The More You Learn the Less You Know?[1]

Interpretive Ambiguity across Three Modes of Qualitative Data Collection

Nicole Angotti
William and Flora Hewlett Foundation Postdoctoral Fellow
Institute of Behavioral Science, University of Colorado-Boulder (USA)
Faculty of Social Sciences/Humanities, Faculty of Public Health, University of the Witwatersrand (South Africa)
Email: nicole.angotti@colorado.edu

Amy Kaler
Associate Professor, Department of Sociology
Adjunct Associate Professor, School of Public Health
University of Alberta (Canada)
Email: amy.kaler@ualberta.ca

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Abstract:

This paper demonstrates how our methods of inquiry affect what we learn about local responses to “HIV testing”-- a key global AIDS intervention-- in a high prevalence rural African setting. It explores differential responses to three HIV testing themes (knowing one’s status, counseling messages (ABCs) and antiretroviral treatment) across three distinct modes of qualitative inquiry (interviews, focus groups and a set of ethnographic journals that capture everyday conversations about HIV/AIDS). We find the most favorable responses to testing themes in the interviews, mixed responses to testing themes in the focus groups, and the most negative responses to testing themes in the ethnographic journals. Careful consideration to situational specifics in our research methods is critical for those evaluating responses to interventions designed for individual and community benefit.

Introduction:

Researchers across various disciplines face a similar challenge: ensuring that 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. 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). 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). Our aim is not to test the reliability of reporting, as indeed other studies have done (Mensch et al. 2008; Plummer et al. 2004; Poulin 2010; Schatz 2003); we do not have a HIV biomarker, for example, to know whether what people say about 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. Our work here is given particular urgency because such objects of interest are explicitly intended to produce social changes and amelioration of social problems, so analyzing and dissecting local responses serves a social as well as a theoretical agenda.

Towards that end, we conducted a study on local perceptions of HIV testing in Malawi, a high prevalence African setting, utilizing two conventional qualitative methods – in-depth interviews and focus groups - and one slightly unusual one, a unique set of ethnographic field journals that capture everyday conversations about HIV/AIDS occurring in natural settings (see http://investinknowledge.org/projects/research/malawian_journals_project). 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; natural setting), and level of what we describe here as "research mindfulness": that is, the extent to which we believe research participants are continuously reminded that they were taking part in a research project, which is a function of the mode of research itself. Interviews are assumed to produce greater research-mindfulness than focus groups, and observational studies are assumed to produce less such mindfulness than either of the other two methods. The larger study aim was both empirical (see Angotti 2011; Angotti, Dionne and

Gaydosh 2011; Kaler and Watkins 2010) as well as methodological. In this paper, we present the methodological lessons.

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, anti-retroviral 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, and have increased in density over the course of the AIDS pandemic (Angotti et al. in progress).

Data & Methods:

The data for this study were collected in two rural districts in Malawi between 2007-2009, 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: in-depth interviews, focus group discussions and a set of ethnographic field journals that capture everyday conversations about HIV/AIDS occurring in natural settings.

In-depth Interviews

Interviews were conducted with local 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. Also included in the study were 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 sample by virtue of having been tested for HIV at the study clinics. Thus, they offer wider community opinions and experiences about testing.

Interviewers asked about personal and family health, experiences with HIV testing[2], knowledge about ART, and local health services. The interviews were conducted privately in respondents’ homes or, very occasionally, in a location of

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[2] 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. Biomarker data were available only to the research director in the field, not the interviewers.

the respondent's choosing. Interviews were conducted in Chichewa by two local interviewers, both female. The interviews lasted 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.

Focus Group Discussions

Five focus groups were conducted, each including five to eight participants of varying ages: three groups had men and women; one group only women; and one group only men. The focus groups lasted between 40 and 60 minutes, with typed transcripts averaging eight pages. Local 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 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 grocer.

The field assistants presented village locals with a series of vignettes about the HIV testing process. Focus group discussions were conducted in Chichewa by three local Malawian research assistants, one male and two female. Like the interview transcripts, focus groups were also digitally recorded; transcripts were translated and typed in the field so that any exchanges or English words that were unclear in the translations could be clarified.

Ethnographic 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 diary of his interactions with clients 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 journal is part of a larger corpus of journals that have been continuously collected for over a decade.[3] 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 and public settings (Watkins and Swidler 2009). 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 Yao. The ethnographic

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[3] Exemplars of the journals are available publically on the MDICP website, www.malawi.pop.upenn.edu. The website also provides details on the overall study.

journals get more naturalistic perspectives on HIV and AIDS, one that captures 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 says, and exercises a further level of 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.

Data Analysis

We tallied all references to the three testing themes (knowing one's status, counseling messages and ART) across the three modes of qualitative inquiry (interviews, focus groups and ethnographic journals) for descriptions and reactions in either positive or negative terms. We did not tally value-neutral remarks (e.g., "VCT is offered at XYZ; ART is taken twice a day"; "We were told we should use condoms"). The following statements are examples of positive and negative statements about the three testing themes[4]:

Goodness:

1) A general statement (e.g. testing is good for the mother and baby; abstinence is best; ART makes you live longer);

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[4] From this point forward, we use the phrases "goodness" and "badness" rather than "positive" or "negative", to avoid confusion with seropositivity and seronegativity.

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 relived; is getting fatter [healthier])

Badness:

1) A general statement (e.g., knowing your status will make you live with worry; condoms have holes in the 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., 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. 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 from mode to mode. Our final tabulations are shown in Table 2.

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 of testing in the interview.

