FACTORS INFLUENCING WOMENS PERCEIVED SEXUAL SELF-EFFICACY IN BOTSWANA: AN IMPLICATION FOR HIV INTERVENTION PROGRAMS

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ABSTRACT

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Background: In Botswana, there is a disproportion of HIV prevalence which is largely skewed towards women. The need to empower women to have a higher sexual self-efficacy to handle various sexual contexts is crucial for their sexual and reproductive health (SRH) and achieving goal 3 of the Sustainable and Development Goals. Therefore the need to examine the factors affecting sexual self-efficacy of women is pivotal to influence and direct SRH policy related interventions especially if the country is to simultaneously reduce HIV prevalence as well as rectifying this disproportion.

Methods: Data from the most recent 2013 Botswana Aids Impact Survey was used which focused on women aged 15-35 years. Perceived sexual self-efficacy is a dichotomous variable with outcomes being high or low. Descriptive, bi-variate and binary logistic analysis was used to examine the factors associated with perceived sexual self-efficacy. A total of 6 independent variables was considered in the analysis.

Results: Marital status, religion, occupation, age, type place of residence and education were associated with sexual self-efficacy at bivariate level. The proportion of women with low sexual efficacy was 56.5%. Odds of low sexual self-efficacy were higher for older women aged 20-24 (OR, 3.733), 25-29 (OR, 1.027) and 30-35 (OR, 1.173). They were also higher for women with secondary (OR, 2.038) and higher education (OR, 1.641). Sexual efficacy was higher for non-religious people, those cohabiting, those living in rural areas as well as non-working students.

Conclusion and Policy Implications: The conclusion is that there is an association of women's perceived sexual self-efficacy with all our independent variables. From our results, we can deduce that as age and educational attainments increase, women's sexual self-efficacy is seen to be low hence intervention strategies should be hinged on targeting these individuals through the appropriate media and institutions. The same applies for people in urban areas, those who have never been married among other groups who have shown to have a low perceived sexual self-efficacy.

CHAPTER 1: INTRODUCTION

Undoubtedly, the HIV and AIDS epidemic in Botswana represents one of the greatest developmental challenges in the country especially considering how it was one of the hardest hit countries both regionally and internationally (Botswana National Policy on HIV and AIDS, 2012). Its emergence in the mid-1980s, and its spread country-wide, has undermined post-independence gains that the country has received kudos for (National AIDS Coordinating Agency, 2015). Today, more than twenty-five years into the AIDS epidemic, gender inequality and unequal power relations between and among women and men continue to have a significant influence on the HIV epidemic which presents another facet of the challenges faced in intervention programs(UNAIDS, 2009). The fact that HIV/AIDS is still a big issue now does not augur well for the country especially if the right measures are not in place to address it.

Over 20% of the new AIDS infections globally are seen in women and 12% in males which is around two times less than females (World Health Organization (WHO), 2014). Similar pattern arise when zooming into the Botswana situation. When probing over the statistics and reports on HIV in the country, it is evident that women seem to be chewing on the shorter end of the stick when it concerns this matter. A report from BAIS indicates that females had a relatively higher prevalence rate of 20.8 percent compared to 15.6 percent for their male counter parts. (BAIS IV , 2013). Furthermore, the male and female patterns show differential peaks, with women's prevalence peaking (nearly 50.6 percent) at an earlier age (35-39) while that of males peaks to 43.8 percent in the 40-44 age group (BAIS IV , 2013). With the juxtaposition of HIV/AIDS in men and women, it is evident that the disparity between these two groups is an issue of concern especially in Botswana.

Sexual and reproductive health and rights are enshrined in a number of international declarations and agreements, including the Millennium Development Goals and serve as a standard when dealing with disparities witnessed in males and females (IPPF, 2014). It has long been recognized that gender inequality exacerbates a range of negative health outcomes in varying contexts around the world and although this has been seen in Botswana, a gender-double standard remains hence the need to consider alternative models in dealing with the situation (PEPFER, 2014). In doing so, a very key issue is brought up which is addressing individual's psycho-social factors, specifically sexual self-efficacy.

