

## Malinowski Award Lecture, 2002

# *Building Social Sciences and Health Research: A Decade of Technical Assistance in South Asia*

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This paper describes main features of a program of technical assistance in South Asia (primarily India) designed to help community health researchers develop more effective data gathering and analysis in applied studies of reproductive health issues. The program was funded by the Ford Foundation (India) and organized under a grant to Johns Hopkins University. Recipients of the technical assistance have been mainly small nongovernmental organizations (NGOs) and some social science researchers in academic institutions in India. In most cases, the participants have been involved in community-based intervention programs, so the research activities have had a directly applied focus. The increasing challenge of the AIDS epidemic brought about a shift in emphasis in the program, as many organizations and individuals took up research on sexual behavior to better understand the patterns of individual actions that are associated with higher risks of HIV infection. An informal “sexual behavior research network” has developed as the program of technical assistance and the communications among the various participants matured. The use of computers for data management and e-mail communication has facilitated these developments.

**Key words:** social mapping, sexual behavior, AIDS, sexual health, training, cultural scripts, India

I am very humbled, but also very proud, to be here before you all to receive the Malinowski Award. In my view, Bronislaw Malinowski stands as a towering figure in applied anthropology. Quietly to myself, I sometimes think of certain parallels between his career and mine. (Mine, of course, on a much smaller scale.)

First, Malinowski insisted that anthropology is a scientific discipline. That is, our work is based on consistent, logical use of empirical data for problem solving (Malinowski 1959, 1960). In my view, that attitude is the most fruitful and productive way to define our discipline.

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*Pertti J. Pelto received his doctorate from the University of California, Berkeley, in 1960. His dissertation was entitled Individualism in Skolt Lapp Society, and published in 1962 in the Finnish Kansatieteellinen Arkisto (Ethnological Archives). His major academic positions have been at Cornell University (1961-63), the University of Minnesota (1963-1969), and the University of Connecticut (1969 to 1993). His book on research methodology, Anthropological Research: the Structure of Inquiry, was first published in 1970, and a new edition, coauthored with Gretel H. Pelto, appeared in 1978. In recent years he has written papers on data-gathering methods for reproductive health and papers summarizing current knowledge of sexual behaviors in India. During the past 12 years Dr. Pelto has been involved in programs of technical assistance in South Asia, aimed at developing more effective qualitative and quantitative research in reproductive health and related matters. His consulting work has been primarily in India, but also includes activities in Bangladesh, Nepal, Pakistan, and Sri Lanka. Retired from the University of Connecticut, he has lived in India since 1995.*

It does not of course mean that all our research must be quantitative.

Second, Malinowski is now most remembered and honored for his contributions to fieldwork methods. He basically invented participant observation and related data-gathering techniques, emphasizing direct observations of peoples' daily lives and activities. Other field researchers had sometimes “done participant observation,” but he formulated these techniques into systematic methodology (cf. DeWalt and DeWalt 2002:3, 5).

I, too, see myself devoting my career to research methodology. My primary and passionate interest has been to refine and develop the ways in which we interact with the world out there—to accumulate useful information. That direction of interest began in the 1960s, when I was writing a book on research methodology for anthropology (Pelto 1970).

The third point of comparison is a bit whimsical: Malinowski became immersed in a field situation—the Trobriand Islands—due to fortuitous circumstances beyond his control. To some extent, my current immersion in a field of action in India and south Asia came about through a series of events I did not foresee or plan.

The past several years of activities in South Asia are the basis for my comments here. Over these years, we have been doing technical assistance—in all aspects of research training and guiding—for people in India and neighboring countries who are gathering data in connection with reproductive health, particularly those involved in HIV/AIDS intervention programs.

The “we” in the above statement refers to a team of technical assistance facilitators that began (in 1990) a program of training and assistance for a loose collection of Indian researchers. The plan for capacity-building in “social sciences and health” was initiated by Saroj Pachauri and her associates at the Ford Foundation’s India office. (Pachauri 1994; Gittelsohn et al. 1994). Peggy Bentley at Johns Hopkins University became the principal investigator for the project, which was entitled “Building Social Science Capacity for Research on Women’s Health in India” (Bentley 2001). Michael Koenig, at the Ford Foundation throughout most of the decade, also played a leading role. There are many other players in the team—too numerous to mention here.

