RESEARCH NOTE

HIV/AIDS Prevention in Sub-Saharan Africa: ‘Abstinence until Marriage’ Education and Girls’ Health in Wakiso District, Uganda
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ABSTRACT

Educational behaviour change interventions specifically targeting adolescent sexual behaviour have been identified as a potential means to reduce troublingly high rates of HIV and AIDS across sub-Saharan Africa. The East African nation of Uganda – once highly acclaimed for the apparent success of its comprehensive ‘ABC’ approach to prevention – has in recent years faced intense criticism for the adoption of an American model of sexual health education exclusively promoting pre-marital sexual abstinence. No empirical studies to date have specifically examined the ways in which an American model of ‘abstinence until marriage’ education impacts upon the ability of Uganda’s most at-risk youth – adolescent girls and young women – to prevent HIV and lead healthy, productive lives. The study proposed herein seeks to evaluate the effectiveness of Uganda’s national sexual health curriculum – the Presidential Initiative on AIDS Strategy for Communication to Youth, or PIASCY – through a qualitative survey of adolescent girls and young women aged 12 to 19 years. Study data will be collected through focus groups, ethnographic interviews, and classroom observations at three primary schools in the Wakiso District of Uganda. The results of this study are intended to provide valuable insight on the plight of young Ugandans as they attempt to confront the localised devastation of the AIDS epidemic with tools and ‘knowledge’ manufactured elsewhere. This research note is intended to provide information on the purposes, background, and methodology of an ongoing doctoral research study; it is not intended to impart preliminary survey findings or to document results. For the purposes of this article, the title ‘researcher’ applies to the note’s author.

ARTICLE INFO

Acknowledgements: The author would like to thank her doctoral supervisor, Dr. Gari Donn, her parents, Steven and Marilyn Barnowe-Meyer, and her partner, Tito June, for their ongoing support and guidance throughout the study's design and implementation

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Introduction

Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) have had a massive and devastating effect on the human population. An estimated 33 million people worldwide are HIV-positive, 23 million of whom reside in sub-Saharan Africa (AVERT 2011; UNAIDS 2010). Young persons aged 15-24 are particularly vulnerable to infection through sexual contact; the majority of infections in sub-Saharan Africa within this age group indeed occur as a result of heterosexual transmission (UNAIDS 2010). Educational behaviour change interventions specifically targeting adolescent sexual behaviour have been identified as potential means by which to reduce inflated rates of infection throughout the African continent (ibid; Campbell & MacPhail 2002; Kirby, Obasi, & Laris 2006; Maticka-Tyndale et al. 2005; Maticka-Tyndale, Wildish, & Gichuru 2010).

The East African nation of Uganda is regarded by many AIDS researchers and public health experts as one of the world’s most compelling success stories in the battle against HIV and AIDS (Barnett & Parkhurst 2005; Slutkin et al. 2006). Unlike the majority of its sub-Saharan counterparts, the Ugandan government has pursued an aggressive prevention, treatment, and care plan since the discovery of the disease in the nation’s southern districts in November 1982. From the late 1980s until 2002, the Ugandan government actively promoted a comprehensive prevention approach to the sexual transmission of HIV. Prevention messages were circulated via school-based educational programmes and a large-scale, media-centred public information campaign, both inundating Ugandans of all ages with messages to abstain, be faithful, and use condoms (Green et al. 2006; Human Rights Watch [HRW] 2005; Slutkin et al. 2006). This strategy, nicknamed the ‘ABC’ approach, produced significant changes in the sexual behaviour of Ugandan men and women (Green et al. 2006; Slutkin et al. 2006), and has been widely cited as the cause of a precipitous decline in the nation’s rates of adult HIV prevalence, from approximately 15% in 1992 to 6% in 2002 (Cohen & Tate 2005).

In 2004, however, the Ugandan Ministry of Education abruptly renounced the ABC approach in favour of an American model of sexual health education focused exclusively on pre-marital abstinence. The government promptly abandoned the nation’s comprehensive School Health Education Project, or SHEP, adopting instead an abstinence-only curriculum modelled on the American statutory definition of appropriate sexual contact and acceptable moral conduct (HRW 2005). The new curriculum, entitled the Presidential Initiative on AIDS Strategy for Communication to Youth (PIASCY), was drafted and launched in Ugandan primary schools in early 2004. Today, PIASCY serves as the nation’s sole HIV/AIDS prevention curriculum in over 18,000 primary schools (Cohen 2006; UNGASS 2010). Little empirical research to date, however, has analysed the impact of an American model of ‘abstinence until marriage’ education on Uganda’s most at-risk and vulnerable youth: adolescent girls and young women. The study outlined below intends to address this critical gap in research, and to answer the following central research question:

Is ‘abstinence until marriage’ education, as culturally embedded in Uganda, an effective method of HIV prevention for the nation’s adolescent girls and young women?

HIV/AIDS Prevention in Uganda

The Ugandan government has led a relatively proactive response to HIV/AIDS following the
discovery of the virus in the nation’s southern districts in the early 1980s. A National AIDS Control Programme (NACP) – spearheaded by President Museveni – was launched with the financial and technical assistance of the World Health Organisation [WHO] in 1986. The programme immediately established safeguards to protect the integrity of the nation’s blood supply, imposed strict new guidelines on Ugandan hospitals and medical clinics regarding the proper sterilisation of surgical devices and transfusion equipment, and established the nation’s first AIDS surveillance network (Green et al. 2006; Tumushabe. 2006). The NACP’s most ambitious project, however, featured a large-scale, media-centred public education campaign designed to inform the population on various modes of viral transmission and methods to prevent infection. In an effort to dispel widespread myths and rumours, the Ugandan government utilised television and radio announcements, as well as newspapers, billboards, posters, and flyers, to communicate factual prevention information, encourage the adoption of behaviour change strategies, and promote life-saving treatment, testing, and care services. In 1986, the NACP launched the School Health Education Project, or SHEP, designed to empower Ugandan boys and girls “to be self-confident decision-makers with the ability to delay sexual debut, negotiate safe sex, and to become responsible citizens.” (HRW 2005, p. 30) Prevention messages in both schools and broader Ugandan society stressed primary and secondary abstinence from sexual activity, condom use, and the importance of fidelity and monogamy in sexual relationships.

This comprehensive prevention strategy – later nicknamed the ‘ABC’ approach– has been credited by a number of researchers as producing a dramatic transformation in the population’s approach to high-risk sexual behaviour. By 1995, a significantly higher number of young Ugandans were reportedly choosing to abstain from sexual activity than had chosen to do so in the late 1980s (Slutkin et al. 2006). The number of Ugandan boys aged 15-19 reporting abstinence increased from 31% in 1989 to 56% in 1995; the number of girls reporting the same behaviour increased from 26 to 46% (ibid.). The use of condoms among unmarried men and women increased from less than 1% in the late 1980s to over 15% in the mid-1990s, with young people reporting considerably higher use rates than their older Ugandan counterparts (ibid.). A longitudinal study conducted by the WHO’s Global Program on AIDS found a sharp decline in the number of adult males reporting three or more non-regular sexual partners between 1989 and 1995 (Green et al. 2006). During this time period, the number of adults reporting casual sexual relationships fell from 35% for men and 16% for women to 15% and 6%, respectively (ibid). Fewer young girls reported engaging in sex with much-older adult male partners – a common practice prior to the behaviour change campaign – and communities began to ostracise or expel men in positions of authority who attempted to initiate such contact (Slutkin et al. 2006).

