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ARTICLE

Meaningful Engagement and Participation of Youth in Health Programmes in Botswana: Challenges and Prospects

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Abstract

This paper highlights the importance of fostering meaningful engagement and active participation of youth in health programmes within the context of Botswana. Recognising the unique challenges and opportunities that the youth population faces, this study explored strategies to empower and involve youth in shaping and benefiting from health initiatives. The study adopted a descriptive research design; cluster sampling was used, and data were collected from 180 participants. The paper emphasizes the development of youth-friendly health services, ensuring accessibility, confidentiality, and effective communication. Education and awareness campaigns are proposed to inform young people about available health resources and to promote the use of various media platforms for maximum reach. Moreover, the establishment of youth advisory boards is recommended to integrate the perspectives of youth into decision-making processes related to health programme development and implementation. Furthermore, the research encourages policy advocacy, urging the active involvement of youth in shaping health policies that directly impact their well-being.

Keywords: Youth participation, health programmes, HIV/AIDS, sexual and reproductive health

Introduction

Botswana, a nation renowned for its commitment to healthcare and social development, stands at a pivotal juncture in addressing the health needs of its population, with a particular focus on its youth demographic. Youths, constituting a significant portion of the country's population, represent not only the future but also a dynamic force capable of shaping the present health landscape (Cowles 2021). Recognising the imperative to involve and empower youth in health-related endeavours, this study explores the concept of meaningful engagement and active participation of young individuals in health programmes within the unique context of Botswana. Health outcomes among youth not only reflect individual choices but are also deeply intertwined with the socioeconomic, cultural, and structural factors prevalent in the country. It is essential to move beyond traditional top-down approaches and embrace strategies that actively involve young people in decision-making processes, programme development, and advocacy efforts (Kaboyakgosi and Marata 2013).

In doing so, we can tap into the invaluable perspectives, energy, and creativity of youth, ensuring that health interventions are not only tailored to their specific needs but also embraced by the very demographic they seek to benefit. Hence, this study aims to shed light on the multifaceted dimensions of meaningful youth engagement in health programmes in Botswana. Future studies could explore strategies to create youth-friendly health services, enhance awareness and education, establish collaborative frameworks with youth organisations, and leverage technology for effective communication. The study explored the significance of incorporating cultural sensitivity, skill-building initiatives, and feedback mechanisms to ensure the sustained relevance and success of health interventions.

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Method

This work adopted a triangulation approach, which refers to the use of three research designs: namely, exploratory, explanatory, and descriptive. According to Natow (2020), the triangulation approach intends to facilitate the validation of data through cross-verification from more than two sources. Hence, the rationale behind the triangulation research design was premised on the fact that the study sought to describe the effects of involving adolescents and young people in HIV/AIDS and Sexual and Reproductive Health decision-making and to explain the benefits that could be obtained from meaningful engagement of adolescents and young people. The work was exploratory because the researcher is not aware of any study that has been conducted exploring the interface between meaningful engagement and the participation of youth in health programmes in Botswana. The study adopted a quantitative method in which the completed questionnaires were examined for completeness and consistency.

It targeted 200 participants but ended up with a total of 180 participants, which is 90% of the target and sufficient to make conclusions. The study was conducted in the Kgatleng District (Mochudi village). Inclusion criteria included an age range between 10 and 24 years old, having experience engaging in health programmes (eg sexual and reproductive health, HIV/AIDS awareness), and willingness to participate and give informed consent. It is worth indicating that assent for minors with parental consent was obtained. For exclusion criteria, the study excluded individuals who had never participated in or had no interaction with health programmes. This ensured that only those with relevant experience contributed to the study. Another exclusion criterion was age outside the defined range of 10 to 24 years old. Older adults or children below the designated age category were not allowed to be part of the study. The last exclusion was lack of consent; the study excluded individuals who did not provide informed consent or, in the case of minors, those who did not have parental/guardian consent.

The data were coded and checked for errors and omissions; they were analysed and presented using descriptive statistics in the form of frequencies, percentages, and charts. This was achieved using Statistical Packages for Social Sciences. Notably, ethical clearance was obtained from the University of Botswana, and a permit was sought and granted from the Ministry of Health and Wellness.

Findings and Discussion

This section presents the findings and discussion to inform research, policy and practice interventions on meaningful engagement and participation of youth in health programmes in Botswana. This paper presents the demographic details of the AYP who participated in the study. The demographic information included information on (a) sex, (b) age, (c) marital status, and (d) education level. Following demographic characteristics, the findings and discussions of the themes are presented.

