

**THE DEVELOPMENT OF A METHODOLOGY TO STUDY FACTORS RELATED
TO RISKY SEXUAL BEHAVIOUR AMONG ALCOHOL USERS IN DIVERSE
CULTURAL SETTINGS:**

**CONCEPTUAL FRAMEWORK AND INSTRUMENTS FOR QUALITATIVE AND
QUANTITATIVE RESEARCH ON ALCOHOL USE-RELATED SEXUAL RISK
BEHAVIOUR IN SOUTH AFRICA**

**Report prepared for the Department of Mental Health and Substance
Dependence, World Health Organization, Geneva, Switzerland**

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EXECUTIVE SUMMARY

This report describes a World Health Organization (WHO)-initiated and funded project that was conducted in South Africa to investigate and develop a methodology for studying alcohol-related sexual risk behaviour.

The project had four phases. Phase 1 involved a review of published and unpublished literature to determine the nature of empirical understanding of alcohol use, HIV risk factors, and alcohol-related sexual risk behaviour. In Phase 2 qualitative assessments were conducted involving key informant interviews, observations in drinking venues, focus groups and in-depth interviews. In Phase 3 a questionnaire was developed. It included measures of alcohol use, sexual risk behaviour and various demographic, economic, community, cultural and individual-level variables which were revealed by the qualitative assessments to be likely predictors of alcohol-related sexual risk behaviour. This instrument was pilot-tested in a mini-survey of 160 adults in Phase 4. Adults in the age group 25-44 years are the age group most involved in 'risky drinking' in South Africa, and along with their partners and other members of two township and one city site in Gauteng province, made up the target populations for the various investigations conducted in the project.

Each stage of the project built upon a previous stage and provided unique insights into the nature of alcohol use and sexual risk behaviour. The key findings were as follows:

- Alcohol use was fairly widespread among adults in the 25-44 year age group. Although less likely to drink, females were slightly more involved in 'risky drinking' (when defined for males and females as 5 or more or 3 or more standard drinks per day, respectively). The abuse of alcohol seemed to have economic, societal, community, familial and intra-personal origins, although alcohol consumption is primarily a social behaviour, with numerous negative consequences.
- Many gender differences in relation to sexuality were in evidence. Males were more likely to have casual and younger sexual partners, and to use condoms. Females were more likely to have much older partners and to endorse the view that sexual intercourse is 'safer' with older men.
- Levels of access to condoms and knowledge about risks of HIV infection due to multiple sexual partnering were relatively high, but levels of condom use were not always commensurate with this knowledge. Condom use was more common and personally and culturally acceptable with a casual rather than a regular partner.
- Sexual risk behaviour was identified as one of the consequences of heavy drinking. Those who drank more often, larger quantities, and had been referred to by others as problem drinkers were those who tended to have a greater number of sexual partners and more sexual encounters that they had regretted. The alcohol-induced changes in feelings and behaviour that were likely causes of this increased sexual involvement were increased sexual arousal and desire, reduced inhibitions, and a reduced sense of responsibility for the behaviours that were performed.
- The correlations between various alcohol use variables and condom use that emerged from the mini-survey were not statistically significant. Similarly, some participants in the qualitative assessments reported on the lack of a detrimental effect of alcohol use on their condom use behaviours. Relatively few drinkers reported that drinking reduced their control and ability to engage in protective behaviours in sexual situations. Those who were most likely to be so affected were those with the least commitment to protecting themselves by using condoms in the first place.

The research suggests that attempts to address alcohol-related sexual risk behaviour should seek to reduce (a) heavy consumption of alcohol, and (b) levels of sexual risk behaviour. Interventions should be comprehensive and target societal, community, contextual, family and individual precursors of alcohol use and sexual risk behaviour. The interventions should reduce opportunities and demand for the behaviours, while at the same time also providing treatment and for those already involved in problem drinking and/or sexual risk behaviour.

BACKGROUND

Alcohol misuse and sexual risk behaviour pose major problems in communities around the globe. The World Health Organisation's Department of Mental Health and Substance Dependence has acknowledged the importance of investigating factors associated with the rising tide of HIV/AIDS particularly in developing countries and countries undergoing socio-economic transition. It has commissioned and funded a number of projects to contribute to developing a methodology for studying factors related to risky sexual behaviour among alcohol users in diverse cultural settings. The project's shorter-term goals include concept clarification and item generation, while in the longer term its findings will be useful for informing interventions and policies for curtailing sexual risk behaviour among alcohol-using individuals.

This report describes the project conducted in South Africa, involving four separate phases, namely: (1) a literature review to determine the nature and extent of empirical understanding of alcohol use, HIV risk factors, and alcohol-related sexual risk behaviour; (2) qualitative assessments to gain better understanding of the factors underlying alcohol-related sexual risk behaviour; (3) the design of a questionnaire; and (4) a mini-survey to test the questionnaire developed from the findings of the qualitative assessments. The key methods, procedures and findings of Phases 1 and 2 are summarised in the following section. This is followed by a detailed description and discussion of the development of the questionnaire (Phase 3), and the methods and findings of the mini-survey (Phase 4). The report concludes with a general discussion of: (a) how the project has enhanced understanding of the nature of alcohol-related sexual risk behaviour in South Africa, and (b) the nature of interventions that can potentially be developed to reduce HIV-related sexual risk behaviour among alcohol-using populations in South Africa.

PHASE 1: LITERATURE REVIEW

The literature review revealed that there have been a substantial number of studies on HIV/AIDS and sexual risk behaviour, a fair number of studies on alcohol use and misuse, but very few studies on the links between alcohol use and sexual risk behaviour in South Africa. It found that alcohol use is widespread in South Africa, occurring among all population groups, and among males more than females. Alcohol consumption is more common among urban than rural people, although people based in rural areas seem to be more inclined to drink at risky levels when they do drink. Numerous socio-economic factors perpetuate the production, availability and consumption of alcohol in South Africa including working conditions on wine farms and in the mines, and the job opportunities that alcohol production and distribution can provide. Prevailing societal norms and attitudes favour alcohol consumption. Across the country alcoholic beverages are very readily available from both licensed and unlicensed establishments. More research is needed at a national level on patterns of alcohol consumption among various sub-groups in South Africa.

Regarding HIV and other STIs, the review pointed to the rapid increase in the rate of HIV infection since 1990, and indicated that HIV and STI rates in South Africa are currently among the highest in the world. HIV transmission occurs primarily as a result of unprotected heterosexual sex. The main 'at-risk' groups include women in their twenties, residents of provinces with higher HIV prevalence rates, miners and other migrant workers and sex workers. Inter-provincial differences in HIV rates stem primarily from poverty levels and migration patterns. Levels of HIV-related knowledge are extremely high among most groups studied, but the translation of knowledge into practise is far from optimal. Condom use is generally uncommon and inconsistent, and many women are not sufficiently empowered to negotiate safe sex and/or fear the repercussions that may arise from such attempts.

There is a growing, but limited, body of literature on the sexual practises and behaviour of young people in South Africa, but a paucity of research about more common sexual behaviour of the adult population. HIV prevalence data are based on the annual survey of

public antenatal clinic attendees; a group that is not representative of the greater population. There is still a lack of accurate information about the HIV prevalence rates of men, and the rest of the population who are not well represented by women attending public antenatal clinics.

There has been very little research on the links between sexual behaviour and alcohol use in South Africa. Most studies have focused on adolescents or youth in educational settings. The studies have been limited to cross-sectional and correlational designs. In the main they have examined the relationship between alcohol use (including the use of other drugs) and sexual behaviour, the use of condoms, and other forms of contraception. One study has investigated the link between alcohol consumption and HIV status among arrestees. The research shows that alcohol use is consistently associated with the number of sexual partners people have, but less consistently associated with engagement in unprotected sex. The research in this area fails to examine potential causes of the links between alcohol use and sexual behaviour. In addition the correlational studies use somewhat different methodologies and hence preclude meaningful comparisons between findings.

In summary, it was revealed that:

1. Alcohol use, HIV-related sexual risk behaviours and HIV are growing problems that affect many sectors of the community in South Africa.
2. Adolescents and youth are particularly affected by both alcohol problems (and particularly binge drinking) and the HIV pandemic.
3. HIV-related knowledge is widespread, but people do not have the skills required to protect themselves from HIV exposure and infection.
4. Women's lack of empowerment is at the heart of their inability to prevent exposure to HIV.
5. The role of alcohol consumption in sexual behaviour is not well understood.

It was concluded that much needs to be done to clarify the determinants of the use and misuse of alcohol, whether alcohol consumption relates to sexual behaviour, and the factors that account for the relationship between the two behaviours. It is also essential to understand the individual/personality, family, community, and broader societal factors that determine people's sexual and alcohol use behaviours. Current research should be augmented by the use of new methodologies rather than simple correlational analyses. Alcohol consumption may play a role in sexual risk behaviour, but this may be the case only for those who drink at all, those who drink at risky levels, or those who binge drink. Ethnographic and exploratory research is a useful route through which such understanding can begin to be realised.

PHASE 2: QUALITATIVE ASSESSMENTS

Guided by the information gathered from the literature review, the project was conducted to explore and better understand the factors that underlie the relationship between alcohol use and risky sexual behaviour. It was decided that the assessments would concern alcohol use and misuse among adults in the general population and that the sexual risk behaviours to be studied would include unprotected sexual intercourse, unplanned sexual intercourse, and sexual intercourse with multiple partners. We acknowledged that people have sexual intercourse with a myriad of different types of partners, and that perceptions about various aspects of sexual intercourse may vary depending on the type of partner.

This phase of the project involved the use of four qualitative assessments: (a) key informant interviews; (b) observations; (c) focus group discussions; and (d) in-depth interviews. Qualitative methods have the advantage of yielding valid and culturally relevant information, and can be used directly for designing prevention and other intervention strategies.

Objectives of the research

Primary objectives

1. To determine the social, psychological, economic, cultural, contextual and gender-related factors that increase alcohol-related sexual risk behaviour.
2. To determine the social, psychological, economic, cultural, contextual and gender-related factors that protect against alcohol-related sexual risk behaviour.

Secondary objectives

1. To explore collective cultural views that pertain to alcohol use and misuse and sexual risk behaviour.
2. To determine communication patterns and language used when referring to alcohol-related sexual risk behaviours.
3. To develop a conceptual framework to describe and explain the phenomenon of alcohol-related sexual risk behaviour.

Methods

Target population

The target population for the study included men and women between the age of 25 and 44 years since adults within this age are more likely than those in other age groups to engage in weekend 'risky drinking' according to the 1998 Demographic and Health Survey (Department of Health, 2002). Weekend 'risky drinking' is defined as the consumption of at least five, or at least three, alcoholic drinks per day during the weekends for males and females, respectively.

Study sites

The study activities were conducted in two comparison sites: (a) a township area on the outskirts of Pretoria, and (b) a suburb within the boundaries of the city of Pretoria. The town site is a racially and socio-economically mixed area inhabited by approximately 23,200 people. Most residents are single, of varied income levels, and owing to the numerous tertiary educational institutions in the area, many university and college students also live in the area. Statistics from the local police services obtained in December 2002 indicated that this area, known for many liquor outlets, had more than 250 such outlets. Recreational facilities are very few in this area, and consist primarily of small parks.

Mainly black African families inhabit the township site. The population of the township site was 174,565 in 1996 (Statistics South Africa, 1996), and more recently has been estimated to be between 250,000 and 300,000. The area has 340 liquor outlets, and its few recreational facilities consist of community halls, parks where music/jazz festivals are held, and sports grounds.

Community Advisory Board (CAB)

In order to ensure the cultural appropriateness of the research approaches and measures employed and to increase the chances that the project's findings would be applied in intervention development, we formed a Community Advisory Board (CAB). Members of the CAB were stakeholders who are familiar with and provide services for alcohol and/or sexual behaviour problems in the research sites. They attended regular meetings to learn about and guide the research process, and reviewed proposed methods and approaches for each of

the stages of the qualitative assessments.

Research Team

Fieldworkers who were trained by the research team, along with members of the research team, collected the research information. The research materials were available in English and translated by the fieldworkers into the main local languages (i.e. seTswana, sePedi which was formerly known as Northern Sotho, and isiZulu), where necessary.

Ethical Issues

During all the phases of the study informed consent was obtained from participants, using consent forms. The research was approved by the Ethics Committee of the Faculty of Health Sciences of the University of Pretoria.

The following sections describe the methods employed in each qualitative assessment.

Assessment Approach 1: Key informant interviews

A total of 18 key informants were interviewed: 11 in the city site and 7 in the township. They comprised individuals who had in-depth knowledge of the target population. The key informant interviews were conducted in order to: (i) refine the research questions; (ii) identify appropriate venues at which to conduct observations; (iii) generate initial hypotheses regarding the alcohol use-sexual behaviour links; and (iv) identify social and cultural contexts of risk behaviour. The interviews were conducted by members of the research team who asked the key informants open-ended questions on their perceptions of the nature of alcohol use and sexual risk behaviour among communities residing in the target sites. The key informants were also asked to suggest places at which useful observations could be conducted. A copy of the interview schedule used can be seen in Appendix A. The interviews lasted for between approximately 45 minutes and one hour. Informed consent was obtained from each key informant.

Assessment Approach 2: Observations

After completing the key informant interviews the observations were started. Their main purpose was to gather information based on observed behaviour and to hopefully corroborate the findings of the key informant interviews. The venues at which to conduct the observations were identified by the CAB members and key informants. The observations were conducted in four venues in the city site (bars) and three venues in the township (shebeens and taverns). Each venue was visited twice, once during the late afternoon, and once late at night for between two and four hours per visit. The fieldworkers discussed their observations at meetings amongst themselves, and subsequently, with the research team and CAB members. The observations took place only after informed consent had been obtained from the owners of the venues. A list of the target behaviours to observe can be seen in Appendix B.

Assessment Approach 3: Focus group discussions

The primary purpose of the focus group discussions was to determine group norms and behaviour pertaining to alcohol use and sexual risk behaviour. Three focus groups were conducted in the city site and consisted of (1) younger male 'risky drinkers', (2) younger female 'risky drinkers', and (3) male partners of 'risky drinkers'. The focus groups that were conducted in the township included (1) older female 'risky drinkers', (2) older male 'risky drinkers', and (3) female partners of 'risky drinkers'. The criteria used to determine 'risky drinkers' were consumption of more than five drinks per day for males and more than three drinks per day for females during some or all weekends within the previous twelve months. Each group consisted of between 8 and 10 participants. The main themes of the discussions

were alcohol use, sexual behaviour and the links between alcohol use and sexual behaviour. A copy of the main focus group questions can be seen in Appendix C. The focus group sessions lasted for between one hour and ninety minutes. Each group member provided informed consent prior to participation in the discussions.

Approach 4: In-depth interviews

Sixteen people were interviewed, eight of whom were based in each of the study sites. They were grouped into (a) male partners of female 'risky drinkers', (b) male 'risky drinkers', (c) female partners of male 'risky drinkers', and (d) female 'risky drinkers'. The aim of these interviews was to elicit the views of members of the target population on issues related to alcohol use and sexual risk behaviour. The interviews were open-ended. A copy of the questions asked during the interviews can be seen in Appendix D. The interviews were conducted in private by the fieldworkers, and lasted for between 40 minutes and one hour. Each interviewee provided informed consent for participation.

Key results

Key informant interviews

The key informants in both sites reported that alcohol abuse is widespread, and drinking occurs openly, and often in combination with the use of other drugs. They reported that drinking has serious negative effects on the community and society, but also acknowledged that alcohol is often drunk in moderation. The key informants were of the opinion that alcohol abuse is a key determinant of people's engagement in violent and risky sexual behaviours. They also reported that sexual risk behaviour and the use of various illicit drugs occur in many drinking venues, with such behaviours being condoned by the owners of the venues.

The key informant interviews enabled us to refine the questions and research approaches intended for subsequent assessments and directed us to appropriate venues for conducting the observations for the second stage of the research. However, the main weakness of this approach was that it elicited perceptions about behaviours from people who were not necessarily involved in those behaviours themselves.

Observations

The observations corroborated many of the findings of the key informant interviews. They suggested that alcohol is used heavily in drinking venues, and that such drinking was conducive to risky sexual behaviour. In some venues visited in the city site, sexual behaviour occurred openly, without apparent concern about such open displays among those who engaged in the behaviours, and those around them. It was also observed that the sexual behaviours became more explicit as more alcohol was consumed. Individuals who were observed engaging in sexual intercourse in these venues seemed to be in casual or commercial sexual relationships with each other.

