exchange for sexual favors.	34.48	33.33	27.59	33.33	17.24	20.83	3.90	4.17	13.79	8.33
19. It is acceptable for a boy to hit his girlfriend	34.38	33.33	27.59	33.33	17.24	20.83	6.90	4.17	13.79	8.33
20. If a boy and a girl have already been intimate, then it is OK for him to	27.59	41.67	27.59	33.33	34.48	12.50	6.90	0.00	3.45	12.50

Survey Item										
force her to have sex even if she wants him to stop										
21. My friends would be shocked if I hit my boyfriend or girlfriend	10.34	8.33	24.14	20.83	17.24	25.00	31.03	37.50	17.24	8.33
22. Boys sometimes deserve to be hit by the girls they are dating	31.03	12.50	24.14	29.17	31.03	29.17	6.90	8.33	6.90	20.83
25. Girls sometimes deserve to be hit by the boys they are dating	37.93	37.50	17.24	29.17	13.79	4.17	10.34	8.33	20.69	20.83
23. If I hit my boyfriend or girlfriend, my friends would think that I was cool	17.24	33.33	31.03	29.17	20.69	8.33	24.14	12.50	6.90	16.67
24. I would feel ashamed if I was violent against my boyfriend or girlfriend	17.24	8.33	17.24	29.17	17.24	25.00	24.14	12.50	24.14	25.00
26. It is acceptable for a girl to hit her boyfriend	37.93	45.83	37.93	29.17	6.90	12.50	17.43	12.50	0.00	0.00
27. Hitting a boyfriend or girlfriend is not a big deal	20.69	37.50	31.03	25.00	17.24	20.83	17.24	0.00	13.79	16.67

Table 3: Differences in Adolescent Participants' Knowledge About GBV Before and After Attending the GBV Program (In Person Pilot)

Survey Item	Before Program (Pre)	After Program (Post)
	% Correct	% Correct
1. Gender is…	24.13%	33.33%

2. Sex is…	20.69%	23.81%
3. Which of the following is NOT a gender stereotype?	10.34%	23.81%
4. Which is an example of physical gender-based violence?	34.38%	43.86%
5. Which is an example of verbal gender-based violence?	10.34%	33.33%
6. Which is an example of sexual gender-based violence?	58.62%	66.67%
7. Which is an example of psychological gender-based violence?	20.69%	38.10%
8. Communicating by expressing your feelings, needs, rights, or opinions in a clear, polite, and respectful way is which type of communication?	20.69%	23.81%
9. Seeking help is a type of weakness (T/F)	64.29%	68.42%
10. If someone witnesses violence, they should consider three strategies. Which of these is NOT one of those strategies?	17.24%	47.62%

Table 4: Differences in All Caregiver Participants' Gender Attitudes and Beliefs Before and After attending the GBV Program.

Survey Item	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	post
	Strongly Disagree	Strongly Disagree	Disagree	Disagree	Don't know/NA	Don't know/NA	Agree	Agree	Strongly Agree	Strongly Agree
1. Only men should work for pay	100.00	50.00		50.00						
2. Girls are smarter than boys	37.50	25.00		50.00			62.50	25.00		
3. Boys are smarter than girls	37.50	25.00	62.50	75.00						
4. A mother should tolerate violence from the father	100.00	75.00						25.00		
5. Boys who act like girls deserve	50.00	25.00	37.50	50.00			12.5			25.00

to be called names											
6. It is acceptable for a girl to act or dress more like a boy	37.50		25.00	100.00			37.50				
10. It is acceptable for a boy to act or dress more like a girl	75.00	25.00	25.00	75.00							
7. It is more important for boys than girls to perform well in school	50.00	25.00	25.00	50.00	12.5				25.00	12.5	
8. It is acceptable for a woman to disagree with her husband	50.00	25.00	37.50						50.00	12.50	25.00
9. Girls should continue in school even if they get pregnant	12.50		12.50				50.00	75.00	25.00	25.00	
11. Boys are better at mathematics and science than girls	12.5	50.00		50.00	50.00		37.50				
12. Girls are better at mathematics and science than boys	37.50	50.00	12.50	25.00	25.00		12.50	25.00	12.50		
13. It is better for girls to be quiet and shy	12.50	25.00	12.50	25.00			25.00	50.00	50.00		
14. It is acceptable for boys to cry	25.00	87.50	25.00				25.00	12.50	25.00		
15. It is acceptable for	87.50	75.00		25.00			12.50				

boys and men to make sexual comments to girls at school or when the girls are walking to school										
16. When girls and boys are dating, it is important that the girl does what the boy wants her to do	62.50	50.00	25.00	50.00			12.50			
17. In order for a boy to be accepted by his teenage friends, he should have sex with his girlfriend	100.00	50.00		50.00						
18. It is acceptable for girls to take things such as a cell phone, money, or jewelry in exchange for sexual favors.	87.50	100.00	12.50							
19. It is acceptable for a boy to hit his girlfriend	75.00	100.00	25.00							
20. If a boy and a girl have already been intimate, then it is OK for him to force her to have sex even if she wants him to stop	62.50	75.00	37.50	25.00						
21.My friends would be shocked if I hit	12.50	25.00	12.50	25.00			75.00			50.00