Gender of participants

In collecting the data, the study sought to identify the gender composition of the participants, and 80% (144/180) of the participants were female, while males accounted for only 20% (36/180), and only one participant did not indicate his/her gender. In this regard, these findings reveal a wide disparity between males and females. However, it is important to note that there are several factors that might have contributed to this finding. For instance, the study adopted a probability sampling technique, which meant that adolescents and young people between the ages of 10 and 24 years, as indicated in the inclusion criteria, were selected.

As such, the researcher had no control over gender, as opposed to when the non-probability sampling technique was used. Moreover, the participants were mostly from youth

serving organisations and civil society organisations. Therefore, these organisations, mainly their clients, are young girls; hence, this reality might have contributed significantly to the greater number of females than males being included in the data collection.

Age of participants

The study established the age distribution of the adolescents and young people who participated. Most participants, 41% (74/180), were aged 15-19 years. The second most common age bracket was 20-24 years, 39% (70/180), and the least common age bracket was 10-13 years, 17% (31/180), whereas 3% (5/180) of the participants did not indicate their age when completing the questionnaires.

Marital status

Most of the study participants, 98% (174/180), were single, while only 1% (1/180) were divorced and the other 1% (1/180) were widowed, while 2% (4/180) did not state their marital status. To a certain extent, it does not seem unreasonable to state that this finding was to be expected since Botswana does not practice forced marriage in children; however, only an insignificant number of participants indicated having gone through divorce, and one being a widower. These findings agree with those of Maundeni (2014), who suggested that the legal framework in Botswana sets the minimum age for marriage at 18 years for both males and females, aligning with international standards. The Marriage Act (Cap 29:01) prohibits the marriage of individuals younger than the age of 18. Furthermore, Botswana has actively engaged in awareness campaigns, educational programmes, and community initiatives to discourage child marriages (Majelantle *et al*. 2014). Noticeably, the government, in collaboration with non-governmental organisations (NGOs) and international organisations, has promoted the importance of education, gender equality, and the protection of children's rights.

Table 1: Educational Level

Education	Count	Percent
PSLE	26	14.4%
JC	53	29.4%
BGCSE	66	36.7%
Certificate	18	10.0%
Diploma	8	4.4%
Degree	9	5.0%
Total	180	100%

Table 1 above indicates that a majority, 36.7% (66/180), of the participants had attained a Botswana General Certificate of Secondary Education (BGCSE), followed by 29.4% (53/180) with junior secondary level education (JSE). Among those, diplomas and degrees were represented by 4.4% and 5.0%, respectively, whereas 14.4% (26/180) had a primary school leaving education (PSLE). These findings are not surprising considering that education in Botswana is heavily subsidised by the government. The government of Botswana has made substantial efforts to provide accessible and affordable education for its citizens (Mbulawa and Mehta 2016).

Mbulawa and Mehta (2016) further indicated that primary education is generally free, and the government covers a significant portion of the costs of secondary education. While tuition fees are often waived or minimal, there might be additional costs such as uniforms, books, and other school supplies that families need to bear (Tabulawa 2023). The government's commitment to education is reflected in policies aimed at achieving high literacy rates and fostering human capital development.

Table 2: Excess to HIV/AIDS and Sexual and Reproductive Health Programmes

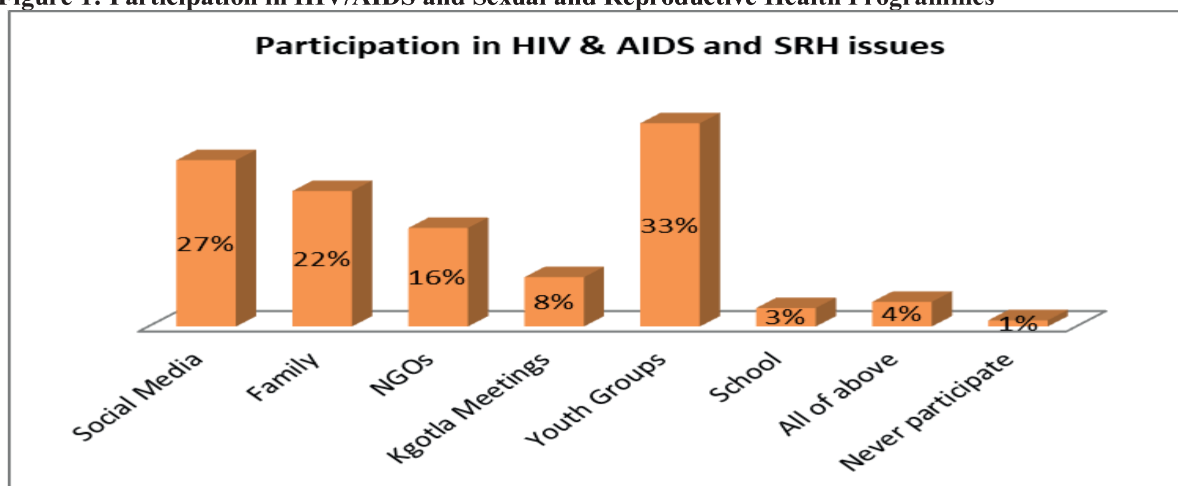
Response	Count	Percent
Missing	2	1%
Unsure	26	14%
No	39	22%
Yes	113	63%
Total	180	100%