There was little evidence of safer sex practises occurring. Possibly for economic reasons, or due to a lack of concern for the patrons, the owners of the venues seemed to do little about protecting the health and safety of their patrons. Many of the venues which were visited were unhygienic and in some of them various risk behaviours were practised by the patrons themselves.

The observations in the drinking venues in the township did not reveal that people engaged in sexual activities openly. This method was not as useful for obtaining detailed information about sexual behaviour among people in the drinking venues in the township, as it was for the city site.

Focus groups

The focus group participants' discussions suggested that rates of alcohol use and abuse in the two sites are very high. It was felt that people drink alcohol for a range of reasons including a lack of alternatives, to pass the time, personal problems, and to relieve stress. Reportedly, the heavy use of alcohol is also facilitated by social acceptance of heavy drinking, and very easy access to alcohol in the two communities.

The discussants suggested that alcohol use can be related to risky sexual behaviour, reporting that it was easier to have sexual intercourse if one wanted to after one had been drinking, than when one was sober. For example, drinking with a member of the opposite sex to whom one was attracted would help to increase rapport and intimacy between the two parties, and eventually facilitated compliance with sexual propositions.

Other reasons for the link between alcohol use and sexual behaviour emerged. The focus group respondents further reported that alcohol consumption stimulates sexual arousal and desire, and reduced inhibitions, which were enhanced further by the drinking environment. Also, they stated that after drinking alcohol people become more inclined to engage in sexual acts that they would not ordinarily find appropriate, such as engagement in sex with casual partners, in awkward locations, and at times and places that they would normally consider to be unacceptable.

The respondents seemed to be well aware of the differences between safe sex and unsafe sex but generally did not practise safe sex. Casual sex seemed to be fairly common and accepted particularly among the men.

In general, the males did not accept heavy drinking by their female partners. In contrast, the women were inclined to report that they did not object to or in some cases were in favour of their male partners' heavy drinking. Such alcohol use sometimes resulted in violent behaviour among partners. Men reported preferring to accompany only casual partners to the drinking venues, if they went along with their partners at all. Feelings of lack of control over their partners' behaviour were expressed particularly by the men. Women seemed to be more accepting of a lack of control in their relationships.

Some women reported that their male partners were more likely to force them to have sexual intercourse when those males were under the influence of alcohol than when they were sober. For their part, women wanted to please their partners sexually, so they were not likely to resist strongly some of these unwanted requests by regular or casual partners. In fact, some women reported on their use of various measures to increase their partners' sexual satisfaction, and a few of them reported using drying agents to tighten their vaginas before engaging in sexual intercourse.

Some men, on the other hand, appeared to be more self-serving in their behaviour. They seemed to be more concerned about their own sexual gratification than that of their partners. The use of alcohol for them seemed to enhance the extent to which they were self-serving in their sexual relationships such that they considered less the sexual needs of or their obligations to remain faithful to their sexual partners.

In-depth interviews

A number of key themes emerged from the in-depth interviews. The results corroborated the findings of previous stages of the project and particularly those pertaining to community patterns of alcohol use.

The in-depth interviews provided, for the first time, some insight into people's motivations for their various behaviours. For example, for the first time we learned that many of those who abused alcohol had had very traumatic life experiences. We also learned that many

individuals would drink due to personal problems and such drinking often served as a buffer for stress. The main types of problems mentioned included being in abusive relationships (familial and spousal), lacking gainful employment, and lacking alternatives to drinking. The findings also indicated that alcohol consumption had numerous negative consequences including increasing the likelihood that individuals would engage in risky sexual behaviour.

Some of the interviewees reported that they would deliberately drink alcohol and visit venues in which they could be guaranteed a meeting with a person with whom they could have sexual intercourse. They agreed that there was a link between alcohol use and sexual behaviour.

Violence seemed to be a strong feature of many relationships. This included violence in current relationships and in previous relationships. The results also indicated that women would sometimes remain in unsatisfactory relationships for financial reasons.

The results revealed that condoms were seldom used and that people rarely engaged in safe sex practices. People continued to engage in risky sexual behaviour despite the risks and many of them seem to be more inclined to take risks when drinking. However, the participants seemed to have a very good understanding of safer sex, which went beyond mere condom use to include being limited to one sexual partner.

Overall, the results suggested that there was an urgent need for intervention among many people in the two communities. In particular, there is a strong need for counselling and therapy services for people whose drinking was attributed by themselves to a history of serious personal problems, trauma and various situations of abuse.

Discussion

From all the methods used it became apparent that alcohol use was widespread, occurred in large quantities, and gave rise to numerous problems. The main risk factors for increased consumption included community acceptance of alcohol use; availability of alcohol; easy access to alcohol; alcohol industry marketing/advertising of alcoholic beverages; family problems; social problems; lack of employment; and a lack of recreational opportunities.

With respect to sex and sexuality the findings revealed high levels of acceptance of and engagement in multiple sexual relations; low levels of condom use but fairly high levels of knowledge about safe sex, HIV/AIDS and STIs. In addition, very high levels of violence were a feature of most relationships. The main factors related to alcohol use and sexual risk behaviour in all the groups studied are shown in Table 1.

Table 1. Identified factors that relate to alcohol use and sexual risk behaviour

	Alcohol use	Sexual risk behaviour
Economic	Lack of employment opportunities; lack of empowerment regarding self-development	Lack of economic opportunities
Cultural/ Societal	Acceptance of alcohol use	Subordinate position of women; acceptability of multiple partnering; lack of acceptance of condom use
Community	Lack of recreational facilities; acceptance of alcohol use; availability of alcohol and drinking venues	Lack of recreational facilities; lack of availability of free condoms; lack of acceptance of condom use
Peer group	Acceptance of and engagement in alcohol use	Acceptance of and engagement in risky sexual behaviour
Family (inter-personal)	History of abuse; poor relationships	History of abuse; poor relationships; partner's attitudes to condom use and multiple partnering
Intra-individual	History of trauma; personal acceptance of alcohol use	History of trauma; favourable attitude to multiple partnering; unfavourable attitude to condom use

The apparent link between alcohol use and sexual risk behaviour was very complex. That is, high levels of alcohol use are associated with increased engagement in sex with multiple partners, and in unsafe sex. Mechanisms by which alcohol use is associated with sexual risk behaviour include alcohol's psychoactive effects on the user. These included real or imagined effects such as reduced inhibitions; increased levels of sexual arousal; increased 'power to perform' sexually; a decreased ability to negotiate safe sex; reduced ability to resist sexual advances; and failure to use condoms because people either do not think about them or do not care about their use at the time of drinking.

The results also suggest, however, that whether or not alcohol use will be associated with increased engagement in sexual risk behaviour depends on a number of factors, referred to here as moderators. That is, alcohol use will not always be associated with increased sexual risk behaviour for some individuals. Instead, it will be associated with an increased risk of sexual risk behaviour given the presence of certain conditions. Two very similar conceptual models of the link between alcohol and risky sexual behaviour are proposed: one for risky sexual behaviour and one for unsafe sexual behaviour (Figure 1 and Figure 2, respectively).

Figure 1 shows that the main precursors of the use of alcohol include factors within the economic, societal/cultural, community, familial, peer group, and intra-personal domains. Individuals report being more likely to use alcohol and to drink at high rates if they are without employment, come from a society and culture in which drinking is acceptable, come from a community in which drinking is acceptable and access to alcoholic beverages is easy, come from a family whose members misuse/misused alcohol, have peers who condone or encourage alcohol use, and have had a history of trauma and violence.

The next link in Figure 1 is between the use of alcohol and its psychoactive effects. From this research we learned that alcohol consumption has effects on people's reasoning abilities, sexual arousal, ability to delay sexual gratification, their inhibitions, their sense of responsibility for their actions and the degree to which risks associated with sexual behaviour are salient.

According to the proposed model these psychoactive changes will in turn give rise to sexual risk behaviour in so far as various moderating factors are present. These include economic

factors (those who were out of a job or of low income would be more likely to engage in risky sex if economic benefits would be forthcoming); societal factors (those who come from a society or culture in which sexual risk behaviours are condoned will be even more likely to engage in them); community factors (those who come from communities in which there are few facilitators of condom use will be more likely to engage in risky sex); drinking environment (being in a drinking environment in which risky sexual behaviours are practised and condoned will increase individuals' chances that they will engage in them); and individual factors (those who have a history of abuse within current or past family situations, who have few employment opportunities and who have expectations that risky sex is a likely consequence of alcohol use will be more likely to engage in risky sexual behaviour after drinking).

The models depicted in Figures 1 and 2 are similar although some of the specific psychoactive effects of alcohol may differ depending on the outcome behaviours of concern. It is important to note that our models have two additional elements that are not depicted in the diagrams. The models should also include feedback loops, indicating that engagement in sexual risk behaviour can give rise to increased drinking. Respondents in the study reported that after such behaviours they often feel guilty, and then drink more in order to dampen their feelings of guilt. Also many, and particularly men, reported that the experiences of engaging in these sexual behaviours were rewarding and that they are behaviours that they would want to repeat on numerous occasions.

A second important point concerns the relationship between the 'moderating factors' and sexual risk behaviour. In addition to the various factors being moderators (factors that strengthen or weaken) of the link between alcohol use and risky sex, we propose that they are also direct predictors of sexual risk behaviour, which may be in operation independently of alcohol use.

Limitations of the qualitative assessments

The qualitative assessments had a number of limitations. First, the project delayed in commencing due to a delay in receipt of ethical approval for the research. Second, some individuals declined to serve as key informants in the study, while others in the township site expressed a reluctance to speak openly about sexual behaviour. Third, we failed to gain permission to conduct observations in mainly affluent areas of the city site. Finally, there was a slight over-emphasis on alcohol use behaviours in this study as the misuse of alcohol was considered to be a major problem by many of the participants, and many of them were not able to discuss sexual matters freely.

Implications for intervention

Numerous intervention activities seem to be needed to address problems related to alcohol-related sexual risk behaviour. The qualitative assessments suggested the need for a multi-level approach to intervention in which the following range of intervention activities are implemented: (a) education, (b) policing and law enforcement, (c) treatment and counselling, (d) policy formation, (e) provision of alternatives to drinking, (f) improvement of employment opportunities, (g) changing norms regarding alcohol misuse and sexual risk behaviour, (h) controlling the availability and distribution of alcoholic beverages, (i) strengthening family ties, and (j) implementing strategies geared specifically to reducing the risk of HIV among alcohol users in various settings (e.g. condom distribution in drinking venues).

Figure 1. Model of alcohol use and risky sex

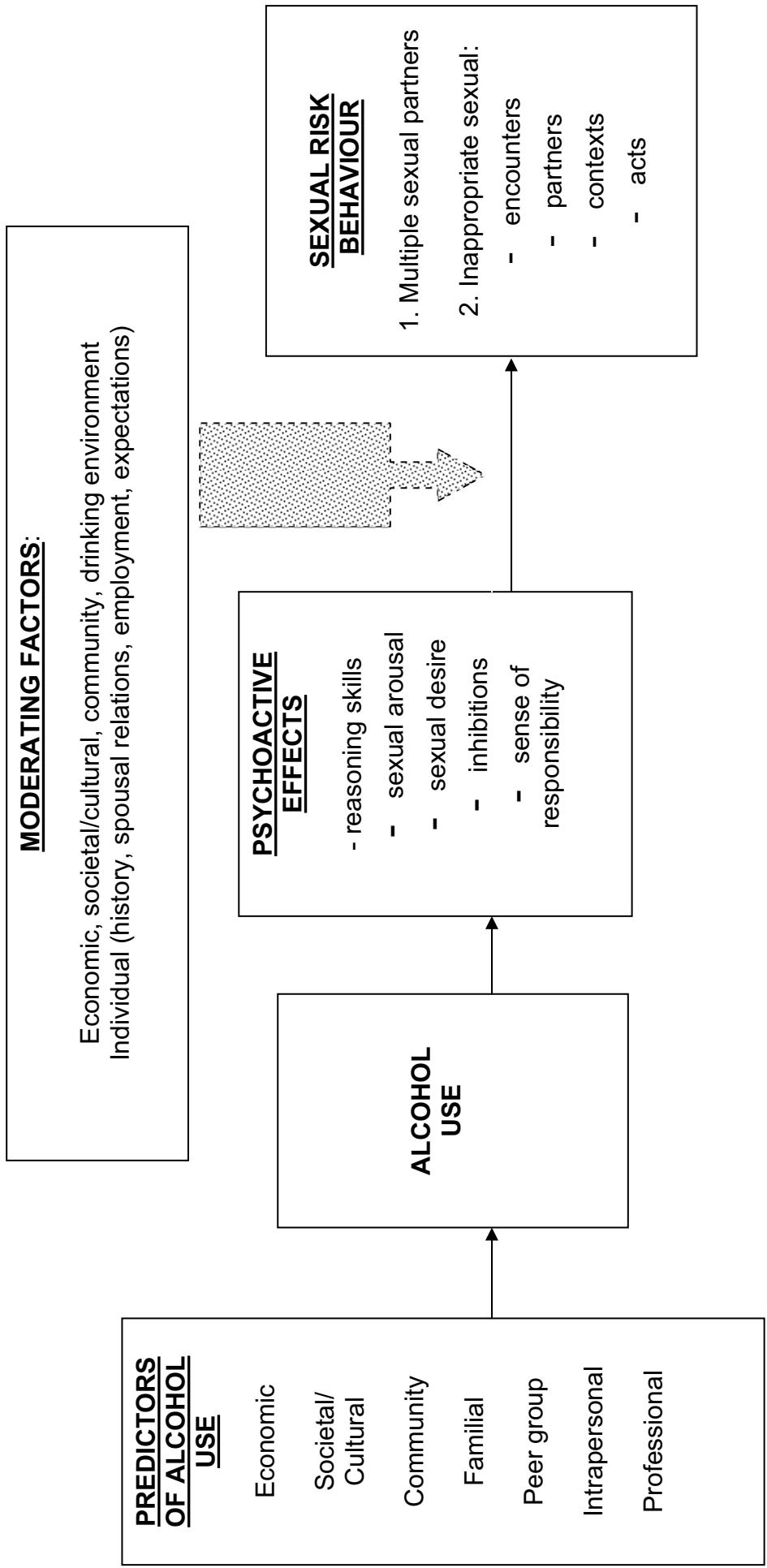
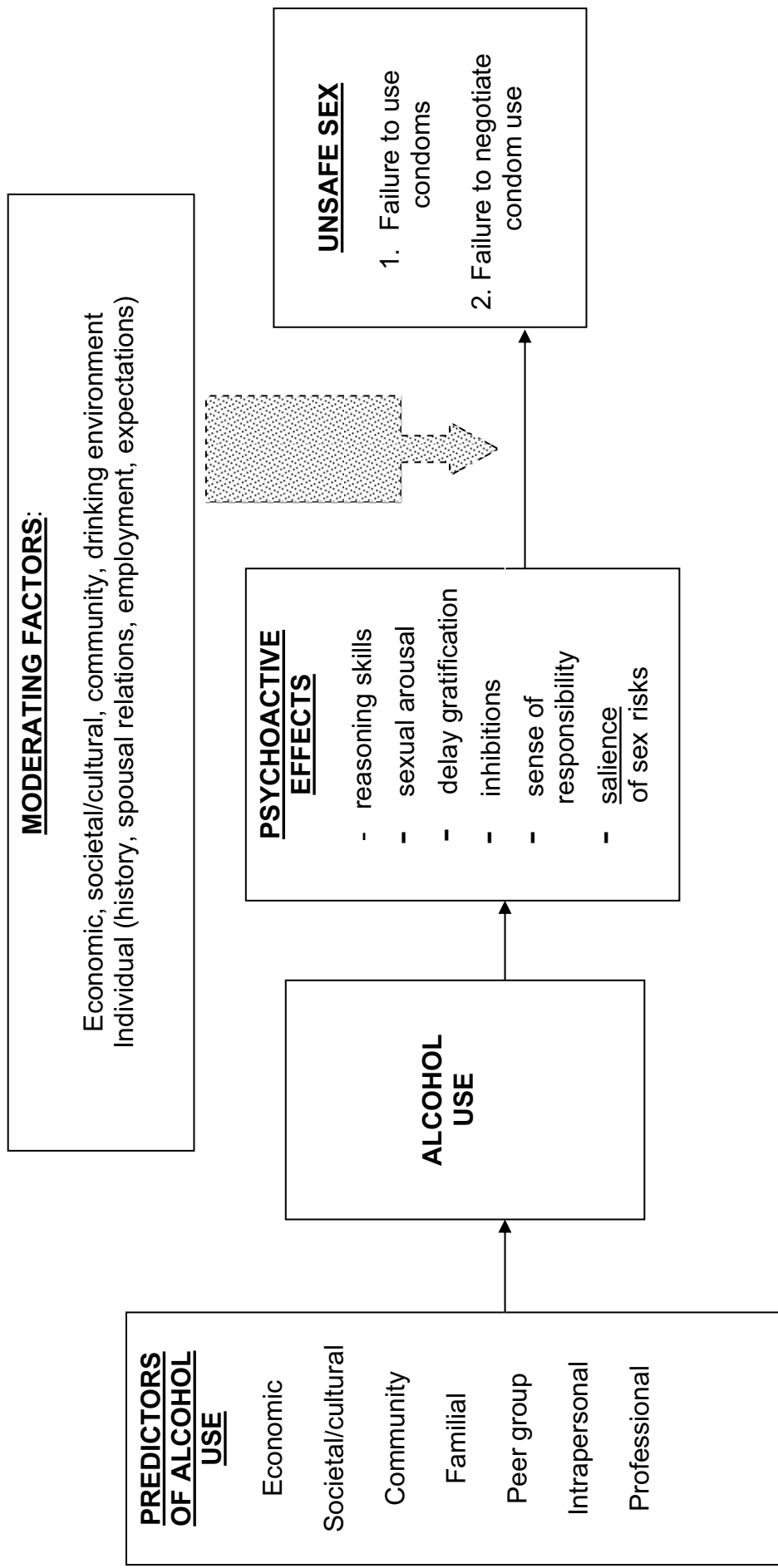


