Pergamon

0277-9536(95)00088-7

Soc. Sci. Med. Vol. 42, No. 2, pp. 221–231, 1996

0277-9536/96 $15.00 + 0.00

RETHINKING METHODS FOR THE STUDY OF SEXUAL BEHAVIOUR

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Abstract—During the past five years, researchers from the Medical Research Council and Uganda Virus Research Institute (MRC/UVRI) Programme on AIDS have studied sexual behaviour to better understand the risk and the spread of HIV infection in a rural Ugandan community. This paper aims at a reflective critique of the application of various methods of studying sexual behaviour in a series of six studies within the programme. The objectives of these various studies have been different: ranging from the natural history of HIV-infection to marital instability to household coping. This variety of foci has led to multiple research strategies.Three methodological factors influencing the research and the results were identified: the research model; the meanings of research questions; and personal factors affecting the interview relationship. Although the impact of these factors could not be entirely eliminated, precautions could be taken to diminish these biases. Comparing data obtained through different methods proved useful not only as a validity test but also as a mean to more deeply interpret the data according to culture, linguistics and society. Lessons learned during this piece of work include the importance to the quality of data by inviting local communities to participate in the research process; broadening the field of sexuality from a health-oriented model to reach an anthropological perspective; considering the influence of research organization on the context in which sexual behaviour takes place as a part of the study objectives and promoting an inter-disciplinary dialogue overcoming dogma and prejudices.

Key words—AIDS, sexuality, methodology, Uganda

INTRODUCTION

Ten years after the identification of HIV, arguably the most devastating sexually transmitted disease in human history, relatively little is known about the effectiveness of various HIV/AIDS control strategies [1]. This failure to estimate the impact of prevention programmes is due, among other factors, to the lack of reliable information about sexual behaviour and therefore the means to assess behavioural change. The crux of the problem is how to obtain accurate information about a domain of personal experience which is so sensitive that it is intentionally kept private in many, if not most, cultural settings.

Early in the epidemic, investigators realized how necessary it would be to look beyond the clinical aspects of AIDS to the social behaviour that contributes to the spread of the virus. Much of the information collected on sexual behaviour in the AIDS era has been obtained through Knowledge, Attitudes, Behaviour and Practices (KABP) studies using large populations, survey questionnaires and statistical analyses. Scientists tracking the spread of HIV, e.g. epidemiologists, often ask questions about the frequency of specific sexual practices. While useful in national or global planning for the pandemic, these quantitative approaches to the study of sexual behaviour have not gone unchallenged [2–5].

Quantitative rigor can not encompass the richness of human life and sexuality [2] and does not consider its social, economic, political and symbolic dimensions [3, 4].* Statistical approaches tend to separate behaviour and social synergy, introduce a fundamental division between the individual and society [5, 6] and ignore that sexuality is related to culture. Sexual acts are counted and scant interest is given to the meaning of these acts [7]. In short, the context in which social acts (including sexual) are taking place is often ignored including the cultural differences between the investigators' and their respondents' understanding of the research topics.

In-depth, qualitative or social methods of research have also proven problematic. In his review of literature, Barton [8] pointed out major "holes in the scholarly literature about sexuality and health in Africa". He noted the historical evolution of the conceptual framework used by researchers to describe sexual behaviour in Africa and identified three steps. During the colonial era, studies "ranged from moralizing by missonary-anthropologists about the deplorable habits of the savages and heathens to

*In his comments on the Packard and Epstein paper on medical research on AIDS in Africa, Carl Kendall noted that 'The biomedical paradigm reflects the reality of HIV at the level of the virus, and epidemiology maps the distribution of the disease and seropositivity. Both approaches touch only peripherally the realm of the social sciences: the social, economic and political world in which behaviours take place'.

