COMMUNITY HEALTH AND WELL-BEING IN MAUNATLALA:
Mainstreaming Disability, Sexual and Reproductive Health, and Alcohol and Substance Abuse

Carlee Conner, Madison Cowles, Gillette Field, Tyler Gray, Nicholas Guardia, Destry Jensen, Courtney Jost, Megan MacDonald, Mikka Nyarko, Tarisa Olinski, Divya Reddy, Michelle Sass, and Sunil K. Khanna[1]

Botswana Global Health Internship Program
College of Public Health and Human Sciences
Oregon State University
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[1] Corresponding author.

TABLE OF CONTENTS

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This report was prepared by all members of the 2019 Botswana Global Health Internship Program team in collaboration with key stakeholders of the Maunatlala community. It has benefited from insightful suggestions from the Maunatlala Health Clinic staff, schoolteachers, and other key stakeholders in Maunatlala.

EXECUTIVE SUMMARY

This report summarizes the findings of the work that the Botswana Global Health Internship Program team carried in June-August 2019 in Maunatlala, Botswana. It includes three separate mini reports describing our work in Maunatlala. In 2019, we worked on three different priorities identified by the Maunatlala community. These priorities include mainstreaming disability, promotion comprehensive sexual and reproductive health (SRH) education among middle school students and their parents, and preventing alcohol and substance abuse by youth in the community. For each of the projects, we worked in collaboration with key stakeholders of the Maunatlala community, the Ministry of Health and Wellness, and the Ministry of Youth Empowerment, Sport, and Culture Development, Republic of Botswana. The report has benefited from insightful suggestions from the staff at the Maunatlala Community Library, Maunatlala Clinic, Maunatlala Counselor, Maunatlala Social Worker, and teachers and staff working at the Maunatlala Junior School and Masupe Primary School.

Key Recommendations/Steps Forward

- Efforts leading to youth empowerment, engagement, and employment are critical to sustainable economic growth, health and well-being, and community- building in Maunatlala.
- Maunatlala youth groups are actively seeking to develop employment and recreational opportunities to effectively engage others in the community. We strongly support such efforts and encourage the local, regional, and national governments to support these initiatives as well.
- The Maunatlala Community Library is well-integrated into the local cultural ethos. It plays an important role in the everyday lives of people in the village. The space available at the library offers an excellent opportunity to strengthen existing and build new youth training, health promotion and education, and community engagement programs.
- There is growing recognition that youth in Botswana present an optimum point for systematic engagement to ensure sustainable economic growth and reverse the trend of the HIV/AIDS epidemic. We strongly recommend to the Ministry of Youth Empowerment, Sport, and Culture Development that a position of Youth Engagement Coordinator be created for rural communities such as Maunatlala. This position can be affiliated with the public libraries (e.g. Maunatlala Community Library). It can play an important role in future workforce development by assisting youth in skill building and to prepare for professional opportunities.
- We recommend that the Ministry of Health and Wellness consider adding a Disability Services Unit to the services that are currently available at the Maunatlala Clinic to improve resources available to persons with disabilities in the community. A select group of clinic staff should be considered for training to become certified Community Disability Workers to meet the unique health needs of individuals with disabilities and promote their social inclusion.
- A teacher training program should be implemented to exclusively focus on issues of students with disabilities. This program would allow both the special education teachers and the general education teachers at Masupe Primary School to gain valuable knowledge on how to work with students with disabilities of both high-incidence and low-incidence disability. Our group will be willing to work with key stakeholders to develop a teacher training program focusing on issues of students with disabilities.
- Establish a social club for children with disabilities as part of the Brighter Kids program in Maunatlala. Such a program can help create a safe and friendly environment for children to interact and play with others like them.
- In 2019, we collaboratively worked with key stakeholders in Maunatlala to develop a culturally sensitive and locally relevant comprehensive sexual and reproductive health (SRH) education program. In June-August 2020, this program will be implemented for students at the Maunatlala Junior Secondary School and parents/community leaders in Maunatlala.
- We recommend recruiting a full-time school-based nurse who is available at all times to directly support students. Currently, the school nurse has little time to spend at the school because of additional responsibilities at the clinic. A full-time school-based nurse will be able to proactively identify and address student needs with timely, accurate, and youth friendly information and care. School-based nurses has been found to be quite effective in preventing the spread of HIV among youth.

- The Maunatlala Clinic should consider establishing youth-friendly services by including a comfortable and appropriate setting where unique physical, psychological, emotional, and developmental needs of youth can be met. These services will allow youth in the community to access sexual and reproductive health education and comfortably seek treatment in a private space. The need for a confidential setting for youth to obtain such information and treatment was identified by community members as a major priority.
- It is important for the community to create a space where the youth can go as a healthy alternative to alcohol use. We recommend that the Maunatlala youth group begin hosting community-based activities for the youth Activities could include craft nights, movie nights, watching sports events, game nights, indoor sports, dancing, or music.
- We recommend police personnel perform random spot checks in the bars to determine if there are minors being served. Bar owners should then face legal repercussions if caught serving to underage minors. By adding legal consequences to drinking, it would desensitize the youth from drinking alcohol.
- We recommend the clinic or the village library to be a central hub for preventative resources for alcohol abuse. Alcohol and substance abuse informational resources such as pamphlets or brochures should be made available in the library or youth-friendly section of the clinic. They should contain information on the health consequences of alcohol and substance abuse and where to obtain help. This would allow youth to access information in a comfortable environment away from interactions that potentially carry judgement or perpetuate stigma.

PROGRAM BACKGROUND

Achieving health and well-being for all is one of the most exciting and pressing issues of our times. This key goal in the global health arena requires coordinated interdisciplinary approaches that engage researchers, community stakeholders, donors, and governments to work in a collaborative, sustainable, and empowering manner.

Supported by the Robert & Sara Rothschild Endowment Fund, the Botswana Global Health Internship Program, is a collaborative effort by Oregon State University's College of Public Health and Human Sciences and the Ministry of Health and Wellness (MOHW) in Botswana to identify and implement locally relevant and sustainable community-based efforts to improve health infrastructure, strengthen health care services and systems, and enhance youth employment, engagement, and empowering activities. Each year, the Botswana Global Health Internship program recruits and trains student interns to engage in community- based work in Maunatlala – a village located in the Central District of Botswana, on health- related issues that prioritized both by the MOHW and the village community.

Key Partners

- **Ministry of Health and Wellness, Government of the Republic of Botswana**
- **Ministry of Youth Empowerment, Sport, and Culture Development, Government of the Republic of Botswana**
- **College of Public Health and Human Sciences**
- **Robert and Sara Rothschild Endowment Fund**
- **The Robert & Sara Rothschild Family Foundation: Building Libraries Empowering Communities**
- **Maunatlala Community**

Eleven student interns participated in the Botswana Global Health Internship program from June 24, 2019 to August 5, 2019. Student interns were selected from diverse academic backgrounds and interests, including public health, pre-medicine/pre-dental, liberal arts, nutritional sciences, and social sciences. The interns worked under the supervision of Dr. Sunil Khanna (Director of the Botswana Global Health Internship Program) and in collaboration with local stakeholders on the topics identified above.

In Spring 2019, student interns participated in five workshops to learn more about topics such as traveling abroad, culture shock, Botswana's culture, infrastructure, health systems, and about the community of Maunatlala – the site of the internship. The interns received training in how to conduct community-based research, especially the use of qualitative methods (e.g. participant observation, in-depth interviews, focus group discussions, etc.). The interns also received reading materials for reference in the field.

Upon arrival in Gaborone, student interns and program director participated in an orientation workshop organized by the MOHW to learn more about the state of health in Botswana. The workshop helped the students identify key priority areas of health service delivery and policy at the national level. Student interns also visited the Ministry of Youth Empowerment, Sport, and Culture Development to meet with key leaders of the Ministry. After completing the orientation training, the team of student interns accompanied by the Director of the program left for Maunatlala – the site of the internship program.

Maunatlala is 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. During our time in Maunatlala offered us an incredibly rich learning opportunity from the people in the village. We engaged in numerous conversations with community leaders and local area politicians. By using both structured and unstructured data collection methods and other complementary field techniques (e.g. participant observation in-depth interviews, focus group discussions, oral history interviews, event

history interviews, and resource mapping) with a diverse group of stakeholders in the village and at the District Health Management Team (DHMT) headquarters in Palapye, we gained a nuanced understanding of multiple perspectives on a broad range of issues related to health and well-being, disability, and alcohol/substance abuse.

Image 1: Orientation Organized by the Ministry of Health and Wellness

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 analysis of data simultaneously while we were in Maunatlala. We focused on concept saturation and triangulation of information and 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.

Both undergraduate and graduate students with diverse disciplinary backgrounds from Oregon State University collaboratively worked with key stakeholders in the Maunatlala community, as well as the Ministry of Health and Wellness and the Ministry of Youth Empowerment, Sport, and Culture Development, Republic of Botswana.

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

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 Ownership, Partnership, and Empowerment (SCOPE) strategy to find community-driven solutions to problems identified by the community. We believe that the best solutions come from people that know their community best and have good ideas about how to remove barriers. With diverse expertise and value-driven approach, SCOPE collaborators ensure that the proposed community-driven programs are successful. We believe that our SCOPE strategy embodies an innovative approach to sustainably improve health and well-being across all stakeholders. SCOPE harnesses science and data to foster high-functioning collaboration across academia, community, civil society sectors, and the regional and national government stakeholders. Ultimately, SCOPE outlines a vision for upscaling and long-term success with deepened engagement from all participating partners.

OVERVIEW

During summer 2019, the Botswana Global Health Internship Program team focused on three overlapping health and social concerns that were identified by the Maunatlala community and the Ministry of Health and Wellness. These concerns included underrepresentation and lack of resources for individuals with disabilities in Maunatlala; need for improving the knowledge and awareness of sexual and reproductive health issues among youth; and identifying locally engaging and sustainable strategies to address alcohol/substance abuse, especially by youth, in the community. The team of 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.

Mainstreaming Disability

A number of individuals in Maunatlala are affected by mental or physical disabilities. However, they are largely underrepresented in the community. This lack of representation may adversely impact the opportunities of those with disabilities to receive proper education, quality healthcare, or positive social interaction. Building on the needs assessment that was carried out by the Botswana program interns in 2018, we evaluated the Masupe Primary School's Special Education program and the Maunatlala Clinic for the level of services offered to individuals with disabilities. We also conducted in-depth interviews and focus group discussions to learn about perceptions and attitudes of community members towards disability. Finally, we engaged diverse stakeholders to develop a comprehensive plan to effectively address the needs of persons with disabilities.