Item										
my boyfriend or girlfriend										
22. Boys sometimes deserve to be hit by the girls they are dating	50.00	25.00	37.50	75.00				12.50		
25. Girls sometimes deserve to be hit by the boys they are dating	62.50	25.00	25.00	25.00					50.00	12.50
23. If I hit my boyfriend or girlfriend, my friends would think that I was cool	87.50	50.00	12.50	25.00					25.00	
24. I would feel ashamed if I was violent against my boyfriend or girlfriend	12.50	25.00	12.50	25.00		62.50			12.50	50.00
26. It is acceptable for a girl to hit her boyfriend	62.50	25.00	37.50							25.00
27. Hitting a boyfriend or girlfriend is not a big deal	62.50	50.00	12.50	25.00		12.50			12.50	25.00

Table 5: Differences in Caregiver Participants' Knowledge About GBV Before and After Attending the GBV Program

Survey Item	Before Program (Pre)	After Program (Post)
	% Correct	% Correct
1.Gender is…	0.00%	0.00%
2. Sex is…	62.50%	100.00%

3. Which of the following is NOT a gender stereotype?	0.00%	50.00%
4. Which is an example of physical gender-based violence?	37.50%	50.00%
5. Which is an example of verbal gender-based violence?	12.50%	50.00%
6. Which is an example of sexual gender-based violence?	87.50%	100.00%
7. Which is an example of psychological gender-based violence?	12.50%	25.00%
8. Communicating by expressing your feelings, needs, rights, or opinions in a clear, polite, and respectful way is which type of communication?	50.00%	50.00%
9. Seeking help is a type of weakness (T/F)	57.14%	75.00%
10. If someone witnesses violence, they should consider three strategies. Which of these is NOT one of those strategies?	12.50%	25.00%

JSS Data

Table 6: Adolescent Participants' Perceptions of School Climate (Take-home Pilot)

Survey Item:	Proportion of student responses (%)				
School Climate	Never	Rarely	Not sure	Sometimes	Always
1	16.00	16.00	4.00	64.00	0.00
2	24.00	8.00	8.00	56.00	4.00
3	4.00	0.00	4.00	16.00	76.00
4	20.00	4.00	0.00	24.00	52.00
5	12.00	4.00	0.00	56.00	28.00
6	20.00	16.00	32.00	28.00	4.00
7	4.00	8.00	4.00	8.00	76.00
8	4.00	4.00	4.00	28.00	60.00
9	16.67	4.17	1.67	29.67	33.33
10	12.00	0.00	0.00	24.00	64.00
11	8.00	16.00	0.00	40.00	36.00
12	8.00	16.00	0.00	20.00	56.00
13	8.70	13.04	17.39	34.78	26.09

14	20.00	24.00	0.00	52.00	4.00
15	20.00	16.00	16.00	32.00	16.00
16	25.00	20.93	8.33	3.33	12.50
17	0.00	8.00	0.00	8.00	84.00
18	0.00	12.00	0.00	36.00	52.00
19	0.00	8.00	0.00	44.00	48.00
20	0.00	16.00	4.00	24.00	56.00
21	12.00	8.00	0.00	24.00	56.00

Table 7: Differences in Adolescent Participants' Gender Attitudes and Beliefs Before and After attending the GBV Program (Take-home Pilot).

| Survey Item | Pre | Post | Pre | Post | Pre | Post | Pre | Post | Pre | post |
	Strongly Disagree	Strongly Disagree	Disagree	Disagree	Don't know/ NA	Don't know/ NA	Agree	Agree	Strongly Agree	Strongly Agree
1. Only men should work for pay	60.00	65.22	32.00	21.74	0.00	4.35	8.00	4.35	0.00	3.35
2. Girls are smarter than boys	18.18	17.39	40.91	52.17	0.00	4.35	27.27	21.74	13.36	4.35
3. Boys are smarter than girls	22.73	30.43	59.09	60.87	0.00	0.00	9.09	4.35	9.09	4.35
4. A mother should tolerate violence from the father	71.43	76.19	19.05	14.29	0.00	0.00	4.76	9.52	4.76	0.00
5. Boys who act like girls deserve to be called names	52.00	56.52	28.00	13.04	0.00	13.04	20.00	13.04	0.00	4.35
6. It is acceptable for a girl to act or	8.33	0.00	1.67	8.90	0.00	21.74	58.33	34.78	16.67	34.78

