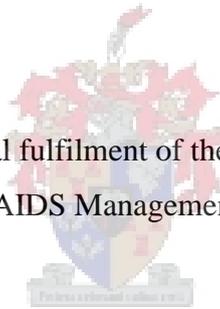


**THE EFFECT OF ALCOHOL ABUSE ON HIGH-RISK SEXUAL  
BEHAVIOUR AMONG STUDENTS IN MAFIKENG**

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Assignment presented in partial fulfilment of the requirements for the degree of  
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## **Declaration**

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the owner of the copyright thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

March 2009

## **Abstract**

Alcohol abuse among the student population in Mafikeng frequently leads to irresponsible sexual behaviour. Too many students acquire sexually transmitted infections (STIs), including the human immunodeficiency virus (HIV) infection or become pregnant. Furthermore, this behaviour can accelerate the spread of HIV among the people in local and surrounding areas. This study focused on the effect of alcohol abuse on high risk sexual behaviour. This risky sexual behaviour by students presents a major challenge to the different sectors (i.e. Learning institutions, Departments of Education, Health and Social Services; and Local AIDS Council) on the management of HIV and AIDS in Mafikeng.

Research has shown that the likelihood that an individual may engage in irresponsible sex increases with the consumption of alcohol. It has also revealed that the level of alcohol consumption is a predictor of sexual involvement.

The major objective of the study was to examine alcohol use and sexual risk behaviour within the student population in Mafikeng. The other objective was to describe the social dynamics of alcohol abuse on risky sexual behaviour among students at the nightclubs and taverns.

The methods used to collect the data from students (higher institution and high school) were focus groups, and interviews were used for clinic administrators and drinking establishment owners within the study area. During fieldwork the participants were selected by approaching individuals at drinking establishments and medical centres. The establishments where participants were selected were located within a radius of 5km from the university.

The findings provide a consistent picture of high rates of alcohol abuse, binge drinking and daily drinking in these places. The health centres also show high rates of cases of sexually transmitted infections and unplanned pregnancies. The findings show clear link between the high rates of cases of sexually transmitted infections and unplanned pregnancies and alcohol abuse.

## **Opsomming**

Alkoholmisbruik onder die studentebevolking in Mafikeng lei dikwels tot onverantwoordelike seksuele gedrag. Te veel studente doen seksueel oorgedraagde infeksies (SOIs) op, insluitende infeksie met die menslike immuuntekortvirus (MIV), of raak swanger. Verder kan hierdie gedrag die verspreiding van MIV onder mense in die plaaslike en omliggende omgewing versnel. Hierdie studie het op die effek van alkoholmisbruik op hoërisiko seksuele gedrag gefokus. Hierdie riskante seksuele gedrag onder studente verteenwoordig 'n groot uitdaging vir die verskillende sektore (d.w.s. leerinstellings, onderwysdepartemente, gesondheids- en maatskaplike dienste, en die plaaslike VIGS-raad) wat betref die bestuur van MIV en VIGS in Mafikeng.

Navorsing het getoon dat die waarskynlikheid dat 'n persoon by onverantwoordelike seksuele gedrag betrokke kan raak met die inname van alkohol toeneem. Dit het ook aan die lig gebring dat die vlak van alkoholverbruik 'n voorspeller van seksuele betrokke is.

Die belangrikste oogmerk van hierdie studie was om alkoholgebruik en seksuele risikogedrag binne die studentebevolking in Mafikeng te ondersoek. Die ander oogmerk was om die maatskaplike dinamiek van alkoholmisbruik en riskante seksuele gedrag onder studente in nagklubs en drinkplekke te beskryf.

Die metodes wat gebruik is om die data onder studente (van tersiêre instansies en hoërskole) te versamel het uit fokusgroepe bestaan, terwyl onderhoude met kliniekadministrateurs en eienaars van drinkplekke binne die gebied van die studie plaasgevind het. Gedurende die veldwerk is die deelnemers gekies deur individue by drinkplekke en mediese sentrums te nader. Die drinkplekke waar deelnemers gekies is was binne 'n radius van 5 km van die Universiteit geleë.

Die bevindinge bied 'n konsekwente beeld van hoë vlakke van alkoholmisbruik, drinkvergryping ("binge drinking") en daaglikse drinkery by hierdie plekke. Die gesondheidsentrums toon ook hoë voorkomssyfers wat betref seksueel oorgedraagde infeksies en onbeplande swangerskappe. Die bevindinge 'n duidelike verband tussen die hoë voorkomskoerse van gevalle van seksueel oorgedraagde infeksies en onbeplande swangerskappe enersyds en alkoholmisbruik andersyds.

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## 1. Introduction

A history of heavy alcohol abuse has been correlated with a lifetime tendency towards high-risk sexual behaviours, including unprotected intercourse, multiple sex partners, sex with high-risk partners (for example truck drivers and prostitutes), incorrect use of condoms and the exchange of sex for money or drugs (Gumedde, 1995; Cooper, 2002; Kaiser Family Foundation, 2007). There is evidence that alcohol increases the likelihood of sexual behaviour that puts a person at risk of contracting STI and HIV. However, the relationship between alcohol use and sexual behaviour is complex and not well understood (Dailard, 2001). It is important to understand the responses of individuals and communities in an attempt to control STIs and to change behaviour (Mataute *et al.*, 2002). It should also be noted that public health education is generally regarded as the single most important step in stemming the spread of HIV infection, which leads to acquired immune deficiency syndrome (AIDS) (Cooper *et al.*, 1999; Lucas *et al.*, 2002).

There may be many reasons for the relationship between alcohol use and risky sexual behaviour (Mataute *et al.*, 2002). For example, alcohol can act directly on the brain to reduce inhibitions and diminish risk perception. However, expectations about the effects of alcohol may exert a more powerful influence on sexual behaviour (Stall, 1986; Avins *et al.*, 1994; Windle, 1997; Dermen *et al.*, 1998; Morojele *et al.*, 2000; Mataute *et al.*, 2002). The potential effects have been researched in diverse fields. Different studies indicate that the perceived effects of alcohol are influenced by the following factors, to mention but a few: culture, religion, personal characteristics and legislation (Briddell & Wilson, 1976; Wilson, 1981; Gumedde, 1995; Markos, 2005).

South Africa is experiencing an increase in the use of various drugs such as alcohol, tobacco and marijuana. Substance abuse is reported to be associated with greater risk behaviour. According to Kalule-Sabiti *et al.* (2007) there has been an increase in substance abuse and risky sexual behaviour in the North-West Province. This has led to an increase in HIV cases among adolescents.

This study, which examines various aspects of alcohol use and high-risk sexual behaviour among students, is organised into five sections. The first section covers the operational definition of the concepts used, the aim and objective and lastly the research hypothesis relating to the study. The literature review section provides the

relevant background and contextual information, including a concise overview of theoretical explanations for the link between alcohol abuse and risky sexual behaviour. The methodology section outlines the methods used in this study, which include preliminary fieldwork, interviews, focus groups, sampling design, recruitment, tools, measures and procedures followed. Furthermore, it indicates the tools used to analyse the data collected. The research findings section summarises the data collected on the prevalence of drinking and sexual behaviour among students in Mafikeng and then reviews and evaluates the evidence for the co-occurrence or overlap of these behaviours. Finally, the fifth section concludes with a summary of findings and offers recommendations for intervention and further research.

