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Research Article

**The more you learn the less you know?
Interpretive ambiguity across three modes of
qualitative data**

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The more you learn the less you know? Interpretive ambiguity across three modes of qualitative data

Nicole Angotti¹

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Abstract

BACKGROUND

Researchers across disciplines face a similar challenge ensuring our methods can give us valid, usable answers to our questions. But what happens when multiple strategies of inquiry give us *different* answers to the *same* research question? We explore this issue through three different modes of qualitative inquiry – interviews, focus groups, and participant observation – oriented around local attitudes to HIV testing.

OBJECTIVE

We introduce the notion of “research awareness” – the extent to which participants are continuously reminded that they are taking part in a research project, which is a function of the mode of research itself. We hypothesize that as participants’ research-awareness decreases across modes, from interviews to focus groups to participant observation, the proportion of statements that conform to officially sanctioned normative discourse about HIV/AIDS will decrease and the proportion expressing non-normative or counter-normative ideas will increase.

METHODS

We tabulated positive and negative references to three themes – knowing one’s HIV status, counseling messages, and antiretroviral treatment – across the three qualitative modes.

RESULTS

The distribution is non-uniform, with favorable responses to testing themes predominating in interviews, mixed responses in the focus groups, and negative responses predominating in the observational data. At least a third of references to testing across all three modes, however, do not support officially sanctioned normative discourse.

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CONCLUSIONS

Researchers who use mixed methods approaches for triangulation should consider the influence of research-awareness on their methods. These situational specifics are crucial for understanding the applicability of research to real life. Substantively, our study revealed a robust level of ambivalence about HIV testing despite normative discourses supporting it at local and global levels.

1. Introduction

Researchers across disciplines face a similar challenge ensuring our methods can give us valid, usable answers to our questions. But what happens when multiple strategies of inquiry give us *different* answers to the *same* research question? This conundrum is especially timely now, as more and more researchers recognize the importance of triangulation and using mixed-methods approaches (for examples, see Coast et al. 2011; Creswell 2009; Schatz 2003; 2012). This paper explores this broad epistemological question through a case study, in which local attitudes to a key global AIDS intervention, HIV Counseling and Testing (“HIV testing”), were gleaned through three different modes of qualitative inquiry. It considers how distinctive elements of these modes shape what we know (or what we think we know), and considers the implications of these modes for understanding the consequences of interventions designed for individual and community benefit.

Social scientists have known for decades that research participants are mindful of, and thus actively shape, what they say to interviewers as well as what they say to one another in informal social interactions. “Presentation of self”, that is, how humans behave in social situations and appear to others, is a sociological axiom (Goffman 1959). Such presentations manifest themselves in research settings, as subjects do not simply produce data to be harvested, but actively engage with researchers in co-creating, and sometimes in redefining, the research experience itself (see Biruk 2012).

Social scientists also recognize that the reliability of reporting is thoroughly affected by the attitudes of respondents towards those who interview them (Miller, Zulu, and Watkins 2001), which may vary cross-culturally (Weinreb 2006); as well as by “third party effects”, whereby the presence of others may affect the types of opinions and behaviors that respondents are willing to articulate (for examples, see Aquilino 1993; Boeije 2004; Smith 1997). Our aim is not to test the reliability of reporting, as indeed other studies have done (for examples, see Mensch et al. 2008; Plummer et al. 2004; Poulin 2010). We do not have a HIV biomarker, for example, to know whether what people say about HIV testing corresponds with what they actually do. Rather, we

aim to show how and why it is we know what we know about our objects of empirical interest, such as health interventions like HIV testing, and in so doing pursue the “communicative constitution” of our research methods and how they might “shape knowledge production” (Kratz 2010:806). Our work here is given particular urgency because interventions like HIV testing are not spontaneously arising objects of study; they are practices that are explicitly intended to produce social changes and amelioration of social problems. Analyzing and dissecting local responses thus serves a social as well as a theoretical agenda.

Towards that end, we conducted a study on local responses to HIV testing in Malawi, a high HIV prevalence African setting, utilizing two conventional qualitative methods – semi-structured interviews and focus group discussions – and one slightly unusual one, a unique set of observational field journals that capture everyday conversations about HIV/AIDS occurring in natural settings. These methods vary in terms of who was present (e.g., an interviewer and a respondent; a group of women), the nature of the interaction (e.g., formal interview; casual conversation), and level of what we introduce here as “research awareness”: that is, the extent to which we believe research participants are continuously reminded that they are taking part in a research project, which is a function of the mode of research itself. Interviews are assumed to produce greater research-awareness than focus groups, and observational studies are assumed to produce less such awareness than either of the other two methods. The larger study aim was both empirical (see Angotti 2012; Angotti, Dionne, and Gaydosh 2011; Angotti 2010; Kaler and Watkins 2010) as well as methodological. In this paper, we present the methodological lessons.

2. Setting

In Malawi, as in other sub-Saharan African countries, testing for HIV is now widely available. Testing services first became available in Malawi in the mid-1990s. In 2004 and 2005, the Malawi Ministry of Health (MOH) received donor support to expand the availability of free HIV testing to all district hospitals, as well as many rural hospitals and clinics. During the rapid expansion of testing services, antiretroviral treatment (ART) also became available in district hospitals for those diagnosed with AIDS and who met the eligibility criteria. Accompanying the scale-up of HIV testing (and treatment) were earnest social marketing efforts encouraging Malawians to be tested. Official statements from the government and energetic media campaigns found on the radio, in newspapers, and on billboards, present testing as an unambiguously good thing, urging Malawians to “know your status”, “condomize”, “live positively”, and more recently with the roll-out of treatment, “to plan for the future”. These public

awareness messages are nearly ubiquitous throughout the country, and have increased in density over the course of the AIDS pandemic (Angotti et al., 2012).

3. Data and methods

The data for this study were collected in two rural districts in Malawi between 2007 and 2009, a time when HIV testing was widely available and treatment, at a minimum, available at government district hospitals. The data include three distinct qualitative methods: semi-structured interviews, focus group discussions, and a set of observational field journals that capture everyday conversations about HIV/AIDS.

