

The meaning, lived experiences and intentions for safer sex communication among young Batswana women in dyadic relationships

Mabel K. M. Magowe

School of Nursing, University of Botswana, Gaborone, Botswana
Email: magowem@mopipi.ub.bw

Received 15 March 2012; revised 18 April 2012; accepted 29 April 2012

ABSTRACT

Increased heterosexual transmission of HIV among young women and their difficulties with safer sex communication calls for women-focused research. This qualitative phenomenological study explored the meaning and lived experiences of women, as part of larger pre-dissertation pilot on health protective sexual communication among young women in Gaborone, Botswana. This was a study conducted in two Gaborone City Council MCH clinics. Twenty women participated in individual in-depth interviews conducted in Setswana, tape-recorded, transcribed verbatim, translated into English for line by line analysis to extract themes and subthemes. Six main themes and nine subthemes emerged from the data. The main themes were: the meaning of HPSC, responsibility for HPSC, HPSC content, facilitating factors, partner's response. Batswana women communicate with their male sexual partners about safer sex but face some difficulties. Further quantitative research can further explore women's experiences with safer sex communication.

Keywords: Lived Experiences; Safer Sex Communication; HIV Prevention

1. INTRODUCTION

The AIDS epidemic is taking a toll on women and girls worldwide. Globally the epidemic is increasing rapidly among women than men [1-3]. Of the 44 million people living with the infection worldwide, 19.2 million are females [2]. It is also estimated that globally, for every 10 men, 12 - 13 women are infected. Over 75% of all women living with HIV live in SubSaharan Africa where women and girls aged 15 - 49 comprise 57% of adults living with HIV. In addition, the problem is more prevalent among young women aged 15 - 25 years who are about three times more likely than young men of their age to be living with HIV.

Botswana has a high HIV sero-prevalence of 17.6% in the general population, highest among women than men, (20.4 and 0.2 percent respectively) [2]. About 18% of all deaths were attributed to HIV/AIDS [5].

Unprotected heterosexual intercourse carries the highest risk of infection for women worldwide [6], based largely on the partner's risk behavior [7] and remains the biggest challenge for HIV prevention in Botswana. In the absence of a cure the control of the epidemic will have to depend largely on the prevention strategies health protective sexual communication with their male sexual, to enhance risk reduction [8-16]. Women can benefit from safer sex communication but the negotiation may encounter barriers, such as gender and cultural norms and role expectations [17].

Partner communication, pertains to the practice of discussing reproductive health risks such as pregnancy and sexually transmitted infections (STIs), and negotiating sex and contraceptive or condom use with sexual partners [18]. Women present with diverse life histories and situations, and that must be understood from the women's perspectives before any supports and interventions can be planned [19]. Few studies exist explore sexual risk communication [20].

2. PURPOSE OF THE STUDY

The purpose of this study was to explore the meaning of HPSC among young women aged 18 - 25 years in Gaborone, Botswana, and their experiences while engaging in HPSC with their male sexual partners. This will inform safer sex interventions and promote HIV prevention behavior. Specific aims of the study were:

- 1) To determine how young Botswana women define and understand HPSC.
- 2) To explain the lived experiences of young women in Gaborone, Botswana while engaging in HPSC with their male sexual partners?

Key research questions

- 1) What do young Botswana women understand by

“health protective sexual communication”?”

2) What was the experience of young Batswana women while engaging in HPSC with their male sexual partners?

3. METHODS

3.1. Design

The study design was based on a phenomenological methodology in which women were asked to respond to question regarding the meaning of HPSC and their lived experiences as they engaged in HPSC with their male sexual partners. The study was a part of a predissertation qualitative pilot designed to elicit themes to guide item construction for a larger instrument development dissertation research study. The data were collected using grounded theory methodology in which theoretical sampling and constant comparison of emerging themes was used to probe further into the topic [21,22].

3.2. Setting

The study was conducted in maternal and child health clinics in Gaborone, Botswana. These clinics were within less than 2 kilometers walking distances from any household. The women received family planning, gynecological and other outpatient services such as general health consultation, treatment (injections and dressings), prenatal care, delivery, and postpartum follow-up at six weeks post delivery and under-five child welfare services. The services from these clinics were provided free within the universal health care system that was financially supported by Botswana government. The provision of free services promotes high service utilization, and women were easily accessible at these facilities to participate in the study.

