Alcohol Use and Sexual Risk Behaviour: A Cross-Cultural Study in Eight Countries

World Health Organization
Geneva

Alcohol Use and Sexual Risk Behaviour: A Cross-Cultural Study in Eight Countries

World Health Organization
Geneva

Mental Health: Evidence and Research
Management of Substance Abuse
Department of Mental Health and Substance Abuse

WHO Library Cataloguing-in-Publication Data

Alcohol use and sexual risk behaviour : a cross-cultural study in eight countries.

1.Alcohol-related disorders 2.Sexual behavior 3.Sexually transmitted diseases - transmission 4.HIV infections - transmission 5.Risk reduction behavior 6.Empirical research 7.Focus groups 8.Socioeconomic factors I.World Health Organization

ISBN 92 4 156289 7 (NLM classification: WM 274)

Printed in Switzerland

CONTENTS

FOREWORD ..... **v**
ACKNOWLEDGEMENTS vi
PREFACE vii
EXECUTIVE SUMMARY viii

CHAPTER ONE: INTRODUCTION 1
1.1 Background 1
1.2 Aim 1
1.3 Methodology 2

CHAPTER TWO: LITERATURE STUDY: A SUMMARY 6
2.1 Introduction 6
2.2 Overview of socioeconomic conditions 6
2.3 Alcohol use and its consequences, and related policies 6
2.4 Sexually transmitted infections, including HIV/AIDS 7
2.5 Alcohol use, sexual risk behaviour and HIV vulnerability 7
2.6 Groups vulnerable to alcohol use, sexual risk behaviour and HIV 8
2.7 Conclusion 9
Literature reviewed 11

CHAPTER THREE: EMPIRICAL STUDY 23
3.1 Introduction 23
3.2 Research process 23
3.3 General site and sample description 29
3.4 Findings 34
3.4.1 Key alcohol use-related patterns of STI/HIV risks 34
3.4.2 Key sex behaviour-related patterns of STI/HIV risks 39
3.4.3 Key patterns of the interaction between alcohol use and sexual behaviour that pose risks for STI/HIV infection 46
3.5 Individual-related behaviour patterns 51
3.5.1 Behaviour patterns manifesting at the level of the individual (the Russian Federation) 51
3.5.2 Behaviour patterns manifesting at the level of the general population, the small group and the individual (Belarus and Romania) 53
3.6 Conceptualization of sexual risk 54
3.7 "Tricky issues" 56
3.8 Conclusion 57

CHAPTER FOUR CONCLUSION: PREVENTIVE IMPLICATIONS 58

4.1 Introduction 58

4.2 Theories of behaviour change 58

4.3 Prevention of health risks related to psychoactive substance use (including alcohol use): Effectiveness of existing strategies 59

4.4 General preventive focuses arising from the empirical study 60

4.5 General strategies for preventing alcohol use and sexual behaviour risks for STI/HIV infection 61

4.6 Preventive recommendations offered within project countries 63

4.7 Research methodology: Recommendations 67

4.8 Closing remarks 68

REFERENCES 68

ANNEX ONE 70

ANNEX TWO 99

ANNEX THREE 115

LIST OF TABLES

Table 1: Summary of the data collection methods and settings in the project countries 3

Table 2a: General research questions/issues in Kenya, South Africa, Zambia and Mexico 25

Table 2b: General research questions/issues in project sites in Belarus, Romania, the Russian Federation and India 26

Table 3: Common research questions/issues across the project countries by data collection instrument 27

Table 4: General characteristics of the research sites 30

Table 5: General characteristics of the research sample by data-gathering instrument 32

Table 6: Key alcohol use-related patterns of STI/HIV risks and particular manifestations of these risks in selected project sites 36

Table 7a: Key sex behaviour-related patterns of STI/HIV risks and particular manifestations of these risks in Kenya, South Africa, Zambia and Mexico 41

Table 7b: Key sex behaviour-related patterns of STI/HIV risks and particular manifestations of these risks in Belarus, Romania, the Russian Federation and India 43

Table 8a: Key patterns of the interaction between alcohol consumption and sexual behaviour that pose risks for STI/HIV infection 47

Table 8b: Key patterns of the interaction between alcohol consumption and sexual behaviour that posed risks for STI/HIV infection 49

Table 9: First pattern: Behaviour with a significant degree of risk 51

Table 10: Second pattern: Risky behaviour 52

Table 11: Third pattern: Behaviour with minimal degree of risk 53

Table 12: Individual-related sexual behaviour patterns in Romania 54

Table 13: Framework for developing interventions related to alcohol use-related sexual risk behaviour regarding STI/HIV infection 62

FOREWORD

Alcohol use and unsafe sex are common behaviours and are responsible for a large proportion of the overall burden of diseases. However, very little literature exists on their co-occurrence and interactions including their likely contribution to HIV infection. This is in marked contrast to substantial literature on injecting drug use and HIV infection. The present publication is an initial attempt to fill this gap.

The enormous problems in studying sensitive issues like alcohol use and sexual behaviour dictated the choice of systematic step-wise research methodology. The present publication reports on two of these steps - a literature search (including unpublished documents) and study on selected respondents using qualitative methods. These two steps have led to some initial findings that require further investigation using quantitative methods and testable hypotheses.

Since alcohol use and sexual behaviour are both culture-sensitive phenomena, it was important to conduct this study in several countries that varied widely in culture, language and prevalence of these behaviours. However, the results showed overlapping themes that highlight some commonalities across cultures.

The results of this study can be used for initiating some policy actions, but the real objective of the study is to attract the attention of programme managers and researchers to design preventive programmes that can then be evaluated systematically. We believe that the interaction of alcohol use and sexual behaviour requires sustained work and has the potential to contribute substantially to decreasing the burden associated with these behaviours. Even a small beginning in developing country-level activities in this area will be adequate reward for this initial effort made by WHO. These activities will strengthen the programmes already in place to prevent alcohol related harms and to prevent HIV/AIDS.

Benedetto Saraceno
Director, Department of Mental Health and
Substance Abuse
World Health Organization
Geneva

Jim Yong Kim
Director
Department of HIV/AIDS
World Health Organization
Geneva

ACKNOWLEDGEMENTS

This manuscript was prepared for WHO/UNAIDS by:

Dr Gabriel Bianchi, Department of Social and Biological Communication, Slovak Academy of Sciences, Bratislava, Slovakia.

WHO also gratefully acknowledges the contributions of community agencies, research respondents, fieldworkers and the following principal investigators and their institutions for carrying out the literature review on alcohol and sexual risk behaviour, as well as the empirical on-site research, analyses and design of the research reports in the particular countries:

Professor Vladimir Nicholaevich Rostovtsev, Belarusian Medical Academy for Post-Graduate Education, Minsk (Belarus), Kalinina Tatjana V., Belorussian Medical Academy for Postgraduate Education, Minsk, Dr B.M. Tripathi and Dr Sameer Malhotra, All-India Institute of Medical Sciences, New Delhi (India), Professor Elizabeth N. Ngugi, College of Health Sciences, University of Nairobi, Nairobi (Kenya), Mrs Gabina Villagran Vazquez, Facultad de Psicologia, UNAM (Mexico), Professor Radu Vrasti, Psychiatric Hospital, Timis (Romania), Professor Eugenia Koshkina, National Research Institute on Addiction, Moscow (Russian Federation), Dr Neo Morojele**,** Ms Millicent Kachieng'a, Ms Anne Pithey, Mr Matsobane Nkoko, Ms Mavis Moshia, Ms Evodia Mokoko and Dr Charles Parry, Medical Research Council, Pretoria (South Africa), and Mr Richard Zulu and Mr Augustus K. Kapungwe, Institute of Economic and Social Research, University of Zambia, Lusaka (Zambia).

Dr B.M. Tripathi is particularly acknowledged for his substantial work in summarizing and compiling the literature review. Mrs Mwansa Nkowane provided technical support to the research institutions and assisted in the compilation of the literature review. Also acknowledged are: Ms Lee Rocha Silva who provided technical assistance to the compilation of the literature review and the final report and Mrs Rosemary Westermeyer who provided secretarial assistance.

The Department of Mental Health and Substance Abuse wishes to acknowledge the financial support of the Joint United Nations Programme on HIV/AIDS (UNAIDS).

Layout and design	Ms Annemarie Booyens
Copy-editing	Ms Ina Stahmer
Text editing	Mrs Mwansa Nkowane and Ms Lee Rocha Silva

SECRETARIAT

Mrs Mwansa Nkowane	World Health Organization, Geneva
Dr Shekhar Saxena	World Health Organization, Geneva
Dr Vladimir Poznyak	World Health Organization, Geneva

PREFACE

Alcohol use occurs in association with sexual behaviour for a variety of social, cultural and other reasons. In most societies, alcohol use was rooted in tradition. However, tradition has lost its grip, causing alcohol to be used in other settings, including where people engage in sex. This has opened the way for sexual risk behaviour. The alcohol-sex linkage has serious implications for the health of populations due to the advent of HIV infection. For example, where young people use alcohol before they engage in sex, risk-taking behaviour occurs, notably unsafe sex. Even in the general population, people are less likely to adopt safe sex procedures when under the influence of alcohol. The perception that alcohol has a disinhibitory effect propels some individuals to consume alcohol in order for them to engage in behaviours they would not normally participate in. The use of alcohol should therefore be recognized as a risk factor in the transmission of HIV and other sexually transmitted infections.

At present AIDS is the leading cause of death in sub-Saharan Africa and the fourth-biggest killer globally. According to current UNAIDS estimates, more than 60 million people have been infected with the virus, with 58% of adult infections occurring in sub-Saharan Africa, 20% in Europe, 30% in South East Asia, and 20% in Europe and the USA. At the end of 2002, an estimated 38.6 million adults were living with HIV infection, of whom almost half were women and with the majority of new infections occurring in young adults. Sexual risk behaviour accounts for a large proportion of HIV transmission and alcohol has been shown to increase such behaviour. In its association with HIV-related sexual risk behaviour, alcohol use is thus a significant public health concern. The social dynamics that surround alcohol use and sexual risk behaviour warrant a search for alternative ways of dealing effectively with the problem in diverse sociocultural settings. Effective counter action is particularly important when considering that although there is treatment to slow down the progression of AIDS, no cure or vaccine has yet been found. As a contribution to effective intervention, research is critical for providing data that are culturally specific and contextual.

WHO is pleased to have had the opportunity to initiate and coordinate this comprehensive process of developing a methodology to study factors related to risky sexual behaviour among alcohol users in diverse cultural settings. The project focused on eight countries from four continents (Belarus, India, Mexico, Kenya, Romania, the Russian Federation, South Africa and Zambia) and consisted of (1) a literature review carried out during 2002; (2) developing methodological premises for a field study aimed at complementing the literature data with up-to-date empirical findings (2002); (3) on-site research in the eight countries, yielding eight country reports (2002/2003); and (4) country-specific findings, which are the subject of this report.

The *synergy* between sexual behaviour and alcohol use enormously multiplies the potential negative consequences of the two behaviours separately. Therefore, it is our sincere hope that researchers and policy and programme implementers will use the findings in this review to respond in specific and appropriate ways to the problem of alcohol use and sexual risk behaviour so as to reduce their impact. At the same time, we do hope that the comprehensive approach encompassed by this methodology and its modifications and improvements will stimulate other countries to conduct similar research with the purpose of improving their health policies.

Dr Shekhar Saxena, Coordinator
Mental Health: Evidence and Research (MER)
WHO, Geneva

Dr Vladimir Poznyak, Coordinator
Management of Substance Abuse (MSB),
WHO, Geneva

EXECUTIVE SUMMARY

The coexistence of alcohol use and sexual behaviour has the potential to increase harms associated with each of these separately. This report reviews the outcomes of a project to better understand as well as develop a methodology to study the factors associated with sexual risk behaviour among alcohol users in diverse cultural settings. The project is to inform preventive initiatives. It was initiated and supervised by the World Health Organization (WHO) with financial support from the Joint United Nations Programme on HIV/AIDS (UNAIDS).

The project was conducted in eight countries and consisted of two distinct phases: (1) A literature study provided an overview of existing knowledge on the subject, i.e. on alcohol, on sexual behaviour and related topics such as sexually transmitted infections, including HIV, and health risks involved in sexual behaviour, and finally on the interaction between alcohol use and sexual behaviour. (2) Following this orientation, an empirical study was conducted to gain first-hand material on which to build prevention measures.

The literature study reviewed available documents on the subject in the project countries, including scientific publications, conference summaries, reports of NGOs and government agencies, newspapers and other media, hospital and health service records, and police and law enforcement records. The emphasis was on quantitative data.

Along with more or less representative pictures of alcohol use and sexual risk behaviours in the studied regions/countries, the following key issues emerged in the review of the literature: the prevalence of certain myths and notions about "masculinity"; a lack of clear and firm alcohol-related policies; increasing HIV prevalence and a need to augment prevention efforts; the interwovenness of alcohol use, sexual risk behaviours and STI/HIV/AIDS; the effect of modernization and the media on the youth, which manifests in early drinking, early sexual activity and increasing vulnerability to risk behaviours; and a paucity of research data on alcohol and sexual risk behaviours. The review also highlighted that the social dynamics of alcohol use and sexual risk behaviours warrant a search for culture-specific and context-specific ways of dealing with the problem.

The empirical study was designed to gather evidence to complement the literature review. A qualitative approach to data gathering and analysis was adopted in which the emphasis was on generalizing (developing "theory") from largely unstructured and multiple observations of "reality". Initially, semi-structured interviews were conducted with key informants (KII) (persons living/working in the studied environments or servicing the target population) in the project countries. These interviews were supplemented with on-site observations of the places where the target population was supposed to engage in the studied behaviour. Following this orientation, focus group discussions (FGDs) and in-depth semi-structured interviews (IDIs) were conducted with representatives of the target population. This approach allowed the gathering of comprehensive data, as well as a gradual refinement of the findings. A data-driven procedure was followed in which presumptions and indications from earlier steps were either refined, supported or omitted/rejected in follow-up steps. Research teams also collected data on the broad socio-economic conditions in the project countries. Some research teams conducted a quantitative survey to corroborate and/or refine the qualitative data.

The empirical study showed that: A wide variety of conceptualizations of risk related to sexuality existed in the project countries, with an individual's subjective conceptualization of risk (e.g. unwanted pregnancy, STI, or losing a partner) significantly correlating with individual behaviour-change potential. Furthermore, patterns of high, moderate and minimal unsafe/risky

behaviour existed. Although some alcohol use and sexual behaviour patterns operated "separately" or independently of one another, a number of patterns of interaction between alcohol use and sexual risk taking were identified, with some of these patterns manifesting a specific individual behavioural scheme, some a cultural scheme and some a cross-cultural scheme.

Key patterns of interaction between alcohol use and sexual behaviour related to the following issues:

1 The construction of maleness in terms of alcohol use

2 A denial and neglect of risk as a way of coping with life

3 The use of alcohol-serving venues as contact places for sexual encounters

4 The use of alcohol at/during (first) sexual encounters

5 The promotion of alcohol use in pornographic material

The findings of the study has implications for prevention programmes for harm related to alcohol use and also harm related to sexual risk behaviour including HIV/AIDS.

Chapter One

INTRODUCTION

1.1 Background

Available literature suggests that the global burden of disease with regard to both alcohol and unsafe sex is considerable. For example, in 1990 alcohol accounted for 3.5% of the total disability-adjusted life years (DALYs) lost globally, and for 2.1% of the total years of life lost; unsafe sex accounted for 3.0% of the total years of life lost globally (Room et al., 2002:17; Murray & Lopez, 1996). The respective contributions of alcohol and unsafe sex to the global burden of disease are, furthermore, amplified through the linkages that have been shown to exist between alcohol, risky sexual behaviour (unintended or unprotected sexual contact) and the spread of sexually transmitted infections (STIs), including HIV infection.

Sexual risk behaviour accounts for a large number of opportunities for acquiring HIV infection, and alcohol use has been shown to increase high-risk sexual behaviour. Moreover, the social dynamics that surround alcohol use, sexual risk behaviour and HIV infection and interactions between these issues warrant a search for alternative ways of dealing with the problem in diverse sociocultural settings, if intervention is to be effective. Only by unravelling the social dynamics of alcohol use-related sexual risk behaviour within particular cultural settings can this be achieved. It can be anticipated that the body of knowledge acquired through proven scientifically sound instruments will not only highlight the relevant preventive measures to be adopted but will bring out relevant clinical and experimental research questions to be considered by all disciplines interested in curbing the problem of alcohol use-related sexual risk behaviour with regard to HIV infection.

Against this background the WHO secured international collaboration in 2001 to promote the exchange of knowledge and experience in the design and testing of the necessary methods, as well as contribute cross-cultural research and analysis regarding the alcohol use-risky sex-HIV nexus. As cross-cultural issues have been shown to play a role in this nexus the results of the present multicultural initiative are anticipated to be of global relevance.

This report provides an overview of the specific aim of this WHO study, the manner (methodology) in which the study has been developed and implemented, as well as the results and the implications of these results for prevention.

1.2 Aim

The overall aim of this project was to identify factors related to alcohol use-related sexual risk behaviour with regard to HIV infection in diverse communities and cultures. These communities/cultures were to be more or less representative of global diversity. The project was, thus, implemented in eight countries namely the African Region (Kenya, South Africa and Zambia), the Central and Eastern European Region (Belarus, Romania and the Russian Federation), the South-East Asia Region (India) and the Region of the Americas (Mexico).

The more specific aims of the project were as follows:

1 To provide the deepest and broadest possible insight into existing knowledge on alcohol use-related sexual risk behaviour through a review of available literature on the subject in the project countries (literature study).

2 To develop a methodology for studying the subject in diverse cultural settings (*methodology*).

3 To collect data—in line with the developed methodology—from diverse cultures/ communities on the subject so as to inform health promotion/preventive initiatives, and contribute towards the improvement of the developed methodology (*empirical study*).

4 To (a) extract general, cultural/social group-specific and individual-specific patterns from the data collected in the empirical study on alcohol use-related sexual risk behaviour, and (b) indicate the implications of these patterns for health promotion/preventive initiatives and for the methodology to be adopted when studying the subject.

1.3 Methodology

The literature study entailed a review of the available documents on the subject in the eight countries, including scientific publications, conference summaries, reports of NGOs and government agencies, newspapers and other media, hospital and health service records, and police and other law enforcement records. The emphasis was on statistical (quantitative) data. The review was directed at orientating and complementing data collection in the empirical study.

As discussed in more detail in (a) the methodological premises noted in the annexes to this report, and in (b) the description of the manner in which the research was implemented in Chapter 3, the empirical study was developed in terms of a qualitative approach to data gathering and analysis. The emphasis was on generalizing (developing "theory") from largely unstructured and multiple observations of "reality". In brief, researchers conducted semi-structured interviews with key informants (KIs) (persons living/working in the studied environments or servicing the target population) in the project countries. These interviews were then supplemented with on-site observations of the places where the target population was engaged in the studied behaviour. Following this orientation, the researchers conducted focus group discussions (FGDs) and then in-depth semi-structured interviews (IDIs) with representatives of the target population.

Researchers were, furthermore recruited as key informants (KIs) persons with (in)direct access to the target population (e.g. bar keeper, commercial sex worker, teacher, police officer). They were either established confidants of members of the target population or temporary bridges between the researcher and the target population. KIs provided information on issues such as (a) the social/cultural context (e.g. (un)acceptable practices) within which psychoactive substance use (including alcohol use) and sexual behaviour occurred in the target population; (b) the status of knowledge, attitudes and practices concerning health-compromising (risky) behaviour; and (c) the status of intervention measures within the target population. In each project country approximately 10 KIs were to be recruited.

The unstructured field observations were conducted at venues where opportunities for psychoactive substance use and related sexual risk behaviour occurred. Attention was given to issues such as type of group members (e.g. who they were, their ages, sex, social class, etc.), behaviour, language/dialect used, interpersonal interaction, social hierarchy or power structures, spontaneous communication with non-members and the health status of the environment (e.g. health promotion messages, condoms). Observations facilitated the identification and specification of target populations and research questions, apart from assist in the validation of the findings. (Various key contact persons enabled researchers to gain unobtrusive access to the

observation venues. Multiple observers/teams who differed in terms of age group and gender facilitated corroboration of the data.)

Focus group discussions (FGDs) were conducted (altogether about four discussions per project country) with alcohol and non-alcohol users (between six and eight participants per group) in an environment that guaranteed group confidentiality. (These discussions provided opportunities for following up on questions that arose from the key informant interviews.) Groups were divided into male, female and mixed-sex groups and discussed descriptive issues as well as dilemmas. Descriptive issues were, for example, related to scenarios in which alcohol use was associated with sexual relations, reasons for drinking alcohol before/during sex, facilitators/barriers to safe sex, the meaning of safe/unsafe/risky sex, and opportunities for and the feasibility of various intervention approaches. Dilemmas addressed in discussions through (a) presenting participants with a fictitious story, and (b) a role-playing exercise related to the research topic.

The participants in the in-depth interviews (IDIs) were selected from the focus groups or the key informants. (Altogether about 10 to 15 IDIs were conducted in each project country.) The interviews took place at a venue where confidentiality was guaranteed. Interviewers elicited (a) in-depth information about motivations for various types of behaviour; (b) insight into decision-making processes and internal conflicts; (c) subjective evaluations of particular forms of behaviour (satisfaction, feelings of guilt, etc.); and (d) other specific and/or intimate information that participants would not disclose in group settings or that would be non-ethical to ask about in groups. More specifically, attention was given to (a) reasons (motives) for intercourse; (b) the occurrence of communication before/during/ after intercourse; (c) the use of alcohol/other psychoactive substances before/during intercourse and expectations in this regard; (d) the use of protection in various situations (including during intercourse) and opportunities in this regard; (e) possibilities regarding the negotiation of safe sex on the part of the partner or on the initiative of the subject, according to the experience of the subject; (f) level of sexual satisfaction (each partner separately); (g) personal history with regard to intercourse; (h) patterns of relationships (casual, steady, combined); (i) the relation between changes in sexual behaviour and changes in social life; and (j) perceived opportunities for preventive interventions.

Table 1 provides a systematic *summary* of the data collection methods that were used in the implementation of the empirical study, the extent to which they were employed and the settings within which they were administered in the project countries.

Table 1: Summary of the data collection methods and settings in the project countries

Country	Method	Number of times administered	Setting
Belarus	Key informant interviews	12 interviews	Field of medicine, education, psychology, social work, safety and security, entertainment (drinking places)
	Observations	4 settings	University hostel, disco, bar, informal gathering in a public garden
	Focus group discussions	6 groups	Students of a medical college, the parishioners of a Protestant Church, patients at a hospital
	In-depth interviews	12 interviews	Protestant Church (parishioners), hospital (patients)
	Interview-administered questionnaire (115 items) in survey	300 respondents	Youth in the general population

Country	Method	Number of times administered	Setting
India	Key informant interviews	10 interviews	Field of NGO work, education, business, labour (skilled work, self-employment, migrant work, commercial sex work), youth work, community work
	Observations	2 types of settings	Roadside refreshment and commercial sex establishments
	Focus group discussions	6 groups	Field of labour (truck drivers, factory, restaurant and migrant workers, commercial sex workers), slum neighbourhoods, performing arts
	In-depth interviews	14 interviews	Labour (business, long-distance driving, commercial sex, trading in alcohol, migrant work, low-paid work, skilled work), estranged husbands/wives
	Interview-administered questionnaire in survey	118 respondents	Representative sample of alcohol users in households in the general population in Delhi
Kenya	Key informant interviews	12 interviews	Field of education, rice trading, entertainment (waiters at drinking places), finance (cashiers), safety and security, housekeeping
	Observations	7 settings	Entertainment establishments (drinking places, restaurants, hotels)
	Focus group discussions	4 groups	Field of labour (commercial sex work), urban neighbourhoods, rural neighbourhoods, various gender groups (females; males and females)
	In-depth interviews	10 interviews	Labour (commercial sex work, bar tendering, waitering, cashier and mechanical work), unemployment
Mexico	Key informant interviews	9 interviews	Field of heterosexual and homosexual entertainment
	Observations	11 settings	Entertainment venues for respectively young heterosexual persons and MSMs
	Focus group discussions	8 groups	Heterosexual persons and MSMs, divided into persons younger than 24 and persons 24 years and older
	In-depth interviews	10 interviews	Heterosexual persons and MSMs
Romania	Key informant interviews	10 interviews	Field of medicine, education, safety and security, entertainment (drinking place), music, social work, transport (truck driving), commercial sex work
	Observations	5 settings	Railway station, university campus, disco, highway where commercial sex workers operated, marketplace
	Focus group discussions	4 groups	Nursing, social work, teaching, safety and security, journalism, music, law, hairdressing, entertainment (drinking places)
	In-depth interviews	10 interviews	Selected participants in the focus groups
South Africa	Key informant interviews	10 interviews	Field of youth work, entertainment (drinking places), social work, medicine and illness (person living with HIV), the church, safety and security, alcohol consumption (drinkers)
	Observations	7 settings	Entertainment venues (bars, jazz clubs) and alcohol retail businesses (bottle stores) in city centres as well as in neighbouring poor districts (townships)
	Focus group discussions	6 groups	Drinkers and their partners within different age groups
	In-depth interviews	16 interviews	Risk-taking male and female drinkers
	Interview-administered questionnaire in survey	160 respondents	Representative sample of the general population in Cape Town

Country	Method	Number of times administered	Setting
The Russian Federation	Key informant interviews	10 interviews	Field of medicine, psychology, pharmacy, university teaching, arts, entertainment venues (restaurants, hotels), labour
	Observations	3 settings	Entertainment venues (nightclubs, beer hall)
	Focus group discussions	4 groups	Students, patients in alcohol-related treatment centres, medical practitioners, lawyers, teachers
	Interview-administered in-depth semi-structured questionnaire in survey	88 respondents	Purposively selected students and persons in professional occupations
Zambia	Key informant interviews	10 interviews	Persons acquainted with risky venues (e.g. barmaids)
	Observations	2 types of settings	Entertainment venues (drinking places, places where commercial sex work occurred)
	Focus group discussions	3 groups	Different gender and age groups
	In-depth interviews, using a semi-structured interview schedule	50 interviews	Commercial sex workers and their clients

The project's approach to data collection allowed comprehensive and diverse data gathering, as well as a gradual refinement of the findings. Indeed, a data-driven procedure was followed in which presumptions and indications from earlier steps were either refined, supported or omitted in follow-up steps. Research teams also collected data on the broad socioeconomic conditions in the project countries. Some research teams conducted a quantitative survey to corroborate and refine the qualitative data. In Foucauldian tradition, the body of data collected in the empirical study was finally subjected to re-analysis within a broader cultural and political context.

Chapter Two

LITERATURE STUDY: A SUMMARY

2.1 Introduction

This chapter provides an overview of the results of the review of available literature on the risk of contracting STIs/HIV where alcohol is used in sexual encounters in the selected project sites. Attention is given to the following issues: broad socioeconomic conditions in the countries concerned; the nature, extent and consequences of alcohol use as well as policies in this regard; the prevalence of sexually transmitted infections (STIs), HIV and AIDS; relationships between alcohol use and sexual risk behaviour with respect to HIV infection; and groups who are vulnerable to alcohol use, sexual risk behaviour and HIV infection. The chapter concludes with a summary of the key issues that emerged from the literature.

It should also be noted that the vast number of documents reviewed complicated referencing to data sources within the text. For this reason and *to distinguish the data sourced in the literature review from all the documents perused in the present project, a complete list of data sources is provided at the end of this chapter* instead of at the end of the publication.

2.2 Overview of socioeconomic conditions

The variable sociodemographic features of the project countries attest to the great diversity among developing countries and countries in transition. India, South Africa, Kenya, Zambia and Mexico have experienced Western/colonial rule. Whereas Belarus is culturally homogenous, India, Mexico and South Africa have significantly diverse cultures. A negative population growth is generally evident in the countries in transition, but in India the population growth is high. Poverty, malnutrition and unemployment affect sub-Saharan Africa and India in particular. Gross economic disparity is evident in South Africa and the Russian Federation. In contrast to the other countries, India is still deeply rooted in its traditions, despite the influence of colonization and modernization. The countries differ in the degree to which urbanization has occurred. About half of the population in South Africa is urbanized. Most of the population in the Russian Federation, Belarus, Mexico and Romania reside in the urban areas, in contrast to India, Kenya and Zambia where most of the population reside in the rural areas. Overall, migration to urban areas is on the increase. This has led to demographic change and socio-economic imbalances. Post-colonial adjustment is evident in South Africa, Mexico and India. Change in the political and socioeconomic systems is marked in Romania, the Russian Federation and Belarus. Economic transition has led to increasing unemployment and social instability (e.g. criminal activity and family disintegration).

2.3 Alcohol use and its consequences, and related policies

Although recorded alcohol consumption has declined during the 1990s in developed countries, it has risen steadily in developing countries and countries of the former Soviet Union. There has been a significant increase in recorded alcohol consumption in India, South Africa, Mexico and Romania in these years.