The primary focus of research training was originally on reproductive health, as suggested in the title of the first collection of research papers, “Listening to Women Talk About Their Health,” which was published in New Delhi in 1994 (Gittelsohn et al. 1994). However, the study topics gradually shifted to a concentration on HIV/AIDS and other sexually transmitted infections, with special attention to the sexual behavior patterns central to the spread of the AIDS epidemic. The coalition of research groups developed into the Sexual Behavior Research Network.

You are all aware of the looming threat of the HIV/AIDS epidemic in India and South Asia. It is now estimated that over four million persons are infected with HIV in India (Hawkes and Santhya 2001). Dire predictions are being made concerning the rates of spread of AIDS in that huge population of over a billion persons. The interventions directed to the HIV epidemic in India have been hampered by the relative scarcity of data on sexual behaviors in the different, immensely varied, sociocultural sectors of the Indian population (Nag 1996).

Our network of researchers in sexual behaviors and sexuality consists of about 30 or more local, mostly small, research and action groups. They are people in nongovernmental organizations (NGOs), some individuals in academic institutions, and a few government people, including doctors in medical facilities. Most are directly involved in intervention programs. Most are not researchers in their primary identity, but all are interested in getting useful data in the AIDS campaign.

The products of the applied research are a series of reports and papers, as well as action programs that are currently operating in a number of different locations. We are now preparing a collection of papers that will present an overview, *Sexuality in the Time of AIDS in India*, edited by Ravi Verma, Archana Joshi, Steven Schensul, and myself. Figure 1 shows the locations of most of our training and technical assistance activities. Much of the action has been centered around Mumbai (Bombay), Pune, and neighboring Gujarat state. There are also several groups farther south, in and around Bangalore and Goa. Those are all areas of rapid increases in HIV prevalence. We have also been working with groups in Calcutta (Kolkata) and Orissa. Outside of India, we have had workshops and other training activities in nearby Nepal, Bangladesh, Pakistan, and Sri Lanka.

## Lessons in Appropriate Methodology

In this technical assistance, we see our mission basically as capacity building, using appropriate ethnographic research methodologies. We are not training people for academic degrees. Most of our colleague-clients will not go for degree programs. Almost all are dedicated to interventions and action, rather than academic work.

Our data gathering strategies are focused mainly on qualitative methods. Qualitative (ethnographic) methods are designed to find out what is going on in a system of action—the processes, complex patterns—of sexual behaviors, sexual health problems, and treatment seeking; and all the other aspects of dealing with HIV/AIDS and other sexual health problems. All are very sensitive topics, about which people are secretive.

It is strange to admit this here, among applied anthropologists, but we are not talking or teaching very much about participant observation. Participant observation is not particularly feasible in relation to most sexual activities, and our researchers don’t have the luxury of time for full-scale participant observation. So what do we do? I will describe some details of our main research tools because this tool kit has proved quite effective in getting the contextualized patterns of sexual behaviors.

## Mapping of Fields of Action

First, we discuss a lot about mapping; especially social mapping. That means asking one or two persons, or small groups in the study communities, to draw on paper the local area and indicate special features.

Where do people go for treatment of health problems?  
Where is illicit liquor available?  
Where do men go for sex?  
Where do people get condoms?  
Where are the truck-halt places on the highway? And the sex workers?

This has been a very successful opening move in field research, as large amounts of descriptive information come out in the discussions among the informants in the course of the mapping. Also, researchers find this tool easy to use and effective in gaining quick rapport with local people. With the street children in Bangalore, researchers asked young boys to map out their fields of activity: their routes for scrap collection; their recreation areas; areas of danger; and areas of sexual activities (Murthy and Karott 2000).

Probably the champion mapping operation so far has been in the Kathmandu Valley in Nepal. The researchers, working for Family Health International, mapped practically all the injection drug users (IDUs) and drug use locations for the entire valley area, as well as the different types of sex workers and their locations. This has resulted in a comprehensive head count of both the IDUs and the sex workers of the valley area (CREHPA 2001).

Figure 1: Study Sites in South Asia



Source of basemap: 1992 Magellan GeographixSM.