Self-efficacy, a term coined by one of the most prestigious social psychologist Albert Bandura has been useful over the years as one of the ways of studying individual's sexual responses. Self-efficacy as defined by Bandura is an individual's belief in their ability to produce a certain outcome (Bandura, 1990). That is, a person's belief in the ability to apply themselves in mapping out particular courses of action hence achieving a desired result. Expanding on this we can say that, sexual self-efficacy is an individual's belief in their ability to produce and manage a certain outcome in any sexual context or sexual domain. Sexual self-efficacy is a wide-ranging construct stretching from sexual negotiation, refusal, fulfillment and the use of contraceptives (Closson, Dietric, Palmer, & Cui, 2018).

In the sexual context, it can be argued that perceptions of control and positive sexual worth may enable women to be individually empowered (Seal, Victor, & Omodei, 1997).The need to empower women to have a higher sexual self-efficacy to handle various sexual contexts is crucial for their sexual and reproductive health (SRH) and achieving goal 3 of the Sustainable and Development Goals. Therefore the need to examine the factors affecting sexual self-efficacy of women is pivotal to influence and direct SRH policy related interventions especially if the country is to simultaneously reduce HIV prevalence as well as rectifying this disproportion between men and women.

STATEMENT OF THE PROBLEM

Various public health campaigns and interventions have been lambasted in some circles for ignoring the specific needs of women and when it pertains to HIV/AIDS and for focusing too narrowly on the spread of HIV. (Seal, Victor, & Omodei, 1997) Even with concerted efforts of the government of Botswana as well as other organizations, we see that the prevalence of HIV AIDS has not dramatically bettered. Furthermore, the disparity between men and women is seen to be continuing. In Botswana there have not been many studies that exclusively address women's perceived sexual efficacy, how this potentially could be a cause for the disproportion and how intervention programs can be curbed to address women's pro-activity.

By nature, HIV/AIDS is never separate from other diseases neither is it detached from social and environmental structures. Using the syndetic approach there is an underlying assumption that such diseases, and thereby health and wellness, exist within social vacuums hence the need to examine factors affecting women's perceived sexual self-efficacy as a step forward in remedying the situation. (Douglas-Vail, 2015)

OBJECTIVES

The objectives of this paper will be;

- To investigate the factors influencing perceived sexual self-efficacy of women aged 15-35 years
- To investigate the sexual self-efficacy status of women aged 15-35 years
- To recommend appropriate intervention strategies

CHAPTER 2: LITERATURE REVIEW

Many HIV/AIDS intervention programs advocate for measures such as condom use, safer sex and other information dissemination platforms aimed at encouraging members of the public to 'take charge' of their health. In a society where women are viewed as subordinates of men, such measures are inadequate as they assume that women are readily able to assert their needs and desires. Campaigns which urge women to use condoms, have safer sex or take charge in protecting themselves have failed to acknowledge barriers which women face when negotiating safer sex (Seal, Victor, & Omodei, 1997).These are psycho-social factors that must be considered in any HIV intervention program for the melioration of their overall effectiveness and empower women to take up a more mindful position as sexual agents.

In a study aimed at examining adolescents' sexual behavior, it was discovered that those who believed in their personal control were better able to exercise it through initiating the use of condoms or better yet, through complete abstinence. (Pearson, 2006) This could largely be attributed to the increase in education and programs over the years in many countries that are attempting to increase sexual education as well as undoing prevailing gender scripts. Education programs have the power to influence gender relations especially when dealing with HIV/AIDS (Carmody & Ovenden, 2013).