Sexual and Reproductive Health

Botswana has the third-highest prevalence of HIV/AIDS globally, which can be argued as an outcome of poor understanding of sexual and reproductive health and means to prevent the spread of HIV and other sexually transmitted infections. Based on our work in Summer 2018, we learned that youth, especially in the 10-17 age group have limited opportunities to learn about sexual and reproductive health issues. This makes them vulnerable to contracting a sexually transmitted infection, unintended pregnancies, and gender-based violence. We worked with diverse stakeholders, including youth groups, schoolteachers, clinic staff, and students to develop a comprehensive sexual and reproductive education (SRHE) program for students studying in the Junior High School and their parents. We plan to implement and evaluate the SRHE program in summer 2020.

Alcohol/Substance Abuse

Several community members, youth leaders, and community leaders identified alcohol/substance abuse as a serious social problem in Maunatlala. As the pastime usage of alcohol has risen, along with the apparent popularity of the local bars, many social problems have arisen concurrently, some of which include theft, violence, and negative health behaviors generally attributable to drinking. Youth have been identified specifically as heavy users of alcohol, largely due to both high rates of unemployment and limited social outlets within the community. To address this issue, we carried out a needs assessment to better understand the current situation and develop a more comprehensive intervention plan to address this social problem.

SECTION I: MAINSTREAMING DISABILITY

I. INTRODUCTION

The global understanding of disability has drastically transformed within the past few decades. The most substantial change lies not in the clinical realm of disability services, rather in varying cultural interpretations of disability. The World Health Organization (WHO) defines disability as "...an umbrella term, covering impairments, activity limitations, and participation restrictions... it is a complex phenomenon, reflecting the interaction between features of a person's body and features of the society in which he or she lives" (World Health Organization, 2017). There is considerable variability in terms of cultural perceptions of disability and how such perceptions impact health outcomes. Research on global perspectives of disability suggests that those living with disabilities are typically far more limited by preexisting social, cultural, and economic constraints than by individualized intellectual or developmental deficiencies (World Health Organization, 2017). According to the WHO, 1 billion people (nearly 15% of the world's population) lives with a physical intellectual, or mental impairment or disability that affects their daily lives (World Health Organization, 2011; Rains, 2010). Individuals with disabilities often face unequal access to health care and rehabilitation, education, and employment. They are recurrently excluded from socioeconomic and political lives of their communities and face social marginalization.

During our time in Maunatlala, we observed limited participation by individuals with disabilities in everyday activities and community life. This marginalization may lead to misconceptions and negative stigma associated with disability, which could negatively impact the overall health and well-being of individuals with disabilities. We validated our observation by talking with key community stakeholders who voiced similar concerns related to the well-being of people with disabilities in the community. Leaders in the Maunatlala community identified creating a more inclusive community for individuals with disabilities as a priority. Community stakeholders agree that the scope of this integration extends beyond health to encompass social justice, community norms, and basic human rights. Based upon this information, we conducted a needs assessment and resource mapping/evaluation to understand community engagement, education structure, and availability of and access to resources for individuals with disabilities in Maunatlala.

II. METHODS

We expanded upon our efforts that we had initiated in 2018 to learn more about the special education program for children with disabilities at Masupe Primary School to include a survey of the entire community. We adopted a qualitative, community-based participatory research design to understand community's perspectives on disability and to collaboratively engage its key stakeholders in identifying possible strategies to promote mainstreaming disability.

Participants

We used purposive and snowball sampling strategies to ensure a representative sample. Thirty-two individuals agreed to participate with twenty-four participants from Maunatlala and eight from Palapye. The study sample included political leaders, local and regional community leaders, health care providers, social workers, and educators. Twenty-two women and ten men participated in this study. All participants were over the age of 18 with the exception of two students who were 8 and 12. Both students attended Masupe Primary School and were interviewed in the presence of a special education aid. Each stakeholder provided invaluable insights into a number of issues related to the lives of individuals living with disability.

Table 1. Sample Size

Participant Title	Number of Participants	Gender	Location
Ministry of Education			
a) Chief Education Officer	1	Woman	Palapye
b) School Head	1	Woman	Maunatlala
c) Special Education Teachers	2	1 Man, 1 Woman	Maunatlala
d) General Education Teachers	4	1 Man, 3 Women	Maunatlala
e) Students	3	2 Men, 1 Woman	Maunatlala
Ministry of Health and Wellness			
a) Clinic Director	1	Man	Maunatlala
b) Health Post Nurse	1	Man	Maunatlala
c) Representatives from DHMT Palapye	6	2 Men, 4 Women	Palapye
d) Physiotherapist	1	Man	Palapye
Ministry of Local Government			
a) Social Worker	1	Woman	Maunatlala
b) Councilor	1	Woman	Maunatlala
Community Members			
a) Caregivers	10	Women	Maunatlala
Total Participants	**32**		

Data Collection

The research team consisted of two faculty members in the College of Public Health and Human Sciences, one Public Health graduate student, and four undergraduate students representing a diverse group of academic majors at Oregon State University. We collected data by using complementary qualitative research methods, including participant observation, in-depth interviews, and focus group discussions with key stakeholders.

We made systematic observations at the Masupe Primary School, the Maunatlala Clinic, the Palapye District Health Management Team (DHMT), the Maunatlala Community Library, and during events organized as part of the Special Olympics celebrations. Infrastructure, resources, interactions between the teachers and students, and student to student interactions were observed at both the Masupe Primary School and the Maunatlala Clinic. These observations were used to formulate questions for interviews and develop generalized understanding of the needs of the individuals with disabilities in the community.

We conducted in-depth interviews (10 open-ended questions) with a number of stakeholders to gain an understanding of the participants' knowledge, experience, and opinions related to disability, and to gain better insight as to how policy related to disability was implemented at the community level in Maunatlala. Each interview lasted for approximately 45 to 60 minutes. Prior to each interview, all interviewees were informed about the purpose of the interview, what we hoped to gain from it, and how we planned to use the interview in our research. We received informed consent from each participation and asked for their permission to take notes before beginning each interview.

We interviewed administrators and teachers at the Masupe Primary School. These included special education teachers, general education teachers, and the school principal. Interviews with special education teachers were helpful in gaining a comprehensive understanding of the special education program offered at the Masupe Primary School. The principal of Masupe Primary School served as an excellent source of information about children with disabilities in the community

and her vision for the special education unit. The school principle played a pivotal role in establishing the special education unit in 2016. Since then the school has admitted 35 students with disabilities. This sparked considerable discussion not only about issues related to individuals with disability in Maunatlala and its neighboring communities, but also about the Masupe school's aspirations to grow its capacity to admit and educate students with disability.

During our visits to the Maunatlala Clinic we spoke with several staff members and collected information about the level of services that are provided to individuals with disabilities. We interviewed representatives of the District Health Management Team (DHMT) in Palapye and the only physiotherapist serving health clinics in the region. We learned how the healthcare system operates at the levels of the hospital, satellite clinics, and health posts. We also learned about the acute shortage of staff, especially health care specialists and other vital resources in the region.

In our numerous interviews with Maunatlala's social worker, we learned about the perceptions of disability in the community, challenges that families with individuals with disabilities face, and the disabilities services that they receive. The social worker facilitated an informative focus group discussion with 10 community caregivers. We learned of the struggles of the caregivers and suggestions to improve their quality of life.

Data analysis

We transcribed all in-depth interviews and focus group discussions. We identified codes and repetitively occurring themes/concepts (concept/theme saturation) in each transcript and across transcripts. We also coded participant observation notes to identify commonly occurring themes. Each interview was reread multiple times, coded for *a priori* codes, which emerged from research objectives and theoretical frames. Thirteen *a priori* codes emerged from the data collected, which were used categorize data:

1. Resources (funding)
2. Transportation
3. Professional training
4. Life skills development
5. Integration
6. Facilities/Equipment
7. Human resources
8. Education structure
9. Community perception
10. Familial perception
11. Suggestions
12. Emotions
13. Stakeholder collaboration

Using multiple methods of research increases the validity and reliability to the study through triangulation and cross-checking for inconsistencies, further supporting the findings. The use of multiple research methods also reduces researcher bias. Lastly, observations of non-verbal communication during interviews also served as another good test of validity and reliability. Based on our research, we have identified four overarching themes; (1) culture of vulnerability, (2) determinants of disability, (3) educational resources available for persons with disabilities, and (4) social cohesion. We used these themes to develop specific recommendations to help the Maunatlala community and key stakeholders to effectively serve individuals with disabilities.

III. RESULTS

The following four themes, relating to people living with disabilities in Maunatlala, emerged as important topics of discussion:

1. Culture of vulnerability
2. Determinants of disability

3. Educational resources for persons with disabilities
4. Social cohesion

Each theme and relative sub-categories are described in detail below, illustrated by representative quotes directly from community stakeholders (Table 2).

Table 2. Community Stakeholders' Perspectives on Disability

Theme		Representative Quote
1) Culture of vulnerability		
1.1)	Perceptions	
a.	Community perceptions	*"*Disability use to be associated with infidelity. If a mother has a child with a disability than they sleep around while they were pregnant. They place blame on the mother or the father." "When it comes to kitchen utensils. They will not allow them to share with those with disabilities. They won't allow themselves to touch or have a bond with these people because they believe that the disability will be passed along. They think they can contract the same illness."
b.	Familial perceptions	"The kids often live with grandparents because someone who is younger expects when they have a child to have a very healthy baby. You do not think of them as crippled. When the baby is born and something is wrong with them the mothers rely on their parents to raise the kids because they do not want to do it or do not know how to take care of someone who requires extra care."
1.2)	Social stigma	
a.	Redirection	"In Maunatlala there is not anyone who has a severe disability, but in surrounding villages they hide them. They are embarrassed or simply do not have the means to care for these people, so they keep them away from the rest of the community. They do it so that they do not bother anyone else."
b.	Silencing	"Sometimes they think their kid is just stupid. They do not realize that there is a problem. Sometimes they do not want to draw more attention to the problem."
2) Determinants of disability		
2.1)	Low-income and socioeconomic status	"He [local boy with severe disability] is seen in the office a lot. He requires medical care like certain food that costs a lot. The government helps, but it is still stressful to the family."
2.2)	Consequences of determinants	
a.	Educational Consequences	"The students just sit at home. They do not go to school. Some of the parents might have enough money to take them themselves, but it is not typical."
b.	Uncertainty of diagnosis	"I wish I knew how to assist my child, but I was never told his problem. I can adapt but need more information. They need to have workshops that can teach us because taking them [person with a disability] and isolating them is what will happen if the parents are not aware."
3) Educational resources for persons with disabilities		
3.1)	Integration structure	