3.3. Population

The study sample consisted of 20 sexually active women aged 18 - 35 years who attended maternal and child health services at Gaborone city clinics. Women in this age group were most at risk for HIV [23]. Purposive sampling using maximum variation was used for selecting the samples for both the individual interviews and the focus groups. This technique is used in qualitative research to select participants based on specified characteristics on the eligibility criteria [24] stated below. Participants were aged 18 - 35 years, having sexual partners, able to read and write in Setswana (the vernacular) and attended maternal and child health services at one of two clinics, one in the north and one in southern Gaborone. Women were excluded from participation in the study if they had apparent debilitating illness, self-reported cognitive impairment or if they did not meet the

age requirements noted above.

3.4. Ethical Considerations

Approval for the qualitative pilot study was first obtained from the Emory University Institutional Review Board (IRB) in Atlanta. Approval was also obtained from the Health Ministry Research Committee, which constitutes the IRB for health research in Botswana, from the Gaborone City Council head office, and from the local clinic authorities. Individual women provided written consent after receiving thorough explanation of the study from the researcher.

3.5. Participant Recruitment

Meetings were held with the health authorities, and providers at the clinics to share the study goals, objectives/ aims, benefits, eligibility criteria, procedures for the study, the target population, and, solicitation of assistance in referring women to the recruiter (the investigator). Health talks were held at each clinic, and participant recruitments flyers were posted at the clinic notice boards to introduce the study to potential participants. The participants' recruitment flyers and health talks based on a researcher developed lesson plan, which focused on information related to the study purpose and objectives, benefits of the study and potential participants, and contact details of the recruiter for further information on the study. The nurse supervisor at each clinic allocated working space for all meetings and for data collection (screening, consent signing and to conduct individual interviews and focus group meetings). Office space with a locked cabinet for data storage was obtained at the University of Botswana.

3.6. Data Collection Procedures

Women who were either referred by the providers or self-referred were given details about the study and requested to participate in either individual interviews. The women who agreed had a consent form read to them and they were asked to initial each page and append their signature on the last page. Women agreed to be interviewed on contact. The Principal Investigator conducted all interviews. All interviews were audio-taped and transcribed verbatim to text. Field notes were taken to facilitate analysis.

3.7. Study Measures

3.7.1. Demographic Questionnaire

Before interviews were started, each participating woman was asked to complete a 10 to 15-minute demographic questionnaire consisting of their age in years, if they had

a sexual partner, educational level, average annual income, marital status, the length of their relationship, whether they had an HIV test and their HIV status. The woman was also asked the same information about her partner.

3.7.2. Face-to-Face Individual In-Depth Interviews

The purpose of the individual interviews was to elicit information on the meaning and experiences of participants when they engaged in HPSC with their male sexual partners. Interviews were conducted in Setswana at an office that provided adequate privacy for women. Each interview took an average of about 45 minutes per.

3.8. Data Analysis

The data analysis was conducted based on the qualitative description method. This method entails a straightforward description of phenomena, in which the descriptions always rely on the perceptions, inclinations and sensitivities of the describer [24]. The method was suitable for this study, which seeks to describe Botswana women's perception about health protective sexual communication from their own perspectives. A line-by-line analysis of the verbatim transcripts was conducted to determine emerging themes and sub-themes. Data analysis was conducted concurrently with data collection to constantly compare responses and confirm emerging themes continuously. The resultant themes were used to develop items for instruments for a further quantitative study.

4. RESULTS

A total of 20 women participated in the study. Respondents' mean age was 25 years. Their mean income was P800.00, equivalent to \$133.00 per month. The mean educational level was grade 8. Only two were married, 37 had children and the mean number of children was two. The mean age difference between women and their partners was five years with the men being older, and the mean difference in educational level was two grades (more men had higher education, although a few women had more education than their partners did). Two of the women were HIV positive and among these, one had a sero-discordant partner. One woman was HIV negative, but her partner was HIV positive. All the women were in committed heterosexual relationships regardless of the partner's or their own HIV status. The names used in the Nvivo quotes are not the real names, but are pseudonyms in respect of the women's. All women had engaged in HPSC with their male sexual partners. Some women said that they initiated HPSC while others said their partners did.

4.1. Major Theme: The Meaning of HPSC

This theme was a response to the question about what health protective sexual communication meant to the women in the study, to establish a common meaning of the key construct under discussion. Women gave responses beyond their understanding of HPSC and included what they thought it involves. Four subthemes emerged under this theme and are discussed below.