Table 2 above shows that most of the participants, 63% (113/180), indicated that they had access to resources for HIV/AIDS and sexual and reproductive health (SHR) projects and/or programmes. Therefore, it can be deduced from the study that the government of Botswana provides certain resources to address issues of HIV/AIDS and SRH among adolescents and young people. The country provides, among other benefits, free SRH education, free treatment for HIV/AIDS, and pre-exposure prophylaxis as a way of driving the country's agenda for ending AIDS as a public health threat by 2030 (Nkomazana 2022). These findings are supported by Tapera *et al*. (2018), who noted that Botswana has faced both successes and challenges in addressing HIV/AIDS and in sexual and reproductive health programmes.

Notable progress has been made in the fight against HIV/AIDS through the implementation of comprehensive prevention, treatment, and support programmes. The widespread availability of antiretroviral therapy (ART) has contributed to improved health outcomes for those living with HIV (Thupayagale-Tshweneage 2010). However, challenges persist. Despite efforts to reduce the prevalence of HIV, stigma and discrimination remain barriers to testing and treatment. Botswana also faces challenges related to high-risk populations, such as sex workers and men who have sex with men, who may experience difficulties accessing healthcare services due to societal stigma (Anabwani *et al*. 2016).

In terms of SRH, while there have been strides in providing information and services, there are gaps in reaching vulnerable populations, including young people and those in remote areas (Brooks *et al*. 2021). Cultural factors may contribute to barriers in discussing and addressing SRH issues openly (Maundeni 2014). Sustaining funding for these programmes is another challenge. Dependence on external funding sources may pose risks to the long-term sustainability of HIV/AIDS and SRH initiatives. Ongoing efforts are required to adapt programmes to evolving demographics, reduce stigma, and ensure inclusivity in reaching all communities, ultimately fostering a comprehensive and effective approach to public health in Botswana.

Figure 1: Participation in HIV/AIDS and Sexual and Reproductive Health Programmes



Source: Author's research data

Figure 1 above shows that most participants (33%) participated in HIV/AIDS and SRH issues through youth groups, followed by social media at 27%, family at 22%, and kgotla (traditional community assembly) meetings at 8%. Noticeably, an insignificant number of participants (1%) reported never participating in HIV/AIDS and SRH issues in their communities, whereas school is represented by 3%, which can be concluded that schools seem not to be playing a key role, as one would expect, especially for adolescents and young people who are in school.

Tagwiregi and Flusks (2023) suggested that youth participation in sexual and reproductive health discourse is crucial in Africa, considering the demographic significance of the youth population in the region. Hence, African governments and various organisations must recognise the need to actively involve adolescents and young people in the planning, implementation, and evaluation of programmes addressing HIV/AIDS and sexual and reproductive health (Tagwiregi and Flusks 2023). The findings in Figure 1 are supported by Habtu *et al.* (2021), who suggested that youth engagement is fostered through initiatives such as peer education programmes, youth-friendly health services, and awareness campaigns tailored to the preferences of the younger generation. Therefore, this paper argues based on the findings that providing comprehensive sexuality education in schools and communities should be a key strategy for empowering adolescents and young people with the knowledge and skills to make informed decisions regarding their sexual health.

Despite progress, challenges persist, including stigma surrounding HIV/AIDS, cultural barriers, and limited access to sexual and reproductive health information and services in certain areas (Daniels 2007). Henceforth, ongoing efforts are required to create safe spaces for open dialogue, address misconceptions, and overcome barriers to accessing healthcare services. The active involvement of youth in advocacy and policy-making processes is vital to ensuring that programmes are responsive to the evolving needs and perspectives of young people. Through meaningful participation, youth can contribute significantly to the success of HIV/AIDS and SRH initiatives, ultimately fostering a healthier and more resilient future for Botswana.