a.	Life skill development	"The intention is to make [the special education unit] a functional learning center. I just want to turn the school into a training center so that the disadvantaged learners could get something in life. Could be independent in life. You know even if the child is being left alone, they can go around and get something to grow/learn." "I talked about the functional curriculum. That is the curriculum that prepares them to be integrated into the society. There are departments where we take the learners into the society. Like example, take them to the shops to teach them how to buy. We take them to the clinic, so they are able to… in case they are sick, they are able to go on their own to the doctor."
b.	Mainstreaming	"My overall goal is to see these kids working and assimilated into day to day life. Whether that be through a mainstreamed education or a vocational skill training, their integration into society is key."
3.2)	Special educator training	
a.	Benefits to educator training structure	"Currently there are around 80% passing so basically the schools are doing very well. The ID students are working closely with ID trained teachers. With Masupe, the advantage itself is the school head, Pinkie, is having the Special education qualifications and she has appeared in special education so it's good when you are having teachers lead by someone with a background in special education."
b.	Gaps in educator training	"I think I have adequate training for general ID. Though, I'll say yes in a way but there are certain aspects that I feel I'm lacking in. More especially when it comes to children with Autism." "I think that our training should be made in such a way that it also trains on multiple disabilities. Right now, it is vague ID [intellectual disability]. Not all learners they have one area of disabilities. They have multiple areas in which we are able to identify developmental delays. For example, they could have autism, ADHD and ID all in one child. So, we are unable to address such learners because we were not trained to work with a multidimensional issue."
4) Social cohesion		
4.1)	Community stakeholder collaboration	"No project, no matter how small, will be complete until staff at the clinic, primary school, and social work come together."
4.2)	Bridging networks	"We [medical professionals] are not trained to work with the disabled population or other organizations that are connected with them. We are limited in this area. All levels of healthcare struggle with this same area. That population is so small, and disability is just now becoming a topic of discussion so many people including healthcare workers are not trained to work with this population."

Theme 1: Culture of Vulnerability

Omission or non-inclusion of disability exacerbates the vulnerability of individuals with disabilities who often face limited choices, in part, due to preexisting social, cultural, and economic constrains.

Many community stakeholders discussed how the success of a person with a disability relies heavily upon their acceptance and inclusion into the family and community. The primary concern was closely linked to cultural misconceptions of disability. Most participants expressed concern that folk beliefs influence the people's perceptions and behavior towards individuals with disabilities. Some of the misconceptions listed below are unique to Botswana and may influence an individual's behavior towards individuals with disabilities.

"The birth of a disabled child suggests that the mother or father engaged in infidelity."
"Kitchen utensils should not be shared with individuals with disabilities."
"Disability is a contagious illness."

Many young parents give up their child born with a disability for adoption or to be raised by grandparents, in part, due to misperceptions and the negative stigma associated with a child with a disability. In such a situation, the child is either taken in by the grandparents or they are neglected or orphaned, thus making them vulnerable.

> *"The kids often live with grandparents because someone who is younger expects when they have a child to have a very healthy baby. You do not think of them as crippled. When a baby is born and something is wrong with the baby, the parents rely on grandparents to raise the child because they do not want to do it or do not know how to take care of someone who requires extra care."*

Several grandparents in Maunatlala raise their grandchildren with disabilities or younger relatives who might not otherwise have a home. Caregivers expressed concerns that their children would not be accepted into the community; however, they explained that they, as parents of children with disabilities, must display overwhelming compassion as a means to counteract the negativity. Regardless of the negative societal constraints associated with disability, numerous caregivers described a sense of reward and humility when asked about their life with a family member with a disability. It seems that strong familial ties and compassion have encouraged caregivers to change their ways of life to adapt to the needs of individuals with disabilities.

> *"You have to let them know that even though they are disabled, it is not the end of the world. They can do something for themselves. We need to see the disabled person as someone who is normal. We need to give them love in order for them to feel welcomed in the community."*

Multiple stakeholders noted that individuals with disabilities are mostly invisible in the community's social life due to embarrassment and stigma associated with disability. Since the topic of disability is not openly discussed in Maunatlala, conversations surrounding this topic often lead to inadvertent linguistic and non-verbal avoidance, which includes coded conversations, omissions, indirections, and silencing of prognosis and treatment. Discussions related to disability may be redirected to focus on a more comfortable issue. Participants were asked about their perceptions of their peers with disabilities and their thoughts of an inclusive society. The data suggests the use of both verbal and non-verbal cues were used by individuals to change the topic. Such redirection indicates an attempt to elude having to express personal opinions about disability.

> *"In Maunatlala nobody has a severe disability, but in surrounding villages, they hide them. They are embarrassed or simply do not have the means to care for these people. So, they keep them away from the rest of the community."*

Silencing of prognosis was arguably the most important mode of avoidance among participants. Disability is stigmatized and considered a taboo topic. Such actions further marginalize individuals with disabilities. Those who work directly with individuals with a disability were inclined to speak more positively about their peers with disabilities than those who lacked such interactions in their daily lives. For example, those working directly with the Special Education Unit at the Masupe Primary School expressed the need to eliminate the negative stigma and instead look at disability not in terms of inability, but adapted ability.

> *"My vision as an individual, to me it is that disability is not inability. I very much want to see them prospering just like any other human individual."*

Such observations suggest that knowledge can counteract the historic stigma that has been so strongly influential on the perceptions of the persons with disabilities in Botswana.

Theme 2: Determinants of Disability

Globally, poverty and disability are inextricably linked. Poor individuals with disabilities have poorer health outcomes than those who have sufficient financial means to support themselves. Poverty adversely impacts the level of health care received by an individual with disability. Key stakeholders in Maunatlala expressed concern that individuals with disabilities in the village have inadequate access to life supporting resources. Such resources include everyday needs and sustenance (food, diapers, crutches, etc.) and specialized care (physiotherapists, speech therapists, psychologists, etc.).

> *"He [local boy with severe disability] is seen in the office a lot. He requires medical care like certain food that cost a lot. The government helps, but it is still stressful for the family."*

Limited education and skill development are some of the serious consequences of such marginalization of individuals with disabilities. The Masupe Primary School Special Education Unit serves five out of the twenty-two villages in the central region of Botswana. The unit has two busses that are able to bring children with varying disabilities from the five villages that are geographically close to the Masupe school. Children with disabilities living in other 17 villages in the region are unable to access the services and infrastructure at the school. Many parents are unable to bring their children to the school due to limited income and resources.

> *"The students just sit at home. They do not go to school. Some of the parents might have enough money to provide private transport, but it is not typical."*

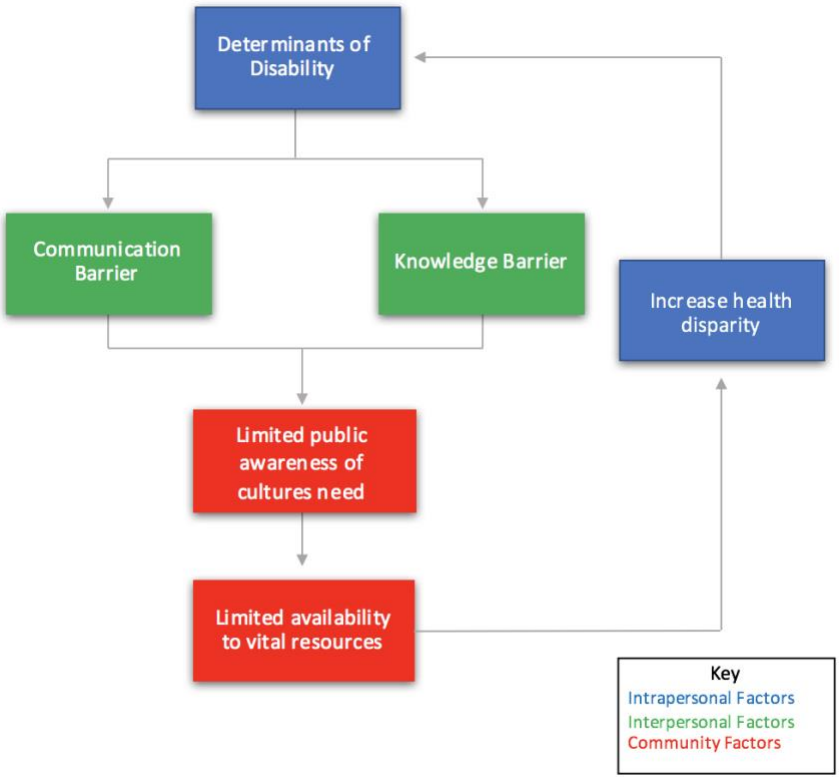
Low household income severely limits the ability of the parents to provide education and skill-building opportunities for their children with disabilities. Furthermore, physicians who assess and monitor individuals with disabilities are located at facilities far away from Maunatlala (Serowe - 130 kms and Francistown - 212 kms), a large number of the patients are unable to seek medical advice and treatment.

> *"I wish I knew how to assist my child, but I was never told his problem. I try to adapt but need more information. They need to have workshops that can teach us because taking them [disabled person] and isolating them is what will happen if the parents are not aware."*

At the Masupe Primary School there are students in the general education classrooms that are in need of special education services. However, they are unable to be properly assessed for learning disabilities by a medical professional. This adversely impacts their academic performance. Students with speech-related disabilities are unable to express their needs and rely heavily on community members to advocate for their well-being. If caretakers are unable to explain the individual's ailments and health professionals lack cultural humility training, this population will most likely be unable to receive sufficient care.

Exposure to these disparities creates a negative cycle impacting individuals with disabilities in Maunatlala (Figure 1). Communication barriers and preconceived notions of disability make it difficult for the general population to understand the health and social needs of this population, people living with disabilities. Since individuals with disabilities are unable to fully express or advocate for the need for vital services and resources, they continue to exist at the margins of the Maunatlala community. However, the local Community Development Officer, working under the Ministry of Local Government, is proactive in bridging the gap between policy and implementation in Maunatlala. She has done an excellent job building a relationship with those with disabilities and key stakeholders within the community. We can build on this excellent work by developing a network of high-ranking government officials from of the Ministry of Local Government, the Ministry of Education, and the Ministry of Health and Wellness to address the issues of individuals with disabilities and their families in Maunatlala and Botswana at large.