Alcohol use is quite common in central and eastern European countries and in Mexico, where alcohol is part of the daily life. Adult per capita alcohol consumption is high in Romania,

Belarus, the Russian Federation, South Africa, Mexico and Kenya. In sharp contrast, alcohol use in India is low and mainly restricted to males. In all the countries, males consume the most alcohol and consume it the most frequently, although there are indications—e.g. in the Russian Federation—that the traditionally smaller consumer segments are growing, namely females and young people. Heavy drinking among those who drink alcohol is common in India and Mexico; as a result a small percentage of the population accounts for a large share of the country's overall alcohol consumption.

Illicit and home-brewed alcohol, which is mainly consumed by the lower strata, is available in all the countries and constitutes a major part of alcohol consumption in Kenya and South Africa. *Changaa* and *kumi kumi* in the African Region, *aguardiente* and *pulque* in Mexico and *arrack*, *desi sharab* and *tari* in India are the popular home-made/illicit brews. The preferred alcoholic beverages are spirits in Romania, Belarus, the Russian Federation and India, and beer in South Africa, Mexico and Zambia.

Alcohol use is associated with considerable morbidity and mortality in the Russian Federation, Mexico and South Africa. Alcohol control policies are, however, either absent or largely ignored. In Kenya, Mexico and South Africa alcohol use is actively promoted.

2.4 Sexually transmitted infections, including HIV/AIDS

The magnitude of HIV/AIDS differs across the countries, with the HIV epidemic having seemingly reached its peak in the African Region. There are large numbers of AIDS-related orphans in Zambia and Kenya, and many children in Zambia and Romania have AIDS. In Zambia and Romania, mother-to-child transmission is high; so is HIV mortality among adults.

The heterosexual route is generally the predominant route of HIV transmission in the project sites. However, in the Russian Federation and Belarus, the majority of the reported HIV infections are related to injecting drug use, although intravenous drug use has been reported as an important route of HIV transmission in Romania. In Mexico, homosexual and bisexual men are the high-risk groups.

In general, STIs are on the rise in all the countries. A high prevalence of STI has been reported in the Russian Federation, e.g. a rate of 186.7 per 100 000 of the population for syphilis, and 119.8 per 100 000 of the population for gonorrhoea. The comparable rates in Romania are 31.2 and 21.8, and in Belarus 105.2 and 98.8. STIs are also prevalent in the African countries. In India the incidence of STIs is estimated at 5%.

2.5 Alcohol use, sexual risk behaviour and HIV vulnerability

There is generally an increase in alcohol use by teenagers and women. Men, however, generally have more social liberties than women, with respect to alcohol use as well as sexual activities. Furthermore, the literature shows that the age for initiating alcohol use and experimenting with sex is on the decline, but the age for marriage is on the rise (e.g. the Russian Federation, India). Teenage pregnancies are also on the rise. Sexual experimentation outside marriage is increasing. Risky sexual behaviours continue despite a confirmed STI/HIV status, as reported in Belarus, Zambia and India. Denial of the problem and social stigma prevent people with STIs to seek treatment. Severity of symptoms is another factor that influences the decision of persons with STIs to seek treatment. Despite knowledge about preventive measures, condom use is limited. The spread of the HIV epidemic from high-risk groups to the general population is a concern in a populous country like India. Male dominance also limits the ability of women to adopt preventive measures such as the use of condoms.

Alcohol use is associated with certain types of sexual activity. Crime often plays a role in unprotected casual sex, group sex and anal sex when participants in these activities are under

the influence of alcohol. Alcohol use has also been linked to early sexual experiences (e.g. Belarus, the Russian Federation, Kenya and South Africa). Alcohol use and sexual risk behaviours are particularly prevalent in settings such as nightclubs, bars, dark houses, highway eating joints and motels, and brothels.

Furthermore, alcohol is commonly used as a disinhibitor, a sex facilitator, a symbol of masculinity, and a means of relaxation, recreation, socializing and improving communication skills (e.g. in Mexico and Romania). Alcoholic beverages are also used as a facilitator in approaching the opposite sex. "Masculinity" is often linked to the ability to have multiple partners, imbibe alcohol and engage in promiscuous behaviour. Among women, alcohol use increases involvement in risky sexual encounters and sexual victimization, exposing them to the risk of unwanted pregnancies and STIs (e.g. in the Russian Federation and South Africa).

It has also been shown that alcohol use and sexual risk behaviours increase during certain festivities and celebrations across countries (e.g. in South Africa, Kenya and Romania). Alcohol use and promiscuity are customary during funerals among certain population groups in Kenya. In contrast, certain religions and religious sects prohibit the use of alcohol and indulgence in risky sexual practices. Dry sex (a preference among certain rural tribes in Zambia and South Africa), sexual cleansing and levirate marriage (Zambia) increase the risk of STIs in Africa.

The media (electronic and print) play an important role in shaping and influencing sexual behaviour and alcohol use patterns. Certain advertisements, pornographic movies, thrillers and romantic programmes glamorize and promote engagement in these activities.

2.6 Groups vulnerable to alcohol use, sexual risk behaviour and HIV

The National Behavioural Sentinel Surveys among high-risk groups in India showed that alcohol use (at least once a week) is increasing among female commercial sex workers (FCSWs), their clients, among men having sex with men (MSMs), and among injecting drug users (IDUs). A number of these groups reported regular alcohol use before sex (FCSWs 15%; clients of FCSWs 13%; MSMs 36%). High rates of alcohol use have also been observed among vulnerable groups such as adolescents, commercial sex workers and their clients in other countries (e.g. South Africa, Belarus, Romania and Mexico). Furthermore, the prevalence of alcohol dependence in men with HIV infection is high in all the countries. It has also been shown that despite knowledge about preventive measures, condom use is low in vulnerable groups, especially when under the influence of alcohol and/or other psychoactive substances.

Alcohol use and sexual risk behaviour go hand in hand in commercial sex encounters. FCSWs use alcohol to cope with the pressures of their work, e.g. a large number of sexual encounters. Many a time they and their clients use alcohol together. Condom use is more evident among paying sex partners than non-paying sex partners of sex workers. Brothel-based workers are able to negotiate condom use better than non-brothel-based workers in India. Most studies suggest that there is greater consistency of condom use in commercial sex than in private encounters, but that levels of alcohol use do not necessarily alter levels of condom use. However, clients' alcohol use has emerged as an important determinant of condom use in some studies. Other studies have found no differences in condom use between FCSWs who use alcohol and those who do not.

Drinking alcohol and visiting commercial sex workers are evident among long-distance drivers all over the world. Transport workers and migrant populations who frequently visit FCSWs, spread STIs and HIV infection from one place to the other and from high-risk groups to the general population. IDUs who are sexually active contribute to the spread of HIV infection in Belarus, the Russian Federation, Romania and India.

Alcohol use, especially among young adolescents, is associated with casual sex encounters, traffic accidents, violence, crime and social problems (e.g. in Belarus, South Africa, Mexico). Early sexual experience, a high level of risk taking and alcohol use increase the risk of contracting STIs and HIV among adolescents.

Direct and indirect links have been demonstrated between alcohol use and sexual risk behaviours in vulnerable groups as well as in the general population, but only a few studies have specifically examined the nature of such linkage and its effect on high-risk behaviour and prevention of health problems. Overall, research on the relationship between alcohol use, sexual behaviour, risk taking, condom use and STI/HIV vulnerability, especially in the general population, is scanty.

There is also some indication that decreased availability of alcohol corresponds with a reduction in risk behaviours in India.

In contrast to the other regions, HIV prevalence is higher among women than among men in the African region. Migrant workers, truck drivers, mineworkers, FCSWs, prison inmates, psychoactive substance users, antenatal clinic attendees, young adolescents and tribal populations are also particularly at risk of HIV in this region.

2.7 Conclusion

The project sites show clear differences in broad socioeconomic features, in lifestyle, in culture, and, indeed, in drinking and sexual practices and related attitudes. They are, however, all undergoing socio-political changes that are reflected in the prevailing practices and attitudes towards alcohol and sexual matters. The literature review underlined the interaction between broad socioeconomic conditions and individual/group behaviour and attitudes. One example is the strain that the large proportion of HIV/AIDS-related deaths among the productive sector in the populations has placed on socioeconomic development. Increasing modernization and liberalization in the project sites have contributed towards more permissive attitudes towards alcohol use and sexual risk behaviour. In developing countries, globalization (e.g. through the media) has contributed towards the erosion of traditional values and the adoption of Western lifestyles, particularly among younger groups.

More specifically, the fact that India, South Africa, Kenya, Zambia and Mexico have been subjected to Western/colonial rule has contributed towards alcohol use no longer being restricted to traditional or ceremonial use of low-alcohol brews by specific population groups; alcohol is now used widely and is socially more acceptable than before. Romania, the Russian Federation and Belarus are no longer under Communist influence and, like the other five countries, witnessed socioeconomic and political change in the late 1980s and 19990s. This has led to changes in lifestyle, a decline in adherence to traditional moral values, in health standards, and to increased vulnerability to alcohol use and sexual risk behaviours (e.g. participation in commercial sex work), and thus to STIs, including HIV/AIDS. An increase in foreign traffic, psychoactive substance use, commercial sex work and STI prevalence have contributed towards an increase in HIV infection in the Russian Federation, Belarus and Romania.

STIs, including HIV/AIDS, are a serious public health problem in the project countries, although the transmission route differs to some extent. For example, whereas heterosexual transmission of HIV predominates in most of the countries, in the Russian Federation and Belarus the majority of the reported HIV infections are related to injecting drug use. In contrast to the other regions, in the African region HIV prevalence is higher among women than among men.

All the countries except India report high levels of alcohol consumption, including the use of homebrews. Furthermore, notwithstanding considerable morbidity and mortality associated

with alcohol use in certain countries (e.g. the Russian Federation, Mexico and South Africa), control measures are largely absent.

A link between alcohol use and sexual risk behaviours in terms of HIV infection has been observed within particularly certain population groups, in certain settings or places where these behaviours take place, and in the case of certain sexual encounters. The literature also shows that this link is embedded in the perceptions and expectations of individuals, which in turn are influenced by sociocultural and other individual-related factors.

In general, alcohol use and engagement in sexual risk behaviours are more common among males, adolescents, the mobile population (truck drivers, migrant workers), commercial sex workers and prison inmates than among other groups. In this respect it is also important to note that the notion that alcohol use and promiscuous behaviour "prove" masculinity seems to be universal. Nightclubs, bars and pubs are emerging as places for alcohol use and initiation of sexual activity at an early age. These venues attract young people.

In short, the following key issues emerged in the course of the review of literature on the subject: the *prevalence of certain myths and notions about "masculinity"; a lack of clear and firm alcohol-related policies; increasing HIV prevalence and the need to augment prevention efforts in this respect; the interwovenness of alcohol use, sexual risk behaviours and STI/HIV/AIDS; the effect of modernization and the media on the youth, which manifests in early drinking, early sexual activity and increasing vulnerability to risk behaviours; and a paucity of research data on alcohol and sexual risk behaviours across the countries.* The review also highlighted that the social dynamics of alcohol use and sexual risk behaviours warrant a search for culture-specific and context-specific ways of dealing with the problem. Despite differences in demographics, in alcohol use patterns and sexual practices across the countries, alcohol use is generally associated with sexual risk behaviours and HIV vulnerability. However, research data on this triangular relationship are limited. The issue needs to be examined from the sociocultural as well as the individual's perspective in order to devise appropriate interventions.

Finally, the literature study suggests that in order to understand the factors that lead to sexual risk behaviours when alcohol is used, it is important to have a basic understanding of:

1 the patterns and settings of alcohol use in diverse cultural settings and regions of the world;

2 the prevalence of HIV infection and STIs in different regions of the world;

3 the sexual norms, attitudes, beliefs and behaviours in different cultures and regions with a focus on sexual risk behaviours, the high-risk groups and the settings in which high-risk behaviours occur; and

4 the association between alcohol and sexual risk behaviours in the different regions.

At the macro level, there is a need for an in-depth understanding of the sociocultural factors that influence risk behaviours, some of them common to most of the sites/countries, such as myths and notions about masculinity, alcohol use and sexual risk behaviours, the role of religion, the media, modernization and social liberalization, the role of substance use, ignorance and poverty/economic disparity, gender inequality, norms, the vulnerability of the teenage population, inadequate implementation of policies related to alcohol use and high-risk groups; and others peculiar to a given region/site, such as alcohol use and sex during funerals in Kenya, polygamy in certain groups in Kenya, dry sex in Zambia and South Africa, factors related to the free market economy and an increase in foreign traffic in Central and Eastern Europe.

At the micro level, it becomes important to understand the links between risk behaviours and cognitive, affective and behavioural factors in the individual at the time of the event. What makes the person drink before having sex? What happens to the risk perception? What kinds of sexual encounters is one likely to engage in? What happens to the likelihood of and the ability

to use condoms under the influence of alcohol in a given individual? What is the likelihood of STI/HIV transmission? Are appropriate steps taken by the individual towards primary or secondary prevention?

LITERATURE REVIEWED

Belarus

Barabanov LG, Navrotskiy AL, Barabanov AL. (2001) The Epidemiological Situation with Respect to Venereal Diseases in Belarus. Compendium. *Pathogenesis, Diagnosis Treatment and Prevention of Sexually Transmitted Infections and Skin Diseases.* Materials of the IVth Congress of Dermatologists and Venereologists of the Republic of Belarus, Minsk, pp. 14-17.

Belarusian Center for Scientific Medical Information. (2001) *Public Healthcare in the Republic of Belarus*. Minsk, Official Statistical Data.

Healthy Way of Life. (1999) *AIDS in Belarus: A Problem of the Young*. Minsk, Republic of Belarus, Healthy Way of Life.

Ivchenkova IP, Efimova AV, Akkuzina OP. (2001) Teenagers' Aims by the Beginning of their Sexual Life. *Problems of Psychology,* 3:49-56.

Kozlovskiy AV, Razvodovskiy YuE, Lelevich VV Zimiatkin SM. (2000) Alcohol Situation in Belarus and its Regions. *Medical News,* 1:21-24.

Loseva OK, Bobkova IN, Kravets TA. (2001) Changes of Sexual Behavior Pattern as a Factor of Syphilis Expansion. *Disease Prevention and Health Boosting,* 3:23-26.

Ministry of Public Healthcare. (2002) *Report on the Execution of the Governmental Program of Nation-Wide Actions Preventing and Overcoming Hard Drinking and Alcoholism.* Minsk, Republic of Belarus, Ministry of Public Healthcare.

Ministry of Statistics and Analysis of the Republic of Belarus. (1998) *Social Status and Living Standard of the Population of the Republic of Belarus: Statistical Compendium.* Minsk, Republic of Belarus, Ministry of Statistics and Analysis of the Republic of Belarus.

Ministry of Statistics and Analysis of the Republic of Belarus. (2000) *Statistical Yearbook of the Republic of Belarus*. Minsk, Republic of Belarus, Ministry of Statistics and Analysis of the Republic of Belarus.

Moroz IN, Moroz VA, Plakhotia AP, Kalinina TV. (2000) *Reproductive Health Problems in Teenagers*. Materials of the IVth Congress of the Social Hygienists and Public Health Officials of the Republic of Belarus, pp. 181-182.

Nikulina EYu. (2001) *Psychosocial Peculiarities of Alcohol and Drug Abuse in Teenagers. Modern Medicine and Pharmacy*. Materials of the Conference of Students and Young Scholars of Vitebsk State Medical University, pp. 206-298.

Razvodovskiy YuE. (2001) Alcohol-Associated Problems in Belarus. *Medical News,* 7:41-43.

Republican AIDS Prevention Center. (1999) *Distribution of Information on the Problem of HIV/AIDS among Various Groups of the Population of the Republic*. Report on a sociological study. Minsk, Republic of Belarus, Republican AIDS Prevention Center, UNAIDS Programme, Institute of Social and Political Research affiliated with the Administration of the President of the Republic of Belarus.

Republican AIDS Prevention Center. (2000) *Distribution of Information on the Problem of HIV/AIDS among Various Groups of the Population of the Republic*. Minsk, Republic of Belarus, Republican AIDS Prevention Center, UNAIDS Programme, Institute of Social and Political Research affiliated with the Administration of the President of the Republic of Belarus.

Republican Health Center of the Ministry of Public Health. (2001) *Student Youth of Belarus. Reproductive Health and Sexual Behavior*. Minsk, Republic of Belarus, UNIPAC Publishing House.

Rychkov AE, Vissenberg YuV. (1999) *Sociological Analysis of Reproductive Behavior of Teenage Girls*. *Belarus Children's Health.* Materials of the VIIth Congress of Pediatricians of the Republic of Belarus, Minsk, Republic of Belarus, pp. 174-175.

Scientific Society of Dermatologists and Venereologists. (2000) *Pathogenesis, Diagnosis Treatment and Prevention of Sexually Transmitted Infections and Skin Diseases*. Materials of the Plenary Session of the Scientific Society of Dermatologists and Venereologists, Minsk, Republic of Belarus.

Shpakov AI, Omelianchik MS. (2000) Epidemiological Studies of School Students' and High School Students' Attitude to Alcohol. *Public Healthcare*, 1:22-24.

Snytko NI. (2001) *Social Problems of Demographic Aging*. Minsk, Republic of Belarus, Law and Economics Publishing Co Ltd.

Zorko YuA. (2001) Studies on Students' Mental Health. *Medical News,* 2:63-65.

Zorko YuA. (1998) Peculiar Features of Students' Mental Health. *Medical News*, 12:9-12.

India

Abraham L, Kumar KA. (1999) Sexual Experiences and their Correlates among College Students in Mumbai City, India. *International Family Planning Perspectives*, 25:139-146.

Advani GB, Sharma HK, Sundaram KR, Mohan D. (1981) Recent trends in alcohol and drug abuse in India. In: Mohan D, Sethi HS, Tongue E, editors. *Current Research in Drug Abuse in India.* New Delhi, AIIMS.

Ambwani PN, Gilada IS. (1998) *Dry alcohol days during festivals to prevent HIV/AIDS.* XIIth International Conference on AIDS, Geneva. AIDSLINE ICA 12/98410386.

Aswar NS, Wahab SN, Kale KM. (1998) Prevalence and some epidemiological factors of syphilis in Madia Tribe of Gadricholi District. Indian Journal of Sexually Transmitted Diseases*, 19:53-57.*

Bryan AD, Fisher JD, Joseph Benziger T. (2001) Determinants of HIV risk among Indian truck drivers. Social Science & Medicine*, 53:1413-1426.*

Chandiramani R, Kepadia S, Khanna R, Misra G. (2001) *Critical review of studies on sexuality and sexual behaviour conducted in India from 1990 to 2000*. Paper presented at the Reproductive Health Research Review Dissemination Workshop, Mumbai, December.

Chandra PS, Bengal V, Ramkrishna J, Krishna VAS. (1999) Development and evaluation of a module for HIV/AIDS related risk reduction among patients with alcohol dependence*. Project report. Bangalore, National Institute of Mental Health and Neurosciences.*

Deb PC, Jindal RB. (1974) *Drinking in rural areas: A study in selected villages of Punjab in wake of Green Revolution*. Monograph. Ludhiana, Punjab Agricultural University.

Dhawan A, Mohan D. (1999) Epidemiology of alcohol and substance abuse. *NIMHANS Journal*, 17:367-376.

FHI. (2001) *What drives HIV in Asia? A summary of trends in sexual and drug-taking behaviours*. FHI/DFID/USAID/Impact.

Gawande AV, Vasudeo ND, Zodpey SP, Khandait DW. (2000) Sexually transmitted infections in long distance truck drivers. *Journal of Communicable Diseases*, 32:212-215.

Gilada IS. (1994) The Bombay model goes international. *AIDS Asia 6. Sexual behaviour in India with risk of HIV/AIDS transmission*, p. 305.

Government of India. (2001) *India 2001- A reference annual*. New Delhi, Publication Division, Ministry of Information and Broadcasting, Government of India.

Jain, MK, John TJ, Keuseh GT. (1994) *A review of human immunodeficiency virus infection inIndia*. Journal of Acquired Immune Deficiency Syndromes, 7:1185-1194.

Jha P, Nagelkerke JD, Ngugi EN, Prasada Rao JV, Willbond B, Moses S, Plummer FA. (2001) Reducing HIV transmission in developing countries. *Science 2001*, 292:224-225.

Kannan AT. (1995) Adolescent health: Issues and concerns in India. *Health for the Millions*, pp. 29-30.

Kar HK, Jain RK, Sharma PK, Gautam RK, Gupta AK, Sharma SK, Hans C, Doda V. (2001) Increasing HIV prevalence in STD clinic attendees in Delhi, India: 6 year (1995-2000) hospital based study results. *Sexually Transmitted Infections,* 77:393.

Kishore J, Singh A, Grewal I, Singh SR, Roy K. (1999) Risk behaviour in an urban and rural male adolescent population. *National Medical Journal of India,* 12:107-110.

Kok P. (2002) *Dynamics of the HIV/AIDS Epidemic and its Implications for Prevention Programmes in Asia*. Draft report, personal communication.

Kootikuppala SR, Pilli RD, Rao AS, Chalam PS. (1999) *Sexual lifestyle of long distance lorry drivers in India: Questionnaire survey*. Paper presented at AIDS Prevention Division, Andhra Pradesh, India.

Lal B, Singh G. (1978) Alcohol consumption in Punjab. *Indian Journal of Psychiatry,* 20:212-216.

Lamptey PR. (2002) Reducing heterosexual transmission of HIV in poor countries. *British Medical Journal,* 324:207-211.

MAP (Monitoring the AIDS Pandemic). (2001) *The Status and Trends of HIV/AIDS/STI Epidemics in Asia and the Pacific*. MAP.

Mohan D, Chopra A, Sethi H. (2001) A rapid assessment study on prevalence of substance abuse disorders in metropolis Delhi. Indian Journal of Medical Research, 114:107-14.

Mohan D, Chopra A, Sethi H. (2002) The co-occurrence of tobacco & alcohol in general population of metropolis Delhi. Indian Journal of Medical Research, 16:150-4.

Mohan D, Sharma HK, Sundaram KR, Advani GB. (1981) *Prevalence and pattern of alcohol abuse in rural community and its correlation with psycho-social sequelae*. Report. New Delhi, Ministry of Social Welfare.

Mohan D, Sharma HK, Sundaram KR, Neki JS. (1980) Pattern of Alcohol Consumption of Rural Punjab Males. *Indian Journal of Medical Research*, 72:702-711.

Mohan D, Sharma HK. (1995) Alcohol and culture in India. In: Heath DB, editor. *International Handbook on Alcohol and Culture*. Westpost, CP Green Wood Publishing Group.

Mohan D, Sundaram KR, Advami GB, Sharma HK, Bajaj JS. (1984) Alcohol Abuse in Rural Community in India. Part II. Characteristics of Alcohol Users. *Drug and Alcohol Dependence*, 14:121-128.

Mohan D, Sundaram KR, Sharma HK. (1983) *A Study on Health Education, Intervention on Non Medical Use of Drugs in the Community*. Report. New Delhi, Indian Council of Medical Research.

Mohan D, Sundaram KR. (1987) *Drug abuse among college students – a replicated study among university students*. Report. New Delhi, Ministry of Welfare, India.

Mohan D. (1999a) Rapid assessment survey on alcohol, tobacco and other substances in districts of Aizawl (Mizoram), Kohima (Nagaland) and Darjeeling (West Bengal)*. Project report. New Delhi, Drug Dependence Treatment Centre, AIIMS.*

Mohan D. (1999b) *Rapid assessment survey on alcohol, tobacco and other substances in districts of Thobul (Manipur), Mandsaur (Madhya Pradesh) and Barabanki (Uttar Pradesh)*. Project report. New Delhi, Drug Dependence Treatment Centre, AIIMS.

NACO, DFID. (2001) *Situational analysis of sexual health in India (SASHI)*. New Delhi, NACO & DFID, India.

NACO. (2001a) *Combating HIV/AIDS in India 2000-2001*. New Delhi, Ministry of Health and Family Welfare.

NACO. (2001b) *National HIV Sentinel Behavioural Surveillance Survey – 2000*. New Delhi, Ministry of Health and Family Welfare, Government of India.

NACO. (2002a) *National Baseline General Population Behavioural Surveillance Survey – 2001*. New Delhi, Ministry of Health and Family Welfare, Government of India.

NACO. (2002b) *National HIV Sentinel Behavioural Surveillance Survey – 2001*. New Delhi, Ministry of Health and Family Welfare, Government of India.

Nag M. (1996) *Sexual Behaviour and AIDS in India*. New Delhi, Vikas Publishing House.

Office of the Registrar General. (2001) Census of India. *http://www.censusindia.net/results/resultsmain.html.*

Panicker R. (1998) Street children and drug abuse in India. In: Ray R, editor. *Drug demand reduction report*. New Delhi, India, UNDCP Regional Office for South Asia, pp. 34-36.

Ramasubban R. (1999) HIV/AIDS in India: Between Rhetoric and Reality. In: Pachauri S, Subramanian, S, editors. *Implementing a reproductive health agenda in India: The beginning*. Population Council, South East Asia – Regional Office, pp. 347-376.

Ramasundaram S. (2002) Can India avoid being devastated by HIV? *British Medical Journal*, 324:182-183.

Rao A, Nag M, Mishra K, Dey A. (1994) Sexual behaviour pattern of truck drivers and their helpers in relation to female sex workers. *Indian Journal of Social Work,* 55(4):603-616.

Rao KS, Pilli RD, Rao AS, Chalam PS. (1999) Sexual lifestyle of long distance lorry drivers in India: Questionnaire survey. *British Medical Journal*, 318:162-163.

Ray R. (1998) *South Asia: Drug Demand Reduction Report*. New Delhi, India, UNDCP Regional Office for South Asia.

Reid G, Costigan G. (2002) *Revisiting the Hidden Epidemic – A Situational Assessment of Drug Use in Asia in the Context of HIV/AIDS.* Perth, Australia, Centre for Harm Reduction, Burnet Institute.

Saxena S. (2000) Alcohol problems and responses: Challenges for India. *Journal of Substance Use*, 5:62-70.

Saxena S. (2001) Alcohol related problems in India: Need for policy oriented approach. In: Murthy RS, editor. *Mental Health in India 1950-2000: Essays in honour of Professor N.N. Wig*. Bangalore, PAMH, pp. 54-59.

Sayal SK, Gupta CM, Sanghi S. (1999) HIV infection in patients of sexually transmitted disease. *Indian Journal of Dermatology, Venereology & Leprology*, 65:131-133.

Sethi BB, Trivedi JK. (1979) Drug abuse in a rural population. *Indian Journal of Psychiatry,* 21:211-216.

Singh IN, Malaviya AN. (1994) Long distance truck drivers in India. HIV infection and their possible role in disseminating HIV into rural areas. *International Journal of STD and AIDS,* 5:137-138.

Singh S, Prasad R, Mohanty A. (1999) High prevalence of sexually transmitted and blood borne infections amongst the inmates of a district jail in Northern India. *International Journal of STD & AIDS*, 10:475-478.

Tripathi BM, Lal R. (1999) Substance abuse in children and adolescents. *Indian Journal of Paediatrics*, 66:569-575.

UNAIDS, WHO. (2001) *AIDS Epidemic Update 2001 revised*. Geneva, UNAIDS/WHO.

UNAIDS, WHO. (2003) *AIDS Epidemic Update 2003 revised*. Geneva, UNAIDS/WHO.

Varma VK, Singh A, Singh S, Malhotra A. (1980) Extent and pattern of alcohol use and alcohol-related

problems in North India. *Indian Journal of Psychiatry*, 22:331-337.

Venkataramana CB, Sarada PV. (2001) Extent and speed of HIV infection in India through the commercial sex networks: A perspective. *Tropical Medicine and International Health*, 6:1040-1061.

World Health Organization. (1999) *Global status report*. Geneva, World Health Organization.

Kenya

Kenya Demographic and Health Survey (KDHS). (2000) Nairobi, Ministry of Statistics.

Kimani V, Olenja J. (1998) A Multicentre Study of Kisumu (Western Kenya). Unpublished data.

Miguda-Attyang J. (1996) A study on behaviour change among commercial sex workers in Kisumu Municipality. Unpublished data.

Ministry of Health. (2001a) AIDS Control Units, HIV Prevalence among Antenatal Clients. Sixth edition. Nairobi, Ministry of Health.

Ministry of Health. (2001b) AIDS in Kenya, Background, Projections, Impact, Interventions, Policy. Sixth edition. Nairobi, Ministry of Health.

Ministry of Health. (2001c) Republic of Kenya. National AIDS Control Council and AIDS Control Unit. Sixth edition. Nairobi, Ministry of Health.

Mwenesi H. (1995) Rapid Assessment of Drug Abuse in Kenya - A National Report supported by United Nations International Drug Programme. Unpublished data.

National AIDS and STD Control Programme (NASCOP). (2001) Guidelines for Voluntary Counseling and Testing. Nairobi, National AIDS Control Council.

Ngugi EN, Costigan A, Moses S. (1999) Strengthening STD/HIV/AIDS Control Project in Kenya: A Report on Knowledge, Attitude and Practices. Survey in Thika. Thika, Touts, Sand Harvesters and Jua Kali Artisans.