3.1 Semi-structured interviews

Interviews were conducted with rural Malawian men and women tested for HIV as a qualitative follow-up study to a larger study on HIV testing and treatment surveillance led by the University of Pennsylvania in conjunction with the District Office of the Ministry of Health in Mchinji District. The sample of respondents was drawn from the population of attendees undergoing HIV testing in November and December 2006 at the two hospitals in the district and one government-run clinic, stratified by health facility and HIV status, and who had consented previously to a follow-up interview.³ Also included in the study was a smaller sample of “near neighbors” to the “testing attendee” respondents. Near neighbors were presumably similar to those in the testing attendee sample, but were not selected into the interview sample by virtue of having been tested for HIV at the study clinics. Thus, they offer wider community perspectives on testing. Forty-nine total interviews were conducted, 30 from the “testing attendee” sample and 19 from the “near neighbors” sample. During the interviews, 10 near neighbors reported previous HIV testing. Our analytic sample for this study is 20 interviews, 8 from the “near neighbors” sample and 12 from the “testing attendee” sample, stratified by those who were tested ($n=13$)⁴, those who were not ($n=7$), and further stratified by HIV serostatus and ART status.

³ The greater study’s ethical approval required previous consent before any follow-up interviews.

⁴ The analytic sub-sample includes one of the near neighbors who, in the interview, reported having been tested.

Interviewers asked about personal and family health, experiences with HIV testing⁵, knowledge about ART (antiretroviral treatment), and local health services. The interviews were conducted privately in respondents' homes or, very occasionally, in a location of the respondent's choosing. Interviews were conducted in chiChewa by two local interviewers, both female. The interviews lasted from 25 minutes to just over an hour, with typed transcripts averaging 11 single-spaced pages. The interviews were digitally recorded; transcripts were translated and transcribed in the field by their respective interviewer so that any exchanges or English words that were unclear in the translations could be clarified.

3.2 Focus group discussions

Five focus groups were conducted, each including five to eight participants of varying (adult) ages: three groups had men and women; one group only women; and one group only men. To our knowledge, there was no difference in the social status between group members. Rural Malawian men and women were recruited for voluntary participation in one of two ways: either the village headman helped the field assistants locate members of his village, or the field assistants approached individuals already congregating together in open settings – such as a group of women seated on a veranda braiding each others' hair or a group of men playing cards outside a local “hawker” (a small grocery store). Thus participants were familiar with one another, either more distally by virtue of living in the same village or more intimately by implication that they were socializing together at the time they were approached by the field assistant. In this sense the focus groups do not conform to the typical model of gathering a bunch of strangers in a room and having the facilitator ask them questions. Indeed elements of some of the transcripts looked more like spontaneously occurring conversational groups than classic research ones.

The field assistants presented participants with a series of vignettes about the HIV testing process. Focus group discussions were conducted in chiChewa by three local research assistants, one male and two female. The focus groups lasted between 40 and 60 minutes, with typed transcripts averaging 11 single-spaced pages. Like the interview transcripts, focus groups were also digitally recorded, and transcripts translated and typed in the field.

⁵ Interviewers did not ask questions that assumed an HIV testing visit. Questions were worded such that respondents would be asked what they knew about testing, not whether they themselves had been tested. Biomarker data were available only to the research director in the field, not to the interviewers.

3.3 Observational field journals

The observational journals we analyze in this paper were written by a local Malawian (pseudonymized as Bashil Kunthani), a field assistant on a larger longitudinal research project who is also a health worker. He kept a journal of his interactions with clients, co-workers and friends concerning HIV and related issues, writing down his daily observations in and around the clinic setting in as much detail as possible. We analyzed 10 journals for content, each averaging 15 single-spaced pages in length.

Kunthani's journals are part of a larger corpus of journals that have been continuously collected for over a decade. They are part of a larger project (the Malawi Diffusion and Ideational Change Project, MDICP) that aims to learn what people say about AIDS when they are talking with each other in conversations in natural settings (Watkins and Swidler 2009).⁶ The journals are written by local villagers, high school graduates with previous experience working with the MDICP as survey enumerators and who live in one of its three rural study sites. The "journalists" were asked to serve as participant observers as they go about their daily routines: if they overheard anything concerning AIDS, they were to make a mental note of it and then write their recollections in a notebook that evening or the following day. The journalists write the journals in English and use parentheses or carets (< >) to bracket explanatory comments or expressions that are untranslatable in local languages, chiChewa or chiYao.

The observational journals get more naturalistic perspectives on HIV and AIDS, ones that capture conversations in real time and space, rather than retrospectively as, for example, in interview accounts. However, they are not impervious to social desirability bias as the journal writer can exercise choice over what s/he chooses to record or to omit. The field journals trade the structures and conventions of the interview situation for those of the group of interlocutors and the social setting.

3.4 Data analysis

We tallied all references to three testing themes [*knowing one's status, counseling messages* (e.g. abstinence, be faithful, and use condoms, known collectively as the "ABCs")⁷, as well as the biomedical advice promoted with treatment use, such as "live positively", eat nutritious foods, etc.), and *antiretroviral treatment* (ART) across the three modes of qualitative inquiry for descriptions and reactions in either positive or

⁶ The journals are available online at: http://investinknowledge.org/projects/rese-arch/malawian_journals_project. The website also provides details on the overall study.

⁷ The term "ABCs" refers to the three ways of preventing AIDS most frequently advocated in public education campaigns: Abstain, Be faithful, or use a Condom.

negative terms. We did not tally value-neutral remarks (e.g., “VCT⁸ is offered at XYZ”; “ART is taken twice a day”; “We were told to use condoms”). The following statements are examples of positive and negative statements about the three testing themes:⁹

Goodness:

1. A general statement (e.g. testing is good for the mother and baby; abstinence is best; ART makes you live longer);
2. A statement about the respondent/speaker’s intention to be tested, to use condoms, to begin ART;
3. A statement about a third party who was tested, or on treatment, and has had a good outcome (e.g., feels relieved; is getting “fatter” [healthier]).