4.1.1. Sub Theme 1: Initiating Safer Sex Discussions

Women explained HPSC meant initiating safer sex discussions with a male sexual partner in order to discuss important issues related to HIV prevention. The women suggested that some of the topics to be included in this discussion should include introducing safer sex topics to partners, talking openly and letting partners know their feelings about protection, asking partners about sexual history and talking about ways to prevent STI's and HIV/AIDS. Women said HPSC involved creating a cozy environment and ensuring confidentiality and privacy to enable free discussions, and adopting a positive and accepting attitude towards partners. Mare said "a cozy, relaxed atmosphere, when both of us are in a jolly light mood".

4.1.2. Subtheme 2: Who Should Initiate HPSC

Some women explained that they initiated the discussions, while others said their partners initiated the discussions. For example, Peno, who is HIV positive and discordant with her partner, said that she was very ill on and off when she was expecting her second child, and it was her boyfriend who suggested she get an HIV test and they used a condom while waiting to get the test. Recca said her boyfriend had an STI, and he asked that they both get an HIV test along with the diagnosis and treatment of STI.

4.1.3. Sub Theme 3: Using Different Sources of Information

Women said that they needed to use different sources of information to prepare themselves for talking to their partners. The sources of information included pamphlets from clinics, health talks given by health workers, information received during counseling, open discussions with friends, relatives and co-workers, employment-based HIV/AIDS educational programs, and billboards. Gonta spoke very firmly and said, "Men are a problem. You need to really know what you want to say to him beforehand. I like to listen to my nurses at the clinic; they are really good and they tell you everything, I was also lucky because at work we had a workshop on HIV/AIDS and I really understood how bad this disease is..." Women also said that they needed to be taught more

about HIV prevention by the nurses, to be well prepared to approach their partners. Support groups were also stated as a need, to share information and to give each other moral support concerning difficulties encountered with HPSC with partners.

4.1.4. Sub Theme 4 Perceived Self-Efficacy for HPSC

Some women said it was easy for them to talk to their partners about safer sex, and the use of safer sex practices. Women said that discussions were sometimes effective, but sometimes there were delaying tactics in using safer sex practices. Some factors were cited as important in assisting women to discuss safer sex effectively and gain compliance for safer sex practices. The age difference between the partners was mentioned, for example Teba said, "He is older than me and he knows everything, so he is supposed to protect me and treat me like a baby. He has to listen to me also, and teach me things..." This confirms women's desire to succumb to male domination. Some women said they would persist with or resume the discussions until a consensus is reached. However, this persistence did not always guarantee agreement for discussions and for the use of safer sex practices. Some said they would even suspend or refuse sex altogether.

4.2. Major Theme 3 Content Discussed (Exchanging Information about Safer Sex with a Partner)

This entailed giving and receiving information about sexual matters including requesting the use of male or female condoms, abstinence, contingent upon some good reason for suspending sex such as when a partner had an STI or was receiving treatment for it), being faithful and maintaining a monogamous relationship.

Koon said, "I told him that since I don't know his background (meaning his past sexual behavior) it is best that we both get an HIV test." Past sexual behaviors such as oral and/or anal sex did not come up. In fact, many women giggled about the strangeness of these when the question was posed. The common response among the women was "Aaaa...!" with facial expression of shyness, and surprise at the thought of engaging in these sexual practices.

Safer sex discussions for women were also deemed to further address other concerns such as future plans like marriage and whether and/or when they would start a family. This would determine whether or not safer sex discussions could even be initiated and whether or not to use protection. For example, Lono said, "it depends on whether I know him well or whether we are going to get married. Then we can decide whether or not we want to prevent pregnancy, when, and how many children we are

going to have. If I don't know him that well, I will insist on protection." Although a few women knew something about the protective role of male circumcision against STIs and HIV, none of them said they would include this in their discussions. Some women either did not know anything about it or had heard about it but did not believe it would work well for that purpose. Some of the women said that it should not really be encouraged. Tshaga said "I don't think it works, I think it even opens up chances for infection. What does the skin have to do with AIDS...? Some of these guys will start going around saying 'I've been circumcised and I won't have these diseases', and so I think it is dangerous because they will use it in the wrong way." Women did not know about the use of microbicides either, which was just being introduced for consideration in the country at the time of data collection for this study.