## **2. Problem statement**

Alcohol abuse among students in Mafikeng frequently leads to irresponsible and risky sexual behaviour. Too many students become pregnant or acquire STIs, including HIV infection. This leads to the spread of HIV among people in the local and surrounding areas. Risky sexual behaviour by students presents a major challenge to different institutions and sectors (i.e. the North-West University, the Taletso Technical College, Mmabatho Nursing College, the Department of Education, Health and Social Services and the Local AIDS Council) with regard to the management of HIV/AIDS in Mafikeng.

The University of the North-West HIV and AIDS risk profile of 2004 indicates that the percentage of sexually active students living in residences increased from 10% to 21% since the earlier risk profile of 2000. The findings in this report indicate that the percentage of students (male and female) who have had sexual intercourse and multiple sex partners increased and that the percentage of sexually active students who used a condom at their last sexual intercourse increased and then levelled off (University of the North-West HIV and AIDS risk profile, 2004). This increase in health risk behaviours corresponds with a simultaneous increase in gonorrhoea and unplanned pregnancy rates among adolescents (Petry, 1999; University of the North-West HIV and AIDS risk profile, 2004).

### **2.1 Operational definition of concepts used**

For the purpose of the present assessment, high-risk sexual behaviour is defined as any behaviour that increases the probability of unplanned pregnancy or contracting

HIV or other STIs (Cooper *et al.*, 1999). These behaviours are considered in two broad categories. The first one is indiscriminate behaviour. It includes having multiple partners, having risky sex with casual or anonymous partners and failing to discuss risk topics prior to intercourse. The second one involves failure to take protective measures, such as the use of condoms and other birth control measures (Dermen *et al.*, 1998; Cooper *et al.*, 1999; Lucas *et al.*, 2002).

The frequency of intercourse is not treated as the only risk behaviour, even though multiple sex partners may increase the risk of exposure (De Vincenzi, 1994). This is because the frequency of intercourse is closely associated with having an exclusive sexual partner (Cooper *et al.*, 1999). Thus intercourse frequency analysed without reference to relationship status (as is typically the case) is an ambiguous risk indicator at best.

### **3. Aim and objective**

Studies consistently demonstrate that people (including students) who strongly believe that alcohol enhances sexual arousal and performance are more likely to practise risky sex after drinking (O'Malley & Johnston, 2002).

The main aim of this study was to examine the extent of alcohol use and also the relationship between alcohol use and high-risk sexual behaviour within the student population in Mafikeng. This was done with the objective of describing the social dynamics of alcohol use and risky sexual behaviour among students at the nightclubs and taverns of Mafikeng.

### **4. Research hypothesis**

Studies in different American states, European countries and sub-Saharan African countries indicate that there is an association between alcohol use and high-risk sexual behaviour (Cooper, 2002). Risky sexual behaviour exposes people to STIs, including HIV infection, and unintended pregnancies. The hypothesis of the study is that alcohol use leads to high-risk sexual behaviour.

## **5. Literature review**

### **5.1 Introduction**

This section reviews literature on alcohol use in pre- and postcolonial days, the effect of alcohol use and abuse and high-risk sexual behaviour. Lastly, other important aspects to be discussed are theories and research regarding alcohol abuse and its link with risky sexual behaviour.

### **5.2 Background and overview**

Since the precolonial period, alcohol has been consumed on different occasions, such as weddings, initiation ceremonies (e.g. circumcision) of girls and boys, ancestral ceremonies and many other family ceremonies (Gumede, 1995). Not everyone was allowed to drink alcohol. The consumption of alcohol was less common among women of childbearing age and the youth (Pithey & Morojele, 2002).

Different religious groupings also take different stances on the drinking of alcohol. Parry & Bennetts (1998), for example, found that various religious groups, such as fundamentalist Christians, permit the consumption of alcohol in moderation and on specific occasions. They also have strong taboos against alcohol abuse or drunkenness. On the other hand, religious groups such as the Muslims and Jehovah's Witnesses do not allow alcohol consumption at all (Parry & Bennetts, 1998; Room *et al.*, 2000).

The drinking of alcohol nowadays is common among different members of society. It is brewed, and delivered for sale in different outlets where it is accessed by a variety of people (Gumede, 1995; Parry & Bennetts, 1998). Sometimes it is brewed and sold illegally. For example, students can access alcohol at bottle stores, shebeens, taverns and nightclubs even when they are below the legal age limit of 18.

According to Rocha-Silva *et al.* (1995), most studies on the prevalence of drinking indicate that it is mostly the youth who are involved in the consumption of alcohol. Music festivals (bashes) and parties are the main opportunities for consumption of alcohol by the youth. It is also at these festivities that they are likely to engage in risky sexual encounters. Existing data suggest that the negative consequences associated with sexual risk taking are common on college, technikon and university campuses

(Desiderata & Crawford, 1995; Halpern-Felsher *et al.*, 1996; Morojele *et al.*, 2002). Substance abuse is documented as one of the greatest health and social problems in tertiary institutions in South Africa and many other countries.

Alcohol is generally the most widely abused drug among students. This drug causes serious and potentially life-threatening problems for students. Drinking and drug-taking trends in a community are frequently used as a general indicator of the quality of life in that community (Dermen *et al.*, 1998; Pithey & Morojele, 2002). Worldwide trends indicate that when a country experiences general and drastic socio-economic or political changes, as is the case with South Africa, these changes frequently cause high-risk behaviour (DiLorio *et al.*, 1998; Siegfried *et al.*, 2001; Plüddemann *et al.*, 2002). It is estimated that 5.8% of the South African population over the age of 15 years is alcohol dependent. There is also a progressive increase in the general level of substance abuse, especially alcohol intake, among adults (Gumede, 1995; Halpern-Felsher *et al.*, 1996; Morojele *et al.*, 2003b; Nelson Mandela Foundation/HSRC study, 2005).

Having unprotected sex is considered a high-risk behaviour that can lead to contracting HIV from an infected individual. The transmission can happen through any sexual practices that facilitate the exchange of blood, semen or other body fluids (Hale *et al.*, 1993; Dermen *et al.*, 1998; McKirnan *et al.*, 2001; Kalule-Sabiti *et al.*, 2007).

According to Pithey and Morojele (2002), studies focussing on the relationship between alcohol use and risky sexual behaviour are inadequate. Therefore, they decided to conduct this kind of study. In their studies Pithey and Morojele found that some people who abuse alcohol may engage in sex with a stranger. Some of them might not take preventive measures. They also found that there were important links between alcohol abuse and risky sexual behaviour (Pithey & Morojele, 2002).

Across studies conducted by different researchers in many countries, the rates of STIs were higher (in some cases, nearly twice as high) among women than men. Again, an estimate of HIV infection rates (from zero-prevalence studies) on campuses of South African higher education institutions shows increases on some campuses (Hale *et al.*, 1993; Halpern-Felsher *et al.*, 1996; Dermen & Cooper, 2000; McKirnan *et al.*, 2001).

According to Graves, research data from his studies suggest that although aggregate rates of HIV infection increases are low among university students on some campuses, the rates on other campuses are alarmingly high: as high as 30 in 100 students. The occurrence of pregnancies and STIs is relatively common on university campuses (Graves, 1995; Dermen *et al.*, 1998; Room *et al.*, 2000). The data further indicate that a substantial minority of college students suffer from one or more of the adverse consequences associated with sexual risk taking, and this underscores the need to identify factors, particularly adjustable ones such as alcohol use, that might contribute to sexual risk taking (Halpern-Felsher *et al.*, 1996; Douglas *et al.*, 1997; Stein *et al.*, 2002; Kaiser Family Foundation, 2007).