Figure 2. Model of alcohol use and unsafe sex



PHASES 3 AND 4: DEVELOPMENT AND PILOT-TESTING OF THE QUESTIONNAIRE

From the findings of the qualitative assessments a questionnaire was developed to assess alcohol-related sexual risk behaviour, and pilot-tested in a community-based mini-survey. This survey had the advantage of involving people who were involved in and affected by alcohol abuse and risky sexual behaviour, as well as other members of the community. It also enabled investigation of community-wide attitudes and perceptions; demographic, cultural, social, and economic characteristics; and patterns of drinking and sexual risk behaviour. The survey was conducted in a township on the outskirts of Pretoria, populated by about 200,000 inhabitants, and having few recreational facilities and many shebeens.

Objectives of the mini-survey

1. To examine social, psychological, economic and cultural characteristics of adults in a community in South Africa.
2. To compare male and female attitudes, beliefs, knowledge and behaviour regarding alcohol use and sexual behaviour.
3. To compare attitudes, beliefs, knowledge and behaviour of residents from low, medium and high income communities regarding alcohol use and sexual behaviour.
4. To examine the relationship between alcohol use and sexual risk behaviour.
5. To determine the correlates of alcohol-related sexual risk behaviour.
6. To recommend interventions for curtailing HIV-related sexual risk behaviour among alcohol-using populations.

Method

Participants

One hundred and sixty adults participated in the study. In total 56, 55 and 49 participants resided in areas classified as low income, medium income and high income communities, respectively. They comprised 95 (59%) females and 65 (41%) males who were aged between 24 and 44 years (Mean = 33.80 years, S.D. = 5.75). Approximately half (53%) of the participants had never been married, while only 27% were legally married at the time of the interviews. A total of 99 (62%) of the participants reported having completed high school and 57% of them were first language SePedi speakers.

Questionnaire

The questionnaire was developed following the completion of the previous qualitative assessment stage of the project which indicated the nature of the psycho-social factors that are associated with alcohol-related sexual risk behaviour. The questionnaire, a copy of which appears in Appendix E, consisted of 13 sections covering the following areas:

- Section 1: Demographic Characteristics
- Section 2: Economic factors
- Section 3: Community factors
- Section 4: Alcohol use
- Section 5: Sexual behaviour
- Section 6: Culture
- Section 7: Condom use
- Section 8: Effects of alcohol consumption
- Section 9: Sexual partners
- Section 10: Expectations regarding sexual behaviour
- Section 11: HIV
- Section 12: Inter and intra-personal factors
- Section 13: General circumstances

The questionnaire was translated into SeTswana by group translators who also conducted the interviews in this study. Most of them are members of the communities in which the research took place.

Sampling and procedures

Using data from the population census of 1996 all the census enumerator areas (EAs) within the boundaries of the township were categorised as 'low income', 'medium income', or 'high income'. The proportion of employed persons between 15 and 65 years of age in an EA was used as a proxy measure of income level of the areas. The highest third, middle third, and lowest third of all the suburbs in terms of employment rate, were categorised as high, medium and low income EAs, respectively. Seven EAs were then randomly selected from each of the low income, medium income and high income sets of EAs, such that there were 21 EAs in total.

The goal was to recruit adults from 12 households per EA. Once the 21 EAs had been identified, census EA maps were obtained for each of the selected EAs. A starting point within each EA was selected at random. Following this, every fifth household on the left hand side of the starting point was selected until 12 households had been identified within each target EA. Interviews were conducted at each target household if one or more eligible adult (i.e. those between the ages of 25 and 44 years, inclusive) resided within those households. Where more than one eligible adult resided at a particular household, one was selected randomly for participation in the study.

The identified adult was informed about the study and those who consented to participate completed and signed two copies of the informed consent forms before the commencement of the interview. (A copy of the informed consent form can be seen in Appendix F). One copy of the consent form was left with the participant while the other copy was delivered back to the researchers by the interviewers. The participants were then interviewed in private.

The mini-survey was approved by the Ethics Committee of the Faculty of Health Sciences at the University of Pretoria. Major risks were not anticipated to occur from participation in the study, while possible minor risks that were envisaged involved participants feeling discomfort on responding to questions about their alcohol use and sexual behaviour. On completing the interviews the participants were given a resource list with contact details of local self-help and counselling or treatment services for alcohol and/or drug problems, and for HIV testing and counselling.

Results

With the assumption that every household would have an eligible adult and a need to reach a target sample of 198 respondents, we over-sampled and visited 246 households. We reached 81% (160) of the target of 198 adults. Seventy-five households did not have eligible adults, and 11 people declined to participate in the study. The results for the 160 participants in the study are presented in three main sections. The first main section shows gender and community income level breakdowns of the participants' responses on the questionnaire items. The second section shows the results of the analyses that were conducted to assess the correlations between alcohol use and sexual risk behaviour. The final section presents results of analyses conducted to determine the correlates of alcohol-related sexual risk behaviour.

Responses on questionnaire items

Demographic, economic and community characteristics

Demographic factors. Table 2 shows that overall there were no major differences between the males and females on their age and educational level. The females were more likely than the males to be married and to be SePedi home language speakers whereas the males were more likely than the females to be first language speakers of SeTswana, and to be unmarried.

Those in the high income community were more likely to report that they had completed high school (69%) than respondents in the low income (55%) and medium income (62%) communities. Respondents in the low income community were more likely to report speaking SePedi (66%) than the respondents in the two other communities, while those in the medium income community were more likely to report speaking SeTswana (29%) than the respondents in the other two communities.

Economic factors. The respondents' overall employment rate was 64%. Compared to the females, the males were more likely to be employed and to have work as a source of income, but less likely to report a spouse as a source of income. There were no differences in the percentages of females and males reporting having experienced hunger often or sometimes (35% and 32%, respectively).

Employment levels were lower in the low-income community, than in the middle and high income communities. Those from the lowest income communities were most likely to report parents as a source of income and the presence of household hunger (41%), but least likely to report work as a source of income (41%).

Community factors. There were few noticeable gender and community income level differences in the responses on the questions concerning the community factors. However, the females (71%) were more likely than the males (51%) to indicate that their communities accepted the abuse of alcohol. The males (72%) were more likely than the females (60%) to indicate that they had easy access to recreational facilities and that there was widespread alcohol consumption in their community.

Respondents in the low income (77%) community were less likely to report easy accessibility of alcohol in their community than were those from the medium (82%) and high (83%) income communities. Respondents from the high income community were less likely than those from the medium and low income communities to report acceptability of alcohol abuse (53% versus 66% and 67%, respectively), advertisement of alcohol (71%, versus 79% and 84%), and satisfaction with community relationships (71%, versus 88% and 87%).

Table 2. Participants' demographic, economic and community characteristics

	GENDER		COMMUNITY INCOME LEVEL			TOTAL
	Female (n=95) n (%)	Male (n = 65) n (%)	Low income (n = 56) n (%)	Medium income (n = 55) n (%)	High income (n =49) n (%)	Total (n = 160) n (%)
Demographic factors						
Age: < 29 years	22 (23)	20 (31)	15 (27)	16 (29)	11 (22)	42 (26)
Age: 30 – 34 years	28 (29)	18 (28)	16 (29)	15 (27)	15 (31)	46 (29)
Age: 35 – 39 years	24 (25)	14 (22)	17 (30)	8 (15)	13 (27)	38 (24)
Age: > 39 years	21 (22)	13 (20)	8 (14)	16 (29)	10 (20)	34 (21)
Completed high school	58 (61)	41 (63)	31(55)	34 (62)	34 (69)	99 (62)
Ever married	52 (55)	24 (37)	26 (46)	27 (49)	23 (47)	76 (48)
Never married	43 (45)	41 (63)	30 (54)	28 (51)	26 (53)	84 (53)
Main home language (SePedi)	52 (55)	39 (60)	37 (66)	26 (47)	28 (57)	91 (57)
Main home language (SeTswana)	18 (19)	17 (26)	9 (16)	16 (29)	10 (20)	35 (22)
Economic factors						
Employed	51 (54)	51 (79)	25 (46)	41 (75)	36 (74)	102 (64)
Household hunger	33 (35)	21 (32)	23 (41)	15 (27)	16 (33)	54 (34)
Source of income (work)	51 (54)	49 (75)	23 (41)	41 (75)	36 (74)	100 (63)
Source of income (spouse)	22 (23)	1 (2)	9 (16)	8 (15)	6 (12)	23 (14)
Source of income (parents)	22 (23)	11 (17)	20 (36)	9 (16)	4 (8)	33 (21)
Community factors						
Presence of many recreational facilities	62 (65)	45 (69)	36 (64)	38 (69)	33 (67)	107 (67)
Easy access to recreational facilities	57 (60)	47 (72)	35 (63)	36 (66)	33 (67)	104 (65)
Accessibility of alcohol for purchase	76 (80)	52 (81)	43 (77)	45 (82)	40 (83)	128 (81)
Acceptability of alcohol abuse	67 (71)	33 (51)	37 (66)	37 (67)	26 (53)	100 (66)
Widespread alcohol advertising	74 (78)	51 (78)	44 (79)	46 (84)	35 (71)	125 (78)
Widespread heavy alcohol consumption	85 (89)	62 (95)	52 (93)	51 (93)	44 (90)	147 (92)
Accessibility of condoms for purchase	81 (85)	56 (86)	49 (88)	48 (87)	40 (82)	137 (86)
Accessibility of free condoms	89 (94)	62 (95)	54 (97)	53 (96)	44 (90)	150 (94)
Satisfaction with comm. relationships	78 (82)	54 (83)	49 (88)	48 (87)	35 (71)	132 (83)

Alcohol use

Table 3 shows that just over half of the sample (55%) reported having drunk alcohol in their life-time, and 48% of them reported having consumed alcohol in the past month. The males (74%) were significantly more likely than the females (42%) to report having consumed alcohol in their lifetime. The males had consumed alcohol on an average of 3.45 (S.D. = 5.50) days during the previous month, which was significantly greater than the average number of days on which the females had consumed alcohol during the preceding month of 1.55 (S.D. = 4.15) days ($p < .05$). The males drank a significantly greater quantity of alcohol (2.63 drinks, S.D. = 1.09) per drinking occasion than the females, who drank on average 2.15 drinks (S.D. = 1.01) per occasion, ($p < .05$). Overall, 63% of the drinkers were 'risky drinkers'. Female drinkers (68%) were significantly more likely than male drinkers (55%) to be defined as 'risky drinkers'. In all, 32% of the total sample of males and 13% of the total sample of females reported having been told that they drink too much, and 43% of the male 'drinkers', and 29% of the female 'drinkers' had been told that they drink too much.

Of all the females, those from the high income communities seemed to be most involved in alcohol use in having the highest rates of lifetime use and risky drinking (among drinkers and all females), and being most likely to have been told that they drink too much. For the males there were few marked community differences in drinking rates, although the medium income community males were most likely to report risky drinking and having been told that they drink too much.

Beverages consumed. The females were most likely to drink cider (39%), wine (34%), or beer (29%), while most of the males (77%) reported usually drinking beer. Some differences between the main beverages consumed by males and females in the different communities were observed. Females in the medium income communities were least likely to report drinking beer (14% versus 33% and 40% for low and high income community respondents, respectively) and cider (13% versus 42% and 47%, for the low and high income respondents, respectively). However, they were most likely to drink wine (43%, versus 25% and 33% for the low and high income community respondents, respectively). Males in the low income communities were least likely to report drinking beer (63%, versus 89% and 78% for the medium and high income communities, respectively).

Typical drinking venues. Most respondents indicated that they would usually drink at parties (81%), friends' homes (73%), and at home (70%). There were no significant differences in the percentage of males and females reporting that they would usually drink alcohol at parties (81% versus 82%), and at friends' homes (73% versus 74%). However, the males were more likely than the females to report drinking in public places such as in shebeens (43% versus 17%), taverns (35% versus 22%), and bars (25% versus 17%). Females in the medium income communities were least likely to report drinking in most venues specified with the exception of home and shebeens. Those from the high income communities were most likely to report drinking in shebeens (33%, versus 8% and 7% for those in the low and medium income communities, respectively).

Main drinking company. Most participants reported that they would drink alcohol with friends (78% for females and 88% for males), while few of them reported drinking alone (5% of the females and 8% of the males). The females were more likely than the males to report that they would drink with their partners (15% versus 2%). Females from the medium income communities were least likely to report drinking with friends (64%, versus 88% and 79% for those from the low and high income communities, respectively), and more likely to drink with their partners (29%, versus 6% and 0%, respectively). Males from the high income communities were least likely to drink with their friends (79%, versus 88% and 94%, for the low and medium income community males), but most likely to report drinking alone (14%, versus 6% and 6% for those in the low and medium income communities, respectively).