4.3. Major Theme 2: Experiences with HPSC

The women had both positive and negative experiences when discussing safer sex with their male sexual partners.

4.3.1. Sub Theme 1, Positive Experiences

These included the fact that their partners listened to them, participated in discussions and used safer sex practices. Some of the partners even gave examples of their encounter with people living with HIV and that they would do anything to avoid it. Women shared experiences with condom use. Nkel said "We talk about the condom and even practice inserting it... so I even help him slip it on him sometimes. I just want to make sure that no mistakes happen. We use it correctly all the time... I'm not afraid of him. We're like friends." Other safer sex practices listed were abstinence, and maintaining a monogamous relationship.

The women shared incidents where they were actually able to discuss safer sex. Sego gave an account of her previous discussion with her partner as follows:

"When we started I had just been to the Tebelopele center where I had been tested for HIV. When I got home, I waited until the moment was right for me to talk about it. I made sure that both of us were relaxed and laughing, and then I said, 'what do you think about this illness that is haunting people these days?' Then he replied that he thinks AIDS is real and it's a dangerous disease.' We then continued to talk about some people that we both knew who were suspected to living with AIDS, and some people that we had seen at the hospital. Then I asked him if that was how he wanted to see himself in the future. I wanted him to think about the consequences of his actions regarding sexual behavior. That's when I started asking that we needed to go and be tested, and that we

should use condoms. He kept quiet for a moment and then he told me that what I was saying was reasonable and that he would think about it. He seemed scared at first, and told me about his fears about being positive. So then I told him that we could go together to the clinic and talk to the nurses. The nurses always explain everything, that there is a lot of support given and about the usefulness of antiretroviral therapy, that some people live longer and healthier lives because of these medicines. I did not tell him that I had already tested. The following day he went without telling anyone and when he came back, his results were negative. So that's when I showed him mine, which were negative. Ever since then we talked about being faithful to each other to avoid anybody coming in and spoiling our health. We are still considering using condoms but we want to have a child first."

Although the above incident is based on self-report, it was used as a proxy to measure actual self-efficacy for HPSC because it is the only evidence available for the behavior having occurred since it too intimate to be observed in the real world.

4.3.2. Sub Theme 2, Negative Experiences

Some women said that partners ignored the m, refused to use safer sex practices, be emotional about the fact that such issues were raised and they were being told by women how to carry on their business, questioning the woman's fidelity or querying that their own fidelity was being questioned. Kuka said, "Well, he was kind-of uneasy and he just kept quiet..., he keeps quiet every time, and even walks away. As for going to the clinic, he says it is a waste of his time, and he does not see himself doing that when he is supposed to be working to feed his children. I don't want him to start yelling at me, so I leave him alone and try again another time..."

Some women had difficulty persisting with discussions on safer sex because of the partner's response and attitude. Rebu said "What can I say? He is the father of my children and I have to respect him. As long as I get '*phalatshe*' (the vernacular for maize meal, used as an expression to mean having food on the table for the family) for my children it's ok". This woman was expressing dependency on her partner and her willingness to comply with his desires. Bogele said, "If I turn myself into a mosquito (expression meaning making too much noise for him) I'll literally be chasing him out of the house, and he will also get it (sex) from someone else".

4.4. Major Theme 4: Factors That Influenced HPSC

4.4.1. Sub Theme 1: HPSC Influence Tactics

Women said that influence tactics enabled them to initi-

ate and sustain HPSC including: direct confrontation; subtle hinting of topics; using charm/tenderness or flirting, persistence, manipulation (using fear language about the horrors of living with AIDS), and silence (not talking to him until he complies); withdrawal from sex; coercion; threatening to leave or actually ending the relationship; suggestive action (sneaking condoms in his drawers, pockets or luggage when he travels), with the hope that the partners would ask questions and thus a conversation would start. They also said that they sneaked them just in case they were needed elsewhere or in emergencies. Sera said, "You can't trust anyone, just put it in there he may remember to use it during those bad times. Even when he comes back and you see that one is missing, don't even ask questions because it means he was protecting you..." Others said they would participate in inserting the condom to ensure that it was used properly. Other enabling factors included the perceived threat of HIV and AIDS, which was also said to play a role in assisting women to engage their partners in discussions. Reminding the partner about people they knew who had AIDS, seemed to start a fruitful conversation for some women. The couples were usually motivated by the love for health and long life that could enable them to raise their children together.