Badness:

1. A general statement (e.g., knowing your status will make you live with worry; condoms have holes in them);
2. A statement of the respondent/speaker’s intention not to be tested/treated/adhere to counseling advice (e.g., I am not ready to know my status; I will not use condoms with my wife);
3. An account of a third party who was tested or treated with a bad outcome (e.g., toxic side effects of treatment; being laughed at).

This paper focuses primarily on the tabulation and quantitative comparison of these statements, and only secondarily on the substantive content of the statements.¹⁰ Qualitative data are inherently difficult to quantify. In tabulating the coded segments, we developed protocols to maximize consistency and comparability across the three modes of data collection. Consistency needed to be balanced with flexibility, as we adapted our tabulation strategy to each mode so as to minimize redundancy and double-counting. For all modes, we used the “conversational incident” – a verbal interaction bounded in time and space – as our unit of tabulation, although our definition of a conversational unit varied necessarily from mode to mode. Our final tabulations are shown in Figure 1.

⁸ VCT stands for “Voluntary Counseling and Testing”. The acronym is ubiquitous in the study area, and is invoked colloquially as synonymous with HIV testing.

⁹ From this point forward, we use the phrases “goodness” and “badness” rather than “positive” or “negative” to avoid confusion with seropositivity and seronegativity.

¹⁰ Where we do offer substantive illustrations from our data, we reference the data sources as follows: interviews by category of respondent (i.e., testing attendee “TA” or near neighbor “NN”) and interview number (e.g. TA Interview #10); focus groups by sex composition of the focus group and focus group number (e.g. Women FGD #1); and observational journals by the journalist’s pseudonym, followed by a year, month, day, format (e.g. Kunthani 080611). All names of individuals and places have been anonymized.

3.4.1 Interviews

The interviews were the mode of data collection in which, we believe, the participant was *most* aware that he or she was taking part in research, as all interaction was contained within the researcher-research subject dyad.

We treated each interview as a single conversational incident. Many of the interviews contained reiterated statements about the goodness or badness of testing, counseling, and treatment. We tabulated a statement as a data point only if it was qualitatively distinct from other statements about the goodness or badness of testing in the interview.

In some interviews, the interviewer asked essentially the same question several times (“How did you feel about being tested?”, “Why did you want to be tested?”, etc.) and got essentially the same response (“I was happy to know the status of my body”, “Because I wanted to know my body status”, etc.). In these cases, we would tabulate the first statement but not the subsequent ones.

In other interviews, the respondent gave qualitatively different responses about the goodness or badness of testing (e.g. “I wanted to know the status of my body”, “I don’t trust my husband because he is often gone at night”, etc.). In this case, we would tabulate the two statements as two different data points.

3.4.2 Focus group discussions

We ranked the focus groups midway between individual interviews and observational journals in terms of the research-awareness of their participants. However, this is not the same as saying that focus group participants occupied a midpoint of research awareness. We know that the participants were more research-aware than those whose conversations were captured in the journals, simply because the focus group participants had been explicitly informed that they were taking part in a research project, as were the individual interviewees. However, the research situation was radically different for focus group participants compared to interviewees. The researcher-participant dyad of the interviews was attenuated by the presence of other parties in the focus groups. In many, if not most, of the groups, participants already knew each other as neighbors or friends, and those pre-existing relationships were expressed and enacted in the discussion. This is evident in the amount of crosstalk going on, in which participants speak directly to, and argue with, each other rather than passing comments through the facilitator. Individual interviews have no equivalent to this crosstalk. In addition, the pressure to contribute and speak is certainly higher in the interviews, where answers were being solicited directly from individual participants, as

compared to the focus groups in which remaining silent was an option. We can thus claim that research-awareness was at least *different* in the focus groups as compared to the interviews; and we can cautiously posit that it was actually lesser in the groups. We do not (yet) have metrics, however, for reliably measuring research awareness across modes.

For the focus group transcripts, we treated each topic introduced by the facilitator, according to a standardized focus group guide, as a separate conversational incident. Even though the discussions of these topics were not separated in time and space, as was the case for the conversational incidents in the interviews and journals (described below), we believe that the switch from one topic to another represented a decisive enough break that, for our purposes, they constituted different incidents. Because of the crosstalk and back-and-forth in the focus groups, as different speakers dominated or led the discussion on different topics, they resembled a sequence of conversations more than they did the scripted, more homogenized question-and-answer format of the interviews. The content and participation patterns of the focus groups were too heterogeneous for us to regard them as single conversational incidents, in the same way that we regarded the interviews. We tabulated the first codeable statement by each speaker in the incident. In other words, if a speaker reiterated the same statement several times in an incident (stating repeatedly that knowing one's status is good, for instance), only the first utterance was counted. If the speaker repeated the same sentiment in response to another question, conversational incident, we considered that a distinct data point. For instance, if a speaker stated that knowing one's status was good in response to a question about what a good life is and repeated the same statement three times as the group was discussing this question; and then expressed that knowing one's status was good in response to a question about what happens during antenatal visits, we considered that two data points. This method of tabulation minimizes redundancy, at the cost of understating the contentiousness of particular questions or the zeal with which participants seized on particular topics, both of which led to people repeating their statements.

3.4.3 Observational field journals

The observational field journals were the data collection mode in which we expected the least amount of research awareness by the participants. Although we presume that all participants knew Bashil Kunthani was a health worker involved with HIV/AIDS (and we expect that most probably also knew he was involved in the MDICP study as a researcher), we did not assume that participants knew that Kunthani was keeping a daily journal and that they were in it. In this mode, "conversational incidents" were naturally

occurring phenomena, interactions separated in time and space. Kunthani did not prompt his interlocutors to provide opinions on testing, counseling, or treatment for the purposes of research (as was the case with the interviews and focus groups), so these journals are the least typical of the data collection methods frequently used in qualitative studies of HIV/AIDS.

As with the focus groups, we tabulated the first codeable statement by each speaker in the incident. In other words, if a speaker repeated the same code several times in an incident (stating repeatedly that knowing one's status is good, for instance), only the first utterance was counted.

