

The negotiating strategies determining coitus in stable heterosexual relationships*



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Abstract

Heterosexual behaviour is a complex subject and one which is aggravated by confounding variables. Few studies have investigated the way in which one variable, namely coitus, is initiated and negotiated in stable marital relationships. As the HIV/AIDS pandemic spreads in sub-Saharan Africa, the subject of marital coitus becomes of increasing concern. This study tests a methodology of semi-structured interviews and diary-keeping techniques to investigate how the activity is initiated and negotiated. A research team monitored the study and evaluated the research techniques. The study concluded that the HIV/AIDS pandemic is affecting the initiation and negotiation of coitus between marital partners and that the partners wish to renegotiate the relationship, but the mechanisms for renegotiation are not at present available.

In the second decade of the HIV/AIDS pandemic certain trends have become noticeable. In developed countries the main HIV high-risk groups are intravenous drug users and homosexuals, while in developing countries, particularly sub-Saharan Africa, the main transmission routes are through perinatal and heterosexual activity. Heterosexual behaviour has been recognized as a transmission route since 1987 and studies which investigated it have tended to focus upon prostitution. Sexual networking has also been investigated in West Africa and it is an important determinant in the transmission of the virus (Caldwell et al. 1993). But these approaches tend to ignore heterosexual behaviour between couples in stable relationships, and as the pandemic continues to spread in sub-Saharan Africa, this is an area which is increasingly worthy of investigation.

Heterosexual behaviour is a complex subject, but one which can be investigated despite its complexity. Part of the complexity stems from the number of variables involved and this study seeks to isolate one specific variable, namely coitus, and focus upon the way in which it is initiated and negotiated between marital partners.

A qualitative methodology which uses semi-structured interviews and diary-keeping techniques, as complementary research instruments, is worthy of evaluation. Using this methodology the fieldwork is described and the findings discussed. With a better understanding of how coitus is initiated and negotiated it is possible to design intervention programs which will give marital partners new interpersonal skills, and, it is hoped, an increased sense of control.

The subject of sexual behaviour is not well understood, partly because of its complexity. Part of the complexity stems from the number of variables which include social, biological,

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economic and psychological factors that act independently, or in combination, and compound attempts to understand it. This study isolates one specific variable of the complicated mosaic, namely coitus, because its importance is a major transmission route in the AIDS pandemic.

It is estimated that 80 per cent of the world's HIV/AIDS cases live in sub-Saharan Africa (AIDSTECH 1991) where the main route of HIV infection is heterosexual activity; it is estimated that 80 per cent of infections occur in this way (Piot et al. 1988). Kenya, with a population of 24 million, is typical of the subcontinent and is the country selected for this study; it has a strong epidemic of recent origins with an eight per cent seropositivity rate (Way and Stanecki 1994). The epidemic has now been recognized as a nationwide concern and it has been written into the national development program. The two most common transmission routes are perinatal and heterosexual activity and both of these are associated with high-risk sexual behaviour.

Nairobi, which is the specific site for this investigation, is the capital of Kenya and has a population of approximately one-and-a-half million; the population has grown as people leave the rural areas for the urban centres in the search for paid employment. It is a multi-ethnic city, although some people have been resident for so long they no longer acknowledge their ethnic origins; indeed, some regard themselves as Kenyan rather than having any ethnic affiliation, and tribal origin is no longer an accurate predictor of social behaviour. To date, investigations in the region have tended to concentrate upon the commercial sex industry which includes high-risk groups such as prostitutes, lorry drivers and military personnel (Ngugi, Plummer and Simonsen 1988; Bwayo et al. 1991; Winsbury 1992). Commercial sex is invariably negotiated around the price, which is largely determined by risk. Prostitutes can bargain for a higher price when the risks are greater, for example, when the customer does not want to wear a condom. The costs and benefits are known, the negotiating behaviour is open and accessible. However, non-commercial sex is becoming increasingly important as a transmission route, particularly between marital partners. It is generally accepted that behaviour change is the most effective means of combating the spread of AIDS and also the virulence of the virus (Ewald 1993).