dress more like a boy									
10. It is acceptable for a boy to act or dress more like a girl	54.17	13.04	20.83	34.78	0.00	13.04	20.83	26.09	4.17	13.04
7. It is more important for boys than girls to perform well in school	50.00	69.57	25.00	17.39	0.00	0.00	8.33	8.70	16.67	4.35
8. It is acceptable for a woman to disagree with her husband	9.09	26.09	27.27	13.04	0.00	13.04	40.91	26.09	22.73	21.73
9. Girls should continue in school even if they get pregnant	36.36	17.39	22.73	26.09	0.00	4.35	31.82	30.43	9.09	21.74
11. Boys are better at mathematics and science than girls	47.62	52.17	42.86	30.43	0.00	13.04	4.76	4.35	4.76	0.00
12. Girls are better at mathematics and science than boys	33.33	30.43	33.33	39.13	0.00	13.04	19.05	8.70	14.29	8.70
13. It is better for girls to be quiet and shy	32.00	30.43	36.00	30.43	0.00	8.70	28.00	21.74	4.00	8.70
14. It is acceptable for boys to cry	13.04	8.70	8.70	8.70	0.00	4.35	34.78	47.83	43.47	30.43
15. It is acceptable for boys and men to make	69.57	73.91	26.09	12.04	0.00	4.35	4.35	4.35	0.00	4.35

sexual comments to girls at school or when the girls are walking to school									
16. When girls and boys are dating, it is important that the girl does what the boy wants her to do	65.22	43.48	17.39	30.43	0.00	13.04	17.39	8.70	0.00	4.35
17. In order for a boy to be accepted by his teenage friends, he should have sex with his girlfriend	69.57	60.87	21.74	4.35	0.00	17.39	0.00	13.04	4.34	4.35
18. It is acceptable for girls to take things such as a cell phone, money, or jewelry in exchange for sexual favors.	77.27	52.17	13.64	21.74	0.00	13.04	4.55	4.35	4.55	8.70
19. It is acceptable for a boy to hit his girlfriend	41.67	69.57	45.83	17.39	0.00	4.35	12.50	8.69	0.00	0.00
20. If a boy and a girl have already been intimate, then it is OK for him to force her to have sex even if	76.00	69.56	24.00	21.74	0.00	4.35	0.00	4.35	0.00	0.00

she wants him to stop									
21.My friends would be shocked if I hit my boyfriend or girlfriend	18.18	4.35	13.64	8.70	0.00	17.39	31.82	47.83	36.36	21.74
22. Boys sometimes deserve to be hit by the girls they are dating	40.91	34.78	31.82	26.09	0.00	13.04	18.18	21.74	9.09	4.35
25. Girls sometimes deserve to be hit by the boys they are dating	40.91	39.13	36.36	21.74	0.00	8.70	18.18	21.74	4.55	8.70
23. If I hit my boyfriend or girlfriend, my friends would think that I was cool	45.83	39.13	27.50	34.78	0.00	13.04	4.17	4.35	12.50	8.70
24. I would feel ashamed if I was violent against my boyfriend or girlfriend	5.00	4.35	10.00	13.04	0.00	8.70	25.00	30.43	60.00	43.38
26. It is acceptable for a girl to hit her boyfriend	45.83	43.48	45.83	17.39	0.00	13.04	4.17	21.74	4.17	4.35
27. Hitting a boyfriend or girlfriend is not a big deal	62.50	47.83	20.83	21.74	0.00	8.70	12.50	4.35	4.17	17.39

Table 8: Differences in Adolescent Participants' Knowledge About GBV Before and After Receiving the GBV Program (Take-home Pilot)

Survey Item	Before Program (Pre) % Correct	After Program (Post) % Correct
1.Gender is…	24.14%	37.50%
2. Sex is…	44.83%	83.33%
3. Which of the following is NOT a gender stereotype?	10.34%	4.17%
4. Which is an example of physical gender-based violence?	34.48%	60.87%
5. Which is an example of verbal gender-based violence?	10.34%	39.13%
6. Which is an example of sexual gender-based violence?	58.62%	91.67%
7. Which is an example of psychological gender-based violence?	20.69%	29.17%
8. Communicating by expressing your feelings, needs, rights, or opinions in a clear, polite, and respectful way is which type of communication?	20.69%	62.50%
9. Seeking help is a type of weakness (T/F)	64.29%	83.33%
10. If someone witnesses violence, they should consider three strategies. Which of these is NOT one of those strategies?	17.24%	4.35%

Table 9: Caregiver Participants' Gender Attitudes and Beliefs the GBV Program (Take-home)