However in developing countries like Botswana, although sexual education especially concerning HIV/AIDS has been pursued, very little has been done in refashioning gender inequality in this matter. Age difference between partners is a form of power imbalance in relationships particularly in patriarchal societies such as those found in Botswana and South Africa where age and seniority are of considerable importance in social life (Langen, 2005)The study showed that it is women whose partners are 10 or more years older than them, women who are abused, and those who are economically dependent on their partners who are less likely to engage in any form of negotiation (Langen, 2005). Women are taught to respect their husbands or male counterparts which make them less efficacious in asserting their desires in various sexual contexts. For example, men might be unwilling to use a condom because they believe that it interferes with their sexual pleasure and the female might have little influence over this decision. (Pearson, 2006)

Another study on youth in Taiwan showed that there are declines in the self-efficacy score as youth become older than 16. This may be because younger individuals are inexperienced hence have not had experience with the situations and are simply responding to hypothetical situations. The older group on the other hand presumably has had to deal with such situations before and hence are less confident of their ability to manage sexual encounters. (Tung, Cook, & Lu, 2011)

In some traditional societies, contraception use is seen more as the women's responsibility as compared to the male's duty. (Pearson, 2006) Furthermore, women who are too sexually knowledgeable and exposed to sex education run the risk of condemnation while sexually active heterosexual young men receive praise (Carmody & Ovenden, 2013). In other context however, a girl who has contraception available is deemed to have anticipated sexual activity, and is presumed to be looking for sex. (Pearson, 2006) Asserting needs challenges the appropriate behavior of women as socially constructed or as is known that is why some women refrain from it. (Seal, Victor, & Omodei, 1997)

It was found that there is a direct contribution to a child's sexual self-efficacy by their upbringing. That is, various interactions with children when growing up helps to build the necessary knowledge that will make them more self-efficacious even in the sexual context. (Van Campen & Romero, 2012). Upbringing and the social context that one grows up in not only influences an individual's social and cognitive capabilities in managing a sexual context, but also whether they see the need to exercise it. People's sexual choices are largely shaped by normative beliefs embedded through a socialization process about men's and women's sexuality. (Pearson, 2006) For example, traditional attitudes about men's roles are more likely to see girls as responsible for contraception, as well as more likely to believe that pregnancy validates masculinity (Closson, Dietric, Palmer, & Cui, 2018). Also if men and women are brought up to believe in the 'in the strong and uncontrollable nature' of men's sexual desires may create dual repercussions. For women, they will tend to have feelings of powerlessness in sexual encounters while strengthening and reinforcing the perception of masculinity in men (Closson, Dietric, Palmer, & Cui, 2018). Many women do not feel positive about their own sexuality partly because they perceive sex as a duty aimed at providing pleasure to a man. (Seal, Victor, & Omodei, 1997)

Women's sexual self-efficacy is also said to vary in the type of relationship that defines that sexual domain. Women in more casual relationships are likely to be more efficacious than those in 'serious' relationships. (Carmody & Ovenden, 2013). Usually, casual relationships are those that are not so formal. However another instance showed that casual sex occurring when an individual is intoxicated or being too drunk suspends their ability to negotiate safer sex. (Carmody & Ovenden, 2013). (Do & Fu, 2011) conducted a study on women's self-efficacy and condom use in marital unions concluded that women living in urban areas, with educational attainments above primary level, had a significant household wealth and had relatively high exposure to media had a relatively high sexual self-efficacy. (Do & Fu, 2011) This shows the importance of union type, education, economic status and place of residence when dealing with sexual self-efficacy. Economic status is an important factor in that many poor women who are alone, uneducated and powerless, must depend on a man to support them and their children and hence are less sexually self-efficacious. (Langen, 2005) Alcohol, drug abuse, multiple concurrent partnerships have been found to be negatively correlated with sexual self-efficacy. (Do & Fu, 2011)

Although there are many studies that show the importance of sexual self efficacy, there are few conducted that go for the jugular by explicitly explaining the factors that influence it. This area has relatively been under-researched in Botswana. Applying findings from other researches in the Botswana situation also brings about many challenges. Most of these studies were conducted in developed countries which has a completely differing context in terms of the nature of unions, cultural influences as well as other factors. Furthermore such studies will be limited in applicability as they would not really portray the effects of a viciously HIV stricken society with the urgent need for potent solutions in addressing the situation.