Ngugi EN, Jackson D. (2000) STD control in female sex-workers in Africa. Health Co-operation Papers, Sexually Transmitted Diseases in the Tropics. Unpublished data, pp. 143-149.

Ngugi EN, Kimani V, Toroitich C. (2000) Gender, Power and HIV/AIDS Vulnerability. Results from a Male Female Condom Use Study of Sex Workers in Nairobi, March to September. Unpublished data.

Ngugi EN. (2000) Interview with a sex-worker (Thika) about her behaviour. Unpublished data.

Njuguna B. (2001) Alcohol and Substance Abuse in Relation to HIV/AIDS among Young People. Paper presented at Straight Talk Clinic, September, Nairobi.

Ong'ang'o J. (2001) Knowledge, Attitudes and Practices on Substance Use among High School Students in Nairobi, Kenya. Thesis submitted in part fulfillment of the master's degree in public health, May, Nairobi.

Pan African News Agency. (2001) Officials Worried by Rising Alcoholism. Pan African News (Dakar), March.

Pathfinder. (no date) HIV/AIDS Training Manual for Youth (10-15 years): HIV/AIDS Prevention through Behaviour Change.

Preventive Health Education Against Drug Use. (1991) A Handbook On Substance Abuse: A Reflection of Mombassa Meeting, August, pp. 21, 48, 49.

Sabo K, Iitus S. (1998) What Do Young People around the World Think about Drug Issues. Paper and work book. Banft, Alberta, Canada, Youth Vision, April.

UNAIDS, WHO. (2002) Report on the global HIV/AIDS epidemic, 2002- Fact sheet. Geneva, World Health Organization.

World Bank. (1995) The World Bank Staff Appraisal Report. The Republic of Kenya Sexually Transmitted Infections Project, February, Nairobi, p. 6.

World Health Organization. (1999) Global Status Report on Alcohol. Geneva, World Health Organization.

Mexico

Annis H, Sobell L, Ayala H, Rybakowski J, Sandahl C, Saunders B, Thomas S, Ziolkowski M. (1996) Drinking-related assessment instruments: Cross-cultural studies. *Substance Use and Misuse*, 31(11/12):1525-1546.

Ayala H, Echeverría L, Sobell M, Sobell L. (1998) Una alternativa de intervención breve y temprana para bebedores problema en México. *Acta Comportamentalia*, 6(1):71-93.

Berenzon S, Carreño S, Medina-Mora ME, Juárez F, Villatoro J. (1996) El uso de alcohol entre la población estudiantil de nivel secundaria y bachillerato en el distrito federal. *La Psicología Social en México*, VI:554-560.

Bernal B, Hernández G. (1997) Las enfermedades de transmisión sexual (ETS): otro reto para la prevención y control de la epidemia del VIH/SIDA. *SIDA/ETS*, 4(3):63-67.

Bronfman M, Amuchástigui A, Martina RM, Minello N, Rivas M, Rodríguez G. (1995) *SIDA en México migración, adolescencia y género.* México, Información Profesional Especializada.

Campillo C, Romero M. (1994) Efectos del abuso de drogas y alcohol en la sexualidad. En: *Antología de la sexualidad humana III*. México, Porrúa y Conapo.

CONASIDA. (2002) *El SIDA en México en el año 2000*. México, CONASIDA-Secretaría de Salud. http://www.ssa.gob.mx/conasida/.

Conde-González CJ, Juárez-Figueroa L, Uribe-Salas F, Hernández-Nevárez L, Schmid H, Calderon P, Hernández-Avila M. (1999) Analysis of herpes simples virus 1 and 2 infection in women with high risk sexual behavior in Mexico. *International Journal of Epidemiology*, 28:571-576.

Crowe LC, George WH. (1989) Alcohol and human sexuality: Review and integration. *Psychological Bulletin*, 105:374-386.

Díaz-Loving R. (1994) Personalidad, valores y patrones sexuales relacionados con el SIDA. En: Piña JA. *SIDA perspectiva psicológica de un problema de salud mundial*. México, UniSon.

González Pérez MJ. (1998) *Personalidad y comportamientos sexuales ante la transmisión del VIH/SIDA en adolescentes*. Tesis de Licenciatura, ENEP Iztacala, UNAM.

Gordis E. (1995) Critical issues in alcoholism research. *International Journal of the Addictions*, 30(4):497-505.

INEGI. (2001) *Tablas estadísticas III-IX Censos Nacionales de Población y Vivienda*. México, Instituto Nacional de Geografía e Informática.

INEGI. (2001b) *Sistema de Indicadores para el Seguimiento de la Situación de la Mujer en México (SISESIM*). Versión 2.0. México: INEGI.

Juárez-Figueroa LA, Wheeler CM, Uribe-Salas FJ, Conde-Glez CJ, Zamilpa-Mejía LG, García-Cisneros S, Hernández-Avila M. (2001) Human Papillomavirus. A Highly Prevalent Sexually Transmitted Disease Agent among Female Sex Workers from Mexico City. *Sexually Transmitted Diseases*, 28(3):125-130.

Kalichman S, Tannenbaum L, Nachimson D. (1998) Personality and Cognitive Factors Influencing Substance Use and Sexual Risk for HIV Infection Among Gay and Bisexual Men. *Psychology of Addictive Behaviors*, 12(4):262-271.

Luna Cadena A. (In press) *Hombres que tienen sexo con hombres: cuartos oscuros en la ciudad de México*. México.

Mayne T, Acree M, Chesney M, Folkman S. (1998) HIV Sexual Risk Behavior Following Bereavement

in Gay Men. *Health Psychology*, 17(5):403-411.

Medina-Mora ME. (2001) Los conceptos de uso, abuso, dependencia y su medición. En: Tapia R, editor. *Las adicciones: dimensión, impacto y perspectiva*. México, Manual Moderno, pp. 21-44.

Mora Barbosa A, Olivier Téllez L. (2001) *Comparación de Estrategias de Afrontamiento en hombres y mujeres ante el diagnóstico de VIH*. Tesis de licenciatura (no publicada). Facultad de Psicología, UNAM.

Mora Ríos J, Natera G, Tiburcio M. (2000) Expectativas de Consumo de Alcohol en Estudiantes Universitarios. *La Psicología Social en México*, VIII:639-644.

Pérez JL. (2001) El papel de los padres de familia frente al consumo de alcohol. *Cuadernos Fisac*, 2, 1, 009:11-15.

Ponce de León M, Castellanos L, Solís R, Alfaro L. (2000) El Consumo de Alcohol entre los Adolescentes y su Influencia en la Familia y Personalidad. *La Psicología Social en México*, VIII:676-681.

Rivera I. (2001) Hábitos y prácticas de consumo de alcohol de los jóvenes en bares y discotecas del país. *Cuadernos Fisac*, 2, 1, 009:35-45.

Rosovsky H, Romero M. (1996) Prevention issues in a multicultural developing country: The Mexican case. *Substance Use & Misuse*, 31(11-12):1657-1688.

Secretaría de Salud. (1998) *Encuesta Nacional de Adicciones*. México, Instituto Nacional de Psiquiatría Ramón de la Fuente.

SSA. (2002) *Principales causas de mortalidad general 2000*. http://www.ssa.gob.mx.

Stern C, editor. (2001) *Reporte del Estudio de la Salud Sexual y Reproductiva de los adolescentes varones y hombres jóvenes en América Latina*. Proyecto financiado por la Organización Panamericana de la Salud.

Trejo MC. (2001) Adolescentes y jóvenes: diversión, sexualidad y consumo de alcohol. *Liber-Addictus*, 50:24-26.

Uribe-Salas F, Del Rio Chiriboga C. (1996) Prevalence, Incidence, and Determinants of Syphilis in Female Commercial Sex Workers in Mexico City. *Sexually Transmitted Diseases*, 23(2):120-126.

Valdespino GJ, García-García MI, Cruz-Palacios C. (1993) Enfermedades de Transmisión Sexual y SIDA. *Clínica, Laboratorio, Psicología y Sociología*. México, INDIRE Secretaría de Salud.

Valdespino J, García M, Izazola J. (1989) Distribución de la epidemia del SIDA. En: Sepúlveda Amor J, Bronfman M, Ruíz P, Stanislawski E, Valdespino J, editors. *Sida, Ciencia y Sociedad en México*. México, Fondo de Cultura Económica.

Villatoro J, Medina-Mora ME, Cardiel H, Alcántara E, Fleiz C, Navarro C, Blanco J, Parra J, Néquiz G. (1999) *Consumo de Drogas, Alcohol y Tabaco en Estudiantes del Distrito Federal: medición otoño 1997*. Reporte Estadístico. SEP, IMP, México.

William HG, Stoner SA. (2000) Understanding acute alcohol effects on sexual behavior. *Annual Review of Sex Research*, 11:92-124.

Zuno LE. (2001) Corresponsabilidad de los jóvenes, las autoridades y la familia en la resolución del problema de consumo de alcohol. *Cuadernos Fisac*, 2, 1, 009:17-33.

Zwerling C, Sprince NL, Wallace RB, Davis CS, Whitten PS, Heeringa SG. (1996) Alcohol and occupational injuries among older workers. *Accident Analysis & Prevention*, 28(3):371-376.

Romania

Anghel F. (1998) *Educatia pentru toti in Romania* [Education for all in Romania]. Bucuresti, Alternative.

Mihailescu R. (2000) Relatia om-alcohol-societate. [The relationship alcohol-person-society.] In: Prelipceanu D, Mihailescu R, Teodorescu R, editors. *Tratat de Sanatate Mentala.* [Handbook of Mental Health.] Bucuresti, Editura Enciclopedica.

Ministry of Health. (1994) *Health Status in Romania.* Bucharest, National Institute for Health Services and Management, Ministry of Health.

Ministry of Health. (1997) *Yearbook of Health Statistics 1996*. Bucharest, Center for Sanitary Statistics and Medical Documentation, Ministry of Health.

Ministry of Health. (1999) *Yearbook of Health Statistics 1998*. Bucharest, Center for Sanitary Statistics and Medical Documentation, Ministry of Health.

Ministry of Health. (2000) *Public health monitoring on HIV/AIDS in Romania*. Bucharest, Ministry of Health.

Ministry of Internal Affairs. (1998) *General Police Inspectorate: Interim Report*. Bucharest, Ministry of Internal Affairs.

Muntean A, Popescu M, Popa S. (2001) *Victimele violentei domestice: femeile si copii*. [Victims of domestic violence: Women and children.] Eurostampa ed., Timisoara.

National Commission for Statistics. (1992) *Census of Population and Dwellings on January 2, Bucharest, 1992*, *2nd Volume: Population-ethnical and confessional structure.* Bucharest, National Commission for Statistics.

National Commission for Statistics. (2000) *Romanian Statistical Yearbook*. Bucharest, National Commission for Statistics.

Romanian National Institute of Statistics & UNICEF. (2001) Social Trends. Bucharest, Romanian National Institute of Statistics.

Traficul de femei si prostitutia fortata [Women traffic and forced prostitution.] (1999) Proceedings of a conference held from 7-11 November, Timisoara.

Russian Federation

Ivanova LYu. (2002) A state and perspectives of HIV infection prevention in the educational establishments of Russia. *Round Table*, 2:58-65.

Koshkina EA. (1999) Drug abuse: Situation among Moscow students. *Pulse*, 9:61.

Koshkina EA. (2001a) The epidemiology of alcoholism in Russia at the modern stage. *Psychiatry and Psychopharmacotherapy,* 3:89-91.

Koshkina EA. (2001b) The prevalence of drug abuse diseases in Russian Federation in 2000. According to the official statistics. *Voprosy narcologii,* 3:61-66.

Koshkina EA, Korchagina GA, Shamota AZ. (2000) *The prevalence of alcoholism and drug abuse in the Russian Federation*. *Guideline for physicians, psychiatrists and narcologists*. Moscow, Russian Ministry of Health.

Kostenko S. (2000) Who will help the prostitute? *Round Table*, 5:34-37.

Kungurov NV, Syrneva TA, Sarapulova IB. (1998) Sexual behaviour of women with venereal illnesses. *The diseases, transmitted by sexual way,* 6:33-35.

Loseva OK, Bobkova IN. (2000) Before marriage, marriage and after marriage sexual behavior and orientation of males and females. *The infections, transmitted by sexual way*, 1:16-22.

Loseva OK, Kravets TA. (2001) Medical and sociological investigations of teenagers' sexual behaviour for the period 1989-2000. *Bulletin of Dermatology and Venereology*, 5:34-36.

Loseva OK, Nashkhoev MP, Platt L. (1999) The outreach new form of the work with the high risk groups. *The infections, transmitted by sexual way*, 3:19-23.

Luzan NV. (2000) The organization of the prevention of STD/AIDS among adolescents from social risk groups. *The infections, transmitted by sexual way,* 1:38-40.

Luzan NV. (1998) The problem of morbidity from diseases transmitted by sexual way among adolescents. *The diseases, transmitted by sexual way,* 1:28-31.

Nashkhoev MP, Iliina SV. (2000) Psychological features of women of the street sex business. *The infections, transmitted by sexual way*, 6:31-36.

Russia in figures. 2000. (2001) Moscow.

Round Table. (2001) It is all the same for me, and what about you? *Round Table*, 5/6:3-15.

Shegai M, Peryshkina A. (2000) The concept of the outreach program and target educational work as the component of AIDS control. *Round Table*, 5:13-17.

Shumov AV, Fedotov AV, Taraskin OV. (2001) The infections, transmitted by sexual way, and female prostitution in territory of the Saratov Region. *Bulletin of Dermatology and Venereology*, 1:69-72.

Shuvalova TM, Tumanyan AG, Sokolova IM, Gevorkyan GKh, Ovakemyan LS. (1998) The prevalence of syphilis in Moscow Region. *The diseases, transmitted by sexual way*, 6:28-32.

The 1999 ESPAD Report. (1999) Paris, The Pompidou Group, Council of Europe.

Tikhonova LI. (2001) The dermatological service of Russia: Problems, searches, solutions. *The infections, transmitted by sexual way*, 3:28-36.

Vyshinskii KV. (1999) *The study of the prevalence of PAS using the example of Moscow*. Synopsis of thesis, Moscow, p. 26.

South Africa

Colvin M, Gouws E, Kleinschmidt I, Dlamini M. (2000) *The prevalence of HIV in a South African working population*. XIIIth International AIDS Conference, Durban, South Africa, 9-14 July.

Community Agency for Social Enquiry. (2001) *Youth in Brief: A summary of the Youth 2001 Report*. Johannesburg, South Africa, Community Agency for Social Enquiry.

Department of Health. (2001) *National HIV sero-prevalence survey of women attending public antenatal clinics in South Africa, 2000*. Pretoria, South Africa, Department of Health.

Department of Health. (2001-2002) *South Africa Demographic and Health Survey – 1998*. Pretoria, South Africa, Department of Health.

Flisher AJ, Chalton DO. (2001) Adolescent contraceptive non-use and covariation among risk behaviours. *Journal of Adolescent Health*, 28(3):235-241.

Flisher AJ, Ziervogel CF, Chalton DO, Leger PH, Robertson BA. (1996a) Risk-taking behaviour of Cape Peninsula high-school students: Part IX. Evidence for a syndrome of adolescent risk behaviour. *South African Medical Journal*, 86(9):1090-1093.

Flisher AJ, Ziervogel CF, Chalton DO, Leger PH, Robertson BA. (1996b) Risk-taking behaviour of Cape Peninsula high-school students. Part X: Multivariate relationships among behaviours. *South African Medical Journal*, 86(9): 1094-1098.

Flisher AJ, Parry CDH, Evans J, Muller M, Lombard C. (2003) Substance use by adolescents in Cape Town: Prevalence and correlates. *Journal of Adolescent Health*, 32(1):58-65.

Gilgen D, Williams BG, MacPhail C, Van Dam CJ, Campbell C, Ballard RC, Taljaard D. (2001) The natural history of HIV/AIDS in a major goldmining centre in South Africa: Results of a biomedical and social survey. *South African Journal of Science*, 97:387-392.

Gumede V. (1995) *Alcohol use and abuse in South Africa: A socio-medical problem*. Pietermaritzburg, South Africa, Reach Out Publishers.

Hlongwa L, Conco N, Beksinska M. (2001) *Comparing the lifestyle of urban and rural youth: A case study of two schools in KwaZulu-Natal*. Paper presented at the AIDS in Context Conference, University of the Witwatersrand, Johannesburg, 4-7 April.

Jewkes R, Penn-Kekana L, Levin J, Ratsaka M, Schrieber M. (1999) *"He must give me money he mustn't beat me". Violence against women in three South African provinces*. Medical Research Council Technical Report. Parow, South Africa, Medical Research Council.

Leclerc-Madlala S. (2001) *HIV/AIDS, youth and the disabling sexual context*. Paper presented at the AIDS in Context Conference, University of the Witwatersrand, Johannesburg, 4-7April.

Leggett T. (2000) Drugs, sex work and HIV in three South African cities. In: NIDA, editors. *Proceedings of the 3rd Global Research Network Meeting on HIV Prevention in Drug-Using Populations, Durban*. US Department of Health and Human Services, Washington DC, USA.

London L. (1999) The "dop" system, alcohol abuse and social control amongst farm workers in South Africa: A public health challenge. *Social Science and Medicine*, 48(10):1407-1414.

London L, Sanders D, Te Water Naudé J. (1998) Farm workers in South Africa – the challenge of eradicating alcohol abuse and the legacy of the "dop" system. *South African Medical Journal*, 88(9):1092-1094.

LoveLife. (2001) *Hot Prospects, Cold Facts*. Parklands, South Africa, Henry J. Kaiser Family Foundation.

MacDonald D. (1996) Drugs in Southern Africa: An overview. *Drugs: Education, Prevention and Policy*, 3(2):127-144.

Macheke C, Campbell C. (1998) Perceptions of HIV/AIDS on a Johannesburg gold mine. *South African Journal of Psychology*, 28(3):146-153.

MacPhail C, Campbell C. (2001) "I think condoms are good but, aai, I hate those things": Condom use among adolescents and young people in a South African township. *Social Science and Medicine*, 52(11):1613-1627.

Malala J. (2001) *The perceptions of the body, illness and disease amongst sex workers in Hillbrow*. Paper presented at the AIDS in Context Conference, University of the Witwatersrand, Johannesburg, 4-7April.

Morojele NK, Parry CDH, Ziervogel CF, Robertson BA. (2000) Prediction of binge drinking intentions of female school-leavers in Cape Town, South Africa, using the theory of planned behaviour. *Journal of Substance Use*, 5:240-251.

Morojele NK, Flisher AJ, Muller M, Ziervogel CF, Reddy P, & Lombard CJ. (2001) Adolescents, HIV and drug abuse in South Africa. In: NIDA, editors. *Proceedings of the 3rd Global Research Network Meeting on HIV Prevention in Drug-Using Populations, Durban*. Washington DC, US Department of Health and Human Services.

Nkhoma P, Maforah F. (1994) Drinking patterns among students in a university self-catering residence at the University of Cape Town. *Urbanization and Health Newsletter*, 21:54-58.

Parry CDH. (2001) Alcohol and other drug use. In: Ntuli A, Crisp N, Clarke E, Barron P, editors. *South African Health Review, 2000.* Health Systems Trust, Durban, South Africa, pp. 441-454.

Parry CDH, Abdool-Karim Q. (1999) Country report: Substance abuse and HIV/AIDS in South Africa. *Proceedings of 2nd Global Research Network Meeting on HIV Prevention in Drug-Using Populations, Atlanta*. Washington DC, USA, US Department of Health and Human Services, pp. 81-88.

Parry CDH, Bennetts AL. (1998) *Alcohol policy and public health in South Africa*. Cape Town, South Africa, Oxford University Press.

Parry CDH, Bennetts AL. (1999) Country Profile on Alcohol in South Africa. *Alcohol and Public Health in 8 Developing Countries*. Geneva, World Health Organization, pp. 139-160.

Peltzer K, Cherian L. (2000) Substance use among urban and rural secondary school pupils in South Africa. *Psychological Reports*, 87(2):582-584.

Plüddemann A, Theron W, Steel H. (1999) The relationship between adolescent alcohol use and self-consciousness. *Journal of Alcohol and Drug Education*, 44(3):10-20.

Ramjee G, Gouws E. (2001) Targeting HIV prevention efforts on truck drivers and sex workers: Implications for a decline in the spread of HIV in Southern Africa. *AIDS Bulletin*, 10(1).

Reddy P, Meyer-Weitz A. (1999) *Sense and sensibilities: The psychosocial and contextual determinants of STD-related behaviour*. Parow, South Africa, Medical Research Council.

Rocha-Silva L. (1989) *Drinking practices, drinking-related attitudes and public impressions of services for alcohol and other drug problems in urban South Africa*. Pretoria, South Africa, Human Sciences Research Council.

Rocha-Silva L, De Miranda D, Erasmus R. (1996) *Alcohol, tobacco and other drug use among black youth*. Pretoria, South Africa, Human Sciences Research Council.

Simpson MR. (1997) *Knowledge of safe sex practices and HIV transmission, propensity for risk taking, and alcohol/drug use in the aetiology of unprotected sex*. MA Thesis (Clinical Psychology). Grahamstown, South Africa, Rhodes University.

Statistics South Africa. (1996) *The people of South Africa: Population Census, 1996. Census in Brief*. Pretoria, South Africa, Statistics South Africa.

Visser M, Moleko AG. (1999) High-risk behaviour of primary school learners. *Urban Health and Development Bulletin*, 2(1):69-77.

Vundule C, Maforah F, Jewkes R, Jordaan E. (2001) Risk factors for teenage pregnancy among sexually active black adolescents in Cape Town: A case control study. *South African Medical Journal*, 91(1):73-80.

Wojcicki JM, Malala J. (2001) Condom use, power and HIV/AIDS risk: Sex workers bargain for survival in Hillbrow/Joubert Park/Berea, Johannesburg. *Social Science and Medicine*, 53(1):99-121.

Zambia

Agha S. (1998) Sexual activity and condom use in Zambia. *International Family Planning Perspectives*, 24(1):32-37.

Agha S, Nchima MC. (2001) *HIV risk among street and nightclub-based sex workers in Lusaka, Zambia: Implications for HIV prevention intervention.* Working Paper No. 38. Washington DC, USA, Population Services International (PSI), Research Division, PSI Research Division.

Baleta A. (1998) Concern voiced over "dry sex" practices in South Africa. *LANCET*, 352(9136):1292.

Central Statistical Office. (1998) *1996 Zambia Demographic and Health Survey*. Lusaka, Central Statistical Office.

Malungo JRS. (1999) Challenges to sexual behavioural changes in the era of AIDS: Sexual cleansing and levirate marriage in Zambia. In: Caldwell JC, et al, editors. *Resistance to Behavioural Change to Reduce HIV/AIDS Infection in Predominantly Heterosexual Epidemics in Third World Countries*. Canberra, Australia, Health Transition Center, National Center for Epidemiology and Population Health, Australian National University.

MOH/CboH. (1997) *HIV/AIDS in Zambia: Background, Projections and Interventions*. Lusaka, MOH/CboH.

University of North Carolina. (2002) *Zambia Sexual Behaviour, 2000*. Chapel Hill, North Carolina (CPC), MEASURE Evaluation, University of North Carolina.

University of North Carolina. (1998) *Zambia Sexual Behaviour Survey, 1998*. Quality of STD Services Assessment. Chapel Hill, North Carolina (CPC), MEASURE Evaluation, University of North Carolina.

Chapter Three

EMPIRICAL STUDY

3.1 Introduction

This chapter presents the key patterns/regularities in the empirical data collected in the project sites. The presentation first provides a comparative overview—across the project sites—of key patterns of risk with regard to HIV/STI contraction in respect of the three main dimensions of the subject, namely alcohol use, sexual behaviour, and interactions between these two. To facilitate understanding and comparison, the presentation is largely in tabulated format. The cross-country comparative presentation of the key findings is followed by a more detailed discussion of the country-specific data collected within selected project countries. This is followed by examples of the results of an analysis of the subjective meanings that individuals attached to the concept of sexual risk in selected countries, as well as a list of very complex patterns of alcohol use-related sexual risk behaviour.

In accordance with the empirical study's underlying assumptions about the subject and ways of studying it (see the methodological premises in the annexes), the comparative presentation and more detailed discussion illustrate the manner in which the data collected in the project countries differentiated in terms of various levels of social interaction, i.e. the level of the individual , cultural/social groups, and the studied countries as regional groups. In fact, regional, cultural/social group-specific and individual-specific regularities or patterns are extracted.

To enhance insight into and usability of the findings and methodology of the empirical study in the overall project, the chapter is introduced with (1) an overview of regularities in the specific manner in which the research actually proceeded in the project countries, and (2) the specific characteristics of the research sites and samples. Readers are reminded that the empirical study basically followed the same overall data-gathering and data-analysis strategy in all the eight countries, as outlined in the methodological premises noted in the annexes.

3.2 Research process

Generally, data-analysis showed that the empirical study employed an abductive research strategy**,** which leans heavily on inductive reasoning (moving from the particular to the general) as well as on retrospective reasoning (moving from a description of empirical data to an explanation that draws attention to not only regularities in the data but also to why these regularities occur, to what is "behind" these regularities). Blaikie (2000:24) describes the abductive strategy as follows:

The starting-point for abductive strategy is the social world of the social actors being investigated: their construction of reality, their way of conceptualizing and giving meaning to their social world, their tacit knowledge. This can only be discovered from the accounts which social actors provide. Their reality, the way they have constructed and interpreted their activities together, is embedded in their language. Hence, the researcher has to enter their world in order to discover the motives and reasons that accompany social activities. The task is then to redescribe these motives and actions, and the situations in which they occur, in the technical language of social scientific discourse. Individual motives and actions have to be abstracted into typical motives for typical actions in typical situations ... These social scientific

typifications provide an understanding of the activities, and may then become the ingredients in more systematic explanatory accounts.

More particularly, within the context of the two broad concerns (risks of contracting HIV where alcohol use and sexual encounters coincide and health promotion/preventive initiatives) in the present project, as well as a special interest in the "hidden" characteristics of the subject, the questions or issues addressed in the empirical study showed the following regularities: (1) a series of general questions/issues that were common among some of the project countries and specific to others, as well as (2) a series of questions/issues that were specific to the respective instruments used in data collection.

Table 2a and Table 2b present the general research questions/issues that the respective project sites addressed. Table 3 indicates the more specific questions or issues that were investigated in the respective phases of data collection, using particular instruments (key informant interviews, observations, focus group discussions, in-depth interviews). Examples of the particular questions that participants in the research were asked during various phases of data collection are presented in the annexes. The characteristics of the research participants and research sites are presented in subsequent paragraphs in this chapter.