4.4.2. Sub Theme 3 Other Influencing Factors

Other enabling factors included the perceived threat of HIV and AIDS, which was also said to play a role in assisting women to engage their partners in discussions. Reminding the partner about people they knew who had AIDS, seemed to start a fruitful conversation for some women. The couples were usually motivated by the love for health and long life to enable them to raise their children together.

4.4.3. Sub Theme 2: Barriers to HPSC

Barriers to safer sex communication included men's non-responsiveness, suspicion about infidelity when discussions were initiated; fear of what would happen if he tested positive and the woman tested negative for HIV; and, the general notion that women were afraid to talk about sexual matters. Some myths and knowledge gaps regarding safer sex strategies were identified, such as condom breakages, condoms bringing illness, and the inability to comprehend the usefulness of male circumcision in STI and HIV prevention. These were some of the barriers to effective communication. Health workers attitudes towards patients were also mentioned. For example, Gonie said that the first time she went to request an HIV test with her partner, the nurse had no time for them, and she did not give them enough information. Therefore, her partner stormed out, and when they got home, he did not want to listen because of the embarrassment they

experienced. She said this to emphasize the importance of the health workers' attitudes, "Young people need someone who has patience, who can talk to them in a gentle way and make them to feel free and relaxed so that they can ask questions and get clarification. Then they can come back, but if you show that you have no time they run away for good, and trouble comes fast..."

Violence was not mentioned as an actual occurrence by any of the women, although some mentioned a few incidents of aggressive non-physical silencing. However, the threat of violence was perceived by women in the focus groups as source of difficulty for talking to partners about safer sex. A lot of them echoed the phrase "we are afraid of them because we don't want to make them mad, we don't want to be beaten." Although some women in the individual interviews maintained that they talked to their partners freely, some contradictions were noted when they were asked to give their experiences during an incident when they discussed safer sex with their partners. For example, Ompi said that her partner told her that he does not need to be told by a woman how to do his business, and that it was hard for her to approach him again.

4.5. Major Theme 5, Partner's Response

The women said that the male sexual partners were significant people in determining the direction and outcome of the discussions. Most women said the men listened and had input in the discussions, with the effect of using condoms. They believed their partners also complied to a monogamous relationship. Others said the men just ignored them, walked away or became angry at the suggestion of such discussions. Some used threats even though they did not engage in actual violence. Some women expressed fear of rejection. Although there was no personal experiences revealed. There was also mention of refusal to use condoms. Some women said they did not feel compelled to comply with their partner's refusal to talk, or to have unprotected sex. Tsheo said, "If he refuses, he does not get me. I don't care I just want to protect myself, so if he does not want to be with me then so be it."

4.6. Major Theme 6: Intention to Engage in HPSC

This theme pertained to the likelihood of engaging in HPSC in the future. Women in this study made statements that indicated some promise to engage in HPSC with their partners in the future. These included continued persistence with HPSC and requests for condom use, being faithful, being monogamous, and periodically checking their HIV status, abstaining as necessary. Kantle emphasized that, "I will still remind him so that we get

our test cleared...I know I'm faithful and will remain like that, but I will remind him about being faithful to me, as it is supposed to be...I will remind him that we should focus on each other and not have eyes for other people (meaning extra-dyadic relationships). We need to be honest with each other, tell each other about everything..., things like that".

5. SUMMARY AND DISCUSSION OF THE FINDINGS

Some women were capable of initiating safer sex discussions with their male sexual partners. Other women said that their partners were able to initiate HPSC, although in most instances it was either attached to their fears when the woman was known to be sero-positive or suspected because of illness. Generally, women said that HPSC was a good thing and that it yielded some positive consequences for their health and life. There were positive and negative experiences and some women were assisted by influence tactics, and other factors to pursue their safer sex discussions. The partner's responses did not hinder them and they would still engage in HPSC in the future, motivated by the grim consequences of living with HIV and AIDS.