Figure 1. Determinants of Disability



Theme 3: Educational Resources Available for Persons with Disabilities

The central district of Botswana has only two special education units assisting children with intellectual disability. One such unit is in Maunatlala (Masupe Primary School) and the other unit is in Palapye. In 2013, the Masupe Primary School noticed the need to develop and implement a special education program that would serve local students living with intellectual disabilities. Sparked by the enrollment of a student with Down's syndrome, the current principal created a clear vision for such special education service. The Masupe Special Education Unit officially opened on April 8th, 2016 under the leadership of individuals who hold educational background in intellectual disability. The leadership established by the current principal has proven to be foundational to developing a progressive program for this community. This program encourages students and staff to work towards classroom integration and minimizing the inequity of education efforts and opportunities for by children with disabilities. Currently, the Masupe Primary School Special Education Unit is has thirty-five total students in the special education unit ranging from age 6 to 23 years. These students come to the school from five local villages, including Maunatlala. There are additional twenty-two villages that fall into the Masupe Special Education boundary, but due to limited resources (transportation, dormitory facilities, classroom space, etc.), the Masupe School's Special Education program is unable to accommodate any more students. By our estimates, an additional seventeen children with disabilities in the region need a special education school.

The Masupe Special Education Unit is designed to promote life skill development and encourage mainstreaming for the higher functioning students. The program works to counter negative misconceptions of disability and encourages the idea that disability is not inability. With the proper tools developed by this special education program, children with disabilities can grow to be productive members of the society. Staff, students, and parents all agree that the overall goal of special education is to promote participant independence and functional skills that sets them up for success in life in addition to academic achievements. The special education unit at the Masupe Primary School is committed to student success. Although some students with intellectual disabilities do well in the classroom setting, others need specialized care and training that goes beyond the general education curriculum.

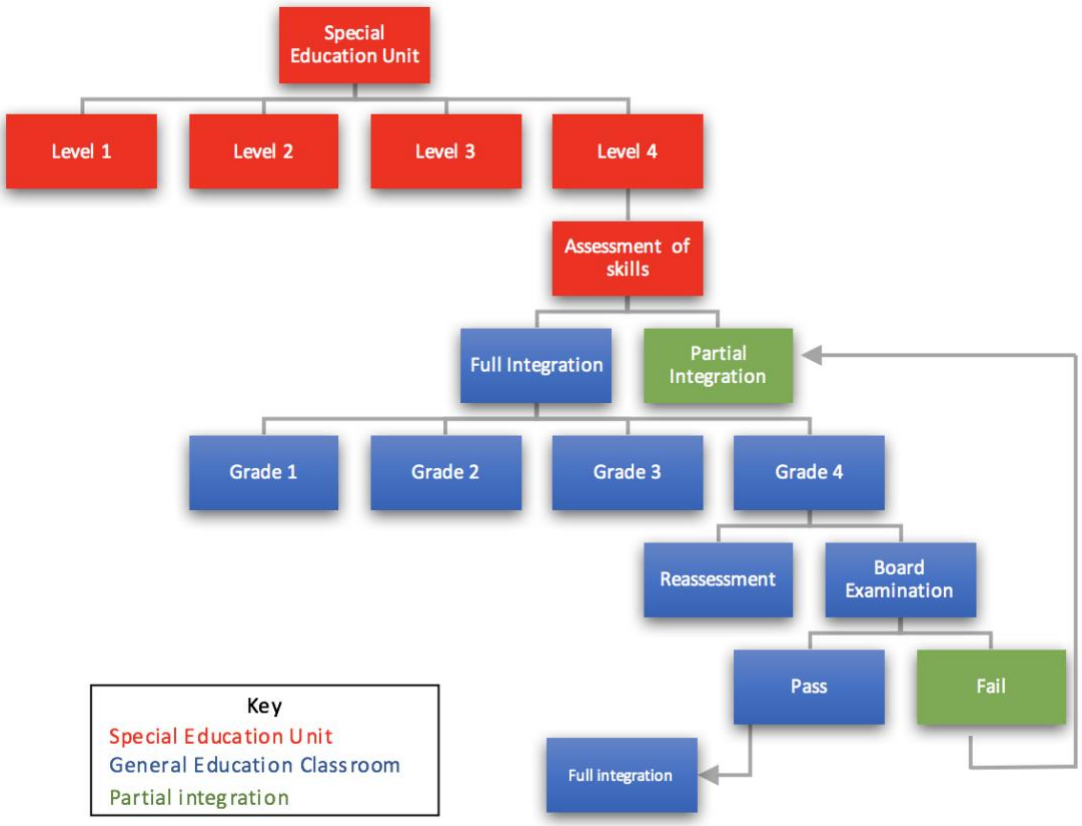
Staff at the Masupe Special Education Unit outlined several functional skills taught to students that focus on four main specialties: (1) labor, (2) family and consumer science, (3) fine motor movements, (4) social interactions. Specific components of these functional skillsets, as described by research participants, are outlined in Table 3.

Table 3. Functional skills taught at Masupe Special Education Unit

Functional Skill	Examples
Labor	Brick laying, welding,
	construction, & plumbing
Family and Consumer Science	Cooking, weaving, gardening, & cleaning
Fine motor movement	Walking/standing, grooming, & self-care
Social interaction	Vocational skills, peer communication
	Outings (doctor office, grocery stores, etc.)

The current curriculum for the Special Education Unit at Masupe Primary School is organized into four levels. Each level is developed to emphasize unique adaptations depending on the student's individual need. The mainstreaming process and assessment for the special education student is outlined in Figure 2.

Figure 2. Process of mainstreaming students in the Special Education Unit



Theme 4: Social Cohesion

Individuals with disabilities are primarily served by four governmental entities: (1) Ministry of Education, (2) Ministry of Health and Wellness, (3) Ministry of Local Government, and (4) Ministry of Youth Empowerment, Sport, and Culture Development. These entities collaboratively play a valuable role in providing services and to ensure the overall well-being of people with disabilities in the community. We spoke with a number of individuals who recognized the need for

more cooperation across different government entities and expressed that competent leadership is vital to raising awareness of disability issues.

> *"No project, no matter how small, will be complete until staff at the clinic, primary school, and social work come together."*

The government entities listed above offer segmented services to individuals with disabilities. There is an urgent need for the government departments to work together to identify areas of overlap, gaps, and synergy in terms of the services that they offer individually. Such a cooperative and collaborative exercise could lead to improvements in the delivery of services that focus in individuals with disabilities. During our study, we learned about need to better link policies/legislation related to disability and the implementation of programs aimed at helping individuals with disabilities. It seems that much of the policy making and program implementation processes related to disability tends to have an urban focus. Rural communities simply do not have the resources or personnel to implement such policies and programs. Furthermore, government entities should consider offering opportunities for disability-related training for medical professionals working at all levels in the healthcare delivery system.

> *"We [medical professionals] are not trained to work with the disabled population or other organizations that are connected with them. We are limited in this area. All levels of healthcare struggle with this same area. That population is so small, and disability is just now becoming a topic of discussion so many people including healthcare workers are not trained to work with this population."*

Care providers, community members with disabilities, and government officials working closely with individuals with disabilities expressed the need to broaden policy and social boundaries through bridging networks. Doing so will encourage open communication among all entities involved and lessen the disparity gap between individuals with disabilities and their peers without.

IV. RECOMMENDATIONS

Recommendation 1: Establish a Disability Services Unit in the Maunatlala clinic

We recommend that the Ministry of Health and Wellness consider establishing an integrated Disability Services Unit at the Maunatlala Clinic. The implementation of a Disability Services Unit would allow for community members with disabilities to have a safe place to go to receive care and information related to mainstreamed disability services. Limited services related to physiotherapy, psychology, and occupational therapy are currently offered at the Maunatlala clinic. Providing this space would allow this population to seek resources in an environment where they feel comfortable surrounded by individuals who are able to advocate for their needs.

Recommendation 2: Employ Community-Based Disability Workers at the Maunatlala Clinic

We recommend that a select group of clinic members be trained to become certified Community-Based Disability Workers. These community-based workers provide help to individuals with disabilities with their healthcare needs and assist in creating an inclusive social environment to promote integration and social inclusion. This strategy would reduce the current disparities between those with disabilities and those without, giving them a sense of normalcy while encouraging their participation in everyday society. Furthermore, community disability workers will help build relationships and gain trust of the individuals they serve and could play a pivotal role in improving community perceptions of individuals with disabilities. Our group will be interested in working with key stakeholders to develop such a training program.

Recommendation 3: Implement Teacher Training Programs for both Special Educators and General Educators

We recommend implementing teacher training program that are specifically designed to address the local training needs of teachers on issues related to students with disabilities. Such a program would allow both the special education teachers and the general education teachers at Masupe Primary School to gain valuable knowledge on how to work with students with disabilities of both high-incidence and low-incidence disability. Currently the special education teachers possess general knowledge of intellectual disabilities. However, after interviewing key stakeholders in the community, we learned that they may need comprehensive training to with students with a broad range of intellectual disabilities.

The training program should focus on low-incidence disabilities, primarily autism spectrum disorders. Teachers who participate in the program will learn how to assist these students educationally and socially through a series of tools and strategies. We recommend that training be mandatory for both the special educators and the general educators. Training for general educators would touch on broader strategies for working with students with disabilities in a manner that would allow them to support students in the general classroom. Our group will be interested in collaborating with key stakeholders to develop a locally relevant teacher training program to support children with disabilities.

Recommendation 4: Implement Community Integration Activities

Misconceptions, overgeneralizations, and communication barriers create negative perceptions and vulnerabilities for the population with disabilities. This in turn makes it difficult to receive proper education and treatment. Additionally, it affects the self-esteem of individuals with disabilities and their integration into society. We recommend the following two programs to address these issues:

I. *Caregiver Workshops*

In order to shift social norms around disability, parents and caregivers should be educated on proper care of individuals with disabilities. There should also be community engagement with those who identify as having a disability. We will assist local stakeholders, especially social workers in Maunatlala to organize a workshop for caregivers and parents on how to care for children with disabilities. Social workers can provide parents and caregivers with clinical and government resources they have access to. The workshop can also help with dispelling misconceptions and uncertainty about individuals with disabilities.

II. *Inclusive Social Club as an Extension of the Brighter Kids Program*

We recommend a social club for children with disabilities as part of the Brighter Kids program in Maunatlala. Such a program can help create a safe and friendly environment for children to interact and play with others like them. Activities can include sports or game nights. They can develop healthy relationships and grow a strong support system. This will increase a child's self-efficacy and self-image and allow themselves to feel comfortable integrating into the community. Additionally, by allowing the community to see that special education children interacting together rather than being hidden, it would gradually normalize their presence in the community. Future directions for this recommendation include developing a proposed program and implementation strategy.

Recommendation 5: Increase Accessibility

Increasing the accessibility in Maunatlala is a multidimensional recommendation that is vital to improving the state of life for those with disability in Maunatlala. Increasing accessibility includes improving the transportation, adding necessary human resources, updating facilities, and providing funding.