Table 3: Sexual Debut

Period	Count	Percent
-10 Years	3	2%
10-14 years	11	6%
15-19 years	76	42%
20-24 years	33	18%
Virgin	50	28%
Total	173	96%
Missing	7	4%
Total	180	100

One of the questions asked of the participants was about their first sexual encounter (sexual debut). As indicated in Table 3 above, most participants, 42% (76/180), stated having sexual encounters at the age of 15-19 years. Noticeably, when the participants were asked whether they were sexually active, a majority, 58% (104/180), indicated that they were sexually active, whereas a significant minority revealed that they were not yet sexually active, 42% (76/180). According to Lesedi *et al.* (2011), sexual debut in Botswana is influenced by a combination of cultural, social, and individual factors. Traditionally, cultural norms in Botswana have emphasized the importance of discretion and privacy regarding matters of sexuality (Maundeni 2014).

However, with changing societal dynamics, especially among the younger generation, there has been a gradual shift toward more openness (Seloilwe *et al.* 2015). Based on the above study results, it can be deduced that the age at which adolescents and young people in Botswana

experience sexual debut varies. For instance, according to the literature, factors such as urbanisation, education, and exposure to global influences play a role in shaping attitudes toward relationships and sexual activity (Tapera *et al.* 2018). The country's comprehensive HIV/AIDS awareness campaigns have also contributed to increased knowledge about safe sex practices and the importance of delaying sexual debut (UNAIDS 2019).

According to Mmeje *et al.* (2020), education, particularly about sexual and reproductive health, plays a vital role in influencing the timing of sexual debut. Programmes promoting awareness about contraception, sexually transmitted infections, and respectful relationships contribute to informed decision-making among youth (Okatch 2021). Despite these progressive trends, challenges persist, including the persistence of gender norms and the stigma associated with discussing sexuality openly. Cultural expectations and the intersection of tradition with modern values contribute to a subtle landscape surrounding sexual debut in Botswana, reflecting the ongoing dialogue between tradition and the evolving dynamics of contemporary society (Underwood *et al.* 2011).

Table 4: Views of Sexuality Within the Community

Response	Count	Percent
Yes	40	22%
No	55	31%
Sometimes	43	24%
Not Sure	39	22%
Total	177	98%
Missing	3	2%
Total	180	100%

Table 4 above shows participants' views on sexuality in their communities. This question was pertinent because evidence from the literature indicates that there are many factors that fuel the spread of HIV among adolescents and young adults, particularly among adolescent girls and young women. These include, *inter alia*, the inability to negotiate safer sex, inconsistent and low condom use, and inadequate knowledge of sexual and reproductive health (SRH) and sexual and reproductive health and rights (SRHR) (Musuka *et al.* 2024). As shown in Table 4, most of the participants, 31% (55/177), revealed that they are not allowed to articulate their views on sexuality in their communities. Therefore, it can be deduced from this finding that one of the priorities of meaningful engagement and participation of youth in health programmes should be to give young people a voice regarding sexual and reproductive health issues. Adolescents and young people should be free to express themselves without socio-cultural norms and practices being used to suppress them (Coast *et al.* 2019).

Noticeably, Majelantle *et al.* (2014) assert that sexuality in Botswana communities is influenced by a combination of traditional values, cultural norms, and evolving social dynamics. Botswana, while experiencing modernisation, retains strong ties to its cultural heritage, impacting perceptions of sexuality. Coast *et al.* (2019) assert that traditional norms often emphasize discretion and modesty, contributing to a degree of reticence in openly discussing sexual matters. However, Cowles (2021) indicates that the younger generation, influenced by globalisation and increased access to information, is gradually challenging these norms, seeking more open dialogue. Despite strides toward acceptance, issues such as stigma surrounding HIV/AIDS and lesbians, gays, transgender and queer and/or questioning (LGBTQ+) rights remain sensitive (Thupayagale-Tshweneage 2010). Hence, balancing tradition with progressive attitudes poses ongoing challenges, reflecting the complex interplay between cultural heritage and the evolving societal landscape in Botswana.