Table 2a: General research questions/issues in Kenya, South Africa, Zambia and Mexico

Africa			Americas
South Africa	**Kenya**	**Zambia**	**Mexico**
• Determination of the social, psychological, economic, cultural, contextual and gender-related factors that increased alcohol use-related sexual risk behaviour • Determination of the social, psychological, economic, cultural, contextual and gender-related factors that protected against alcohol use-related sexual risk behaviour • Exploration of cultural views on alcohol use-related sexual risk behaviour • Determination of communication patterns and language used when referring to alcohol use-related sexual risk behaviour • Development of a conceptual framework to describe and explain the phenomenon of alcohol use-related sexual risk behaviour	• Extent and nature of alcohol use among vulnerable groups, both female and male (e.g. quantity and frequency of alcohol intake; time and setting of alcohol use) • Extent and nature of sexual behaviour of vulnerable persons, the nature of their partners, the nature of the sexual contact, and the nature of protective sexual behaviour • Association between alcohol use and sexual behaviour • Attitudes, knowledge, skills, barriers, and perceptions of alcohol use and sexual behaviour • Itemization of factors that predicted and/or contributed to alcohol use-related sexual risk behaviour in the different cultural settings • Assessment of alcohol's effect on sexual risk behaviour among some groups of predisposed people • Itemization of factors (general, cultural, social and individual patterns) that predicted and/or contributed to alcohol use-related sexual risk behaviour	• Extent and nature of alcohol use among vulnerable groups, both female and male (e.g. quantity and frequency of alcohol intake; time and setting of alcohol use) • Extent and nature of sexual behaviour of vulnerable persons, the nature of their partners, the nature of the sexual contact, and the nature of protective sexual behaviour • Association between alcohol use and sexual behaviour • Attitudes, knowledge, skills, barriers, and perceptions of alcohol use and sexual behaviour • Itemization of factors that predicted and/or contributed to alcohol use-related sexual risk behaviour in the different cultural settings • Assessment of alcohol's effect on sexual risk behaviour among some groups of predisposed people • Itemization of factors (general, cultural, social and individual patterns) that predicted and/or contributed to alcohol se-related sexual risk behaviour	• Determination of individual, social and cultural factors related to the association between the use of alcohol and other psychoactive substances and unsafe sex in the transmission of HIV/AIDS in two groups of people (episodic users): heterosexuals and men having sex with men (MSMs) over the age of 15 • Why young people used alcohol and/or other psychoactive substances (regular and occasional users) • Contexts in which young people used alcohol and other psychoactive substances (regular and occasional users) • Types of sexual behaviour that young people engaged in while using or not using alcohol and other psychoactive substances • Use of condoms where alcohol and other psychoactive substances were used during intercourse

Table 2b: General research questions/issues in project sites in Belarus, Romania, the Russian Federation and India

Central and Eastern Europe			South East Asia
Belarus	**Romania**	**The Russian Federation**	**India**
• Extent and nature of alcohol use among vulnerable groups, both female and male (e.g. quantity and frequency of alcohol intake; time and setting of alcohol intake) • Extent and nature of sexual behaviour of vulnerable persons, the nature of their partners, the nature of the sexual contact, and the nature of protective sexual behaviour • Association between alcohol use and sexual behaviour • Attitudes, knowledge, skills, barriers, and perceptions of alcohol use and sexual behaviour • Itemization of factors that predicted and/or contributed to alcohol use-related sexual risk behaviour in the different cultural settings • Assessment of the effect of alcohol use on sexual risk behaviour among some groups of predisposed people • Itemization of factors (general, cultural, social and individual patterns) that predicted and/or contributed to alcohol-related sexual risk behaviour	• Determination of the extent and nature of alcohol use-related sexual risk behaviour; knowledge, attitudes and behaviours in the general population with regard to HIV/AIDS/STIs in Timis County for the development of intervention and control activities to contribute to the reduction of sexual risk behaviour when alcohol was used • Distinction of the particular sex behaviour patterns that increased the risk for contracting HIV/AIDS and STIs and the role of alcohol use in this • Traditional habits and beliefs regarding alcohol drinking in sexual relationships • Sexual effects expected from the use of alcohol • Seeking sex partners and alcohol use • Awareness of sexual risks and the influence of alcohol use • Use of condoms during casual sex	• Extent and nature of alcohol use among vulnerable groups, both female and male (e.g. quantity and frequency of alcohol intake; time and setting of alcohol intake) • Extent and nature of sexual behaviour of vulnerable persons, the nature of their partners, the nature of the sexual contact, and the nature of protective sexual behaviour • Association between alcohol use and sexual behaviour • Attitudes, knowledge, skills, barriers, and perceptions of alcohol use and sexual behaviour • Itemization of factors that predicted and/or contributed to alcohol use-related sexual risk behaviour in the different cultural settings • Assessment of the effect of alcohol use on sexual risk behaviour among some groups of predisposed people • Itemization of factors (general, cultural, social and individual patterns) that predicted and/or contributed to alcohol use-related sexual risk behaviour	• Extent and nature of alcohol use among vulnerable groups, both female and male (e.g. quantity and frequency of alcohol intake; time and setting of alcohol intake) • Extent and nature of sexual behaviour of vulnerable persons, the nature of their partners, the nature of the sexual contact, and the nature of protective sexual behaviour • Association between alcohol use and sexual behaviour • Attitudes, knowledge, skills, barriers, and perceptions of alcohol use and sexual behaviour • Itemization of factors that predicted and/or contributed to alcohol use-related sexual risk behaviour in the different cultural settings • Assessment of the effect of alcohol use on sexual risk behaviour among some groups of predisposed people • Itemization of factors (general, cultural, social and individual patterns) that predicted and/or contributed to alcohol use-related sexual risk behaviour

Table 3: Common research questions/issues across the project countries by data collection instrument[x]

Key informant interviews	Observations	Focus group discussions	In-depth interviews
• Advantages and disadvantages of drinking alcohol before sex Ke, Ru, In • Understanding of the risky sex/safe sex concept with regard to HIV/AIDS Be, Ke, Ru, Za, In • Effects of alcohol use on sexual behaviour (risk taking) Be, Ke, Ro, SA, Za, In • Expectations of using alcohol before sex Ke, Ro, Ru, Me, In • Protection during sex – behavioural patterns Be, Ke, Za, In • Protection – condom availability Be, Me, In • Patterns – alcohol consumption Be, Me, Ro, Za, SA, In • Patterns – sexual behaviour Be, Me, Ro, Za, In • Non-drinkers Me • Prospects for preventive intervention Be, Me, Ru, SA, In • Commercial sex and alcohol consumption Ro, Za, In • Commercial sex and HIV/AIDS Za • Attitudes towards drinking in the community SA • Attitudes towards sexual risks in the culture Ro	• Character of people observed Be, Ke, SA, In • Type of language Be, Ke, SA, In • Nature of behaviour Be, Ke, SA, In • Interpersonal interaction Be, Ke, In • Social hierarchy Be, Ke, SA, In • Hygiene Be, Ke, SA, In • Behaviour towards observers/researchers Be, Ke, SA • Indicators of previous preventive measures and health promotion Be, Ke • Risk reduction strategies Ke • Drinking patterns SA, In • Educational awareness SA • Availability of security (bouncers) SA, In • Availability of condoms SA	• Reasons for drinking alcohol before sex Be, Ke, Ro, Ru, Me, In • Advantages and disadvantages of drinking alcohol before sex Be, Ke, Ro, Ru, SA, In • Understanding of the sexual risk behaviour/safe sex concept with regard to HIV/AIDS Be, Ke, Ro, Ru, SA, In • Prospects for preventive intervention Be, Ke, Ro, Ru, SA, In • Effect of alcohol/other psychoactive substance use on decisions about protection against STDs/HIV/AIDS as well as pregnancy Be, Ke, SA, Za, Me, In • Casual sex Be, Me, SA • Behavioural differences between men and women Me • Pressure to drink Me, In • Commercial sex and alcohol use Za, In • Multiple sexual/polygamous relationships SA, Me • Types of sexual intercourse e.g. oral, anal SA	• Effect of alcohol use on sexual behaviour Be, Ke, Me, Ro, SA, In • Expectations of using alcohol before sex Be, Ke, In • Protection Be, Ke, Me, Ro, Ru, SA, In • Prospects for HIV/AIDS-related preventive intervention Be, Ke, Me, SA, In • Sexual satisfaction Be, Ke, Ro, SA • Motives for sexual relationship Be, Ke, In • Nature of episodes when preventive measures were not taken Be, Ru, Za, In • Negotiating safe sex with partner Be, Ke, Ro, SA, In • Occasional sex Ru • Oral, anal, group sex Ru

[x] Abbreviations below the questions/items refer to the particular countries in which the question concerned was posed: Be=Belarus, In=India, Ke=Kenia, Me=Mexico, Ro=Romania, Ru=The Russian Federation, SA= South Africa, Za=Zambia, In=India.

To facilitate comprehensiveness, corroboration and refinement and, thus, enhance integrity, multiple sources and methods/techniques were used in data gathering and analysis. For example, three levels of phenomena were sourced, namely:

1 **Microsocial phenomena** focusing on individuals (e.g. particular individuals representing certain others, informants), small groups, and social episodes

2 **Mesosocial phenomena** focusing on particular communities (e.g. homosexual groups, school-mate groups), cohorts (e.g. household women, sex workers), organizations or settings (e.g. restaurants, bars, clubs, universities)

3 **Macrosocial phenomena** focusing (to a limited extent, as the issue was addressed through the earlier discussion of the literature) on broad socioeconomic conditions

Data on these phenomena were, furthermore, sourced within the following three general settings:

1 Natural social settings (observations)

2 Semi-natural social settings (focus group discussions and in-depth interviews with participants on the practices studied, as well as with persons who had frequent contact with these participants, i.e. various "experts" on the activities studied)

3 Social artefacts, i.e. objects of or information on the real-life environments of the studied population.

Primary, secondary and tertiary data were gathered. For example, national research teams collected primary data and complemented these with secondary data (the findings of completed surveys and census and other statistics) to facilitate a thorough interpretation. In the re-analysis below the results of the eight national reports on the empirical study conducted were used as tertiary data sources.The country reports were at the same time used as secondary data sources, as new or additional insight into the primary data emerged when the data were placed within the broader international context within which they were collected.

Although there was a clear **preference for qualitative data**-gathering instruments, **quantitative instruments were also used**. For example, within the qualitative tradition, semi-structured site observations, focus group interviews and in-depth interviews were employed. Key-informant interviews were also used, but were largely structured. Respondents in the focus groups, in-depth interviews and key-informant interviews were purposively sampled and through the snowball technique. Furthermore, the literature study yielded predominantly quantitative knowledge on broad socioeconomic conditions in the project countries, including health conditions related to alcohol and other psychoactive substance use and sexual behaviour. Building on this, research questions were formulated so as to gain deeper insight into the social and cultural context of sexual health. Frequently, **qualitative data were converted into numeric data** (via a categorization procedure). In addition, quantitative instruments were applied, e.g. an introductory questionnaire for participants in focus group discussions in Belarus and a post-hoc survey questionnaire in South Africa.

Descriptive statistical techniques were used in the analysis of the quantitative data. In the analysis of the qualitative data, the emphasis was largely on description, categorization and typification, which are defined in the methodological premises noted in the annexes.

The **researchers** in the project countries **played a variety of roles**. Whereas all of them accommodated the needs of the research situation, different researchers adopted at different stages of the research and to a variable extent the following roles that are described in some detail in the methodological premises noted in the annexes: detached observer, faithful observer, mediator of languages (language interpreter) and dialogic facilitator.

3.3 General site and sample description

To synthesize the empirical findings from the specific environments in which they were gathered into a more comprehensive image of problems "globally" related to alcohol use-related sexual risk behaviour, Table 4 presents a comparison of the general characteristics of the various research sites. The sex-health problems and broad moral/cultural context in these sites are compared. Table 5 presents the variety of participant groups and venues where data were collected in each country per data-gathering instrument/method.

Table 4: General characteristics of the research sites

Country	Moral-religious and cultural-value context	Target population	Specific reason for selecting the target	Other important "independent variables"	HIV transmission modes
Belarus	- Ruled by a single-party authoritarian political system; in a sense an island among post-totalitarian, democracy-developing countries - Historically a Christian culture with Catholic and Greek Orthodox Churches dominating (about 70% of population)	- Young people	- Binge drinking and extremely high syphilis rate	- Rapid increase of children born out of wedlock (18.6% of total births and23.7% of births in rural population in 2000). This indicated a radical transformation of the partnership/marriage patterns - The mortality rate was growing (from 7.6 to 14.0% between 1970 and 2001; for men from 11.7 to 15.0% and for women from 10.7 to 12.2% between 1991 and 2000); there was a significant difference between rural and urban people (21.6% and 12.2% respectively in 2000) - Large amounts of uncontrolled illicit alcohol were being produced	- 1996: HIV related to sexual intercourse in 7.4% cases; 2001: HIV related to sexual intercourse in 20.5% cases and to intravenous drug use in 78.2% cases - Total incidence of HIV-positive cases: 3 858 - The most vulnerable groups were young people, psychoactive substance users, female commercial sex workers, homosexual men and convicts - Women were at particular risk—46% of HIV-positive women had been infected through sexual intercourse with their long-term partner or husband
India	- Multiligual and multicultural society - Majority Hindu - Significant post-colonial changes in patterns of alcohol use and sexuality - The majority of people do not drink - Traditional society in which discussion of sexuality was tabooed.	- Groups such as transport and roadside restaurant workers, migrant workers, clients of FCSWs and MSMs, as well as a random sample of the general population in Delhi, stratified in terms of five types of housing clusters (400-500 households)	- High risk groups and alcohol users in the targeted general population	- Risk perception was overall low in vulnerable groups	- Sexual contact (mainly heterosexual) - Intravenous drug use in some parts of the country
Kenya	- Key informants represented various professions and who often reported on entertainment venues/bars, focus group discussions with several samples from the general population including two commercial sex workers, in-depth interviews with commerial sex workers, entertainment employees	- General population			- Heterosexual contact

Country	Moral-religious and cultural-value context	Target population	Specific reason for selecting the target	Other important "independent variables"	HIV transmission modes
Mexico	- Country dominated by Roman-Catholic church, officially very restrictive (e.g. abortions are illegal); the research team found only one heterosexual participant for an in-depth inteview) - Strong presence of male domination (macho image)	- Men, hetero- and homosexual, aged 15-41	- Most afflicted by HIV and engaged in episodic drunkenness	- Alcohol consumption was associated with the highest number of deaths	- Main mode was sexual transmission: 20% homosexual; 20% bisexual; 55% heterosexual - Male population was affected the most: 88% of HIV-positive cases; 70% of them had any form of sex with a man (MSMs)
Romania	- Rapid social change after decades of communist dictatorship	- Timis Region (western part of Romania): key informants from various spheres of life (sex business, entertainment, transport, police, NGOs, public health); observations at railway station, university campus, "Discoland", main road to the West, marketplace; individual interviews with sex worker, taxi drivers, truck drivers, nurse, DJ, waiter, student	- Casual sex - Commercial sex - Extramarital sex	- High proportion of illicit alcohol production—for home consumption AND for sale	- 5 730 HIV cases were registered in 1998, of whom only 690 were adults, the rest being children
South Africa	- Multicultural and patriarchal society - Few sanctions against pre-/extra-marital sexual relations - Since 1994 rapid sociopolitical change and high rates of violence, crime, HIV/AIDS, unemployment	- General population aged 25-44	- Weekend risky drinking	- The most endangered groups were young people aged 18-20 because of their drinking, and women in general because of being forced into sex by drunk men	- Heterosexual contact
The Russian Federation	- Rapid social change one decade after abolishing the communist regime, strong tradition of Russian Orthodox Church, incremental introduction of free market economy, liberal moral values, sex entering the public sphere after being repressed for decades	- Experts and patients of psychiatric clinics - Alcohol addicts - Observations in night clubs - Focus group discussions were conducted with medical students, lawyers and police, and teachers - The target population, the young people, were contacted to a very limited extent		- Alcohol use was traditionally extremely high in Russia, and was growing, although the type of alcohol was changing - Young people predominantly drank beer	- Mainly through intravenous drug use to the general population
Zambia	- Almost 20% of the adult population was HIV positive - The Christian religion was about half/half catholic/protestant (at least in the target sample of commercial sex workers)	- Vulnerable groups: FCSWs, their clients, uniformed officers, students in colleges from four high-risk places in Zambia	- Overall poverty rendered sex work a significant means of survival for many women		

Table 5: General characteristics of the research sample by data-gathering instrument

Country	General research interest	Key informant interviews	Observations	Focus group discussions (FGDs)	In-depth interviews	Other
Belarus	Young people (teenage years up to 25 years)	N=12: experts (medical, educational, psychological, social work, police) and one bar assistant	University hostel, disco, bar, informal gatherings in a public garden	-Students of medical college, 2 groups, N=15 -Parishioners of Protestant Church, 2 groups, N=13 -Patients of dermato-venerology department, 2 groups, N=9	N=12 10 participants of FGDs (parishioners and patients) and 2 KII	Questionnaire (115 questions) administered to additional 300 respondents
India	General population and some risk populations	10 informants: 2 NGO workers, businessman, self-employed person, skilled worker, HIV infected migrant labourer, school teacher, youth leader, community leader, family of sex workers	Roadside venues, sex work localities	6 FGDs: truck drivers, factory/migrant workers, restaurant/migrant workers, slum dwellers/folk artists (male and female group), commercial sex workers	14 interviews: long distance truck driver, businessman, commercial sex workers (brothel and non-brothel based), trader in alcohol, migrant and low paid workers (bus and car driver, restaurant worker, maid servant), skilled worker, government employee, separated husband, separated wife	Structured interview with 118 persons (alcohol users) in general population
Kenya	Regular and risk population	6 men and 6 women: teachers, housekeeper supervisors, rice traders, bar waiters/tresses, cashiers, security guard etc.	7 sites: bars, restaurants and hotels	4 FGDs: 2 rural and 2 urban; 1 purely female and 3 mixed; participants were "regular" people; 1 FGD included 2 female commercial sex workers	10 participants (6 female and 4 male), including 2 female sex workers, bar tenders, a waitress, a cashier, a mechanic, an unemployed person	None
Mexico	This was the only site where there was a serious focus on homosexual/MSM issues	5 informants from heterosexual venues and 4 informants from MSM venues	5 entertainment venues for young heterosexuals and 6 venues for entertainment of MSMs	8 FGDs: heterosexuals younger than 24, heterosexuals over 24, MSMs younger than 24, MSMs over 24	N=10: 3 with heterosexuals, 7 with MSMs	None
Romania	Regional specifics of the area of Timis, and population at increased risk	10 participants: nurse, sex worker, policeman, teacher, bar keeper, physician, musician, truck driver, social worker, member of NGO protecting commercial sex workers	Main railway station, university campus, "Discoland", highway with street commercial sex workers, main marketplace	4 FGDs, mixed sexes, mixed professions: nurse, social worker, teacher, policeman and policewoman, journalist, sex worker, bar keeper, DJ, musician, waiter, guard, physician, lawyer, counsellor, hairdresser	N=10: recruited from FGDs	None

Country	General research interest	Key informant interviews	Observations	Focus group discussions (FGDs)	In-depth interviews	Other
South Africa	Population labeled as "risky drinkers" and their sexual partners	N=18: youth coordinator, bar manager/owner, social worker, drinker, person with HIV, physician, nurse, policeman/woman, church minister	7 venues: 4 in city, 3 in township (bars, taverns, jazz club, bottle store)	6 FGDs: Younger and older male and female drinkers and their partners	N=16: male and female risky drinkers	Structured interview with a sample of 160 people in general population
The Russian Fede-ration	Main focus on young people/students	N=10: 3 physicians, psychologist, pharmacist, university teacher, art director, restaurant and hotel manager, worker	2 nightclubs and 1 beer hall	4 FGDs: -Students -Patients in alcoholism-treatment unit -Physicians and biologists -Lawyers, teachers	None—because of refusal to answer intimate questions	Instead of in-depth semi-structured interviews a questionnaire was administered to 88 people (students, physicians and people of various occupations)
Zambia	Risk population: commercial sex workers, their clients, uniformed officers and students in colleges and universitites	People with knowledge about risky venues, e.g. barmaids	Venues where alcohol use and sexual behaviour took place	3 FGDs: Young women, young men, older men	Individual "semi-structured interviews" with 27 commercial sex workers and 23 clients	None

3.4 Findings

This section first presents the key findings of the analysis of the empirical data gathered in the eight countries with regard to alcohol consumption and sexual risk behaviour related to STI/HIV transmission as well as interactions between alcohol use and sexual behaviour. With regard to each of these dimensions and to facilitate an understanding of the extent to which the data differentiated into *cross-country and country-specific patterns* of alcohol use and sexual risk behaviour, a table provides a comparative overview of the incidence of the relevant key risks in the project countries with examples of the specific manner in which the risks manifested in particular countries. A more comprehensive list of the specific risks within the respective project countries is presented in the annexes.

The presentation of key findings is followed by a more detailed discussion of the data collected within selected project sites to illustrate that alcohol use-related sexual risk behaviour differentiated into *patterns* that manifested *on the level of the individual and/or specific cultural/social groups*. The discussion is followed by examples of the results of an analysis of the *subjective meanings* that individuals attached to the *concept of sexual risk* in the selected countries, as well as a list of very complex patterns of risk behaviour.

3.4.1 Key alcohol use-related patterns of STI/HIV risks

Table 6 presents the key patterns/regularities that emerged in the analysis of the data reported in the country reports regarding the risks that alcohol consumption posed for STI/HIV infection. The table shows that within the context of sexual activity various alcohol-related psychological factors, sociocultural factors and environmental factors (e.g. behaviour settings/situations) placed individuals at risk of STI/HIV infection. In brief, and to a varying extent across the project sites, drinking manifested as "a lifestyle"; occurred at places (bars, pubs) and times (weekends) when the focus was on such activities (e.g. in the form of drinking competitions); and was "encouraged in family settings and by peers", particularly in the case of males. These sociocultural and environmental factors were supported by beliefs such as the following: that alcohol use was "normal" and signified "maturity" and, more particularly, "maleness or masculinity"; that beer was a non-alcoholic drink; and that alcohol consumption was "integral in partnership development" and functional in sexual encounters. Gender differences also occurred in drinking practices and expectations concerning alcohol's effects in the project countries.

More specifically and as shown in Table 6, analysis showed that "drinking was an indispensable part of social life" in nearly all the project sites. India was an exception. The table underscores this generalization within individual countries by drawing attention to more detailed findings such as the following: In the African region and specifically in South Africa, "alcohol was referred to as the friendship brew". In Mexico "social gatherings constituted an excuse to drink". In Belarus, "any celebration" was synonymous with "binge drinking"; and "alcohol use accompanied all important events in life" in Romania.

Table 6 also shows that in Mexico and Belarus drinking started early, as reflected in the finding that "children were encouraged to take alcohol in the family setting" in these countries. Moreover, the occurrence of "drinking as a lifestyle" was observed among young and old there. Table 6, for example, notes that in Belarus "an overwhelming majority of the population, including young people, were regularly intoxicated by alcohol". In all the project sites—to a lesser extent in India—young people also experienced direct pressure to drink, and to drink heavily in the case of South Africa. Table 6, furthermore, shows that in nearly all the countries (India was an exception) young and old tended to drink at times (weekends) when and in settings (pubs and discos) where pressure to drink could be expected.

Alcohol consumption tended to be a male rather than a female phenomenon in all the project countries, although to a lesser extent in Belarus and South Africa. Table 6, for example, notes that in Belarus "usage was increasing among women and teenagers". In South Africa "men and women (particularly those who visit shebeens and bars very often, spend much of their leisure time drinking, are regular and heavy drinkers, and sometimes are unemployed) drank almost equal amounts; and in some instances women drank more". Consistent with the finding that drinking tended to concentrate among males in the project countries, Table 6 indicates that in all the project countries—except in India—alcohol consumption was believed to signify maleness. In South Africa, for example, "being able to hold one's drink and drink heavily were regarded as signs of masculinity". In Mexico "a man was expected to drink whenever he was offered a drink so as to prove his masculinity and social independence"; and in Romania "males tended to use stronger alcoholic beverages ... [which they] associated ... with maleness".

What is particularly significant in terms of vulnerability to STI/HIV infection and considering the disinhibiting properties of alcohol, is that Table 6 shows that alcohol was found to be "integral in partnership development" in all the project sites, to a lesser extent in India. In Mexico, the integration of alcohol consumption and partnership development manifested specifically within the homosexual environment. Furthermore, Table 6 notes gender differences in expectations about the effects of alcohol within the context of sexual activity in some countries—Mexico and Romania. For example, in Mexico "men had higher expectations of alcohol as concerns the facilitation of social interaction, sexuality and feelings of power than women, and expected women to experiment with alcohool in order to stimulate sexual behaviour". In Romania "women were believed to have a stronger 'censor' and were thus expected to be more 'responsible' and to control male behaviour; men were [also] expected to be more rude and aggressive than women".

Table 6: Key alcohol use-related patterns of STI/HIV risks and particular manifestations of these risks in selected project sites[x]

Key alcohol use-related patterns of STI/HIV risks	Africa	Americas	Central and Eastern Europe		South East Asia
	South Africa	Mexico	Belarus	Romania	India
Drinking as a lifestyle (urban)	Yes, drinking alcohol was a kind of lifestyle, mainly in the urban environment.	Yes, particularly among young people.	An overwhelming majority of the population, including young people, were regularly intoxicated by alcohol.		
Drinking was incorporated into social life; was an undispensable part of social life	Alcohol was referred to as the "friendship brew", and considered to be a vital part of social functions; enjoying a party meant using alcohol.	Social gatherings constituted an excuse to drink.	Any celebration is a synonym for binge drinking. "Binge for three" - a new form of the traditional binge drinking at every possible "celebration" (personal, family, public). No celebration without alcohol use.	Alcohol use accompanied all important events in life.	
Places of consumption	Public: bars, taverns, shebeens, public parks. Private: homes.	Bars, pubs.	Young people particularly used alcohol at parties, sport events, discos and bars.	Bars, pubs.	Private places (e.g. homes).
"Weekend" pattern of drinking alcohol	Yes, alcohol was used mostly on weekends, except for the unemployed who drank on weekdays, mornings and afternoons.	Yes, the main drinking pattern was excessive drinking on weekends, and none or little during weekdays.	At student residences—all celebrations get shoved in over the weekend.		
Drinking competitions	"Last man standing" competitions among young men.	Supported by restaurants/bars/ beer halls—free snacks awarded after certain number of drinks.			
Children encouraged to take alcohol in the family setting		Yes, families encouraged children to drink alcohol at the young age of 10-12 years (boys were being more encouraged than girls).	Yes, "initiation" into alcohol use mostly took place at home—with parents.		
Sex differences in alcohol consumption	Men and women (particularly those who frequented shebeens and bars very often, spend much of their leisure time drinking, are regular and heavy drinkers, and sometimes are unemployed) drank almost equal amounts (but separately); and in some instances	Alcohol consumption more common among males; in families, boys rather than girls were encouraged to consume alcohol.	Mostly males consume alcohol, but usage was increasing among women and teenagers. Furthermore, males mostly preferred vodka, and females "champaign".	Males rather than females used alcohol; men drank beer and spirits, women wine and sweet liquor.	Alcohol consumption was common among men, very rare among women.

Key alcohol use-related patterns of STI/HIV risks	Africa	Americas	Central and Eastern Europe		South East Asia
	South Africa	Mexico	Belarus	Romania	India
	women drank more and seemed to fit the concept of "risky drinker" more frequently. In a survey men rather than women admitted ever having drunk alcohol.				
Peer pressure to drink	Yes, especially among younger males; also pressure to hold one's drink or to drink heavily as evidenced from the occurrence of drinking competitions.	Yes, particularly among young people and at the venues frequented by young people.	Young people in particular were pressurized into initiating alcohol use.		Generally not the case.
Alcohol drinking was "normal" and signalled maturity	Particularly among males.	Particualrly among males.	The state of alcohol intoxication is not considered scandalous by most people.	Alcohol use regarded as non-normal only if a person gets into real trouble; no negative perceptions of alcohol in the general discourse on alcohol; usage a sign of maturity, happiness, omnipotence, humour.	
Alcohol and maleness	Being able to hold one's drink and drink heavily were regarded as signs of masculinity; drinking alcohol was proof of "maleness"; some women stated that partners who did not drink, tended to complain and nag around the house, or "had a problem."	Alcohol drinking signalled maleness; any male behaviour under the influence of alcohol tended to be excused; a man was expected to drink whenever he was offered a drink so as to prove his masculinity and social independence.	Males tended to use the stronger alcoholic beverage (vodka); they associated this beverage with maleness.	Males tended to use the stronger alcoholic beverages (spirits, beer); they associated these beverages with maleness.	
Beer was considered to be a non-alcoholic beverage			Beer is the most frequently consumed alcoholic beverage, and regarded as non-alcoholic.		
Alcohol integral in partnership development	Many sexual partnerships are initiated in drinking venues.		In discos alcohol was much more consumed by those who showed up single and was looking for a partner.	Alcohol drinking was part of all stages of dating.	Occurs in risk groups.
Sex differences in expected effects of alcohol and alcohol "management"		Men had higher expectations of alcohol use as concerns the facilitation of social interaction, sexuality and feelings of power than		Women were believed to have a stronger "censor" than men and were thus expected to be more "responsible" and to control male	

Key alcohol use-related patterns of STI/HIV risks	Africa	Americas	Central and Eastern Europe		South East Asia
	South Africa	Mexico	Belarus	Romania	India
		women; and men expected women to experiment with alcohol in order to stimulate sexual behaviour. Another justification for male alcohol use in heterosexual relations was disclosed: "Women do not need alcohol to cry and feel melancholic, but men do." Therefore a man "had to" drink in order to get in tune with his partner..		behaviour; men were also expected to be more rude and aggressive than women, and stopping drinking may result in a man becoming more gentle in his sexual behaviour.	
Homosexual environment and alcohol		Alcohol facilitated homosexual socializing.	Yes, among homosexual men the use of soft psychoactive substances, including alcohol, prevailed.		Alcohol "enabled" performance of homosexual sexuality.

[x] The data collected in the countries cited did not necessarily manifest the risk categories noted in the table, thus the empty cells. The table also does not include data from Kenya and Zambia in Africa as well as the Russian Federation in Central and Eastern Europe as the findings in these countries either did not relate to the risk categories cited or generally coincided with the data reflected in the table.

3.4.2 Key sex behaviour-related patterns of STI/HIV risks

Tables 7a and 7b present the key patterns in respect of the risks that sexual behaviour posed for STI/HIV infection in the project sites, as identified in the analysis of the data reported in the country reports. These risks included psychological, sociocultural and environmental issues such as (a) a poor understanding of the transmission of STI/HIV, (b) risky sexual orientations, (c) a need for immediate gratification, (d) sexual violence against women, (e) opportunities to engage in casual/commercial sex at public places of entertainment, (f) inadequate access to condoms, and (g) an increase in traditionally tabooed sexual practices. More specifically, Tables 7a and 7b show that in all the project sites there were misunderstandings of the modes of transmission of HIV. In Africa and the Americas, for example, misunderstandings such as shown in Table 7a presented:

1 "Fat people did not have HIV" (Kenya);

2 "One cannot be HIV positive if one has a healthy living child" and "older people are unlikely to be living with or contract HIV" (South Africa);

3 The view among commercial sex workers that an HIV-positive person could be distinguished in terms of his/her outward appearance (Zambia);

4 "HIV was just an issue for homosexuals and prostitutes"(particularly among women in Mexico);

5 HIV infection could be prevented through "cleaning genitalia with alcohol, urine or antiseptic solutions", through "finishing the sexual act quickly", or through "ejaculating 'outside'" (Mexico).