Improving the transportation system amongst the villages surrounding Maunatlala would be beneficial in several ways. First, it would allow more students with disabilities to attend the Special Education Unit at Masupe Primary School. Masupe currently provides an adapted education opportunity for five of the total twenty-two villages in the region. Children with disabilities, whose parents cannot afford transportation, are unable to go to school and are confined to their homes. Adding transportation would allow more students to attend school at the special education unit and would be especially beneficial for those who are unable to walk. Secondly, improving the transportation system would allow for more individuals with disabilities to access general care at the clinic or specialized care in Palapye.

Increased accessibility to human resources also plays a large role in improving resources for those with disabilities in Maunatlala. Individuals living with disabilities need trained caregivers and personal aids who can help them with daily tasks so they can be integrated into the community. People with disabilities are also in need of specialty care from physiotherapists, occupational therapists, speech therapists, among others. There is currently only one physiotherapist with a single occupational therapist assistant for the entire central district located in Palapye who only visits Maunatlala once a month. If individuals with disabilities are unable to reach the clinic on the schedule day the physiotherapist is there, they forfeit their care for the entire month.

SECTION II: SEXUAL AND REPRODUCTIVE HEALTH (SRH)

I. INTRODUCTION

Globally, youth are highly vulnerable to negative sexual and reproductive health (SRH) outcomes. Such health outcomes include unintended pregnancies, maternal morbidity and mortality, gender-based violence (GBV), and sexually transmitted infections, including HIV/AIDS. With a total population of 2.3 million, Botswana has the fourth highest HIV prevalence (20.3%) in the world, despite the provision of universal free anti-retroviral treatment (ART) to people living with HIV. (UNAIDS, 2018). Botswana's youth face many challenges, including lack of access to knowledge about SRH issues. Moving youth from a position of vulnerability to a position of empowerment is essential to improve health outcomes and ensure an HIV/AIDS free generation in Botswana. Providing comprehensive SRH education is 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 wellbeing and reverse the HIV/AIDS epidemic and improve health and well-being.

Based on our comprehensive engagement with key stakeholders in Maunatlala and the Ministry of Health and Wellness, since 2017, we propose to implement a comprehensive SRH education program that is locally relevant and culturally sensitive and empowering to the Maunatlala community. In 2017 and 2018, we undertook an extensive needs assessment on SRH-related issues following the principles of community-based participatory research. We engaged key community stakeholders in Maunatlala to develop a program for students studying at the Junior Secondary School in the village. These key stakeholders included clinic staff, schoolteachers, parents, and youth. Our proposed program will use both school-based and family-based intervention strategies. In summer 2020, we plan to pilot test the comprehensive SRH education program at the Junior Secondary School in Maunatlala. We will collaborate with youth volunteers and a select group of parents to train as implementors of the program and to periodically conduct monitoring and evaluating to assess the outcomes and impact of the program. Through community engagement and implementation of this program, we aim to foster a healthy, self-confident, and HIV/AIDS free generation.

II. METHODS

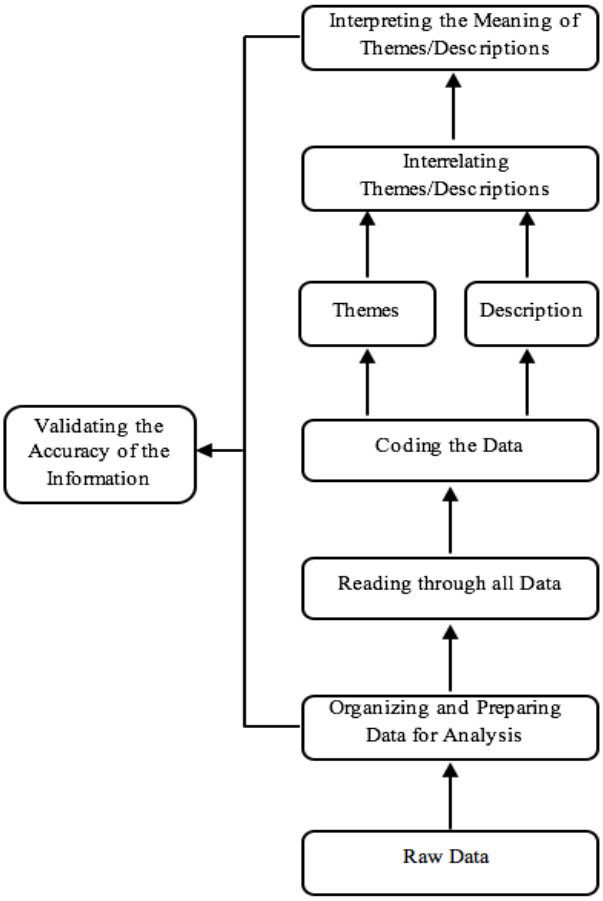
In summer 2019, we identified key topics of the comprehensive SRH education program using the Sustainable Community Ownership, Partnership, and Empowerment (SCOPE) strategy – an extended form of community based participatory research – to promote reciprocal learning and community empowerment. As part of the SCOPE strategy, researchers and community stakeholders work together throughout the research and intervention process. They are co-learners and form an equal and collaborative partnership fostering reciprocal learning, community ownership and empowerment, sustainability, and capacity building.

We began by recruiting key community stakeholders to work with us to design a program that is locally relevant and culturally sensitive. Eligible study participants had to be 18 years and older. We collected qualitative data using in-depth interviews and focus group discussions (FGD). During these interviews, a participant's consent was obtained through verbal agreement. We asked open-ended questions, and recorded responses through note taking and voice recording. Data were collected until we reached a point of concept saturation where no new patterns or themes emerged.

We transcribed all interviews and FGD recordings. After data cleaning, where we identified what information was usable or relevant to our study, we engaged in deeper immersion and analysis of the data. We analyzed all qualitative transcripts using the recommended data analysis protocol, which included chunking or clustering, assigning *a priori* and grounded theory codes, and identifying recurring themes. Coding was reviewed and validated by at least one researcher (see Figure 1).

A key component of the SCOPE strategy is the dissemination of research findings to the community. Therefore, we presented our preliminary findings and training components to community members of Maunatlala and government entities, including members of the Ministry of Youth and Wellness and the Ministry of Youth Empowerment, Sport, and Culture Development for feedback. The final SRH education program incorporates the feedback that we have received from all of the above-mentioned stakeholders.

Figure 1. Data analysis steps in qualitative research



III. RESULTS

Thirty-five individuals from Maunatlala participated in the study. We conducted In-depth interviews with seven parents, six health professionals, four youth group representatives, two government officials, and seven schoolteachers. We conduced a focus group discussion session each for men and women. Some of the patient-participants, who stay in Palapye, visit Maunatlala clinic for ART due to their medical history with this clinic. In-depth interviews and FGDs focuses on the knowledge of sexual and reproductive health among youth between the age group 10-15 years. All the participants are >18 years and part of the Maunatlala community. The following themes emerged as a result of the qualitative data analysis.

1. Sexual and reproductive health knowledge
2. Puberty, Reproductive Anatomy and Physiology, and Pregnancy
3. Social issues
4. Gender-Based Violence

Table 1. Themes and Representative Quotes

Theme	Representative Quotes
1) Sexual and Reproductive Health Knowledge	
1.1) SRH risks	"It's very important to teach them about reproduction, sexual reproduction because most of Botswana they didn't, they don't know the consequences of having sex without protection, so it is very important to learn so that they can be protected from diseases, STIs, and other diseases like HIV/AIDS" - Father
a) STD/ HIV	"People around here are worried because most of the people have died due to HIV and other STIs. They are worried but some they are not worried because if they were worried like us then they must use condoms to protect themselves. Most of the people are worried because families are finished because of HIV and other STIs" – Father
b) Teenage pregnancy	"It's because they see a lot of problem in our country, because nowadays in our country we find that a young girl having a child, having a child at the age of 15 is a problem because, it's because of lack of knowledge because currently in our culture you can't say anything about sex with a young child as a parent. It is our culture." – Mother
c) Contraceptives	"They are using implant and pills, and when they are using those things they forget about HIV/AIDS they don't take care of themselves and do not use condoms is when they get HIV/AIDS ... they have to be taught that when you use implant, pills, or depo, you must always use a condom." - Father
- side-effects of contraceptives leading to fear of use	"Yeah this one is a problem. Some they take. some they take and some they are saying (men) their partners. males…they say that they are killing us. Because they are taking tablets… my kidneys will be destroyed. They don't allow their partners to take them. Even them... the women they have a belief that there are side effects. If they have seen somebody or if they had heard somebody saying that "I was using depo Provera the injection... I took it for a long time. I did not get my periods for a long time. Either it took time, or it can come and go in 2 weeks. Periods are mostly on and off and sometimes there are just some drops. So, they don't take it because they believe that even they can have this problem. Some they take and some they won't take. They won't use them." – Health Professional
d) Inability to discuss SRH topics leading to lack of knowledge	"They are saying in our culture you just, you just see yourself growing breasts and menstruating. No one will tell you that this … something like this is going to happen. Most of them were crying, they thought they were sick because no one told them to expect that, but like we are saying these days it is better because it is there in schools, but there is this gap between parents and their daughters, like our culture most of it … it doesn't allow like, we are not free to talk to our daughters because of the culture … where when uh, the mothers are not free to talk to their daughters like you should expect this. Like this is how you should behave so most of the time if it is taught in schools like this it will be better because maybe the teachers will do their job." – Mother
- Limited number of people comfortable discussing it,	"We cannot talk about it to our family, but we can talk about it only at the clinic as a health worker. But not much outside because it is confidential." – Health Professional

	generally those whose job it was to talk about it (i.e. teachers or clinic staff)	
	- Not teaching children leads to risky behaviors and spread of disease	"In our culture we find that some knowledge about sexual reproduction is private, so it's not spoken of. It's, it's like we have when a child grows up, those stages of growth where you give them personal information about the stage where they are, the sometimes it's too late because you, you either withheld information until too late." - Mother "[Some children] they are born from HIV/AIDS. So, when they are having sex without knowing they will affect others. Others they will be infected because they don't know, they don't have knowledge, they are not taught about these things." - Father
2) Puberty, Reproductive Anatomy and Physiology, and Pregnancy		
2.1) General knowledge of reproductive systems and pregnancy		"I remember one of them was asking me in fact, "what are the fallopian tubes?" And I was asking him why he was asking such a question, he said, "the teacher has asked us to know about the fallopian tubes" then he was asking it in Setswana, he was a boy and he asked, "Do I have fallopian tubes also?" And I said no, fallopian tubes are only females not in males." - Mother
	a) Lack of knowledge about puberty	"Children in the village are not taught about puberty. When they attain puberty, they feel that there is something wrong happening with their body. They fail, and they lose confidence. There is a lot of stigma around menstrual hygiene in the Maunatlala community." – Health professional "
	b) Information about pregnancy	We are never open with our kids when it comes to sexual reproduction. I will give you a typical example, when a kid comes to you and says, 'I've seen this lady with a big tummy', we don't feel comfortable to tell her that the lady is pregnant and that this is actually what happened for her to get to that stage. We normally say, 'she's carrying a watermelon and then she is going to buy the baby at the clinic'. Or something like that, I am indirectly answering you, but you get what I mean." – Mother
	c) Need to promote antenatal care	"They are aware because in the morning we have health talks. Yes... morning health talk, we talk about those things. Even when a teenager is having a baby, we encourage them to deliver the baby at the hospital and not at the clinic. We are trying to avoid what can happen because they are still young. We always talk about SRH. Sometimes we talk about it, not always. But most of the time. Because this is the concern in our village." – Health Professional
3) Social Issues		
2.3) Alcohol and drug abuse		"most of them they are getting these diseases HIV/AIDS and STIs at the bars when they are drunk, they have alcohol and then they are drunk. If you take her around the corner and take (have sex) different men without a condom, is where they get HIV/AIDS." – Father
	a) Relationship of alcohol and SRH issues	"They like to ask about the impact of the teenage pregnancy, dangers of sexually transmitted diseases. Hmm What else… even they like to ask about this question, not question... it's a comment... if you take or if you abuse drugs or alcohol... you may end up falling pregnancy, you may end up having STIs because you will be drunk, you cannot when you are drunk.