As HIV prevalence rates in many other parts of the world rose dramatically throughout the 1990s, Ugandan rates began an extraordinary decline (Cohen & Tate 2005; UNAIDS 2010). Surveillance data suggests adult prevalence in Uganda peaked between 12 and 16% in the early 1990s, indicating a national epidemic similar in scope to that of many other states in sub-Saharan Africa at that critical time (Allen 2006; Green et al. 2006; Tumushabe 2006; UNAIDS 2008). However, as rates continued to increase on the rest of the continent throughout the 1990s, Ugandan rates fell sharply to between 7-9% by the year 2001 (UNAIDS 2010). Prevalence rates continued to decrease well into the
first decade of the 21st century, and were estimated to be as low as 5.4% in 2007 (see Figure 1; UNICEF 2010). Based largely on this reported drop in prevalence, Uganda is considered by many “one of the world’s earliest and most compelling national success stories in combating the spread of HIV.” (Green et al. 2006, p. 336) Public health experts have repeatedly heralded Uganda’s behaviour change campaign as testament to the strength of an intensive, comprehensive AIDS prevention strategy (Barnett & Parkhurst, 2005).

In spite of this acclaim, in 2004 the Ugandan government largely abandoned the ABC approach, favouring instead educational policies and public rhetoric emphasising strict abstinence until marriage. PIASCY radically transformed the way adolescents and young adults receive information about the virus and learn about viable prevention methods as part of the Ugandan school curriculum. The abrupt change in strategy followed on the heels of the 2003 launch of an ambitious global HIV/AIDS initiative spearheaded by the administration of U.S. President George W. Bush. Known as the President’s Emergency Plan for AIDS Relief, or PEPFAR, the initiative committed an unprecedented US$15 billion to prevention, treatment, and care services worldwide. Fifteen PEPFAR ‘focus’ nations – including Uganda – were selected to receive

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**Figure 1.** Estimated adult (aged 15-49) HIV prevalence, Uganda, 1990-2007. *Source: UNAIDS, 2008.*
defined by U.S. law – of abstinence from sexual activity until marriage. Mere months after Uganda’s incorporation into PEPFAR, President Museveni released the final version of the PIASCY curriculum.

To fully understand the implications of the decision to adopt an American model of abstinence education as Uganda’s primary HIV/AIDS prevention strategy, it is necessary to examine how this form of education has been conceptualised and implemented in the country of its origin. The following section briefly explores the history of abstinence education in the United States, from its controversial inception in the early 1980s to its dramatic expansion with the introduction of PEPFAR in 2003.

**Abstinence Education in the United States**

Abstinence education in the modern era was introduced into American schools with the passage of the Adolescent Family Life Act (AFLA) in 1981. The legislation’s primary goal was to provide federal grant assistance to organisations and educational programmes steeped in “traditional family values” (Saul 1998, p. 5). The legislation was quickly met with public criticism, however, as the majority of its initial grants were awarded to conservative religious groups, many of which used funds to develop the “first generation of so-called fear-based [abstinence] curricula.” (ibid, p. 10) These curricula relied on scare tactics – often in the form of inaccurate or misleading scientific information – to dissuade teenage students from using alternative methods of contraception and disease prevention (ibid). Human rights organisations advocating religious freedom and tolerance repeatedly challenged the constitutionality of the law, and in 1995 the U.S. government agreed to place conditions on the allocation of AFLA funds to faith-based organisations.

Shortly thereafter, a new abstinence education policy emerged in the United States with the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. The Act established an eight-part definition of abstinence education stressing the federal government’s preference for pre-marital abstinence as both a prevention strategy and a moral obligation. The Act declares “abstinence from sexual activity outside marriage the expected standard for school age children,” adding that sexual activity outside the context of a heterosexual marriage – at any age – is likely to have “harmful psychological and physical effects” (U.S. Congress, 1996, Section 912). Educational programmes and curricula based on these criteria were intended to promote “adolescent chastity and self-discipline,” as well as to counteract what conservative policymakers perceived as a government funding bias toward family planning providers and health educators allegedly “[promoting] teen sexual activity and abortion” (ibid, p. 5).

Although exceedingly popular with policymakers from across the ideological spectrum, empirical studies have consistently found the nation’s abstinence programmes to be both ineffective and misleading. A longitudinal study of four of the nation’s most popular abstinence programmes found programme youth “no more likely than control group youth to have abstained from sex,” and indeed reported both similar numbers of sexual partners and initiating sex at the same mean age (Trenholm et al. 2007, p. xvii). Thirteen randomised controlled trials of 16,000 American students enrolled in abstinence-only HIV prevention programmes found that students enrolled in abstinence education, when compared with students in control groups, reported no difference in age of sexual initiation, number of partners, incidence of unprotected sex, or condom use (Underhill, Montgomery, & Operario 2007). One trial found that students in abstinence-only programmes
troublingly reported *greater* frequency of sex and *higher* rates of sexually transmitted infections (STI) than students assigned to the corresponding control group. Kohler, Manhart, and Lafferty (2008) compared the self-reported sexual behaviour of adolescents enrolled in abstinence-only and comprehensive sexual education programmes – those emphasising “the benefits of abstinence while also teaching about contraception and disease-prevention methods, including condom and contraceptive use” (Collins, Alagiri, & Summers 2002, p. 1) – with students receiving no formal sexual health education. Students enrolled in comprehensive programmes were *less* likely to report teenage pregnancy and *less* likely to engage in sexual intercourse than those enrolled in abstinence-only programmes or those with no formal sexual health education.

Reviews of abstinence-only programmes by Kirby (2001, 2002a, 2002b, 2007) and by Manlove, Romano-Papillo, and Ikramullah (2004) failed to find “scientific evidence that abstinence-only programs demonstrate efficacy in delaying initiation of sexual intercourse.” (Society for Adolescent Medicine 2006, p. 84). Although a small number of recent studies suggest that abstinence-only programmes do result in delayed sexual initiation among adolescents (Denny & Young, 2006; Kim & Rector 2008, 2010; Weed, Ericksen, & Birch 2005; Weed et al. 2008), these studies have been criticised for failing to adopt rigorous experimental standards or for utilising “inherently coercive” and scientifically flawed curricula (Society for Adolescent Medicine 2006, p. 83; Kirby 2007). In addition to these findings, a congressional investigation of 13 of the nation’s most popular abstinence curricula found over 80% to contain “false, misleading or distorted information,” gender stereotypes, and blatant scientific inaccuracies (U.S. House of Representatives, 2004, p.i).