Survey Item	Pre Strongly Disagree	Pre Disagree	Pre Don't know/NA	Pre Agree	Pre Strongly Agree
1. Only men should work for pay	28.57	42.86			28.57
2. Girls are smarter than boys	20.00	40.00			20.00
3. Boys are smarter than girls	40.00	40.00			20.00
4. A mother should tolerate violence from the father	28.57			42.86	28.57
5. Boys who act like girls deserve to be called names	33.33	33.33		33.33	

6. It is acceptable for a girl to act or dress more like a boy	14.29	28.57		57.14	
10. It is acceptable for a boy to act or dress more like a girl	42.86	42.86		14.29	
7. It is more important for boys than girls to perform well in school	66.67	33.33			
8. It is acceptable for a woman to disagree with her husband	33.33	33.33		16.67	16.17
9. Girls should continue in school even if they get pregnant	14.29	14.29			71.43
11. Boys are better at mathematics and science than girls	14.29	85.57			
12. Girls are better at mathematics and science than boys	28.57	57.14		14.29	
13. It is better for girls to be quiet and shy	28.57	28.57		28.57	4.29
14. It is acceptable for boys to cry	28.57	14.29		42.86	14.29
15. It is acceptable for boys and men to make sexual comments to girls at school or when the girls are walking to school	42.86	28.57		28.57	
16. When girls and boys are dating, it is important that the girl does what the boy wants her to do	42.86	28.57		28.57	
17. In order for a boy to be accepted by his teenage friends, he should have sex with his girlfriend	71.43	28.57			
18. It is acceptable for girls to take things such as a cell phone, money, or jewelry in exchange for sexual favors.	100.00				
19. It is acceptable for a boy to hit his girlfriend	100.00				
26. It is acceptable for a girl to hit her boyfriend	71.43	28.58			
20. If a boy and a girl have already been intimate, then it is OK for him	85.71	14.29			

to force her to have sex even if she wants him to stop					
21.My friends would be shocked if I hit my boyfriend or girlfriend	33.33	16.67		33.33	16.67
22. Boys sometimes deserve to be hit by the girls they are dating	28.57	28.57		28.57	14.29
25. Girls sometimes deserve to be hit by the boys they are dating	42.86	28.57		14.29	14.29
23. If I hit my boyfriend or girlfriend, my friends would think that I was cool	71.43	28.57			
24. I would feel ashamed if I was violent against my boyfriend or girlfriend	14.29			71.43	14.19
27. Hitting a boyfriend or girlfriend is not a big deal	85.71	14.29			

Table 10: Caregiver Participants' Knowledge About GBV Before the GBV Program (Take-home)

Survey Item	Before Program (Pre)
	% Correct
1.Gender is…	14.29%
2. Sex is…	71.43%
3. Which of the following is NOT a gender stereotype?	14.29%
4. Which is an example of physical gender-based violence?	71.43%
5. Which is an example of verbal gender-based violence?	33.33%
6. Which is an example of sexual gender-based violence?	100%
7. Which is an example of psychological gender-based violence?	50.00%
8. Communicating by expressing your feelings, needs, rights, or opinions in a clear, polite, and respectful way is which type of communication?	16.67%
9. Seeking help is a type of weakness (T/F)	100%
10. If someone witnesses violence, they should consider three strategies. Which of these is NOT one of those strategies?	66.67%

SECTION V: ALCOHOL PREVENTION AND POSITIVE YOUTH DEVELOPMENT

I.   INTRODUCTION

Youth alcohol use is a growing public health concern among youth in Botswana that has cross-cutting implications for other public health challenges (Emang Professional Services, 2017; Riva et al., 2018; World Health Organization, 2018). At the national level, heavy episodic drinking in the population is estimated to be 19%, while estimates among youth indicate similarly concerning trends (World Health Organization, 2018). In 2016 it was estimated that roughly 12% of adolescents engaged in heavy drinking, of which 20% of males and 4% of females were involved in heavy episodic drinking (World Health Organization, 2018). A separate report on an alcohol consumption survey of over 5,000 respondents found that up to 42% of youth 15-30 years of age reported being current drinkers (Emang Professional Services, 2017).

Prior research also demonstrates that alcohol abuse and addiction are associated with other public health issues, such as gender-based violence (GBV), HIV/AIDS, sexual risk behaviors, and motor vehicle accidents (Aruffo et al., 1994; Campbell, 2003; Malete, 2007; Phorano et al., 2005). Much of the past literature and interventions have responded to alcohol abuse as a complementary component to HIV and gender-based violence prevention and through policy approaches with mixed results (Ferreira-Borges et al., 2015; Pitso & Obot, 2011; Sinkamba, 2015; Zetola et al., 2014). Given the rise of adolescent alcohol consumption and its associated outcomes, there is a need for comprehensive youth development programming that has cross-cutting public health impacts.