There is a popular belief that sexual activity in sub-Saharan Africa is the domain of the man, who expects coitus to be available on demand (Gwede and McDermott 1992). While this belief exists, there is little documentation to substantiate it, and it may be somewhat simplistic; indeed, in West Africa studies have found that the behaviour of women who engage in extramarital sex is largely condoned (Caldwell, Orubuloye and Caldwell 1991). The belief is further complicated by the fact that coitus is ubiquitous, highly conditioned by tradition, and particularly private (Smith, Helitzer-Allen and Obetsebi-Lamprey 1990). These factors confound attempts to investigate coitus; the strategies which marital partners use to initiate and negotiate it have not been clearly identified, and because the subject is essentially private it is not normally discussed (Balmer 1991). Studies which have investigated conversations between marital partners have found that sexual behaviour, fertility and contraception were not included (Makomva, Falala and Johnston 1991).

The literature concerning the initiation and negotiation of coitus is rather sparse. Some general surveys of sexual behaviour have been completed, most of which have relied upon questionnaires (Kinsey, Pomeroy and Martin 1948; Masters and Johnson 1970). The same approach has been used in AIDS surveys in sub-Saharan Africa (Carael et al. 1991; Cleland et al. 1992), although some studies have supplemented questionnaires with interviews (Orubuloye, Caldwell and Caldwell 1991). Anonymous questionnaires are useful in gaining sensitive data, but are best used once the variables have been identified, and while they have the advantage of anonymity and can be administered to large sample sizes, they have the possible disadvantage of obscuring individual differences. What seems to be missing from the data is any in-depth study of how heterosexual behaviour is initiated and negotiated between stable heterosexual partners in the privacy of their homes. Privacy appears to be another

factor which is difficult to surmount and so far studies have concentrated upon public behaviour.

Some specific studies of sexual behaviour have used techniques such as story completion: romantic vignettes were given to college students and they were asked to complete the sketch (Perper and Weis 1987). This technique depends upon a rational response and is somewhat hypothetical. It tends to ignore that two people actively participate and that sexual behaviour can be irrational, impulsive and dominated by emotional feelings which are difficult to control. Observational methods have also been used, but these have been restricted to courtship behaviour in social settings (Moore 1985) and much of the information generated concerned non-verbal behaviour. However, there was no attempt to discover if the courtship behaviour ended in coitus. This observational method would be inappropriate for this study.

At this preliminary stage of investigation into heterosexual behaviour between people in stable relationships there seems to be merit in an idiographic approach based upon qualitative methods: the methods chosen for this study are semi-structured interviews and diary-keeping techniques. The techniques have proved to be effective: semi-structured interviews have been commonly used in qualitative studies (Hammersley and Atkinson 1983), and diary-keeping techniques have been used in medical settings (Robinson 1971). Diary-keeping affords the possibility of gaining access to naturally occurring sequences of sexual behaviour which are otherwise covert (Coxon 1988). Diaries have been shown to be more effective than questionnaires (Conrath and Higgins 1983), while using both diaries and interviews has provided the most reliable and accurate data (Zimmerman and Wielder 1977).

Methodology

Because the methodology adopted is qualitative and experimental, it was decided to restrict the sample to ten men and ten women. It is accepted that the small sample size limits the generalizability of the results, but this was tolerated for logistical reasons. The sample was drawn from the population of people in stable marital relationships which had lasted for more than one year. The sample was drawn from family planning clinics, social service centres and health centres in Nairobi. People who presented at the centres were referred and the aims and methodology were outlined and discussed. The prospective subjects were advised that the study would run for three months and that they would be required to keep a diary of their sexual activities, also to participate in one-hour weekly semi-structured interviews, which would be tape recorded. They were further advised that a payment of approximately US\$2 would be made each session to cover transport and any other incidental expenses incurred. The payment was obviously an inducement, but given their transport costs they were unlikely to make a financial return. There is no indication that it unduly affected the research process and indeed the participants who dropped out were unemployed and in greatest financial need.

