

## **THREE-COUNTRY ASSESSMENT OF ALCOHOL-HIV RELATED POLICY AND PROGRAMMEMATIC RESPONSES IN AFRICA**

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### **ABSTRACT**

The significant role of alcohol in HIV transmission and treatment has not been addressed in Africa. Given the widespread use of alcohol in Africa and its impact on HIV/AIDS, decision makers are now recognizing that action is needed. The authors conducted a situational analysis of the relationships between alcohol and HIV in three sub-Saharan countries: Kenya, Zambia and Rwanda. Key findings emerging from these countries include: the importance of youth as a risk group for harmful use of alcohol and increased HIV risk; the lack of enforcement of laws relating to alcohol leading to increased HIV risk; the central role of traditional and informal alcohol production in alcohol use; the lack of alcohol screening tools in antiretroviral therapy (ART); and the lack of alcohol treatment availability especially linked to voluntary HIV counselling and testing (VCT) and ART.

**KEY WORDS:** alcohol, HIV, policy, Kenya, Zambia, Rwanda

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### **INTRODUCTION**

The association between alcohol use, reduced sexual inhibitions, HIV transmission and individual behaviour has been demonstrated in numerous studies in both the developed and developing world (Cook & Clark, 2005; Klinger, Kapiga, Sam, Aboud, Chen, Ballard, and Larsen,

2006; Markos, 2005; Shaffer, Njeri, Justice, Otero, and Tierney, 2004; Talbot, Kenyon, Moeti, Hsin, Dooley, El-Halabi, and Binkin, 2002; WHO, 2005; Zablotska, Gray, Serwadda, Nalugoda, Kigozi, Sewankambo, Lutalo, Mangen, and Wawer, 2006) Population-based evidence also exists for the link between sexual behaviour and alcohol (Chesson,

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Harrison, and Stall, 2003; Lugalla, Emmelin, Mutembei, Sima, Kwesigabo, Killewo, and Dahlgren, 2004). Alcohol use is particularly problematic among groups that are at increased risk of HIV infection including mobile populations, commercial sex workers and youth (Amayo, 1996, Ao, Sam, Nasenga, Seage and Kapiga, 2006; Madhivanan, Hernandez, Gogate, Stein, Gregorich, Setia, Kumta, Ekstrand et al., 2005; Malta, Bastps. Pereira-Koller, Cunha, Marques and Strathdee, 2005; Seloilwe, 2005; Hoffman, O'Sullivan, Harrison, Dolezal, and Monroe-Wise, 2006; Wechsberg, Luseno, Lam, Parry, and Morojele, 2006). To date, however, HIV prevention programmes have generally overlooked or only marginally addressed this transmission factor. The significance of alcohol and HIV and AIDS programming has recently assumed a measure of interest among public health professionals in Africa, with regard to the role alcohol plays in promoting risky sexual behaviour, accelerating progression to disease, reducing efficacy of HIV treatment, and reducing adherence to drug regimens.

Political and public health leaders in eastern, central and southern Africa are beginning to address the impact of alcohol consumption on HIV and also in relation to economic productivity, household and community security, road safety and overall health. An important step in highlighting the links between alcohol and HIV was a three-day technical meeting held in Dar es Salaam in August 2005 that focused on "Alcohol, HIV Risk Behaviours and Transmission in Africa: Developing Programmes for the United States Emergency Plan for AIDS Relief." Sponsored by the Office of the Global AIDS Coordinator (OGAC), the conference was attended by 80 people from 13 countries. Conference speakers

provided technical updates on alcohol use related to HIV risk behaviours; discussed policies and best practices on effective HIV prevention interventions; and provided information on treatment for alcohol dependence and implications for HIV treatment adherence.

Following the meeting, the East, Central and Southern Africa (ECSA) Health Community Secretariat, with funding from the United States Agency for International Development (USAID)/East Africa (formerly the Regional Economic Development Services Office [REDSO]) of the U.S. Agency for International Development, commissioned a review of the impact of alcohol on health, HIV transmission, HIV disease progression and treatment compliance and efficacy.