Positive youth development (PYD) is a strength-based perspective on how adolescent experiences contribute to their well-being (R. M. Lerner et al., 2005). Unlike approaches that aim to improve adolescent development by targeting deficits, this approach views youth as resources to be nurtured through opportunities (Burkhard et al., 2019). PYD considers development as the product of intrinsic factors, such as knowledge and skills, and extrinsic factors, such as family, community, culture, and the broader environment (R. Lerner, 2004; R. M. Lerner et al., 2005). PYD proposes that youth with lower developmental assets are more likely to engage in health-risk behaviors, such as alcohol use (Alvarado et al., 2017; Catalano et al., 2019).

For these reasons, the Alcohol Prevention and Positive Youth Development (PYD) project aims to examine the relationship between youth development and alcohol use, which is achieved through 3 primary study components:

1. Youth Survey – This is a youth (18-24 years of age) survey that measures the developmental assets of youth and alcohol use behaviors. By the end of the entire study, 150 surveys will be delivered.
2. Focus Group Discussions (FGD) – FGDs are conducted with two populations: youth (18-35) and community stakeholders. In total, 4 FGDs will be conducted with youth, and four will be conducted with community stakeholders. This activity aims to gather detailed information on youth development and alcohol use from the perspectives of youth and community stakeholders.
3. Youth Development Community Advisory Board (CAB) – A Youth Development CAB will be established to ensure community stakeholders have a voice and role in implementing this research study. More importantly, the CAB will help interpret and communicate the results of this study. This creates a sustainable and equitable partnership between Oregon State University researchers and local village members.

During the Summer of 2022, the Alcohol Prevention and PYD research team sought to carry out the pilot phase of this project, which involved:

- Building local capacity to conduct the Youth Surveys and FGDs
- Pilot testing the Youth Survey and FGD Questions by conducting 30 surveys and 2 FGDs
- Establishing a Youth Development CAB

II.   METHODS

Capacity Building
Central to this project is building local research capacity by training local youth to conduct surveys and facilitate focus group discussions. Working with our local program coordinator, OT, we identified several youths with experience in survey facilitation who expressed interest in participating in this project. To ensure research activities would be conducted to fidelity, local youth participated in a survey and FGD training.

The training involved participating in four training sessions (two for survey facilitation and two for FGD facilitation), instructed by two OSU graduate students. Each session lasted approximately 4-5 hours and involved hands on-training and practice sessions. These sessions also allowed local youth to receive coaching and feedback from the OSU research team to improve their confidence. By the end of this training, seven local youth received certificates of completion for administering surveys and FGDs. The final step of their training involved guided implementation for the survey, in which the newly trained youth implemented surveys with the support of the OSU graduate students. It also involved observing the two OSU graduate students conduct two separate FGDs.

The second component of building local capacity was establishing a Youth Development CAB. The CAB is a diverse group of stakeholders from various institutions and sectors that work collaboratively to improve youth development in Maunatlala. The CAB aimed to recruit 1-2 members from the sectors in the table below. Sectors in bold represent the sectors that one or more individuals currently represent.

• Schools	• Parents	• Law Enforcement
• Local Government	• Healthcare	• Social Services
• Faith-based community	• Local business owners	• Youth (18-35 years of age)
• Library		

Youth Survey
The Youth Survey uses survey items from the Developmental Assets Profile (DAP) survey, the WHO Alcohol Use Disorder Identification Test (AUDIT), and four supplemental items that ask about participant characteristics.

DAP Section - The DAP section measures developmental assets organized into eight categories described in Figure 1. Responses to the DAP item are scored based on the Asset Category Scores, Internal, External, and Total Asset scores, with their respective ranges detailed below.