In Belarus, Romania, the Russian Federation and India (Table 7b), misunderstandings regarding the transmission of STI/HIV such as the following: In Romania STI/HIV was considered as "bad fortune" among especially superstitious men, and as "a phenomenon of Africa or the USA". In the Russian Federation it was believed that "all diseases were curable"; and in India that cleaning agents and particular ways of performing the sexual act could prevent HIV infection.

Risky sexual orientations manifested to a varying degree in the project sites, including views and beliefs such as the following (Tables 7a and 7b):

1 Men's unquestioning engagement in multi-partner or polygamous sex (Kenya and Zambia; homosexual men in Mexico; Belarus, Romania and the Russian Federation; and to some extent India);

2 The belief among women that they were expected to "please men sexually" and "tolerate" their sexual needs and behaviour (South Africa);

3 The view that stable partners should insist on mutual trust rather than on the use of condoms (Kenya, South Africa and Mexico);

4 The belief that the use of condoms signified sexual promiscuity, as reflected in the observation that "heterosexual encounters usually had symbolic meaning and included rituals such as going for coffee/dinner, which rendered open negotiations on condom use improper"; that "many young people were too shy to buy condoms"; and that "girls had, or pretended to have, little experience of sexual issues and therefore did not insist on condom use or did not carry condoms" (Mexico);

5 The association of condoms with the prevention of unwanted pregnancy rather than with the prevention of HIV infection (Mexico; Belarus, Romania and the Russian Federation).

A tendency to prefer material gain or sexual pleasure to safe sex is also noted in Tables 7a and 7b with regard to all the project sites but especially in Belarus, Romania and the Russian Federation. In South Africa "sugar daddy and sugar mummy relationships were commonly engaged in for money and gifts and unsafe sex was often part of these relationships". In Mexico such relationships presented within the context of homosexuality—"older men (sugar daddies) paying for drinks and giving gifts to young men in exchange for sex" were observed there. Similarly, in Belarus "promises of rewards in the form of money, clothes, etc persuaded young people to have sex". In Romania "some taxi drivers allowed their clients to pay them by having sex with them". In Zambia a willingness to engage in unprotected sex for an increased fee was noticed among commercial sex workers. A preference for the "natural way" (Romania and India) or "flesh-to-flesh sex" (South Africa) was observed in some countries. In Mexico "condoms were believed to reduce sexual sensitivity".

Tables 7a and 7b, furthermore, note that sexual violence against women occurred in Belarus, the Russian Federation and in South Africa. Participation in casual and/or commercial sex took place in all the project sites except in India, with such practices being tolerated and in some cases facilitated (e.g. in Russia) in public places of entertainment (e.g. in toilets, on balconies, at street corners, in rest/dark rooms of bars, restaurants and discos). In Mexico, some fitness centres catered specifically for homosexual encounters. A lack of (free/ affordable) condoms at places of entertainment (e.g. in Kenya, South Africa, Mexico, India and Belarus) increased vulnerability to STI/HIV.

Table 7b, finally, draws attention to the social process of sexual "liberalization" in Belarus, the Russian Federation and in India. This process was facilitated by increased travelling and the (electronic) media as well as free time. It was characterized by changing values/attitudes and practices with regard to sex, such as increased tolerance of practices such as multi-partner sex (e.g. extramarital partnerships) and casual sex (Romania), and a regard for "sex and sexual pleasure" as "the most sought after pleasures" (the Russian Federation).

Table 7a: Key sex behaviour-related patterns of STI/HIV risks and particular manifestations of these risks in Kenya, South Africa, Zambia and Mexico[x]

Key sex-related patterns of STI/HIV risks	Africa			Americas
	Kenya	South Africa	Zambia	Mexico
Myths and/or wrong understandings of modes of HIV transmission	Fat people did not have HIV.	Relatively good knowledge in general; some wrong understanding included the belief that one cannot be HIV positive if one has a healthy living child; another myth was the view that older people are unlikely to be living with or contract HIV.	About half the sex workers and their clients believed they could distinguish an HIV-positive person by simply looking at him/her; young people less informed than adults regarding modes of HIV transmission.	Cleaning genitalia with alcohol, urine or antiseptic solutions, finishing the sexual act quickly, or ejaculating "outside" might prevent HIV transmission.
"HIV is just an issue for homosexuals and prostitutes"				Yes, and is a stereotype that has been acquired mainly by women.
Gendered meaning of sex patterns of partners	A polygamous conceptualization of male sex given by males.	Some young men attached three meanings to sex—procreation, love and recreational sex; women were socialized to please men sexually; men's sexual needs and behaviour were tolerated; men "feared" more an infection from their stable partners, whereas women feared more an infection from their casual partners.	Women frequently believed a man could not be sexually satisfied with only one woman.	Homosexual men expressed their "masculinity" through engaging in multiple sexual relations with other men. The man who has had the highest number of sexual partners is considered "the best of the best".
Barriers to condom use	Condom use was estimated to be very low—5% of sexually active people. Condoms were for sale at almost all visited hotels and bars, but sales were low. Safe sex was often seen as "mutual trust", and such was insisted on ("We should learn to trust our partners and stick to the trusted one instead of using condoms"); condom use was seen as proper for casual sex and commercial sex.	Limited access to condoms at drinking venues. Some men who would seek out casual sexual relations in drinking venues failed to carry condoms for fear of being caught by their regular partners.	Young people were more uninformed than adults about the protection offered by condoms.	Condoms were expensive and were believed to reduce sexual sensitivity; heterosexual encounters usually had symbolic meaning and included rituals such as going for coffee/dinner, which rendered open negotiations on condom use improper. A repressive male-dominated culture entailed, for example, the fact that many young people were too shy to buy condoms. Girls also had or pretended to have little experience of sexual issues and therefore did not insist on condom use or did not carry condoms. Young men, furthermore, did not stop to get condoms as they did not want to "sexually scare" their partners (who could change their minds).

Key sex-related patterns of STI/HIV risks	Africa			Americas
	Kenya	South Africa	Zambia	Mexico
Unwanted pregnancy perceived as main risk; condoms mainly/only used to prevent pregnancy				Yes, young women mainly associated unsafe sex with unwanted pregnancy. The main perceived reason for using a condom was to prevent unwanted pregnancy, not STI/HIV. Family members who instructed young people to use condoms did so out of aversion to pregnancy, not fear of STI infection.
"Natural way of doing it" as a barrier to condom use		Men wanted flesh-to-flesh sex.		
Casual and/or commercial sex in public places (bars, toilets)		In commercial sex, intercourse was performed on balconies, in toilets, corners, even in the company of other visitors sitting at the same table and bench.	Yes, in rest rooms (not toilets, but brothel-like rooms) that were rented for a few hours.	Yes, sexual intercourse occurred, e.g. on the floors and in rest rooms of restaurant bars. Oral sex was tolerated in semi-dark areas of some bars, even though this was officially forbidden.
Homosexuality				Homosexual men are constructed as men and as homosexuals, and in order to prove both these identities (manhood and homosexuality) they need to have many sexual relations and engage in risky sexual behaviour.
Separate homosexual venues				Yes, some fitness centres were being used on certain days for homosexual encounters. Condoms were seldom offered for free or sold at homosexual venues (e.g. in bars and discos).
MSMs engaged in sex for the "adrenalin" surge				Yes, and occurred without the use of condoms and in "dark rooms".
Violence and unwanted sex		Frequently reported between partners, mostly because of various fears and mistrust and jealousy among men; unwanted sex reported more by males than females.		
Non-professionalism in sex work		Sugar daddy and sugar mummy relationships were commonly engaged in for money and gifts, and unsafe sex was often part of it.	Sex workers with low self-esteem took more risks (less consistent condom use);unprotected sex was accepted for additional pay.	Frequently older men (sugar daddies) paid for drinks and gave gifts to young men in exchange for sex.

[x] The data in the countries cited did not necessarily relate to the respective risk categories noted in the table, thus the empty cells.

Table 7b: Key sex behaviour-related patterns of STI/HIV risks and particular manifestations of these risks in Belarus, Romania, the Russian Federation and India[x]

Key sex-related patterns of STI/HIV risks	Central and Eastern Europe			South East Asia
	Belarus	Romania	The Russian Federation	India
Myths and/or wrong understandings of modes of HIV transmission		STI/HIV was considered bad fortune, an attitude more prevalent among superstitious men. Young people had superficial and inconsistent knowledge of sexual risks and STIs. Some people believed that HIV/AIDS was a phenomenon of Africa or the USA.	"All diseases are curable".	Cleaning genitalia with alcohol, urine or antiseptic solutions, finishing sexual act quickly, or ejaculating "outside" might prevent HIV transmission.
Gendered meaning of sex patterns of partners	Premarital "purity" was expected more of women than men; macho construction of maleness; multiple sex partners for men were tolerated; girls often associated sex with material hardship.	Frequent involvement in sex and having multiple partners were considered male behaviour. Men were more superstitious and women more realistic about sexual risks.		Faithfulness to partner an expected norm, although males have more liberties than females.
Barriers to condom use	Condoms were expensive; were never or seldom used by many; the Church was against condom use.	Limited discussion about sexual matters (tabooed); limited use of condoms among particularly older people. Although condoms were sold in every shop, people were too ashamed to buy them; some people also refused to use condoms because of the belief that it reduced pleasure and hampered spontaneity. Some people did not believe HIV/AIDS was a reality in Romania and never used condoms, even though they had multiple partners.	Condoms were never used, particularly during group sex, and during oral and anal sex . Alcohol use (including heavy drinking) is common before sexual activity as alcohol is believed to remove pressure, inhibition and relaxed).	The belief that there is no necessity in using condoms exists. A lack of time during the sex act is also given as a reason for not using condoms. Partners sometimes object to condoms. The unavailability of condoms is another barrier to usage. The use of alcohol during commercial sex is also seen as a barrier to condom use.
Unwanted pregnancy perceived as main risk; condoms mainly/only used to prevent pregnancy	Yes, if condoms were used, prevention of pregnancy was the chief reason, and was offered as motivation when women requested men to use condoms.	Yes, unwanted pregnancy was seen as the major risk in sexual relations.		
"Natural way of doing it" as a barrier to condom use		Yes, the main barrier to safe sex was the insistence on "preserving the natural way of doing it".		Some people do not like using condoms.
Casual and/or commercial sex in public places (bars, toilets)	Wherever possible—apartments, hostels, parks, public gardens,		In a disco in Moscow there were "individual video telephone	

Key sex-related patterns of STI/HIV risks	Central and Eastern Europe			South East Asia
	Belarus	Romania	The Russian Federation	India
	benches, night clubs, basements, porches, disco bars. Apartments were leased for 24 hours or less. In student hostels almost all sexual activity occurred when visits were allowed; the remaining roommates had to leave the room. Discos were seen as places for meeting sexually willing persons.		relaxation" booths, where sex was being performed, and on another floor there was a long corridor with dark rooms (illuminated only by screens with porno films) where any sexual activity was tolerated.	
Homosexuality	In boys' boarding schools 100% of students engaged in homosexual practices.			
Violence and unwanted sex	Girls submitted to pressure to have sex because of fear of jeopardizing their relationships. Early sexual debut, sexual activity under the influence of alcohol and rape particularly common among rural people.	Comments such as the following occurred among research participants: "When my father was drunk he was rude and pushed my mother into having sex neglecting that his children were there. I first learned popular and vulgar language about sex and then what were appropriate and civilized words for that." Girls in rural villages were sometimes raped by acquaintances and relatives.	Groups of young people "on the edge" of criminal circumstances performed "condom-protected rape".	
Non-professionalism in commercial sex work	Commercial sex workers attended private hospitals/clinics when in need of care because the treatment in government institutions was "inhumane". Self-treatment of STIs occurred. Although prostitutes in hotels and call girls refused unprotected sex, street prostitutes were more willing to engage in unprotected sex. Frequently promises of rewards in the form of money, clothes, etc persuade young people to have sex.	Commercial sex workers included call girls, girls at motorways who worked together with pimps and girls at low-budget bistros and bars. Street children (e.g. young girls at railway stations) also engaged in prostitution. Some taxi drivers allowed their clients to pay them by having sex with them. Taxi drivers and older men frequently bought sex.	Commercial sex was reportedly performed with 100% condom use.	Brothel-based commercial sex workers are in favour of protected/safe sex.

Key sex-related patterns of STI/HIV risks	Central and Eastern Europe			South East Asia
	Belarus	**Romania**	**The Russian Federation**	**India**
"Problematic" liberalization of sexuality	Liberalization (media, internet, travel) occurred without any effective health promotion or discourse on sexual risks/effective strategies on condom use support. A lot of free time and unspent energy contributed towards sexual activity.	Liberation of sexual activity, with extramarital sexual relations becoming more frequent; and differences between rural and urban sex life were disappearing.	Sex and sexual pleasure were becoming the most sought pleasures (including multiple partners), and casual sex with alcohol was a norm; the "older" group seemed to take consistently more risks, although they also had more developed risk-preventing skills (e.g. condom use).	Changing social values/attitudes towards sex, especially among young people and adolescents in particular.

[x] Empty cells relate to the fact that the data that were collected in the countries cited did not necessarily relate to the respective risk categories noted in the table.

3.4.3 Key patterns of the interaction between alcohol use and sexual behaviour that pose risks for STI/HIV infection

Analysis of the data collected in the project sites also showed that not only did alcohol use and sexual behaviour separately pose risks for STI/HIV infection, but also collecively. In a number of ways alcohol use and sexual behaviour and beliefs actively "supported" one another, with alcohol use and beliefs acting as both precursors and outcomes of sexual behaviour. The particular manner in which alcohol use and sexual behaviour interacted, however, varied to some extent across the eight countries. Furthermore, the key patterns of risky alcohol use-sex interaction that emerged in the course of the analysis related to the following matters that were consistent with the issues noted in earlier discussions: (cultural) acceptance of alcohol as a facilitator of sexual encounters and maleness, and/or a reliever of sex-related stress, and/or an enhancer of the sexual experience, and/or an excuse for irresponsible behaviour such as risky sex; the use of alcohol-serving venues as contact places for sexual encounters; and the promotion of alcohol at venues catering for pornography.

More specifically, and with regard to the contribution of alcohol consumption to sexual activity, Tables 8a and 8b show, for example, that "being under the influence of alcohol was culturally accepted as an excuse for irresponsible behaviour, including risky sex" in Kenya and South Africa, in Mexico, as well as in Belarus, Romania and the Russian Federation. In Romania, alcohol consumption was not only culturally accepted as an excuse for irresponsible behaviour but also as an excuse that specifically applied to men, implying that alcohol use-related irresponsible behaviour was culturally accepted as an assertion/manifestation of maleness.

Tables 8a and 8b, furthermore, show that alcohol was consumed to attract sexual partners and initiate sexual encounters. For example, in Zambia "buying alcohol for women showed that a man had money". In Belarus in particular "alcohol use was conventional and an essential part of sexual relations"; and "at discos alcohol was much more consumed by those who showed up single and searched for a partner than those who came with a partner". In Russia "it was typical to invite a woman to a restaurant and treat her with alcoholic drinks".

Beliefs that alcohol facilitated or enhanced sexual intercourse contributed towards consumption before or during sexual intercourse. For example, Table 8a shows that in Kenya it was observed that "alcohol use was believed to reduce fears connected to sex and encouraged risky sex, and to provide extra power for sex"; and in South Africa some research participants noted that "alcohol use and sex were a match made in heaven". In Mexico "young people and homosexual men used alcohol to build courage to approach a possible sexual contact". Table 8b also indicates that in India "alcohol's positive effect on arousal and pleasure was particularly reported by high-risk groups". In Belarus "alcohol use was perceived as very important in sexual activity", with some persons noting that alcohol use during sexual intercourse made "them become more attractive". It was also found in Belarus that alcohol use was the third most frequent reason for girls to have sex the first time. In Romania it was noted that, as a rule, "alcohol was taken as a socializer and a facilitator of sex". In the Russian Federation "there was a common misconception that a person without alcohol was incapable of engaging in sex".

Tables 8a and 8b also indicate that alcohol consumption occurred as an outcome of (stressful) sexual encounters in some project countries. For example, in Kenya it was reported that some commercial sex workers "drank to cope with dirty clients" (Table 8a), and in India female commercial sex workers reported that alcohol was used "to cope with" commercial sex (Table 8b).

Finally, situational factors such as the promotion of alcohol consumption at venues for drinking and sex-related demonstrations "strengthened" the active contribution of alcohol use to risky sexual behaviour. Table 8a, for example, notes that in Mexico homosexual encounters particularly occurred in bars and discos, drawing attention to the finding that "the best seats in bars/discos (near the dance floor) were bound to purchasing a whole bottle of alcohol, not just a drink".

Table 8a: Key patterns of the interaction between alcohol consumption and sexual behaviour that pose risks for STI/HIV infection[x]

Risky patterns of alcohol-sex interaction	Africa			Americas
	Kenya	South Africa	Zambia	Mexico
Being under the influence ofalcohol was culturally accepted as an excuse for (any) irresponsible behaviour; construction of malenness in terms of alcohol consumption; acceptance of alcohol as a means for attracting sexual partners	Yes, culturally, alcohol use served as an excuse for any incorrect behaviour, a warranty for irresponsibility	Under the influence alcohol, men could be guaranteed meeting women who would be willing to engage in sexual encounters with them. A high visibility of drunken people performing sexual activities, e.g. in parks and pubs. Some women were sexually abused by their drunken husbands.		Yes, alcohol and other psychoactive substance use was considered an excuse to engage in sexual risk behaviour
Buying alcohol for women showed that a man had money			Sex was paid for with money/gifts and with drinks, particularly in the case of commercial sex work.	
Commercial sex workers and alcohol use	Some drank to cope with dirty clients.	Commercial sex workers would often visit drinking venues which were mainly frequented by men.	Commercial sex workers frequently reported enjoying their commercial sex, particularly when combined with alcohol use. In fact, many sex workers and clients indicated that they enjoyed sexual intercourse most when they were drunk. Some commercial sex workers pretended being drunk to seduce clients.	Older visitors to night bars and discos generally bought alcoholic drinks for younger visitors in order to persuade them to have sexual intercourse
Alcohol-serving venues were important contact places for homosexuals/MSMs				Yes, because of the repressive attitude towards homosexuality in society; and because of a lack of places other than bars where homosexuals could meet and have sex. The best seats in bars/discos (near the dance floor) were bound to purchasing a whole bottle of alcohol, not just a drink.
Low awareness of alcohol use-related sexual risk behaviour				Yes, especially among young people. When young people asked about possible riks of alcohol intake, sexual risks were seldom mentioned.

Risky patterns of alcohol-sex interaction	Africa			Americas
	Kenya	South Africa	Zambia	Mexico
Subjective or psychological importance of alcohol use in sexual intercourse	Alcohol use reduced fears connected to sex, and encouraged risky sex; alcohol use believed to provide extra power for sex	High prevalence of people drinking and involved in erotic/sexual behaviour in public. "Alcohol with sex" increased with social status. Alcohol use and sex were a "match made in heaven"—inseparable.		Yes, young people and homosexual men use alcohol to build courage to aproach a possible sexual contact
Alcohol intake during first sex				
Alcohol use was expected to improve quality of sex and pleasure	Yes, alcohol use was expected to increase power for sex and keep mind fixed on the act	Repeatedly and very frequently reported. Included numerous myths concerning particular alcoholic drinks and their specific positive effects on sex. Various alcoholic drinks were expected to improve sex, and women reported this more frequently. There was a positive correlation between satisfaction with partner and having sex under the influence of alcohol.		
Influence of alcohol intake upon condom use		In commercial sex, unprotected sex was performed in public places (balconies, toilets, corners, even in the company of people sitting at the same table and bench). Alcohol intake correlated positively with several sex-risk indicators, but the correlation with condom non-use was negative, suggesting that when under the influence of alcohol people would become more vigilant about condom use.		

[x] Empty cells relate to the fact that the data that were collected in the countries cited did not necessarily relate to the respective risk categories noted in the table.

Table 8b: Key patterns of the interaction between alcohol consumption and sexual behaviour that posed risks for STI/HIV infection[x]

Risky patterns of alcohol-sex interaction	Cental and Eastern Europe			South East Asia
	Belarus	Romania	The Russian Federation	India
Being influenced by alcohol was culturally accepted as an excuse for (any) irresponsible behaviour; construction of maleness in terms of alcohol consumption	In some cases alcohol use was conventional and an essential part of sexual relations. At discos alcohol was much more consumed by those who showed up single and searched for a partner than those who came with a partner.	The public aware of a connection between alcohol use and deviant sexual behaviour and that family violence (mainly by men) occurred under the influence of alcohol. It is believed that women had a stronger censor than men, thus their behaviour under the influence of alcohol was not so "disturbed", i.e. women took more responsibility for what happened.	In the development of sexual partnerships it was typical to invite a woman to a restaurant and treat her with alcoholic drinks.	
Commercial sex workers and alcohol use				FCSWs reported that alcohol use was part of their lifestyle; alcohol use increased business; alcohol was also used to keep clients company, to increase sexual pleasure, to prolong the sex act, and to cope with the situation
Alcohol-serving venues were important contact places for homosexuals/MSMs				Generally "no"; "yes", in some high risk groups
Low awareness of alcohol use-related sexual risk behaviour			The lower the social status, the more the alcohol use and the less safe the sex.	
Subjective or psychological importance of alcohol use during sexual intercourse	Alcohol use was perceived as very important in sexual activity. "I become more attractive".		There was a common misconception that a person who has not taken alcohol was incapable of engaging in sex. Alcohol use was typical during casual sex.	"Yes" in risk groups
Alcohol intake during first sex	Occurred among especially men (20% of cases). Alcohol use was the third most frequent reason for girls to have sex the first time. Initiation into sexual activity facilitates initiation into alcohol use and vice versa.	Almost as a rule. Alcohol was taken as a socializer and a facilitator of sex.		12% among alcohol users in general population
Alcohol use was expected to improve quality of sex and pleasure			.	Alcohol's positive effect on arousal and pleasure was particularly reported by high risk groups

Risky patterns of alcohol-sex interaction	Cental and Eastern Europe			South East Asia
	Belarus	**Romania**	**The Russian Federation**	**India**
Influence of alcohol intake upon condom use	"High" alcohol use was related to having had more sex partners and and more risk indicators. Alcoholism was related to a high STI incidence.		The lower the social status, the more the alcohol use and the less safe (condom use neglected) the sex.	Condom use was high during paid sex among FCSWs despite alcohol use. Among transport workers and the general public condom use was higher when drinking occurred.
Pornographic films promoted alcohol use before sex			Yes, with discos providing alcohol, pornographic material and places for sexual activity	

[x] Empty cells relate to the fact that the data that were collected in the countries cited did not necessarily relate to the respective risk categories noted in the table.

3.5 Individual-related behaviour patterns

Exploring the views, norms and expectations related to alcohol use and sexual behaviour in the eight countries was expected to highlight factors that increase the risk of contracting STI/HIV. The previous section showed, as expected, that these factors differentiated into *country-specific, culture-specific* and *"universal" or cross-cultural constructions or patterns*. However, and as expected, certain *individual patterns* arising from interactions between specific traits and specific contexts—at the level of specific individuals, small groups or the general population in a country—also showed up in the analysis. This section illustrates the key patterns/regularities in the manner in which alcohol use-related sexual risk behaviour manifested in terms of individual behaviour at the level of specific individuals, the small group and the general population by drawing attention to the data collected in Belarus, Romania and the Russian Federation.

3.5.1 Behaviour patterns manifesting at the level of the individual (the Russian Federation)

The analysis showed differences in individuals' risky sexual behaviour related to alcohol use, namely behaviour with a significant degree of risk, risky behaviour and behaviour with a minimal degree of risk. These three behaviour patterns are illustrated in Tables 9-11 in terms of the data collected in the Russian Federation.

Table 9: First pattern: Behaviour with a significant degree of risk

Age at sexual debut (SD)	Early: 13-15 years.
Reason for SD	Curiosity, violence, intoxication.
Use of a condom during SD	Seldom.
Duration of communication with the first sex partner	Practically absent: "one day", "one night ", "one hour", "three minutes " etc.
Sex partners	Both steady and random. A condom was seldom used with steady partners, but with random partners almost always, to prevent STIs. Random partners could be persons known before or strangers.
Kinds of sexual contacts	All kinds of contacts: vaginal, oral, anal, group. Also contacts with prostitutes and people with venereal diseases. As a rule, condoms were used mainly during group sex or when partners were known to have an STI.
Contraction of venereal diseases	Present throughout life.
Use of alcohol	Typically throughout life in great amounts, the alcohol being strong alcoholic drinks and beer. Direct relationship between the use of alcohol and sex. There was no doubt that the partner was under the influence of alcohol.
Estimation of level of knowledge of alcohol and STIs	From "satisfactory" up to "very good", arising from personal experience.

The following narrative (extracted from semi-structured in-depth interviews in the Russian Federation) illustrates the particular manner in which the behaviour in Table 9 manifested in the recorded empirical data:

A 21-year-old man from a military establishment was interviewed. He was also a student at an academic institution at the time of the interview. He had never been married, and had no children. He used alcohol in significant amounts, and replied "Yes" to the question as to whether he had practised sex in a state of strong alcohol intoxication. He first engaged in sex when he was 13 years old, and did so out of curiosity. His association with his first partner

lasted a day and did not involve condom use. He was heterosexual. After his first sexual encounter he had random sexual contacts with partners he knew before and with strangers. He also had some long-term partners. He never used condoms, except when the partner insisted on their use. Although he suffered from venereal disease, he tested negative for HIV/AIDS. As a rule, he and his partners used a significant amount of alcohol before sex. During the previous year he practised group sex several times, sometimes using a condom and always in a state of alcohol intoxication. In the previous month he practised sex four times and paid money for it but did not use a condom. He had had sex with persons suffering from venereal diseases, and also when he was sick himself. "Safe sex" for him meant "not to be infected", and "risky sex" meant "sex with women suffering from venereal diseases".

Table 10: Second pattern: Risky behaviour

Age at sexual debut (SD)	Average: 16-19 years.
Reason for SD	Curiosity, love.
Use of a condom during SD	Seldom.
Duration of communication with first sex partner	1–3 years.
Sex partners	Presence of several constant partners with whom there was an emotional bond and confidential relations, which resulted in condom use, mainly to prevent pregnancy. Casual sexual contacts were also possible, but usually these were persons known before.
Kinds of sexual contact	Vaginal, oral, less often anal. Group sex was practically excluded. No contacts with prostitutes. If casual sex did occur, it did so in "their company", i.e. among acquaintances.
Contraction of venereal diseases	Seldom occurred.
Use of alcohol	Typically throughout life in big or average amounts, basically consisting of strong alcoholic drinks, wine and beer. However, no rigid link between alcohol use and sex. Women were generally dissatisfied when their partner was under the influence of alcohol.
Estimation of level of knowledge of alcohol and STI	Considered themselves informed enough.

The following narrative (extracted from semi-structured in-depth interviews in the Russian Federation) illustrates the manner in which the behaviour in Table 10 manifested in the recorded empirical data:

A 27-year-old female nurse was interviewed. She had never been married and had no children. She lived in a municipal apartment with a sister of 29 years. She first engaged in sex when she was 17, and did so out of love. The first relationship lasted one year. Since then she had had some permanent and random sex partners. She had random sexual contact only with men whom she knew earlier. Usually she used a condom, and did so out of fear of contracting venereal diseases or falling pregnant. Therefore she always bought them herself, though her partners might also do so. She had never suffered from venereal diseases, but did not know whether her partners were healthy. She had never practised group sex and sex for money. Before sexual contact she and her partner might drink one to two measures of an alcoholic drink. However, she was averse to using plenty of alcohol because "the drunk person loses control over himself and is not protected". She estimated her level of knowledge about alcohol, venereal diseases and AIDS to be "satisfactory". She understood "safe sex" as "one constant partner of whom she is sure and the use of a condom". "Dangerous sex" meant "random partners, unprotected sex".

Table 11: Third pattern: Behaviour with minimal degree of risk

Age at sexual debut (SD)	Late: 20–23 years.
Reason for SD	Curiosity, love, marriage.
Use of a condom during SD	Used as a rule.
Duration of communication with first sex partner	More than three years. Frequently SD resulted in a long-term relationship or marriage.
Sex partners	One constant partner. Condoms were used to prevent pregnancy if the partners were not yet ready to have a child, but other contraceptives were used more often. There was mutual trust between the partners.
Kinds of sexual contact	Basically vaginal and oral, less often anal.
Contraction of venereal diseases	None.
Use of alcohol	Aversion to taking big doses of alcohol before sex. Small amounts of light drinks (wine, champagne) to create "romantic atmosphere", which was culturally accepted.
Estimation of level of knowledge of the alcohol use—STI relationship	Basically good.