The review demonstrated that alcohol influences high risk behaviour, such as unprotected casual and indiscriminate sex, sex with commercial sex workers (CSWs) and unprotected sex with multiple partners. In addition, alcohol consumption is highest in poor communities where potent home-brewed alcohol, such as *mnazi* in Coast Province, Kenya, is cheap and readily available. Quality control is weak, meaning alcohol content can at times be dangerously high. Some local government authorities regulate production of home-brewed alcohol as well as drinking age but regulations are often un-enforced.

Several studies have demonstrated that alcohol consumption can reduce drug compliance and efficacy, harming the patient and breeding drug-resistant strains of HIV. (Aweeka, Lizak, Karan, et al, 2003; Braithwaite, McGinnis, Conigliaro, Maisto, Crystal, Day, et al, 2005; Kresina, Flexner, Sinclair, Correia, Stapleton, Adeniyi-Jones, Cargill and Cheever, 2002; Mugisha, and Zulu, 2004) Alcohol can further suppress the immune system

of HIV-infected individuals, which might speed the onset or exacerbate the pathology of AIDS and related illnesses. Governments in the region have limited infrastructure to provide antiretroviral therapy (ART) and related services and cannot afford to waste limited treatment slots.

The review also described the role of formal sector alcohol producers in the region. Producers spend significant sums on advertising, positioning alcohol as essential to an enjoyable, well-rounded lifestyle. While the alcohol lobby funds some social campaigns, such as responsible drinking campaigns, they rarely draw sharp connections between alcohol consumption and domestic violence, HIV transmission and other negative consequences. Health advocates do not have the resources to effectively counteract media that glamorizes alcohol.

Finally, alcohol-treatment programmes in developing countries are generally scarce or non-existent. There is an absence of clear national health policies related to the role of alcohol in HIV/AIDS prevention, care, support and treatment and there are no consistent national strategies or protocols relating to prospective ART patients who are heavy alcohol users or abusers.

These findings and related topics were summarized in a policy paper developed by ECSA and presented to the 42<sup>nd</sup> Regional Health Ministers Conference in Mombasa, Kenya, in February, 2006. The paper resulted in the passage of a resolution recognizing that an effective response to the HIV/AIDS epidemic must address the underlying social factors that drive risk behaviour. The resolution expressed concern about the high percentage of people, including youth, who turn to alcohol to deal with societal and poverty-related stress. It noted that excessive alcohol use increases

vulnerability to HIV transmission, reduces the efficacy of HIV medicines and reduces drug compliance. The ministers urged the member states to put issues related to alcohol in their national HIV/AIDS strategies and ensure that appropriate alcohol and HIV/AIDS policies and programmes are in place. They endorsed the appointment of national technical working groups to spearhead the implementation of alcohol and HIV/AIDS programmes.

The resolution requested a situational analysis on policies, programmes and legal frameworks in member countries selected to represent the three regions of the secretariat. The ECSA secretariat, with technical and financial support from USAID East Africa through Family Health International, conducted a three country assessment in Rwanda, Kenya and Zambia to validate the observations and findings of the desk review and gather information on the availability of alcohol and HIV/AIDS policies, programmes, needs and gaps in these three countries. These countries were selected because they were representative of different regions in the ECSA regions and demonstrated willingness to participate in the assessment. All three countries have generalized HIV epidemics of varying intensities. The epidemic in these countries is primarily driven by unprotected heterosexual sex. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), in Zambia the adult male prevalence is 3.6-11.9%, female 4.0-13.6%, while in Rwanda the prevalence is 0.7-0.8% and 1.9-2.0%, Kenya 0.7-0.8% and 4.5-6.0% respectively. (UNAIDS, 2006) The discordance between males and female prevalence is an important feature of the HIV epidemic in sub-Saharan Africa. The alcohol consumption in these countries according to the World Health Organization

(WHO) Global Status Report on Alcohol varies from approximately 5 litres per capita in Rwanda, 2.5 litres in Zambia to 1.75 litres in Kenya. (WHO, 2005) These figures do not include unrecorded alcohol consumption which, according to expert opinion, varies from 5 litres per capita in Kenya, 4.3 litres in Rwanda to 1.0 litre in Zambia although no quantitative data exists for this important source of alcohol in sub-Saharan Africa.