- Developmental Asset Category Scores – The Developmental Asset Category scores range from 0-30, with lower scores indicating a lower level of development for each respective category.
- Internal Asset Scores – Internal Asset scores reflect survey respondents' self-perception, values, and skills associated with positive youth development. Internal Asset scores range from 0-30, with lower scores indicating lower levels of youth development.
- External Asset Scores – External Asset scores reflect survey respondents' social support, relationships, and opportunities in their environment, all associated with positive youth development. External Asset scores range from 0-30, with lower scores indicating lower levels of youth development.
- Total Asset Scores – Total Asset scores reflect the combination of Internal and External Asset scores, which gives a broad summary of youth development. Total assets scores are the combined total of the Internal and External Asset scores, ranging from 0-60. Similarly, lower scores indicate lower levels of youth development. Scores can also be classified according to the following categories associated with adverse academic and health behaviors.
  - Good = 52-60, Adequate = 42-51, Vulnerable = 30-41, Highly Vulnerable = Less than 30
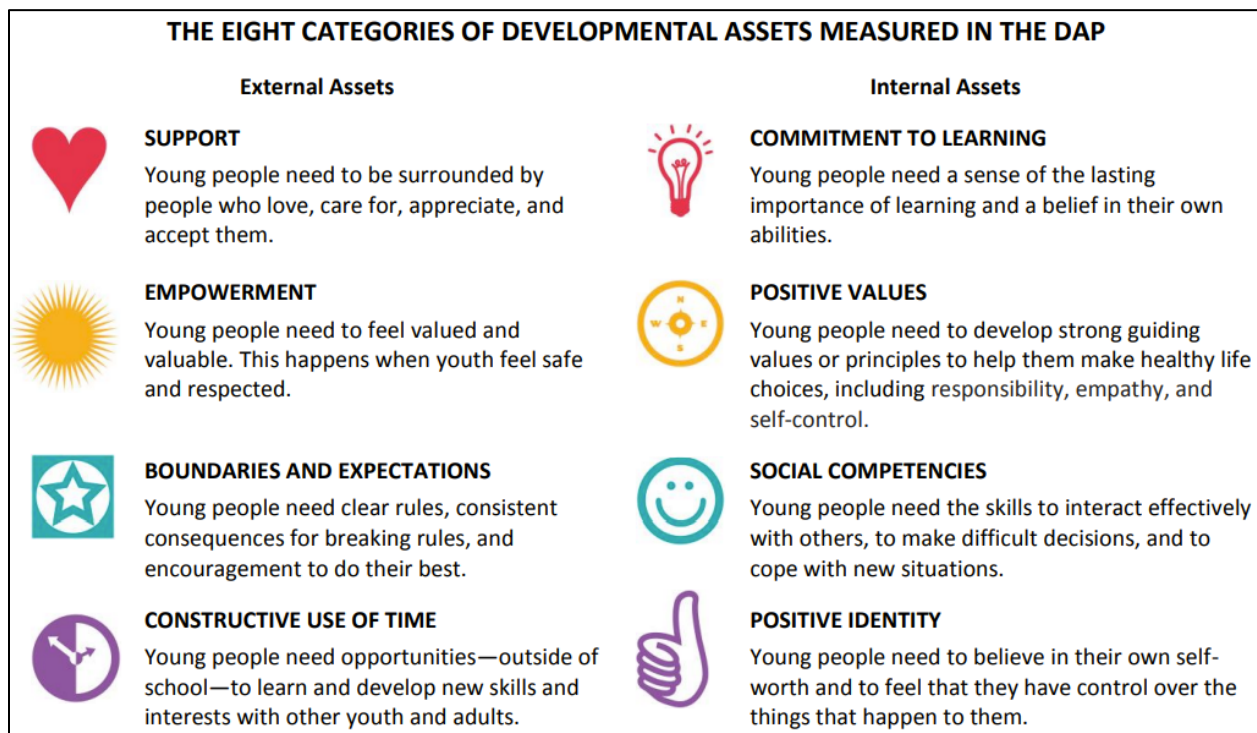

Figure 1. Developmental Asset Categories. This figure defines and describes the eight developmental asset categories discussed in the Search Institutes (2016) User Guide for the Developmental Assets Profile.

AUDIT Section - The AUDIT questions capture respondents' alcohol use behaviors, including consumption volume, frequency of consumption, risky consumption behaviors, and adverse outcomes from alcohol use. The AUDIT Score is the total score of each AUDIT question. The range for the AUDIT is from 0-40. Higher AUDIT scores are associated with greater health risks. However, research in Sub-Saharan Africa has suggested that AUDIT score risk categories should be adjusted for younger populations. The table below displays both AUDIT risk category systems recommended by the WHO and the literature.

WHO Score Ranges		
Risk Level	AUDIT Score	Intervention
Zone 1	0-7	Alcohol education
Zone 2	8-15	Simple advice
Zone 3	16-19	Simple advice plus brief counseling and continued monitoring
Zone 4	20-40	Referral to specialist for diagnostic evaluation and treatment
Adjusted Score Ranges		
Non-Drinkers	0	
Low-Risk Drinkers	1-4	
High-Risk Drinkers	≥ 5	

Survey Implementation - Once local youth were certified and trained, they received blank surveys to administer to local youth (18-24 years of age). The first survey day was a collaborative effort between the OSU graduate students and the local survey team, where they administered surveys to local youth. After the initial survey day, more blank surveys were distributed to the local survey team, who collected the remaining surveys to complete 30 total.

The Youth Survey was implemented in partnership with local stakeholders and with the support of the Youth Survey Team. Local Stakeholders provided insight as to how best to reach the target population. Existing approaches to reaching youth, such as Facebook, WhatsApp, and in-person meetings with youth were used to promote the survey. Surveys were returned to the OSU research team for quality checks and preliminary analysis.

Focus Group Discussions
Focus group discussions were framed around the developmental assets and alcohol use behaviors, as they relate to the five environmental contexts: community, school, family, social, and intrapersonal contexts. Two focus group discussions were conducted in July 2022, where trained facilitators discussed youth development and alcohol use in Maunatlala. To recruit participants, WhatsApp, Facebook, and in-person meetings were used to promote the opportunity to participate in this research activity. This approach was guided by local stakeholders and community partners to identify the participants best. The first FGD involved female youth (18-35 years of age), while the second comprised police officers and library staff.