Table 5: Adolescents and Young People in Decision Making Bodies

Response	Count	Percent
Yes	35	19%
No	142	79%
Total	177	98%
Missing	3	2%
Total	180	100%

Table 5 shows that a larger number of participants, 79% (142/177), were not members of any of the decision-making committees in their communities. As such, this substantiates evidence from UNICEF (2018) that consultations with adolescents and young people in Botswana have established that youth participation is minimal or non-existent in national development processes, including in the planning and delivery of HIV and health programmes. Hence, the need to strengthen the engagement and involvement of AYP in policy design and programme delivery has been identified, particularly the establishment of a platform that elevates and amplifies voices.

The above finding does not concur with UNAIDS (2019) that the government of Botswana has recognised the importance of involving youth in shaping policies and programmes related to healthcare, including sexual and reproductive health and HIV/AIDS. Initiatives such as the Botswana National Youth Council and District Youth Committees have been established to integrate the perspectives and voices of young people in discussions, planning, and decision-making processes (Diraditsile 2021). However, according to the findings of the present study, many of the participants were not included in these committees. This is a phenomenon that warrants further investigation to determine the underlying reasons.

Table 6: Awareness of the structures in place

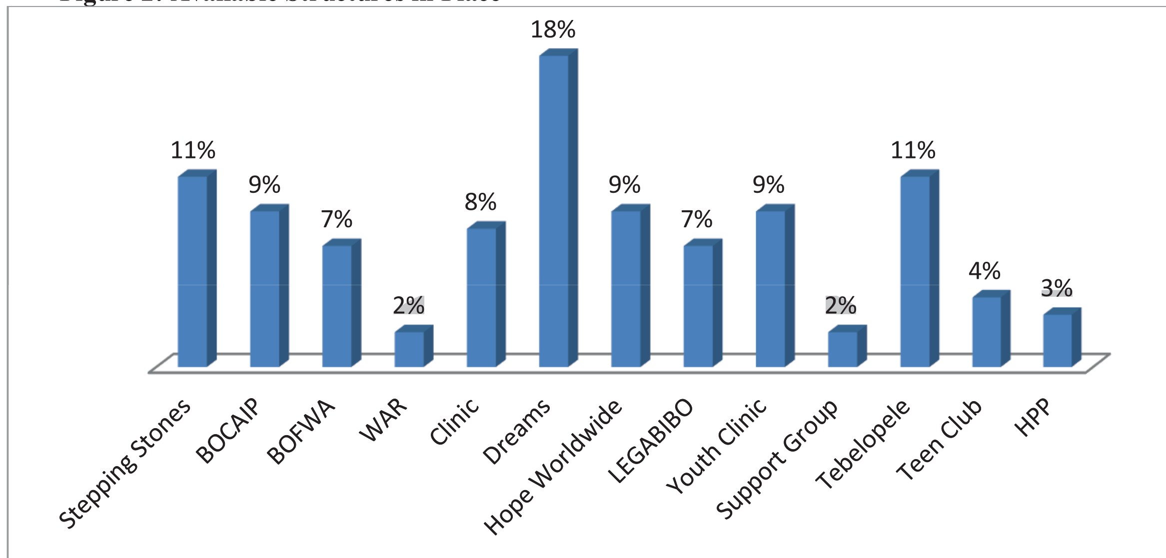
Response	Count	Percent
Yes	45	25%
No	72	40%
Unsure	60	33%
Total	177	98%
Missing	3	2%
Total	180	100%

Table 6 indicates that most of the participants, represented by 40% (72/177), were not aware of any structure(s) that exist in their communities to tackle HIV/AIDS and sexual and reproductive health issues among adolescents and young people in Botswana. Only a small number of participants, represented by 25% (45/177), indicated awareness of structures that exist in their communities tackling HIV and SRH issues among the youth. Based on the above findings, participants had no knowledge of the structures in their localities, and some were unsure. This is a concern considering that Botswana is committed to 'ending AIDS' among adolescents and young people aged 10-24 years by 2030. As a result, the country, with support from UN agencies such as UNICEF and UNFPA (United Nations Population Fund), developed a five-year (2019-2024) National HIV and AIDS Programming Framework for AYP, which has been guiding and informing the AYP response. The abovementioned strategy and the AYP national forum complement interventions articulated in the National Strategic Framework (NSF III) for HIV/AIDS response.

However, it is worth noting that several factors could contribute to youth not being fully aware of the structures in place to support them in Botswana. Sabone *et al.* (2007) noted that limited access to information due to geographical disparities, insufficient outreach and communication strategies, and cultural barriers may hinder awareness. Additionally, a lack of

engagement and participation channels tailored to the preferences of young people could impede their awareness of existing support structures. Educational gaps and the stigma surrounding certain health issues may also play a role (Mbulawa and Mehta 2016). Addressing these challenges requires comprehensive communication strategies, targeted outreach, and the active involvement of youth in the design and implementation of support structures (Setambule 2022).