CHAPTER 3: METHODOLOGY

DATA SOURCE

The study utilizes secondary data from the most recent Botswana AIDS Impact Survey IV (BAIS IV) which was carried out in 2013. The intended purpose of the survey or primary objective of the BAIS IV 2013 was to update current information on the sexual behavior patterns of the population aged 10-64 years and the HIV prevalence and incidence rates among those aged 18 months and older at national, district and sub-district level. (BAIS IV , 2013) Its production is a collaboration between Statistics Botswana and National AIDS Coordinating Agency where results are expected to shed light on policy directions and implementations. The baseline for the survey is its first edition produced in 2001. In this one, the response rate is estimated to have been 83.9%. (BAIS IV , 2013).

SAMPLE

The study sample comprises women aged 15-35 years old who had completed the questionnaire as well as those who represent the youth according to the described definition as stated by the Revised Youth Policy (BAIS IV , 2013) (Ministry of Youth, Sports and Culture, 2010) The women were group into various age cohorts. There were a total of 322909 women were selected.

MEASUREMENT OF VARIABLES

DEPENDENT VARIABLES- From our research focus we can deduce that Perceived Sexual Efficacy is our dependent variable. It was obtained by forming a composite variable from the responses of three questions in the BAIS IV;

Question 320-Could you persuade your sexual partner to use a condom?

Question 321- Could you persuade a sex partner **NOT** to have sex if you weren't interested?

Question 526- Do you agree that a woman has a right to decide if she will have safe sex?

For question 320 and 321, the variable was re-coded such that the response 'Yes, All the time' was 1 and 'Yes, sometimes', 'No' and 'Don't know' were 0. A similar thing was done for question 526 where 'Yes' was re-coded as 1 and 'No' as well as 'Unsure' were re-coded as 0. The justification for grouping the 'Yes, sometimes', 'Don't know' and 'Unsure' is that the operational definition of a person with high sexual self-efficacy in this study is that they believe and are unwavering about their ability to control a sexual context.

Self-efficacy is a concept similar to personal control that refers to people's assessment and belief in their ability to achieve a desired effect through their actions and their effectiveness in this. (Pearson, 2006) This is only reflected by a sure 'Yes' response.

Such responses were put with those who said 'No' for that reason because they themselves are not convinced which has been taken as a 'No'. The highest score for the index was 3 which reflected a 'Yes' in all the questions- this represents individuals with a high sexual self-efficacy. A score of 0-1 is therefore the people who did not get a perfect score and hence are categorized as those with low sexual self-efficacy. This follows a similar re-coding of sexual self-efficacy that was presented by Ngome when investigating the determinants of condom use in Botswana. (Ngome, 2012)

INDEPENDENT VARIABLE- Selected variables were included in order to examine their influence and how they relate to women's sexual self-efficacy status. All variables were obtained from questions from the survey and were re-coded for convenience in the study's analysis. The selected variables are as follows.

Demographic variables

Age: Age has been re-coded into five age categories ranging from 15-35 years being; 15-19, 20-24, 25-29 and 30-35 years. This was guided by the fact that these are expected to be sexually active group and hence the need to determine the sexual self-efficacy separately. Also, this is the prescribed age group describing youth by the Revised National Youth Policy in 2010. (Ministry of Youth, Sports and Culture, 2010)

Place of residents: Based on a question from the survey, outcomes were Cities/Towns, Urban Villages and Rural Areas. These were presented as they are on the survey and were not re-coded.

Marital status: From the survey, the outcomes for marital status were; Married, Never Married, Living Together/Cohabitating, Separated, Divorced and Widowed. Those Married, Never Married, Living Together were left as they are. However, the Separated, Divorced and Widowed were grouped together to form the Ever Married category which is a group of women who at some point in their lives were married but now are not. We expect this group to have similar behavioral traits. Co-habiting in Botswana is a very common union that is why it was left as it is. Seal highlights the importance of the type of unions when studying sexual self-efficacy hence the reason for such a categorization that encompasses and represent both casual and non-casual unions. (Seal, Victor, & Omodei, 1997)

Socio-economic characteristics

Occupation: The survey asked respondents what their employment status was. For the study, this was re-coded into Occupation which was befitting in categorizing the possible responses in the study which were Working, Non-working and Students. The Working comprised; Full-time employed, Part-time employed, Self-employed and Working at own lands/cattle post. The Non-Working comprised; Actively Seeking Work, Too Old To Work, To Sick To Work and Others. The students were left just as they are as they are expected to possess different behavioral characteristics from the working and the non-working. In, the 19th International Conference of Labour Statisticians ICLS, held in 2013, the definition of employment was narrowed to refer only to activities performed by individuals in exchange for pay or profit hence the nature of re-coding of this variable. (ILO, 2019)