Focus group sessions were approximately 1 hour and 30 minutes long and consisted of an interactive conversation involving notecard and poster exercises. Each participant also completed a brief questionnaire at the end of the FGD.
To analyze FGD data, OSU researchers transcribed and analyzed audio recordings, notecards, and posters. These transcripts were subsequently open-coded and thematically analyzed.

III.   RESULTS

Introduction – The following results are preliminary and reflect only the first 30 surveys and 2 FGDs conducted during the Summer of 2022. These results are made available to demonstrate initial findings from this project and highlight areas of interest. It also provides early context for what to expect in the final analysis.

Youth Survey Results

Participant Characteristics – The average age of our surveyed population is roughly 20 years of age. Approximately 50% of our participants indicated having completed BGCSE (11th-12th grade). Over 40% of surveyed youth indicate not having enough money to meet basic needs, while 50% of respondents live with one parent. Lastly, the average household size of the surveyed participants includes approximately six members.

DAP Section – The lowest score for the Developmental Asset Categories (for Internal Assets) was for Social Competencies, with an average score of 20.0 out of 30. The highest average score among the Internal Assets was Commitment to Learning, with a score of 22.1 out of 30.

The lowest score for the Developmental Asset Categories (External Assets) was for Constructive Use of Time, with an average score of 18.8 out of 30. The highest average score among the External Assets was Boundaries and Expectations, with a score of 23.0 out of 30.

Internal Asset Category Summary	N=30 Mean (SD)	External Asset Category Summary	N=30 Mean (SD)
Commitment to Learning	22.1 (7.84)	Support	21.1 (7.51)
Positive Values	21.5 (5.70)	Empowerment	20.2 (6.96)
Social Competencies	20.0 (6.69)	Boundaries and Expectations	23.0 (5.87)
Positive Identity	20.5 (6.31)	Constructive Use of Time	18.8 (7.46)

The average Internal Asset Score for the surveyed population was 21.1 out of 30, while the average for External Asset Scores was 20.7. The average for the Total DAP Score was 41.8 out of 60. Meanwhile, Total DAP scores were categorized by risk levels associated with adverse behavioral, academic, and health outcomes. Results indicate that 60.0% of respondents fell into the "Adequate" and "Good" categories, while 40.0% of respondents fell into the "Vulnerable" to "Highly Vulnerable" categories.

DAP Internal, External, and Total Score Summary	N=30 Mean (SD)
Internal Asset Score	21.1 (5.92)
External Asset Score	20.7 (6.30)
Total DAP Score	41.8 (11.8)

Total DAP Score by Risk Category	N=30 Count (%)
Good	7 (23.3)
Adequate	11 (36.7)
Vulnerable	8 (26.7)
Highly Vulnerable	4 (13.3)

AUDIT Section- According to the Sub-Saharan Africa risk categories, approximately 30.0% of surveyed youth fall into the high-risk drinker category. Using the WHO categories, approximately 13.3% of surveyed youth fall into the two highest risk categories, warranting brief counseling and referral to a specialist.

AUDIT Risk Categories	N = 30 Count (%)
AUDIT score risk category according to SSA cut-off scores	
Non-Drinkers	16 (53.3)
Low-Risk Drinkers	5 (16.7)
High-Risk Drinkers	9 (30.0)
AUDIT score risk category according to WHO cut-off scores	
Risk Level 1	22 (73.3)
Risk Level 2	4 (13.3)
Risk Level 3	1 (3.33)
Risk Level 4	3 (10.0)

Focus Group Discussions

FGD results were organized and evaluated within the eight developmental asset categories. A summary of the findings and select relevant quotes are provided to illustrate each significant finding.

Support – Support for youth in the community of Maunatlala comes from social clubs, the faith-based community, and law enforcement. Social clubs contribute to youth development by providing safe spaces for youth to engage with one another, feel accepted, and share ideas. The faith-based community offers support for youth via guidance and counseling. Lastly, law enforcement supports youth development through guidance and communication.

- "[Pastors] meet with a lot of youth, [they] speak to a lot of youth…guide them… [and] encourage them to do something with their future.

- "Sometimes [Police] arrest [youth], put them in a police cell just trying to talk to them. So, talk to them like brothers, so that they can behave. Try to develop them … 'cause if you get arrested [and]

fingerprinted, [it can] be difficult for youth to be able to find a job or to develop themselves. [Police are] trying…trying to talk to them….trying to …give them chances."