Table 3. Alcohol use

	GENDER		COMMUNITY INCOME LEVEL				TOTAL		
	Female (n = 95) n (%)	Male (n = 65) n (%)	Low income (n = 56)		Medium income (n = 55)		High income (n = 49)		
			Female n (%)	Male n (%)	Female n (%)	Male n (%)	Female n (%)	Male n (%)	
Frequency of use									
Life time alcohol use	40 (42)	48 (74)	12 (43)	16(57)	14 (44)	18 (56)	14 (50)	14 (50)	88 (55)
Past month alcohol use	33 (35)	43 (66)	9 (16)	14(25)	13 (24)	16 (29)	11 (22)	13 (27)	76 (48)
Risky use ^a (drinkers)	28 (68)	27 (55)	9 (75)	8 (50)	7(50)	12 (67)	12 (85)	7 (50)	55 (63)
Risky use ^a (total sample)	28 (29)	27 (42)	9 (26)	8 (36)	7 (23)	12 (48)	12 (39)	7 (39)	55 (35)
Problem use ^b (drinkers)	12 (29)	21 (43)	3 (43)	4 (57)	3 (21)	11 (79)	6 (50)	6 (50)	33 (37)
Problem use ^b (total sample)	12 (13)	21 (32)	3 (11)	4 (15)	3 (9)	11 (34)	6 (21)	6 (21)	33 (21)
Beverages consumed									
Beer	12 (29)	37 (77)	4 (33)	10 (63)	2 (14)	16 (89)	6 (40)	11 (78)	49 (55)
Cider	16 (39)	7 (15)	5 (42)	3 (19)	4 (13)	2 (11)	7 (47)	2 (14)	23 (26)
Wine	14 (34)	4 (8)	3 (25)	2 (13)	6 (43)	2 (11)	5 (33)	0 (0)	18 (20)
Coolers	3 (7)	2 (4)	0 (0)	1 (6)	1 (7)	0 (0)	2 (13)	1 (7)	5 (6)
Spirits	2 (5)	3 (6)	1 (8)	1 (6)	1 (7)	2 (11)	0 (0)	0 (0)	5 (6)
Homebrew	0 (0)	2 (4)	0 (0)	1 (6)	0 (0)	1 (6)	0 (0)	0 (0)	2 (2)
Typical drinking venue									
Party	33 (81)	40 (82)	11 (92)	13 (77)	9 (64)	17 (94)	13 (87)	10 (71)	73 (81)
Home of friend(s)	30 (73)	36 (74)	9 (75)	10 (59)	9 (64)	15 (83)	12 (80)	11 (79)	66 (43)
Own home	26 (63)	36 (75)	6 (50)	9 (53)	10 (71)	16 (89)	10 (67)	11 (85)	62 (70)
Park(s)	17 (42)	22 (45)	5 (42)	9 (53)	3 (21)	8 (44)	9 (60)	5 (36)	39 (43)
Festivals/concerts	16 (39)	23 (47)	6 (50)	7 (41)	3 (21)	11 (61)	7 (47)	5 (36)	39 (43)
Shebeen	7 (17)	21 (43)	1 (8)	4 (24)	1 (7)	10 (56)	5 (33)	7 (50)	28 (31)
Restaurant	14 (34)	13 (27)	4 (33)	3 (18)	2 (14)	7 (39)	8 (53)	3 (21)	27 (30)
Tavern	9 (22)	17 (35)	2 (17)	4 (24)	1 (7)	9 (50)	6 (40)	4 (29)	26 (29)
Bar	7 (17)	12 (25)	2 (17)	3 (18)	1 (7)	6 (33)	4 (27)	3 (21)	19 (21)
Car parks	3 (8)	5 (10)	1 (8)	1 (6)	0 (0)	2 (11)	2 (14)	2 (14)	8 (9)
Typical drinking company									
Friend(s)	32 (78)	42 (88)	10 (88)	14 (88)	9 (64)	17 (94)	13 (87)	11(79)	74 (83)
Partner	6 (15)	1 (2)	1 (8)	1 (6)	4 (29)	0 (0)	1 (7)	0 (0)	7 (8)
Alone	2 (5)	4 (8)	1 (8)	1 (6)	1 (7)	1 (6)	0 (0)	2 (14)	6 (7)
Other	1 (2)	1 (2)	0 (0)	1 (0)	0 (0)	0 (0)	1 (7)	1 (7)	2 (2)

^aUsual consumption of 5 or more (males) or 3 or more (females) drinks.

^bHaving been told that one drinks too much.

Sexual behaviour

Nature of sexual partner. Table 4 shows that most of the respondents (88%) reported having a regular sexual partner while just under one third (31%) reported having a casual sexual partner. The males were more likely than the females to report having a regular (92% versus 85%) and casual (48% versus 20%) sexual partner. The females (54%) were significantly more likely than the males (5%) to report having partners who were more than five years older than them, while the males (38%) were more likely than the females (6%) to report having partners who were at least five years younger than them. Participants from the medium income communities (8%) were less likely to report involvement with older sexual partners than were those from the other two communities (13% in each), but there were no significant community differences in the percentages reporting having younger sexual partners. Those from the high income communities (96%) were more likely to report having a regular sexual partner than were those from the low (88%) and medium (83%) income communities.

Relationship with sexual partner. Almost all (90%) of the respondents reported satisfaction with their relationships with their partners, with no gender differences observed, but the high-income participants were least satisfied with such relationships. Most of the participants (78%) reported that disagreements with their partners sometimes occurred. Levels of reported violence were low (13%), while most participants reported trust in their relationships (78%). The males were more likely than the females to report that they had control (65% versus 55%) and trust in their relationship (87% versus 71%), but there were no significant differences in the percentages of males and females reporting disagreements or violence in their relationships. The respondents from the medium income communities seem to have had the most positive relationships with their partners in being more likely than those from the low income and high income communities to report having control (70%, as opposed to 56% and 52%, respectively), and trust (85%, as opposed to 79% and 70%, respectively). Levels of reported inter-partner violence of 17% were highest among those from the lowest income community as compared with those of 9% and 13% reported by the medium income and high income communities' participants, respectively. The medium income community respondents (71%) were also less likely to report disagreements in their relationships than were those from the low income (85%) and high income (78%) communities. The males (26%) were more likely than the females (9%) to report cultural acceptability of spousal abuse, but such beliefs were less likely to be indicated by those from the low income community (13%) than those from the other two communities (18% in each).

Reasons for refusing/acquiescing to unwanted sex. Table 4 shows that 16% of the respondents (18% of the males and 14% of the females) reported having engaged in sex that they regretted during the past three months. Twenty per cent of those from the low income community, as compared with 13% and 14% of those in the medium and high income communities reported having engaged in sex that they had regretted during the preceding three-month period. Overall, 39% of the respondents indicated that they sometimes engaged in sexual intercourse because their sexual partner expected it of them. The males (42%) were slightly more likely than the females (37%) to report engaging in such expected behaviour. However, females were more likely to agree that they engaged in unwanted sex because they feared refusing to do so (27% versus 15%), and were fearful of financial (15% versus 11%), emotional (12% versus 8%), verbal (26% versus 17%) and physical (9% versus 5%) ramifications of doing so.

Those in the high income communities (33%) were more likely to report fear of refusal to have sex than were those in the low (18%) and medium (18%) income communities. Those in the low income communities (18%) were more likely to report financial consequences of sexual refusal than were those in the medium (9%) and high (12%) income communities. No

other marked differences in the responses of the participants from the three communities on these questions were in evidence.

Sexual 'safety' of older/younger partner. The males were more likely than the females to indicate that sex is safer with a younger woman (27% versus 20%) or a younger man (16% versus 9%), while the females were more likely to indicate believing the opposite to be true. Respondents from the medium income community (32%) were more likely than those from lower and higher income communities to agree with the stereotype that sex is safer with an older woman (18% and 26% for those from the low and high income communities, respectively), and an older man (41%, versus 29% and 32% for those from the low and high income communities, respectively).

HIV vulnerability. The males were more likely than the females to consider themselves to be vulnerable to HIV infection (35% versus 29%), less likely than the females to consider their casual partners to be HIV positive (32% versus 40%), but did not have significantly different beliefs from the females regarding the likelihood that their regular partners were infected with HIV (23% versus 25%). Respondents from the high income communities were significantly more likely to report personal vulnerability to HIV (43%, versus 34% and 20% for those from the low and medium income communities, respectively); and HIV vulnerability of their regular partners (37%, versus 16% and 13% for those from the low and high income communities, respectively), and casual partners (57%, as compared with 33% and 21% of those from the low and medium income communities).

Multiple sexual partners

Number of sexual partners. Table 5 shows that about one third of the participants reported having had more than five sexual partners in their lifetime, and 11% indicated having had more than one sexual partner during the preceding three-month period. The males were significantly more likely than the females to have had more than five sexual partners in their lifetime (38% versus 26%), and more than one sexual partner in the past three months (20% versus 4%). Respondents in the high income community were more likely to report having had more than 5 sexual partners in their lifetime (37%) than those in the low (29%) and medium (29%) income communities. They were also more likely to report having had more than one sexual partner in the past three months (18%) than were those in the low (4%) and medium (11%) income communities.

Attitudes to multiple sexual partners. The males were more in favour of having sex with more than one partner than were the females in that they were more likely than the females to perceive such behaviour as being enjoyable (25% versus 14%), healthy (18% versus 7%), culturally acceptable (46% versus 14%), easy to engage in (54% versus 49%) and to be influenced by pressure from their peers to engage in the behaviour (15% versus 7%). However, their perceptions of the risk of contraction of HIV as a result of such behaviour were not significantly different from those of their female counterparts (91% for the males and 95% for the females).

There was only one significant difference between the attitudes of the participants from the three communities' attitudes to multiple sexual partners: respondents from the low income communities were significantly less likely to report positive health effects of having more than one sexual partners (only 5%) than were those from the medium (13%) and high (18%) income communities, respectively. More than 90% of the respondents in each of the communities reported that having more than one sexual partner increases the risk of HIV infection.

Table 4. Sexual behaviour

	GENDER		COMMUNITY INCOME LEVEL			TOTAL
	Female (n=95) n (%)	Male (n = 65) n (%)	Low income (n = 56) n (%)	Medium income (n = 55) n (%)	High income (n =49) n (%)	Total (n = 160) n (%)
Nature of sexual partner						
Older partner	44 (54)	3 (5)	18 (13)	11 (8)	18 (13)	47 (33)
Younger partner	5 (6)	23 (38)	9 (6)	12 (9)	7 (5)	28 (20)
Have regular sexual partner	81 (85)	60 (92)	49 (88)	45 (83)	47 (96)	141 (88)
Have casual sexual partner	19 (20)	31 (48)	20 (36)	18 (33)	12 (24)	50 (31)
Relationship with partner						
Relationship satisfaction	75 (90)	56 (90)	47 (90)	43 (93)	41 (84)	131 (90)
Disagreements with partner	64 (78)	62 (79)	44 (85)	33 (71)	36 (78)	113 (78)
Violence in relationship	11 (13)	8 (13)	9 (17)	4 (9)	6 (13)	19 (13)
Control in relationship	45 (55)	40 (65)	29 (56)	32 (70)	24 (52)	85 (59)
Trust in relationship	58 (71)	54 (87)	41 (79)	39 (85)	32 (70)	112 (78)
Cultural acceptance of partner physical abuse	9 (9)	17 (26)	7 (13)	10 (18)	9 (18)	26 (16)
Personal belief in male entitlement to sex	18 (19)	8 (12)	8 (14)	11 (20)	7 (14)	26 (16)
Regretted sex and sexual refusal						
Engaged in regretted sex ^a	13 (14)	12 (18)	11 (20)	7 (13)	7 (14)	25 (16)
Engage in sex due to partner expectation	35 (37)	27 (42)	21 (38)	21 (38)	20 (41)	62 (39)
Fear refusal of partner advances	26 (27)	10 (15)	10 (18)	10 (18)	16 (33)	36 (23)
Financial consequences of sexual refusal	14 (15)	7 (11)	10 (18)	5 (9)	6 (12)	21 (13)
Emotional consequences of sexual refusal	11 (12)	5 (8)	7 (13)	4 (7)	5 (10)	16 (10)
Verbal consequences of sexual refusal	24 (26)	11 (17)	10 (18)	12 (22)	13 (27)	35 (22)
Physical consequences of sexual refusal	9 (9)	3 (5)	4 (7)	3 (5)	5 (10)	12 (8)
'Safety' of sex with older/younger partner						
'Safer' with older woman	26 (29)	13 (20)	10 (18)	17 (32)	12 (26)	39 (25)
'Safer' with younger woman	18 (20)	17 (27)	15 (27)	10 (19)	10 (22)	35 (23)
'Safer' with older man	36 (39)	17 (27)	16 (29)	22 (41)	15 (32)	53 (34)
'Safer' with younger man	8 (9)	10 (16)	7 (13)	5 (9)	6 (13)	18 (12)
HIV vulnerability						
Perceived personal vulnerability to HIV infection	28 (29)	23 (35)	19 (34)	11 (20)	21 (43)	51 (32)
Perceived HIV vulnerability of regular partner	20 (25)	14 (23)	9 (16)	7 (13)	18 (37)	34 (21)
Perceived HIV vulnerability of casual partner	6 (40)	10 (32)	5 (33)	3 (21)	8 (57)	16 (35)

^aIn past three months

Table 5. Multiple sexual partners

	GENDER		COMMUNITY INCOME LEVEL			TOTAL
	Female (n=95) n (%)	Male (n = 65) n (%)	Low income (n = 56) n (%)	Medium income (n = 55) n (%)	High income (n =49) n (%)	Total (n = 160) n (%)
Number of partners						
More than 5 sexual partners (life-time)	25 (26)	25 (38)	16 (29)	16 (29)	18 (37)	50 (31)
More than one sexual partner (past 3 months)	4 (4)	13 (20)	2 (4)	6 (11)	9 (18)	17 (11)
Attitudes to multiple sexual partners						
Enjoyable	13 (14)	16 (25)	10 (18)	8 (15)	11 (22)	29 (18)
Healthy	7 (7)	12 (18)	3 (5)	7 (13)	9 (18)	19 (12)
Culturally acceptable	13 (14)	30 (46)	7 (13)	10 (18)	9 (18)	26 (16)
Easy to have more than one sexual partner	46 (49)	35 (54)	12 (22)	18 (33)	13 (27)	43 (27)
Pressure to have multiple sexual partnerships	7 (7)	10 (15)	5 (9)	8 (15)	4 (8)	17 (11)
HIV risk increased due to multiple sexual partners	90 (95)	59 (91)	53 (95)	51 (93)	45 (92)	149 (93)

Condom use

Condom use behaviour. Table 6 shows the respondents' reported condom use behaviours, attitudes and cultural perceptions. Males (72%) were more likely than females (51%) to report past year condom use, past 3-month condom use with regular partners (63% versus 46%), and past three-month condom use with casual partners (71% versus 42%). The main inter-community difference in reported condom use behaviour was that the respondents from the low income communities (40%) were significantly less likely than those from the medium (61%) and high (92%) income communities to report having used condoms consistently with their casual partners during the previous three months.

Condom use importance. Overall, significantly more of the participants indicated that condom use was important with a casual partner (86%) than with a regular partner (56%). The females were more inclined than the males to report that condom use was important with a regular partner (61% versus 49%), but less likely to consider it important with a casual partner (82% versus 92%). There were no marked differences in the beliefs about the importance of condom use of the respondents from the three communities. The majority (i.e. more than 80%) reported that condom use with a casual partner was important, but only a little over half of them in each community indicated that condom use with regular partners was important.

Culture and condom use. The respondents were more likely to indicate that their culture accepted condom use with casual partners (62%) than with regular partners (51%). Respondents from the low income communities (59%) were more likely to report cultural acceptance of condom use with a regular partner than were those from the medium (46%) and high (47%) income communities. However, they did not differ in their reporting of the importance of condom use with casual partners. Males' and females' views on cultural acceptability of condom use with a regular partner did not differ substantially, but did differ slightly on cultural acceptance of condom use with a casual partner; males believed condom use with a casual partner to be more culturally acceptable than females (69% versus 56%).

Table 6. Condom use

	GENDER		COMMUNITY INCOME LEVEL			TOTAL
	Female (n=95) n (%)	Male (n = 65) n (%)	Low income (n = 56) n (%)	Medium income (n = 55) n (%)	High income (n =49) n (%)	Total (n = 160) n (%)
Condom use behaviour						
Condom use (past year)	48 (51)	47 (72)	32 (57)	33 (60)	30 (61)	95 (59)
Condom use with regular partner (past 3 months)	37 (46)	37 (63)	22 (47)	26 (58)	25 (53)	74 (52)
Condom use with casual partner (past 3 months)	8 (42)	22 (71)	8 (40)	11 (61)	11 (92)	30 (60)
Condom use attitudes						
Importance of condom use with regular partner	58 (61)	32 (49)	31 (55)	31 (56)	28 (57)	90 (56)
Importance of condom use with casual partner	77 (82)	60 (92)	46 (82)	49 (91)	42 (86)	137 (86)
Cultural acceptance						
Acceptance of condom use with regular partner	47 (50)	34 (52)	33 (59)	25 (46)	23 (47)	81 (51)
Acceptance of condom use with casual partner	53 (56)	45 (69)	33 (59)	34 (63)	31 (63)	98 (62)

Alcohol-related sexual risk behaviour

Sex under the influence of alcohol. As shown in Table 7, 28% and 2% of the respondents reported that during the past three months they had engaged in sexual intercourse under the influence of alcohol while only 2% reported that they had engaged in sexual intercourse under the influence of illicit drugs. The males (38%) were more likely than the females (20%) to report having engaged in sex under the influence of alcohol. Those who were from the low income communities were less likely to report having engaged in sexual intercourse under the influence of alcohol during the past three months (18%) than their counterparts from the medium income (31%) and high income (35%) communities.

Effects of alcohol use on sexual behaviour. The males were more likely than females to report that drinking affected them sexually by increasing their desire to engage in sex with their regular partner (47% versus 39%), and their desire to engage in sex with a casual partner (45% versus 18%), and their chances of engaging in sex that they would later regret (26% versus 20%). They were also more likely than the females to indicate that certain forms of impairment would result from drinking alcohol, namely becoming less able to resist unwanted sexual advances (19% versus 7%), less likely to consider using condoms when engaging in sexual intercourse (22% versus 12%), or to insist on condom use (17% versus 12%).