There are alternatives to our coding scheme. One approach, for example, might have "weighted" the statements in the focus groups and journals more heavily than the statements in the interviews, on the grounds that in interviews the participants had effectively no choice but to articulate an opinion when they were asked directly by the interviewer, whereas in the focus groups and conversational incidents captured in the journals, such statements were more likely to be on an individual's own initiative and desire to participate in the conversation, and thus likely to reflect more strongly-held beliefs. However, we are not speculating on the depth of conviction of these statements; instead we are being as parsimonious as possible in our speculation about the participants, and tracking only the existence of their statements.

3.5 Hypothesis

Our foundational hypothesis rests on the concept of "research-awareness". By research-awareness, we mean not only participants' knowledge that they are part of a research study, but also the extent to which the conditions under which they participate provide continual reminders of research, cuing an intensified awareness of research. Research-awareness is thus a continuum, from high to low. Some modes of research produce high research-awareness by means of the environmental, contextual and interpersonal cues provided, while other modes provide fewer such cues. Cues may include the "pre-scripting" of the research encounter, producing an obvious appearance of artificiality with minimal room for improvisation, or the composition of the participants in the research encounter, who may be people who would be unlikely to meet and interact in the course of non-research life. We believe that modes of research such as covert observation or ethnography will generate lower levels of research-awareness than modes such as survey research or one-on-one interviewing, subject to the caveats in the discussion of focus groups above.

We assume that the degree of research-awareness is related to the data participants generate during research. Our main hypothesis is that as participants' research-

awareness decreases across modes, from interviews to focus groups to observational journals, the proportion of statements that conform to officially-sanctioned normative discourse about HIV/AIDS will decrease and the proportion expressing non-normative or counter-normative ideas will increase. Specifically, we expect that interview participants will conform most to normative discourse, focus group participants will conform less, and speakers quoted in the observational journals will conform least.

At this juncture, it is important to note that there is no single, unitary and homogenous “normative discourse” on AIDS in Malawian society. As noted above, public health messaging from the government or from NGOs, often with a heavy influence from international donors, is pervasive in public life, but it coexists with other sources of ideas about sex, morality and sickness, which also generate normative expectations of behavior. We know, for instance, that churches and faith organizations put forth their own messages concerning AIDS, which usually stress abstinence and fidelity (Trinitapoli and Weinreb 2012). Some religious organizations emphasize kindness to those who are infected or sick, while others stress the moral content of AIDS and its association with sinful behavior (*ibid.*).

In addition to contemporary religious discourses, Malawians constantly create, alter, and recreate local social norms of what is acceptable or desirable to do in the face of AIDS risk, drawing on histories of tension between the genders and the economic uncertainties of the present day. The evolution of these norms has been tracked by Wilson (2007; 2008), Watkins (2004), Kaler (2006), Kaler and Watkins (2010), and Swidler and Watkins (2007). However, despite the presence of coexisting and sometimes competing sources of ways to talk about AIDS, the normative discourse to which the interview participants hewed most closely was that of the state and the NGOs that promote “AIDS awareness” and “sensitization”, focusing on the ABCs and on testing and treatment. This suggests to us that participants identified the research endeavor closely with those particular ways of thinking and talking about AIDS. Thus, when we refer to “normative messages”, those are the messages we mean.

We expect that levels of research-awareness will be manifested in the prevalence of statements which contravene the normative messages associated with public discourse on AIDS – get tested, use condoms, stay faithful to one’s marital partner, and so forth – based on our assumption that subjects will suppress counter-normative statements in contexts in which they are aware that they are participating in research, and are constantly receiving contextual cues to that effect.

The presence of statements supporting normative behaviors is not by itself indicative of high research awareness, as such statements may express attitudes which participants genuinely hold, and which they would express in any setting. However, the variations in the frequency of counter-normative statements, with more occurring in low-research-awareness settings than in high ones, is quite significant. It is the

proportion of normative statements relative to counter-normative ones which we are interested in.

This hypothesis – that there is a positive relationship between modes of qualitative inquiry exhibiting high research-awareness and the proportion of statements that conform to normative discourse about HIV testing – rests on the assumption that participants in interviews will have the strongest awareness that they are participating in research, because they are interacting solely with an interviewer; while focus group participants will know that they are taking part in research, but do not have a researcher (or proxy) as their sole interlocutor because they are talking with each other as well as the interviewer; and speakers cited in the observational journals were not aware that they were being incorporated into research, because they did not interact with their interlocutor as a researcher, and he wrote down his observations at the end of the day rather than while the speakers were present.

Two examples, which stood out to us while reading interview and focus group transcripts in the field, illustrate this. The first is from an interview. At the close of the interview, the interviewer asks the respondent if there is anything else she would like to say that she has not yet had the opportunity to, a gesture consistent with the participant-centered nature of the interview situation we had hoped to create, but also of course, one that implicitly reinforces the reminder of participation in research. The respondent replies by asking the interviewer if the answers she provided throughout the interview were “correct” (presumably, in line with normative discourse); if they were not, the interviewer should let her know:

Respondent: I don't have anything to add, I just want to thank you on what, your coming, you should be enlightening us on what, on mistakes which we make that here you are making mistakes, here you are right, yah. Maybe I left some [out] on VCT or ARVs you should enlighten me that here you made a mistake. Thank you. (TA Interview #6)

The respondent's remarks are similar in form to other interview transcripts we read insofar as they reflect a perception of the research team as identified with officialdom and other formal institutions through which research is carried out, thereby creating a single hegemonic discursive relationship.

Like the interview transcript above, there is also evidence from the focus group transcripts that participants sought validation from the interviewer, but perhaps in a more subtle way. In the example below, participants stopped to ask the facilitator for his opinion, as they engage in a heated discussion about whether religious leaders should require young people to be tested for HIV before marriage:

Man 1: I think the pastor is still on the wrong in this case. You want to marry and he should be asking if you went for blood test?

Woman 1: [adds] Go for HIV testing first.

Woman 4: It's not the pastor's responsibility.

Man 1: [asking Facilitator] You want to marry and the pastor is telling you to go for HIV testing, what would you do?