Cooper suggests that “targeting drinking proximal to intercourse as part of a strategy to reduce sexual risk taking would prove effective, however, only to the extent that drinking causally promotes risky behaviours” (Cooper, 1992). Although alcohol is widely assumed to be a causal factor of such behaviour, a number of plausible alternative models exist that might account for the relationship between drinking and sexual risk taking (Halpern-Felsher *et al.*, 1996; Parry, 2000), some of which speculate a causal effect for alcohol abuse.

The two most widely endorsed models, developed by Steele and Josephs (1990), are briefly described. The first model assumes that the acute effects of alcohol intoxication cause one to take sexual risks that would not be taken if alcohol was not taken. At least two plausible mechanisms have been theorised to underlie this effect. According to the alcohol myopia theory (Steele & Josephs, 1990), alcohol disinhibits behaviour primarily as a result of its pharmacologic effects on information processing. By reducing the scope and efficiency of information processing, simple, highly salient cues that instigate behaviour (for example, sexual arousal) continue to be processed whereas more distant and complex cues that would ordinarily inhibit behaviour (for example the possibility of contracting AIDS) are no longer adequately processed (Steele & Josephs, 1990).

Accordingly, alcohol abuse is hypothesised to have its strongest effects when the behaviour is controlled by instigatory and inhibitory cues that are strong and nearly equal in force. When instigatory cues are strong and inhibitory cues are weak, the

behaviour is likely to occur regardless of the individual's sobriety. Under the reverse circumstance, the behaviour is unlikely to occur again, regardless of the individual's sobriety (Steele & Josephs, 1990; Kaiser Family Foundation, 2007).

According to Steele and Josephs (1990), the spurious model, a second alternative model, invokes a third-variable explanation according to which stable aspects of the individual or of his or her life situation are thought to cause both drinking and risky sex. For example, a person may engage in both behaviours to satisfy thrill- or sensation-seeking needs, because of poor impulse control or coping skills or in an effort to cope with negative emotions (Steele & Josephs, 1990; Cooper, 1992; Leigh & Stall, 1993; Morojele *et al.*, 2003b).

Alternatively, an individual may drink and have risky sex as part of a larger lifestyle, such as being single or living in a fraternity house (Hull & Bond, 1986) where both behaviours are tacitly or, in some cases, explicitly encouraged. Research lends support to this perspective by showing that the same personality factors (impulsivity and negative emotionality) predict possible involvement in both behaviours (George & Stoner, 2000) and that parallel motivational processes underlie both behaviours (Cooper, 2002).

To summarise, two widely accepted models have been advanced to account for the relationship between drinking and risky sex. Moreover, even though these models appear to offer opposing accounts of the relationship between drinking and risky sex, empirical evidence supports both. Thus, despite commonly endorsed beliefs that alcohol promotes risky sexual behaviour, theory and empirical data paint a more complex picture of their relationship (Petry, 1999; Morojele *et al.*, 2003a). Many researchers suggest that people in general use this principle to justify their bad behaviour and to evade personal responsibility.

## **6. Methodology**

### **6.1 Introduction**

This section briefly explains the methodology used to collect data from students (higher institution and high school) at the drinking establishments and public and private medical centres within the study area. In this study the methods used were

interviews and focus groups. The section also covers techniques used for sampling design, recruitment methods, study area and analysis. The variables addressed include the following: gender, knowledge of HIV/AIDS, condom usage and information on STIs from local clinics.

## **6.2 Preliminary fieldwork**

Fieldwork was used to provide the primary data and select drinking establishments and medical centres within the study area. This data were collected at two government clinics (Montshioa Clinic and Unit 8 Clinic) and two private medical centres (Mmabatho Medical Centre and Mafikeng Campus Clinic). The cases (prevalence) of STIs are growing in all centres. There is high need for the morning-after pill (medication) to prevent pregnancy is information has a significant bearing on the interpretation of survey findings and on the identification of appropriate targets for effective interventions and social policies. Personal investigation to determine the possibility of finding study participants and establish the area of study was undertaken. The reason for this investigation was to assess the arrangement of the drinking places. Appointments with the owners of the drinking establishments were made to explain to them the nature of the discussions to be conducted on their premises when interviews were held.

## **6.3 Interviews**

Two groups of face-to-face structured interviews were conducted. The first set of interviews was conducted with the owners of the nightclubs and two taverns within the study area. The second set of interviews was held at the two private medical centres and the two local government medical clinics. The interviews were conducted with site managers or senior clinic administrators. The interviews took approximately 30 to 40 minutes with each participant and covered both closed and open-ended questions. All the discussions were tape recorded with the permission of the participants.

## **6.4 Focus groups**

In order to gain further information on prevention approaches and issues surrounding alcohol use and high-risk sexual behaviour among students (higher institution and high school) who patronise nightclubs and taverns, focus group sessions were conducted. The discussions addressed high-risk behaviour occurring at the nightclubs

and taverns. The discussions also covered the causes and perceptions of alcohol use in risky sexual behaviour and the potential success of student-targeted HIV- and STI-prevention interventions at these drinking establishments. The total number of participants in the different discussion sessions (focus groups) was 255. Twenty-six focus group sessions consisting of five to ten people were conducted in six months.

### **6.5 Sampling design and recruitment**

Recruitment of participants for the study focused on two types of drinking environment frequented by students. The first was nightclubs and the second was taverns that have music and offer drinking services.

Site visits and key informant focus group sessions were conducted to identify drinking establishments popular among both male and female students. It was noted that venues located in higher-density areas attracted some older men who work in government departments and private sectors. The researcher selected the drinking establishments and time periods that represented the highest number of students to make recruitment more efficient.

Recruitment periods were on Friday and Saturday nights between 20:00 and 24:00 and Sunday afternoons between 14:00 and 18:00, when several nightclubs in the town operate. An appointment to visit for the purpose of recruitment of the participants was made with the managers or owners of the nightclubs and taverns before each visit or focus group session. Two males and three females were trained as research assistants and their role was to assist (for example, recruit other participants when the session was in progress) during the recruitment processes only.

The research team obtained a sample of male and female students who patronised the selected nightclubs and taverns within a six-month period. The students were approached as they entered a predetermined intercept zone in front of the nightclubs and taverns. The trained assistant team members and the researcher approached every person entering the intercept zone to determine eligibility.

Eligibility meant male and female students who were not intoxicated and who were frequent patrons of the nightclubs and taverns. All the participants were requested to show an identity card (higher institution or high school student card). In cases where

the selected person did not meet the inclusion criteria, the next (any) person entering the intercept zone was selected.

Each eligible person was immediately invited to a private area set up by the research team inside or outside the drinking establishment. The purpose, procedures, risks and benefits of the study were explained to the participants. The participants were given an information sheet containing details about the research. Informed consent was obtained orally and participants were assured that the information gathered would be kept confidential and used only for academic purposes. No names or other personally identifying information were recorded.

As incentives to take part, participants were given T-shirts, ballpoint pens, condoms for males and females, condom compartment key-rings and booklets with information on HIV/AIDS prevention and the importance of testing.

## **6.6 Tools**

Three sets of structured guideline questions were used together with an information sheet. The first set of questions was used for the owners (five) of the drinking establishments to gather data. The second set of questions was used during the focus groups sessions (26). The third set of questions was used during the interviews with the managers of the two private medical centres and the senior professional nurses at the two government clinics. The guidelines had closed and open-ended questions. The questions were prepared in the local languages in case participants had a problem with English. The protocol for this study was reviewed, approved and monitored by the Mafikeng Local Research Committee (Greater Mafikeng Municipality).