The females, on the other hand, were more likely to report that the pleasure of sexual intercourse increased when they had been drinking alcohol (46% versus 37%). There was no significant difference in the percentage of males (39%) and females (37%) indicating that their sexual performance improved after they had been consuming alcohol.

Those from the low income communities were least likely to report that after drinking there was an increase in their desire to have sex with regular partners (33%, as opposed to 47% and 48% for the medium and high income communities' participants), and in the pleasure of sexual intercourse (35%, versus 47% and 41% for the medium and high income communities' respondents, respectively). The low income communities' participants were most likely to report that drinking decreased their consideration of condom use (27%, as compared with 13% and 14% for the medium and high income communities' participants, respectively). Participants from the medium income communities were significantly less likely to report a reduction in their ability to resist unwanted sexual advances (3%) as a result of alcohol consumption than those from the low (22%) and high (17%) income communities. However, they were most likely to report engaging in regrettable sex as a result of drinking (28%, versus 19% and 21% for those in the low and high income communities, respectively). Respondents from the high income communities (48%) were most likely to report that their sexual performance improved as a result of alcohol consumption as compared with 35% and 31% for those from the low and medium income communities, respectively.

Table 7. Alcohol-related sexual risk behaviour

	GENDER		COMMUNITY INCOME LEVEL			TOTAL
	Female (n=95) n (%)	Male (n = 65) n (%)	Low income (n = 56) n (%)	Medium income (n = 55) n (%)	High income (n =49) n (%)	Total (n = 160) n (%)
Sex under the influence of alcohol/drugs						
Sex under the influence of alcohol (past 3 months)	19 (20)	25 (38)	10 (18)	17 (31)	17 (35)	44 (28)
Sex under the influence of illicit drugs (past 3 months)	1 (1)	2 (3)	1 (2)	1 (2)	1 (2)	3 (2)
Effects of alcohol use on sexual behaviour						
Increased sexual desire (regular partner)	16 (39)	22 (47)	9 (33)	15 (47)	14 (48)	38 (43)
Increased sexual desire (casual partner)	7 (18)	21 (45)	8 (30)	12 (38)	8 (29)	28 (32)
Increased pleasure	19 (46)	17 (37)	9 (35)	15 (47)	12 (41)	36 (41)
Improved performance	16 (39)	17 (37)	9 (35)	10 (31)	14 (48)	33 (38)
Reduced ability to insist on condom use	5 (12)	8 (17)	5 (19)	4 (13)	4 (14)	13 (15)
Reduced ability to resist unwanted advances	3 (7)	9 (19)	6 (22)	1 (3)	5 (17)	12 (14)
Reduced consideration of condom use	5 (12)	10 (22)	7 (27)	4 (13)	4 (14)	15 (17)
Increased chance of engaging in regretted sex	8 (20)	12 (26)	5 (19)	9 (28)	6 (21)	20 (23)

Relationship between alcohol use and sexual risk behaviour

Pearsons correlational analyses were conducted to examine the relationship between alcohol use and sexual risk behaviour. Table 8 shows that there were significant positive correlations between each of the alcohol use variables (past month alcohol use frequency, typical quantity of alcohol consumed and problem alcohol use) and two of the three sexual risk behaviour variables: engagement in sexual intercourse that was regretted and number of lifetime sexual partners. However, condom use frequency was not significantly related to any of the three alcohol use variables.

Table 8. Correlations between alcohol use and sexual risk behaviour

	Past month alcohol use frequency	Typical quantity consumed	Problem alcohol use ^a
Regretted sexual intercourse (past 3 months)	.191*	.357***	.204**
Number of sexual partners (lifetime)	.320***	.436***	.358***
Condom use (past 3 months)	-.088	-.123	-.116

* $p \leq .05$; ** $p \leq .01$; *** $p \leq .001$; ^aHaving been told that one drinks too much.

Correlates of alcohol-related sexual behaviour

This section presents results of Pearson's and point-biserial correlational analyses that were conducted to determine the main psycho-social correlates of four separate measures of alcohol-related sexual risk behaviour: (a) engagement in sexual intercourse under the influence of alcohol (past three months); (b) alcohol-related increased sexual performance/desire/pleasure; (c) alcohol-related impaired sexual control; and (d) alcohol-related regretted sexual behaviour.

Correlates of engagement in sexual intercourse under the influence of alcohol

In total, 44 respondents (28%) reported having engaged in sexual intercourse under the influence of alcohol during the past three months, 19 of whom were female (20%) and 25 (38%) male. Table 9 shows that the factors which were significantly related to frequency of engagement in sexual intercourse under the influence of alcohol were: gender, past month alcohol use, typical alcohol use quantity, having been told one has a problem, having had sex that one had regretted, beliefs about cultural acceptability of condom use, beliefs about cultural acceptability of multiple sexual partners, recency of condom use, and the degree of satisfaction with one's relationship with spouse/regular partner.

Correlates of alcohol-related increased sexual performance/desire/pleasure

As shown above, some participants reported that their use of alcohol would improve their performance (38%), increase their desire (32%) and increase the pleasure (41%) of sexual intercourse. A 3-item scale assessing alcohol-related increased desire/performance/pleasure was created by summing respondents' scores on the three separate items (Cronbach's alpha = .77). The analyses were conducted for the 88 respondents who reported having consumed alcohol in their lifetime. Table 9 shows that those who were more likely to report that alcohol use increased their sexual performance/pleasure/desire were more likely to be younger, working, to drink larger quantities of alcohol when they did drink, to have work as a source of income, to not have a spouse as a source of income, to have been told that they have an alcohol problem, to have engaged in sexual intercourse that they had regretted, to not believe that males were entitled to sexual intercourse when they wanted to engage in it with their sexual partners, and to have engaged in condom use more recently.

Correlates of alcohol-related impaired sexual control

The next set of analyses was conducted to determine the correlates of alcohol-related reduced control in sexual situations. A three-item scale of reduced sexual control was created by summing respondents' scores on the items assessing the degree to which their drinking would decrease their ability to insist on condom use, to resist unwanted sexual advances, and to remember to think about using condoms (Cronbach's alpha = .64). The third column of Table 9 shows that those who reported that alcohol use impaired their control in sexual situations were less likely to report that condoms are important, more likely to feel that they were vulnerable to HIV infection and less likely to report that they had used condoms in the past three months.

Correlates of alcohol-related regretted sexual behaviour

The fourth column of Table 9 shows that those who were more likely to report that alcohol use increased their chances of having sex that they regretted reported having engaged in sex that they had regretted (during the past three months) most frequently, had not used condoms recently, and had engaged in condom use least frequently with their regular sexual partner during the preceding three-month period.

Table 9. Correlations between alcohol-related sexual risk behaviour and psychosocial factors

Domain	Variable	Sex under influence of alcohol	Alcohol-related increased desire/pleasure	Alcohol-impaired sexual control	Alcohol-related regretted sex
Demographic	Age	.03	-.25*	.01	.04
	Gender	.25**	-.10	.16	-.10
	Education	-.11	.14	-.10	-.08
	Married	-.14!	-.18!	.03	.06
Economic	Employed	.07	.23*	.05	-.03
	Household hunger	-.09	.09	.15	.07
	Source of income (work)	.02	.22*	.01	-.05
	Source of income (spouse)	.01	-.32**	-.05	-.01
	Source of income (parents)	-.02	-.11	.03	.05
Community	Access to recreational facilities	-.02	-.20!	.01	.05
	Access to condoms	.07	.11	-.12	-.09
	Satisfactory community relationships	-.04	-.16	-.13	-.09
Alcohol use	Past month alcohol use	.45***	.08	.04	-.09
	Typical use quantity	.31**	.28**	-.03	-.05
	Told that drink too much	.36***	.34**	-.06	-.11
Sexual behaviour	Regret sexual intercourse (past 3 months)	.23**	.25*	-.13	-.27**
	Engage in unwanted sex	.14!	-.06	.10	.08
	Negative consequences of refusal	.11	.09	.01	-.01
Culture	Male entitlement to sex favour	.09	.27*	.05	-.02
	Condom use acceptability	.18*	.09	.01	-.02
	Cultural acceptance of multiple partners	.22**	.26*	-.02	-.10
Condom use	Last time used condoms	.21**	.31*	-.19!	-.24***
	Past 3 month condom use with regular partner	.09	.12	-.28*	-.22**
	Importance of condom use	.04	.13	-.26*	-.13!
HIV	HIV risk increases	-.04	-.12	-.08	-.01
	Perceived personal vulnerability	.10	.13	.27*	.15!
	Perceived regular partner vulnerability	.07	.20!	.14	.15!
	Perceived casual partner vulnerability	-.11	.02	-.01	.04
Inter-personal factors	Satisfaction with parents	-.12	-.01	-.11	.01
	Satisfaction with partner	.27**	-.17	-.04	.04

! $p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$

Discussion

Summary of findings

The mini-survey was conducted among 160 males and females between the ages of 25 and 44 years, most of whom were unmarried. About half of the sample reported lifetime use of alcohol, with men being more inclined than women to drink. About two thirds of those who consumed alcohol drank at 'risky' levels, with females being more likely to drink at 'risky' levels than males. Beer, cider and wine were the most popular beverages consumed. Drinking was mainly a social behaviour, occurring mainly at parties and in the company of friends, but rarely with partners, particularly for the males.

All of the participants had had sexual intercourse during their lifetime. Most of them had regular sexual partners at the time of the interviews. About half of the women were in relationships with partners who were at least five years older than them, while the males were inclined to have much younger sexual partners. Males were more inclined to believe that sexual intercourse was safer with younger people while females were more inclined to believe the opposite to be true.

An overwhelming majority of the participants reported being in satisfactory relationships with their partners, which involved trust. About half of them reported on the presence of control, and a minority, on the presence of physical violence in their relationships.

Sexual intercourse was not always voluntary. Just under half of both males and females reported that they would sometimes engage in sex with their partners because it was expected of them. Some participants indicated that they would sometimes have sexual relations with their partners to avoid emotional, financial, verbal and physical consequences of refusal to engage in sex.

About one third of the participants, with males more than females, reported feeling vulnerable to infection with HIV. They were less inclined to believe that their regular partners had such vulnerability. About one third of those with casual sexual partners believed that such partners were likely to be infected with HIV.

A minority of the participants had had more than one sexual partner during the preceding three-month period, with males having had more sexual partners than females. Males were also more likely to be in favour of and to indicate cultural acceptance of their engagement in such behaviour, although only a minority of the participants as a whole indicated such positive attitudes to the behaviour. The majority of the participants indicated that there was an increased risk of infection with HIV associated with having multiple sexual partners.

Condom use behaviours were more in evidence among the males than the females. Overall condom use was considered to be more important and more culturally acceptable for sexual relations with casual partners than with regular partners. Levels of community accessibility of free condoms and condoms for purchase were very high.

About half of the male and female drinkers reported having engaged in sexual intercourse under the influence of alcohol during the preceding three-month period. The most commonly reported changes in sexual behaviour to result from drinking were an increase in desire to engage in sexual intercourse with a regular partner, followed by an increase in the pleasure of sexual intercourse, an improvement in sexual performance, an increase in the desire to have sex with a casual partner and an increase in the chances of engaging in regretted sex. The less commonly agreed upon sexual consequences of alcohol use were a decreased chance of thinking of using condoms, reduced ability to insist on condoms and reduced ability to resist sexual advances.

There were significant correlations between the participants' extent of alcohol use and the number of sexual partners they had had, and the frequency with which they had engaged in sexual intercourse that was regretted. However, their extent of alcohol use was not significantly related to the frequency of their condom use.

Alcohol-related sexual behaviour in this study took various forms including, engagement in sexual intercourse under the influence of alcohol, alcohol-related increased performance/desire/pleasure, alcohol-related impaired sexual control, and alcohol-related regretted sexual intercourse. Various demographic, economic, alcohol use, sexual behaviour, cultural, condom use, HIV beliefs, and inter-personal factors were associated with engagement in sex under the influence of alcohol, and experiencing greater sexual desire/performance/pleasure as a result of drinking. These two types of behaviour are indicative of an increased likelihood of engaging in sexual intercourse because of alcohol use. The two other alcohol-related sexual risk behaviour variables involved impaired control in sexual situations. They were associated mainly with variables of concern within the domains of sexual behaviour, condom use, and HIV, but not with any of the alcohol use or other psycho-social factors.

Limitations

The mini-survey relied on a self-report method to elicit information about the participants' alcohol use and sexual behaviour. Despite our attempts to encourage honest self-reporting of such behaviours, it is conceivable that some of the participants provided socially desirable responses about their involvement in these behaviour.

Although some strong associations were observed between various alcohol use, sexual behaviour and psycho-social variables, the use of a cross-sectional design precludes understanding of the direction, and possible causality of the observed relationships.

The fact that the mini-survey was conducted in one community in one part of such a culturally-diverse country requires caution in generalising from the findings to other regions of South Africa.

CONCLUSIONS

This final report describes key findings of a four-phased project seeking to understand alcohol-related sexual risk behaviours in various communities, and develop a methodology for assessing such behaviours. The project highlights the value of using both qualitative and quantitative methods, in allowing for triangulation of results to gain a fuller picture of the nature of alcohol use as it relates to sexual risk behaviour among communities in South Africa. From the present study the following conclusions can be reached about the nature of alcohol use and sexual risk behaviour.

With respect to the use of alcohol there is evidence that females lag behind males in terms of the proportions involved in drinking at all, but are somewhat more involved in risky drinking, according to the definitions of 'risky' drinking we used of 5 or more drinks for males and 3 or more drinks per day for females. Alcohol use did not seem to be very widespread among the mini-survey respondents, since only about half of them reported ever having consumed alcohol. The view that emerged from the qualitative investigations that the abuse of alcohol is widespread could be based on people's exposure to the social impact of alcohol abuse in their respective communities. The project's findings regarding the social nature and patterns of drinking and the beverages consumed are consistent with those found in numerous other studies conducted in South Africa and other African countries.

This project's various sub-studies suggested that sexual intercourse with casual sexual partners is more common among and more accepted by males than females. The qualitative studies suggested that multiple sexual partners are common, whereas only a minority of those in the mini-survey reported on such behaviour. These differences could be due to the differences in the target population of the two sets of investigations. The qualitative assessments' target population included alcohol 'risky drinkers' and their partners, whereas the mini-survey included all members of the same age-group in a community sample.

The study also pointed to a tendency for females to have regular partners who are much older than them consistent with the finding of the phenomenon of 'Sugar Daddy', which describes older men in relationships with younger women, who provide for their economic needs. In addition to having partners who are older than them, the women were also likely to endorse the view that sexual intercourse is 'safer' with older men. Males were far more likely to be in relationships with younger females, and to endorse the view that sexual intercourse is 'safer' with younger women than with older women.

There appear to be high levels of access to condoms and knowledge about risks of HIV infection that result from multiple sexual partnering. However, levels of condom use with casual and regular partners were not high overall. Also, condom use seems to be considered to be more acceptable by the culture and by individuals themselves if it occurs among casual sexual partners than for sexual interaction with regular partners or spouses. Consistent with other research, condom use with regular partners is looked upon unfavourably.

There is consistent evidence from all phases of the project of a strong relationship between alcohol use and sexual behaviour. Those who are more inclined to drink alcohol or to drink high quantities of alcohol are more inclined to have had more sexual partners and to report engaging in sex that they regret. This complements the existing literature by providing new insights into how alcohol use might be associated with sexual risk behaviour. Specifically, participants in the project reported that drinking gives rise to changes in their sexual arousal and feelings which in turn increases the chance of a sexual occurrence. They also indicated that drinking can decrease their control in sexual situations.

The relationship between alcohol use and condom use on the other hand was not strong. There were instances in the qualitative study of participants reporting that they would use condoms even if extremely intoxicated. The research has been equivocal on the subject, and the findings may differ depending on the age group of concern, with most of the existing literature having pertained to adolescents.

The study suggests that males' sexual behaviours are more likely than those of females to be affected by their consumption of alcohol. In the present study the men referred to being most affected sexually by drinking, and most likely to lose control in sexual situations as a result of their consumption of alcohol. They were also most likely to drink, to drink larger quantities when they do drink, to drink in public (e.g. bars, taverns and shebeens), and not as likely to drink with their regular sexual partners. Public places such as bars, taverns and shebeens are seen to be places in which encounters with potential sexual partners are most likely to occur.