		How can I express it... you lose decision making capacity." – Health Professional
	b) Examples of issues like unprotected sex and rape at/near the bar	"most of them they are getting these diseases HIV/AIDS and STIs at the bars when they are drunk, they have alcohol and then they are drunk. If you take her around the corner and take (have sex) different men without a condom, is where they get HIV/AIDS." - Father
	c) Gender Based Violence due to alcohol and substance abuse	"There is a problem with the men, the men have so many problems, we have cancers, HIVs and what else… and we are rapists. But the main problem with the men is disappearing…we should create workshops for the men, because all of the men they are the head of the house, but [comments Setswana] because we take the drugs, smoking, but men we are [comments Setswana] main problem … its better for them to be taught so they can take care of their homes and their children … Workshops at different villages as well, on how to be a good man." – Father
2.4) Lack of parental involvement		
	a) Culture doesn't allow them to discuss it	"Usually here the parents don't talk about these things with their children. They directly say that I don't want to talk about these things to my children" - Mother
	b) Parents lack knowledge on the subject	"If they feel shy talking about their sexual issues with their children and the children again, they are afraid of talking to their parents or teachers about these sexual issues." – Youth Group
	c) Issues with Grandparent providing SRH knowledge to their grandchildren	"If they go to their grandmother, they will not say anything to the children. They will just say that it is late, come and sleep. They don't know for what. Even if they have menstruation and if my mother is there, she cannot help because in Botswana grandmothers and grandfathers are shy to talk about these topics." - Mother
4) Gender-Based Violence		
3.3) Gender-based Violence due to societal pressures		"We have got so many people suffering. So many women, suffering in their marriages. You will find that a woman is married, but her husband is not taking care of their family, even if he is working. He's working, *unclear*, taking money to the bus, and after the bus he is coming home to beat the wife and children in the house/ but there are no numbers. A person might be suffering, but they are not free to tell others that they have so and so problems. They are afraid to tell. If that man hears that they said this, he's going to kill you. It's better for you to hide it for yourself. That's why we have created this group, we want to open up and talk to each other so that we can help each other." - Father
3.4) Lack of male involvement in teaching children		"Fathers should be involved. They should I think find time. The father should be taught about the development that their daughters go through and they should know that this is not for the women only. They should find time to talk to their daughters. They should talk freely so that their daughters also feel free to share their problem with their fathers. Because the fathers in Botswana are too busy. They just go to work, provide for the family and they feel that other things are only for the women. So, I think if they can be much involved in the development of their children, that would be much better." - Father
	a) Leads to girls having better knowledge than boys generally	"It is even worse with the boys, boys are normally left out as compared to women. I mean women normally find it appropriate to talk with their daughters about this subject. But they will never call the boys in, its normally maybe one sided. Its normally girl chat, not boy chat." - Father

	b) Disproportionate parental involvement.	"Okay, is a very…mothers are better than fathers because fathers also we are very angry. They don't want to talk with the kids, yeah." - Father
3.5)	Menstrual health/stigma	"Even this culture is also an hinderance because I remember that once we were preparing people for the menstrual hygiene, they felt that this is an insult to talk about the menstrual blood." – Health Professional
	a) Stigma	"Some of this they are not taught about and some of them it will be a new experience in their life. Like when we did the menstrual hygiene day they were so surprised that they have such things. Even the boys who went to the junior secondary school or primary school laugh at the girl child when they have periods. I think that is what is limiting their thinking capacity." – Health Professional
	- Children lacking knowledge causes problems	"It's not good, because you will find that a lot of teenage girls drop out of school and there are a lot of puberty issues because um they drop out of school at a young age and then others don't go back to school they become poor." – Youth group
	b) Cultural practices/examples	"Allowed in school: menstruation, personal hygiene, sexual relationship but not in depth because of conflict with parents/culture" – Teacher
	c) Lack of access to menstrual health resources	"We donated 600 packets of sanitary towels to these girls in schools. This campaign is menstrual health campaign. During this campaign we went around the schools to teach young girls about the reproductive system and what happens in the reproductive system during menstruation, how to take care of yourself during that period, the hygienic part of it. Sometimes we go door to door to teach the parents about menstruation. And ask them how they deal with this issue. We found that only women are taking part in this and education is less. We did not receive any funds from the government. We just went door to door to collect donations, writing letters to the different stakeholders, businesses. Currently we don't have a sponsor, we just ask the community to assist." – Health Professional
3.6)	Social inequality/income inequality	"There should be also a balance, because we find that our men, there is also a problem. Because of the perceptive, they think what is happening with a woman as soon as they get money. Like you hear the remarks that as soon as a woman goes into parliament, she has a position, she divorces. They think it's causing a problem. So, a man also- we need to let women know that they are- they feel neglected in the home as soon as we become economically independent. Because they're not respected as the Bible says we should respect the man as the head of the family. If you are now the head, he just feels that I can go and get another woman! So, there is a lot of education needed for a couple so that they know there should be a balance. Not because you can provide for the family to make your man feel inadequate, so the education should be balanced." – Mother

Theme 1: Sexual and Reproductive Health Knowledge

1.1 SRH Risks: STIs and HIV/AIDS

Botswana has the fourth highest prevalence rate of HIV/AIDS in the world. Most participants who were interviewed stated that STIs should be included in a sexual and reproductive health course. A father from Maunatlala commented that "most of the people are worried because families are finished because of HIV and other STIs." Although free condoms are available at the clinic, people are usually hesitant to take advantage of this facility primarily because the condoms are placed in a box in the waiting room, which is an open area that is often filled with community members who know each other. One youth leader expressed that this influences youth, because they are ashamed to be seen by elders in the community when they go to the clinic for contraceptives. A healthcare worker suggested that "we need a youth friendly clinic or youth friendly services at the clinic that are just for youth. This will promote privacy." This view is shared by many stakeholders, including youth leaders.

1.2 SRH Risks: Teenage Pregnancy

In 2017-18, there were 16 cases of teenage pregnancy in Maunatlala. One health worker expressed their concerns with the issue in an interview stating that, "I believe that the topic of teenage pregnancy is the most important topic as it is on the rise in the community." A negative outcome of teenage pregnancy has been a high dropout rate among teens. Study participants agreed that most youth in the village become sexually active between the age of 13 and 16 years. A healthcare provider suggested that some youth become sexually active as early as 10 years. A lack of knowledge of safe sexual practices and a trend of engaging in sexual activity at an early age both contribute to teenage pregnancy in Maunatlala.

1.3 SRH Risks: Use of Contraceptives

Many women participants suggested that they have used Implanon – a small plastic rod implanted into the skin of the upper arm. However, many participants were not fully informed about how this form of birth control works. Misconceptions and lack of knowledge about how different contraceptives work emerged as a common theme across our in-depth interview and FGDs. We strong believe that such misconceptions can lead low uptake of contraceptives, which can impact their sexual and reproductive health (Table 1).

1.4 Inability to Freely Discuss SRH Topics

Another theme that consistently emerged during our work in Maunatlala related to the culturally prescribed taboos surrounding discussions related to sexual and reproductive health. Parents rarely talk to their children about sexual and reproductive health. Nevertheless, many participants felt that it was important for parents to be involved in teaching their children about sexual and reproductive health. A mother from the women's focus group suggested that:

> *"In our culture you just, you just see yourself growing breasts and menstruating. No one will tell you that this … something like this is going to happen. Most of them were crying, they thought they were sick because no one told them to expect that."*

Healthcare workers consistently suggested that they were comfortable talking to youth about SRH topics. According to a healthcare worker:

> "*I love these topics and I love talking about this information to the youth and I discovered that they relate well to me."*

However even among this group the cultural prohibitions were important:

> *"We cannot talk about it to our family, but we can talk about it only at the clinic as a health worker."*

A father in the men's focus group expressed this balance of cultural pressure and the importance of teaching your children in the following way:

> *"The children are going to do what you are doing. They learn from their parents. Most important part is our culture. So, in our culture, there are things that are not good. So we must teach our children about what is good and what is not good."*

Communication between parents and children is key because not communicating with children about sexual and reproductive health can lead to the spread of HIV. In Table 1 under section 1-A-IV, one father shares that some young children may engage in sexual activity without really knowing what they are doing. Because some children are born with HIV due to the high prevalence in the country, it is possible that they will unknowingly infect others because they were not taught about HIV and sexual health.

Theme 2: Puberty, Reproductive Anatomy and Physiology, and Pregnancy

2.1 General Knowledge About Reproductive System, Puberty, and Pregnancy

Lack of knowledge about puberty is an issue that was brought up in multiple interviews. Many participants shared stories of young girls feeling afraid during menstruation because they think that there is something wrong with them. Most youth in the community lack basic knowledge about reproductive system, puberty, and pregnancy. They are unaware and unprepared for what is happening in their bodies. According to a health care provider in the village:

> *"Children in the village are not taught about puberty. When they attain puberty, they feel that there is something wrong happening with their body. They fail, and they lose confidence. There is a lot of stigma around menstrual hygiene in the Maunatlala community."*

The following comment from a parent also demonstrates the understanding in the community that children need to be taught earlier about puberty than they used to be:

> *"According to our culture it used to be a hidden thing for a child to know all these things so we talk about teenage puberty whenever culture-wise it used to be like you have to grow first to a certain age to know all these things, now things have changed and we need to know things as early as possible."*

In addition, our study identified many obstacles to discussing and maintaining menstrual hygiene. Discussion of menstruation is considered a taboo topic. Lack of knowledge about menstruation and the lack of sanitary products among the teenage women causes them to drop out of the school at puberty, making it a vicious cycle which again decreases the level of knowledge among the young girls. Finally, a strong need for education about pregnancy emerged as another important theme. Several participants from different stakeholder groups pointed out misconceptions about pregnancy that were prevalent among youth in the community. These groups suggested that our SRH education program focus on pregnancy, childbearing, menstruation, and family planning methods, especially on how the baby develops.