If the candidates wished to participate they were asked to return one week later to be enrolled. Then guarantees of confidentiality and anonymity were given. The place for the study was a family planning clinic and access was from a busy main street where people could enter without attracting attention. Thirty three people were interviewed to draw a sample of 20. Of the 13 who refused the following reasons were given: the fieldwork was scheduled during working hours and this was not convenient; some people were highly mobile, travelling constantly between urban centres and rural areas, and regular attendance could not be guaranteed; two people said that the study was too intrusive. The sample consisted of men and women aged 23 - 47 years (mean 31), who had been married to their present partners for 1 - 15 years (mean 6.5), and all had children. They were mainly from lower socio-economic groups. Given the precariousness of employment and the absence of career paths it is difficult to generalize about the participants' social class and whether it had any implications for behaviour. The participants had all benefited from primary school

education and one third had been educated at secondary school, so it was possible to infer a reasonable standard of literacy. Only four were in permanent employment, five had casual jobs and the rest were either housewives or active in roadside kiosks. No formal data were collected about participants' spouses.

Four facilitators were used, two male and two female: one social worker, one medical educator and two university researchers. The facilitators were selected on the basis of present employment, maturity, and the ability to form relationships characterized by genuineness, empathy and warmth. The facilitators were trained in the research techniques to standardize the intervention. The subjects were randomly assigned to one of the male or female facilitators on the basis of sex and number; the facilitators had a sample of opposite and same-sex participants to control for gender bias, as in the following table.

Facilitator	Participants
1 Male	3 Males and 2 Females
1 Male	2 Males and 3 Females
1 Female	3 Males and 2 Females
1 Female	2 Males and 3 Females

Once a participant had been assigned to a facilitator the arrangement was not altered; this worked well and confidential and trusting relationships were soon established. Participants were given convenient weekly appointments which were maintained throughout the three months of the study. On a few occasions participants turned up at the wrong time but in these cases they were seen by the co-ordinator; it was emphasized that they should keep to the appointed times. There was no perceptible difference in the relationships where the sexes were mixed between participants and facilitators; the information which was disclosed was generally similar and therefore it was concluded that there was no gender bias. Attendance was good but some participants missed sessions. Occasionally it became apparent during a session that the participants would not be able to make the following session, and an arrangement was made for an alternative time. Engaging the participants in the decision appeared to encourage a greater degree of commitment. Where absence was unavoidable the participant was encouraged to complete the diary for two weeks and submit both diaries the following session. Only three of the sample dropped out during the three months and there did not appear to be a definite reason. The process began when they missed sessions; although when their absence was mentioned at the following session they gave assurances of continued interest and participation, the number of absences increased until they failed to attend at all.

A research team, comprising a co-ordinator, research assistant, the four facilitators, a sex therapist and a secretary, was constituted to monitor and evaluate the study: this was done through the process of triangulation and respondent validation. Triangulation refers to the comparison of data relating to the same phenomenon, but derived from different sources (Adelman 1977). In this analysis the phenomenon was the initiating and negotiating strategies and the different sources were the participants and the members of the research team; this process has been used in a variety of settings (Maticka-Tyndale 1990). The process of respondent validation (Bloor 1978) is the test as to whether the participants, whose beliefs, attitudes, opinions and conclusions the research team purported to represent, recognized the validity of their findings. The research team met weekly and minutes were kept. The minutes served as a method of enabling retrospective analysis and provided a qualitative data base from which conclusions could be drawn.

Findings

During the first meetings the participants were reminded of the aims and methodology of the study and the guarantee of confidentiality and anonymity was repeated. They were advised that they could have access to their diaries or the tape transcripts at any time. From the beginning the tape recorders did not seem to inhibit the participants.