In spite of documented failures and pointed criticisms directed at domestic abstinence programmes, in 2003 President Bush announced the development of PEPFAR, an international initiative that, among other aims, was intended to promote abstinence as the primary HIV/AIDS prevention strategy in 15 of the world’s most disease-ravaged nations. The original PEPFAR authorisation legislation mandated at least half of all HIV prevention funds be directed to elimination of sexual transmission of the virus; of that half, at least *one-third* of funds were to be allocated to prevention programmes specifically promoting pre-marital sexual abstinence (Dietrich 2007). In 2005, an executive committee issued new funding guidelines greatly expanding the provision of abstinence education in PEPFAR focus nations. The new guidelines required that *at least 66%* of prevention funds dedicated to eliminating sexual transmission be earmarked for programmes *exclusively* promoting abstinence until marriage (U.S. General Accountability Office [GAO] 2006). The guidelines prohibited PEPFAR funds in all recipient countries from being used to discuss the preventive benefits of condoms with youth under the age of 15, and strictly forbade the establishment of “marketing campaigns that target youth and encourage condom use as a primary prevention strategy” (Dietrich 2007, p. 289; GAO, 2006; Office of the U.S. Global AIDS Coordinator 2005; Rawls 2006).

A number of critics lambasted PEPFAR’s rigid funding guidelines and exclusive emphasis on abstinence. Many complained of the administration’s pattern of contradictory, conflicting, and confusing policies (Rawls 2006); in a 2006 GAO survey of PEPFAR country focus teams, over two-thirds of those surveyed reported a lack of clarity on PEPFAR guidelines that led to frequent “interpretation and implementation challenges,” noting that adherence to
rigid funding requirements undermined their ability to develop educational interventions “responsive to local epidemiology and social norms.” (Dietrich 2007, p. 288)

In 2008, Congress re-authorised, revised, and extended PEPFAR, rescinding portions of restrictive operational guidelines – including prohibitive mandates establishing threshold funding requirements – and increasing funding levels to US$48 billion through 2013. Enthusiasm for abstinence programmes in the United States appeared to be waning in the late 2000s, however, as an increasing number of states and public opinion abandoned abstinence curricula in favour of more comprehensive approaches to sexual health (Bleakley 2006; Hart 2007; Sexuality Information and Education Council of the United States 2012).

Abstinence Education in Uganda: The Presidential Initiative on AIDS Strategy for Communication to Youth (PIASCY)

The Ugandan government - apparently undeterred by (or unaware of) the rising tide of opposition to domestic abstinence programmes in the United States – enthusiastically embarked upon a plan to develop a model of abstinence education strikingly similar to that of its PEPFAR beneficiary (Evertz 2010; HRW 2004). Development of a nationwide, school-based HIV/AIDS-prevention curriculum had in fact begun in Uganda several years prior to the launch of PEPFAR. Following a 2001 visit to the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS, President Museveni shared his bold vision for a national HIV/AIDS curriculum “that would reach every single pupil in the country, from the well-heeled youth in urban Kampala to the thousands of neglected orphans in the country’s conflict-stricken north” (Cohen 2006; HRW 2005). President Museveni called his visionary curriculum the Presidential Initiative on AIDS Strategy for Communication to Youth (PIASCY).

Within months, AIDS educators throughout Uganda began drafting the PIASCY curriculum (Cohen 2006). The development process was fraught with conflict and controversy from nearly the start, as religious groups, public health experts, and progressive educators frequently disagreed on curricular messages and the content of instructional materials. Compromise was eventually reached, and in March 2003, President Museveni launched the first set of PIASCY teacher manuals for circulation in primary schools. The manuals contained chapters on “how HIV is transmitted and how to prevent infection, as well as basic information on the importance of safer sex, condom use, being faithful, and getting tested for HIV” (Darabi et al. 2008, p. 23).

Shortly after their release, however, several evangelical groups expressed passionate opposition to the manuals’ content, protesting the inclusion of any information or images appearing to contradict messages promoting abstinence until marriage. In late 2003, faced with mounting opposition, the government pulled the first set of PIASCY teacher manuals from circulation (Cohen 2006). USAID quickly convened a series of ‘stakeholder meetings’ to revise the materials, inviting a number of religious organisations not included in the initial development process to take part (ibid). USAID also placed a technical advisor in the Ugandan Ministry of Education to oversee the drafting process, warning Ministry officials that any future drafts must have the approval of all stakeholders, including conservative evangelicals. First-hand reports indeed suggest that faith-based organisations – including many new recipients of PEPFAR grant funds – exercised effective veto power over the tone and content of PIASCY materials (Cohen 2006; HRW 2005).
Two new PIASCY teacher manuals – one for instruction of pupils in grades P3-P4 and one for instruction of pupils in grades P5-P7 – were launched in February 2004. The manuals contain numerous techniques and pre-planned exercises to encourage abstinence in youth, focusing strongly on partnership in decision-making, gender equality, and the rights and responsibilities of children (Uganda Ministry of Education 2004a, 2004b). Their content and tone largely reflects the wishes and desires of powerful Ugandan religious institutions (Cohen 2006). A chapter entitled ‘Ethics, Morals and Cultural Values’ was added to both manuals, and all ‘offensive’ images – including diagrams depicting condoms, safer sex, puberty, and genital hygiene – were “purged” (ibid). Information regarding condoms and safe sex practices, included in previous manuals, was also excised. The final PIASCY teaching manuals strictly conformed to the American statutory definition of abstinence education – the so-called A-H criteria – established in late August 1996. Eight months following their distribution, in November 2004, the Ugandan government published a strategy document entitled the Uganda National Abstinence and Being Faithful Policy and Strategy on Prevention of Transmission of HIV. Although touted as the first policy of its kind in the world, the definition of abstinence education outlined in the document copies the A-H criteria almost verbatim (HRW 2005). Notably, there is no reference anywhere in the text of the Ugandan policy to the U.S. legislation from which this definition is drawn.

Shortly following the launch of the new PIASCY manuals, USAID hired the Uganda Program for Human and Holistic Development (UPHOLD) to train 40,000 Ugandan primary teachers in curricular content and delivery. UPHOLD trainers – financed by USAID – repeatedly encouraged Ugandan teachers to refrain from speaking about condoms “because PIASCY was an ‘abstinence-only’ curriculum” (ibid; HRW 2004). Although recent statistics on implementation and funding levels are not publicly available, as of 2009, the PIASCY curriculum – as published in 2004 – was taught in more than 18,000 Ugandan primary schools (UNGASS, 2010). As of 2012, draft materials for a secondary school PIASCY curriculum have not yet been piloted, finalised, or distributed. Although Ugandan secondary schools have long examined issues relating to HIV and AIDS through both PIASCY-themed activities and a number of extracurricular channels, formal coverage of the topic is neither uniform nor pervasive (Jacob et al. 2007). As noted by Jacob et al (ibid, p. 115), “[h]undreds of secondary schools still use textbooks published before the HIV/AIDS pandemic”; as a result, “much of the current information for prevention and treatment of HIV and AIDS is not only inadequate but non-existent.”