The following narrative (extracted from semi-structured in-depth interviews in the Russian Federation) illustrates the manner in which the behaviour in Table 11 featured in the recorded empirical data:

A 22-year-old woman. She had specialized secondary education, and was studying at a pedagogical university. Her first sexual contact took place when she was 19, and she did so out of love. She had been married four years, and did not have other sex partners. She had no children. She did not engage in random sex. She always used a condom as her partner and she were not ready to have a child. Neither her partner nor she had suffered from venereal diseases. Before intimacy they sometimes had 1–2 measures of alcohol. She considered it acceptable to have wine, champagne or beer for this purpose. She did not use strong drinks. According to her, if one had a child, alcohol should be banished from the home. She understood "safe sex" as sex with a beloved person whom she entirely trusted, and "risky sex" as sex associated with random contacts. She regarded her knowledge of alcohol as satisfactory, but her knowledge of venereal diseases and AIDS as unsatisfactory.

3.5.2 Behaviour patterns manifesting at the level of the general population, the small group and the individual (Belarus and Romania)

The following behaviour patterns that were extracted from the data collected in **Belarus** illustrate the finding that within countries alcohol use-related sexual risk behaviour differentiated into behaviour patterns on the level of the individual as well as the general population:

1 At the national/general population and small group level

- Alcohol was used on any occasion.
- Culturally, polygamy and casual sex relations were acceptable; the general attitude to sexual relations was irresponsible and "immoral"; and men typically had insufficient motivation for using means of protection and women typically felt ashamed to negotiate protection.
- At society level, ideological and moral principles were partially destroyed by reforms (modernization/liberalization) and the stagnation of socially significant institutions in the previous ten years.

2 At the individual level

- Little volition and therefore conformity with and inclination to imitate others, and accepting behavioural stereotypes.
- Alcohol use-related sexual risk behaviour increased due to lack of social self-fulfilment, social maladaptation and the occurrence of hypo-depressive moods and conditions.
- Alcohol use and risky sexual behaviour strongly correlated.

The empirical findings in **Romania** showed the following behaviour patterns:

1 At the national/general population and small group level

- Sexuality was getting more liberal while the existential financial "cruelty" of everyday life increased. At the same time extramarital relations were tolerated more, or were acceptable as long as they were not disclosed, or were accepted by wives as long as husbands brought money home. The values of honesty and chastity were fading.
- Culturally, alcohol use was connected with almost all social activities, had a positive connotation, and was a symbol of maturity, happiness, power and hospitality. Many people believed in luck and trusted fortune to protect them against risk. Furthermore, "risk" mainly meant unwanted pregnancy. One participant explained the ignorance towards risks: "People in Romania got accustomed to confront a lot of [non-sexual, existential] risk and *to deny and neglect risks as a way of coping with life*." A major risk environment was the university campus, which seemed to be regulated by its own unwritten rules in the absence of police. Sex was sold for perfumes, costumes or dinner.

2 At the individual level

Table 12 illustrates behaviour patterns that manifested on the level of the individual in Romania.

Table 12: Individual-related sexual behaviour patterns in Romania

Taxi driver	Alcohol use irrelevant, risk neglected, sexual behaviour highly risky, no protection.
DJ	Alcohol regularly and modestly used, awareness of risk, false sense of ability to distinguish risky partners, sexual behaviour was risky, condom use was inconsistent.
Truck driver	Alcohol use irrelevant, awareness of risk, sexual behaviour was highly risky, condom use was consistent.
Casual sex seeker	Regular alcohol use, low awareness of risk, not controlling sexual urge, impulsive, sexual behaviour was highly risky, inconsistent or no condom use.
"Objects" of casual sex	Some women accepted being the "objects" of casual sex in the hope of beginning a romantic affair (and, finally, meet a life-time partner).

3.6 Conceptualization of sexual risk

As insight into the *subjective meanings of the concept of risk* among *individuals* in different groups, populations and communities is essential to counter unsafe sex, this section highlights key aspects that emerged in the course of analysis, using the empirical findings of selected countries as an illustration. Analysis generally showed that the conceptualization of sexual risk differentiated in terms of condom use, partner selection, pregnancy, STI and HIV, violence and rape.

In the **Russian Federation,** for example, understandings of or opinions on the meaning of "*safe sex*" could be classified into the following three categories:

1 Some participants mentioned *prevention of STI and HIV*, some only prevention of pregnancy.

2 Others defined safe sex by means of a certain *status or patterns of behaviour*, such as a constant partner, and matrimonial sex.

3 Finally there were definitions by *type of behaviour/device used*:

o Sex without alcohol.

o Sex with contraception (the spiral, tablets)

Risky sex seemed to entail engaging in sex without a condom or other contraceptives, sex with alcohol, and having numerous sex partners.

With regard to *condom use* the following issues emerged:

1 Men were unwilling to use condoms but little is known about women's willingness.

2 Condoms were not used in marriage and with regular partners, except for family-planning purposes. One female participant stated that she encouraged her boyfriend to use a condom despite his opposition.

3 Condoms were often used with casual partners, especially if a person had a casual partner(s) simultaneously with a steady partner.

4 Condoms were almost always used in paid sex (but only for vaginal intercourse); commercial sex workers used condoms with their clients as well as their steady partners.

5 Young people were keen to use condoms, but older people rejected them quite consistently.

In **Belarus** understandings of or opinions on the meaning of "*safe sex*" highlighted the following issues:

1 Using condoms—80% of the respondents.

2 Having one permanent partner—59% of the respondents.

3 Knowing your partner well enough—44%.

4 Using contraception—27%.

It should also be noted that there was an erroneous belief that oral sex was "safe" and protected one against STIs. Furthermore, the participants in the focus groups expressed several naive and/or bizzare opinions concerning safe sex such as the following: Safe sex is "when there is psychological readiness to have sex with a particular partner"; "sex with a beloved person"; "sex in marriage"; "*sex with cooks, doctors and representatives of other professions that are subject to regular medical supervision*". Based on these opinions, their recommendations were also naive. For instance, risk could be prevented by upbringing, self-education, awareness, children being informed of the harmful consequences of premarital sex from the beginning of their school years, keeping young people busy, the unavailability of cigarettes and alcohol, and boys and girls talking separately.

Regarding the meaning of *risky sex*, analysis identified the following nine opinions on what increased sexual risk:

1 Early age of sexual debut—at age 16 (70% of the 14–17 year olds had had sex).

2 Premarital sex—95% of first sex events were premarital.

3 Unfaithfulness of stable partners.

4 Attitude to safe sex—condom non-use.

5 Alcohol and other psychoactive substance use.

6 Persons addicted to psychoactive substances.

7 MSMs.

8 Sex business.

9 Lack of HIV/AIDS awareness.

It seems that female partners of psychoactive substance users practised predominantly unprotected sex, the main motive for this being fear of hurting the partner's feelings or losing him.

In **Romania,** understandings of or opinions on the meaning of *risky sex* highlighted that men considered pregnancy as a women's issue. The following order of perceived importance of risks from casual sex also manifested:

1 Unwanted pregnancy and related expenditure, blackmail, new responsibilities, need to change one's way of life, a forced marriage.

2 STI.

3 Family problems.

4 Theft (e.g. of personal belongings).

5 Physical aggression.

Furthermore, *ignorance towards risks* was explained as follows: "People in Romania got accustomed to confront a lot of [non-sexual, existential] risk and to deny and neglect risks as a way of coping with them."

Analysis also showed that a social stereotype was attached to the concept "*risk group*": They were careless, excitable, impulsive, restless, took alcohol etc. The participants claimed that those who could not distinguish the "group at risk" were prone to engage in unsafe sex.

3.7 "Tricky issues"

Analysis finally identifed some extremely risky behaviours that were very hard to address, change or challenge because of their complexity. These included the following:

In **Mexico** some members of NGOs with a health promotion mission were owners of venues that animated/encouraged high-risk sex, e.g. dark rooms (for anonymous sex). Furthermore, drinking venues posed particular problems in Mexico. There were places and particularly drinking venues and strategies that induced customers to engage in extremely risky behaviour, e.g. certain bars in Mexico City where one could get to the rest room only by passing the "dark room" (and there were only men's rest rooms). (In South Africa the drinking venues in certain sites had similar problems, such as shared toilets, poor lighting, sexual harrassment of women by owners and sellers, and very low levels of disapproval of risky sexual behaviours in the venues.) In Mexican beer halls, food was sometimes offered for free if a customer drank a certain number of beers. Moreover, drinking venues also hosted contests to see who was able to drink the most. The contests were organized by the owners and the reward was alcohol. Men and women participated. In some bars visitors were "forced" to drink by waiters walking among them and offering them tequila (for the competition).

India had a high proportion of illiterate people (7–17%) for whom written health messages meant nothing. Of the FCSWs, 68% were illiterate. Moreover, the general level of education was low or people were not educated at all. These people had specific values and types of reasoning and discourse that were non-rational.

In **South Africa** alcohol advertisements used seductive images of men and/or women. South African police officers were seen drinking in uniform at venues where they joined women, and

were considered to be not very helpful in protecting these women in situations where police protection would be needed. Some South Africans believed sex with sugar mummies and sugar daddies was safe. South African parents who were unhappy about their children's promiscuity warned them that "Omo" (AIDS) would deal with them.

In **Russia** pornographic films promoted alcohol use before sex, thus creating a destructive sex norm. Furthermore, the **Romanian** country report implicitly called for normative instruments when noting that the country was experiencing a "lack of sexual restrictions to 'normalize' sexual behaviour". Thus desirable behaviour was "to be promoted" (e.g. setting limits for sexual intercourse, defining an "acceptable partner", limiting the number of spouses, outlining criteria for offensive sex etc.).

3.8 Conclusion

Analysis of the data collected in the eight project sites revealed the key factors involved in alcohol use-related sexual risk behaviour regarding the contraction of STI/HIV. As expected, these included psychological factors, sociocultural factors and environmental or situational factors. Strong cultural, social and economic bonds were shown to exist between sex partners. The most striking risks seemed to stem from (a) the gendered meaning of sex which warrants free sex for males and approves sexual violence against wives/women, as well as (b) the chaotic disintegration of traditional norms and their mixing with the norms of urbanization and modernization, resulting in confusion. Also, the influence of alcohol use on sexual behaviour differed much between women and men, this being the result of different social norms for the two groups.

The factors involved in the alcohol use-related sexual risk behaviour with regard to STI/HIV infection were, furthermore, shown to differentiate on a cross-country/regional, country/culture-specific and individual level. This differentiation underlines the importance of initiating preventive programmes with not only a cross-cultural focus but also a culture-specific and individual-specific focus.

Finally, analysis highlighted that the link between alcohol consumption, sexual behaviour and STI/HIV infection was far from linear. The risks that various alcohol use and sex-related issues in themselves posed for the contraction of STI/HIV infection were shown to be intensified by various interactive links between alcohol use and sexual behaviour—alcohol consumption not only presented as a "precursor" of risky sex, but also as an outcome of it. Key patterns of the interaction between alcohol use and sexual behaviour that posed risks for STI/HIV infection related to the following issues: the construction of maleness in terms of alcohol use; a denial and neglect of risk as a way of coping with life; the use of alcohol-serving venues as contact places for sexual encounters; the use of alcohol at/during (first) sexual encounters; and the promotion of alcohol use in pornographic material.

Chapter Four

CONCLUSION: PREVENTIVE IMPLICATIONS

4.1 Introduction

Effective prevention of health risks (including HIV) requires systematic planning (Reddy & Meyer-Weitz, 1999:5-20). Instead of "jump[ing] from a perceived problem to an intervention", it is essential to carefully investigate the issues concerned as well as assess the nature and quality (evidence base) of available options before deciding to implement particular interventions (Reddy & Meyer-Weitz, 1999:15).

In view of the importance of scrutinizing the existing evidence base on ways of preventing risk behaviour and, in fact, of facilitating behaviour change, this chapter briefly reviews (1) theories of behaviour change as well as (2) evidence on ways of preventing health risks related to psychoactive substance use (including alcohol use). It then draws attention to the key findings of the empirical study in the overall project and in particular to the preventive focuses implied by these findings before concluding with recommendations for preventive efforts. The latter recommendations are based on the reviews of existing theories of behaviour change, the preventive recommendations offered by the respective research teams in the project countries, as well as the results of the empirical study. Methodological recommendations are also made.

4.2 Theories of behaviour change

There are numerous theories upon which intervention aimed at behaviour change may be built. These theories include the work of, for example, Kegeles et al. (1996), Sweat and Dennison (1995), Auerbach et al. (1994), and Fishbein et al. (1992). Characteristic of the respective theories is that they tend to focus on a particular level rather than multiple levels of social behaviour. However, the multi-levelled manifestation of risky behaviour suggests that a number of the available theories on behaviour change should be considered in the development of interventions. A basis for developing multi-levelled interventions is provided in Dubois-Arber and Carael (2002). These scholars note the following theories of behaviour change that are generally considered in intervention programming, their main features and (main) proponents:

The **Theory of Diffusion of Innovation** (proposed by for example Kegeles) highlights the mechanisms of the gradual acquisition of new behaviour mainly due to media influence mediated by the participation of prominent personae (celebrities) who support the new behaviour. This role-model related theory has been proven effective, as in the case of the increase in condom use.

The **Social Influence or Social Inoculation Model** (proposed by Howard and McCabe) presumes media and culture pressures towards performing unhealthy behaviour and formulates a strategy for learning skills to withstand these pressures. Skills training includes teaching assertiveness and, concerning sexuality, encompasses guidance to expressing authentic sexual needs. One example of a positive outcome is postponed sexual debut.

The **Social Networks Theory** (proposed by for example Auerbach) views social behaviour through relationships and in particular the manner in which these relationships are constructed and maintained, that is, the selective mixing of partnership patterns in a dyad, the smallest

social unit, and the resultant partnership variation. Therefore the very processes of constructing a partnership need to be addressed directly if behaviour is to be changed.

The **Theory of Individual and Social Change or the Empowerment Model** (proposed by Parker) considers evidence that participatory action increases problem-solving capacity and empowers individuals to take action to improve their situation because they learn to understand the personal, social, economic and political forces in their lives better. This empowerment features in persons/individuals, organisations or communities. This theory has proven to be effective, e.g. in the adoption of positive condom use habits/skills.

In contrast to the above theories, the **Theory of Gender and Power** (proposed by Connell), a sociostructural theory, addresses the wider social and environmental issues surrounding individuals and in particular women, such as the distribution of power and authority, affective influences, and gender-specific norms within heterosexual relationships. This theory asserts that commitment to a relationship and lack of power can influence one's (mostly the woman's) risk reduction choices and the ability to negotiate safe sex and conduct an effective family-planning strategy.

In line with the previous theory, the **Theory of Structural and Environmental Factors** (proposed by Sweat and Denison) takes cognizance of multiple evidence that civil and organisational elements as well as policy and economic issues influence behaviour and may be crucial for behaviour change. This theory is also about being sensitive to concepts such as "risky situations", "risky environments", "environments facilitating vulnerability" etc.

The **Social Ecological Model of Health Promotion Theory** (proposed by for example Laver) acknowledges the importance of the interplay between the individual and the environment, and considers multi-levelled influences on unhealthy behaviour. The importance of the individual is thus to some extent de-emphasized in the process of behaviour change. This theoretical "reminder" is especially important when designing programmes that teach new skills/behaviour to indivuals. Without creating a behaviour-change friendly, accepting (or at least tolerant) social environment, individual behaviour change will be significantly obstructed.

4.3 Prevention of health risks related to psychoactive substance use (including alcohol use): Effectiveness of existing strategies

Based on a substantial review of current literature on prevention of harm (including illness) associated with psychoactive substance use (Hawks, Scott & McBride, 2002), the following generalizations may be made as to the effectiveness of existing preventive strategies:

The *regulation of the physical and economic availability* of alcohol is a significant intervention aimed at reducing alcohol consumption. Increasing the costs of alcohol has been found to be one of the most effectvie though least popular means of reducing problems associated with alcohol. Increases in availability generally lead to higher consumption. However, it is useful to distinguish between consumption in general and risky consumption. Nevertheless, these two forms of consumption are strongly related as is shown in an increase of both when alcohol becomes more available. To reduce drinking, multiple targeted programmes should be introduced. This is obvious from the finding that the introduction of zero blood alcohol tolerance in drivers resulted in the reduction of the proportion of young drivers involved in motorcar accidents, but failed to reduce general or even risky consumption in other environments. Furthermore, the regulation of the physical and economic availability of *illicit psychoactive substances* by means of policing has been found to affect mostly the shape of the market, the purity of the substances available and their price, but has as yet not been able to eradicate the problem. The use of the *mass media* on its own, particularly in the presence of countervailing influences, has not been found to be an effective way of reducing different types

of psychoactive substance use. It has however been found to raise information levels and to lend support to policy initiatives. Combined with reciprocal and complementary community action, particularly environmental changes, media campaigns have proven more successful in influencing attitudes towards psychoactive substance use. Health warnings associated with licit psychoactive substance use have been an effective way of communicating the hazards of such use, particularly to heavy users and when combined with other economic and environmental initiatives. A media production may include health advocacy that enhances incentives as well as removes disincentives for healthy behaviour. Bans on the broadcast of alcohol advertisements have been shown to be associated with lower per capita consumption. Thus, any reduction in psychoactive substance use advertisements may be expected to contribute to a reduction in consumption.

Scare tactics in media messages are usually ineffective, except for audiences who are little aware of the problems connected to substance use; with high-awareness audiences, strategies modelling beliefs about non-use or normative use seem to work better.

Changes resulting from *community-based interventions* were observed more often than changes resulting from health-oriented policies and increased knowledge. All such community initiatives, however, need to be supported by the relevant community agencies. A decisive aspect of success is the involvement of key stakeholders of the community and participatory development of the programme. Links with governmental and non-governmental programmes may increase the effects of community programmes.

For *school-based interventions* there is evidence that programmes aiming at abstinence consistently fail to produce behavioural effects, suggesting that there is a need to develop programmes with outcomes other than abstinence as their goal. School programmes must match the developmental psychological phases. Basically there are *three critical periods***:** (1) the inoculation phase (before real substance use begins); (2) the initial exposure period; and (3) the later period of increasing consumption. *General health/life skills programmes* can produce greater change than programmes that teach skills to avert substance use only. It is thus necessary to provide teachers with professional training on health/life skills. The knowledge provided to students must be "utility" knowledge, i.e. knowledge directly linked to, for example, the negative effects of alcohol use. The main focus, however, should be on behaviour change—not knowledge and attitudes. Education should be interactive and invite students to create and discuss their own opinions and attitudes.

4.4 General preventive focuses arising from the empirical study

As suggested by the pre-project review of literature on alcohol use-related sexual risk behaviour with regard to the contraction of STI/HIV, the results of the analysis of the empirical data collected in the eight project countries underline the importance of multi-levelled and multi-perspective preventive programmes. Such programmes need to have an individual and/or a specific culture/country perspective as well as a cross-cultural/cross-country perspective. Consideration also has to be given to sociocultural, psychological and environmental or situational issues such as the following: patterns and settings of alcohol use and sexual behaviour and in particular the risks that these pose for STI/HIV infection; attitudes and beliefs regarding alcohol use and sexual behaviour (including perceptions of risk related to sexuality) within the context of STI/HIV infection; and interactions between alcohol use and sexual risk behaviour.

More specifically, regarding the risks that alcohol consumption poses for STI/HIV infection, prevention initiatives have to take cognizance—to a varying extent across the project countries/regions—of issues such as the following:

1 The manifestation of drinking as "a lifestyle"; as occurring at places (bars, pubs) and times (weekends) when the focus is on such activities (e.g. in the form of drinking competitions); and as being "encouraged in family settings and by peers", particularly in the case of males.

2 The belief that alcohol use is "normal" and signifies "maturity" and, more particularly, "maleness or masculinity"; that beer is a non-alcoholic drink; and that alcohol consumption is "integral in partnership development" and functional in sexual encounters.

Regarding the risks that sexual behaviour poses for STI/HIV infection in the eight countries, preventive initiatives have to address—to a varying extent across the project sites—issues such as the following:

1 A poor understanding of the transmission of STI/HIV, e.g. that HIV infection could be prevented through "cleaning genitalia with alcohol, urine or antiseptic solutions", through "finishing the sexual act quickly", or through "ejaculating 'outside'";

2 Risky sexual orientations, e.g. a tendency to prefer material gain or sexual pleasure to safe sex, and the belief that "condoms reduce sexual sensitivity";

3 Sexual violence against women;

4 Opportunities to engage in casual/commercial sex at public places of entertainment;

5 Inadequate access to condoms; and

6 An increase in traditionally tabooed sexual practices.

The metanalysis, furthermore, draws attention to the importance of preventive initiatives taking cognizance of the social process of sexual "liberalisation" that prevails to a varying degree in the project countries, and which is facilitated by increased travelling and the (electronic) media as well as free time. The process is characterized by changing values/ attitudes and practices with regard to sex, such as increased tolerance of practices such as multi-partner sex (e.g. extramarital partnerships) and casual sex, and a regard for "sex and sexual pleasure" as "the most sought after pleasures".

Preventive initiatives also have to note the key patterns of alcohol use-sex interaction that emerged in the course of the metanalysis. These patterns relate to the following issues that are consistent with the issues noted in earlier discussions: (cultural) acceptance of alcohol as a facilitator of sexual encounters and maleness, and/or a reliever of sex-related stress, and/or an enhancer of the sexual experience, and/or an excuse for irresponsible behaviour such as risky sex; the use of alcohol-serving venues as contact places for sexual encounters; and the promotion of alcohol use at venues catering for pornography.

Finally, cognisance needs to be taken of the finding that a wide variety of conceptualizations of risk related to sexuality exist in the project countries, with an individual's subjective conceptualization of risk (e.g. unwanted pregnancy, STI, or losing a partner) significantly correlating with his/her willingness to engage in "safe" sex, indeed with his/her behaviour-change potential.

4.5 General strategies for preventing alcohol use and sexual behaviour risks for STI/HIV infection

Against the background of the results of the metanalysis, the following generalizations seem appropriate with regard to the development of strategies for preventing alcohol and sexual behaviour risks for STI/HIV infection:

1 In countries with a traditionally strong Christian religion (e.g. Romania, the Russian Federation, Belarus) and currently undergoing rapid social change (recovering from the

communist totalitarian period when sexuality and intimacy were not publicly discussed) there is insufficient public discourse on the intimate aspects of the liberated forms of sexuality such as casual and non-marital sex. Parents and teachers refrain from offering advice on these issues, as the topic is tabooed and constructive education on healthy/safe casual and non-marital sex is absent. Thus there are only "prohibitory" regulations focusing on marital sex as a norm, which regulations are irrelevant to the current reality of young people's sex life.

2 Before any preventive efforts are put in place, the context in which sex and psychoactive substance use coincide and varieties in these behaviours should be thoroughly analysed. The preventive efforts must be informed in the following three areas in order to match the particular population/behaviour (Bell, 2002:293-303):

- Exhaustive knowledge on the behaviour patterns of sexual partners, e.g. regarding first intercourse, the selection of a partner for marriage, casual sex, multiple partners, commercial partners (e.g. who drinks with whom and why);
- Full-scale mapping of the content of sex and substance use (e.g. vaginal, oral, anal, heterosexual, MSM, commercial sex, loving relationship involved or not, drinking what, where, when); and
- Knowledge on the subjective meaning of sex (e.g. for pleasure, for procreation, for power/status, for pleasing the partner), and reasons for drinking (e.g. for pleasure, out of sorrow, habit, addiction).

The above generalizations and the earlier review of theories of behaviour change as well as strategies for preventing psychoactive substance use suggest the following decision-making matrix (Table 13) as guideline for developing interventions with regard to the prevention of alcohol use-related sexual risk behaviour with regard to STI/HIV infection. It is essential to bear in mind that the matrix offers only a broad framework for designing interventions and, thus, will have to be adjusted to the conditions in a particular region or community at a particular point in time. Consideration also has to be given to the particular preventive strategies recommended by the research partners in the project countries and noted in the conclusion to this chapter.

Table 13: Framework for developing interventions related to alcohol use-related sexual risk behaviour regarding STI/HIV infection

Issue to be addressed	Reason	Recommended intervention/messages	Matching theory/model
Commercial sex—clients	Without protection	Campaign with well-known personae	Diffusion of Innovation Theory
Commercial sex workers—"professional"	Without protection and with alcohol	Peer-group workshops, promoting self-protection and building skills for assertive safe sex negotiation	Theory of Individual and Social Change or Empowerment Model; Social Networks Theory
Commercial sex workers—"occasional/amateur"	Without protection and with alcohol	Preventing this form of "unwanted" commercial sex work by rendering institutional social support to underprivileged and disadvantaged women/mothers	Theory of Structural and Environmental Factors
Casual sex	Without protection and with alcohol	Addressing the values of sexuality, partnership and parenthood in public	Social Networks Theory; Social Ecological Model of Health Promotion;

Issue to be addressed	Reason	Recommended intervention/messages	Matching theory/model
		discourse; providing sexual education (schools), teaching skills to resist male pressure and emotional and material blackmail; running campaigns and involving popular personae	Diffusion of Innovation Model; Theory of Gender and Power
Casual sex—MSMs	Without protection	Promoting safer sex; campaigns with famous personae	Social Networks Theory
Sexual debut	Without protection and with alcohol	Prevent peer pressure towards sexual debut; address values of sexuality; provide secular health and culture-oriented sexual education (school)	Social Influence or Social Inoculation Model; Theory of Gender and Power; Social Ecological Model of Health Promotion
(Marital) sex with risky partner	Extramarital unprotected sex among (mainly male) partners, which endangers spouses	Public campaigns to highlight power differences between men and women and dependence of women; workshops for women should empower them and increase awareness and skills	Theory of Gender and Power; Theory of Individual and Social Change or Empowerment Model
(Marital) sex with violent partner	Traditional tolerance of man-to-woman violence; conceptualization of women as "sexual servants" to please the partner any time; economic dependence of women	Public campaigns to highlight power differences between men and women and dependence of women; workshops for women should empower them and increase awareness and skills; campaigns against domestic violence with celebrities to increase public awareness and thus facilitate individual behaviour change	Social Ecological Model of Health Promotion; Theory of Gender and Power; Theory of Individual and Social Change or Empowerment Model; Diffusion of Innovation Theory
Family planning/sexual health in general population	Traditional barriers to family planning, negotiating sexual health issues between spouses/partners	Creating a macro discourse in society about sexual health itself, about health promotion, protection, family planning, facilitating conditions for individual behaviour change	Social Ecological Model of Health Promotion
Entertainment venues/settings (including drinking places); general employment conditions in country	Opportunities for risky sex	(Government) mechanisms (e.g. policy) for facilitating the institution of entertainment structures that promote health; constructive employment initiatives	Theory of Structural and Environmental Factors

4.6 Preventive recommendations offered within project countries

Although the results of the analysis of the data collected in the empirical study in eight countries and four world regions on alcohol use-related sexual risk behaviour regarding STI/HIV infection underline the importance of devising general and cross-country/ cross-cultural preventive strategies, the results at the same time remind preventive agencies to tailor preventive initiatives in terms of the particular circumstances in countries. It, thus, seems

appropriate to note the preventive recommendations offered within the respective project countries. In fact, participating researchers in the project countries offered the following country-specific preventive recommendations and comments, based on the findings of the empirical study:

Belarus

1 Civil marriage should be "recommended" as a feasible model of monogamy. (This recommendation is based on the argument that civil marriage is an alternative to church marriage, which induces risky sexual behaviour through the prohibition on condom use.)

2 Alcohol advertising and particularly the message that having a good time—even finding a partner of one's dreams—go hand in hand with alcohol use.

3 The social acceptance of alcohol-intoxicated persons needs to be addressed.

4 "Celebration" needs to be disconnected from alcohol consumption, especially the practice of "binging for three" at all festive occasions (personal, family, public).

5 Free and anonymous venerological services should be introduced in order to prevent non-treatment of venereal infections among sex workers.

6 The extremely restrictive attitudes and opinions regarding sexual behaviour among education, health and security agencies need to be addressed (simultaneously with running health promotion programmes for young people) if positive change in sexual health is to be achieved. The restrictive attitudes contribute to promiscuity ("sex for the sake of satisfying one's desires") among young people, indeed towards young people being misinformed as to what constitutes appropriate/healthy sexual behaviour.

7 The macho construction of maleness (e.g. the view that "it is prestigious to have several partners, especially for a man") needs to be addressed.

8 Sex education needs to be broadened to education on family life/relationships ("start teaching subjects related to family life in secondary school and stop teaching sexology"), and commercial sex work should be strictly controlled ("establish control over the sphere of prostitution").

9 Family-planning clinics, providing both medical and psychological assistance to young people, have to be established.

India

Within the broader framework of the National AIDS Control Organization of the Ministry of Health, emphasis should be placed on the establishment of school and community-based prevention (non-) government programmes, focusing on:

1 health and sex education, inter alia addressing the link between risky sex and psychoactive substance use (including alcohol use);

2 promotion of condom use among males and females within risk groups (commercial sex workers, transport workers, migrant populations, and psychoactive substance users) as well as the general population;

3 anti-needle-exchange programmes in some parts of the country.