Normally, meetings began with a discussion about sexual activities and how they had been initiated and negotiated. The participants were encouraged to narrate how different situations developed. The discussions focused upon the normal range of sexual activities, but also included unsought sexual advances, use of condoms, sexual affairs outside the relationship, lack of privacy, and other issues drawn from the semi-structured interviews and the diaries. The facilitators gave as much direction as they thought necessary, but generally left the participants to select topics. It was clear from the outset that many participants were nervous and found it difficult to verbalize their sexual behaviour. The most reticent were young women and the interviews tended to be question and answer sessions.

The discussion then focused upon the diary. The diary was a record of the participant's sexual activity during the previous week. The participants were given advice on how the diary should be kept and were encouraged to record all of their sexual activities, although they were not given any training and the method had not been pre-tested. They were advised that the diaries were sensitive documents and needed to be treated with circumspection. Although there was no hesitation in revealing information, participants were unsure whether they were writing about the appropriate topics. They were assured that the diaries were personal records and whatever they decided to record was valid. The diaries were surrendered each week and replacements provided. Some of the participants were reluctant to disclose to their partners that they were keeping a diary, thinking that it might create conflicts. Where partners were told, it did not seem to be a contentious issue, and in one instance the husband offered to write the week's comments on behalf of his wife.

The initial information generated confirmed the popular belief that coitus was a male preserve and was often initiated in response to a physical need. Most women seemed to accept that it was a male prerogative and submitted to their partners' demands; sometimes they had no alternative. One male participant, who worked in the armed forces, insisted that coitus was his right and that his wife had to comply with his demands. 'I am the lion of the house and she does not have the right to say no', he insisted. Coitus was a regular and routine activity and it generally took place three times a week. If it occurred less, the women became worried that their partners were engaging in extramarital affairs and some women who wished to withhold sex as a form of punishment, also worried that their husbands would have affairs. There was little variation of sexual positions and most preferred the missionary position. Women did not feel that they could verbalize their need for coitus or suggest a particular position. This was partly cultural, because if a woman did this, it would be assumed that she had gained her knowledge through extramarital affairs.

External factors also played a part in the ability of the couple to negotiate. There was often little privacy: sometimes a family shared the same bedroom and spaces were divided by a curtain. Noise during coitus became a primary concern and it generally took place in the late evening or early morning. One man welcomed the rain because the sound drowned out the noise and he could make love vigorously. One woman reported that she submitted against her will because she did not want the arguments to be heard by the neighbours.

There was an implicit assumption that married couples would be monogamous and condoms were unnecessary: this may account for the fact that the poorest knowledge of condoms occurs in sub-Saharan Africa (Goldberg et al. 1989). Wives treated the subject as taboo and had no strategies for persuading their husbands to use them; men were reticent and resisted attempts to introduce the topic. Previous studies show that condom negotiation is

facilitated when there is a feeling of sexual equality between the partners; when it is possible to acknowledge sexual relations with other partners; when the sexual relationship has a commercial basis; and when sex exists for women as an activity in its own right and not as an avenue to motherhood (Worth 1989). None of these conditions appear to apply to the women in this study. Participants were guarded on the subject of condoms and did not show any interest in discussing them. Family planning was reviewed as a routine activity at this stage; the issue was raised by a number of women and it was clear that their knowledge was meagre. Pregnancy was a matter of concern; some women did not wish to become pregnant and used contraceptive methods without the knowledge of their husbands. There was no mention of extramarital affairs.

As the facilitator-participant relationship developed the level of disclosure moved to greater psychological depth. Both men and women disclosed that there was more negotiation than was at first admitted. It was conceded by the men that their partners did have the right to reject their overtures; however, they asserted that the rejection was time-limited. The 'lion of the house' conceded that his wife could reject his advances, but only, he maintained, 'for a day or two'. When they now returned to the issue of family planning, one woman with seven children said she wanted a tubal ligation, but her husband was opposed to the idea and refused to give his consent for the operation. In another case a woman was interested in learning more about family planning, but her husband was opposed to the issue. She confided that she had sought information and she had secretly resorted to injections as a method of preventing pregnancy. Another woman desperately wanted to become pregnant, but because her husband insisted upon protection she lost all interest in coitus.