Map by Laura Kriegstrom

### In-depth Interviews: Cases

To learn about people’s sexual behaviors, their “scripts of sexual relations,” and to understand their concepts of sexuality, we need to get extensive narratives—individual histories of sexual actions. The best studies are those that have 50, 60, or more cases, with two or three interview sessions with each person. This gives strong validity to the sexual

narratives or sexual scripts—and gives a basis for some small-scale numbers—frequencies of particular actions: How many sex workers did they go to? Any male-to-male sexual activity? Alcohol use? Condom use? And other details to contextualize sexual activities.

The in-depth case interviews are excellent data foundations for developing intervention strategies. In rural Gujarat, Archana Joshi and her colleagues collected three interview

sessions with each of 124 married and unmarried young men in a cluster of villages (Joshi and Dhapola 1998). Their data include short-term and longer-term sexual relationships, experiences of sexually transmitted infections, and some data on patterns of abortion-seeking for unwanted pregnancies. The data on abortions were totally unexpected, as the interviewers had not been instructed to ask about unwanted pregnancies.

In-depth, open-ended interviewing is the most difficult element in our tool kit of research techniques. Many of our “clients” are familiar with the structured interactions in quantitative surveys, and they crave clear, step-by-step guidelines for interviews. They do not easily switch to the idea of letting the informant narrate “stories.” They also have difficulty learning how to “probe for more details.” Until a few years ago it was widely believed in India that “people won’t talk about their own sexual behaviors,” as it is a seriously tabooed subject in south Asia. Our research network’s experiences have demolished that myth.

### **The Language of Sexual Behaviors and Sexual Health Problems**

Time and again we come back to language, vocabulary, and cultural constructions of sexual action. One of the most effective means for getting sexual vocabularies is the simple free-listing technique. Small collections of lists give us inventories and vocabularies in specific cultural domains, and also give us indications of relative importance, or salience, based on the percent of informants who mention particular items.

Free listing has produced startling revelations in many areas—especially in relation to men’s sexual health problems. In relation to HIV/AIDS most medical people and policy makers have been fixed on sexually transmitted infections (STIs). But in free listing, the Indian researchers found that many of the main sexual concerns of south Asian males are focused on semen loss—from masturbation, nocturnal emissions and other causes. There are many other anxieties about noninfectious, non-STI concerns—premature ejaculation, penis size, sexual weakness, and impotence.

The language, and the related assumptions, lead to thousand-year-old Ayurvedic physiological concepts, some of which were described by the physician, Morris Carstairs (1967), over 30 years ago, and more recently by Professor Obeyesekere (1998) in Sri Lanka. The psychiatrist, Kakar (1996), has discussed the importance of those traditional beliefs about semen loss in relation to the “Indian psyche.”

Knowledge of cultural beliefs and anxieties about semen loss give HIV intervention people credibility in their messages and counseling of young men. Some of the Indian HIV/AIDS programs have paid special attention to unmarried men’s anxieties about masturbation and have gained rapport (and acceptance of condom use) among young men through understanding and discussions of the “semen-loss anxiety complex” (Deepak Charitable Trust 2000).

The free-list technique has also produced striking results in determining: “What are all the sexual acts?” For example, anal sex was the most frequently mentioned item by male street children in Bangalore (Murthy and Karott 2000). On further study, this turns out to be a centrally important feature of daily life and social relationships among the young boys in the streets of Bangalore and almost certainly among street children in other cities as well, though there are very few in-depth studies in other urban areas.

The items from free listing give researchers basic inventories of the contents of cultural domains (Weller and Romney 1988). Further insights into the cultural patterns, or cognitive maps, are gathered through pile sorting and ratings. Researchers use index cards with the items written on the cards in local terminology, sometimes accompanied by pictures. The men in a poor Mumbai neighborhood sorted “male sexual health problems” into two basic groups: 1) items reflecting “semen anxiety” and other noncontact problems about sexual performance and impotence; and 2) items indicating sexually transmitted infections, using both medical and lay terminology. Pile sorting by medical practitioners (mostly unqualified) who treat sexual health problems showed a sharper separation of the STI-like items, reflecting their practice of prescribing antibiotics and other treatment (Verma et al. 1998).