6. IMPLICATIONS FOR THE QUALITATIVE STUDY RESULTS

The results of this qualitative study support findings of research in HPSC [9,11,12,14-16,25-28]. These results also highlight the need to address some information gaps for women. Although information about HIV and AIDS is widespread in Botswana, some new critical information needs to be incorporated into the public education strategy, such as the emerging research about the importance of male circumcision. The need to emphasize the importance insisting on the use of protection at all times with or without knowledge of the partners sero-status is critical, especially in Botswana where the prevalence is high and a negative test results may occur during the window period when the body is still mounting an antibody response to HIV. Women need assertiveness training, information and skills for HPSC. HPSC barriers need to be further studied and addressed. Myths and misconceptions about HIV and AIDS still need to be addressed.

Health workers, especially nurses, play an important role as indicated by the women in this study, but their attitudes need to be addressed through continued dialogue and in-service updates. Information updates on HIV and AIDS need to be disseminated to health care providers, (practitioners and students) and they should be encouraged to pass it on during health talks and counseling. The national information, education and communi-

cation strategy needs to incorporate HPSC and encourage partners to talk about safer sex. Talking about safer sex should be demystified, contextualized, and made simpler for couples to comprehend and enact, and incorporate it their intimate discussions. Men also need special interventions related to HPSC since they have been identified as a potential source of difficulties in dyadic HPSC.

This study has set the stage for more quantitative research to measure HPSC among a similar groups of women in larger samples to develop culturally specific and woman focused instruments that can facilitate further identification of HPSC issues among the young women in Botswana and guide related HIV prevent interventions.