One man who worked in Nairobi had four children who lived with his wife in the rural area. He commented:

My wife insists on using natural family planning method, but I think it has a high failure rate. She wants more children and I'm worried that she will trap me into having another child.

His infrequent visits home made the effectiveness of natural planning somewhat improbable. One man suspected that his wife was deliberately trying to become pregnant; this caused suspicion and identified one area where men felt insecure. One preventive method was condoms, but generally men did not choose this option. However, they would use them for other reasons. One man admitted:

The week before Easter I had sex with a woman, then over Easter I was back at home and had sex every day with my wife. I used condoms but was still always worried she might get an STD.

The issue of family planning was generally sorted out between couples where there seemed to be complete trust; where there were hints of ulterior motivation this led to mistrust. A male participant said that the use of family planning by his wife would lead her into having loose morals. Extramarital sexual behaviour was now admitted. One attitude expressed was that as long as a wife and children were cared for, the man was free to explore different sexual behaviour with other women: 'A man is not a *panga* (large knife) that cuts with only one side'. Extramarital relationships could place a further strain upon sexual relationships:

I make arguments with my wife to avoid sex after moving [having coitus] with someone else, till I'm sure that I'm not infected.

Men were invariably suspicious of their wives: ‘Women take advantage when men go to work’. Some men became violent and beat their wives who were understandably afraid. If a husband returned home drunk he would sometimes demand sex and his wife had to acquiesce.

Even when my husband comes in late after having had sex with another woman somewhere he can still want it with me. I have to give in, even with the knowledge of AIDS, and I just pray to God that I don’t get infected.

One man used to sleep with other women, but has since refrained following the death of a friend from AIDS. Given the amount of extramarital sex that the men engaged in it seemed that a psychological defence mechanism prevented them from imagining that their wives might be involved with somebody else. Many men had stopped having extramarital affairs because of fear of HIV/AIDS and wished to negotiate a monogamous relationship with their wives. They accepted that there should be a reciprocal responsibility and they recognized that monogamy implied that partners should be able to ask each other for coitus. However, they found this difficult to discuss because there was no tradition of dialogue.

The semi-structured interviews included taboo subjects chosen by the research team, and introduced when the facilitators judged that the participants were ready to self-disclose to the necessary psychological depth. These subjects included sexual preferences, such as oral and anal intercourse, which they all maintained were culturally taboo. By this time the relationships between participants and facilitators were based upon trust and confidentiality. Some of the participants were grateful for the opportunity to disclose their emotions and found the process therapeutic; others welcomed the chance to explore and discuss topics which they had never consciously thought about. Disclosure was frank and open and the ‘lion of the house’ now admitted that on occasions his wife’s rejection was final: ‘If she doesn’t want sex she pinches the baby and makes her cry. Then she picks her up and brings her into bed’. He was aware of his wife’s strategy, but he never confronted her about it.