This paper describes the methodology and results of the assessment and a discussion on the way forward.

### **METHOD**

A descriptive study using qualitative data collection methods, including focus group discussions (FGD), key informant interviews (KI) and literature review was undertaken. A team of consultants with expertise in the areas of epidemiology, prevention and treatment of HIV/AIDS, public health policy in Africa and substance abuse conducted the assessment. The process of the study in each country included coordination with Ministry of Health officials, the national AIDS control body, and related stakeholders. FGDs and KI interviews with stakeholders and community members were completed by the consultant team over 14 consecutive days.

In each country, a review of existing country legislation and policy was undertaken through inquiry of public sector, private sector, civil society and faith-based organisations. National and local epidemiological studies or other studies that addressed the impact of alcohol on the transmission or treatment of HIV/AIDS were reviewed. In addition, a Medline search was carried out for relevant scientific literature, using keywords such as alcohol, HIV, Africa, and risk factors. Selected experts and all

participants in FGDs and KIs also were asked for unpublished and other literature.

FGDs and KI interviews also were conducted in each of the three countries. A semi-structured guide was used to ask general questions about culture, programmes, policies, existing data and strategies around alcohol and HIV. Focus groups discussions were used to gather information from a broad cross section of stakeholder groups in the areas of research, monitoring and evaluation, prevention, treatment, civil society, gender, private sector, and public sector. Discussions were undertaken with groups of 8 - 12 individuals representing stakeholders in the areas of HIV and/or alcohol. Community members, including persons living with HIV/AIDS (PLWHAs) were also included. These discussions were organized by topic areas, including HIV prevention, gender and domestic violence, public sector responses, civil society responses, HIV treatment and care of AIDS patients, and alcohol treatment.

Key informant interviews were used to triangulate information obtained from focus groups and to allow relevant individuals to elaborate upon key themes. Interviews were undertaken with specific stakeholders selected for their strategic positions or special areas of expertise. Key informants were identified by the consultants and, in each country, included policy makers from the public and private sectors, and from civil society.

In addition, site visits took place in each country to locations where the nexus of alcohol use and risky sexual behaviour were felt to predominate. Observed sites were selected by stakeholders and local experts. Site visits usually lasted one to two days for each location. Onsite KI interviews and FGDs were undertaken where feasible. Groups and individuals interviewed included PLWAs, purveyors

of traditional alcohol, providers of ART, mobile populations, youth, women, alcohol treatment providers, peer educators, community members and HIV prevention specialists.

## RESULTS

### *Legislation, policy and taxation*

Table 1 shows the presence or absence of legislation in each of the three countries on operating hours for drinking establishments and legal age of consumption of alcohol. The table also lists any legislation pertinent to the production and sale of traditional alcohol; whether a national policy framework of alcohol exists; whether alcohol is a component of the National HIV Strategic Plan; and whether there are specific alcohol taxes. Documents reviewed included national HIV strategic plans for each country and legislation on alcohol and taxation when present. These

documents are important indicators of the degree of engagement with alcohol and HIV as an issue by the public sector and are frameworks that may be built upon to strengthen national responses. As noted below, legislation and laws are present in all countries but are either outdated or poorly informed. In Rwanda and Zambia legislation largely dates from the colonial era; however, in Kenya some reforms have been instituted to address public health and contemporary issues. An overarching multi-sectoral alcohol policy framework in all countries is absent. Informal alcohol production is poorly regulated and not systematically addressed in any of these countries. With regards to HIV the issue of alcohol has been incorporated into national strategic plans but only in a cursory way and only in relation to behavioural risk. Even here the issue of alcohol is not prioritized and has not resulted in any response to the problem.