Theme 3: Social Issues

3.1 Alcohol and Drug Abuse

As discussed in a later section in this report, alcohol and substance abuse by youth is a serious problem in Maunatlala. Men start drinking in this community due to different reason – peer pressure, unemployment, or because of "sugar moms" and "sugar dads." Men in the focus group shared that it is a woman's responsibility to make sure that men are using condoms before sexual intercourse as they believe that when men are drunk, they cannot take correct decisions. And this leads to the spread of HIV and other STIs. One of the participants shared that there is less awareness among the people of Maunatlala about the usage of female condoms. Females must be taught that contraceptive like depo injections, implants and pills will not protect them from STIs.

> *"They are using implant and pills, and when they are using those things they forget about HIV/AIDS they don't take care of themselves and do not use condoms is when they get HIV/AIDS is what he is saying. They have to be taught that when you use implant, pills, or depo, you must always use a condom."*

Alcohol abuse is associated with gender-based violence in the community. Men rid themselves of responsibilities towards their family and take money to the bars to get drunk. Participants said that alcohol abuse leads to domestic violence towards their spouses and children.

> *"So many women, suffering in their marriages. You will find that a woman is married, but her husband is not taking care of their family, even if he is working. He's working, *unclear*, taking money to the bar, and after the bars he is coming home to beat the wife and children in the house."*

3.2 Lack of Parental Involvement

Following the normative cultural behavior, parents in Maunatlala are less involved in communicating with their children sexual and reproductive health issues, including teenage pregnancy, HIV, and STIs. Generally, mothers are responsible for preparing their daughters for puberty. Fathers play limited role in this domain. In our focus groups discussions, participants suggested that both mother and father should take charge and talk to their children about issues related to sexual and reproductive health. There was strong support for educating/training parents They should be trained about the physical development happening to their daughters so that they feel more comfortable talking to them.

> *"Fathers should be involved. They should find time. The father should be taught about the development that their daughters go through and they should know that this is not for the women only. They should find time to talk to their daughters. They should talk freely so that their daughters also feel free to share their problem with their fathers."*

In some cases, grandparents are involved in taking care of their grandchildren. Just like parents, they do not communicate with grandchildren about puberty, HIV, STIs, or teenage pregnancy related issues. They feel shy or awkward discussing these issues with their grandchildren.

> *"If they go to their grandmother, they will not say anything to the children. They will just say that it is late, come and sleep. They don't know for what. Even if they have menstruation and if my mother is there, she cannot help because in Botswana grandmothers and grandfathers are shy to talk about these topics."*

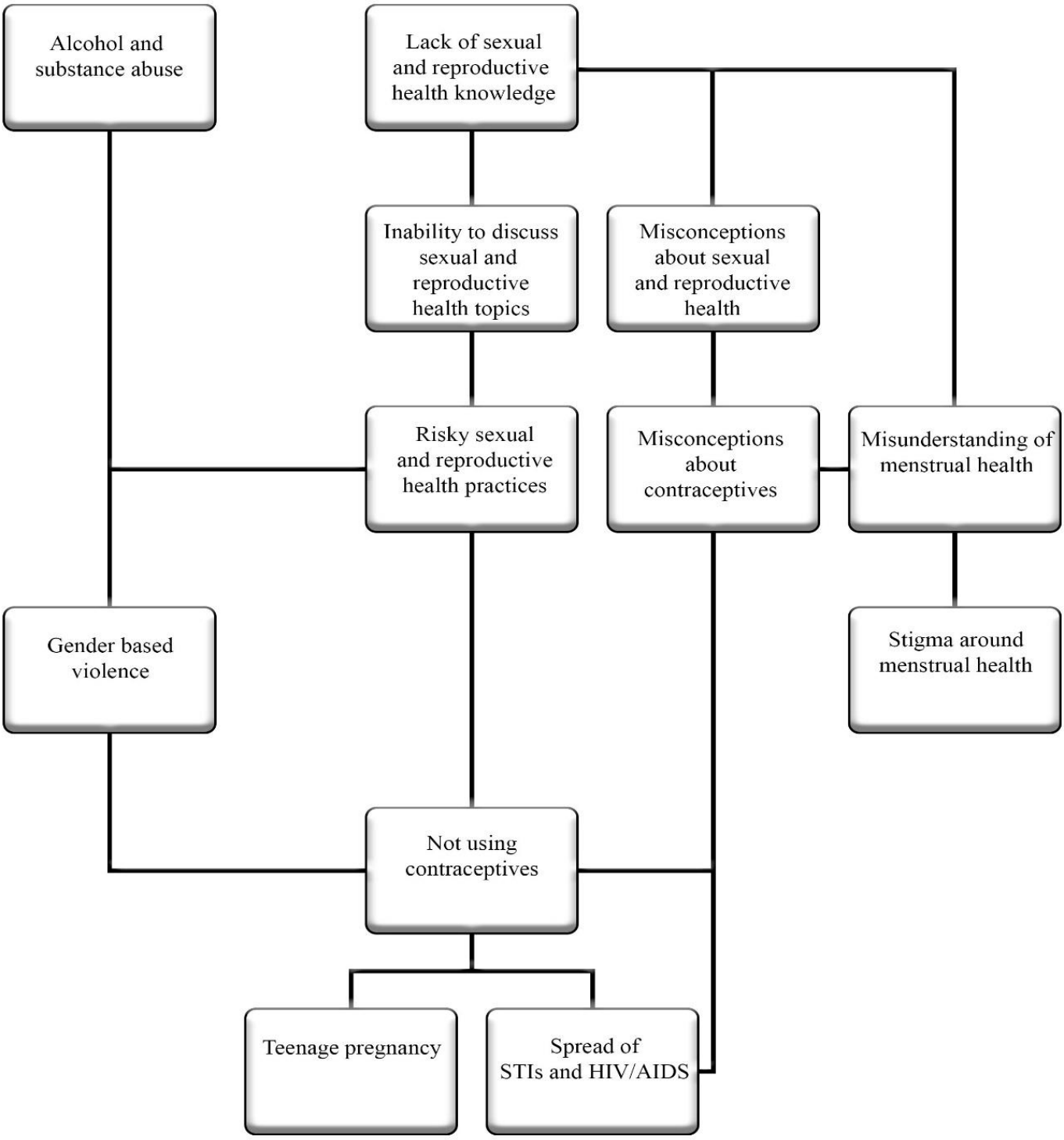
Theme 4: Gender Based Violence

Gender-based violence emerged as another common theme. Several women spoke about "suffering in their marriage." Often married women experiencing gender-based violence are also responsible for providing financial resources to maintain the household. Study participants identified alcohol and substance abuse by men as a major cause of gender-based violence. In the words of a woman study participant:

> *"He's taking money to the bar, and after the bar he is coming home to beat the wife and children in the house. A woman might be suffering, but she may not be free to tell others that she haa so and so problems. She is afraid to tell. If that man hears that she said this, he's going to kill her. It's better for the woman to hide it.*

Majority of study participants strongly advocated for including a discussion of strategies to prevent gender-based violence as part of our proposed SRH training program.

Figure 2. Flowchart showing the relationship between sexual and reproductive health and alcohol/substance abuse.



IV. RECOMMENDATIONS

I. Implementing a Comprehensive Sexual and Reproductive Health Education Curriculum

We propose to develop and implement a comprehensive SRH education curriculum for students at the Maunatlala Junior Secondary School. The curriculum will include the following key topics:

Section I	Who AM I? [Personal, family and community values, communication, adolescent development, sexuality, reproductive anatomy and physiology, and harmful traditional practices]
Section II	Where Am I Going? [Gender roles, gender equity, forming healthy relationships, and identifying and responding to positive and negative peer pressure]
Section III	How Am I Going to Get There? [Teenage pregnancy, HIV/AIDS, STIs, alcohol and substance abuse, planning for the future, sexual and reproductive rights]

As part of the SCOPE strategy, we plan to identify and train student leaders to help us implement the SRH education program. Student trainers will become role models and educators for their peers. By involving student leaders in this role, we hope to develop a local workforce that will not only effectively implement the program, but also play a critical role in changing the normative views related to SRH issues in the community. The proposed comprehensive SRH education curriculum will be modified to be used to educate parents about how to effectively communicate about SRH issues with youth in the family. For educating parents, we will adopt a strategy that is similar to the ones that will be used to implement the school-based program. We will identify and train parent leaders to help us educate other parents in the community. We will initially recruit parents of students at the Junior Secondary School as leaders, and then open such positions to other key community stakeholders.

II. Recruit Full-Time School Based Nurse

We recommend recruiting a full-time school-based nurse who is available at all times to directly support students. Currently, the school nurse has little time to spend at the school because of additional responsibilities at the clinic. This part-time situation is not enough to meet the health care, especially SRH related care, of students in the school. A full-time school-based nurse will be able to proactively identify and address student needs with timely, accurate, and youth friendly information and care. School-based nurses has been found to be quite effective in preventing the spread of HIV among youth.

III. Promote Youth Friendly Services

The Maunatlala Clinic should consider establishing youth-friendly services by including a comfortable and appropriate setting where unique physical, psychological, emotional, and developmental needs of youth can be met. These services will allow youth in the community to access sexual and reproductive health education and comfortably seek treatment in a private space. The need for a confidential setting for youth to obtain such information and treatment was identified by community members throughout our research. Providing this space would allow youth to seek resources and treatment in an environment where they feel most comfortable seeking help and asking questions, away from interactions that may potentially carry judgement or further perpetuate stigmas. This recommendation is being made based on its direct link with improving availability and access to health services, as well as reducing negative SRH outcomes.