Suggestions for further research

This project suggests a number of avenues for further research. A large-scale comprehensive study of the predictors of alcohol consumption, alcohol abuse and sexual risk behaviour would be of use. This section describes specific research questions that are worth addressing in future research.

First, although alcohol use seems to be associated with sexual risk behaviour, such an association is not inevitable. It seems that alcohol's effects on sexual behaviour might be mitigated by various protective factors, such as individuals' underlying beliefs about the importance of protecting themselves in the first place. Further research would be useful to determine the extent to which different types of sexual risk behaviour result from alcohol use, and the factors that might protect against alcohol's effects on sexual behaviour.

Second, the research suggested that rates of alcohol consumption in the general population are relatively low, but that for those who do drink, levels of 'risky drinking,' especially during weekends, are relatively high. Further research would be important in understanding why people drink at 'risky' levels. Such research can answer questions that arose in the researchers' minds on reviewing transcripts from the qualitative assessments such as (a) does heavy drinking exonerate people from the consequences of their behaviour? (b) is a conscious decision made to drink to intoxication in order to then engage in behaviours that violate the individual's moral and social code of conduct? (c) are such processes conscious, deliberate and or planned?

Third, are cultural beliefs about drinking by men vis-à-vis women impediments to drinking in a more sociable manner? For example, we became aware of resistance by males to visit drinking venues with their regular partners and their displeasure at having female partners who consumed alcohol. Females are less likely to frequent public drinking places, and those who do are more likely to be seen by males as targets for sexual advances. Would there be value in discouraging males with regular partners to drink alcohol in public drinking venues without their partners, and thereby reduce their chances of a meeting with and having risky sexual liaisons with unattached female strangers at those venues?

Fourth, sexual interactions are not always voluntary, but sometimes engaged in because people believe that they are under an obligation to provide their partners with such sexual favours. There were also indications of emotional, physical and financial consequences of refusing to engage in sexual intercourse with partners. Further research would be useful to examine the extent to which people, and particularly females, may be empowered to be able to refuse unwanted advances even in spite of social, emotional and financial consequences that may ensue.

Fifth, the research has focused on alcohol use as a precursor of sexual risk behaviour. However, the opposite might hold true. For example some focus group respondents reported on how sometimes, due to guilt that ensues following an alcohol-induced regretted sexual encounter, further drinking would occur and reduce the feelings of guilt. Further exploration of a possible cyclical association between alcohol use and sexual risk behaviour would be worth exploring.

Finally, little emphasis has been given to the role of alcohol use among HIV infected and affected individuals. Is there any chance that increased rates of drinking result from having a positive HIV status? Further research would be useful to investigate whether heavy alcohol use is in any way being fuelled by the HIV epidemic in South Africa.

Implications for intervention

This research indicates that the consumption of alcohol increases the chances of sexual encounters and sexual risk behaviour occurring. It is suggested that the main goals of interventions to reduce alcohol-related sexual risk behaviour should be to reduce (a) overall quantities of alcohol consumed, and (b) levels of engagement in sexual risk behaviour. Given the complexity of the behaviours, reducing them should require interventions at various levels identified in this research, including societal, cultural, community/contextual, family, and individual levels.

The research also has implications about the groups of individuals for whom interventions should be designed. It emerged that there were gender differences between some of the risk factors thereby necessitating targeted approaches to intervention for males and females. In addition, those who drink alcohol at 'risky' levels and their partners, and economically disadvantaged individuals should be a particular focus of interventions. The settings in which interventions might occur include communities, drinking venues, clinics and homes of community members.

With reduction of heavy alcohol consumption as one of the key goals of intervention, Table 10 provides examples of proposed strategies for preventing 'risky' drinking and treating those who engage in 'risky' drinking or exhibit a dependence on alcohol. Four approaches to intervention are proposed, which include, promoting norms discouraging alcohol intoxication, reducing access to and opportunities for heavy alcohol use, providing alternatives to alcohol consumption and providing treatment for those already abusing or dependent on alcohol.

Table 11 shows the proposed interventions for reducing sexual risk behaviour among people who engage in alcohol use. These include changing social norms, reducing opportunities, and empowering people to be able to negotiate safer sex behaviours with their partners.

Table 10. Proposed interventions for prevention and treatment of alcohol abuse

Level	Promote norms against 'risky' drinking (intoxication)	Reduce access to alcohol/opportunities for heavy drinking	Provide alternatives	Provide treatment/support
Societal	Introduce and enforce stricter laws and regulations for alcohol advertising	Introduce and enforce stricter laws and regulations regarding price, taxation, operating hours and licensing	Job creation; Increase availability/ access to recreational facilities	Increase government and NGO treatment, rehabilitation and counselling programmes
Cultural	Reduce cultural acceptance of intoxication/abuse	Target cultural occasions involving/promoting heavy drinking	Increase accessibility of non-drinking cultural events	Re-awaken culture/spirit of <i>ubuntu</i>
Community	Reduce community acceptance of intoxication/abuse	Reduce number of outlets; Close illegal venues; Monitoring operations of venues/outlets by community members	Increase/ improve community social clubs/ recreational facilities	Increase treatment, rehabilitation, counselling and self-help programmes
Contextual	Discourage high levels of intoxication in drinking venues; Sell refreshments and provide free drinking water	Provide server training to discourage intoxication among patrons; Increase server accountability for behaviour in venues	Introduce alternative entertainment in drinking venues	Provide resource lists in drinking venues
Familial (inter-personal)	Discourage heavy drinking in family settings	Target family occasions/functions involving/promoting heavy drinking	Encourage greater social interaction among families	Provide family therapy services; Encourage family intervention and support
Individual	Change positive attitudes to intoxication (e.g. health education); Increase accountability for alcohol-related negative consequences; Develop coping skills	Avoid places/functions where intoxication is condoned	Cultivate alternative interests and hobbies	Provision of individual therapy and counselling

Table 11. Proposed interventions for promoting safer sexual behaviours among alcohol users

Level	Promote norms in favour of safer sex	Increase opportunities for engaging in safer sex	Empowerment
Societal	Curtail alcohol advertisements that promote link between alcohol and sex; Encourage safer sexual behaviour; Encourage condom use; Encourage monogamy	Increase government and NGO condom distribution	Economic development; Job creation; Increase economic and social independence of women; Increase educational opportunities for men and women; Provide skills training
Cultural	Reduce cultural acceptance of multiple sexual partners; Increase acceptability of condom use with regular partners; Improve social position of women	Improve opportunities to access condoms by increasing cultural acceptance of condom use	Improve social position of women; Discourage women from placing sexual needs of partners above own
Community	Encourage/reward safer sexual practises; Disapprove of multiple partnering;	Easy access to condoms; Increase open communication about safer sex	Job creation; Provide social skills training; Increase educational opportunities
Contextual	Display attractive educational materials in drinking venues; Encourage safer sexual behaviour; Improve/upgrade quality of drinking venues	Easy access to condoms in drinking venues; Encourage vigilance where there are many opportunities for sexual encounters; Discourage transactional sex in drinking venues	Equip with skills for negotiating safer sex and resisting unwanted sexual advances
Family (inter-personal)	Encourage favourable attitudes towards safer sexual behaviours among partners	Encourage trust and open communication about safer sexual behaviour	Reduce power imbalances in relationships
Individual	Discourage attitudes in favour of multiple partners and against condom use	Encourage vigilance with respect to safer sex behaviours	Improve knowledge about sexual risk behaviour (e.g. dispel myths about HIV infection)

Interventions that have taken place as a result of the study

Since the start of the project the following interventions have been initiated within communities involved:

1. The owners of a number of venues in which the observations took place have embarked on renovating their venues and upgrading previously unhygienic toilet facilities.
2. The police have expressed great interest in using the results to inform their crime prevention activities.
3. The final report of the qualitative research was used by one CAB member involved in the revision of the liquor policy of the province of Gauteng, and another to support programmes on violence against women.
4. Some of the participants in the in-depth interviews indicated that they found beneficial having a rare opportunity to speak about personal problems to a person in whom they had confidence.
5. The report has been used to justify and leverage funding for a number of city improvement initiatives that are being planned for the city site in which the qualitative assessments were conducted.
6. Some participants have used the resource list that we distributed during the research successfully to access help for alcohol and HIV-related problems.
7. There was much enthusiasm about the study among members of the various communities in which the research took place, all of whom indicated that the research was very worthwhile.

APPENDICES

APPENDIX A

KEY INFORMANT INTERVIEW GUIDE QUESTIONS

Introduction

Thank you very much for agreeing to take part in this interview. This interview forms part of the first phase of our study. The main aims of this interview are to ask you about your perceptions of the use of alcohol in this community and the effects of alcohol use on people's behaviour in general and their sexual behaviours in particular.

Please note that there are no right or wrong answers to the questions. We are interested in your knowledge and understanding of alcohol and sexual risk behaviour. Your responses will remain confidential and will only be shared with the research team. You are free to decline to answer any questions you may not want to answer and to terminate this interview at any time.

Finally, please do remember that your name will not appear on this form. There will be no way of being able to identify you as the interviewee from this interview guide.

Before we begin I need to record some details about this interview.

Date: _____

Exact time: _____

Location: (the name of the site was inserted here)

Section 1: Drinking patterns of people living in _____

First we would like to ask you about drinking patterns of adult males and females who live in this area.

1. Tell me about the drinking patterns and habits of people in this community?

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2. To what extent do people use alcohol in this community?

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2a. Probe: Are there people who drink in moderation?

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3. Where do such people drink alcohol and why do they go there?

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3a. Probe: Do people drink indoors, outdoors or both? Please elaborate.

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3b. Probe: Are there any shebeens in this area?

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4. What types of alcoholic beverages do people drink?

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4b. Probe: What about home brews?

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5. Can you mention some of the brands of alcoholic drinks that they drink?

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5b. Probe: What about brands or types of home brews?

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6. How do they drink?

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6a. Probe: What kinds of containers do people drink out of?

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6b. Probe: Do people drink their drinks “neat” or do they “sponge” them or add mixers to them?

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6c. Probe: When they drink what other activities do they take part in, if any?

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6d. Probe: When they drink do they sit, stand?

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6e. Probe: Do they drink alone or with others? If with others, with whom do they drink?

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7. When do they drink - time during the day and period of the month?

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8. What does the drinking environment look like?

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8a. Probe: What kinds of people drink in these places?

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9. Describe the differences in drinking patterns of males and females, if any?

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10. What are the ages of those who abuse alcohol (or those who, in your opinion, drink too much)?

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11. Tell me about this community's reactions to drinking by people under 18 years of age (under-age drinking).

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11a. Probe: What about the reactions of people who sell or serve alcoholic drinks?

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12. How do you feel about alcohol use in [this site]?

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12a. Probe: What would you regard as acceptable and unacceptable alcohol use?

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13. What do people who drink alcohol think about their own drinking?

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14. Do they see it as the abuse of alcohol?

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15. What does the “name of site” community think about drinking?

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16. Why do people in “name of site” drink?

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17. What role does the culture or lifestyle of people in this community play in people’s drinking, if any?

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18. Does alcohol use go hand in hand with the use of other drugs?

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18a. Probe: What about the use of dagga? Do people who drink alcohol use dagga?

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19. Do you see alcohol as a drug?

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19a. Probe: What about people who drink. Do they see alcohol as a drug?

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20. What signs would help identify people who abuse alcohol?

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20a: Probe: What if they are not drunk?

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21. Tell me about alcohol advertising.

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21a. Probe: Are there a lot of alcohol advertisements in "this site"?

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21b. Probe: What forms do those alcohol advertisements take?

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21c. Probe: What impact does alcohol advertising have on drinking, if any?

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Section 2: Now we would like to move on to questions about the effects that drinking has on people.

22. What are the main positive consequences of drinking?

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22a. Probe: What about positive effects on the way people feel?

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22b. Probe: What about positive effects on the way people behave or interact with other people?

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22c. Probe: What about positive effects on people's physical health?

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22d. Probe: What about positive effects on people's mental health?

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23. What are the main negative consequences of drinking?

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23a. Probe: What about negative effects on the way people feel?

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23b. Probe: What about negative effects on the way people behave or interact with other people?

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23c. Probe: What about negative effects on people's physical health?

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23d. Probe: What about negative effects on people's mental health?

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Section 3: Alcohol use and sexual risk behaviour

Now we would like to talk about how people's sexual behaviour may change after drinking alcohol.

24. In your opinion what effects does drinking have on people's sexual behaviour if any?

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25. Are there any visible changes in sexual behaviour after people drink alcohol?

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26. Are the effects of alcohol on sexual behaviour the same for all people?

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26a. Probe: What about the effects on sexual arousal?

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26b. Probe: What about the effects on sexual performance?

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26c. Probe: What about the effects on sexual satisfaction?

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26d. Probe: What about the effects on safe/safer sex?

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26e. Probe: What about the effects of different types of alcoholic beverages?

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27. How do people feel about these effects?

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27a. Probe: Before drinking

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27b. Probe: During drinking

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27c. Probe: After drinking

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28. Who are the people most affected by risky sexual behaviour as a result of alcohol misuse?

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29. Are there differences in behaviour changes between males and females?

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30. Does the drinking environment contribute to behaviour change after alcohol consumption?

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31. What should be done to prevent alcohol abuse in this community?

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32. What should be done to prevent sexual risk behaviour in this community?

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Section 4: Follow-up research activities

33. As I have mentioned previously, this is the first the stage of the research. I am most grateful for your participation. Our next stage involves observational research. We hope to gain a first-hand understanding of people’s drinking, the venues in which it takes place, how people behave in those venues and what preventive measures can be put in place to minimise harm that can result from the abuse of alcohol.

Please can you tell me of venues in “this site” to visit in order to learn more about people’s drinking behaviour. Please mention the names of those venues and their location.

Once we have the names of those venues we will ask the owners for permission to conduct our research at those venues.

Please note that we will not mention your name as the person who has informed us about that venue. We will simply mention that one of our informants has told us that it is a useful venue to visit.

Venues	Name of venue	Type of venue	Location
Venue 1			
Venue 2			
Venue 3			
Venue 4			
Venue 5			
Venue 6			
Venue 7			
Venue 8			
Venue 9			
Venue 10			

34. Is there anything else we should know about drinking in this community and/or the effects of alcohol use and/or abuse on people's sexual risk behaviours?

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35. How do you feel about this interview? Was it worth it? How can we improve this tool?

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36. The main interview is now over. However, we would now like to fill in some details about you to help us with the analyses of the information that you have given us and that we are receiving from other people.

<u>Age</u>	Under 20	1
	21-25	2
	26-30	3
	31-35	4
	36-40	5
	41-45	6
	46-50	7
	51-55	8
	56 and above	9
<u>Gender</u>	Male	1
	Female	2
<u>Occupation</u>		
<u>Highest educational level</u>	Std 1	1
	Std 2	2
	Std 3	3
	Std 4	4
	Std 5	5
	Std 6	6
	Std 7	7
	Std 8	8
	Std 9	9
	Std 10	10
	Tertiary education (specify)	
	Post-graduate studies (specify)	
<u>Current place of residence</u>		
Duration of residence at current place		
<u>Race/Ethnicity</u>	White	1
	Black/African	2
	Coloured	3
	Indian	4
	Other	5

Thank you very much for your assistance. It is appreciated very much

APPENDIX B: OBSERVATION GUIDE

TARGET BEHAVIOURS/ACTIONS FOR OBSERVATION

People involved

Age, socio-economic status, race and gender

Attitudes and behaviour of proprietor

Encouraging/discouraging risky sexual behaviour/drinking

Behaviour

- Individual behaviour during the process of intoxication
- Effects of intoxication on behaviour

Language used

- During the process of intoxication (e.g. vocabulary, tone)
- Non-verbal cues (signs, contact, provocative gestures, petting and pinching)

Interaction

- The kind of people interacting (based on age, gender, marital and social status, and style of dress)
- Drinking partners (girl/boyfriends, wives/husbands)
- Kind of drinks
- Approximate quantity of alcohol consumed

Social hierarchy

The kind of people involved

Approach to non-group members/researchers

Interaction with new people or strangers

Environment/facilities

- Hygiene (e.g. in toilet facilities and bar/shebeen)
- Availability of condoms
- Availability of security (bouncers)
- Availability of sex workers
- Availability of accommodation
- Availability of transport services
- Availability of communication facilities (e.g. public phones)
- Nature of food served
- Type of music played

Timing

When do these activities take place most? (e.g. weekdays, weekends, public holidays, end of the month)

Educational awareness

About alcohol use, drug use, condom use, HIV/AIDS and smoking zones (through posters).