**Table 1.** Alcohol legislation, policy and taxation

Policy component	Zambia	Rwanda	Kenya
Existing legislation on opening hours and age of consumption	Present	Present	Present
National policy framework on alcohol	Absent	Absent	Absent
Traditional alcohol legislation existent	Present*	Present*	Present*
Alcohol as component of National HIV Strategic Plan	Present**	Present**	Present**
Differential taxation on alcohol products	Present	Present	Present
	*Legislation exists from colonial era	* Legislation exists from colonial era	*Legislation in draft form, some forms illegal e.g. change
	**Mentioned as risk factor	**Mentioned as risk factor	**Mentioned as risk factor

### *Focus group discussion results*

FGDs and KI interviews were undertaken in the capitals of the three

countries, (Lusaka, Zambia; Kigali, Rwanda; and Nairobi, Kenya) and at other sites. Those included truck stops, border

crossings, geographic areas of intense informal alcohol use, ART sites, and alcohol treatment sites. Results are presented by theme: legislation, policy and

taxation, prevention and treatment, and gender. Table 2 reports the numbers of participants in FGDs and the number of KI interviews conducted in each country.

**Table 2.** Numbers of focus group discussions and key informant interviews in the three countries

Data collection method	Zambia	Rwanda	Kenya
Number of focus groups carried out	8	8	12
Number of participants in focus groups	44	31	86
Key informant interviews	16	8	14

Focus groups were held with stakeholders from research, monitoring and evaluation, prevention, youth, treatment, gender, civil society, and the public sector. PLWHA were incorporated into the KI interviews and FGDs in all three countries where possible. Youth themes and comments have been incorporated into the discussion of other theme areas as there was considerable overlap. The number of private sector stakeholders available was small so they were interviewed as KI and their themes are presented below. Transcripts and notes were reviewed, and key themes and messages identified in relation to the areas of interest.

*Prevention:* Focus groups working in the area of HIV prevention were held in all three countries. Participants included voluntary counselling and testing (VCT) providers, leaders of community-based prevention programmes, national prevention programming representatives from non-government organisations (NGOs) and public sector focal points for prevention. In all three countries these groups emphasized the important role that alcohol plays in the transmission of HIV in their target populations and the need to address misuse of alcohol in the context of prevention activities. Community members questioned in separate FGDs

substantiated these findings. None of the prevention activities described by participants in the focus groups addressed alcohol misuse. Those implementing prevention activities that participated in the FGDs receive no training in the area of substance abuse and have no addiction counselling skills. When hazardous drinkers are identified in any of these programmes there are no referral options for treatment of substance abuse except in the major urban areas in Kenya where limited services exist in the private sector.

Several at risk populations for alcohol misuse and high risk sex were identified in FGDs in Rwanda, Zambia and Kenya. University students, out-of-school youth, mobile populations such as transport workers, CSWs and military and uniformed services were identified as “most at risk populations.” In Kenya men who have sex with men (MSM), intravenous drug users (IDUs) and prisoners were also identified as groups at high risk.

The issue of alcohol misuse and masculinity was emphasized in FGDs in all countries. In Zambia existing research also supports this link. (Haworth,1995). FGD participants report that heavy drinking is expected in men but not women in Kenya, Zambia, and Rwanda. In Rwanda men are expected to consume

large amounts of alcohol but not appear to be intoxicated. Women in Rwanda who are HIV-positive frequently cite alcohol as a risk factor in acquisition of HIV. FGDs indicated that in Kenya gender roles regarding drinking are changing in urban environments such as Nairobi and both men and women are consuming alcohol regularly. This is linked to a shift toward perceived western cultural norms in Kenya which is especially pronounced in youth. In Rwanda where more than 90% of the population is rural this shift has not been pronounced. In Zambia this theme was not emphasized in the FGDs. Both men and women in the three countries who are HIV-positive cite alcohol as a risk factor in acquisition.

Preliminary results from a national study in Kenya looking at alcohol misuse in VCT clients in Kenya demonstrates that there are multiple alcohol related problems relevant to the VCT setting that are not being addressed. (Kiragu & Mackenzie, 2006). VCT facilities in Kenya are not identifying alcohol as an issue in risk counselling nationally and counsellors lack the tools to address the problem. In Rwanda and Zambia VCT providers in the FGDs did identify alcohol as an issue in risk counselling but there are no alcohol treatment referral options for individuals with substance abuse disorders.