A number of researchers have examined the controversial implementation of PIASCY since its launch in 2004. Shortly following the distribution of the revised PIASCY teaching manuals, HRW (2005) conducted a series of interviews with Ugandan students, teachers, and school principals. Although the majority of respondents spoke favourably of PIASCY, implementation challenges were apparent. Many teachers expressed difficulty reconciling instructions to “preach” abstinence only with their professional desires to respond to the needs of their students, many of whom were already sexually active (ibid, p. 33). HRW noted “considerable variation in the information provided to pupils,” particularly with regard to condom use (ibid, p. 34). Some teachers described the need to include information on condoms as a vital component of a holistic strategy to prevent HIV, while others presented the virus as “a curse on immoral people who engage in...
sex” and encouraged abstinence only (ibid, p. 40). These divergent tactics suggest that PIASCY, particularly in its early stages, has not been implemented as intended (ibid).

A follow-up evaluation was conducted in February 2009 by the African Population and Health Research Center. The study by Mudege and Undie (2009) utilised focus groups, informant interviews, and school-based observations to evaluate the extent to which the PIASCY curriculum was meeting both the expectations of its planners and the needs of its constituents. Child-centric, interactive PIASCY activities incorporating music, dance, and drama were regarded by both teachers and students as having the strongest positive impact. Textual PIASCY materials, however, were perceived as less effective and less stimulating. Although interactive activities were believed to inspire and empower young pupils, the lack of written student materials and English language proficiency among some learners posed serious challenges in the classroom. Teachers in several regions reported incorporating information on condom use into their PIASCY lessons; this behaviour, however, was interpreted by the study’s authors as an “honest misunderstanding of PIASCY objectives, rather than a serious attempt to ‘rebel’ against them” (Mudige & Undie 2009, p. 2). Some teachers also reported censoring curricular messages inconsistent with their personal beliefs, focusing on topics such as personal hygiene “rather than placing emphasis on life skills education, such as saying ‘no’ to sex” (ibid, p. 2). In spite of mostly positive comments from both teachers and their students, Mudege and Undie found teacher training efforts lacking and monitoring programmes largely non-existent. Although considerable progress had been made since the 2004 HRW review, many challenges clearly remained.

In addition to these studies, several others have cited the impact of PIASCY on various aspects of life and practice in Ugandan schools. Several studies conducted prior to and since the launch of PIASCY indeed present the nation’s schools in a shockingly negative light. These studies describe the nation’s primary and secondary schools as sites of hegemonic masculinity, gendered discipline and instructional patterns, sexual harassment, violence, and coercion (Leach 2008; Mirembe & Davies 2001). A 2001 study examining the ‘culture’ of Ugandan schools – including administration, curriculum, pedagogy, and classroom environment – found males to overwhelmingly dominate nearly all administrative and student leadership positions within the institutions surveyed (Mirembe & Davies 2001). Girls were regularly portrayed by focus group and interview participants as helpless and incompetent, while boys were generally perceived as academically and intellectually superior. Girls were often subjected to more rules and regulations than male peers, and were frequently cited by teachers and school officials for ‘tempting’ incidents of harassment, teasing, and bullying. Access to knowledge in a number of subjects was tightly controlled and gender-specific, as girls and young women were often “channelled into the ‘right’ future career” (ibid, p. 408). Sexual coercion and harassment – including abusive language, unwanted touching, sexual graffiti, and deliberate intimidation – were reportedly experienced regularly by both female teachers and girl students. Such harassment was widely tolerated, frequently disregarded, and, as a result, rarely reported to school officials.

Gendered power imbalances, as noted by the study’s author, are profoundly “incompatible with the general notion of partnership in disease prevention” (ibid, p. 414). HIV/AIDS curricula promoting
abstinence and equal partnership in decision-making are thus “in conflict with, and neutralized by, an informal school culture which permits widespread sexual harassment and abuse of girls.” (Leach 2008, p. 61) Indeed, studies conducted following the introduction of PIASCY have found the curriculum, “with its focus on abstinence and moral judgment associated with it, [to have] created problems that have acted as barriers to improvements in gender equality” (Kakuru 2008, p. 45). These studies have also found that PIASCY’s emphasis on abstinence “fails to address the particular circumstances in which young people are living” today (ibid, p. 55).

In spite of these important findings, no empirical research to date has explored the specific impact of an American model of abstinence education on the self-reported HIV/AIDS prevention efforts of Ugandan girls and young women. The empirical study proposed below aims to do precisely that. It is premised on the belief that educational policies and programmes – particularly those implemented in dynamic social environments – require frequent evaluation, analysis and if needed, revision. To what extent an American-manufactured, abstinence-driven educational model adequately addresses the needs of young Ugandans is a crucially important area of inquiry. After nearly two decades of steady decline, adult HIV prevalence in Uganda has since risen slightly and stagnated at approximately 6% (UNAIDS, 2010). Critical analysis of what works – and what does not – in the country’s education sector is desperately needed as the Ugandan population continues to struggle against the onslaught of a relentless and deadly epidemic.

The following section outlines the study’s research questions and further explores its methods, target population, duration, inclusion and exclusion criteria, and plan for data analysis. It also briefly details the process of informed consent and assent, potential risk to participants, measures to maintain confidentiality, and the researcher’s qualifications.

**Research Questions and Methods**

The study intends to answer the following research question and sub-questions:

- Is ‘abstinence until marriage’ education, as culturally embedded in Uganda, an effective method of HIV prevention for the nation’s adolescent girls and young women?
  - Does the PIASCY curriculum adequately provide adolescent girls and young women with the requisite skills and knowledge to prevent HIV/AIDS?
  - How do adolescent girls and young women interpret the PIASCY curriculum’s moralistic appeals to remain abstinent until marriage?
  - How does the classroom and school environment impact upon the ability of adolescent girls and young women to absorb and act upon PIASCY curricular messages?
  - How does poverty impact upon the ability of adolescent girls and young women to remain abstinent until marriage?

The study is based on a qualitative survey of adolescent girls and young women aged 12-19 years. Although quantitative survey and questionnaire data have undoubtedly proven useful in identifying gaps in health knowledge and health behaviour, few qualitative studies to date have analysed why gaps in knowledge continue to exist in Uganda despite widespread information and behaviour change campaigns, or indeed how specific educational programmes and policies work to influence sexual behaviour (Robinson
It is important to note that the study outlined below is not intended to add to the extensive body of quantitative data on health knowledge and health behaviour; rather, it is designed to provide an understanding of individual and group perceptions of PIASCY, and the ways in which the content and presentation of the curriculum impact upon the ability of girls and young women to prevent HIV and AIDS.