Education: Information on the respondent's highest level of educational attainment was collected. Primary or less includes those with no education, non-formal education and primary education. These groups are assumed to have similar behavior. Secondary education includes those with junior secondary education and senior secondary education. Those with Higher education were left being in a category of their own. This also follows suit to how information on education is presented by Statistics Botswana Annual Report. (Statistics Botswana, 2018)

Religion: The survey also asked respondents of their religion. Botswana has no state religion and the freedom of religion is guaranteed by law but it does have a large Christian community. (Matemba, 2005). By this, Christianity was left as it is and was not re-coded. Also, Islam, Muslim, Bahai, Hinduism and others were grouped together as Non-Christians. Those believing in African Traditional Religion (Badimo/ATR) and those with No Religion were also not changed and left as they are. Culture is esteemed highly in Botswana in Botswana and is likely to have some influence on women's perceived sexual self-efficacy as explained by Langen. (Langen, 2005). No religion was left as it was so as to see how the absence of 'binding' religious or cultural affiliations would influence person's sexual self-efficacy.

STATISTICAL ANALYSIS

Descriptive analysis, binary analysis and well as a binary logistic regression were utilized in the analysis of this study. Since women with low sexual self-efficacy are our group of interest when targeting interventions, our bi-variate analysis focuses on interpreting results from this particular group.

The Pearson's chi-square statistics (χ 2) was used in order to test whether or not there is a significant relationship between women's perceived sexual efficacy and the selected variables. The default level of significance of $P < 0.05$ was used to test this relationship and is the base of our interpretation.

Binary logistic regression (BLR) is used in the study because our dependent variable, Sexual Self Efficacy. has only two possible outcomes which are high and low. A binary logistic regression (BLR) is suitable for a dependent variable with a dichotomous outcome such as this one. By BLR, we can utilize the Odds Ratio in order to measure the significance of the relationship between our dependent variable and the independent variables. In interpreting the odds ratio, we must first note that for the independent variables and dependent variables, there is more than one category. This means that the first category for each variable is used as a reference category for the analysis. In this instance, people with high sexual self-efficacy are kept constant meaning that our interpretation will exclusively be for those with low sexual self-efficacy in the multivariate analysis.

CHAPTER 4: RESULTS

FREQUENCY DISTRIBUTION ANALYSIS

Table 1: Frequency of Sexual Self-Efficacy Status (BAIS IV, 2012)

	FREQUENCY	PERCENTAGE
Sexual Self-Efficacy Status		
High Sexual Self-Efficacy	140327	43.5
Low Sexual Self-Efficacy	182582	56.5
Total	322909	100

Table 1 shows that there are more women with a low sexual self-efficacy (56.5%) than with a high sexual efficacy (43.5%).

Table 2: Frequency of Selected Socio-economic and Demographic Independent Variables (BAIS IV,2012)

VARIABLE	**FREQUENCY**	**PERCENTAGE**
AGE		
15-19	75501	23.2
20-24	86423	26.6
25-29	84809	26.1
30-35	78137	24.1
EDUCATION		
Primary or less	34290	10.6
Secondary	222466	68.5
Higher	68114	21.0
PLACE OF RESIDENCE		
Cities/Towns	86654	26.7
Urban Villages	139601	43.0
Rural Areas	98615	30.3
MARITAL STATUS		
Married	26366	8.1
Never Married	205192	63.2
Living Together	91754	28.2
Ever Married	1558	0.5
OCCUPATION		
Working	125366	43.8
Non-working	81868	28.6
Students	78679	27.6
RELIGION		
Christianity	288319	88.7
Non-Christians	2360	0.7
African Tradition Religion	6747	2.1
No Religion	27444	8.4
TOTAL	**324870**	**100**

In terms of age, there is more or less the same proportion in each of the age groups. There were more people with the highest level of educational attainment of secondary level (68.5%) than higher level (21%) and primary level or less (10.6%). More women were living in urban villages (43%) followed by rural areas (30.3%). Over 50% of women were never married (63.2%) and about 28% of them were living together. A very small number of them were ever married (0.5%). The highest proportion of the women were working (43.8%). Women who were not working or were students had a similar proportion of close to 28%. The highest proportion of women where Christians at 88.7% with very low proportions for other religious affiliations.