*Treatment:* FGDs with ART providers in Rwanda, Zambia and Kenya revealed similar findings. Alcohol problems are generally perceived as minimal in patients receiving ART. Drop out rates due to non-adherence were reported as generally low and even lower as a consequence of alcohol misuse. In all countries there is limited counselling done at intake which addresses the need to abstain from alcohol while in treatment. In Rwanda there are strong community linkages to support

adherence in patients on ART and these linkages may be linked to the low reported rates of alcohol misuse. In Kenya and Zambia there are also community linkages to support adherence in some programmes but not nationally as in Rwanda.

The scope of the problem of alcohol misuse in treatment settings is not clear in Rwanda, Zambia, or Kenya. The FGDs revealed discordance between community feedback and providers of care. There are no existing mechanisms to estimate the actual quantity of alcohol consumption in treatment settings by biological testing and there are strong disincentives for patients on ART to accurately self report alcohol use due to fear of exclusion from treatment. In Kenya FGDs with groups working with PLWAs consistently report that alcohol is used by the majority of patients on ART and anecdotal reports from FGDs in Rwanda and Zambia are consistent with that finding. Another related finding is that even though the epidemic in Africa has affected females in greater numbers there are a disproportionate number of women receiving ART relative to men in these countries. Men are much more likely to engage in hazardous drinking in Kenya, Zambia and Rwanda and are less likely to access health care services. HIV-positive problem drinkers, therefore, are more likely to be men, less likely to access health care services generally and ART specifically. FGDs with treatment providers working in the slums of Nairobi are consistent with this point as they report that problem drinkers are rarely seen in HIV treatment settings even for intake despite the high prevalence of serious drinking in these areas.

There are no services for alcohol linked to HIV treatment settings in

Zambia, Rwanda or Kenya. Where these services are available in the private sector in Kenya there are barriers due to cost and lack of a referral network from HIV treatment facilities to substance abuse treatment.

*Gender:* In addition to the points raised above related to gender issues in prevention and treatment, several other pertinent themes related to gender were raised in both the Kenyan, Zambian and Rwandan FGDs. The civil society groups working with gender all described gender based violence and domestic violence linked to alcohol in all these countries. In Rwanda rape and forced sex was linked closely with alcohol. A common scenario described in many of the FGDs is that of the intoxicated husband returning home and forcefully demanding sex from his wife. Wives are unable to negotiate condom use with HIV-positive intoxicated husbands who often have engaged in unprotected sex under the influence of alcohol. One NGO working with women with HIV/ AIDS pointed out that this scenario comes up repeatedly in dramas created by HIV-positive women which were performed throughout Rwanda as a part of the NGO's intervention to support women living with AIDS.

Other prominent themes from the FGDs in the three countries link female headed households, the promotion of transactional sex, trans-generational sex and the selling of traditional alcohol or home brews. Older single women in both countries are often in desperate economic situations where the only option open to them is to brew traditional alcohol (home brews). When this occurs in their homes male customers may engage in trans-generational sex with their daughters. These informal drinking venues are also areas where CSWs trade sex for money

with male patrons. In Rwanda widows were identified as being significantly affected by alcohol abuse. The problems associated with gender based violence, domestic violence, and forced sex are widespread in the rural areas of Rwanda. Some areas in Kigali, Rwanda are also significantly associated with gender/alcohol related problem. In Kenya the gender based issues described are more significant in certain geographical areas such as fishing villages on Lake Victoria in Western Kenya, slum areas of Nairobi and specific impoverished areas on the Kenyan Coast.

*Public sector stakeholders:* Public sector stakeholders included officials of the Ministries of Agriculture, Health, Defense, Home Affairs, Trade and Commerce, Local Government, Education, Gender, Justice, Finance, Youth, Planning, Internal Affairs, and alcohol related parastatals. The public sector groups in general were aware of alcohol as a risk factor for transmission of HIV; however, they had no specific direction to reshape alcohol policy or strategies to reduce the impact of alcohol on the spread of HIV. The exception is Rwanda, where alcohol was considered in a multi-sectoral way by ministries. The level of public sector engagement in other countries in alcohol as an HIV issue was minimal, especially outside the Ministry of Health. However, in Kenya the prison services had identified substance abuse as a major issue related to behaviour and were looking for tools to address it. The public sector group also identified informal use of alcohol and lack of enforcement of current laws as important issues in the alcohol HIV response in their countries. High risk groups for alcohol abuse identified by these stakeholders included youth, CSWs, mobile populations including transport workers and people in the correctional

system. Stakeholders also identified defense forces and police forces as at risk for alcohol misuse.