Empowerment – Youth feel empowered when there is access to safe spaces that welcome youth. Maunatlala has an opportunity to empower youth through improving access to mental health, counseling, and other healthcare services.
- "There's nowhere they can receive maybe counseling. When a youth has some problem, they all talk to the social workers. But I think if there were some organizations that are based on helping youth maybe there would be a difference."
- "For me, I was saying lack of safe places, or places where young people should, can go and talk to professionals, maybe like people who do counseling or therapy, so people like that…. Most especially young people, like they'll go through so much, but they don't have anyone to talk to."
- "If there is a youth clinic in the village … they tend to get help in each and everything they need, [such as] if they need advice on prevention method[s]…. If there's a youth clinic, I think somethings will be implemented, eh friendly, youth-friendly methods, they will be implemented for us to be free to talk to them, for us to be free to ask, each and every question."

Boundaries & Expectations – Setting boundaries and expectations is essential to youth development by fostering patience, problem-solving, responsibility, resourcefulness, and self-discipline. Focus group participants stated that parents, and the broad community, struggle to set boundaries and expectations for youth.
- "I have realized that there are laws, but they're not enforced. Like if I might say, here I think those who are allowed to partake [in] alcohol that [are] 18 and above, but uh those laws are not enforced."
- "You find that young people, or youth as they said, they spend more time on the shebeens (local bars), or the bars, because there is no one that is monitoring them, like the parents … so they have ample time to drink or to go party or do whatever they want to do with their friends."
- "Those who are in authority [such as] chiefs, church leaders, and anyone who is an influential person … they have a right to discipline those who are not behaving. [However] these children, they fear nothing. They know that the chief cannot do anything to them.

Constructive Use of Time – Both youth and community stakeholders have expressed a need for recreational spaces and activities. Youth desire mentorship and opportunities to express their talents, develop their business and other skills to become more employable or generate an income.
- "I think a lack of…recreational places or facilities that will keep them busy, that will keep them with skills that they can help themselves. Or Maybe I can give an example of acting. There's nothing like that."
- "'Cause there is nowhere to go after school or if there could be a recreational, something for them to at least spend their spare time there. The only entertainment is going to the shebeens and bars."
- "Because of lack of unemployment [youth] tend to get involved with a young girl and an older man whether married or not because of unemployment."

Commitment to Learning – Nothing significant on Commitment to Learning has yet been captured in our two focus group discussions.

Positive Values – Focus group participants acknowledge that youth have been taught responsibility. However, they also expressed that some youth in the village lack respect, empathy, and self-control.
- "Yeah, youth at schools are being taught responsibility."
- "[In regard to self-discipline] 'Cause they've been taught. They know. They don't have to be ordered to do something personally themselves. To learn to discipline themselves. 'Cause from an early age, they've

been shown what is bad and what is not bad. I don't think anyone can say it was never taught, so it's upon the youth."

Social Competencies – To effectively interact with others, focus group participants stated that developing skills relating to stress management, problem-solving, networking, and communication among youth could help young people with decision-making and coping with new situations.

- "Another thing could be said about problem-solving skills, if I have the skills to solve any problem that comes my way, I wouldn't have a problem in becoming a better person or avoiding bad things happening to me. For example, if I have stress management skills, I wouldn't have any problems; like anything that comes my way, I will take it, and I would work to make that thing better or have a good impact in my life."

- "For me, I will say communication skills because to grow as a person, you have to understand how communication works; you have to know when to talk and when to listen."

- "Networking skills, the ability to network or to build new relationships with people from your outer circle that you're living in, that helps you to grow as well; if you start to network, you start to build new relationships, and you start to have new things come into your life."

Positive Identity – Focus group participants observed that youth in Maunatlala do not believe in their self-worth. Negative peer pressure was emphasized as a concern contributing to youth feeling like they have no control over their lives, leading to low self-esteem.

- "One thing can be peer pressure, like the kind of people you associate with. Like, one can be among the people who are good, just because of peer pressure, or among the people who are not good. So lack of self-esteem can somehow affect [someone]."

- "Most youth become old before old age, they condemn themselves and think they are useless and keep on abusing alcohol. They even lose their self-dignity, uh and their lives. The alcohol abuse endangers their lives and their health."

IV.   RECOMMENDATIONS

Preliminary findings in the surveys and FGDs indicate that the developmental assets that require the most attention include Constructive Use of Time and Social Competencies. Constructive use of time was a recurring theme among FGDs, in which respondents discussed the need for positive recreational spaces and opportunities for occupational development and opportunities. The low asset score for the Constructive Use of Time category further supported this.

Similarly, respondents in the FGDs identified Social Competencies as an area of youth development that presented an opportunity for growth. Specifically, they discussed needing to instill problem-solving, stress management, and networking skills within youth to help them adapt to new situations in life. The low asset score for Social Competencies also supported this finding. While preliminary results are insufficient for informing program development, these initial findings point to areas of youth development worth investigating further.

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