Kenya

1 Young people should be educated on sexual risk prevention and this should be the responsibility of the family (e.g. parents) and the school (e.g. teachers).

2 Health risk education programmes for commercial sex workers are needed, especially since such programmes among these individuals have been effective. (Female commercial sex workers who passed an HIV prevention programme, for example, refused sex if the partner refused to use condoms.)

3 The myth that a married partner is (sexually) safe needs to be addressed/ challenged in educational programmes. The focus should be on young people and especially women.

4 As condoms are expensive, easier access should be facilitated.

Mexico

1 As peer pressure is a signifcant trigger for alcohol drinking, the psychological maturity of the adolescent personality is of crucial importance; a person with low self-esteem, with an urgent need to be accepted/loved by someone, or with any other psychological frustration, has less capacity to resist peer pressure. This finding is consistent with results from other studies (Popper et al., 1998) and supports general psychological knowledge on individual risk-behaviour management. Therefore, health promotion efforts need to consist of two very distinct branches:

- Specific approaches addressing particular issues (e.g. alcohol risk, sexual risk); and
- General educational efforts to increase the psychological maturity of young people and provide special support to the underprivileged strata of the population.

2 A shift of focus is required from "homosexual men" to "men having sex with men" (MSMs) because numerous men do perform sex with men even though they do not regard themselves as homosexual.

3 The preventive measures need to focus on especially security/safety promotion, and only after that on condom use promotion and more liberal environments for homosexual entertainment.

4 Schools should give more information on harm related to psychoactive substance use.

Romania

1 Men's unwillingness to use condoms (as in other countries) needs to be addressed.

2 Preventive efforts need to build on the positive outcomes of previous campaigns regarding condom use, and especially the emerging willingness of at least young women to carry condoms.

3 The belief that "women have a stronger censor than men and for this reason their behaviour under the influence of alcohol is not so disturbed" needs to be addressed.

4 Irrationality and superstition need to be addressed, and in particular the strong belief—mainly among the male population—that all problems related to sex (STIs, unwanted pregnancy) are due to fate and bad fortune, as this belief operates as an excuse for irresponsible behaviour and leans on female rationality and care.

5 The belief in the mediating role of alcohol use in sexual intercourse needs to be addressed, and in particular the issue of alcohol being an accompaniment in all stages of a partner relationship—in courtship, during dating, asking the partner to marry you, engagements, weddings, ceremonies and in negotiating commercial sex (e.g. when a man invites a woman for a drink, accepting the drink may be interpreted as agreement towards a sexual relationship).

6 The "main barrier to safe sex in Romanian culture is the mentality to preserve the natural

way of doing". Moreover, some people consider it easier to quit alcohol use than change sexual behaviour. Cognizance needs to be taken of the following belief: "Propaganda [health promotion] is for gentlemen, i.e. well-educated people who work in offices and have a good salary ... It is difficult to change habits of individuals if they do not change their life or jobs."

7 In schools a curriculum on sexual education should be introduced.

8 HIV awareness should be raised by public campaigns.

9 Information centres for prevention of sexual risks and promotion of safe sex should be set up.

10 Professionals should be recruited and trained for work in schools, information centres and prevention programmes.

11 Research programmes should be supported.

The Russian Federation

1 The issue of pornographic films that promote alcohol use before sex needs to be addressed.

2 The family, school and church should cooperate with regard to sexual matters, with special attention being given to value system differences among these agencies (e.g. the fact that the Orthodox Church opposes condom use).

3 The conception that safe sex is equal to preventing pregnancy needs to be addressed.

4 A variety of educational initiatives are recommended, e.g. the provision of ethical education with the aid of films (movies) and books, ensuring that parents set an appropriate example, and ensuring "moral education".

5 The following sources of health risks need to be addressed:

- Use of alcohol
- Non-use of condoms
- Numerous sexual partners
- Casual partners
- Sex with prostitutes
- Sex with STI patients
- Practising oral, anal and group (unprotected) sex
- Early start of sexual life
- Little knowledge of risk factors

South Africa

1 There is a need for government-supported initiatives towards establishing health-promoting recreational opportunities.

2 Preventive programmes need to focus on poverty alleviation, "sugar mummies", and the social acceptability of heavy alcohol use or binge patterns of drinking as part of a city lifestyle.

3 More employment opportunities are needed (seen as the best way of overcoming drinking problems, as drinking seems to be a way of coping with difficult times).

Zambia

1 Commercial sex workers should be economically empowered. (Cognizance is taken of the fact that sex work in Zambia is presumably still not part of "organized crime" and more than 50% of sex workers still work without pimps. This is an advantage, as safety measures can be introduced without being "contaminated" by pimp dependence and power abuse. In Zambia 55% of sex workers are also known to be willing to stop sex work if they can find a job or start another business. Also, 25% would stop sex work once they get married.)

4.7 Research methodology: Recommendations

Analysis of the actual research process in the project countries highlighted the usability of the methodological premises that directed the process. However, the following reminders to future users are appropriate:

1 Existing knowledge on the subject (sexual risk) points to the need for researchers to focus on a *wide range of persons/groups* vulnerable to sexual risk, instead of concentrating on, for example, commercial sex workers and young people.

2 The overall qualitative approach to data gathering and analysis requires researchers to be *open to new and unexpected questions* arising during research.

3 The qualitative research approach implies that special care needs to be taken to *record the discursive material* on which analysis is based and not to lose this material in the reporting of analysis results, e.g. by reporting identified categories of data in terms of percentages. Where machine recording is prohibited for confidentiality reasons, a useful approach is the drafting of case vignettes (e.g. in focus group discussions).

4 Care must be taken to *respect the right of interviewees*/respondents to confidentiality, indeed to not feeling "threatened" by having to divulge (in detail) personal experiences and views to "strangers" and peers. Researchers, for example, need to take care not to ask participants in focus group discussions to talk about "what they personally would do".

5 Data collection and analysis should strive towards optimal and systematic exploration of the subject (e.g. in the integration of the data), while taking care to avoid biased recording/interpretation (e.g. researchers need to avoid imposing personal views and particularly values onto the data; they should strive towards *ethical "neutrality"*).

6 Concerning research *instruments*, and in view of developing integrated knowledge, an *interactive approach* should be followed in the use of multiple methods/data sources, with individual instruments informing one another (e.g. using the information of the interviews and observations to design a survey instrument). In this respect care must be taken to synchronize the choice of instruments, e.g. in terms of persons/groups sampled.

7 In the use of in-depth interviews, the emphasis should be on *depth rather than width*, i.e. on exhausting the categories that emerge in the course of the interviews.

8 As the aim in focus group discussions is to gain insight into the nature and social construction of behaviour norms, interviewees should *include representatives of the target population* (young people) and not only agents/agencies working with young people in the area of risky sexual behaviour and alcohol use.

9 Care must be taken to *avoid inhibiting open discussion* in focus group context through (1) rigid pre-structuring that prohibits the introduction of discussions during the administration of self-completed questionnaires, and (2) including persons in treatment in discussions (besides ethical reservations, the sensitivity of the subject can be expected to inhibit truthful responses).

10 In the analysis of data, researchers need to be sensitive to the identification of *behavioural patterns around three distinct degrees of risk*: significant risk, risk and minimal risk.

4.8 Closing remarks

Against the background of HIV/AIDS being at present the leading cause of death in sub-Saharan Africa and the fourth-biggest killer globally, and indications that alcohol consumption and sexual behaviour have the potential to increase vulnerability to HIV/AIDS, the present project deepened insight on the subject.

The link between alcohol consumption, sexual behaviour and STI/HIV infection was shown to be complex. Apart from various alcohol use and sex-related issues in themselves posing risks for the contraction of STI/HIV infection, these risks were intensified by various interactive links. Alcohol consumption not only presented as a "precursor" of risky sex, but also as an outcome of it. Furthermore and as expected, the results showed that the social dynamics that surround alcohol use-related sexual risk behaviour require alternative ways of dealing effectively with the problem in diverse sociocultural settings, besides cross-cultural initiatives. The importance of a public health preventive emphasis was underlined, i.e. a concern with individuals as well as the environment (settings) within which these individuals find themselves. The contextual dimensions of alcohol use-related sexual risk behaviour also underlined the importance of developing research-based preventive initiatives.

Finally, numerous more specific recommendations for health promotion and prevention of alcohol use-related sexual risk behaiour have been extracted from the findings of the study. These, however, have to be translated into effective preventive action, e.g. preventive media messages, campaigns and regulations. The process of developing and testing the methodology to study factors related to risky sexual behaviour among alcohol users in diverse cultural settings has also been completed. The methodology proved to be useful, apart from pointing out areas that require improvement such as (a) the provision of additional training to fieldwork teams in (selected issues of) qualitative research design and methods, if required; (b) close coordination of activities before and during the fieldwork, including efforts to ensure regular contact between participating partners/teams; and (c) close coordination of the process of analysing the qualitative empirical data.

REFERENCES

Auerbach JD, Wypijewska C, Brodie KH. editors (1994) *AIDS and behaviour: An integrated approach*. Washington DC, National Academy Press.

Bell R. (2002) Unconventional sexual lifestyles. In: Miller D, Green J. editors. (2000) *The psychology of sexual health*. Oxford, Blackwell Science.

Blaikie N. (2000) *Designing social research*. Cambridge, Polity.

Dubois-Arber F, Carael M. (2002) Behaviour change for STD prevention and sexual health. In: Miller D, Green J. editors (2000) *The psychology of sexual health*. Oxford, Blackwell Science.

Fishbein M, Bandura A, Triandis HC, Kanfer FH, Becker MH, Midlestadt SE, Eichler A. (1992) *Factors influencing behaviour and behaviour change: Final report—Theorist's workshop*. Rockville MD, NIMH.

Hawks D, Scott K, McBride N. (2002) *Prevention of psychoactive substance use: A selected review of what works in the area of prevention*. Geneva, World Health Organization.

Kegeles SD, Hays RB, Coates TJ. (1996) The M-Powernent project: A community-level HIV prevention intervention for young gay men. *American Journal of Public Health*, 86:1129-1136.

Mason J. (1996) *Qualitative researching*. London, Sage.

Murray CJL, Lopez AD. editors. (1996) *The global burden of disease—a comprehensive assessment of mortality and disease, injuries and risk factors in 1990 and projected to 2020*. Cambridge, Harvard University Press.

NACO. (2002) *National Behavioural Surveillance Surveys (Female sex workers and their clients; MSM & IDU)*. New Delhi, Ministry of Health and Family Welfare.

Popper M, Bianchi G, Lukšík I. (1998) Sociálne ospravedlnenia rizikového sexuálneho správania. In: Sarmány-Schuller I, Košč L, Jaššová E. editors. *Človek na počiatku nového tisícročia*, SPS, ČMPS, MOSR, Bratislava, 1997, pp. 109-111.

Reddy SP, Meyer-Weitz A. (1999) *Sense and sensibilities: The psychological and contextual determinants of STD-related behaviour*. Tygerberg, Medical Research Council.

Riley L, Marshall M. (1999) *Alcohol and public health in 8 developing countries*. Geneva, World Health Organization.

Saxena S. (2000) Alcohol problems and responses: Challenges for India. *Journal of Substance Use*, 5:62-70.

Sweat M, Dennison J. (1995) Reducing HIV incidence in developing countries with structural and environmental interventions, *AIDS*, 9(Supplent A):225-257.

UNAIDS, WHO. (2001) *AIDS Epidemic Update 2001 revised*. Geneva, UNAIDS/WHO.

UNAIDS, WHO. (2002) *Report on the global HIV/AIDS epidemic, 2002*. Geneva, World Health Organization.

World Health Organization. (1999) *Global status report on alcohol*. Geneva, World Health Organization.

World Health Organization. (2000) *The Rapid Assessment and Response Guide on Psychoactive Substance Use and Sexual Risk Behaviour*. Geneva, World Health Organization.

Annex One

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

INTRODUCTION

This annex provides an overview of the methodological premises—and the underlying theoretical-epistemological assumptions—that directed the empirical studies in the eight project sites. These guidelines facilitated the standardization of the fieldwork procedures—at least generally—and thus comparisons of datasets across the research sites. However, in the development of the guidelines cognizance was also taken of the particular conditions within the respective project countries.

The annex is divided into the following five sections:

1 Section A: an outline of the methodology that guided the empirical studies in the project countries;

2 Section B: the theoretical-epistemological premises that anchored the methodology;

3 Section C: prototypical examples of the main subject of the study, namely behaviour patterns, which were expected to manifest on a general (cross-cultural), cultural, social as well as individual level;

4 Section D: another expected research "product", namely the subjective meanings that research participants attached to a key concern in the study, namely the concept of "risk" within the context of HIV/AIDS, sexual behaviour and psychoactive substance use;

5 Section E: examples of informed consent sheets that research participants were expected to complete to ensure ethically responsible research.

Section A

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

World Health Organization
Department of Mental Health and Substance Abuse

Acknowledgements

The World Health Organization (WHO) acknowledges the contribution of Dr Gabriel Bianchi of the Department of Social and Biological Communication, Slovak Academy of Sciences, Slovakia, in drafting these guidelines. The sustained commitment to this project of all principle investigators in the eight participating countries is also gratefully acknowledged.

Secretariat

Dr Shekhar Saxena Coordinator, WHO MSD/MER

Mrs Mwansa Nkowane Technical Officer, WHO MSD/MER

Background

The social dynamics that surround alcohol use-related sexual risk behaviour warrant a search for alternative ways of dealing with the problem in diverse sociocultural settings, if the problem is to be addressed effectively. Sexual risk behaviour accounts for a large number of opportunities for the acquisition of HIV infection, and alcohol use has been shown to increase risky sexual behaviour. It is therefore important to establish what enhances alcohol use-related sexual behaviour that could result in the acquisition and transmission of HIV infection. The body of knowledge acquired through scientifically sound research methods will not only highlight the relevant **preventive measures** to be adopted but will bring out relevant clinical and experimental research questions for all disciplines interested in curbing the problem of alcohol use-related sexual risk behaviour. International collaboration in this project is expected to promote the exchange of knowledge and experience that are required to design and test intervention instruments based on culture-sensitive studies.

Project design

The project design involves four phases:

1 Concept clarification and item generation;

2 Development of research instruments;

3 Consolidation of methodology; and

4 Research application to intervention development.

Overall objective

The overall aim was to itemize possible predictors and/or contributors to alcohol use-related sexual risk behaviour in order to develop a methodology for studying them in diverse cultural settings.

Introduction to the methodology

The methodology was meant to facilitate work on the second phase of the project, which involved use of *qualitative methods among some groups of predisposed persons in an attempt to identify specific factors related to alcohol use-related sexual risk behaviour, as well as to clarify concepts***.** Please note that the envisaged ultimate outcome of this project is an integrated document on the methodology for studying factors associated with alcohol use-related sexual risk behaviour in diverse cultural settings. Although it was anticipated that there would be some cultural variations in the various settings, the basic foundation of the process was meant to be similar in all participating sites. In terms of the overall objective of the project, the guide is aimed at facilitating the process of:

1 Exploring collective views about cultural conditions;

2 Determining communication patterns in the community, and the language used in respect of the topic under study;

3 Gathering basic knowledge about aspects of cultural conceptualizations on alcohol use relative to risky sexual behaviour;

4 Identifying key social contexts in which beliefs and values are turned into actions, and establishing conditions that strengthen the risk factors or encourage protective factors;

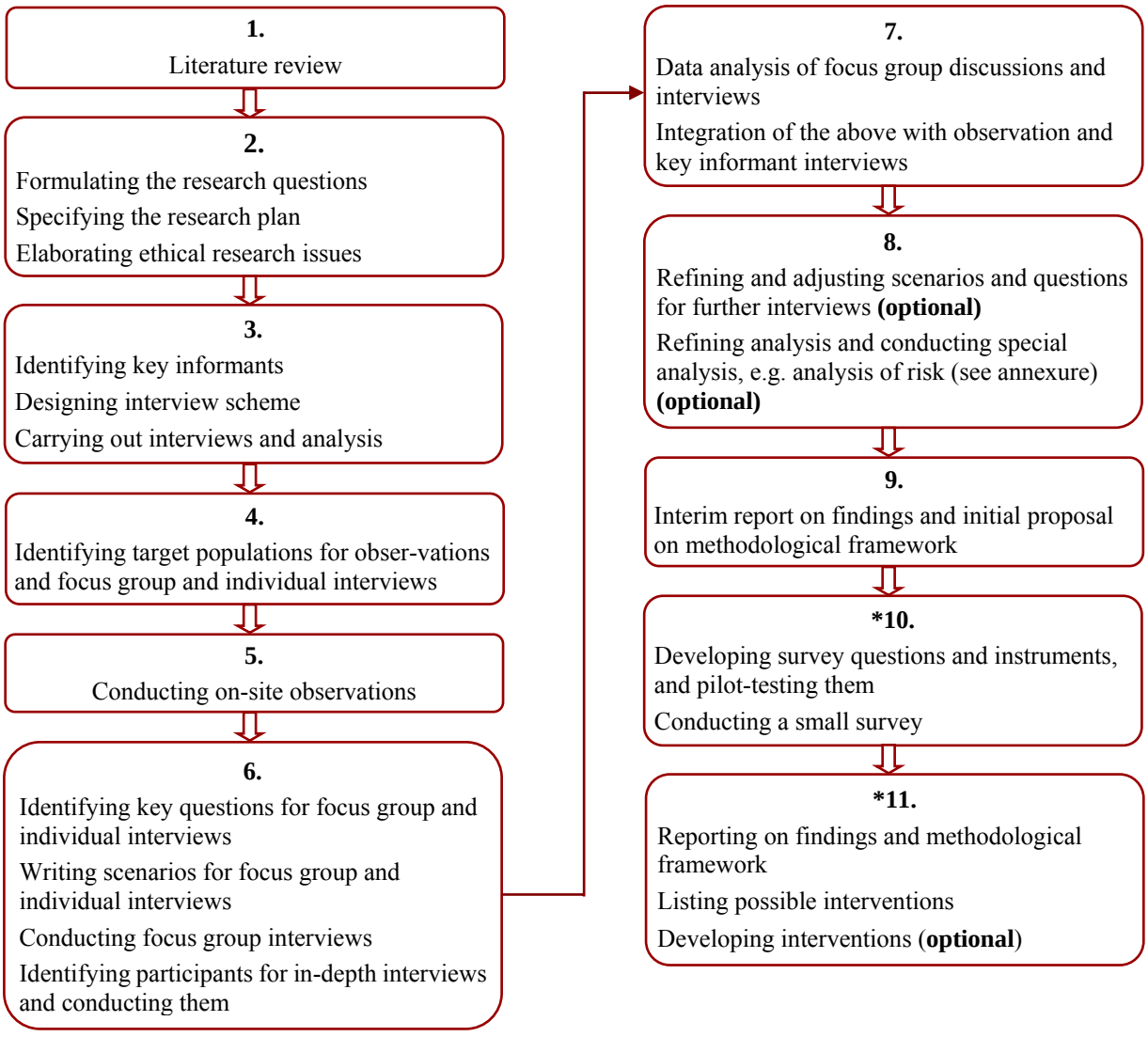
5 Determining the key symbolic and communication conditions imposed by cultural systems that relate to health behaviour, behaviour change and decision-making; and

6 Developing a conceptual framework as well as determining the structure and relationships among elements of that conceptual domain.

To review the theoretical basis of this process, see Section B of this annex.

The main steps/activities

The flow chart* below illustrates the general activities involved.



* Please note that this flow chart includes the survey, but the qualitative data-gathering phase of the work could be completed in step 9. Further direction needs to be given with regard to steps 10 and 11.

The formulation of research questions

The research questions **(**RQs) address the current actual state of the problem in theparticular cultural and social settings of concern. (Why do young people drink? Who do young people drink with? What do they do after drinking?) The literature review should help answer the following **general questions that concern the assessment**:

1 What "area" of alcohol use will be studied? (Regular users, occasional users, addicts or …?)

2 Which types of sexual behaviour will be studied? (Casual sex, commercial sex, marital sex or …?)

3 Which type of risk to health will be studied? (Unplanned pregnancy, HIV/STI, rape, violence, pressure to have sex, psychic terror or …?)

4 Which alcohol-sex interactions will be studied? (Effects on: pressure, condom use, satisfaction, STI/HIV infection, unplanned pregnancy, violence or …?)

5 What is the target population for the project? (Young people in general, a specific target population, alcohol addicts, unemployed people, persons of a particular education level and social "class" or …?)

* Please note that all population groups are to be subjected to these considerations. The study needs to focus on not only one population group but on a variety of alcohol users within a given cultural context/site.

Examples of **possible RQs** for this project:

1 What are the most risky interactions between alcohol use and sex?

2 How can these interactions be prevented or positively challenged?

Recommended framework for RQs for this project:

1 What are the general, cultural, social and individual patterns of risky sexual behaviour including alcohol consumption?

A detailed explanation as to why behaviour patterns need to be studied is given below.

Behaviour patterns

Behaviour patterns are an extremely useful framework for any behaviour-change oriented initiative. Compared to just measuring traditional psychological variables as attitudes or motivation, behaviour patterns are complex expressions of cognition, emotion, attitudes, values, skills, social relationships, moral aspirations, etc. Moreover, they also express the dynamics of human behaviour—decision-making, self-reflection, satisfaction, etc.

There are at least four levels of **behaviour patterns that need to be taken into account: individual, social, cultural and** "**general**" (examples are also given in Section C). These four levels overlap to a large extent. The distinction between them is driven mainly by the need to get a more schematic view upon which responses/interventions may be designed. The four levels of behaviour patterns are shown in the box below.

"General" behaviour patterns represent scenarios of relevant behaviour (e.g. alcohol consumption patterns related to sexual behaviour) that are applicable to a wider population, including various cultures/sub-cultures. At this level the patterns relate more to specific aspects of risky/unhealthy behaviour that may be observed in a country (e.g. alcohol use is included in all celebrations; whether to drink or not is decided by men; it is impolite to refuse an alcoholic drink; erotic initiative is expected to come from men).

Cultural patterns express scenarios of relevant behaviour that are typical for particular cultures/sub-cultures (ethnic, regional, ideology-based groupings, etc.), e.g. the marital partner is selected by the parents; sexual education is absent or restricted; strict role-division occurs between spouses; tolerance of certain forms of sexual pressure exerted by the husband; alcohol use considered as an excuse for violence; serial monogamy as a cultural norm of "moral" behaviour, etc.

Social patterns express scenarios of relevant behaviour that are typical in particular social settings, in which people may be, or have to be, involved (school, youth organizations, the military, work, sport clubs, etc.), e.g. ritualized grief (group drinking after the girlfriend of one of the soldiers deserts him); celebrations in sport clubs; "initiation" rituals in youth groups; indirect teenager peer pressure to have sex; and drinking in the workplace as a sign of obedience to the authority offering the drinks.

Individual patterns express relevant behaviour—typically comprehensive, although virtual "cases" also occur. The material for drawing an individual pattern does not necessarily come from just one participant. It is more the focus on the individual that makes this level of pattern an individual one. An individual pattern may synthesize facts for several similar participants in order to make a strong illustration of what a risk-taking/safety-conscious individual is like. The usefulness of these complete individual "stories" lies in their illustrative potential. They can be used as images of typical behaviour when communicating health-promoting messages to the public (e.g. first intercourse without condom and under influence of alcohol; engaging in casual sex with the first possible partner after being left by boyfriend; perceiving the proposal of a sexual partner for condom use as proof of being unreliable).

Apart from identifying risky behaviour patterns (at all four levels), the identification of **positive behaviour patterns** is also important. The identification **of risky patterns** is mainly aimed at itemizing factors that predict and/or contribute to alcohol use-related sexual risk behaviour. Risky behaviour patterns are also **useful indicators of a need for particular preventive measures, interventions and services, and of where intervention is needed.** On the other hand, **positive (low-risk) patterns are useful** for disseminating, promoting and facilitating positive forms of behaviour. Both types of patterns—risky and positive—should be looked for.

In order to facilitate the identification of particular "items" of behaviour that may be observed in the abovementioned patterns, a list of possible items is provided in Table 1. These items may point to cultural and contextual differences within and/or between research sites. As the list of items is not exhaustive, you are invited to add those items you identify during the study.

Table 1: Possible behavioural factors

Possible items to be identified in:	General behaviour pattern	Cultural behaviour pattern	Social behaviour pattern	Individual behaviour pattern
Number of sexual partners	Yes	Yes	Yes	Yes
Casual sexual partners–if ever had	Yes	Yes	Yes	Yes
Number of casual sexual partners within last 12 months		Yes		Yes
Cultural acceptance of extramarital sex		Yes		
Drinking alcohol before sex	Yes			Yes
Drinking alcohol before last casual sex				Yes
Condom use in steady relationships	Yes			Yes
Condom used in last casual intercourse				Yes
Rejecting condom use				Yes

Possible items to be identified in:	General behaviour pattern	Cultural behaviour pattern	Social behaviour pattern	Individual behaviour pattern
Warranties/excuses for non-use of condoms	Yes	Yes		Yes
Talking with sexual partner about protection BEFORE having sex	Yes	Yes	Yes	Yes
Other				

Recommended qualitative methods

The following **methods for data collection** are recommended for use in this phase of the project:

1 Key informant interviews

2 Observations

3 Focus group discussions

4 Individual in-depth interviews

Key informant interviews

A key informant (KI) is a person who has more or less direct access and contact with the target population. A KI may not or may be a member of the target population, or an ex-member. There are many examples—a prostitute, an ex-prostitute. It should be stressed that the KI is not an expert and therefore the information needs to be verified (e.g. by comparing the information of several KIs). This person can provide a significant portion of information and knowledge on the behaviour or the target population, on the rules and regulations within the target population, recommendations on who, how, where and when to recruit participants for interviews and focus group discussions. The KI may either be/remain in a confidential position, or may serve as a bridge between the researcher and the target population. The interviews with the KIs are usually aimed at identifying social and cultural contexts of risk behaviour. This may include specific cultural/sub-cultural norms of what is considered as appropriate behaviour and what is likely "in-group" behaviour. Some examples of possible KIs are:

1 Bar keepers

2 Drug dealers, (ex-) prostitutes, specific alcohol users

3 Medical staff, social workers

4 Teachers, police

*There is no criterion as to the number of KIs to involve. Their number is determined by the number of different positions that can be identified in the relevant social environment. Usually there is no need to have more than one KI of the same category. More important is to enroll as many different KIs as possible. KIs should be interviewed personally. Only when face-to-face interviews cannot take place should a questionnaire with predominantly open-ended questions be applied. Examples of areas to be covered in the interviews are:

Social and cultural context:

1 Habits/practices (patterns) in sexual behaviour—what is considered as appropriate in the target population

2 Gender factors that influence the adoption or non-adoption of protection in a sexual context

3 Habits/practices/usual forms (patterns) of substance use including alcohol—how, when, where, with whom and what in the target population are considered as normal

4 Influence of peer groups with respect to alcohol use and risky sexual behaviour

5 Venues for alcohol use and risky sexual behaviour

Risks:

1 Knowledge of risks and risk perception—sexual risks, risky psychoactive substance use

2 What is considered as "acceptable risk" in the target population

3 Condom accessibility—condom machines, etc.

Intervention:

The main impediments to the introduction of strategies targeting alcohol use prevention and sexual risk reduction.

*It is recommended in this project that at least 10 KIs be interviewed, each from a different category.

Observations

This part of the study is to be conducted through field observations at venues where alcohol use and related sexual risk behaviour occur. These sites may be country specific. The field notes gathered as a result are collated with the data collected from other sources. The observations should take place in the following settings:

1 Venues where alcohol use is likely to take place

2 Venues where opportunities for risky sexual behaviour may occur

*The observations within this project should be scheduled before the focus group discussions (FGDs) and in-depth interviews (IDIs) with individuals (see flow chart on page 6). The role of observation here is to assist in identifying/ specifying the target population and research questions. However, observations may be conducted again after the FGDs and IDIs in order to validate the findings. In this project mainly unstructured observation is recommended. The observer should gain access to the particular venue; for effective observation, unobtrusiveness is crucial. Therefore contact persons need to be approached first, especially if sensitive places (e.g. where commercial sex and illegal trafficking of psychoactive substances occur) are to be observed.

The observation should follow the natural stream of everyday life. The observer should be alert to concepts or categories that appear meaningful to the subjects, broader trends, patterns and styles of behaviour.

*It is recommended that observations be carried out before and after FGDs and IDIs in this phase of the project.

Observation—in an optimal situation—should be performed (repeatedly) until researchers achieve knowledge saturation, that is, when the generic features of their findings consistently replicate earlier ones. Multiple observers or teams, diverse in age and including males and females, are recommended so as to validate observations. The validation may also be achieved by testing emerging propositions against negative cases. In this way grounded and "universal" assertions can be formulated.