prurient reporting of bizarre sexual practices intended to titillate readers back home in England". After the colonial era, anthropologists began to react against such an ethnocentric view of African customs and paid much greater attention to the content of traditional behavioural codes such as: premarital sexuality, pubertal initiation and sex education, age of marriage, bridewealth, forms of marriage, adultery, incest, punishment or constraints for transgressing against the code, definitions of illegitimacy and deviance, etc. The contemporary European perspective tends to adopt a universalist view of sexuality, i.e. "...sex in Africa is the same and means the same as sex elsewhere in the world"* which is an overly narrow perspective. In conclusion, Barton notes that most researchers did not look for specific information about numbers of sexual partners and "only gave evidence about extra-marital activity in anecdotal terms or discussed its existence without quantification". In other words, in their concern with qualitative values and social organization, anthropologists have not paid sufficient attention to quantitative issues—such as numbers of contacts or consistency of condom use—that could have been relevant to understand the spread of AIDS.

During a five year period since 1989, the Medical Research Council/Uganda Virus Research Institute (MRC/UVRI) Programme on AIDS has studied sexual behaviour—using various methods—in order to help understand the risk and spread of HIV infection in rural Uganda. The aim of this paper is to critically review the methods used in this series of studies, to describe the obstacles encountered, and to come to a better understanding of how social anthropologists and epidemiologists may approach the sensitive topic of sexuality.

BACKGROUND

This paper draws on data collected in six studies conducted within the MRC/UVRI Programme on AIDS in Uganda between 1990 and 1993. The primary aims of this Programme are to study the dynamics of HIV-1 transmission, the natural history of HIV-associated diseases, and strategies for AIDS control in a rural population. The study area is a rural subcounty in Masaka District, 2 hr drive southwest of Kampala. Most of the population are Baganda, living in dispersed settlements and small trading centers where they farm bananas and coffee. On average, although the people in the area consider themselves to be poor because cash is scarce, malnutrition and other indicators for outright poverty are rare. The study population includes the inhabitants of a cluster of 15 neighbouring villages with a total population of approx. 10,000, about half of whom are over 13 years of age and therefore potentially sexually active.

*With the exception of the constructivist approach which has entered the academic world only very recently.

METHODOLOGY

The data collection methods used in the six studies reviewed in this paper are presented in the following paragraphs and summarized in Table 1.

Clinical cohort study

A sample of 300 adults, drawn from the general population cohort have been participating in a clinical study on the natural history of HIV-infection since 1990. The cohort participants visit the MRC/UVRI clinic quarterly where a clinician administers a medical questionnaire in the vernacular (average half an hour) and carries out a medical examination (average 15 min). Individuals' HIV status is not known to the researchers; participants are free to enquire about their status at the counselling service. Detailed questions on sexual practices are included in the medical history questionnaire. In 1991 a female social scientist interviewed (average half an hour) about half of the same participants using a semi-structured questionnaire in a formal setting to elicit information on recent sexual practices. In 1992 a male social scientist took over this role. This enabled us to appreciate the effect of discipline (clinician vs social scientist) and gender of interviewer on the data collected.

Obstacles to sexual behaviour change study

In 1990/1 thirty focus groups of women and men, divided by gender, village, age and marital status were convened to discuss their views on present sexual behaviour in their communities and the obstacles which need to be addressed to promote behaviour change. Six villages in the study area were selected to represent different types of villages (trading centres, different religious and ethnic groupings). Fifteen focus groups were conducted with a total of 62 participants. The sessions included groups of married women or men <45 years old; unmarried women or men <45 years old; married or unmarried women or men over 45 years old. Local residents trained as interviewers were responsible for conducting the focus groups: one as facilitator, one as note-taker and one as observer. Genders of the facilitators and participants were matched. All discussions were conducted in the vernacular and lasted for about 2 hr.

Reproductive health study

In 1991 a random sample of 300 respondents, aged 15 and above, stratified by gender and age-group, were selected from three villages in the same sub-county as the MRC/UVRI study area but outside the study area. Extended interviews in the vernacular (average 2 hr) covered perceptions of sexually-related health conditions, terminology, taboos, risks, STD, reproductive health and sexual behaviour. Respondents also completed a projective exercise, drawing and naming reproductive and sexual parts on an outline diagram of the body. Interviews were carried out with an