## **6.7 Measures**

Two male and three female trained research assistants (who were involved in HIV/AIDS peer education programmes as peer educators) played a major role in the recruitment processes of the focus group sessions. Furthermore, the peer educators were involved because they were trained in issues regarding sexuality and behaviour. The consultations included asking general demographic questions and specific questions regarding alcohol use, sexual activity and condom use. The information, including reasons for attendance at nightclubs and patterns of sexual activity when under the influence of alcohol, was recorded.

## **6.8 Selected research area**

Mafikeng is the capital of the North-West Province, which is the sixth largest province in South Africa. The geographical location of Central Mafikeng is South 25°52' latitude and longitude 25°36' east. The selected research area is northwestern Greater Mafikeng. The precise study areas are the title deed Land of Montshiwa Township and the units (1, 2, 5, 6, 7, 8, 9, 10, 12, 13, 14 and 15). Since 1994, Mafikeng has experienced a number of changes, one being the fast growth of small businesses (formal and informal). For example, there are liquor outlets such as shebeens, taverns and night clubs in the town. Mafikeng also experienced immigration from neighbouring villages of the province and a large number of students from Botswana who study at the Mafikeng campus of the North-West University.

This study was conducted at the following taverns and nightclubs:

1. Liberty Tavern – Unit 7
2. Kathy Tavern – Unit 5
3. Shwabini's Club – Unit 2
4. Club Nouvea – industrial site
5. The Rail Club – Unit 6

## **6.9 Analysis**

The approach in this paper is descriptive. Quantitative measures, presentations as proportions or mean (with standard deviations) and medians, were carried out by using Stata 7.0 software. Differences in proportions were assessed by using the chi-square test. Differences in continuous variables or ordered categories were assessed by the Wilcoxon rank sum test. Qualitative information from the focus groups and open-ended questions were presented to elaborate on concepts arising from the quantitative survey.

## 7. Research findings and discussion

### 7.1 Introduction

In order to better understand that high-risk sexual behaviour leads to STIs and HIV infection, the following set objectives of the study had to be achieved: to examine alcohol use and high-risk sexual behaviour and to describe the social dynamics of alcohol use and risky sexual behaviour among students at the nightclubs and taverns. Lastly, the association between alcohol and sexual behaviour was examined.

The number of eligible students who agreed to participate in the focus group sessions was 255. Of this number, 152 (59.6%) were female and 103 (40.4%) were male.

### 7.2 Sample background characteristics and drinking establishments

**Table I:** Background characteristics of the participants

CHARACTERISTICS	GENDER		TOTAL 255	PERCENT
	MALE <i>N = 103</i>	FEMALE <i>N = 152</i>		
<b>AGE</b>				
< 19	21	34	55	<b>21.6</b>
20–25	58	98	156	<b>61.2</b>
> 26	24	20	44	<b>17.2</b>
<b>PLACE OF RESIDENCE</b>				
Home	28	31	59	<b>23.1</b>
Tertiary residence	63	103	166	<b>65.1</b>
Renting locally	12	18	30	<b>11.8</b>
<b>STUDY LEVEL</b>				
High school	16	25	41	<b>16.1</b>
Tertiary institution	87	137	214	<b>83.9</b>
<b>TOTAL</b>				<b>100.0</b>

The background characteristics of the respondents are illustrated in Table I. This table shows the age range of the participants, from younger than 19 years to older than 26 years. More than 60% of the participants were in the age group 20 to 25 years. A significant 21.6% of the focus group participants were younger than 19 years. The majority of this group were first-year students at the higher institutions. About 17.2% of

the participants shown above were older than 26 years of age. Most of the participants indicated that they were at postgraduate level.

With regard to place of residence, 65.1% of the participants indicated that they stayed at residences (university, technical college and nursing college residences). Approximately 25% of the participants were staying at home, that is with parents, guardians or close relatives. Lastly, about 10% of the participants lived in outside rooms of the local people and in apartments.

As this study was focused on students, the participants were requested to produce student cards to verify their study level. The majority of the participants managed to show their student cards because this card is needed for entry at the drinking establishments and to obtain a discount. About 84% of the participants were students at different tertiary institutions (university, technical college and nursing college) within the study area. Almost 16% of the participants indicated that they were local high schools students (Table I). Some had high school student cards, which were sufficient to prove that they were students. Almost all the high school students stayed at home nearer to the drinking establishments located in residential areas.

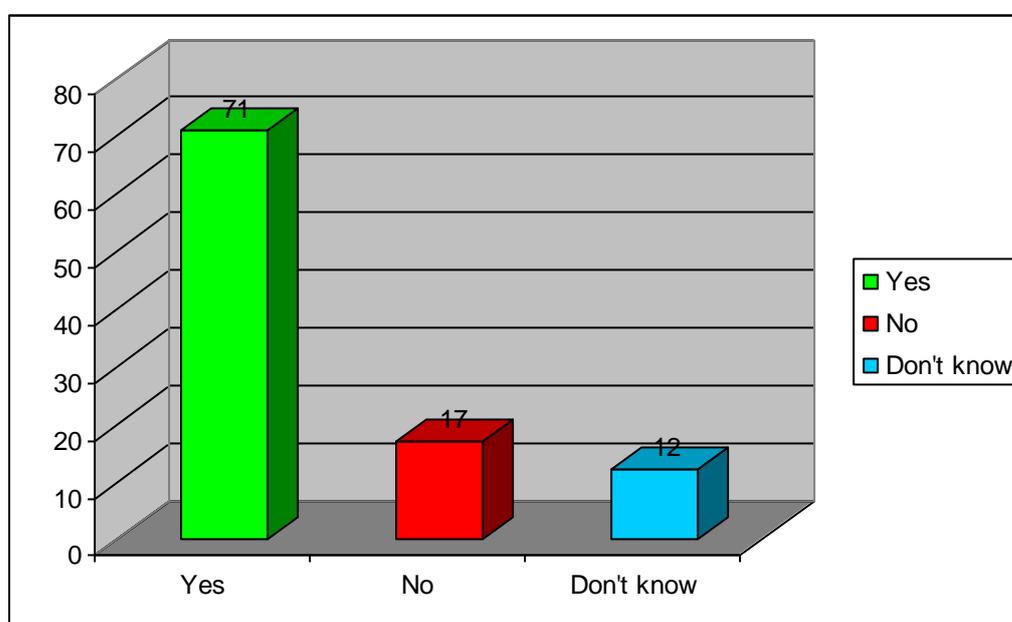
**Table II:** Drinking establishments and number of respondents

DRINKING ESTABLISHMENTS	GENDER		TOTAL	PERCENT
	MALE	FEMALE		
Liberty Tavern	20	27	47	18.4
Kathy Tavern	16	17	33	12.9
Shwabini's Club	22	36	58	22.7
Club Nouvea	17	23	40	15.6
The Rail Club	28	49	77	30.2
<b>TOTAL</b>	<b>103</b>	<b>152</b>	<b>255</b>	<b>100</b>

The statistics on the taverns and nightclubs are shown above (Table II). The Rail Club, Shwabini's Club and Kathy Tavern are located nearer to the Mafikeng campus of the North-West University, Taletso Technical College and Mmabatho Nursing College. The taverns and nightclub owners reveal that the patrons of these clubs are mostly students and general workers.