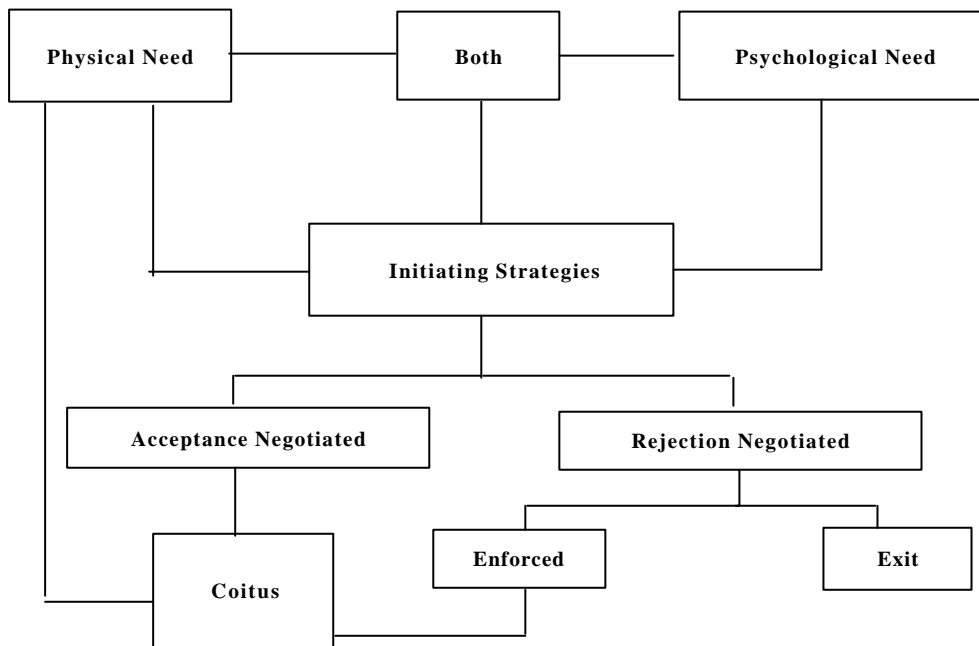
When the three months were over the following strategies had been identified. The process appeared to move from a recognition of a conscious need, to initiation behaviour which was either accepted or rejected. If accepted it proceeded to coitus, but if rejected, two options were open: either the initiator gave up, or coitus was forced by the man.

Initiating strategies used by women	Initiating strategies used by men
Cook a favourite meal	Bring a gift home
Put children to bed early	Come home early
Wear a particular nightdress	Show love for children
Give a romantic glance or a coy smile	Touch and caress partner
Touch partner’s thigh, chest, genitals	Take partner out for drink or a meal
Lean on his shoulder	Give a romantic glance or look
Choose a particular topic of conversation to discuss in bed	Give compliments
Place legs over partner’s	Use pet name
Kiss, caress, hug	Display caring
Prepare bath for partner	Encourage romantic talk
Keep partner company when eating late	Ask
Lie closely and face partner when in bed	Move physically closer in bed
Invite partner to touch and hold close	Kiss and hug

Rejecting strategies used by women	Rejecting strategies used by men
Lie away from partner	Pick a quarrel
Avoid eye contact	Put pyjamas on
Lie in a different bed	Complain of tiredness
Pick a quarrel	Give negative verbal comments
Use children in some way to make coitus impossible	Say no
Menstrual periods	Physically reject with force
Complain of sickness, tiredness or exhaustion	Talk suspiciously
Not play any active part	
Say no	
Avoid intimate situations	

Both sets of strategies depended upon both physical and psychological needs. The process is outlined in Figure 1.

Figure 1



The model outlines the initiating and negotiating processes and shows that they are motivated by either physical or psychological needs, or both. Physical needs were common to both sexes. The husbands sometimes found physical needs so pressing they demanded coitus irrespective of their partners' feelings, and without negotiation. Then the rest of the process was bypassed, for example, when the husband had been drinking. Women sometimes expressed an urgent physical need, for example, when their menstrual period had finished, although women could not use physical force. The psychological needs were also common to both partners and arose from a variety of feelings. Men had to be sexually dominant and to be certain that their sexual technique satisfied their wives. Sometimes the men bypassed the negotiation, forcing the women to coitus, which was tantamount to rape. The psychological needs of women correlated with the amount of caring they perceived in their partners, and

also with their wish for emotional security. Women also wanted benefits which lay outside coitus, namely physical protection and social status. The recognition of needs led to the initiation strategies listed above, which were largely non-verbal. The range of strategies demonstrated that the desire for coitus could commence during the day. It would prompt a husband to buy a present or to return home early, or a wife to prepare a favourite meal. Other signals had evolved during the relationship and were unique to one couple; definite signals were to wear a particular nightdress or bring a chicken home.