Ratings have been used in several projects to assess the perceived seriousness of sexual health problems—AIDS is invariably the top item—and other dimensions of interest. In Nepal, the researchers collected ratings of the availability and men’s preference for various drugs. They found that “brown sugar” (heroin) was rated “most preferred,” but actual patterns of drug injection reflected the ready availability and low cost of synthetic pharmaceuticals. (CREHPA 2001).

### **The Qualitative-Quantitative Mix**

In India and other locations in South Asia the ideal research models for the study of sexuality and sexual behaviors start with qualitative methods and then, where time and funding are available, are followed by carefully constructed quantitative surveys. This is another area of conceptual difficulty. It has proved difficult to develop clear, systematic connections between the qualitative data and broad, quantitative surveys. However, an immediate major contribution from qualitative data (in-depth interviews and free lists from informants) has been to frame survey questions in appropriate local (vernacular) language.

One of the major findings from the very best surveys is that the percentage of young men involved in premarital sex is relatively low in most sectors and regions of India, compared to Africa, Europe, and North America. In Mumbai (Bombay), only 15 to 30 percent of college men reported having sexual experience, and many of those had experienced sex only once or a few times (Abraham 1997; Rangaiyan and Verma 1999). The percent of college women reporting sexual experience is much lower, although we don’t

consider their responses to questionnaires to be a true measure because of the strong stigma of premarital sex for females.

The rates of young men going to sex workers reported in quantitative surveys is very much lower than impressions circulated in the popular media. In one excellent set of survey data from rural areas in five different states, only 5 to 6 percent of the men had ever gone to sex workers (Verma and Lhungdim 2001). These quantitative data from different parts of India make it clear that interventions concerning safe sex need to focus where possible on that minority of sexually aggressive, sexually adventurous, multipartner “players” (Kheladis), or as one research group labeled them—the “Casanovas.”

### **Training Workshops and Site Visits**

Most of effective research training and advising is through word of mouth and hands-on interactions—role play, demonstrations, and practical exercises. That means dozens and dozens of workshops, plus one-on-one consultations. Training is most effective when we work with a group in its own research location and send members out to do fieldwork. This enables us to assess and discuss their field materials, and they can bring back experiences about what worked and what didn't.

Also, the training is most effective when each research group has its own individual project, so the training is built up around specific data gathering of which they have ownership and emotional commitment. The Ford Foundation (India) funded several small grants programs in Baroda (Gujarat), Pune (Maharashtra), and Bangalore (Karnataka). For example, the small grants program in Bangalore, at the National Institute of Mental Health and Neurosciences (NIMHANS), has 11 small projects, most in the Bangalore area. Dr. J. Ramakrishna (2001) heads the program. She calls workshops and meetings several times a year to continue development of research skills, computer techniques, and data analysis among the participants. Many of the training sessions are conducted in a mixture of English and the local language. Fieldworkers discuss their data and experiences in the actual fieldwork language, and the principal investigators translate the discussions back to us, the resource people.

### **Use of Computers and Appropriate Technology**

Twelve years ago, in our first workshop sessions, when we talked about computers most of the participants said their organizations (small NGOs) could never afford to get computers, and they themselves felt they would not be able to learn to use computers. In that first discussion, only two groups out of 15 had started using computers, cautiously. Now the great majority—80 to 90 percent—of these research groups use computers. In the past three or four years almost all have acquired e-mail addresses. Practically every workshop or training session includes hands-on computer work.

For analysis of free listing, pile sorting, and ratings, the groups have developed skills in ANTHROPAC (Borgatti 1990). The groups have explored a variety of programs for management and analysis of qualitative textual data, including dtSEARCH (D.T. Software 1991-1995), ATLAS/ti (Scientific Software Development 1997), and others.

### **Data Analysis, Writing, and Dissemination**

During the last three or four years we have been devoting much attention to helping the groups analyze data and write for publication. About half of our network partners have presented papers at international conferences, particularly at the 2000 Asia-Pacific Social Science and Medicine Conference (APSSAM) in Sri Lanka and the 2001 AIDS conference in Australia.