The Rail (30.2%) and Shwabini's (22.7%) clubs appear to be frequently visited drinking establishments (Table II). The participants pointed out that they visit these clubs because they are closer to their place of residence (university, technical college and nursing college). Furthermore, the participants like the setup in these clubs. To the question of why they do not visit other clubs or taverns in the area, some of the participants indicated that entertainment places such as Club Nouvea are a bit far from their residence. The participants further indicated that they usually obtain small amounts of liquor at taverns during the week. The researcher found that Club Nouvea usually has live music performances and the entry fee is sometimes very high, thus encouraging students to visit it.

### 7.3 Participants' views on HIV/AIDS and condom use

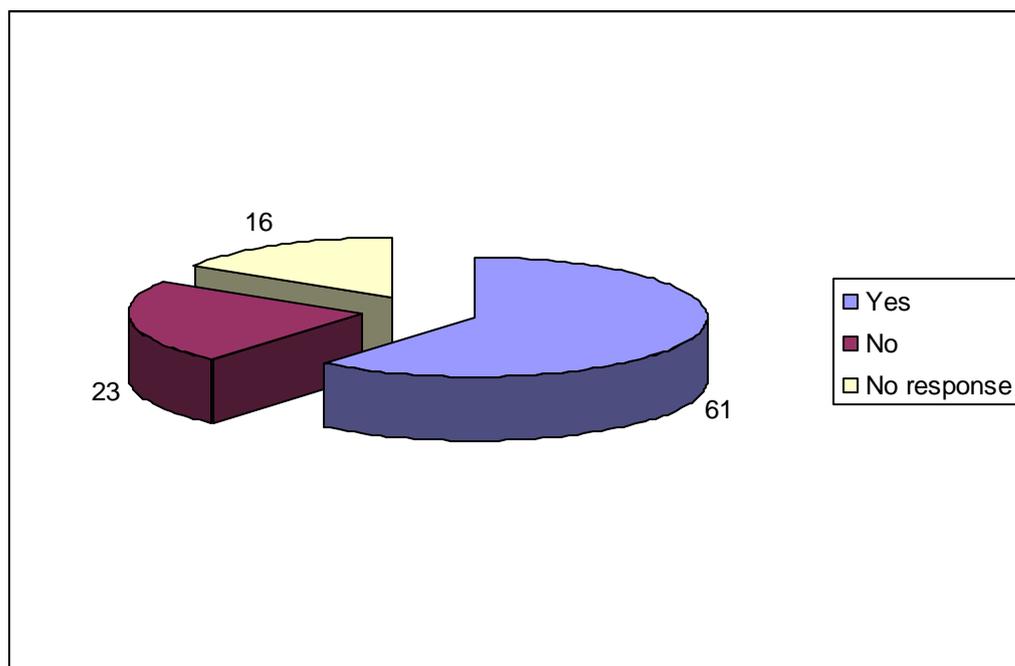


**Figure 1:** Participants' knowledge of HIV/AIDS

Knowledge about HIV/AIDS is a primary question for a subject like this. Therefore, some basic informational questions were asked to check understanding of HIV transmission and prevention. Figure 1 above shows that close to 75% of the participants had knowledge of HIV/AIDS. The main sources of HIV/AIDS information were clinics, other medical centres and friends. Additional information sources were electronic (radio and television) and print media brochures. The majority of students were aware that they could contract HIV from one episode of intercourse.

The most disturbing fact is that more than 25% of the participants were unclear in their knowledge of HIV/AIDS issues. Therefore, this percentage can be dangerous to society in general.

Furthermore, in focus group discussions and interviews, parts of the discussion addressed issues such as voluntary counselling and testing. Some of the participants indicated that they had learnt more about HIV/AIDS during different educational and awareness programmes and that encouraged them to be tested for HIV. The reaction of the participants in this study demonstrated that tavern- and nightclub-based HIV/AIDS-prevention interventions are highly feasible. These interventions are feasible because these places are mostly frequented by students from different institutions and this is where a great deal of alcohol is sold.



**Figure 2:** Use of condoms

The promotion of condom usage is one of the most commonly used interventions in HIV prevention. Some countries distribute condoms free of charge and some sell them at low prices. To the question of using condoms during sexual intercourse, 61% of the participants indicated that they use condoms. Furthermore, 23% of the participants indicated that they did not use condoms during the last sexual intercourse. About 16% of the participants were not in position to indicate whether they had used or not used condoms during the last sexual intercourse.

**Table III:** Participants' reasons for using condoms

Reasons for using condoms	Gender		Total	Per cent
	Male	Female		
Use as contraceptive	17	48	65	<b>25.5</b>
Use to avoid HIV infection	40	53	103	<b>40.4</b>
Use to avoid STI	21	37	58	<b>23.0</b>
Once had STI	15	14	29	<b>11.1</b>
	103	152	255	<b>100.0</b>

The survey participants specified their reasons for using condoms. Table III illustrates the rationale for using condoms. About 40.4% of the participants indicated that they used condoms to protect themselves against HIV infection. In addition, 25.5% used condoms as a contraceptive. About 23% of the participants used condoms to protect themselves against STI. Some indicated that they once had STI and were advised to always use condoms. Therefore, participants showed that they were using condoms for different reasons.

**Table IV:** Participants' reasons for not using condoms

Reasons for not using condoms	Gender		Total	Per cent
	Male	Female		
Not available	51	61	112	<b>44.0</b>
Partner objects	09	63	71	<b>27.7</b>
Not necessary	27	34	61	<b>24.0</b>
Do not think of condom	07	04	11	<b>4.3</b>
	103	152	255	<b>100.0</b>

The participants were also asked to give reasons for not using condoms. About 44% of the participants indicated the unavailability of condoms during their sexual intercourse. It was surprising to hear from the participants about the unavailability of condoms. The government offers free condoms at different government medical establishments, for example medical clinics and hospitals. Furthermore, 27.7% of the participants indicated that their partners objected to the use of condoms during sexual intercourse. About 24% of the participants pointed out to their partners that it was not necessary to use a condom during sexual intercourse. Lastly, 4.3% of the participants indicated that they did not think about using a condom during sexual intercourse. Therefore, there is a need for more intervention to educate and empower some of the people involved in sexual intercourse without condoms.

Some of the participants reported that they and their partner had not used a condom in the past few days. The majority of the interviewees indicated that they forgot to protect themselves because they were intoxicated. Some indicated that during the sexual act, they did not have time to look for and put on a condom. A small number complained about the unavailability of condoms in their areas.

#### 7.4 Sexual behaviour and alcohol consumption of the participants

**Table V:** Sexual behaviour

SEXUAL BEHAVIOR		GENDER		TOTAL 255	PERCENT
		MALE <i>N = 103</i>	FEMALE <i>N = 152</i>		
Ever had sex	Yes	86 <b>83%</b>	108 <b>71%</b>	194	<b>76.1</b>
	No	10	29	39	<b>15.3</b>
	None	7	15	22	<b>8.6</b>
Ever had a one-night stand	Yes	42	59	101	<b>32.2</b>
	No	44	72	116	<b>67.8</b>
	None	17	21	38	<b>14.9</b>
Ever had an STI	Yes	37	55	82	<b>39.6</b>
	No	76	97	173	<b>45.5</b>
Ever received treatment for STI	Yes	52	98	150	<b>58.8</b>
	No	40	43	83	<b>32.5</b>
	None	11	15	26	<b>10.1</b>
Ever had an HIV test	Yes	29	85	114	<b>44.7</b>
	No	74	67	141	<b>55.3</b>
<b>TOTAL</b>					<b>100.0</b>

Table V above shows the sexual behaviour of the participants. On the subject of whether the participants ever had sexual intercourse (vaginal, anal or oral sex) during the past 12 months. Participants indicated different responses from the focus groups. Almost 76% of the participants confirmed that they had had sexual intercourse. Regarding gender comparisons, 83% of males and 71% of females show a very big number of students involved in this act. About 15% of the participants specified that they had not engaged in sexual intercourse for the past 12 months. About 9% of the participants indicated that they were not sure about when they last had sexual intercourse.