Facilitator: [laughs]

[Woman 1 & 2 jointly]: Yes let's hear your opinion. You are part of the discussion. (Mixed FGD #2)¹¹

Despite ensuing pressure from participants to join them, the facilitator cleverly deflects attention away from himself and manages to make himself superfluous:

Facilitator: You know what I probably want to know more here is, what if you took the test and find out that the man is [HIV] negative and the female is [HIV] positive. What will these people want to hear from the counselor?

Woman 1: That's the end of marriage plans.

Man 1: [disagrees] No way, they will get married... (ibid.)

The conversation then returns to the participants, signaling how research-awareness can ebb and flow in a focus group as the discursive relationship between participants and interviewers is diluted by the multiple relations amongst members of the group.

¹¹ Participants also asked the facilitator for his opinion in another focus group discussion (the bracketed comments are those of the facilitator, who also transcribed the discussion):

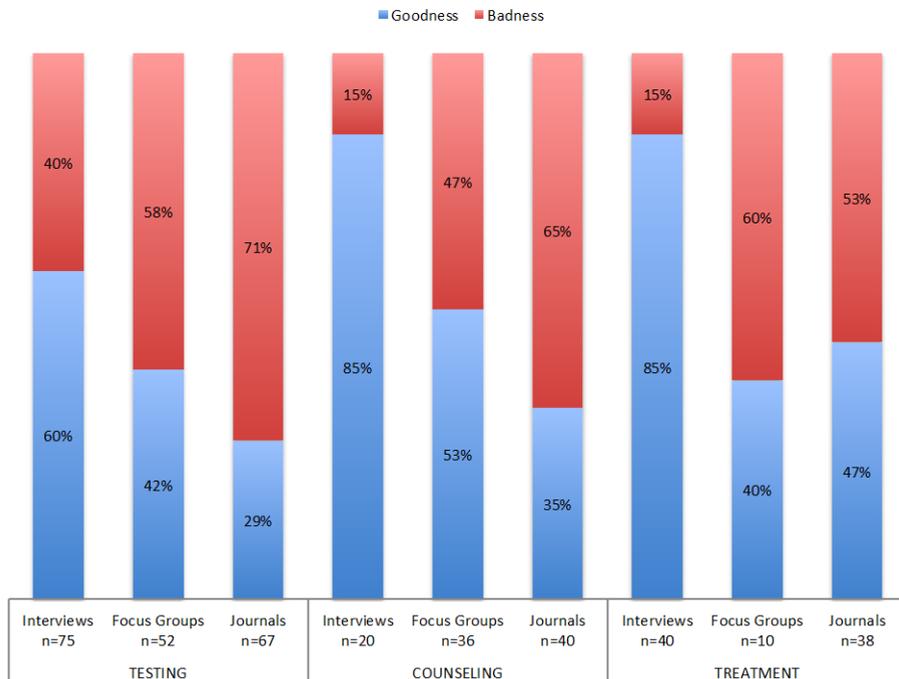
Man 2: Yes we are talking amongst ourselves. I think we need to know what you [facilitator] think. All agree in succession, Yes ...yes we also need to know what you are thinking.

Facilitator: [laughs] We are just observing but not taking part in the discussion hearing your opinion. However [all laugh in a way as if signaling to me that I have something to say but I just don't want to contribute]. I would like to know what happens at VCT clinic. (Mixed FGD #1).

4. Results

Our results are presented in Figure 1. “Total” refers to the total number of statements addressing the theme. “Goodness” refers to the proportion of statements suggesting support for a positive attitude towards testing, counseling or treatment; and “badness” refers to the proportion of statements suggesting opposition to or a negative attitude towards these themes.

Figure 1: Distribution of statements about the goodness and badness of HIV testing, counseling messages, and treatment



The distribution of statements is, as expected, variable across the three modes. Support for normative messages about testing, counseling messages, and treatment decreases from interviews to focus groups and from focus groups to journals, with the most precipitous decline between the interviews and the focus groups (though the focus

groups are slightly more negative about treatment than the journals). In some instances, the change in the distribution of “goodness” and “badness” statements across modes of research is quite striking. For instance, when comparing statements about testing between the interviews and focus groups, the proportions expressing goodness and badness are almost perfect inversions. In the focus groups and journals the majority of statements are negative, with somewhat less disapproval expressed towards counseling messages in the focus groups.

Our hypothesis that the more research-aware participants are, the more likely they are to express agreement with normative messages about AIDS is borne out, with the added refinement that these messages are especially likely to be regarded negatively in the least research-aware contexts. The change from situations constructed for the purposes of research, such as the interviews, to more organic situations such as those in the journals, is associated with a particularly strong decrease in support. The attitudes expressed in the focus groups ranked in between those expressed in the mode we know to be highly research-aware (the interviews) and the mode we know to be very low or completely lacking in research-awareness (the journals), confirming our hypothesis that focus groups fit somewhere in between those two poles. Striking to us, however, is the similarities between the focus groups and the observational journals in the distribution of goodness and badness statements across the three testing themes, which we think may be unique to the composition and characteristics of our focus groups, as previously described.

Statements expressing the goodness of testing, counseling, and treatment are not surprising, given Malawi’s saturation with information and educational media urging people to get tested, get treated, follow the ABCs of HIV prevention and the bio-behavioral prescriptions of ART adherence. The “badness” statements, however, are more noteworthy as they run counter to normative exhortations about AIDS. We address this issue in turn in the Discussion section.

5. Limitations

As with any study our results are attenuated by several considerations. First, what information is shared by respondents in interviews and focus groups is subject to the vagaries of interviewers’ styles: some interviewers are better at probing than others, or follow up on something that they thought was interesting or would merit elaboration, such as a bad experience someone had that invited others to comment. All interviews, however, were conducted by only two people; both were women, the same age, and their transcripts were quite similar in terms of the flow of the interview and the extent of elaboration. Similarly, the focus groups had three facilitators, one male, two female,

roughly the same ages; their transcripts were also, by in large, similar in terms of length and the quantity and quality of their probes.