BIVARIATE ANALYSIS

Below we shall consider the bivariate analysis of the main dependent variable (Sexual Self-Efficacy) and our selected independent variables. Since women with low sexual self-efficacy are our group of interest when targeting interventions, our bi-variate analysis focuses on this particular group.

Table 3: Cross-tabulation of Sexual Self Efficacy Status and Selected Socioeconomic and Demographic Independent Variables (BAIS IV,2012)

	LOW SEXUAL SELF-EFFICACY		**HIGH SEXUAL SELF EFFICACY**		
VARIABLE	**FREQUENCY**	**PERCENTAGE**	**FREQUENCY**	**PERCENTAGE**	**TOTAL**
AGE					
15-19	61309	81.5	13950	18.5	75259
20-24	41802	48.5	44364	51.5	86166
25-29	42756	51.1	40948	48.9	83704
30-35	36714	47.2	41065	52.8	77779
TOTAL	182581	56.5	140327	43.5	322908
P value	000.0				
EDUCATION					
Primary or less	22012	65.1	11801	34.9	33813
Secondary	131164	59.4	89831	40.6	220995
Higher	29406	43.2	38695	56.8	68101
TOTAL	182581	56.5	140327	43.5	322909
P value	000.0				
PLACE OF RESIDENCE					
Cities/Towns	48981	56.7	37370	43.3	86351
Urban Villages	72447	52.1	66538	47.9	138985
Rural Areas	61154	62.7	36419	37.3	97573
TOTAL	182582	56.5	140327	43.5	322908
P value	000.0				

MARITAL STATUS					
Married	15083	57.5	11159	42.5	26242
Never Married	119990	58.9	83687	41.1	203677
Living Together	46558	50.9	44874	49.1	91432
Ever Married	951	61.0	607	39	1558
TOTAL	126241	56.6	158242	43.5	284483
P value	013.0				
OCCUPATION					
Working	61271	49.1	63470	50.9	124741
Non-working	37745	46.5	43513	53.5	81258
Students	59226	75.5	19258	24.5	78484
TOTAL	182581	56.6	140327	43.5	322908
P value	000.0				
RELIGION					
Christianity	158659	55.3	128007	44.7	286666
Non-Christians	2053	87.0	307	13	2360
African Tradition Religion	4791	71.2	1942	28.8	6733
No Religion	17079	62.9	10071	37.1	27150
TOTAL	182582	56.5	140327	43.5	322909
P value	001.0				

P-values of the independent variables are significant meaning that there is an association between independent variables and women's sexual self-efficacy status since they are less than 0.05. Women aged 15-19 had the least sexual self-efficacy at 81.5% followed by those aged 25-29 years. As educational attainments increase, less women have a low sexual self-efficacy with those having primary level or less education being the least sexually self-efficacious at 65.1%. Women in rural areas had the least sexual efficacy (62.7%) while those living in cities/towns and urban villages had a similar low sexual self-efficacy. Low sexual self-efficacy was highest among the ever married women (61.0%). Students had the least sexual self-efficacy at 75.5% while those working and non-working had a similar low sexual self-efficacy status. Non-Christians were less sexually efficacious (87%) followed by women who subscribed to African Tradition Religion (71.2%).

BINARY LOGISTIC REGRESSION ANALYSIS

In interpreting the odds ratio, we must first note that for the dependent variable and independent variables, we have more than one category, hence the first category for each variable is used as a reference category for the analysis. In this instance, people with high sexual self-efficacy are kept constant meaning that our interpretation will exclusively be for those with low sexual self-efficacy. The default confidence of 95% was used throughout the analysis.