*Civil society:* FGDs with civil society organizations were conducted with faith-based organisations (FBOs), NGOs, and community-based organizations (CBOs) in all three countries. These organisations included youth groups, women's groups, multi-faith/single faith organisations, and groups working with marginalised populations. They reported many of the alcohol related problems listed in the sections on gender and prevention. Another finding of civil society FGDs was that women often seek help from their religious leaders and community groups with alcohol problems in their families. These community groups, pastors, priests and imams have no training in substance abuse problems and usually have nowhere to refer individuals seeking their counsel for help in dealing with alcohol issues. Other prominent themes from these FGDs were the prevalence and insidious nature of informal alcohol on the social fabric of the societies and the impact of the lack of law enforcement on these issues. All stakeholders had consensus over the issue of lack of enforcement of laws and pointed to both lack of leadership and in some instances complicity in the law enforcement community.

#### *Key informant interviews*

KI interviews were done in all three countries. Individuals in the public sector, civil society and private sector were interviewed. This included specialists in ART and alcohol abuse. Topics included the cultural setting for alcohol use in the country, perceived drinking patterns and social norms,

sector specific questions about programme responses, policies and strategies on alcohol as it relates to HIV and the sector represented by the KI.

*Prevention:* The KI interviews substantiated the findings of the FGDs. The linkage between alcohol and HIV risk was apparent to all. High risk groups for alcohol abuse identified were youth, mobile populations, CSWs, and the unemployed. Cultural aspects that contributed to behavioural risk included the use of informally produced alcohol and the lack of enforcement of laws regarding opening hours and age limits on sales to minors. The prevention KIs highlighted the need for VCT to serve as an entry point for services designed to reduce the impact of alcohol on HIV transmission. KIs indicated that currently there was little training around these issues except in isolated programmes in select countries.

*Treatment:* Overall, ART interventions pay little attention to alcohol as a factor in adherence and toxicity and KIs were divided on its importance. In general, providers reported that alcohol was not an active issue in ART. In opposition to this view, KIs from the civil society organisations, including those working with women, felt that alcohol was a significant problem that was minimised by beneficiaries of services in discussion with providers. Both groups agreed that some form of screening tool on intake into ART programmes was needed and surveillance for abuse was warranted. Those few alcohol treatment specialists interviewed in the countries felt that ART was being instituted as vertical stand alone programmes and that alcohol related technical expertise where present was not being utilized.

**Table 3.** Summary of key informant interview results

## ALCOHOL-HIV RELATED POLICY

Thematic Areas	Zambia	Rwanda	Kenya
Policy	Some interest at public sector policy level limited to health	Interest at public policy level to deal with issue in a multi-sectoral manner	Interest at the public policy sector level limited to health
Civil Society Engagement	Civil society acknowledges problem and displays willingness to respond	Civil society acknowledges problem and displays willingness to respond	Civil society engaged and involved in response
Availability of Treatment for Alcohol Abuse	Private treatment of alcohol very limited and not linked to HIV ART	Limited private treatment sector for alcohol not engaged or linked to HIV ART	Private treatment sector involved in treatment of alcohol and other substances but not linked to HIV ART
Gender	Gender issues central to alcohol HIV risks	Gender issues central to alcohol HIV risks	Gender issues central to alcohol HIV risks
Enforcement and Regulation	Lack of enforcement of current laws.  Informal sector alcohol production and consumption a major issue in risk behaviours	Lack of enforcement of current laws.  Informal sector alcohol production and consumption a major issue in risk behaviours	Lack of enforcement of current laws.  Informal sector alcohol production and consumption a major issue in risk behaviours

*Gender:* The gender-related KIs in these countries agreed that gender-related violence and associated high risk sexual activity was directly linked to alcohol. KIs reported that cultural determinants related to male roles and drinking patterns underlie these serious behaviours. Rape and domestic abuse were common and related to alcohol. Frequently HIV was an element in this mix of issues. An important theme articulated by KIs in all three countries was that informal alcohol production was done primarily by female headed households as a means of subsistence survival that frequently led to either household commercial sex work or abuse of the children in the household.