SECTION III: ALCOHOL AND SUBSTANCE ABUSE

I. INTRODUCTION

The pastime usage of alcohol, particularly by youth, has become an increasingly prevalent problem in Maunatlala. Community members between the ages of 18 and 35 years are most likely to be heavy users of alcohol and other illegal substances. This has become both a cause and outcome of high rates of unemployment amongst this demographic. We validated such views of community stakeholders by making systematic observations at the local bars. We also noticed the lack of community engagement activities for village youth. A variety of social problems stem from the use and abuse of alcohol and other substances. A number of crimes, including theft, assault, rape, and gender-based violence are common occurrences resulting from the influences of alcohol. Other issues stem from a lack of law enforcement, such as drunk driving, public intoxication, and underage drinking. Furthermore, a wide range of negative health outcomes, including elevated rates of teenage pregnancy and STI transmission.

This problem was initially identified by community leaders in the village, who subsequently brought it to our attention as an issue with need for further exploration. In order to better understand the situation, we decided to conduct a needs assessment, with research pertaining to both proactive measures, such as alcohol education practices within the community, and reactive measures, such as addiction resources and law enforcement. Based on the information obtained, a more detailed and comprehensive plan can be developed in order to promote and target increasingly relevant alcohol related issues within the Maunatlala community.

II. METHODS

In order to conduct the preliminary needs assessment, we first defined the parameters for obtaining information. Observations and interviews were selected as our methods of data collection as they were accessible and provided an opportunity to gain a broad understanding of Maunatlala. Observations were completed while being immersed in the community, as well as during interviews.

We then established a list of key stakeholders to interview and observe. A set of criteria were followed when selecting the target stakeholders, which included: the individual's or group's understanding of youth in the community, the individual's or group's role in the village, and individuals or groups that potentially had a considerable amount of interaction with those participating in alcohol consumption. Our goal was to gain a well-rounded understanding of alcohol and substance abuse in Maunatlala from many different perspectives.

Using those criteria, we decided to focus our observations and interviews on members of the youth group (aged 18 to 35 years), clinic staff, and village leaders, all of whom were men and women in the age range of 18 to 65 years. We then developed interview questions that were both unique to their role in the community and related to alcohol and substance abuse. The questions proposed were open-ended, allowing for thoughts to be open and frank with little outside influence. Our intention was to facilitate a free-flowing conversation in order to receive candid information.

The interviews were conducted over a three-week period. During each interview we took detailed notes and made observations related to non-verbal communication. We also voice recorded interviews with prior verbal permission from the interviewees). After each interview, data were organized and analyzing using the standard protocol for qualitative data analysis. Both the a priori and grounded theory codes allowed us to determine the common themes across all interview transcripts. The themes were then used to make initial recommendations regarding positive youth engagement and alcohol and substance abuse in the community.

III. RESULTS

Of the many topics and themes that emerged throughout our interviews, youth engagement activities, or rather the lack thereof, was a prominent one. This apparent lack of youth engagement activities was described to us as one of the

leading causes of alcohol and substance abuse in Maunatlala. The only activities for youth that were brought up by community members were participation in sports and attending church. Only a limited number of young people in the village participated in these activities. Sports participation is dominated by men and limited to the daylight hours, while church is attended by only those in the community who are religious. The lack of employment opportunities for youth in the community is tied to the lack of youth friendly activities, with a community politician stating that "most of the youth are drinking too much alcohol because there are no jobs." One youth group member described alcohol as "a hobby that keeps [youth] busy," while another said youth "use alcohol as their part time exercise." Overall, it is apparent that both the lack of employment and youth friendly activities in the community have caused youth to turn to alcohol as a means of entertainment and social engagement.

Another theme that emerged during the interviews was that of perceptions of alcohol. This theme presented itself in the way people felt or thought about alcohol use in the community. We have grouped these perceptions into three broad categories. First relates to how the youth perceive alcohol to be cool. One youth member explained that "[youth] think alcohol is cool so they continue to drink more and more." On the contrary, the second perception comes from those who do not abuse alcohol. They view alcohol abuse as being a real issue in the community. One adult community member said "[alcohol] destroys life," while another explained that "most adults view [alcohol] as dangerous to use." Additionally, a clinic worker explained that "[alcohol] is perceived as one of the influencers of social ills in the community, such as theft and violence." Finally, the third perception of alcohol has stemmed from a lack of law enforcement in the community, in which youth perceive consuming alcohol as having no consequences. A youth group member explained to us as, "the drinking age is not enforced. Those engaging in alcoholic behaviors are not scared of the laws and think they can do anything." These perceptions of alcohol in a community are crucial to understanding alcohol and substance abuse in the community.

Beyond the perceptions of alcohol, we identified a third theme that relates to resources. As of now, there are no sustainable resources that currently exist to combat alcohol and substance abuse in Maunatlala. There are some preventative measures to combat alcohol abuse in the community, such as discussions in schools during health education sessions. However, these sessions are infrequent and do not always teach students to avoid alcohol or how to drink responsibly. Additionally, preventative discussions also occur in the kgotla, when leaders warn community members to "beware of alcohol." There are also two volunteers who work to prevent alcohol abuse by visiting various locations in the village to sensitize the community about alcohol and drug abuse issues. While we admire these attempts of the Maunatlala community, the current preventative resources in the village are unsustainable, infrequent, and ineffective. Beyond limited preventative resources, there are no clinical resources available to handle alcohol related issues in the community. Clinic staff do not treat individuals who are visibly intoxicated, which sparks concern that many are suffering from conditions such as alcohol poisoning without seeking medical assistance. There are also no resources available at the Maunatlala clinic specifically for those facing an alcohol addiction, nor are there any resources available outside the clinic.

Finally, despite there being very limited resources to combat alcohol abuse in the community, there are numerous alcohol related issues that were identified. From a legal perspective, drunk driving and underage drinking are abundant in the village. Several community members expressed concern for the large number of deaths that result from driving under the influence. Furthermore, crime was identified as an alcohol related issue, including theft and rape. General violence was also strongly associated as an alcohol related issue, with many instances of gender-based violence and fights commonly resulting from intoxication. In addition, unsafe sexual activity was identified as an alcohol related issue. When intoxicated, many forgo the use of condoms which can increase the spread of HIV/AIDS and other sexually transmitted diseases. This can also increase instances of teenage pregnancy. In fact, many community members associated teenage pregnancy with alcohol abuse. Beyond unsafe sexual activity, alcoholism and substance abuse have negative health impact and adversely affects academic performance by becoming a distraction from school and studying. The prevalence of inappropriate sexual relationships between young women and older men or young men and older women was also identified as an alcohol abuse related issue as older individuals often provide youth with money and alcohol in return for sexual favors. These relationships are then often tied to teenage pregnancy and are of grave concern to many community members in Maunatlala. Lastly, alcohol is easily available to members of the community. There are four bars in the village. This has created an issue as when bars close, as previous laws have limited their hours

of operation, alcohol is sold by individuals from their homes. This creates a ready supply of alcohol that is always available, which is clearly problematic due to the multitude of alcohol related issues that exist in Maunatlala.

IV. RECOMMENDATIONS

Based on our observations, needs assessment, and interviews with members of the *Botshelo Luengo* Youth Group, the Village Development Committee, and the village social workers, we were able to assess the issue of alcohol and substance abuse among the youth in Maunatlala.

- There are very few activities to engage youth within the village. While there is a football field and some teams who compete in tournaments a few times a year, this activity appears to be primarily male-dominated and can only be utilized in the daytime due to the lack of streetlights. For this reason, we recommend that the Maunatlala youth group begin hosting community-based activities for the youth at either the local fairgrounds building or the Maunatlala Public Library. Activities could include craft nights, movie nights, watching sports events, game nights, indoor sports, dancing, or music. It is important for the community to create a space where the youth can go as a healthy alternative to alcohol use. Additionally, group activities can help to develop lifelong skills and interests, as well as positive relationships with other youth in the community. We also recognize that for some time, the *Botshelo Luengo* youth group has had goals of establishing a community recreation center in Maunatlala. While we initially recommend that the youth group serve as the host for positive community engagement activities, as we feel it is imperative that such activities be currently implemented, we believe plans for the recreation center should continue to develop as interest in the program grows.

- In Botswana, the legal drinking age is 18 years. However, youth in the community starting as young as 15 years have been known to be engaging in alcohol abuse. The main source of alcohol in Maunatlala are the village bars, which often serve alcohol to minors. To curtail this, we recommend police personnel perform random spot checks in the bars to determine if there are minors being served. Bar owners should then face legal repercussions if caught serving to underage minors. By adding legal consequences to drinking, it would desensitize the youth from drinking alcohol. Bar owners would also be less inclined to sell alcohol to minors for fear of the legal and financial consequences.

- There are limited resources within Maunatlala for the prevention and treatment of those suffering from alcohol abuse and related conditions. There is currently an educational alcohol prevention program run by volunteers who go to schools in the village. However, there are no resources available in the Maunatlala Clinic. We recommend the clinic or the village library to be a central hub for preventative resources for alcohol abuse. Alcohol and substance abuse informational resources such as pamphlets or brochures should be made available in the library or youth-friendly section of the clinic. They should contain information on the health consequences of alcohol abuse and where to obtain help. This would allow youth to access information in a comfortable environment away from interactions that potentially carry judgement or perpetuate stigmas. Clinic nurses should also be trained in addiction counseling for individuals suffering from alcohol and substance abuse. Training should include psychological counseling, healthy coping mechanisms, and social reintegration. This would give those suffering from alcohol abuse a place to go and talk to someone. Individuals needing further counseling beyond initial treatment should be directed to an alcohol addiction support group. A support group would allow for individuals to share their experiences, find healthy ways to cope, and develop an encouraging support system. This would result in long-lasting and sustainable health outcomes, making the investment in initial treatment worthwhile.

Overall, we recognize that these recommendations propose relatively immediate solutions to the issue and that there are further changes that still need to be made. However, we make these recommendations because we deem it essential to begin tackling the issue immediately for the best long-term outcome. Moving forward, we hope a more comprehensive plan can be developed in the future.

V. CONCLUSION

With the apparent issues and the potential for manifestation, we found it imperative for action to be taken. It has become clear that the youth of the Maunatlala community are struggling to find direction and are lacking in positive resources, both as a result of high rates of unemployment and the lack of positive community engagement activities. The rise in alcohol and substance abuse in the community poses a large threat to productivity and safety, with the social, physical, and mental detriments that result from such abuse being far too important to ignore.

For these reasons, the information collected regarding health care resources, issues stemming from alcohol abuse, and the lack of positive community engagement activities have resulted in an urgent need for change. The recommendations made regarding law enforcement, clinical resources, and a space for youth to engage in positive interests were constructed to combat the issue at hand. Throughout our assessment, youth in the community expressed concern and demonstrated that they are willing and eager to better their community. With this in mind, we are confident in presenting these findings and understand that our work will be taken seriously. We now hope to see progress towards change being made in the near future.

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