In some interviews, the interviewer asked essentially the same question several times (“How did you feel about being tested?” and “Why did you want to be tested?” etc.) and got essentially the same response (“I was happy to know the status of my body” and “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 of treatment (e.g. “I wanted to know the status of my body” and “I don’t trust my husband because he is often gone at night”). In this case, we would tabulate the two statements as two different data points.

2. Focus group discussions

For the focus group discussions, we assumed the participants would be moderately research-mindful, midway between the high-mindfulness interviews and the low-mindfulness journals. Participants knew they were taking part in a research project, but the intensity of the participant-researcher dyad in the interviews was diluted by the presence of other participants and the ensuing cross-talk among the participants, not always directed at the interviewer. This was evident in the transcripts for the focus groups, where the facilitators usually succeeded in establishing a multi-directional flow of conversation so that participants were talking to each other as much as they were talking to the facilitator him/herself.

For these 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, we believed that the switch from one topic to another represented a decisive enough break that for our purposes, they constituted different incidents.

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. Ethnographic field journals

The ethnographic field journals were the data collection mode in which we expected the least amount of research mindfulness 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, so these journals are the least typical of the data collection methods typically 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.

Hypothesis:

Our foundational hypothesis is that as participants' research-mindfulness decreases across modes, from interviews through focus groups to journals, the proportion of statements which conform to officially-sanctioned normative discourse about HIV/AIDS will decrease. Specifically, we expected that interview participants will conform most to normative discourse, FGD participants will conform less, and speakers quoted in the journals will conform least.

This hypothesis 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 FGD 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 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.

Table 1 below describes the characteristics of the three research modes by the specifics and dynamics of the setting in which the data were collected.

Table 1: Research Mode Characteristics

Dimension	*Research-Mindfulness*	*Predetermined structure*	*Heterogeneity*
Mode			
Interview	High	High	Low
FGD	High/Medium	Medium	Low/Medium
Journals	Low	Low	Medium/High

Results:

Our results are presented in Table 2. “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.

Table 2: Distribution of Statements about the Goodness or Badness of HIV Testing, Counseling and Treatment

Theme:	**Testing**			**ABCs (Counseling)**			**Treatment**		
Mode:	Total	Goodness	Badness	Total	Goodness	Badness	Total	Goodness	Badness
Interview	65	42 (65%)	23 (35%)	14	12 (86%)	2 (14%)	33	31 (94%)	2 (6%)
FGD	69	43 (62%)	26 (38%)	54	42 (78%)	12 (22%)	17	12 (71%)	5 (29%)
Journals	52	19 (36%)	33 (63%)	38	25 (66%)	13 (22%)	24	9 (38%)	15 (63%)

The distribution of statements is, as expected, variable across the three modes. Support for normative messages about testing, ABCs and treatment decreases from interviews to focus groups and from focus groups to journals, with the most precipitous decline between the focus groups and the journals. Indeed, in the journals the majority of statements about testing and treatment are negative, with somewhat less disapproval expressed towards ABC messages.

Our hypothesis that the more research-mindful participants are, the more likely they are to express agreement with normative messages about AIDS is borne out, with the added refinement that testing and treatment are especially likely to be regarded negatively in the least research-aware contexts, and that the change from situations constructed for the purposes of research, such as the interviews and the focus groups, to more organic situations such as those in the journals is associated with a particularly strong decrease in support.

Statements expressing the goodness of testing, ABCs and treatment are not surprising, given Malawi`s saturation with information and educational media urging people to get tested, get treated, and follow the ABCs of HIV prevention. The “badness” statements, however, are more noteworthy as they run counter to normative exhortations about AIDS. Because these statements are both more prevalent and more detailed in the journals as compared to the other two modes, in Table 3, we break down the substantive content of “badness” statements in the journals:

Table 3: Distribution of Statements about the Badness of HIV Testing, Counseling, and Treatment in the Journals

Theme:	**Testing**	**ABC**	**Treatment**
Proportion of statements expressing badness	*63%*	*22%*	*63%*
Proportion of badness statements referencing concerns that:			
Test results will not be kept confidential	30%		
A positive test result will lead to emotional distress	21%		
Marital relationships will disintegrate as a result of testing	18%		
Condoms are not viable to use in marriage		85%	
Treatment leads to social decay because people			50%

on treatment will infect others			
Treatment has noxious side effects			25%
Treatment doesn`t work			25%
Other	31%	15%	0%

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 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 enumerators, one male, two female, same ages; their transcripts were also, by in large, similar in terms of length and the quality of their probes. The ethnographic field journals were written by the same field assistant.

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 they say and just probe for elaboration. The opposite is true of focus groups, which by their design encourage disagreement among participants. 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, etc., from the journalist's mind to his 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 messages that accompanied them, were rolled-out across the study site. However, we believe there was enough temporal overlap across the sampling for each mode to be confident that we are picking up on one unfolding process, rather than three distinct episodes in Malawi's HIV history.

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-mindfulness may vary across modes, in no case are participants free of contextual pressures which may influence them to articulate certain views and suppress others. In other words, interviews, focus groups and journals 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 which 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 ethnographic 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.

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, ABCs and treatment came from interviews/focus groups/ethnographic 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 ABC 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 the same conclusions about ambivalence around testing, but we would ascribe more ambivalence to support for ABC strategies and even more ambivalence to treatment. If all we had were the journals, we would conclude that Malawians are deeply cynical about biomedical interventions such as testing and treatment, but broadly supportive of behavioral advice about sexual practices and lifestyles, whether or not they actually practice 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 1/3 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 express agreement. 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 testing, the ABCs of prevention and treatment. Thus, 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 which 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 ambiguity rather assume unequivocal agreement with the import of testing (and treatment), may be a more effective strategy.

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