APPENDIC C: FOCUS GROUP QUESTIONS

PART ONE: DRINKERS

Section One: 20 minutes

We would like to talk about alcohol use in this area. Please feel free to discuss this topic. You are not going to be judged as being wrong or right.

Checklist

- Frequency of drinking
- Who drinks (e.g males, females, older and youth)
- Kinds of drinks consumed
- Other drugs used if any
- Encouraging factors [e.g. culture, availability, access and advertisement]
- Time of drinking
- How alcohol is consumed (e.g. bottles or glasses or sponging)
- Other activities with alcohol use
- Where drinking takes place
- Advantages and disadvantages of alcohol use (effects)

Section Two: 30 minutes

We would like to now discuss sex and sexuality. Please feel free to talk/discuss

Checklist

- Understanding of risky sexual behaviour and safe sexual behaviour
- Who is sexually active
- Do they practice safe sex (condom use)
- Sexual partners (Sugar Daddy/Mummy, homosexuality, causal sex)
- Sexual satisfaction
- Sexual arousal
- Multiple sexual relationships/polygamous relationships
- Types of sexual intercourse e.g. oral, anal
- What does the community say about sexual behaviour (acceptable or unacceptable)

Section Three: 30 minutes

We have discussed alcohol use and sexuality. Is there or is there not a link between alcohol use and risky sexual behaviour? Please feel free to discuss/talk about this issue. No one is right or wrong.

Checklist:

- Sexual performance (better or frustrating)
- Multiple sexual relationships
- Inconsistent condom use
- Sexual arousal and desire
- Sexual courage
- Verbal discussion before and after sexual intercourse

Section Four: 10 minutes

Based on your experience and the communities' and the discussions we have just engaged in, what do you think needs to be done to prevent alcohol abuse and risky sexual behaviour.

FOCUS GROUP GUIDE QUESTIONS AND CHECK LIST

PART TWO: PARTNERS

Partners of alcohol users (males and females of age group 25-44)

Section One: 20 minutes

We would like to discuss what it is like to be in a relationship with, or be a partner of a person who drinks alcohol.

- Frequency of drinking
- Who drinks
- Kinds of drinks consumed
- Other drugs used if any
- Encouraging factors (e.g. culture, availability, access and advertisement)
- Time of drinking
- How alcohol is consumed (e.g. bottles or glasses or sponging)
- Other activities with alcohol use
- Where drinking takes place
- Advantages and disadvantages of alcohol use (effects)
- Money spent
- Effects e.g health, diet, sleep, violence
- Life style

Section Two: 30 minutes

We would like to now discuss sex and sexuality. Please feel free to talk/discuss.

Checklist

- Understanding of risky sexual behaviour and safe sexual behaviour
- Who is sexually active
- Do they practice safe sex (condom use)
- Sexual partners (Sugar Daddy/Mammy, homosexuality, casual sex)
- Sexual satisfaction
- Sexual arousal
- Multiple sexual relationships/polygamous relationships
- Types of sexual intercourse e.g. oral, anal
- What does the community say about sexual behaviours (acceptable or unacceptable)

Section Three: 30 minutes

Let us now discuss the sexual behaviour of partners of alcohol users. How does drinking affect sexual behaviour of (a) people who drink (b) partners of people who do drink?

- Performance
- Satisfaction
- Arousal
- Safe sex
- Multiple partners
- Sex with other persons or sex workers
- Emotions
- Frustration
- Happiness
- Health (STDs and HIV/AIDS)

Section Four: 10 minutes

Based on your experience of the communities and the discussions we have just engaged in what do you think needs to be done to prevent alcohol abuse and risky sexual behaviour.

Appendix D: IN-DEPTH INTERVIEW QUESTIONS

Questions for 'Risky Drinkers'

A. Personal factors

I would like to ask you questions about your experiences concerning alcohol use and sexual behaviour please feel free during the interview.

A1. Can you please tell me about yourself?

A2. What do you find most meaningful in your life?

Probes for personal factors

1. *Family history and relationships*
2. *Professional issues*
3. *Relation with others*
4. *Intimate or private issues*
5. *Traumatic experience*
6. *Emotional experiences*
7. *Experiences with being loved*
8. *Personal relationships (Steady, casual or both).*
9. *Previous personal/romantic relationships*
10. *Ability to open up and discuss with someone*
11. *Ability to relate with others easily*

B. Alcohol use

You have been selected because you drink alcohol. Tell me about your drinking. (Reasons for drinking).

Probes for alcohol use

1. *Family experiences with alcohol use*
2. *Is drinking, a serious problem in your life?*
3. *Alcohol and other drugs*
4. *Change in social life (Possible effect on sexual behaviour and drinking patterns).*
5. *Internal feelings*
6. *Feelings of satisfaction or dissatisfaction about drinking*

C. Sex and sexuality

C1. Some people mention that their drinking influences their sexual behaviour. Some people say the influences can be positive. Some people say the influences can be negative. Please tell me about your own experiences.

C2. What about safe/safer sex? What is your understanding of why people need to practice safe sex does this apply to you? Please elaborate

Probes for sex and sexuality

- 1. How do you feel about sex?*
- 2. Sexual satisfaction in relation to alcohol use*
- 3. Sexual abilities and confidence (Arousal, impotence, premature ejaculation, orgasm, rigidity, size, etc.).*
- 4. Sexual aggression vis-à-vis sexual passiveness.*
- 5. Health in general*
- 6. STDs and HIV/AIDS*
- 7. Satisfaction with own sexuality (Manhood or womanhood).*
- 8. Personal beliefs about condom use (Initiating the use of condoms or not).*

D. Intervention

If you were to have any problems with drinking or sexual behaviour, what could be done to help you?

Probes for intervention

- 1. Ability to negotiate safe sex.*
- 2. Possible suggestions for intervention*
- 3. Ability decrease/control alcohol use*
- 4. Ability to seek professional/medical help*

Questions for Partners of 'Risky Drinkers'

A. Personal factors

I would like to ask you questions about feelings about your partner's drinking and sexual behaviour. Please feel free during the interview.

A1. Tell me about yourself

A2. What do you find most meaningful in your life?

Probes for personal factors

1. *Family history and relationships*
2. *Professional issues*
3. *Relation with others*
4. *Intimate or private issues*
5. *Traumatic experience.*
6. *Emotional experiences*
7. *Experiences with being loved*
8. *Personal relationships (steady, casual or both).*
9. *Previous personal/romantic relationships*
10. *Ability to open up and discuss with someone*
11. *Ability to relate with others easily*

B. Alcohol use

You have been selected because you have a partner who drinks alcohol. Tell me about your partner's drinking.

B1. Tell me about your feelings about your partner's drinking

B2. Do you drink yourself? Let's talk about it.

Probes for alcohol use

1. *Family experiences with alcohol use*
2. *Is drinking a serious problem in your life?*
3. *Alcohol and other drugs*
4. *Change in social life (Possible effect on sexual behaviour and drinking patterns).*
5. *Internal feelings*
6. *Feelings of satisfaction or dissatisfaction about drinking*

C. Sex and sexuality

Some people mention that their partner's drinking can influence sex between them. Some people say the influences can be positive. Some people say the influences can be negative. Please tell me about your own experiences.

C1. How would sex with your partner be different if he or she did not drink alcohol?

C2. What is your understanding of the notion of safe or safer sex?

C3. Why do people need to practice safe sex? Does this apply to you? Please elaborate

Probes for sex and sexuality

1. *How do you feel about sex?*

2. *Sexual satisfaction in relation to alcohol use*

3. *Sexual ability and confidence (Arousal, impotence, premature ejaculation, orgasm, rigidity, size, etc.).*

4. *Sexual aggression vis-à-vis sexual passiveness.*

5. *Health in general*

6. *STDs and HIV/AIDS*

7. *Satisfaction with own sexuality (Manhood or womanhood).*

8. *Personal beliefs about condom use (Initiating the use of condom or not).*

D. Intervention

If you were to have any problems with drinking or sexual behaviour, what could be done to help you?

1. Ability to negotiate safe sex.

2. Possible suggestions for intervention

3. Ability to decrease/control alcohol use

4. Ability to seek professional/medical help

APPENDIX E: MINI-SURVEY QUESTIONNAIRE

ALCOHOL & HEALTH STUDY

QUESTIONNAIRE

Questionnaire Number

Interviewer Number

Community

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ALCOHOL & HEALTH STUDY

EXACT TIME NOW: _____

DATE: _____

GENERAL INSTRUCTIONS

This interview is part of a study on alcohol use and sexual behaviour. The questions will cover a variety of topics concerning your attitudes, feelings, experiences and behaviour.

There are no right or wrong answers to the questions asked. Please feel free to answer just what you think. If there are questions you really do not want to answer, you may skip them. You may also refuse to answer all the questions in this questionnaire. If you happen to change your mind at any time after having consented to participate, you are free to withdraw your consent and your questionnaire from the study.

PLEASE REMEMBER THAT YOUR NAME WILL NOT BE PUT ON THIS QUESTIONNAIRE. Your answers will not be shared with anyone. Only the research staff will have access to the questionnaire once it has been completed.

We will work through the questionnaire as follows: All your answers will be marked in my copy of the questionnaire. I will ask the questions and give you the answer choices. You will have a copy of the questionnaire so that you can follow along. Pick the answer that is the closest to how you feel. Usually I will want you to tell me the number that goes with the answer you pick. When we get to the sections on alcohol use and sexual behaviour we will swap the questionnaires. You will then mark your answers in the questionnaire. I will not see your answers. Nor will I ask you what your answers are.

The interview will take between twenty minutes and forty minutes to complete.

Thank you for helping us with this study.

Throughout the questionnaire, please circle the correct response.

Section 1: Demographic Characteristics

First we would like to ask you a few questions about yourself.

1.1 How old were you at your last birthday? _____ Years

1.2 Male or female? [Code by observation]

Female	1
Male	2

1.3 What is the highest standard/grade you completed at school?

Less than one year completed	1
Sub A/Class 1/Grade 1	2
Sub A/Class 2/Grade 2	3
Standard 1/Grade 3	4
Standard 2/Grade 4	5
Standard 3/Grade 5	6
Standard 4/Grade 6	7
Standard 5/Grade 7	8
Standard 6/Grade 8	9
Standard 7/Grade 9	10
Standard 8/Grade 10	11
Standard 9/Grade 11	12
Standard 10/Grade 12	13
Further studies – incomplete	14
Diploma/other post school – complete	15
Degree	16

1.4 What is your current marital status?

Legally married	1
Traditionally married	2
Living with man or woman in union	3
Never married	4
Divorced	5
Married but separated	6
Widow/ed	7

1.5 Which of the following is the main language spoken at home? (Please circle only one)

English	1
Afrikaans	2
IsiXhosa	3
IsiZulu	4
SeSotho	5
SeTswana	6
SePedi	7
SiSwati	8
TshiVenda	9
Xitsonga	10
IsiNdebele	11
Other (please specify)	12

1.6 Which race group do you consider yourself to belong to?

Black/African	1
Coloured	2
White	3
Asian/Indian	4
Other	5

Section 2: Economic factors

Now we would like to ask a few questions about you, your work and the money that you have to spend.

2.1 Which of the following describes your current employment status?

Unemployed	1
Self employed part-time	2
Self employed full-time	3
Employed part-time	4
Employed full-time	5

2.2 What kind of work do you do? (If working, please tell me your occupation. For example, plumber, street trader, cattle farmer, primary school teacher, domestic worker)

Not working	1
Working	2

2.3 If you are not working, how do you spend your time when other people are at work?

2.4 Let us speak about the household and what it can afford. Would you say that the people here often, sometimes, seldom or never go hungry?

Often	1
Sometimes	2
Seldom	3
Never	4

2.5 Please indicate which of the following are your sources of income. Please answer this question whether or not you are currently employed. (Please circle all that apply)

My job	1
Spouse/partner	2
Parents	3
Brothers and/or sisters	4
Children	5
Donations	6
Other, please specify	7

Section 3: Community factors

Now we would like to ask you a few questions about this community. Please indicate how strongly you agree or disagree with each of the following statements.

3.1 There are many recreational facilities in your community

Strongly agree	1
Moderately agree	2
Neither agree nor disagree	3
Moderately disagree	4
Strongly disagree	5

3.2 You can easily use the recreational facilities in your community

Strongly agree	1
Moderately agree	2
Neither agree nor disagree	3
Moderately disagree	4
Strongly disagree	5

3.3 It is easy for you to buy alcohol in your community if you want to.

Strongly agree	1
Moderately agree	2
Neither agree nor disagree	3
Moderately disagree	4
Strongly disagree	5

3.4 A lot of people drink heavily in your community.

Strongly agree	1
Moderately agree	2
Neither agree nor disagree	3
Moderately disagree	4
Strongly disagree	5

3.5 Your community accepts the abuse of alcohol

Strongly agree	1
Moderately agree	2
Neither agree nor disagree	3
Moderately disagree	4
Strongly disagree	5

3.6 There are many advertisements of alcoholic drinks in your community

Strongly agree	1
Moderately agree	2
Neither agree nor disagree	3
Moderately disagree	4
Strongly disagree	5

PLEASE SWOP THE QUESTIONNAIRES

Section 4: Alcohol use

The questions in this section are about your drinking of alcoholic beverages.

4.1 Have you ever drunk alcohol?

Yes	1
No	2

If response is no, please move on to Section 5.

4.2 On how many days have you drunk alcohol during the past month?

Days	
------	--

4.3 How often have you drunk alcohol in the past twelve months?

Never	0
Only a few times	1
Less than once a month	2
About once a month	3
Less than once a month but more than once a week	4
Once or twice per week	5
Three or four times per week	6
Five or six times per week	7
Every day	8

4.4 What type(s) of alcoholic beverages do you usually drink? (Please circle all that apply)

Beer	1
Cider	2
Wine	3
Coolers (e.g. Bacardi Breezer, Solantis, Smirnoff Ice)	4
Spirits	5
Home brew	6

4.5 How many alcoholic drinks do you usually consume on a typical occasion when you are drinking? (Please note that one drink is equivalent to one can or bottle of beer, cider or coolers, one glass of wine, or one tot of spirits).

I never drink	0
About 1-2 drinks	1
About 3-4 drinks	2
About 5-6 drinks	3
More than 6 drinks	4
Other, please specify. (If respondent drinks homebrew please ask him or her to indicate the name of the homebrew, size of container and quantity.)	5

4.6 In which type(s) of venues or events do you usually drink alcohol? (Please circle yes to all that apply and no to all that do not apply)

	Yes	No
Home	1	2
Park	1	2
Restaurant	1	2
Tavern	1	2
Shebeen	1	2
Bar	1	2
Car park(s)	1	2
Friend's home	1	2
Party	1	2
Festival/Concert	1	2
Other (please specify)	1	2

4.7 With whom do you usually drink alcohol?

Alone	1
With friend(s)	2
With whoever is in the 'drinking venue'	3
With potential or actual client	4
With partner	5
With other (please specify)	6

4.8 How often have you used drugs (such as dagga, mandrax, or shabba) while you were drinking alcohol?

Every time I drink	1
Most times when I drink	2
Sometimes when I drink	3
Rarely when I drink	4
Never	5

4.9 Whom among the following family members has had an alcohol problem? (Please circle yes to all that apply and no to all that do not apply)

	Yes	No
Mother	1	2
Father	1	2
Uncle	1	2
Aunt	1	2
Sister	1	2
Brother	1	2

4.10 Have you ever been told that you drink too much?

Yes	1
No	2

Section 5: Sexual Behaviour

This section deals with sexual behaviour.

5.1 Your spouse or current regular partner is....

More than ten years older than you	0
Between five and ten years older than you	1
About the same age as you (not more than 5 years older or younger)	2
Between five and ten years younger than you	3
More than ten years younger than you	4
Do not have a spouse or regular sexual partner	9

5.2 What is the total number of sexual partners you have had in:

	Your lifetime	The past three months
None	0	0
1	1	1
2-3	2	2
4-5	3	3
6-7	4	4
8-9	5	5
More than 9	6	6

5.3 How often have you had sex that you regretted having had in the past three months?

Never	0
1-3 times	1
4-6 times	2
7-9 times	3
10-12 times	4
More than 12 times	5

5.4 How often have you had sex under the influence of alcohol in the past three months?

Never	0
1-3 times	1
4-6 times	2
7-9 times	3
10-12 times	4
More than 12 times	5

5.5 How often have you had sex under the influence of illicit drugs (such as dagga, mandrax or shabba) in the past three months?