Writing papers that combine qualitative and quantitative data is very difficult, and many of our colleagues have little experience in writing for international journals. Of course, we also look to publications and other dissemination in local, South Asian publications, in English and in local languages. Indian research culture, particularly among NGOs, has a feature, referred to as the “dissemination workshop,” that is practically unknown in the West. When a research group finishes its data analysis and writing, it announces a workshop and invites other researchers, action groups, and NGOs working in the same general (topical and geographical) area. Government policy makers, media people, and local community persons are also invited to these meetings, sometimes as “guests of honor.” Dissemination workshops are an important means of transmitting new knowledge around the informal regional networks of action organizations.

For most of the groups we work with, it seems to require at least four training sessions to cover the main sectors of the research process:

1. Proposal development workshop.
2. Training in the primary tools of qualitative research, including use of computers.
3. When they have collected sufficient field materials, we have a session on data analysis and further computer training.
4. Presentation of results, followed by critique and revision of the products.

### **Closing Remarks**

The sustained effort—over the past 10-12 years—has been a rich learning experience for all of our people, especially as we learned that it takes many years of slow, steady work to transfer and “re-invent” the complex cultural system of social sciences research technology. The Sexual Behavior Research Network, with about 20-25 key members, has taken many years to develop. But this diverse network of people and organizations is the best assurance that a strong foundation

of research and social knowledge will have momentum and can be sustained.

Our team is developing substantial understanding of the complex scripts, cultural beliefs, and action systems of sexuality and sexual behaviors in India. There are now increased contacts with researchers in neighboring countries, particularly Bangladesh and Nepal. Data show there are many different kinds of vulnerable groups in relation to the AIDS epidemic:

1. People involved in commercial sex work are highly exposed to HIV infection and other health risks. The statistics on seroprevalence reported by the National AIDS Control Organization (NACO) show steady, alarming, increases in HIV among sex workers (Hawkes and Santhya 2001).
2. Truckers and other transportation people, along with various categories of migrant workers, are also exposed to high risks. Street children and men who have sex with men (Kulkarni et al. 2000) are highly vulnerable and exceedingly difficult to reach, especially through the usual forms of intervention programs.
3. Many categories of women, especially in low-income, crowded residential areas of the cities, as well as working women in rural areas, are particularly exposed to coercive sexual relations (cf. George and Jaswal 1995; Maitra and Schensul 1999).
4. Systems of arranged marriage, and complex extended family structures, place newly married women into vulnerable positions, especially if their husbands are involved in multipartner sexual relations. Fortunately, the frequencies of extramarital sexual relations in India are not as high as in many other parts of the world.
5. These ground-level data must be linked to the broader macrolevel social, economic, and political environments within which sexual actions take place. This complex of information is essential for developing interventions to prevent a catastrophic spread of the AIDS epidemic. India is an immensely complex field of action. People's sexual behaviors and related actions are affected by cultural concepts, economic relations, political processes, caste structures, and other factors that are significantly different from our Western models.

Although the AIDS epidemic has given a particular direction to the research efforts I have described, the data about sexuality and sexual behaviors have much wider importance. Researchers in the network are paying increased attention to women's empowerment in sexual relations and family life, to domestic violence, and to the broad needs for increased education and information about reproductive and sexual health. If the AIDS epidemic had not happened, the expanded research on sexuality and sexual behaviors would still have great importance for dealing with ongoing changes and developments in Indian (and South Asian) family life and other sociocultural institutions.

I am very proud to accept the Malinowski Award. I am also very proud that a number of my former students—several of whom are here tonight—are in the forefront of the

practical applications programs, in the United States and many other parts of the world, that are the central mission of applied anthropology.

In closing, I will return for a moment to Malinowski, his views of science, and our tasks in anthropology. He wrote: "The minimum definition of science, therefore, implies invariably the existence of general laws, a field for experiment or observation, and last, but not least, a control of academic discourse by practical application" (Malinowski 1960:11). It is that last phrase that deserves our careful attention: "*control of academic discourse by practical application.*"

With Malinowski, we in applied anthropology are constantly concerned with empirical verification of our data, examining and reexamining our data-gathering methodologies; and, then, testing our understanding in the complex, often frustrating real world of practical applications. In seeking empirical knowledge and workable strategies to combat the AIDS epidemic, in South Asia and elsewhere, our applied social science now faces its greatest *agni pariksha*—the Hindu concept of an ultimate "trial by fire."

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