Similarly, the observational field journals we analyzed were written by the same field assistant. It is indeed *possible* that Kunthani might have focused more on the negative comments that he heard, or that his accounts are outliers in some other way, thereby biasing the results in a negative (“badness”) direction. However, we do not think this is probable. In their analysis of “testing talk” in the full available set of Malawi journals, Kaler and Watkins (2010) used a similar analytic strategy to quantify the distribution of “goodness” and “badness” statements about HIV testing occurring in everyday conversations. Their results are remarkably similar to ours: between 2006-2009, 38% referred to the goodness of testing and 62% to the badness (915:2010).¹² For our purposes here, using just one journalist (Kunthani) affords greater quality control as we know this particular journalist from our experience working in Malawi, and we know that he is a trusted field assistant and a precise and careful observer. As a health worker, he is also at the epicenter of on-the-ground testing and treatment activities by virtue of the time he spends in and around the clinics.

A second consideration is that each research mode entails different strategies. In interviews, for example, interviewers are trained not to challenge what a respondent says – to accept what s/he says and probe for elaboration. The opposite is true of focus groups, which by their design encourage discussion and potential disagreement. Ethnography as well has its limitations insofar as we can only know what an ethnographer writes in his/her field notes, in effect filtering the content of exchanges, discussions and disagreements from the journalist’s mind to his/her notebook.

A final consideration is that the data are not synchronous; rather, they were collected over a two-year span (2007-2009) in which the landscape around the medical management of HIV in Malawi was changing rapidly. As such, we cannot control for how perspectives might have changed over time as testing (and treatment), and the social marketing or public information messages that accompanied them, were rolled-out across the study site. However, all three modes of data collection were carried out in close temporal and geographical proximity to each other. We believe there was enough temporal and spatial overlap across the sampling for each mode to be confident that we are picking up on an unfolding process rather than distinct episodes in Malawi’s HIV history.

This belief is strengthened by previous work on ideas about HIV prevention and testing in Malawi, which show that new ideas or technologies related to HIV, whether

¹² Similarly, in their analysis of local perceptions of routine HIV testing in antenatal clinics in rural Malawi utilizing interviews, focus groups and the observational journals, Angotti, Dionne, and Gaydosh (2011) find more negative reactions to the perceived mandatory testing requirement for pregnant women in the journals than in the interviews or focus groups.

these be risk reductions strategies, condoms, tests, or treatment, pass through “zones of ambivalence” lasting several years, in which popular opinion about these new ideas and technologies is both positive and negative (Kaler 2003; Kaler and Watkins 2010; Wilson 2008). As time passes, we observe the ambivalence clarifying, as these innovations become woven into the collective imagination. For example, we find very few references in the most recent Malawian data to doubts that AIDS is transmitted through sex or that condoms are capable of preventing transmission, while data from earlier decades show much more mixed attitudes about these components of HIV prevention. From these precedents, we think it is reasonable to assume that the data we capture in this paper, from 2007-2009, represents a similar “zone of ambivalence” concerning testing and treatment, which may clarify and resolve itself as other zones before it have done.

6. Discussion

Although we demonstrate that support for normative discourse about AIDS in the form of “goodness” statements varies across modes of inquiry, we do not have evidence to argue that any particular mode is “truer” or more valid than any other. While research-awareness may vary across modes, in no case are participants free of contextual pressures that may influence them to articulate certain views and suppress others. In other words, interviews, focus groups, and observational methods all represent socially constructed situations; none of them provide access to participants’ authentic or unmediated beliefs. We can make educated guesses about the contextual factors, or biases, shaping each of the situations, particularly the interviews and the focus groups because these are deliberate artifacts of the research process, but we can never know all the factors that may facilitate the expression or repression of ideas. This is particularly true when researchers are cultural outsiders, who may not be attuned to the particular plays of status, power and authority at work in any social situation.

This caveat is especially important in the case of the observational journals, which may appear to have the authority of naturalism, in that they do not depend on situations created by researchers solely for research, but are embedded organically in daily life. However, we do not believe that this embeddedness necessarily confers epistemological authority. For instance, participants’ willingness to express negative attitudes about testing and treatment to Kunthani may have been connected to their social position relative to him, in terms of age, gender or other categories. Had Kunthani been older, younger, of a different gender, more familiar or less familiar to his interlocutors, we might have obtained quite different, but equally valid, results. The authors, in dialogue with others closely involved in the collection and analysis of the journals, agree that the

journalists see themselves as writing for a particular audience, in this case the overseas investigators who hire them, and that they claim to speak the truth about what they have heard, as that is what is being asked of them. But as readers, we can only assess their plausibility (even if we know the journalists personally) by virtue of the persuasiveness of their texts (Watkins and Swidler 2009).

If our results here do not enable us to privilege one mode of inquiry above others, what then do they give us? We can approach this question by asking, to paraphrase Watkins (1993), "If all we knew about attitudes towards testing, counseling messages, and treatment came from interviews/focus groups/observational journals, what would we know?" If all we knew came from interviews, we would know that Malawians are somewhat ambivalent about the value of going for an HIV test, but endorse counseling messages more enthusiastically. We would also know that they regard antiretroviral treatment as an (almost) unambiguously good thing. If all we knew came from focus groups, we would draw a similar conclusion about ambivalence around testing, but we would ascribe more ambivalence to behavioral prescriptions found in counseling messages, and a lot less support for treatment. If all we had were the journals, we would conclude that Malawians are cynical about biomedical interventions, such as testing and treatment, as well as the behavioral advice about sexual practices and lifestyles that accompany it.

Clearly, different implications for policy and practice would flow from each of these modes of investigation. Our juxtaposition of the three different modes does not at first glance appear to offer a way out of this dilemma; contradiction and ambiguity do not easily translate to policy solutions. However, though our research modes yield different findings, one thing is consistent: at least a third of all references to testing across all modes of inquiry do not support normative discourse, despite what we assume to be varying levels of inducement to suppress disagreement with such discourse. We believe this qualifies as a robust finding, indicating that there is not the same level of trust in testing that is predicted by all the global (and national) information and persuasion that has been rolled out in favor of it.