*Public sector:* In Zambia there was expressed interest on the part of the public sector informants to engage in policy development and reform around prevention of HIV as it relates to alcohol but this was primarily limited to the

health sector. There was also an acknowledgement of a lack of current effort in this area. In Rwanda this interest was broad based and extended to all public sector participants with acknowledgement of alcohol HIV prevention linkages and concrete plans for multi-sectoral responses. In Kenya the responses were similar to Zambia in terms of recognition of the issues around alcohol and prevention but only health sector interest in intervention and policy reform.

All public sector stakeholders emphasized the importance of youth as a high-risk population; the role of traditional alcohol in this area; and the lack of enforcement of current laws as significant issues in prevention.

*Civil society:* All civil society informants in the three countries saw clear linkages between alcohol and HIV prevention and in all countries were

willing to respond if called upon. This included informants from NGOs, FBOs, and CBOs. They also emphasized the issues of traditional alcohol and the damage this has done to the communities in the three countries as well as the importance of the non-enforcement of current laws and regulations.

*Private sector:* The private commercial sector did not express interest in any of these countries in engaging in multi-sectoral responses and did not highlight the linkage between high risk behaviour and alcohol. In the private medical sector there was engagement over the issue of treatment of alcohol in Kenya but this was lacking in the other two countries.

## DISCUSSION

In addressing the prevention and treatment of HIV, it is essential to acknowledge and define the underlying core determinants for transmission and effective treatment. Alcohol has increasingly been recognised as a driving force in transmission related to risky sexual behaviours and the dangers of alcohol use in ART are well known in the developed world. Twin challenges facing policy and decision makers in developing countries involve how to respond to alcohol use in HIV care and prevention. This assessment validated many of the preconceptions that have been expressed both at the policy and operational level in the selected countries. The results of this assessment are also consistent with the range of concerns presented by the ECSA Secretariat to the 42<sup>nd</sup> Health Ministers Conference in Mombasa, Kenya, in February 2006 and with the resolutions passed by the Health Ministers at that meeting.

### *Policy, Legislative and Regulatory Issues*

Currently at the policy, legislative

and regulatory level there is an existing alcohol policy framework in all three countries but not that specifically address the linkage with HIV. The existing legal frameworks for alcohol in Zambia and Rwanda date from colonial times and in Kenya are of more recent origin. Specific legislation regulating hours of operation of retail outlets and bars is present in all these countries and uniformly limits sale of alcohol to comparatively short times of operation. Traditional alcohol is regulated in Zambia and certain forms of traditional alcohol are outlawed in Rwanda and Kenya. No country has an integrated alcohol policy that incorporates the various sectors involved in its consumption, regulation and consequences. Alcohol is mentioned in the HIV plans of all three countries but only as a passing reference to HIV prevention and behaviour.

A serious area of concern articulated by all stakeholders in FGDs and KI interviews was the nearly complete lack of enforcement of existing regulation and laws in the three countries. This is particularly true of laws regulating the opening hours for selling alcohol and the legal age required to purchase alcohol products. The magnitude and consequence of this lack of enforcement differed by country but certain elements were common in all three countries. These were: the undermining of social order and regard for law that followed from widespread disregard for alcohol-related regulation, the access to alcohol in all three societies at any time of day or night and the widespread and misuse of potent forms of traditional alcohol that also were the least expensive alcoholic beverages available in the marketplace. This last point is particularly relevant to the linkage between hazardous drinking and risky sex as inexpensive home brews are consumed by impoverished

populations where higher prevalence rates of HIV and more limited understanding of HIV prevention practices are predominant. This issue of informal alcohol production and links to high risk sexual activities was raised by all FGDs and KIs.