REFERENCES

- [1] Peter, L. (2002) Facing the HIV/AIDS epidemic. http://www.findarticles.com/p/articles/mi_qa3761/is_200209/ai_n9109145/pront
- [2] AIDS Epidemic Update (2004) Women and AIDS. http://www.unaids.org.org/wad2004/EPIupdate2004_html_en/Epi04_04_en.htm
- [3] Quin, C.T. and Overbaugh, J. (2005) HIV/AIDS in women: An expanding epidemic. *Science*, **308**, 1582-1583. [doi:10.1126/science.1112489](https://doi.org/10.1126/science.1112489)
- [4] Government Central Statistics Unit, Botswana (2008)
- [5] Government Central Statistics Unit, Botswana (2011)
- [6] National Institute of Allergy and Infectious Diseases (2011) HIV infection in women. <http://www.niaid.nih.gov/topics/hivaids/understanding/po-pution%20specific%20information/pages/womenhiv.aspx>
- [7] Wong, K. H. and Lee, S. S. (1996) Maintaining low HIV sero-prevalence among injecting drug users. *The Journal of the American Medical Association*, **275**, 596. [doi:10.1001/jama.1996.03530320020024](https://doi.org/10.1001/jama.1996.03530320020024)
- [8] Whitaker, D.J., Miller, K.S., May, M.C. and Levin, M.L. (1999) Teenage partners' communication about sexual risk and condom use: the importance of parent-teenager discussions. *Family Planning Perspectives*, **31**, 117-121 [doi:10.2307/2991693](https://doi.org/10.2307/2991693)
- [9] Catania, J., Coates, T. J., Stall, R., Turner, H., Peterson, J., Hearst, N., Dolcini, M., Hudes, E., Gagnon, J., Wiley, J. and Groves, R. (1992) Prevalence of AIDS-related risk factors and condom use in the United States. *Science*, **258**, 1101-1106. [doi:10.1126/science.1439818](https://doi.org/10.1126/science.1439818)
- [10] Catania, J., Coates, T. J., Stall, R., Turner, H., Peterson, J., Hearst, N., Dolcini, M., Hudes, E., Gagnon, J., Wiley, J. and Groves, R. (1992) Prevalence of AIDS-related risk factors and condom use in the United States. *Science*, **258**, 1101-1106. [doi:10.1126/science.1439818](https://doi.org/10.1126/science.1439818)
- [11] Catania, J.A., Coates, T.J. and Kegels, S. (1994) A test for the AIDS risk reduction model: Psychosocial correlates of condom use in the AMEN cohort survey. *Health Psychology*, **13**, 1-8. [doi:10.1037/0278-6133.13.6.548](https://doi.org/10.1037/0278-6133.13.6.548)
- [12] DiClemente, R.J., Wingood, G.M., Crosby, R., Cobb, B.K., Harrington, K. and Davies, S.L. (2001) Parentadolescent communication and sexual risk behaviors among African American adolescent females. *The Journal of Pediatrics*, **139**, 407-412. [doi:10.1067/mpd.2001.117075](https://doi.org/10.1067/mpd.2001.117075)
- [13] DiIorio, C., William, N.D., Lehr, S. and Soet, J. (2000) Correlates of safer sex communication among college students. *Journal of Advanced Nursing*, **32**, 658-665. [doi:10.1046/j.1365-2648.2000.01525.x](https://doi.org/10.1046/j.1365-2648.2000.01525.x)
- [14] Malow, R.M., Corrigan, S.A., Canningham, S.C., West, J.A. and Penna, J.M. (1993) Psychosocial factors associated with condom use among African-American drug abusers in treatment. *AIDS Education and Prevention*, **5**, 244-253.
- [15] Rickman, R.L., Lodico, M., DiClemente, R., et al. (1994) Sexual communication is associated with incarcerated adolescents. *Journal of Adolescent Health*, **15**, 383-388. [doi:10.1016/1054-139X\(94\)90261-5](https://doi.org/10.1016/1054-139X(94)90261-5)
- [16] Sheahan, S.L. Coons, S.J. Seabolt, J.P. Churchill, L. and Dale, T. (1994) Sexual behavior, communication: Communication, and chlamydial infections among college women. *Health Care for Women International*, **15**, 275-286. [doi:10.1080/07399339409516120](https://doi.org/10.1080/07399339409516120)
- [17] Soler, H. Quadagno, D., Sly, D.F., Riehman, K.S., Eberstein, I.W. and Harrison, D.H. (2000) Relationship dynamics, ethnicity and condom use among low-income women. *Family Planning Perspectives*, **32**, 82-101. [doi:10.2307/2648216](https://doi.org/10.2307/2648216)
- [18] Kirby, D. (2001) Emerging answers: Research findings on programs to reduce teen pregnancy. National Campaign to Prevent Teen Pregnancy, Washington, DC.
- [19] De Zalduando, B. (1991) Prostitution viewed cross-culturally: Toward recontextualizing commercial sex work in AIDS Intervention research. *Journal of Sex Research*, **28**, 223-248.
- [20] Forsyth, A.D. and Carey, M.P. (1998) Measuring self-efficacy in the context of HIV risk reduction: Research challenges and recommendation. *American Psychological Association*, **17**, 559-568
- [21] Draucker, C.B., Martsolf, D.S., Ross, R. and Rusk, T.B. (2007) Theoretical sampling and category development in grounded theory. *Qualitative Health Research*, **17**, 1137-1148. [doi:10.1177/1049732307308450](https://doi.org/10.1177/1049732307308450)
- [22] Thorne, S. (2000) Data analysis in qualitative research. *Evidence-Based Nursing*, **3**, 68-70. [doi:10.1136/ebn.3.3.68](https://doi.org/10.1136/ebn.3.3.68)
- [23] The National AIDS Coordinating Agency (2002) Botswana 2002 second-generation HIV/AIDS surveillance: A technical report. Government Printers, Gaborone.
- [24] Sandelowski, M. (2000) Focus on research methods: What ever happened to qualitative description? *Research in Nursing and Health*, **23**, 334-340. [doi:10.1002/1098-240X\(200008\)23:4<334::AID-NUR9>3.0.CO;2-G](https://doi.org/10.1002/1098-240X(200008)23:4<334::AID-NUR9>3.0.CO;2-G)
- [25] Buysse, A. and Ickes, W. (1999) Communication patterns in laboratory discussions of safer sex between dating versus non-dating partners. *The Journal of Sex Research*, **36**, 121-134. [doi:10.1080/00224499909551977](https://doi.org/10.1080/00224499909551977)
- [26] Quina, K., Harlow, L.L., Morrokoff, P.J., Burkholder, G.

- and Deiter, P. (2000) Sexual communication in relationships: When words speak louder than actions. *Sex Roles*, **42**, 523-549. [doi:10.1023/A:1007043205155](https://doi.org/10.1023/A:1007043205155)
- [27] Wingood, G.M. and DiClemente, R.J. (1998) Partner influences and gender-related factors associated with non-condom use among young adult African-American women. *American Journal of Community Psychology*, **26**, 29-51. [doi:10.1023/A:1021830023545](https://doi.org/10.1023/A:1021830023545)
- [28] Morokoff, P.J., Harlow, L.L. and Quina, K. (1995) Women and AIDS. In: Stanton, A.L. and Gallant, S.J., Eds., *Women's Health*, American Psychological Association, Washington DC, 117-169.