Table 4: Multivariate Analysis for Sexual Self Efficacy Status and Selected Socio-Economic and Demographic Variables

	(95% CI)	
VARIABLE	**SIGNIFICANCE (p-value)**	**EXP(B)**
AGE		
15-19	.000	1
20-24 (1)	.000	3.733
25-29 (2)	.026	1.027
20-35 (3)	.000	1.173
EDUCATION		
Primary or less	.000	1
Secondary (1)	.000	2.038
Higher (2)	.000	1.645
PLACE OF RESIDENCE		
Cities/Towns	.000	1
Urban Villages (1)	.000	.846
Rural Areas (2)	.000	.678
MARITAL STATUS		
Married	.000	1
Never Married (1)	.000	.559
Living Together (2)	.000	.319
Divorced (3)	.000	.353
OCCUPATION		
Working	.000	1
Non-working (1)	.000	.506
Students (2)	.000	.387
RELIGION		
Christianity	.000	1
Non-Christians (1)	.000	.691
African Tradition Religion (2)	.275	1.094
No Religion (3)	.001	.893
Constant	**.000**	**5.653**

From the table, we deduce that all the independent variables are significant since the p-values are all less than 0.05 (except for African Religion Tradition). Women aged 20-24 (OR 3.733) are close to 3 times more likely to be less sexually efficacious than those aged 15-19. Those aged 25-29 (OR 1.027) as well as 30-35 years (OR 1.173) have a similar sexual self-efficacy with those 15-19 years. Also, those having secondary level and their highest educational attainment were 2 times more likely to have a low sexual self-efficacy that those with primary education or less. Women living in urban villages are about 20% (OR 0.846) less efficacious than those living in cities/towns while those living in rural areas are about 30% (OR 0.678) less efficacious. In terms of marital status, woman who are in 'living together' unions (OR 0.319) and ever married (OR 0.353) are about 70% less efficacious that women married women. Those women who were never married were about 50% (OR 0.559) less efficacious than married women. As compared to working women, non-working women were less sexually efficacious by about 50% (OR 0.506) while female students were about 60% (OR 0.387) less sexually efficacious. Women with no religious affiliation were about 10% (OR 0.893) less efficacious than Christian women; those who were non-Christians were close to 30% (OR 0.691) less sexually self-efficacious than Christian women.

CHAPTER 5: DISCUSSION

From our results, we see that there are more women with a low sexual self-efficacy in Botswana than with a high sexual self-efficacy proving that it is expedient to address this in intervention programs. Our discussion will focus more on the results obtained from the multi-variate analysis.

From the bi-variate analysis, most women aged 15-19 years had low sexual self-efficacy which could be attributed to the fact that in this age group, we expect them to be recent entrants into sexual activity hence the reason for them having the least sexual self-efficacy. However, the results from the binary logistic regression results indicate something different. We see that women aged 20-24 were close to 3 times more likely to be less sexually efficacious than those aged 15-19. This proves the findings from (Tung, Cook, & Lu, 2011) that showed how women's sexual self-efficacy decreases as one gets older because after dealing with so many situations, their confidence diminishes with age. Another consideration is that most young women between ages 15-19 years are still under the care of their parents and guardians. Such closeness, monitoring and proximity to guardians in their households will also influence how they will behave (Van Campen & Romero, 2012).

Women living in rural areas are about 30% less efficacious than those in cities/town. Usually rural areas tend to esteem cultural practices the most as well as uphold certain beliefs and reflect patriarchal societies (Langen, 2005).This is unlike in urban areas where the standards of living are better off and there is relatively more 'freedom'. In rural areas men are highly regarded and are to be respected this is why it is harder for a women to assert her stance in any sexual context. This could be also linked to the fact that there is higher unemployment in rural areas and that most women there are more dependent on their male counterparts as compared to women in the urban areas.

In terms of marital status, woman who are in 'living together' unions and never married were less efficacious than married women. This is contrary to the findings of (Seal, Victor, & Omodei, 1997) that outlined how women in more casual relationships were more likely to be sexually efficacious than women in more formal relationships such as those who are married. In Botswana, marriage is such a respected institution that many girls dream of getting into. In fact, it is embedded in the mind of most girls to get married which is why some women will be taught to 'behave' themselves in order to get married. This is why they might not be articulate enough to voice out their desire as means of protecting the marriage they could possibly get in the future.