**Target Population**

The study focuses specifically on adolescent girls and young women as they confront particularly difficult challenges in the battle against HIV and AIDS. Indeed, recent research suggests that girls and young women in Uganda are 9 times more likely than their male peers to contract the virus in their youth (Darabi et al. 2008; Kibombo, Neema, & Ahmed 2007). Girls and young women are more likely to engage in certain types of high-risk sexual behaviour, including initiating sex at younger ages, accepting gifts or money in exchange for sex, and engaging in sexual relationships with much older adult male partners (Darabi et al. 2008; Moore et al. 2007; Neema et al. 2006; Nyanzi, Pool, & Kinsman 2001). Girls are also more likely than their male peers to be the victims of sexual assault and forced intercourse, and to readily relinquish control of the use of condoms and other prophylactic devices to their male partners (ibid; Moore et al. 2007; Neema et al. 2006). Cultural norms have also been found to place girls in an inferior social position in many mixed-gender environments – including the classroom, as previously noted – further confounding their ability to actively engage in school-based sexual health programmes (Kakuru 2008; Leach 2008; Mirembe & Davies 2001). According to Kibombo, Neema, and Ahmed (2007), the majority of Ugandan adolescents – particularly girls – believe that eventually contracting HIV is more or less a foregone conclusion, an “inescapable reality.” These considerations make an in-depth study of their lived experiences and their unique perspectives on abstinence, sexual behaviour, and HIV/AIDS a particularly vital and compelling project.

**Sampling of Schools and Study Participants**

A total of three primary schools (or blended primary/secondary schools) in Wakiso District will be selected for study participation. Wakiso, the nation’s second most-populated district, was chosen for its high concentration of both urban and rural (or semi-rural) primary schools and its close proximity to the capital city of Kampala.

Research approval and registration for this study is pending; no schools have yet been approached to participate. Upon receipt of study approval and registration, selection of schools will be made in cooperation with officials and personnel from the Wakiso District Local Government office. Selection criteria will be based on the following broad considerations:

- Programmatic options: the school must offer the PIASCY curriculum;
- Location: the entirety of the school campus and grounds must be located in Wakiso. At least one school must be classified as ‘urban’;
- Size: the school population must exceed 100 students;
- Gender composition: the school must have a female student population of at least 40%. Of the three schools sampled, one must have an all-female student population;
- Age composition: the school must enrol students of the target age population (12-19 years). Schools
will not, however, be required to enrol students within the full range of the target population (i.e. a school need not enrol students 18 or 19 years of age to participate).

All primary schools (and blended primary/secondary schools) within Wakiso district will be eligible for study inclusion provided they conform to the criteria outlined above. Head teachers at schools meeting inclusion criteria will be approached by the researcher to take part in the research study. Head teachers and PIASCY subject teacher(s) will be provided with full information regarding the study’s aims and objectives, methodology, analytical procedures, and measures to maintain confidentiality, and will further have access to collection tools such as questionnaires and focus group/interview guides. Participating schools will not be identified by name or precise location in the dissemination of study results.

Any female student at a participating school aged 12-19 years with regular school attendance (>75%) will be eligible to take part in the research study. Female students attending school at a rate of less than 75% will be excluded on the basis of their lack of experience with the PIASCY curriculum. Girls under the age of 12 are unlikely to be sexually active (Darabi et al. 2008), and are therefore unlikely to be directly applying the curriculum’s abstinence messages to potential sexual encounters. Young women over the age of 19 are unlikely to be enrolled in primary/secondary schools, and thus unlikely to be directly exposed to the PIASCY curriculum.

Inclusion/exclusion criteria will be assessed by the researcher. Student age will be confirmed during the process of informed consent and parent/guardian assent (see section below). School attendance records, if available, will confirm if attendance eligibility requirements have been met.

Study Recruitment

To recruit study participants, written questionnaires will be administered to all eligible female students enrolled in PIASCY classes at participating schools. The questionnaires will be short in length (10-15 open-ended questions) and brief in duration (10-15 minutes). The questionnaire serves two important study purposes:

- It will gather initial data on the students’ understanding of 1) the PIASCY curriculum, 2) their school environment and 3) their local community. If applicable, the researcher will use this information to modify and/or target focus group and interview questions to particular topics and/or areas of interest.
- It serves as the researcher’s first point of contact with prospective research subjects. Students will be asked in writing at the conclusion of the questionnaire to indicate their interest in further study participation in a focus group session and/or interview series. It is anticipated that the majority of students will decline to do so; however, interest from a small number of students is sufficient for study purposes.

The results generated by this survey will be used for informational purposes only, and will not be used for statistical measurement or analysis. Participation in questionnaire administration is entirely voluntary; no student will be obligated to complete a questionnaire if unable or unwilling.

Data Collection Methods

Qualitative data will be collected from eligible study participants through focus groups, interviews, and classroom observations. The study seeks to enrol approximately 30-40 female students in focus group
sessions and approximately 8 female students in ethnographic interviews. No material compensation will be provided for study participation.

**Focus Groups**

The vast majority of empirical data collected in the course of this study will emerge from focus group discussions with adolescent girls and young women. As defined by Robinson (1999, p. 905), a focus group is “an in-depth, open-ended group discussion of 1-2 hours duration that explores a specific set of issues on a predefined and limited topic.” Focus groups are “premised on the mechanics of one-to-one, qualitative, in-depth interviews being replicated on a broader (collective) scale” (Parker & Tritter 2006, p. 26), one in which both the cognitive and emotional responses of participants – as well as underlying group dynamics and synergies – can be investigated, explored and analysed (Heary & Hennessy 2002; Robinson 1999).

Group interaction is an integral component of focus group methodology; participants “provide an audience for each other [that] encourages a greater variety of communication” (ibid, p. 108), while at the same time enabling complex dimensions of human exchange to be revealed that are not accessed by more traditional methods of data collection (Robinson 1999). Focus groups do not “easily tap into individual biographies or the minutia of decision making during intimate moments” (Kitzinger 1994, p. 116), but are nonetheless highly useful tools for identification and analysis of cultural values and group norms established as a result of shared and common knowledge (Robinson 1999).

Focus groups have been identified as particularly appropriate research tools when working with children and adolescents, specifically in the study of sexual health and disease prevention. Barker and Rich successfully implemented adolescent focus groups in their 1992 study exploring factors influencing teenage sexual behaviour in Nigeria and Kenya, noting that focus groups were particularly useful as a measure of “peer interaction as a factor in decision making about sexual activity” (Heary & Hennessy 2002, p. 49). Thomas, in a 1996 study evaluating young people’s understanding of the relationship between sexual activity and good health, “found the method valuable in accessing adolescent’s opinions about sex, which was perceived as a potentially embarrassing subject” (Robinson 1999, p. 911). Watson and Robertson (1996) reported similar findings in their survey of senior school children enrolled in an HIV/AIDS education programme in the Lothian region of Scotland.