The initiative behaviour was either accepted or rejected. If it was accepted, the time interval between acceptance and coitus was generally short; if it was rejected then the partner normally retired from the process. The husbands had the option of physical force. Women had a range of rejection strategies; they were often limited in effectiveness, but occasionally they seemed to work. Enforced coitus did take place and in some of these cases the husband was violent and beat his wife. One woman referred to herself as a sex prisoner: her husband demanded coitus each night and she did not enjoy it, except occasionally after her menstrual period. When she did attempt to reject his advances he accused her of being unfaithful. Women who were forced into coitus relied upon non-verbal behaviour to show that they objected, and they became passive actors. However, women were afraid that their husbands might take a second wife, which was both culturally and legally permitted. Although women do have some power, this must be used subtly, discreetly and indirectly: consequently their behaviour appeared to be shrewd and cunning to the point of deviousness.

One of the principal difficulties in investigating the subject is that commonly recognized signals were renegotiated in private: each couple evolved its own set of signals. This tends to reinforce existing taboos; most initiating and negotiating strategies were acquired unconsciously and people found difficulty in talking about them. Because sexual behaviour is primarily non-verbal, couples were not used to talking about it, therefore it was difficult to negotiate. This is exacerbated by the limitations of vocabulary: the medical vocabulary emphasizes the clinical aspects while the alternative vocabulary tends to be crude and abusive. Some couples did have a private vocabulary, but this focused upon genital parts rather than encouraging a discussion of responsibility or fidelity. Women were reluctant to verbalize their feelings or opinions and this reluctance increased the significance of non-verbal communication. It was difficult to explore non-verbal strategies without talking about them, and other methods should be found. Men thought that more sex education in schools would help women to talk about sex.

Some of the participants mentioned that the study had changed their attitudes. Women were traditionally not supposed to be interested in sex, and if a woman asked for sex, or suggested a different coital position, it would be assumed that she was having extramarital sexual relations. The study seemed to empower some of the women to broach the subject with their husbands. One male participant expressed the hope that because of the sessions he would find a way of getting his wife to initiate coitus. This was an example of men realizing that if they were to be monogamous then their wives also had to be monogamous and they needed to talk about the matter to reach a consensual agreement. However, starting to talk was the problem. One woman said:

My sex life has progressed since the program started. I discuss it with my partner and we think about it much more seriously and discuss it more often.

Conclusions

The methodology proved effective; the semi-structured interviews were a successful way of gaining sensitive information. The interviews needed to be focused, otherwise the participants tended to ramble repetitively about inconsequential matters. Many of the participants commented that the study had caused them to think about their sex lives, which had improved because they had started to discuss the matter openly with their partners.

The information contained in the diaries was variable. Some diaries were full, but the information was not relevant; others were relevant, but superficial. Generally they had not considered the factors that affected the negotiation of coitus; literacy level was also a contributing factor and the entry was sometimes difficult to understand. Diaries are very personal records of activities, and some instruction or pre-testing might have improved their effectiveness.

The research team meetings were successful in allowing the study to be monitored and evaluated. The meetings generated substantive explanations regarding coitus through the process of triangulation, which terminated in a set of conclusions discussed with the participants for their validation. The conclusions were amended in the light of their comments.

At present, the status of women is inferior in terms of negotiating power, but some men are prepared to sacrifice power in return for the guarantee of safe sex; they are prepared to give up the excitement of extramarital sex, but want to find the same excitement with their wives. They also want women to express their preferences more readily; in return, they accept that the negotiating powers should be more equal. There is now more distrust and suspicion surrounding coitus; this has been caused by the fear of AIDS. To avoid the risk of infection with HIV married couples wish to have a monogamous relationship, and recognize that this is only feasible if both partners agree, and if they wish to re-negotiate the relationship.

In this crucial and sensitive area, there is a need for programs such as the one described here. These programs should improve interpersonal skills; they would also increase self-esteem and help to develop a suitable vocabulary and negotiating strategies which would allow marital partners to re-negotiate the sexual contract.

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