In a follow-up question, the participants were asked to indicate whether they had ever had a one-night stand (having sex with somebody one does not and will never have a relationship with) because of alcohol use. Almost 68% of the participants declared

that they never had this type of sex. On the other hand, about 32% of the participants indicated that they once had a one-night stand. About 15% of the participants who ever had a one-night stand specified that alcohol use was not a reason for having a one-night stand. Some of the participants indicated that sometimes the people they had a one-night stand with would like them to establish a relationship.

People with a history of STIs are more likely to be infected with HIV/AIDS (Cooper, 2002). To the question of whether the participants had ever received treatment for STIs in the past 12 months, almost 58% (Table V) of the participants reported that they had never contracted an STI. Table V also shows that about 40% of the participants had had an STI. The researcher anticipated that the participants who had had an STI would be more aware of the risks involved than those who had not.

One of the most powerful weapons to halt the spread of HIV/AIDS has proven to be voluntary counselling and testing (UNAIDS, 2005). This is because people who test negative for HIV undergo quality risk-reduction counselling and prefer to change their behaviour to maintain their negative status. Those who test positive and receive counselling are motivated to protect themselves and others from HIV infection and to seek medical, social and psychological support (Fawcett, 2003). On the same note, the participants were asked to indicate whether they had ever been tested for HIV. More than 55% indicated that they had never been tested for HIV. According to Table V about 45% of the participants had been tested for HIV.

On testing for HIV, some of the male respondents from focus group sessions said the following:

“To know your HIV status is like a death sentence and it is better not to test.”

“My behaviour is good so there is no need to test.”

“VCT is for promiscuous people.”

Furthermore, some of the female participants said the following:

“I do not see the importance of testing for HIV if one is living a clean life.”

“You are afraid to feel the pain of knowing that you are positive and afraid of needles.”

“One is afraid of being rejected by students and family if one is HIV positive.”

This shows that there is little information on voluntary counselling and testing. Some people still view voluntary counselling and testing in a negative way.

**Table VI:** Frequency of alcohol consumption

DRINKING PERIOD	GENDER		TOTAL	PER CENT
	MALE	FEMALE		
Every weekend	47	25	72	<b>28.3</b>
Two to three times per week	28	17	45	<b>17.7</b>
In the past week	15	47	62	<b>24.3</b>
Not in the past two weeks	8	36	44	<b>17.2</b>
Occasionally (special celebrations e.g. parties)	5	27	32	<b>12.5</b>
<b>TOTAL</b>	<b>103</b>	<b>152</b>	<b>255</b>	<b>100</b>

According to Morojele *et al.* (2006), the real quantities of alcoholic beverages consumed in Africa are difficult to establish because as much as 50% of the consumption is estimated to be unrecorded, often comprising non-commercially produced beverages.

Of the students frequenting the alcohol outlets three to four times per week, 45% of females and 49% of males indicated that they had drunk to intoxication at least two or three times in the preceding week. A significant minority of focus group respondents, 28.3% (Table VI), indicated that they drink almost every weekend. Moreover, about 24.3% of the respondents indicated that they had visited taverns and night clubs during the previous weeks for drinking alcohol. Other participants specified that they had not drunk in the past two weeks. According to some of the participants, the reason for not having drunk in the previous two weeks was because they had to wait for their monthly allowance from the government or their parents.

Table V indicates that 43% of female participants and 40% of male participants were sexually active. Furthermore, about 17% of the participants indicated that they were not sexually active or were not in a position to respond to this question. To the question of having sex under the influence of alcohol, 40% of females and 30% of males reported having had sex under the influence of alcohol in the previous five months. Student sexual relationships (often between young females and older men) were often initiated at nightclubs and taverns. Sixty per cent of females surveyed had received free drinks for sex and 20% of males reported having paid for sex in the last

four months. The studies of Stall *et al.* (1986), Avins *et al.* (1994), Windle (1997), Dermen *et al.* (1998), Morojele *et al.* (2000) and Mataute *et al.* (2002) specify that alcohol may exert a powerful influence on sexual behaviour. Lastly, on the subject of alcohol, some female interviewees stated the belief that alcohol increased sexual desire as they were actually more likely to initiate sexual intercourse after drinking than after an alcohol-free period.

**Table VII:** Type of sexual partner by gender

TYPE OF PARTNER	GENDER		TOTAL	PERCENT
	MALE	FEMALE		
Casual partner	36	34	70	<b>27.4</b>
Steady partner	47	77	124	<b>48.6</b>
Regular partner	20	41	61	<b>24.0</b>
<b>TOTAL</b>	103	152	255	<b>100.0</b>

Table VII shows the statistics on the types of sexual partner of the focus group participants. Almost 50% of the participants indicated that they had steady partners. Some of the participants specified that their partners were at home and some said they were out of town. About 27% of the participants indicated that they had casual partners. Furthermore, 24% said that they had regular partners. In the follow-up question, the participants were requested to clarify how they maintained these types of relationship. The participants with casual partners indicated that they met occasionally at the drinking establishments.

The participants with regular partners indicated that almost every time they visited drinking establishments, they met and had a good time. More importantly, the surveyed participants had had three or more long-time sex partners and only a minority took adequate safety measures to prevent pregnancy or STIs. Some of the female respondents in the focus group sessions indicated that they had more than two partners because of socio-economic problems. Some of the participants indicated that their first episode of sexual intercourse occurred after they had drunk alcohol.

## **7.5 Opinions of drinking establishment owners**

The drinking establishment owners were interviewed to find out their opinions with respect to the drinking behaviour of the students and their business operation. Regarding the question of operating hours, the business owners highlighted different times. The nightclub owners indicated that their businesses start to operate mid-weekend (Wednesday), which is known as ladies' night. During weekend, Friday Saturday and Sunday businesses start to operate afternoon. The tavern owners indicated that they start business in the afternoon every day of the week. They further highlighted that the business profit during the week differs from that during the weekend. The clientele on weekends prefer to drink at the taverns and others buy and go.

Taverns open early and provide a place where people can begin to socialise and drink before the nightclubs open. In addition, alcohol is cheaper at bottle stores than in nightclubs. Outside of the taverns, people congregate in small groups to drink and socialise. There are frequently vendors selling roasted meat and other food.