The age of respondents must, naturally, be taken into careful consideration in the design and implementation of focus groups. As noted by Heary & Hennessy (2002, p. 51), the “optimum size of a focus group with children is generally smaller than adults”; although focus groups of adults are generally composed of 8-12 members, those with children should be limited to no more than 4-6 participants. The appropriate length of group discussions is also limited to approximately 60 minutes for children aged 12-14, and no more than 90 minutes for older adolescents and young adults (ibid).

Group composition is also critically important. Although Parker & Tritter (2006) recommend that participants should not be known to one another prior to formation of the group – to encourage spontaneity and lively debate – precisely the opposite is true when working with children. Indeed, “to obtain maximum output from focus group discussions with children, the composition of the group must be planned in advance, if at all possible,” (Heary & Hennessy 2002, p. 52) and should be carefully organised by gender, age, and, if appropriate, by ‘friendship group.’ As noted by Kitzinger (1994, p. 105), pre-existing friendship groups
allow the moderator/facilitator to explore how young people might speak about sexual relationships and HIV/AIDS in “the various and overlapping groupings within which they actually operate” in real life, “the people with whom one might ‘naturally’ discuss such topics, at least in passing.” Children and adolescents are “essentially social beings and spend much of their lives in groups … the [focus] group setting represents a familiar and reassuring environment for children.” (Heary & Hennessy 2002, p. 53)

In spite of their many advantages, focus groups are also limited in some respects. The number of questions that may be discussed and adequately resolved is less, on average, than that of one-to-one interviews, surveys, or questionnaires. There are certain types of personal information which participants are prepared and willing to share with a single researcher – in person or via their questionnaire – which they are not prepared to share openly with a group of their peers (Kitzinger 1994).

Focus groups can also reveal “the nature and range of participants’ views, but less so their strength” (Sim 1998, p. 351). The most frequently noted disadvantage of focus groups, however, is the emergence of power struggles, of the oft-cited ‘dominant voice’ (Heary & Hennessy 2002; Kitzinger 1994; Sim 1998). It is possible within group discussion that certain members “may be more assertive or articulate than others, and their views may come to dominate the proceedings.” (Sim 1998, p. 348) In turn, less self-confident or articulate members may be silenced or intimidated, inhibiting interaction and the exchange of alternative viewpoints (ibid).

Participants’ verbatim statements should be recorded using the least intrusive method possible, a process that “should not itself have reactive effects on group participants” (Sim 1998, p. 3). Audio recording of verbatim statements is generally recommended, supplemented by written notes capturing the identity of the speaker, non-verbal cues, and group dynamics (Onwuegbuzie et al. 2009). Verbatim transcription of audio-recorded focus group sessions is undoubtedly complex and extremely time-consuming in light of frequently interrupted or incomplete speech, producing – on average – between 50-70 pages of text per group (ibid). Nonetheless, previous studies utilising focus groups report that the time and energy devoted to verbatim transcription is well rewarded in the richness and quality of the data (Campbell & MacPhail 2002; Onwuegbuzie et al. 2009). In addition to verbatim statements captured by digital audio recording equipment, written notes of the proceedings will also be taken to record group behaviour, dynamics, and synergy. A reflective diary will also be kept daily to capture the researcher’s personal thoughts, observations, and tentative conclusions immediately following focus group sessions (Burns 2002).

For the purposes of this study, focus groups will be carried out with adolescent girls aged 12-14 and young women aged 15-19. The researcher will serve as the sole group facilitator and moderator; to maintain strict confidentiality, no other adult will be present during group sessions. Given the information provided above, each group session will be small in size (4-6 student participants), familiar in composition (organised by pre-existing friendship or acquaintance group), and short in duration (1-1 ½ hours). Participants will be asked to partake in one group session only. The date and location of focus group sessions will be selected at the participants’ convenience, but will likely be conducted on school grounds. Participation will be entirely voluntary; no student will be obligated to participate in group sessions if unable or unwilling.

Focus group sessions will follow a semi-structured discussion guide. However, conversation in group
sessions will be dictated primarily by the interests and feedback of group participants, and will not necessarily follow these guides explicitly. It is not possible to determine the exact content or nature of focus group discussions at this time, although topics to be explored include participants’ general understanding of PIASCY goals and objectives, the incorporation of condom use in the curriculum, gender dynamics in schools and classrooms, as well as the impact of both socio-economic conditions and of moral, cultural, and religious values on one’s understanding of sexual behaviour.

Ethnographic Interviews

Semi-structured, individual ethnographic interviews will be conducted with one member of each focus group. The use of individual ethnographic biographies is intended to supplement information garnered from focus group discussions with invaluable insight on the daily lives of a small number of group participants. The lived realities of Ugandan youth extend far beyond both the classroom and school environment, necessitating deeper understanding of their daily activities, interactions, and relationships in light of (or perhaps despite) their exposure to an abstinence-only curriculum. Ethnographic methodologies, first applied in anthropological research, have since been extended to qualitative research in a number of other study areas as well, including curriculum design, implementation, and analysis (Fasse & Kolodner 2000).

The researcher will solicit volunteers to engage in an interview series from the pool of participating focus group subjects. A series of three semi-structured interviews will be carried out with each participant selected for individual ethnographic study (Seidman, 2006) The first interview will establish the context of the participant’s experience, their understanding of the topic under study, and their personal connection or association with the topic up to the present day. Participants will be asked to share their experiences in their families, in school, with friends, in their community, and, if applicable, in their place(s) of work. The second interview will allow the participant to reconstruct the details of their lived reality with regard to the topic under study (ibid). To place their experiences within the context in which they occur, participants will be encouraged to speak about their understanding of the PIASCY curriculum and of HIV/AIDS prevention generally both in terms of the conditions of their immediate and local surroundings, and in terms of their relationships with friends, peers, teachers, parents, and their wider social community. The third and final interview will allow the participants to reflect upon their experiences, and to share the meaning such experiences hold (ibid). Participants will be urged to share the “intellectual and emotional connections” between their lived experiences and the messages delivered through the PIASCY curriculum (ibid).

Interview sessions will be recorded using digital audio-recording equipment, supplemented by written notes of the proceedings. A reflective diary will also be kept daily to capture the researcher’s personal thoughts, observations, and tentative conclusions. To maintain strict confidentiality, no other adult will be present during interview sessions. Each session will be approximately 1 hour in duration, resulting in approximately 3 hours of total interview participation. The date and location of interview sessions will be selected at the participants’ convenience, and may or may not be conducted on school grounds. Participation will be entirely voluntary; no student will be obligated to participate in interview sessions if unable or
unwilling.

Each interview session will follow a semi-structured question guide. However, interview sessions will be dictated primarily by the interests and feedback of research subjects, and will not necessarily follow this guide explicitly. Interview questions may be adjusted and omitted at the researcher’s discretion, as needed, based on the age and/or maturity of the research subject.