### *Prevention issues*

With regards to HIV prevention, all three countries acknowledge the link between alcohol and HIV in their HIV strategic plans, in particular, alcohol-related behavioural changes predisposing individuals to high risk sexual interaction. However, there is no systematic incorporation of alcohol or substance abuse control as a strategy in the HIV response and it is not seen as a cross-cutting issue by policy makers in their existing documentation of approaches to the HIV epidemic in these three countries. This is especially true in Kenya and Zambia where FGDs and KI interviews among public sector participants demonstrated the absence of any such approach. In Rwanda there was the beginning of a cross ministry policy at the public sector level but this was in its infancy. More specifically the link between alcohol and VCT as the entry point into alcohol interventions and risk reduction has not been developed in any of the countries. In the FGDs and KI interviews drinking alcohol was frequently cited by groups involved with those having had high-risk exposure as the behaviour that put them at risk. In Kenya some isolated programmes have incorporated alcohol into their VCT approach and used the VCT encounter as an opportunity to address identification of alcohol misuse. Also in Kenya there was an attempt at a public media campaign linking alcohol use and high-risk behaviour but this was aborted due to alcohol industry pressure. No country had

a general public health campaign targeting alcohol misuse but all had national alcohol promotion advertising linked to national brewers and other related industries.

### *HIV treatment issues*

In terms of HIV treatment the linkages and framework for alcohol interventions were weaker than those for prevention. As mentioned, none of the three HIV strategic plans linked the idea of alcohol control or use and treatment of HIV. All HIV treatment programmes addressed alcohol in their national programmes but this typically took the approach of being mentioned in ARV uptake and rarely mentioned after this. From the discussions and document survey no national HIV programme had a screening tool or method for quantification of alcohol use either on ARV intake or follow-up. Not surprisingly no programme visited or treatment provider interviewed had recorded significant alcohol misuse. But the beneficiaries of treatment, both PLWAs and civil society groups working with them, identified alcohol misuse as prevalent among those on ARTs. The lack of disclosure of alcohol use between clients and providers is likely the reason for this, as one KI from a women's PLWHAs group stated, "they are scared that if they disclose alcohol use to their providers they will be removed from their ART." In all countries this was identified as an issue but it was especially evident in Kenya.

### *Treatment for alcohol-related problems*

Only Kenya had significant treatment options for alcohol abuse and dependence. Both Zambia and Rwanda have both a paucity of qualified substance abuse professionals and a lack of support services. In Kenya treatment

professionals are concentrated in the urban areas and are in the private fee for service sector. Also there is a notable absence of linkage between existing ARV therapeutic responses and alcohol treatment where these are present. This theme was constant across the countries, where technical support for alcohol interventions are present there is no structure or linkage for this to be implemented in the HIV prevention or treatment arenas.

### *Gender*

An important cross-cutting issue in all three countries is the gender aspect of alcohol as it impacts on HIV. In these countries alcohol consumption was generally seen by the participants as a male dominated recreational activity and this remains the case in all but a few exceptions. These exceptions are female sex workers who use alcohol extensively and urban youth in countries such as Kenya where the assimilation of modified Western values regarding alcohol is becoming increasingly common. All stakeholders in FGDs and KI interviews expressed linkages between sexual and gender violence and alcohol. These behaviours were also linked to high-risk sexual behaviours and non-use of condoms. The issues of forced sex, rape and linkages to unprotected sex are clearly a part of the alcohol problem in these countries as has been recently demonstrated. (Kiene et al., 2006)

There is clearly a need for a multi-sectoral approach to the issue of alcohol and HIV in this sample of sub-Saharan African countries and likely the whole region. This includes roles for civil society and especially faith-based groups, local government and police in addressing this issue at the grass roots level. Also needed are updated legal and policy frameworks that acknowledge the public

health significance of alcohol in HIV transmission and treatment. Most important is the enforcement of these laws and regulations so compliance with the law becomes the normative behaviour in these societies. Linked to this is the regulation and formalizing of traditional alcohol so that misuse of this form of intoxicant can be reduced.

The mainstreaming of alcohol misuse identification and alcohol education into VCT and other interventions is an important preliminary step toward development of alcohol services within HIV prevention activities. With regard to HIV treatment the incorporation of screening and monitoring tools and systems for problem identification in follow-up care are obvious next steps. Treatment interventions for alcohol should be included in the national HIV treatment campaigns and expertise on alcohol treatment made available in the public sector of each of these countries. In all these areas there is a need to identify, evaluate and disseminate any current best practice in the area and start pilot interventions based on best practices.

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