As compared to working women, non-working women female students were less sexually efficacious. This could be that since these women do not receive pay or do not earn a lot, they tend to be financially dependent on their male counterparts. This describes the dependence that (Langen, 2005) talked about that makes women have a sense of powerlessness in asserting sexual needs. Since the male figure is the 'provider' as society constructs coupled up with the fact that women are receiving less income, then such women will be less confident in asserting their needs.

Women with no religious affiliation and those who were non-Christians were less sexually self-efficacious than Christian women. This is because in many Christian circles, women are taught to refrain from sexual activity as it is not accepted in their religion. For such reasons, such women are conditioned to be firm in voicing their sexual desires as compared to women who are not expose to such religious expectations.

CHAPTER 6: LIMITATIONS OF THE STUDY

The major limitation of this study is that secondary data was used, hence limiting the researchers to variables only available on the dataset. Sexual self-efficacy is a multi-dimensional concept which is not easily measurable. The fact that an individual is sexually efficacious with one partner may not be the case with the next partner. Also, even though the privacy conditions around the collection of data are likely to have minimized purposeful misreporting in some way, there is bound to be some bias. The data were collected via self-report questionnaire and, therefore, there might have been some bias there. This is true especially also considering how in Botswana talking about sex explicitly is not very acceptable and makes people uncomfortable. Furthermore, this study in the case of Botswana is under-researched so there was very little reference in context of the environment in the country.

CHAPTER 7: RECOMMENDATIONS AND CONCLUSIONS

The conclusion is that there is an association of women's perceived sexual self-efficacy with all our independent variables and that women's perceived sexual self-efficacy is generally low which could have a major impact on the spread of HIV/AIDS. According to self-efficacy theory, individuals that possess an internal locus of control are more likely to be proactive in adopting, maintain as well as initiating health promoting rather than health-compromising behaviors. (Van Campen & Romero, 2012). This might be the missing link in the HIV intervention programs and initiatives in Botswana as they have not majored in addressing and looking beyond individual behaviours to the contextual factors conditions that make people vulnerable to HIV infection and influence behaviour.

Even with so much information dissemination platforms that have even become a mantra for the population, the situation has not dramatically bettered as is expected. People have received the knowledge of what must be done to avoid HIV transmission, prevention however the results do not reflect it. The knowledge of how to exercise control and manage sexual situations seems to be deficient and becomes apparent when one is tasked with actually dealing with these issues (Tung, Cook, & Lu, 2011).This affects women more than it does men which could explain they skew of HIV/AIDS towards women which has been perpetuated not only in Botswana but also in other regions.

Educational messages that simply tell people to "use a condom" or to "say no" to unprotected sex or multiple concurrent partnerships place a heavy load on one's competency .Actually taking on the courses of action for a certain result is a completely different story. Such messages do not address the power imbalance between men and women (Langen, 2005). For women specifically, they ignore the barriers that the face in actually doing this.

Central to developing alternative models is the need to move away from a moral panic approach that fears and seeks to influence individuals sexually behaviour without actually empowering them to take charge of their sexual and reproductive health (Carmody & Ovenden, 2013). Barriers that come from the nature of the culture where information on sexuality and the skills that can protect women is withheld must be done away with. Education programmes must be meticulously designed to have the capacity to foster new configurations of gender development as well as to think beyond popular discourses.

Although women are the most affected, there must be an understanding that sexual relations are of mutual negotiation and hence the need to empower both men and women according to what is relevant for them. Most importantly, majoring on the skills that facilitate effective communication for both parties that will enable them to be active participants that are not solely influenced by prevailing gender scripts. In developing alternate discourses coupled with improving on what has been done, factors such as sexual self-efficacy are pivotal in influencing and directing sexual and reproductive health policy related interventions. This is especially needful if the country is to simultaneously reduce HIV prevalence as well as rectifying the disproportion between men and women and for an HIV freed society.

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