Classroom Observations

In addition to focus group sessions and individual interviews, data will also be collected through short-term, non-participatory classroom observations. As noted by Fasse and Kolodner (2000, p. 193), observation is critical to gaining “an in-depth understanding of [the] classroom”; indeed, documentation of the classroom’s context is invaluable for the analysis of any curriculum applied in real-world schools (ibid). Non-participatory observation is a “relatively unobtrusive” data collection method in which the researcher observes and records classroom phenomena but “has no specific role as a participant” in activities or instruction (Savenye & Robinson 2004, p. 1053). For the purposes of this research study, classroom observations will serve a number of vital epistemological functions, including 1) as a source of information on the true nature and content of PIASCY lessons, 2) as a means of framing focus group discussions and individual interviews, and 3) as a means of understanding the environment in which the PIASCY curriculum is both taught and absorbed.

Two formal classroom observations will be conducted within each school setting; the first taking place prior to the initiation of focus groups and individual interviews, the second following these sessions. Given the unpredictable and dynamic nature of primary and secondary school classrooms, it is impossible to determine the precise criteria by which each PIASCY classroom will be evaluated. However, preliminary criteria have been developed and include categories such as ‘physical space/classroom provision,’ ‘teacher characteristics,’ ‘lesson content and duration,’ ‘student characteristics,’ ‘teacher-student dynamics,’ and ‘student-student dynamics.’ The researcher will not participate in classroom activities or interact with students during observations in any way. All classroom observations will be recorded as written field notes.

Informed Consent & Assent

Written informed consent will be obtained from all focus group and interview participants prior to data collection. Prospective research subjects meeting eligibility requirements will be provided with two (2) copies of a ‘Consent for Study Participation – Student Participant’ form. Those subjects aged 18 and under will also receive two (2) copies of an ‘Assent for Study Participation – Parent/Guardian of (Minor) Student Participant’ form, to be delivered to a parent, de facto guardian, and/or legal representative for signature. The forms are designed to provide participants, parents and guardians of the study’s aims, objectives, methodology, confidentiality procedures, and research affiliations, as well as important information on the rights and responsibilities of research subjects. The researcher assumes responsibility for responding to questions and comments regarding the study in a thoughtful, truthful, and timely manner. Following the satisfactory resolution of any questions or concerns, the prospective participant will be asked to sign one (1) copy of the consent form, return it to the researcher, and retain one (1) copy for their personal records. The parent/guardian of the prospective participant will also be asked to sign (or place his or her thumbprint upon) one (1) copy of
the assent form, return it to the researcher (via the student participant), and retain one (1) copy for their personal records.

No prospective research subject will be permitted to participate in a focus group or interview session without completion of the appropriate informed consent and assent forms.

Supplementary verbal consent will be obtained at the outset of focus group and interview sessions. Verbal consent will also be obtained from students and subject teachers prior to the initiation of classroom observations. All research subjects will be duly notified and repeatedly reminded of their rights to voluntarily withdraw from the study or to reject the investigator’s presence at any time without notice, explanation, loss of benefits, or fear of penalty.

**Study Duration**

Total anticipated study duration in Uganda is 2 to 3½ months. Duration of participation for individual research subjects will vary by data collection method, as follows:

- **Focus groups:** approximately 1 to 1½ hours.
- **Ethnographic interviews:** approximately 1 hour per interview session, totalling approximately 3 hours participation.
- **Non-participatory classroom observations:** approximately 1-hour observation on two occasions per school surveyed.

**Qualitative Data Analysis**

**Constant Comparison Analysis & Grounded Theory**

Throughout the collection process – rather than merely following it – focus group and interview data will be analysed using a form of content analysis known as constant comparison analysis (Onwuegbuzie et al. 2009). Although many forms of quantitative and qualitative analysis take place only after completion of data collection, within this approach – based on grounded theory – data collection and analysis are interrelated processes (Corbin & Strauss 1990, p. 5). Constant comparison analysis relies upon an emergent-systemic research design, in which later focus groups and interviews are used to clarify and investigate thematic content which has emerged in earlier groups and one-on-one discussions (Onwuegbuzie et al. 2009). It is not necessary within this approach to establish substantive coding sets or categories *a priori* or between early group sessions and interviews, nor is it necessary to repeatedly draft new question guides to reflect the emergence of novel themes. Rather, it requires the immediate recognition of major themes and cues to be incorporated into future focus group sessions and interview discussions, the source of which is often written observational notes rather than intensive examination of audio recorded statements. As noted by Corbin & Strauss (1990, p. 5), “carrying out the procedures of data collection and analysis systematically and sequentially enables the research process to capture all potentially relevant aspects of the topic as soon as they are perceived.” It also minimises the likelihood of later coding bias on behalf of the researcher, as major themes are continually reinforced by the participants themselves (Rabiee 2004). This process is a “major source of the effectiveness of the grounded theory approach” (Corbin & Strauss 1990, p. 5).

Research designs based on grounded theory are intended to “develop a well integrated set of concepts that provide a thorough theoretical explanation of [the] social phenomena under study” (Corbin & Strauss 1990, p. 5). Grounded theory seeks not only to uncover relevant social conditions, but to determine how the
actors under those conditions respond to their changing reality, and to the consequences of their actions within it (ibid). A grounded theoretical approach was chosen for this study based upon a desire to understand the true nature of the social and cultural conditions under which ‘abstinence until marriage’ education has been embedded in Uganda. Previous reported success with focus groups – particularly those pertaining to health education – was also a major factor in this decision (Rabiee 2004).

Formal data analysis will be carried out by means of a five-stage framework developed by Krueger (1994) and elaborated by Richie & Spencer (1994). These five stages include familiarisation; identifying a thematic framework; indexing; charting; mapping and interpretation.

1. **Familiarisation.** Familiarisation begins with verbatim transcription of audio-recorded group and interview sessions, a process which may take several days per group and hours per interview. Following transcription, deeper immersion with the raw data will be accomplished by listening to audio-recorded tapes in full, reading and re-reading transcripts in their entirety, and reading observational notes or diary entries (Rabiee 2004). The aim of familiarisation is to become as knowledgeable as possible about the details of raw conversational material prior to formally separating and sorting the data (ibid). Major substantive themes should begin to emerge during this process, which, as described above, is partially completed during data collection.

2. **Identifying a thematic framework.** The establishment of a thematic framework may be accomplished by detailed, line-by-line examination of transcribed conversations, in which the researcher writes memos, short phrases, or brief descriptive or conceptual statements in the margins of the text as a means of identifying early categories for analysis. Again, this stage is partially completed during data collection.

3. **Indexing.** Indexing, also known as open coding, involves “sifting the data, highlighting and sorting out quotes and making comparisons,” both within and between groups and individuals, and assigning initial codes to these small categorical chunks of data (Rabiee 2004, p. 657; Onwuegbuzie et al. 2009).