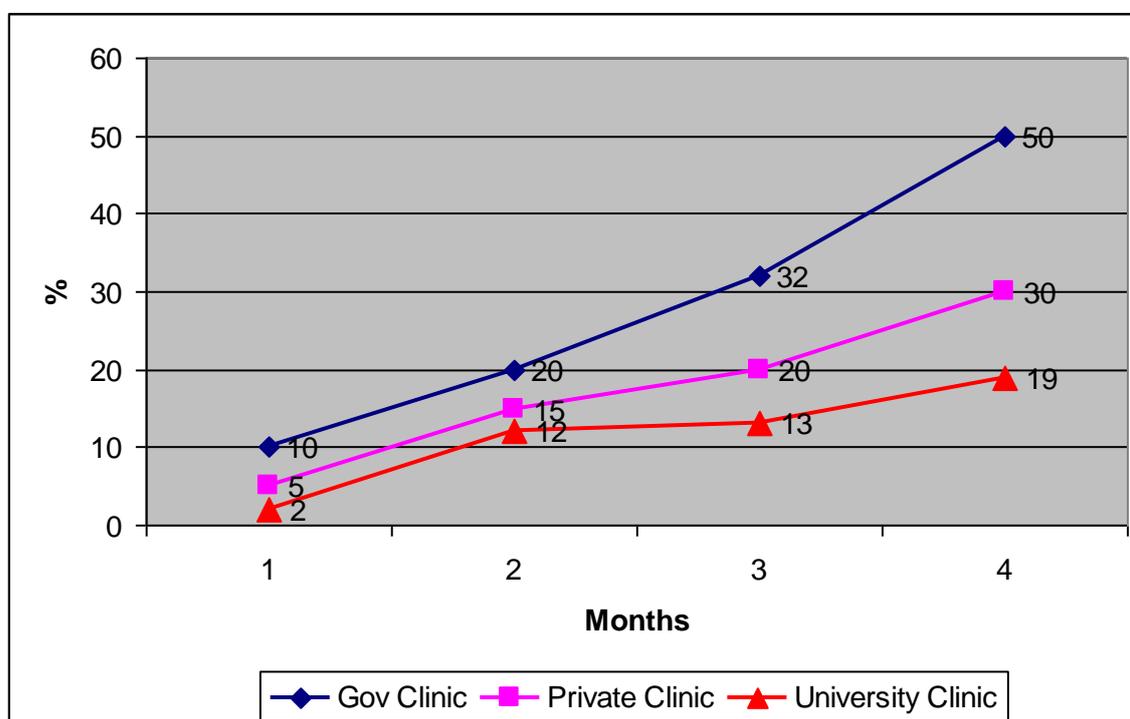
Regarding the question of control of underage people, the interview respondents highlighted the rule from the South African Liquor Act that prohibits children who are under 18 years from entering liquor outlets. All the interview respondents indicated that to control access they had security personnel who always require identity cards from patrons at the entrance of their business.

The tavern and nightclub owners highlighted different marketing strategies. The tavern owners indicated that they usually play music and that liquor promoters market new products at their place. The night club owners indicated that they mostly market their clubs in the local print media. For example, when they host popular entertainers they advertise in the local newspapers and print some flyers or brochures and distribute them at different strategic points, such as tertiary institutions.

Regarding the question of awareness of or information on drinking responsibly, the interviewed respondents indicated that they do not have a formal strategy. However, the liquor distributors usually supply them with posters to encourage people to drink responsibly. Three of the drinking establishment owners indicated that they have food available on a small scale and usually encourage the clientele to eat before drinking.

All the tavern and nightclub owners recognise that HIV/AIDS is not merely a personal health issue but one that concerns the entire community in every possible respect. The drinking establishment owners indicated that they have condom containers and HIV/AIDS posters mounted on the walls of their premises. Furthermore, the nightclub owners indicated that they sometimes display HIV/AIDS awareness messages on big-screen televisions during the music shows. They also pointed out that the Department of Health supply them with posters and condoms. Two of the interview respondents highlighted that every February they are visited by groups of people who demonstrate and distribute condoms to the clients. Therefore, the drinking establishment owners strongly believe that they are in a way assisting to mitigate the impact of HIV/AIDS on their clientele.

### 7.6 Health practitioners' views at the different health centres



**Figure 3:** Estimated STI cases at different medical establishments

According to interviews with health practitioners, there are at least 25 different STIs that are now universal. Some have minimal medical impact on those infected while others can have fatal consequences. Some STIs are easily treated but others have no cure. Furthermore, several STIs are mostly transmitted by infected body fluids

coming into contact with partners' uninfected body fluids, such as blood, semen and vaginal secretions. Additional STIs are transmitted by direct skin-to-skin contact. Some STIs are caused by viruses while others are caused by bacteria or other organisms such as protozoa, lice and mites (Department of Health, 2006).

The health practitioners were asked to indicate the types of regular case they treat or experience in their health clinics. STIs were at the top of the list. Figure 3 shows the cases in government, private and university clinics. The government and private clinics display general data on STIs. The university clinic mostly shows data for students. This is simply because the health practitioners at the university clinic indicated that their clients are mostly students. The three clinics show an increased rate of STIs.

Another regular experience at the health centres is patients requesting the morning-after pill. According to the manager of the university (campus) health centre the morning-after pill makes no difference to the pregnancy rate. She highlighted that it is better for people to take precautions before or during sex than afterwards. The four health centres consulted indicated that the morning-after pill was in high demand by female student patients. The health practitioners also indicated that the demand was very high because some males want to buy the morning-after pill for their female partners.

Three health centres were in a position to show the number of people who attended the voluntary counselling and testing (VCT) site.

Regarding HIV prevalence, the medical centre authorities acknowledged that they do have cases of HIV-positive people. Counsellors at the four centres indicated that they experience an increased need for voluntary counselling and testing on Mondays and Tuesdays after weekend events. At the university clinic, a professional nurse pointed out that during music festivals (bashes) the students consume a great deal of alcohol, leading to their engaging in risky behaviour. The clinic experiences an increase in the number of students who present with STIs on days after these activities.

This study indicated that alcohol use and sexual activity without protection are common among students. It established that the same persons engage in both

behaviours and, more importantly, that the likelihood of engaging in one behaviour depends on involvement in the other. This study demonstrated that some percentage of students engage in both behaviours. Therefore, the two behaviours are reliably linked.

## **8. Summary of the study**

The findings revealed gender differences regarding both alcohol consumption and sexual behaviour. Alcohol is more frequently consumed by male than by female participants (Table 6). More than 28.3% of the participants stated that they consume alcohol every weekend (Table 6). The participants reported experiences with more than one type of alcoholic beverage and considered their drinking as being extreme.

Of all the participants, 76.1% (Table 5) admitted that they are sexually active. The majority of these consume alcoholic beverages and have sex, as it was indicated that six of nine students drink and have sex always and three of nine students drink and have sex sometimes. The participants who drink alcohol frequently during the week are associated with this sexual behaviour. The proportion of those who are sexually active differs from that of those who frequently drink alcohol and have sex (Tables 5 and 6). There are fewer female than male participants with regard to being sexually active and the frequency of drinking per week.

The above investigation supports a number of conclusions about the links between alcohol use and risky sexual behaviour among students and more generally among adolescents and young adults. First, existing research indicates that alcohol use and certain types of sexual behaviour covary. Female participants disclosed that in the nightclubs men like to fondle any woman they bump into regardless of whether they have a partner or not. According to female participants, males who go to drinking establishments believe that any girl there is on offer for sex. In addition, the likelihood for individuals to engage in sex increases when they have consumed alcohol. Finally, the level of alcohol consumption is a predictor of sexual involvement.

The findings also suggest that HIV/AIDS awareness is high among drinking establishment patrons. Nevertheless, despite this knowledge and awareness, intoxicated students report low levels of condom use with perceived risky partners.

In contrast to the relatively clear-cut results linking alcohol use to increased participation in indiscriminate sexual behaviours (especially having casual sex), studies examining the link between drinking before sexual intercourse and decreased protective behaviours (that is, condom and birth control pill use) reveal a weaker link.

The survey data provide a consistent picture of high rates of alcohol use, binge drinking and daily drinking at drinking establishments. Another important index of alcohol use by university students is the extent of alcohol-related adverse consequences.