Figure 2: Available Structures in Place



Source: Author's research data

Figure 2 shows the available structures in place to tackle HIV/AIDS and sexual and reproductive health issues. The findings in Figure 2 concur with Lesedi *et al*. (2011) that in Botswana, organisations such as the UNFPA, WHO, and IPPF (International Planned Parenthood Federation) often collaborate with local NGOs in various countries. Moreover, the above finding is supported by Brooks *et al*. (2021) that Botswana has established structures to support adolescents and young people on HIV and AIDS and sexual and reproductive health programmes.

These include youth-friendly health services and providing confidential and accessible healthcare tailored to the needs of young individuals (Brooks *et al*. 2021). Educational programmes in schools and communities address SRH and HIV/AIDS prevention. Youth advisory boards and committees offer platforms for active participation and decision-making (Diraditsile 2021). Moreover, NGOs and community-based organisations collaborate to provide information, counselling, and support. These structures collectively aim to empower and engage young people, ensuring their awareness and active involvement in promoting their sexual health and well-being.

Mechanisms that Can be Adopted

On ways in which the government can increase meaningful participation of the participants on SRH issues, a larger number of participants, 59% (106/180), revealed that young people should be supported and trained if the government intends to increase their participation in SRH issues. Thus, based on these findings, this paper argues that the government can employ several strategic approaches to enhance meaningful participation in sexual and reproductive health issues, ensuring the active involvement of its citizens, particularly young people. For instance, implementing comprehensive and inclusive sexuality education in schools and communities is

crucial because, as indicated earlier, the results showed that there is low sexuality education in schools.

Tapera *et al*. (2018) noted that engaging in targeted awareness campaigns using diverse media channels, including social media, can effectively reach a broad audience. They further indicated that campaigns should address stigmas surrounding SRH issues, encourage open dialogue, and reduce misconceptions. Anabwani *et al*. (2021) asserted that establishing youth-friendly health services ensures accessibility and confidentiality. Therefore, this paper argues that by creating spaces where young people feel comfortable seeking SRH services, the government can encourage regular health check-ups and promote responsible behaviour.

Conclusion

In conclusion, the meaningful engagement and participation of youth in health programmes in Botswana are critical components for the success of public health initiatives and the overall well-being of the nation. This study has illuminated various strategies and considerations to enhance the involvement of youth in shaping their own health outcomes. The establishment of youth-friendly health services has been identified as a foundational step, ensuring that healthcare facilities are not only accessible but also tailored to the unique needs and preferences of young individuals. This includes effective communication and the creation of welcoming environments that resonate with the youth. Leveraging diverse communication channels, including social media and community-based events, can enhance the reach and impact of health-related information.

Moreover, the establishment of youth advisory boards fosters a participatory approach, integrating the voices of young people in decision-making processes related to health programme planning and implementation. Peer education and support networks create a sense of community and shared responsibility, tapping into the power of peer influence for positive health behaviours. As shown in the discussions, cultural sensitivity remains a cornerstone of successful youth engagement, recognising and respecting the diverse cultural contexts within Botswana. Collaboration with youth organisations and community groups further amplifies the impact of health programmes, utilising existing networks and expertise.

The government should actively involve young people in decision-making processes related to SRH policies. Creating platforms for youth participation, such as advisory committees or consultations, ensures that policies are reflective of the needs and aspirations of the young population. By fostering collaboration with NGOs and community leaders, the government can tap into existing networks, enhancing the effectiveness of SRH programmes. Additionally, continuous evaluation and feedback mechanisms allow for adaptive strategies, ensuring the relevance and success of initiatives over time. In essence, a holistic and collaborative approach that incorporates education, awareness, technology, and youth involvement will empower Botswana’s government to meaningfully address SRH issues and promote the well-being of its citizens.

In the future, it is imperative to implement and adapt the above-mentioned strategies in a dynamic and responsive manner. Ongoing research, collaboration, and flexibility in approach will be crucial in addressing emerging health challenges and harnessing the full potential of the youth demographic. To this end, the way forward involves collective commitment from healthcare providers, policymakers, community leaders, and the youth themselves to foster an environment where meaningful engagement and participation become embedded in the fabric of health programmes. In doing so, Botswana as a society can pave the way for a healthier, more resilient future where young people not only benefit from but also actively contribute to the nation's well-being.

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