Although we stress the discontinuities and ambiguities across modes of research in this paper, our work nonetheless points to some strong thematic consistencies across these modes. Importantly, the strongest thematic consistencies to emerge from this project are not necessarily ones that were envisioned when the data collection commenced. This points to the importance of maintaining an inductive mindset in data analysis, even in the midst of the pre-set questions and categories that characterize at least two of our modes, interviews and focus groups.

One strong thematic consistency is mistrust of health facilities and personnel. Attitudes towards health institutions were not elicited specifically in interviews and focus groups, but emerge from the data as mediating factors conditioning attitudes

towards testing and treatment. It is hardly news that many people do not believe that health workers and institutions are purely benevolent (for examples, see Booth 2004; Jewkes, Abrahams, and Mvo 1998; Kaler and Watkins, 2001; Maternowska 2006; Richey 2008). What is of interest here is how this mistrust translates into affective responses to testing and treatment, responses that are most muted in the more research-aware settings (interviews and focus groups), but which can blossom into outbursts and public displays of anxiety in the least research-aware settings (observational journals).

Mistrust of health clinics and personnel runs through Basil Kunthani's journals. As both a health worker and a research assistant, he encounters people who do not trust the institutions he represents, and he himself shares that lack of faith. This mistrust appears to be related not to the actual processes of testing and treatment as much as to the flow of information surrounding it. In the journals, people complain that information about test results is both too tightly controlled and too loosely available. The flow of information is both under- and over-regulated, depending on context.

For instance, Kunthani recounts a post-test group counseling session, in which he discusses the potential significance of test results with people who have been tested, before they receive their individual results:

One of the clients who we stay in the same area had this to say: "[...] If I am infected, everybody will know about it, you people [health workers] do not keep confidentiality, by the time I am at home everyone will know about it". I assured her that if this was the case with the other counselors; I am not the [same] type. I observe and follow the ethics and code of conduct. ... I then asked her if she would be comfortable that I find another counselor [to deliver her results] in my place. She told me "[...] you are all the same". I concluded by telling her that if she will hear of her status from any other individuals who she had not disclosed her results to, she should report the matter to the health authorities so they should revoke my certificate. She said "[...] Just give me my results." (Kunthani_080401)

While the majority of the issues about information flow concern the belief that health workers are too free with individual information, Kunthani also recounts incidents suggesting that health institutions are perceived as being too restrictive in sharing information. In one case, the husband of a patient comes to the clinic and begins to verbally abuse the staff, in public, for testing his wife for HIV without his permission:

He shouted at his wife, why had she come for an HIV test without his consent and also lambasted the health personnel why they allow married

women to have an HIV test without the permission of their husbands. He said all this is nonsense and an abuse of his marriage rights. (Kunthani_090102)

Dissatisfaction and concerns about information flow are not limited to clients. Kunthani writes of informal meetings with fellow health workers in which confidentiality requirements are perceived as not only cumbersome but inappropriate in a world in which HIV positive clients cannot be counted on to be honest with their partners:

[A colleague] asked what is the use of confidentiality when it will promote the virus and later have people die? [Another colleague] then said as counselors we need to gang up and organize a march to enlighten policy makers that a barrier to the fight against HIV and AIDS is the issue of confidentiality, and other counselors said “we second the motion, let it [be] passed”. ...[A third colleague] said “as for me if it happens that my sister or brother’s partner has been found with HIV I will risk my job telling her that [her] partner has HIV. If I lose my job and they recall my certificate, I can find another career.” (Kunthani_080601)

Although information flow is the catalytic issue for the expression of dissatisfaction, the dissatisfaction itself is broader and extends to beliefs about the personal character and behavior of the health workers. Kunthani reports many encounters outside his work hours with casual acquaintances who inform him that, among other accusations, health workers are crooks who divert money and food intended for AIDS patients (Kunthani_080421) or that they can risk being sexually promiscuous because if they get infected, they have (presumed) privileged access to antiretroviral drugs (Kunthani_080410). Importantly, Kunthani himself perceives these concerns to be widespread, to the extent that he does not defend his fellow health workers “because I knew that I would be quoted out of context” (Kunthani_080410). He also writes of being selective as to which colleagues he allows to remain present in the room when he delivers results, because he believes particular colleagues are likely to breach confidentiality while drinking or socializing after work in the community (Kunthani_080421).

Our other two modes of research also contain evidence of distrust of health institutions, although in a much attenuated form as compared to the journals, and thus consistent with our hypothesis. In the focus group discussions, in which participants were explicitly asked to describe what they thought would typically happen at a clinic in a range of scenarios involving testing and treatment, the majority of responses reiterated the benevolence of clinic workers, the usefulness of the information and

services they provide, and the importance of complying with their advice. For example, even when the focus group facilitator probed for opinions on whether health workers ever revealed test results, participants stated that that would not happen: “We haven’t heard that counselors are publicizing results. We have been tested a number of times, but have heard nothing” (Mixed FGD #3). In another focus group, participants affirmed that “even if the VCT counselor is your friend to the extent that you eat from the same plate, he cannot tell you [someone else’s results]” (Women FGD #1).

However, at the same time as asserting that health workers were trustworthy and did not release results, participants occasionally raised the hypothetical possibility of a breach of confidentiality. In the same focus group cited above, where the participants agreed that health workers were trustworthy, one woman stated, “If I hear that the health worker is disclosing my HIV results, I will definitely cut the counselor with a *panga* because he is tarnishing my image” (Mixed FGD #3). Another focus group referred to the importance of knowing about the personal traits of a counselor before trusting him with knowledge of test results:

Man 3: Well, the VCT counselor ... what is his behavior like? Does he drink beer? When he is drunk, how does he speak? Does he speak about things happening in his workplace or things happening at a beer place only? ...

Man 5: Let me comment on that. The VCT counselors are people who are well behaved. They went to school and are told to ensure confidentiality. So they cannot disclose test results.

Man 2: When they are drunk?