Health educators, health practitioners and peer educators need to construct strong prevention messages that stress the specific relationships between substance use, multiple sexual partners, failure to use condoms and STI and HIV infection. One of the health practitioners indicated that the distinct set of associations found between different temporal aspects of substance use and this sexual behaviour suggests that discrete prevention strategies may be needed. For example, if substance-induced disinhibition is causing sexual risk taking, education and counselling should inform students about the possible effect of alcohol. Educators and counsellors should highlight the connection between substance abuse and risky sexual behaviours in certain community contexts.

Furthermore, education and counselling should assist students with recognising the community signs involved and should help them avoid the social situations that may lead to risky sexual behaviour. Education programmes should prepare students to be responsible people. Therefore, the programmes should deliver their messages in forms suitable to the nightclub and tavern situation. For example, posters should be pasted in front of urinals and elsewhere in toilets. The messages might also be delivered at nightclubs and taverns through visual, musical and dramatic presentations.

One professional nurse said that disinhibition is primarily influencing intercourse with new sexual partners. Therefore, education and counselling should specifically stress the outcome of risky sexual behaviour and its relationship to the heightened risk of STI and HIV infection. But if personality or individual factors are driving sexual risk taking (for example failure to use a condom), there is a need to target young risk takers by designing specific prevention messages and to channel potentially destructive risk-taking impulses into less damaging activities. A variety of

government HIV-prevention programs have shown success in targeting specific at-risk populations with tailored prevention messages.

## **9. Conclusion**

In conclusion, the problem of irresponsible sexual behaviour among students that can lead to their contracting STIs, including HIV infection, and becoming pregnant can be solved if efforts are combined. For example, students should not view alcohol use and HIV/AIDS programmes as puritanical strategies to change their lifestyle.

This research supports a number of findings about the association between alcohol abuse and risky sexual behaviour among students. Furthermore, the results provide new insight into the potential cross-national differences on important issues, such as the gender gap in drinking and the protective role that learning institutions may play. These findings could be used to advance research on heavy drinking on campuses across the North-West Province.

The existing research indicates that alcohol abuse and certain types of sexual behaviour covary. Not only does the likelihood that an individual has ever drunk alcohol predict the likelihood that he or she has ever had sex, but the level of alcohol consumption also predicts the level of sexual involvement. The results further suggest that drinking in a potentially sexual situation (for example on a date) is associated with an increased probability of intercourse on that occasion and that drinking prior to intercourse is associated with risky partner choice as well as with decreased risk discussion on that occasion.

Research that examines relevant personality factors as mediators of the global associations between alcohol consumption and risky sexual behaviour and that also tests for an event-level relationship between alcohol and condom use would help to provide a better understanding of the nature of this relationship. This survey shows little evidence that being intoxicated during sexual activity affects the likelihood that condoms will be used. In other words, people who tend to use condoms with a new or casual partner when they are sober also use them when drinking. Students whose first experience with sexual intercourse occurs under the influence of alcohol are less likely to have planned for sexual activity and contraception and HIV-risk-reduction strategies are less likely to be used.

On the other hand, attitude concerning the effects of alcohol on risky sexual behaviour also appears to play an important role. Indeed, overwhelming evidence indicates that people believe that alcohol promotes risky sexual behaviours. This information suggests that overall the relationship between alcohol use and protective behaviours is weak because these behaviours are part of a larger multivariate network of relationships in which the two variables are only indirectly linked or in which any direct relationship they have is obscured by a countervailing process.

Lastly, a follow-up survey examining the link between drinking and risky sexual behaviour should include information from both partners. Because sexual behaviour is played out in intimate, interpersonal contexts and requires mutual action, gaining the perspective of only one partner is inherently limited. This may be especially correct in the present arena where the effects of alcohol on risky sexual behaviour appear to depend heavily on individual meanings qualified (presumably by both partners) to the main behaviour.

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## APPENDIX A

### GUIDELINE QUESTIONS FOR FOCUS GROUP/S NIGHTCLUBS AND TAVERNS PATRONS

**1. What is your sex**

Male

Female

**2. Age**

< - 19

20 - 25

26 - >

**3. Study level**

High School

Tertiary Level

Other Specify

**4. Place of Residence**

Home

Tertiary Residence

Renting Local

Other Specify

**5. Knowledge regarding HIV and AIDS**

Sleep in the same room with HIV positive person

Share a meal with someone who is HIV positive

Talk to someone with HIV and AIDS

Treat a family member with HIV and AIDS

Use utensil and toilet, swim, socialize, work and study with HIV positive person

**NB:** *to be classified as having knowledge on HIV/AIDS you should answer all questions*

**6. Have you ever received treatment for sexually transmitted disease?**

Yes

No

**7. Who treated you for sexually transmitted disease?**

Traditional healer

Private Doctor

Nurse

Other

**8. When was the last time you had a sexually transmitted disease?**

- Never
- Last week
- Last month
- A year ago
- More than once

**9. Did you ever felt like you want to do any thing to decrease your risk of infection with HIV?**

- Yes
- No

**10. What did you try to do to decrease your risk of infection with HIV?**

- Abstain from sex
- Have less partners
- Used a condom more often
- Tried to get partner to change behaviour
- Others

**11. From which sources have you learn about HIV and AIDS**

- Friend
- Parents
- Media, TV, Pamphlets, newspapers
- Health Clinic
- Formal course –programme

**12. How do you describe your current sexual life?**

- Casual Partner
- Steady Partner
- Regular Partner

**13. Have you ever had sexual intercourse?**

- Yes
- No

**14. Did you have any sexual intercourse during the twelve months?**

- Yes
- No

**15. Did you use a condom and Why?**

- Yes
- No

**16. How many other partners have you had sex with during the twelve months?**

- None
- One
- Two
- Three
- More

**17. Did you ever have one night stand?**

- Yes
- No

**18. Did you ever have HIV test?**

- Yes
- No

**19. Frequency of alcohol consumption**

- Every weekend
- 2 /3 times per week
- Past week
- Not past 2 week
- Occasional

**20. How do you come here?**

- Walking
- Friend's car
- Public transport
- Others specify

**21. Do you use of morning after pill?**

- Yes
- No

## APPENDIX B

### GUIDELINE QUESTIONS FOR DRINKING ESTABLISHMENT OWNERS

1. What days of the week do open and why?

.....  
.....

2. What time is business start and why?

.....  
.....  
.....

3. What time is closing and why?

.....  
.....  
.....  
.....

4. Who are your customers?

.....  
.....

5. How do you control entry against under age people? e.g. (no people under 18 years)

.....  
.....  
.....

6. Do you limit number of liquor for clientele?

.....  
.....  
.....

7. Attractions approaches/ Marketing

.....  
.....  
.....  
.....

8. Any credit

.....  
.....

9. Any drinking responsibility poster or information?

.....  
.....  
.....

10. Any HIV and AIDS awareness poster or information?

.....  
.....  
.....

**APPENDIX C**

**GUIDELINE QUESTIONS FOR HEALTH PRACTITIONERS**  
(Alcohol and sexual behaviour)

1. What type of regular cases do you experience?

.....  
.....  
.....

2. Who are regular customers or clientele for abovementioned cases?

.....  
.....  
.....

3. What day/s of the week

.....  
.....  
.....  
.....

4. How is the rate of STI cases for the past six months?

.....  
.....  
.....  
.....

5. How is the rate of HIV cases for the past six months?

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6. How many times do you offer morning after pill?

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7. What is your view with alcohol and sexual behaviour?

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