4. **Charting.** Indexing is followed by a charting process, also known as axial coding, in which quotes are lifted from their original context and re-arranged under the newly-developed appropriate thematic codes (ibid). This stage, as well as stage 5, will be conducted with the assistance of a computer-based qualitative research software package such as N-Vivo, NUD*IST or Atlas.ti.

5. **Mapping and interpretation.** In this final stage, the researcher performs selective coding, developing one or more substantive themes that reflect the discursive content of each focus group (Onwuegbuzie et al. 2009).

Focus group analysis is often carried out by examining the group itself as the unit of analysis (Morgan 1997). Although the themes which emerge from such analysis are often enlightening, they frequently fail to capture the opinion and viewpoint of individual or group dissenters (Onwuegbuzie et al. 2009). Failure to agree with a majority viewpoint by no means detracts from the validity of alternative opinions; argumentative interactions can indeed add great richness to data (Kitzinger 1994; Onwuegbuzie et al. 2009). As such, individual participants – rather than the group itself – will serve as the primary unit of analysis for group data in this study.
Reliability, Validity & Methodological Limitations

As noted by Kidd and Parshall (2000, p. 302), it is useful to evaluate reliability for focus group and interview data in “conventional terms of stability, equivalence, and internal consistency.” Given the one-off nature of the focus groups proposed in the study, it is not necessary to monitor the composition of repeat groups, only to ensure that uniformity in general respondent attributes (i.e., age, gender, school attendance, etc.) is established and maintained throughout data collection. Ensuring equivalence “is primarily an issue when multiple moderators or coders are used,” (ibid, p. 302) although the sheer amount of data emerging from focus group sessions and interview series may indeed also pose coding difficulties for studies led by a single researcher. Heary and Hennessy (2002) propose credibility testing with the participants themselves, suggesting it advisable to present focus groups and interview subjects with major substantive themes that have emerged from previous discussions for clarification, following the rationale of emergent-systemic analysis. The internal consistency of coding is enhanced when a single researcher assumes responsibility for conducting both data collection and analysis (ibid), as in the case of this study.

Focus groups and ethnographic interviews are – as reported by Heary and Hennessy (2002, p. 48) – likely to have “high face validity.” Both methods acknowledge adolescents and young adults as experts with regard to their lived reality and daily experiences. In focus groups specifically, “the emergence of a substantively similar viewpoint on some issue in multiple focus groups, especially if they are geographically dispersed, will [therefore] tend to support content validity.” (Kidd & Parshall 2000, p. 303) A particular disadvantage of focus groups, however, is an inability to accurately measure the strength of opinion across different groups. The strength of a particular viewpoint cannot, and should not, be measured by the number of participants who express it, the intensity with which it is expressed, and the number of those who agree or dissent (ibid). Focus groups “are not oral surveys; that is, participants’ comments should not be tallied, counted, or otherwise taken out of the context in which the comments originated” (Ashbury, 1995, 148). Given an entirely disparate group or context, “the force or emphasis with which a particular individual voices a view may change significantly.” (Sim 1998, p. 349).

Despite these concerns, Sim (1998) suggests a differentiation between empirical and theoretical generalisation of focus group and interview data. Empirical generalisation suggests that data is assumed “to represent a wider population of people, events or situations in a strict probabilistic sense.” (ibid, p. 350) Theoretical generalisation, on the other hand, suggests that data collected from a particular study may provide “theoretical insights which possess a sufficient degree of generality or universality to allow their projection to other contexts or situations which are comparable to that of the original study.” (ibid, p. 350) The likeness or comparability of the two contexts therefore exists at a logical or conceptual level, “not one based on statistical representativeness.” (ibid, p. 350) The study outlined herein is not intended to produce results which establish a form of empirical generalisation based on statistical representativeness; rather, it is hoped that insights will emerge from the data which sufficiently suggest theoretical transfer to similar contexts.

Potential Risks to Study Participants

The nature of the research – evaluation of a nationwide sexual health curriculum – necessitates
some exploration of potentially sensitive, embarrassing, and/or uncomfortable topics. Although the discussion of such topics is unlikely to cause psychological stress, it is possible that some participants will feel mild embarrassment and/or discomfort. Prospective participants will be fully informed of the research aims and questions during the process of informed consent, and repeatedly reminded of their rights to voluntarily cease participation at any point in the study’s proceedings. Participants will be reassured that they are under no obligation, and will not be encouraged, to share information regarding their personal sexual activity, behaviour, and/or relationships (or lack thereof), and will not be asked to discuss topics related to sexual activity beyond the scope and content of the PIASCY curriculum (with the exception of a general discussion on the topic of condom use in the curriculum).

No other foreseeable risk will be posed to study participants. The study is for behavioural research purposes only; it is not a provision of medical care. Research subjects will in no way be exposed to experimental treatment or methodology.

Confidentiality and Research Ethics

Confidentiality, anonymity, and the articulation of participants’ rights are critically important ethical considerations in any research inquiry, particularly those including children and/or adolescents. Guarantees of confidentiality and anonymity are somewhat problematic, however, with respect to data collection in focus group settings. Although the researcher can express his or her full intention to safeguard the true nature of their identity and shared information, “it is difficult (if not impossible) to ensure that participants themselves will adhere to such strict stipulations.” (Parker & Tritter 2006, p. 33) It is also not possible to ensure participants that they “will not be upset or offended by one another’s comments,” (Heary & Hennessy 2002, p. 53) a concern particularly important in groups which involve discussion of sexual behaviour and attitudes toward HIV and AIDS. These disadvantages may, to some degree, be overcome by organising focus groups by ‘friendship group,’ as previous research suggests that friends or acquaintances are more likely to have discussed such topics previously in the course of natural conversation and to furthermore value the privacy of other group members with whom they have a personal connection (Rabiee 2004). The importance of individual and collective confidentiality will be clarified and emphasised at the outset of each focus group and interview session.

Only the researcher will have access to the raw data in audio recordings and written materials. The identity of participants will be kept strictly confidential throughout the entirety of the study. At no time during data collection or dissemination will a participant’s statements be attributed to their true identity, and at no time will a participant’s identity be shared with a third party. All data collected will be anonymously coded and securely stored in a password-protected electronic vault and in a locked document safebox.

In addition to the ethical considerations and informed consent/assent procedures previously noted, the study will also conform to the guidelines and regulations of the British Educational Research Association (2004) and the Uganda National Council for Science and Technology’s (UNCST) National Guidelines for Research Involving Humans as Research Participants (2007).
Footnote

1. Miss Brooke Barnowe-Meyer is a PhD candidate at the University of Edinburgh in Edinburgh, Scotland. The study proposed herein forms the empirical foundation for Miss Barnowe-Meyer’s doctoral thesis. She possesses a Master of Science (MSc) in Education from the University of Edinburgh and a Bachelor of Arts (BA) in Political Science from the University of Washington in Seattle, Washington, United States. Miss Barnowe-Meyer has been thoroughly trained in research methods and methodology as well as interview and focus group moderation.

References