Man 5: They cannot. (Men FGD #1)

Interestingly, while focus group participants generally did not identify unethical health workers as a problem, they shared the concerns expressed in the journals about flows of information around testing, whether these flows were too lax or too constrained. However, focus group participants were more likely to associate information flow problems with the broader institutional context of testing and treatment than with health workers per se.¹³

Focus group anxieties about information flow and confidentiality were more likely to be expressed in the form of stories about people running into friends or neighbors

¹³ There is one exception. In a focus group discussion among a group of men, the men discuss a notorious VCT counselor in their village, one reputed to be a ‘young drunkard’ whom they would not trust to keep information confidential (Men FGD #1).

when coming to the clinic to collect treatment, or being hailed by fellow patients in settings where they would have preferred to remain anonymous, such as when drawing water. For instance, one participant claimed that

the majority of people who go for HIV testing at Village A ... do not keep secrets. ... They don't hide. Myself and another person, we go to collect ARVs, and we know each other, we are coming from the same village and we draw water from the same point, and you will find this person talking about other people, "so and so, we meet while collecting ARVs"! Now one person, she was on the list of people receiving ARVs, she was not happy about it. (Women FGD #1)

While focus groups participants were clearly concerned about the flow of information, they were much less likely to identify health workers – the agents of official policy and programs, and representatives of the state – as the source of information flow problems, compared with the conversations captured in the journals.

The interviews presented a similar pattern. Respondents described their overall satisfaction with testing and treatment, their appreciation for confidentiality, and their positive impression of the clinic staff. Other complaints related to health services were aired, such as a lack of clean water at the clinics, long waiting times, or doctors who sometimes misdiagnose illnesses as having "bad bones". However, complaints directly related to the subject of the research, HIV testing and treatment, were largely muted.

As in the focus groups, however, anxieties about information flow sporadically ruptured the apparent consensus on the high quality of testing, counseling and treatment services. Again as in the focus groups, these anxieties were attributed to the institutional context of testing and treatment, not to the behavior of health workers. For instance, one respondent explained her fear that her HIV status would be revealed by reference to the physical location of testing and counseling services:

When you are found with the virus they tell you to go for one week of lessons [pre-treatment counseling] and this place is open, people know that this place is for those who are found with *kachilombo* [HIV] and those people who have seen you there spread the news that they saw you there, you are with *kachilombo*. If the counselors want these things to really secret, they should work in a more secret place, it's better for a client to reveal on his own rather than to be seen that you are learning about your *kachilombo*. (NN Interview #1)

Concerns about confidentiality thus run through the three modes of research, but only in the journals do these concerns crystallize prominently around distrust of and

dissatisfaction with health workers. In the more research-aware modes these anxieties are expressed as hypothetical possibilities or as outcomes of the institutional arrangement of treatment and testing, rather than as direct criticisms of the agents of the HIV testing and treatment enterprise: the health workers.

We do not claim to explain the relative muting of direct criticism in the focus groups and interviews as the result of inhibition by the research situation, as we have no way to evaluate such a claim. What we can establish, however, is that anxiety about information flow is a substratum of the attitudes toward HIV testing expressed across all modes. Thus, we believe it is a significant finding of this study, even though in two of the modes of inquiry it is relatively weak compared to the prevalence of assertions of the positive value of testing. This assertion-- that concerns about information pervade the collective imagination of testing and treatment-- is an example of the ways in which the use of multiple methods of inquiry can produce robust findings, as well as apparently disjunctive and contradictory ones.

If this conclusion is accepted – that anxiety and suspicion about information flow pertaining to HIV pervades the social world of rural Malawi – one might reasonably raise the question “so what?”. Why does this matter, beyond being an interesting sociological observation? To fully answer the “so what?” question, we would need types of behavioral data that are not available to us. These anxieties about information flow cannot be tied directly to behavior, as we do not follow all the participants in the three research modes to see whether their actual use of testing, treatment, or other clinical services is impacted by these concerns.

However, we think it would be impossible to argue that these pervasive anxieties have no impact on behavior, among health workers as well as among the intended beneficiaries of their services. Kunthani himself, as noted above, changes his actions and watches his words because he is conscious of the possibility of being misquoted or subject to misinterpretation because of broad distrust of health workers (Kunthani_080410). In the journals, we repeatedly come across accounts of individuals who enact their suspicion rather than simply talking about it, such as the man who berates his wife for coming for testing in the presence of other clients and staff (Kunthani_090102). Such mistrust must, at the very least, undermine the effectiveness or efficiency of HIV-related services, which cannot possibly function as well as they might if they were not subject to such high levels of suspicion. In other words, what we have identified here is not a purely discursive phenomenon – we have reason to believe it is a behavioral one as well.

7. Conclusion

We believe this study should function as a cautionary moment for policymakers, demonstrating the potential drawbacks of placing excessive faith in any one mode of research, as well as one for researchers, insofar as it suggests the pitfalls of attempting to triangulate and reconcile divergent findings from different methods, as researchers are often tempted to do. We draw attention to what is different across methods, in addition to emphasizing what is (more or less) the same.

All the modes of research we investigate here represent the “downstream moment” of policy: the moments when those people who are the targets of policy articulate their experiences on the receiving end of policy initiatives, such as the rollout of testing and treatment. As the divergences among our modes indicate, these experiences are by no means unitary or easy to summarize. What this study can offer is a better understanding of the *impacts* of policy – it shows the unintended consequences of policy efforts in the settings for which they are envisioned. We see these findings as an essential part of a feedback loop that unites stories from the field, in the form of qualitative research, with programming and policy. Based on this finding, we believe that program and policy efforts that respond to ambivalence, rather than assume unequivocal agreement about the value of HIV testing and treatment, may be a more effective strategy.

In our case, we believe that much of this ambivalence is rooted in concerns about information flow. This may be a barrier to uptake of testing, and it certainly colors public understanding of the work of the clinics and the health workers, yet the existence of this barrier would not have been evident if all we knew about attitudes towards testing and treatment came from a single mode of inquiry. Program efforts that specifically seek out and address the wellsprings of ambivalence and skepticism may improve their “fit” with local social dynamics over those that rely solely on evident benefits of HIV testing and treatment programs.

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