Never	0
1-3 times	1
4-6 times	2
7-9 times	3
10-12 times	4
More than 12 times	5

Section 6: Culture

This section has questions concerning your culture. We are interested in knowing what kinds of behaviour would be acceptable according to your culture and the kinds of behaviour that would be unacceptable according to your culture.

- 6.1 According to your culture is it always, usually, sometimes or never wrong for men to have sexual intercourse with their female partners whenever they want to have sex with them?

Always wrong	1
Usually wrong	2
Sometimes wrong	3
Never wrong	4

- 6.2 According to your culture, is it always, usually, sometimes or never wrong to hit your spouse or partner?

Always wrong	1
Usually wrong	2
Sometimes wrong	3
Never wrong	4

- 6.3 According to your culture, is it always, usually, sometimes or never wrong for you to use condoms when you have sexual intercourse with your spouse or regular partner(s)?

Always wrong	1
Usually wrong	2
Sometimes wrong	3
Never wrong	4

- 6.4 According to your culture, is it always, usually, sometimes or never wrong for you to use condoms when you have sexual intercourse with your casual partner(s)?

Always wrong	1
Usually wrong	2
Sometimes wrong	3
Never wrong	4

Section 7: Condom use

The questions in this section concern condom use.

7.1 When was the last time you used a condom, if ever?

Within 24 hours	1
Within the past week	2
Within the past month	3
Within the past three months	4
Within the past six months	5
Within the past nine months	6
Within the past twelve months	7
More than a year ago	8
Never used a condom	9

7.2 How frequently have you used condoms with your spouse or regular partner(s) in the past 3 months?

Always	1
Sometimes	2
Seldom	3
Never	4
Not applicable (respondent had no spouse or regular partner in the past 3 months.)	9

7.3 How frequently have you used condoms with casual partners in the past 3 months?

Always	1
Sometimes	2
Seldom	3
Never	4
Not applicable (respondent had no casual partners in the past 3 months.)	9

7.4 How easy is it for you to buy condoms in your community?

Very difficult	1
Quite difficult	2
Neither easy nor difficult	3
Quite easy	4
Very easy	5

7.5 How easy is it for you to get free condoms in your community?

Very difficult	1
Quite difficult	2
Neither easy nor difficult	3
Quite easy	4
Very easy	5

7.6 How important is it for you to use condoms when you have sexual intercourse with a casual partner?

Extremely important	1
Quite important	2
Neither important nor unimportant	3
Quite unimportant	4
Extremely unimportant	5

7.7 How important is it for you to use condoms when you have sexual intercourse with your regular partner?

Extremely important	1
Quite important	2
Neither important nor Unimportant	3
Quite unimportant	4
Extremely unimportant	5

Section 8: Effects of alcohol consumption

The questions in this section concern the ways in which your drinking influences the way you think, feel and behave.

Yes	1
No	2

8.1 Have you ever drunk alcohol in your life?

If you have never drunk alcohol in your life, please move on to Section 9.

When you drink alcohol....

8.2 Your desire to have sex with your spouse or regular sexual partner...

Increases a great deal	1
Increases slightly	2
Remains the same as when not drinking	3
Decreases slightly	4
Decreases a great deal	5

8.3 Your desire to have sex with a casual partner...

Increases a great deal	1
Increases slightly	2
Remains the same as when not drinking	3
Decreases slightly	4
Decreases a great deal	5

8.4 The pleasure of sexual intercourse...

Increases a great deal	1
Increases slightly	2
Remains the same as when not drinking	3
Decreases slightly	4
Decreases a great deal	5

8.5 Your sexual performance...

Improves a great deal	1
Improves slightly	2
Remains the same as when not drinking	3
Worsens slightly	4
Worsens a great deal	5

8.6 Your ability to insist on using condoms with your sexual partner...

Improves a great deal	1
Improves slightly	2
Remains the same as when not drinking	3
Worsens slightly	4
Worsens a great deal	5

8.7 Your ability to resist (or say no to) unwanted sexual advances...

Improves a great deal	1
Improves slightly	2
Remains the same as when not drinking	3
Worsens slightly	4
Worsens a great deal	5

8.8 Drinking alcohol before having sex...

Makes you very much more likely to think about using condoms	1
Makes you a little more likely to think about using condoms	2
Does not change your thoughts on using condoms	3
Makes you less likely to think about using condoms	4
Makes you completely forget about using condoms at all	5

8.9 Drinking alcohol before having sex...

Makes you very much more likely to have sex that you will regret	1
Makes you a little more likely to have sex that you will regret	2
Does not change your sexual behaviour	3
Makes you less likely to have sex that you will regret	4
Makes you very much less likely to have sex that you will regret	5

Section 9: Sexual partners

We would now like to ask you how you feel/or would feel about having more than one sexual partner in your life.

9.1 For you to have more than one sexual partner is:

Extremely enjoyable	1
Moderately enjoyable	2
Neither enjoyable nor unenjoyable	3
Moderately unenjoyable	4
Extremely unenjoyable	5

9.2 For you to have more than one sexual partner is:

Extremely healthy	1
Moderately healthy	2
Neither healthy nor unhealthy	3
Moderately unhealthy	4
Extremely unhealthy	5

9.3 For you to have more than one sexual partner is:

Extremely acceptable according to your culture	1
Moderately acceptable according to your culture	2
Neither acceptable nor unacceptable according to your culture	3
Moderately unacceptable according to your culture	4
Extremely unacceptable according to your culture	5

9.4 For you to have more than one sexual partner is:

Extremely easy	1
Moderately easy	2
Neither easy nor difficult	3
Moderately difficult	4
Extremely difficult	5

9.5 For you to have more than one sexual partner is:

Completely under your control	1
Moderately under your control	2
Neither under your control nor out of your control	3
Moderately out of your control	4
Completely out of your control	5

9.6 Most people who are important to you think that you should have more than one sexual partner

Strongly agree	1
Moderately agree	2
Neither agree nor disagree	3
Moderately disagree	4
Strongly disagree	5

9.7 For you to have more than one sexual partner increases your chances of contracting HIV:

Strongly agree	1
Moderately agree	2
Neither agree nor disagree	3
Moderately disagree	4
Strongly disagree	5

Section 10: Expectations regarding sexual behaviour

The following questions concern what may happen if you do or do not have sex with your sexual partner.

10.1 Sometimes you have sex even if you do not want to because it is expected of you by your sexual partner:

Strongly agree	1
Moderately agree	2
Neither agree nor disagree	3
Moderately disagree	4
Strongly disagree	5

10.2 Sometimes you have sex even if you do not want to because you are afraid to say no:

Strongly agree	1
Moderately agree	2
Neither agree nor disagree	3
Moderately disagree	4
Strongly disagree	5

10.3 If you refuse to have sex with your sexual partner he or she will refuse to give you money or pay the bills:

Strongly agree	1
Moderately agree	2
Neither agree nor disagree	3
Moderately disagree	4
Strongly disagree	5

10.4 If you refuse to have sex with your sexual partner he or she will stop giving his/her love:

Strongly agree	1
Moderately agree	2
Neither agree nor disagree	3
Moderately disagree	4
Strongly disagree	5

10.5 If you refuse to have sex with your sexual partner he or she will become angry or shout at you:

Strongly agree	1
Moderately agree	2
Neither agree nor disagree	3
Moderately disagree	4
Strongly disagree	5

10.6 If you refuse to have sex with your sexual partner he or she will hit you or beat you:

Strongly agree	1
Moderately agree	2
Neither agree nor disagree	3
Moderately disagree	4
Strongly disagree	5

Section 11: HIV

The questions in this section concern your thoughts on safety in sexual behaviour and HIV. Please note questions 11.1 and 11.2 concern your thoughts and not your experiences.

11.1 Which is safer? Sex with an older woman or sex with a younger woman?

Sex with an older woman is safer	1
Sex with an older woman is as safe as sex with a younger woman	2
Sex with a younger woman is safer	3

11.2 Which is safer? Sex with an older man or sex with a younger man?

Sex with an older man is safer	1
Sex with an older man is as safe as sex with a younger man	2
Sex with a younger man is safer	3

11.3 How likely are you to become infected with HIV?

Extremely likely	1
Quite likely	2
Neither likely nor unlikely	3
Quite unlikely	4
Extremely unlikely	5

11.4 How likely is it that your spouse or regular sexual partner is infected with HIV at present?

Extremely likely	1
Quite likely	2
Neither likely nor unlikely	3
Quite unlikely	4
Extremely unlikely	5
Not applicable (respondent has no spouse or regular sexual partner)	9

11.5 How likely is it that any of your casual sexual partners are infected with HIV at present?

Extremely likely	1
Quite likely	2
Neither likely nor unlikely	3
Quite unlikely	4
Extremely unlikely	5
Not applicable (respondent has no casual sexual partner)	9

INTERVIEWER TO TAKE BACK THE QUESTIONNAIRE

Section 12: Inter and intra-personal factors

12.1 You are satisfied with your relationship with your parents or primary caregivers:

Strongly agree	1
Moderately agree	2
Neither agree nor disagree	3
Moderately disagree	4
Strongly disagree	5
Not applicable (respondent has no parents)	9

12.2 You are satisfied with your relationship with members of your community:

Strongly agree	1
Moderately agree	2
Neither agree nor disagree	3
Moderately disagree	4
Strongly disagree	5

12.3 You are satisfied with your relationship with your spouse/partner:

Strongly agree	1
Moderately agree	2
Neither agree nor disagree	3
Moderately disagree	4
Strongly disagree	5
Not applicable (respondent has no spouse Or partner)	9

12.4 Sometimes there are serious disagreements between you and your spouse/partner:

Strongly agree	1
Moderately agree	2
Neither agree nor disagree	3
Moderately disagree	4
Strongly disagree	5
Not applicable (respondent has no spouse Or partner)	9

12.5 Sometimes there is hitting or slapping between you and your spouse /partner:

Strongly agree	1
Moderately agree	2
Neither agree nor disagree	3
Moderately disagree	4
Strongly disagree	5
Not applicable (respondent has no spouse Or partner)	9

12.6 You have a lot of control in your relationship with your spouse/partner:

Strongly agree	1
Moderately agree	2
Neither agree nor disagree	3
Moderately disagree	4
Strongly disagree	5
Not applicable (respondent has no spouse Or partner)	9

12.7 There is a lot of trust between you and your spouse/partner:

Strongly agree	1
Moderately agree	2
Neither agree nor disagree	3
Moderately disagree	4
Strongly disagree	5
Not applicable (respondent has no spouse or partner)	9

12.8 Sometimes there are serious disagreements between you and your spouse/partner:

Strongly agree	1
Moderately agree	2
Neither agree nor disagree	3
Moderately disagree	4
Strongly disagree	5
Not applicable (respondent has no spouse or partner)	9

Section 13: General circumstances

13.1 Please name the most positive thing about the community in which you live

13.2 Please name the most positive thing about your culture

13.3 Please name the most positive thing about the way you grew up

13.4 If you could change one thing about your life now, what would it be?

13.5 Please name one thing about your life that you would like to keep unchanged.

THANK YOU VERY MUCH

WE REALLY APPRECIATE YOUR HELP

I certify that this interview has been completed in full; with the respondent, and according to the instructions I received from the trainers; and that the information I received will be kept strictly confidential.

SIGNED:

(INTERVIEWER'S SIGNATURE)

(DATE)

(EXACT TIME OF COMPLETION)

APPENDIX F: PARTICIPANT INFORMATION LEAFLET AND INFORMED CONSENT:

(Each participant must receive, read and understand this document before the start of the study)

STUDY TITLE

Alcohol use, health and sexual risk behaviour among adults in Pretoria, South Africa: Phase 2

INTRODUCTION

You are invited to volunteer for a research study. This information leaflet is to help you to decide if you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions, which are not fully explained in this leaflet, do not hesitate to ask the investigator. You should not agree to take part unless you are completely happy about all the procedures involved.

WHAT IS THE PURPOSE OF THIS STUDY?

The main purpose of the study is to explore the ways in which alcohol misuse is linked to sexual risk behaviour. During the study you will be interviewed. In other words, you will be asked questions about yourself, your work situation, your relationship with other people, your attitudes, feelings and behaviour with respect to the use of alcohol and sexual behaviours. Please note that you have the right to read through the questionnaire before deciding whether or not you want to participate in the study.

WHAT IS THE DURATION OF THIS STUDY?

If you decide to take part you will be one of approximately 198 people involved. The entire study will last for up to two months during which time you will be interviewed on only one occasion. The interview should last for between twenty and forty minutes.

HAS THE STUDY RECEIVED ETHICAL APPROVAL?

The study Protocol was submitted to the Faculty of Health Sciences Research Ethics Committee of the University of Pretoria and written approval has been granted by that committee. The study has been structured in accordance with the Declaration of Helsinki (last update: October 2000), which deals with the recommendations guiding doctors in biomedical research involving human/subjects. A copy of which may be obtained from the investigator should you wish to review it.

WHAT ARE MY RIGHTS AS A PARTICIPANT IN THIS STUDY?

Your participation in this study is entirely voluntary and you can refuse to participate or stop at any time without stating any reason. You can also withdraw your consent at any time, before, during or at the end of the interview.

MAY ANY OF THESE STUDY PROCEDURES RESULT IN DISCOMFORT OR INCONVENIENCE?

You may feel uncomfortable about answering some of the questions as they deal with some sensitive issues. For this study we will ask you some sensitive questions concerning the use of alcohol and sexual behaviour. If you do feel uncomfortable about answering certain questions you may decline to do so. The questions will be asked in a language that you understand.

WHAT ARE THE RISKS INVOLVED IN THIS STUDY?

The only potential risk involved in this study is the chance that you may feel uncomfortable when answering some of the sensitive questions on alcohol use and sexual behaviour.

WHAT ARE THE BENEFITS INVOLVED IN THIS STUDY?

This study will provide a better understanding of how alcohol use impacts on sexual behaviour. The information that is gained from this study will be useful for policies and programmes aimed at preventing sexual risk behaviour and alcohol misuse among people in communities.

SOURCE OF ADDITIONAL INFORMATION

The project manager for the overall duration of the study is Ms. Millicent Kachieng'a. If at any time during the study you feel uncomfortable as a result of answering questions in the interview or you have any questions, please do not hesitate to contact her. The telephone number at which she can be reached is (083) 994-6985.

CONFIDENTIALITY

The interviews will take place in private. All information obtained during the course of this study is strictly confidential. The questionnaires will all be stored in a locked filing cabinet in the office of the Principal Investigator (Dr. Neo Morojele) at the Medical Research Council when not in use. The research material will only be seen by members of the research team. Results of the study that may be reported in scientific journals will not include any information which identifies you as a participant in this study, or this community as the study site.

INFORMED CONSENT

I hereby confirm that I have been informed by the investigator, Dr Morojele, or her associate, about the nature, conduct, benefits and risks of the study. I have also received, read and understood the above written information (Participant Information Leaflet and Informed Consent) regarding the study.

I am aware that the results of the study, including personal details regarding my sex, age, date of birth, and initials will be anonymously processed into a study report.

I may, at any stage, without prejudice, withdraw my consent and participation in the study. I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.

Participant's name _____ (Please print)

Participant's signature _____ Date _____

Investigator's name _____ (Please print)

Investigator's signature _____ Date _____

I, Dr Morojele/Delegate, herewith confirm that the above participant has been informed fully about the nature, conduct and risks of the above study.

Witness's name* _____ (Please print)

*Consent procedure should be witnessed whenever possible.

Witness's signature _____ Date _____

VERBAL PARTICIPANT INFORMED CONSENT

(applicable when participants cannot read or write)

I, the undersigned, Dr Morojele/Delegate have read and have explained fully to the participant, named and/or his/her relative, the participant information leaflet, which has indicated the nature and purpose of the study in which I have asked the participant to take part. The explanation I have given has mentioned both the possible risks and benefits of the study. The participant indicated that he/she understands that he/she will be free to withdraw from the study at any time for any reason and there will be no negative consequences associated with not participating in the study.

I hereby certify that the participant has agreed to participate in this study.

Participant's Name	_____	(Please print)
Investigator's Name	_____	(Please print)
Investigator's Signature	_____	Date _____
Witness's Name	_____	(Please print)
Witness's Signature	_____	Date _____