Observations need to be recorded—preferably soon after they have been carried out. If multiple or team observation is performed, all observers should complete their own record immediately after the observation without discussing it with other observers. Observations should only be discussed after the recording in order to prevent excision of differing impressions from the body of dominant observations. Some recommendations on WHAT can be observed follow:

1 People involved (who, sex involved, social class, etc.)

2 Types of behaviour

3 Language and/or dialects used

4 Interpersonal interaction

5 Social hierarchy and power structure in the observed community

6 Signals of spontaneous approach towards non-group members/researcher

7 Environment (safety, hygiene, condoms, needles, etc.)

8 Indicators of previous preventive measures and health promotion messages

Focus group discussions

Invite a group of alcohol and non-alcohol users to participate in focus group discussions **(**FGDs). Each group consists of between six and eight participants.

*A total of four FGDs should be conducted per site/country. These discussions are also meant to provide an opportunity to follow up any questions arising from key informant interviews. FGDs should be conducted in an environment that guarantees group confidentiality. Separate male and female and mixed-sex groups are recommended for FGDs; if not possible, mixed-sex groups are the most important.

There are two types of discussion themes:

1 Descriptive issues

2 Dilemmas

*Although it was initially communicated that three FGDs be conducted, we recommend that four be carried out in this phase of the project.

Below are examples of descriptive questions for FGDs:

1 In which scenarios could alcohol use be associated with sexual relations?

2 Why do people drink alcohol before sex?

3 What are the advantages of drinking alcohol before sex?

4 What are the disadvantages of drinking alcohol before sex?

5 What are the facilitators and barriers to practice safe sex?

6 What is the understanding of sexual risk and safe sex?

7 Which intervention approaches to sexual risk reduction are considered feasible?

8 What opportunities for preventive interventions exist?

Creating dilemmas for FGDs:

FGDs are most useful when presenting a dilemma to the group. This “projective” situation stimulates discussion among the participants and helps to expose “below-surface” arguments, expectations, attitudes, myths, etc. A fictitious story or a role-playing exercise may be presented to the participants.

Fictitious story: The story presented below is aimed at stimulating the expression of different aspects of health, sexuality and alcohol use.

Story (read out to the group):

Silvester has served three months as a soldier in the military service. He has a girlfriend Hermina at home, with whom he has been going out for half a year before entering the military service. Since few soldiers have a sufficient level of education in the garrison, the commandant repeatedly puts on duty those who are able to carry out complicated techniques. Silvester is one of those soldiers and except for one furlough immediately after joining the army, he has not been permitted to go home for a visit. During his furlough, Silvester could only see Hermina for a few hours. Hermina's parents are very strict and they would not allow her to visit Silvester because he is too far away and it is dangerous. Once, visiting a pub with his friends, Silvester gets a little drunk. After some time, two girls enter suddenly. They are awfully cold and soaked to the skin. They do not refuse alcohol to warm up and after a while one of them shows interest in Silvester. She asks him to accompany her home and on the way her affection for him arouses him sexually. This leads to spontaneous sexual intercourse without any discussion. The girl manages to whisper, "Be careful."

Ask the following questions:

Needs in the field of sexuality

1 What does casual sex mean to the target population in comparison to sex in a steady relationship?

2 What types/strategies of protection do people from the target population use? What are the differences between people?

3 What is the effect of alcohol/other psychoactive substance ("drug") use on decision-making about protection?

Role-playing exercise: "Suppose you were a boy/girl (from the target population) facing an indirect offer for sex from an attractive girl/boy at a disco party. Both of you have had some drinks and there are no condoms at hand. What would you do?"

Try to focus the ensuing discussion on:

1 How far is risk considered in this situation?

2 What risk-reduction strategies would be used by the "actors"?

3 How could the safety of that sexual encounter be increased?

NOTE: The fictitious story and the role-playing exercise should be adapted to the particular target population in each country.

In-depth interviews

Participants should be selected from the focus groups or the key informants. *Between 10 and 15 in-depth interviews **(**IDIs) should be carried out in each site/country. IDIs are good for obtaining:

1 In-depth information about motivations for the behaviour in question;

2 Insight into decision-making processes and internal conflicts;

3 Subjective evaluations of particular forms of behaviour (satisfaction, feelings of guilt); and

4 Other specific and/or intimate information that participants would not disclose in group

settings or that would be non-ethical to ask in groups.

All IDIs should take place at a venue where confidentiality can be guaranteed. Participants for IDIs may be identified either directly, by snow-balling, or some focus group participants with greater experience or more well-considered opinions may be asked for a follow-up in-depth interview. The interviewers must be trained to respond to any sensitive information volunteered and possible feelings of distress and embarrassment expressed by the participants. If necessary, the interviewer must provide support to the participant or recommend a professional.

*For the purpose of this project we expect at least 10 to 15 IDIs were to be conducted. These IDIs are a natural follow-up to the FGDs and hence very important.

Key areas to be covered by the IDIs include:

1 Reasons (motives) for intercourse

2 Communication before/during/after intercourse

3 Alcohol/other psychoactive substances used before/during intercourse—why, expectations from, real effect

4 Protection during intercourse

5 Satisfaction (each partner separately)

6 Personal history of intercourse

7 Patterns of relationships (casual, steady, combined)

8 Protection used in various situations

9 Alcohol/other psychoactive substances used before and/or during intercourse—why, expectations from, real effect

10 Changes—relation between changes in sexual behaviour and changes in social life

11 Possibilities of introducing safe sex/ condom use in the situations described, according to the experience of the subject

12 Perceived opportunities for preventive interventions

13 Possibilities for negotiating safe sex with the partner, according to the experience of the subject

A note on ethics

These guidelines relate to research on sexuality and alcohol use, both socially sensitive issues. Disclosure of personal information on sexuality and/or alcohol may lead to psychological discomfort or crisis. The IDIs may offer the first opportunity for some participants to talk (and directly think) about these issues. Therefore, the following ethical measures have to be applied:

1 Provide full anonymity to all participants and key informants.

2 Ensure that key informants and participants in FGDs and IDIs sign consent forms.

3 Support participants and their opinions during IDIs and provide a psychologically secure atmosphere.

4 Produce a list of accessible services in respect of sexual health and psychoactive substance use (telephone numbers, addresses, working hours); the list should be offered to participants on request or if they show signs of discomfort.

Qualitative analysis

For the purposes of data analysis and method selection the following two questions are critical:

1 What did we learn by **manifest/descriptive analysis** from the interview text/factual information about alcohol use and risky sexual behaviour? This kind of analysis yields **descriptions** of what was reported by the participants/interviewees. Within the framework of this project the following descriptions may be of particular interest: narratives (episodes) of drinking; narratives (episodes) of sexual encounters; and identification of key issues/concepts in the behaviour patterns of the participants. These key issues may then be subjected to a thematic/conceptual analysis (see further).

2 Why are things being described in this way and what does it mean? This question is answered by means of a **thematic/ conceptual** approach and an **immersion/ crystallizing** approach. Also, if communication patterns are to be studied, **interaction analysis** may be applied. Finally, the analysis may be completed by an **idiographic analysis** (yielding biographic (linear) or trajectory (key) episodes) or interpretative phenomenological analysis (J. Smith). This will produce comprehensive narratives (case studies) of typical behaviour.

Each of the following types of qualitative analysis is to be used to identify all the behaviour patterns (general, cultural, social, individual). In other words, by using descriptive, thematic, immersion, interaction or idiographic analysis indicators of a particular risky cultural behaviour pattern may be identified. However, a particular form of analysis may be more applicable than another for obtaining qualitative material from respectively key informant interviews, observations, focus group discussions and in-depth interviews. Table 2 presents an overview.

Table 2: Applicability of specific types of analysis for obtaining qualitative material

	Descriptive analysis	Thematic/conceptual analysis	Immersion analysis	Interaction analysis	Idiographic analysis
Key informant interview	Yes	Yes	Not much	Not much	No
Observation	Yes	Not much	No	Yes	No
Focus group discussion	Yes	Yes	Yes	Yes	Yes
In-depth individual interview	Yes	Yes	Yes	Yes	Yes

Thematic analysis

The purpose of thematic analysis is to study in more depth particular key issues that may have crucial importance in the development of risky patterns of behaviour. Within this project, key issues might be first alcohol drinking ever; most frequent company for alcohol drinking; casual sexual intercourse when both partners are under the influence of alcohol; and condom use practice in casual sex. Thematic analysis has three aims:

1 Categorization of various types of a particular behaviour;

2 Identification of links to other issues/ concepts, e.g. which type of company for drinking is connected with which type of condom use in casual sex; and

3 Determination of why particular types (i.e. categories) of the particular behaviour occur.

Why particular types of the particular behaviour occur should be determined by disclosing the following:

1 **General, cultural and social specific patterns of behaviour,** mainly by analyzing the macro aspects of discourse. (Why do people in a specific cultural and/or social setting generally behave in a particular way?)

2 **Individual patterns of risky behaviour** (observable in general, but also in specific settings), mainly by doing a "Verstehen" analysis of discourse. (What is a good example of a particular person behaving in a risky/safe way?)

3 **Individual excuses for unsafe behaviour**, mainly by analyzing the micro aspects of discourse. (How do people excuse their unsafe/risky behaviour?) The excuses may be targeted in preventive messages later on.

Immersion/crystallizing analysis

When applying a rapid research approach, immersion may be unfeasible due to lack of time. However, if time is available, this approach can yield deeper insight into problems and new ideas for intervention/responses. Immersion occurs when you do a repeat, delayed and "untargeted" reading of all transcribed interview material in order to allow unexpected knowledge to surface.

Interaction analysis

This is an analysis of the communication patterns between participants involved in the risky behaviour (e.g. sexual partners). Interaction analysis is aimed at disclosing the dynamism of mutual expectations, offers, pressures, negotiation, etc. It may be performed even if only one partner was interviewed. However, if interaction analysis is required, it should be thoroughly planned in advance of the interview to ensure that the interactions of the participants and their partners are the focus of attention.

Idiographic analysis

Focus group discussions and in-depth interviews should be tape-recorded in order to perform this analysis. The participants' consent for recording the interviews must be obtained (see Section E). For an optimum analysis, full transcripts of the recordings are required. In the transcripts, names must be replaced by symbols and full anonymity of participants must be ensured. After transcription the tapes/minidiscs must be destroyed/deleted.

If material or human resources for transcription are limited, the analysis may be performed also directly from the tapes/minidiscs, although this may pose significant limitations. Transcripts are extremely important if several experts analyze the material to prevent subjective bias. Usually at least the most important segments of the interviews/discussions are transcribed.

Note on reporting of results

All collaborating sites are expected to produce comprehensive reports on the activities and outcomes of this phase of the project. Note that the ultimate aim of this phase is concept clarification and item generation. We propose that the report be submitted in the following general format:

1 **Summary**. To include the scope of the activities, methods used, participants, geographical coverage, findings and major conclusions.

2 **Introduction**. To cover the general introduction to the activities of this phase in detail, including the scope, location and target group and the justification of specific decisions given the particular cultural conditions. Any other preparatory work done should be described, including limitations encountered and attempts to overcome them.

3 **Qualitative assessments**. Each qualitative assessment method used should be given equal weight in describing the use, process, when and on whom it was used, and the specific questions asked.

4 **Analysis and findings**. These should be described for each method used.

5 **Conclusion**. To present the salient features of alcohol use-related sexual risk behaviour pertaining to the cultural and social context under study. The conclusion should also include a table that summarizes the identified factors involved in alcohol use-related sexual risk behaviour in all the groups studied.

6 **Annexes.** These should include all questions asked in each group, all observations made, consent forms used, and any other materials of importance used in the assessment. In addition, there should be a one to two-page proposal on possible survey questions and a suggestion for a target group for the next phase of the study.

Section B

THE THEORETICAL-EPISTEMOLOGICAL BASIS OF THE RESEARCH PROCESS

The overall research process is to be understood as an endeavour to improve the understanding of the issues, their interrelatedness, contexts and consequences (mainly health consequences). With certain reservations, the epistemological concept of this project may be taken to be a quasi grounded theory approach (grounded theory being the paradigm introduced by Glaser and Strauss (1967) in opposition to the deductive positivist way of creating theory and knowledge). Thus an inductive, bottom-up process of stepwise knowledge construction was proposed for this study. During each step evidence should become more reliable, and new and unexpected research questions should arise. To address these, further tools needed to be utilized.

In addition to the theoretical argument for a predominantly inductive approach, the study is supposed to abide by an ontological presumption about the social construction of our being: Important issues in our lives (concepts, norms, expectations, plans, satisfaction, success, etc.) are constructed socially in people's interactions, mainly language interactions.

Qualitative methods/tools (semi-structured interviews, focus group discussions, observations) are recommended for this inductive and social interactionist research; knowledge from qualitative methods is to be extracted by **interpretative** methods and not by statistical methods (which is the case when using quantitative methods). Note that both the participants (whose behaviour is of interest) and the researcher engage in interpretation, which informs the outcome of the research. Interpretative knowledge means:

1. The researcher is looking for **subjective meanings** of issues relevant to the research problem—how participants understand what they are doing and what is going on around them (in relation to health, risk, happiness, pleasure, sex, etc.). As these subjective meanings are expressed in language, a substantial portion of qualitative research is based on analyzing language/dialogue.
2. The researcher tries to understand **how people in their interaction create the network of meanings that constitute their culture and social reality.**
3. The researcher determines **how cultural and social contexts or norms are reflected in people's subjective perceptions, expectations and behaviour.**

This approach matches with the concept of an **emic (idiographic) perspective**, which is the expression of internal, subjective views by actors/participants. This perspective is opposed to the traditional scientific **etic (nomothetic) perspective**, expressing the logic of a theory-derived, empirically verified and (more or less) universally valid knowledge applicable to all. However, through the methodological paradigm of **hermeneutics** the social sciences generally accept both perspectives.

Hermeneutics originates from the interpretation of religious texts, e.g. the Bible. It uses knowledge derived from a theory as well as interpretative work with meanings; researchers are "invited" to use all levels of applicable knowledge in order to understand most adequately the particular issues. They may use everyday/lay theories, scientific theories and narratives collected from participants (from interviews, discussions, observations). The use of theories in a hermeneutic approach is, however, different from the use of theories in a positivist approach.

Hermeneutic researchers do not seek confirmation or negation for a single theory in order to explain a particular issue; in contrast, they critically use, compare and/or integrate several theories (their elements) and find supporting evidence for them in the empirical narratives in order to maximize the understanding of the studied issues. This type of hermeneutics can be best labelled as **phenomenological hermeneutics**, meaning an attempt to understand the meaning of issues (in this case of risky behaviour) by the critical (or careful) use of all accessible sources of knowledge.

The main advantage of using an interpretative epistemology (and within it qualitative methods) is in the **high validity** of the produced knowledge. What we learn by this kind of research (1) is closely connected to real-life issues and (2) can directly be used for designing effective prevention/intervention actions. The frequently doubted reliability of "subjective interpretations of subjective interpretations" may be satisfactorily countered by comparing various sources of information (participants, key informants, documents) and various interpretations of the results by several researchers (in or outside the team). Glaser and Strauss (1967) also support the use of **qualitative methods** by stressing that qualitative instruments are crucially important if we seek to identify *consequences of a particular behaviour, deviations from the norm, processes and systems*; all these are at the core of this research project. Moreover, qualitative methods contribute to the formulation of hypotheses even for quantitative surveys.

The multi-site/multi-culture approach of this research allows for comparative confirmation of evidence and the explanation of (at times) obscure national specifics. Therefore the effect of this study should be maximized by international co-operation—not only technically, but also methodologically and at the level of analysis of empirical materials.

Section C

EXAMPLES OF BEHAVIOUR PATTERNS

The following pages present examples of general, sociocultural and individual behaviour patterns that have been identified within the WHO sponsored SEX-RAR project conducted in the Slovak Republic among soldiers in mandatory military service (MMS) (Bianchi, G. et al., 2000; Bianchi, G. & Popper, M., 2000).

Interaction of psychoactive substance use and sexual risk behaviour

The data obtained from a questionnaire were collated with information gained from focus group discussions and in-depth interviews. The findings on the interaction between psychoactive substance use and sexual risk behaviour, based on qualitative material, are presented in the form of behaviour patterns at three mutually complementary levels:

1 General behaviour pattern during MMS

2 Specific sociocultural behaviour patterns reflecting particular types of military camps

3 Individual behaviour patterns during MMS, compared to civil life before entering MMS

1. Risky behaviour—a general behaviour pattern

A pattern of high-risk behaviour—having unprotected casual sex under the influence of alcohol—was found in less than 20% of our sample of 432 soldiers. However, they nevertheless constituted a significant health risk sub-group, which sub-group is present in all military locations. We therefore treated this as a general behaviour tendency. Soldiers have limited opportunities to visit their steady partner at home or to build a steady relationship with a local partner, and a shortage of opportunities for meaningful leisure activities. This leads to their spending leisure time mostly in local pubs and discos, where both alcohol and casual sex are readily available.

1 *"Actually, it is almost the same with boozing as with sex; when you are 'locked up' for a week and you can't go out, and then you go out for a weekend after being stuck here for a week, then it's worth it [boozing]."*

2 *"When you are not permitted to go home for seven months, then ... [you look for casual contacts]."*

3 *"You have a drink, and when you do that, it somehow ... girls–pub-goers–come and join you at the table ... and then it [casual sex] happens."*

Alcohol is known to not only diminish sexual inhibitions, but also to undermine the ability to adequately evaluate risks (for example, of unwanted pregnancy, STIs, HIV/AIDS). Moreover, the overwhelming majority of soldiers doing their MMS are only conscious of unwanted pregnancy as a threat in relation to casual sex. STIs and HIV/AIDS are mostly perceived by soldiers as a threat that does not apply to them:

1 *"I don't go there thinking that I'm going to have sex, so I don't have protection with me. Casual means that the sex happens without protection."*

2 *"... It won't be me that will have the kid. She will, it's her problem. I'm an unknown soldier."*

3 *"... in Slovakia, who has AIDS? Mostly drug users, maybe Ukrainians, men who screw with African women. I don't know who they are, maybe Arabs, mostly those who use needles in Bratislava. There they are all of them."*

2. Specific sociocultural behaviour patterns

In addition to the general pattern of risky behaviour, examining the different types of army environments yielded two more specific sociocultural behaviour patterns. First, in Bratislava, the capital of Slovakia, the attitude to casual sex among MMS soldiers tends to be more sophisticated, more opportunities exist for stable relationships and high-risk behaviour is relatively uncommon. Second, and in contrast, in certain more rural settings, the tendency to engage in high-risk behaviour is strong.

Limitations on high-risk behaviour

There are many university graduates among the conscripts in the military camp in Bratislava, and the soldiers tend to be from families of higher social, economic and educational level. The majority of these soldiers report having ample free time, permanent residence in the town and opportunities to meet their steady partners. While it is also easy to find a casual sex partner, condoms are almost always used when engaging in commercial or casual sex. Bratislava is the city with the highest incidence of drug use and HIV-positive persons in Slovakia. The soldiers' responses show they are well aware of the risks and protect themselves:

1 "I personally wouldn't go with a girl without a condom."

2 "In my opinion, it [a condom] is used."

Exacerbation of high-risk behaviour

In two locations we observed that high-risk behaviour tended to be strengthened by local conditions. The first location, Ruzomberok, is a town known for having a large number of secondary schools, mostly for girls, and factories where mainly women work. Soldiers can relatively easily have casual relations with two sets of women:

1 Girls aged 12 to 16 who are keen to make contact with soldiers in pubs. According to the soldiers, the majority of these girls merely want to be bought drinks, but as soon as sex is about to occur, they usually make an excuse and go away. However, because of their age and lack of experience—or even because they have had too much to drink— they are not always able to resist soldiers who see them as "fair game".

"She [local girl], as long as the soldier is paying, she kisses him and hints something. And if the soldier then wants something, she disappears and comes back the following day."

1 Women aged 30 to 40 who are single, divorced or sexually unsatisfied in their marital relationships, who actively seek out casual sex with soldiers.

In the second location, Jelšava, the military camp is situated in an extremely small district and there are limited opportunities for soldiers to go to the neighbouring villages and spend their free time there. However, there are local girls and women who are willing to have casual sex. These are mostly Romanians who, in Slovakia, are the objects of considerable racism and have very low socioeconomic status. The soldiers also see them as "fair game"—as willing to drink with soldiers who will pay for them, and "willing to pay for it". The soldiers use them for sex, but when they are sober, the soldiers avoid them.

The soldiers' perception that there are women locally who are "fair game" (because they are prepared to exchange sex for alcohol) leads to a culture in which there is a close association

between the use of alcohol and having casual sex without protection among both the soldiers and the girls/women concerned.

3. Individual behaviour patterns

Finally, the high-risk patterns were analyzed at an individual level with the aid of an example of low, moderate and high-risk behaviour. Each illustrates a more generally applicable pattern of individual behaviour, and each could apply to many individuals. The individual behaviour of the soldiers during MMS was consistent with their individual behaviour before it, and there were similarities between individual behaviour and general behaviour before and during MMS. The results show that persons whose behaviour was more risky in the nexus of **(casual) relationships-alcohol-unprotected sex** before MMS behaved more risky also during MMS, although some specifics occurred in the military setting too**.** In contrast, persons with less risky behaviour before MMS behaved also less risky during MMS. We use extracts from the three selected interviews for illustration.

The first interview reflects a low-risk lifestyle, the second a medium-risk lifestyle and the third a high-risk lifestyle.

3.1 Small-risk behaviour

Interview in Presov, code name "3"

Relationship	Steady, without casual partners
Alcohol use	Rarely during sex and in small amount
Protection	At first none, later hormones
Changes compared to civil life	None

Sexual relations before MMS

First sexual intercourse: 20 years, one one-week relationship, without protection, both partners without alcohol.

Sexual history: Steady relationship with the partner with whom he had his first sex; lasts till today (4½ years).

Casual relationship: None.

Sexual relationships during MMS

Steady relationship: Throughout MMS person concerned had a steady partner (relationship lasted 4½ years).

Casual relationship: Person concerned had no casual contacts, and did not search after any.

"No, I didn't go to disco [during MMS]. When I go, in principle, it is for beer. I mostly go with the graduates like myself from the neighbouring unit, and as for girls, we naturally look at the pretty ones, but it is rather impossible that we would chase after girls."

"I would definitely not try to search for [a casual contact] ... if there were a nice girl who would try to put pressure on me ... if she were very provoking, I don't know, I can't say a hundred percent that I would be able to withstand something like that."

Pychoactive substance use before MMS

General drinking: Average drinking in small amount and never completely drunk.

"... we didn't indulge [in alcohol], that our performance [in drinking alcohol] would be rising, that we would drink a bit more ... During my studies, mostly, when we went, we drank so, that

we drank wine or a wine with soda while playing billiards, for example, but it was not a great amount either ... It was such a period, that we had two semesters for example, that we went to play billiards twice a week."

Alcohol use during sex: Now and then under the influence of alcohol, but sex was not a result of being drunk:

"It happened several times, but it wasn't a rule, it was rather rare, that we simply went out for dinner and we had a drink or some wine."

Illicit psychoactive substance use: Marijuana twice during university studies.

Psychoactive substance use during MMS

General drinking: Irregular drinking, about the same amount as before MMS.

During sex: Rarely, only a glass, e.g. with dinner.

Illicit psychoactive substance use: Marijuana once.

Protection before MMS

Steady relationship: The first half year of the relationship without protection, the partner was on the pill that day.

Protection during MMS

Steady relationship: The partner was on the pill.

3.2 Medium-risk behaviour

Interview in Bratislava, code name "Anonymous"

Relationship	Steady and casual partners
Alcohol use	During sex (mostly non-coital), more during MMS
Protection	Steady partner: Different kinds. Casual partners: Without protection
Changes compared to civil life	Increased amount of alcohol consumption during non-coital sex

Sexual relations before MMS

First sex: Intercourse at 16 years, one-year relationship, without protection.

Sex history: Steady relationship with a partner with whom he had first sex. Lasted to date, with two breaks. During this relationship he had had a spontaneous sexual relationship for two years (lasted to date).

Casual relationships: Four other partners during the primary relationship (always friends, known). Had had sex with two of them, only non-coital activities with the other two.

Aware of the difference between the encounter with the steady partner and with the spontaneous partner:

"It is more emotional and more gentle with the [steady] partner; with the [simultaneous] partner it is in principle just sex."

Reasons:

"A man lives here in principle as a priest the whole week, then he goes home and tries to compensate for it—alcohol, discos, the women of course. When the girlfriend is not at hand, it is a good involvement, although even if there is another one, or the longer lasting acquaintance."

Alcohol use before MMS

During sex**:** Rarely (he was drunk once during one casual sex encounter).

Alcohol during MMS

General consumption: Effort to compensate for the lack of opportunities during weekends**,** with friends.

During sex: Alcohol use at discos during weekends, looking up girls mostly for non-coital activities.

Protection before MMS

Steady relationship: At first condom, then contraception, later coitus interruptus.

Casual relationship: Sex without protection in all casual contacts.

Protection during MMS

Steady relationship: Coitus interruptus.

Casual relationship and spontaneous sex: No protection.

3.3 High-risk behaviour

Interview in Lešť, code name "Mirkovce"

Relationship	Steady and casual partners (casual only during MMS)
Alcohol use	During sex often (both before and after MMS)
Protection	With steady partner: First time condom, later hormonal contraception With casual partners: No protection
Changes compared to civil life	Only casual partners during MMS

Sexual relations before MMS

First sexual intercourse: 15 years, casual, without protection, a little alcohol used by him.

Sex history: Steady relationship for 14 months.

Casual relationships: About three, mostly friends, known, pick-ups at discos.

"They were mostly from my circle of friends, we often went out together or, well, mostly, it was from discos."

"... we simply were making acquaintance [with casual girls], began talking together, drank something, began dancing. It was sort of getting closer, of course–those touches and such things–and we went to the second, third disco, and that [sex] happened then. We simply slept together. Then many times, when my friends' parents were out, then we left the disco–we did not wait, we took girls and we took them to the flat. There we had some more drinks, put a cassette on, we put something erotic or porno on purpose, to show what we were there for. Each took a girl into a room, and we had sex with them there."

Sexual relations during MMS

Steady relationship: None.

Casual relationship: Five girls, no repeated sex with any of them, pick-ups, mostly at discos (but when he was in another barracks or at home, on leave).

"... I had only three girls during the whole MMS, and I had another two when I was on leave and that was with two friends of mine whom I knew well."

Pychoactive substance use before MMS

General drinking: Above average.

During sex: Often.

Illicit psychoactive substance use: Marijuana several times.

"One could say that it headed for regularity."

Alcohol use during MMS

Less than before.

Protection before MMS

Steady relationship: Condom used only once in life, the partner was on the pill.

"I used a condom for the first and the last time when I had been with my girlfriend for some time and I wanted to try it. She took no contraception, she had no reason to, because we didn't sleep together [first three months of relationship]. Then she started using contraception and about a week later I bought condoms to try it ..."

Casual relationship: Did not use any protection.

Protection during MMS

Casual relationship: No protection.

Section D

RISK PERCEPTION ANALYSIS

This analysis supplements the analysis of behaviour patterns illustrated in the previous appendix. An optional analysis, it represents a "Socratic dialogue" around a particular concept relevant to the area of interest, in this case "risk". It can be described as a deep and systematic exploration of the particular concept from the variety of perspectives of participants, and a search for the **common meaning** of the concept. Below is an example taken from Bianchi et al. (2000). "Health", "sex" and "responsibility" may also be fruitful concepts for analysis.

Summary of risk perception related to casual sexual intercourse

1 The overwhelming majority of soldiers participating in mandatory military service (MMS) perceive only unwanted pregnancy as a real threat in casual sex; the risk of getting infected with STDs and HIV/AIDS is overlooked. Their more frequent approach to solving the problem of unwanted pregnancy is to shirk responsibility. This is often facilitated by soldiers' non-disclosure of their names to their casual partners, so the latter can hardly identify the father of the child should they fall pregnant.

2 STDs and HIV/AIDS are mostly perceived by soldiers as abstract threats. Although some of them fear HIV/STD infection, they generally argue that HIV concerns drug addicts and foreigners and is a problem in large cities, and that STD can be cured.

3 Risk perception also transpires from MMS soldiers' level of knowledge about the transmission of diseases and risk avoidance (e.g. that oral sex is not risky and that to have a steady partner (serial monogamy) protects one against risks). In addition, desire to have sex often overrides knowledge about risk and its prevention. It appears that the more limited the opportunity for having sexual intercourse (Lest, Jelsava), the more risky the behaviour.

The main risks are listed below and illustrated with authentic quotations from focus group discussions.

Regarding casual sex, soldiers are more aware in general of the risk of unwanted pregnancy than the risk of STD/HIV, regardless of the locality of the military camp where they live.

B FB/13/15

"I think that we still live in a period when a young couple or the two young people are afraid more of getting pregnant than of infectious diseases."

"I don't know how it is that people do not realize it. I don't know whether it is so because there was silence on it [HIV/AIDS] so long. People think about it simply. Pregnancy is primary for them and they forget about the diseases."

L_FB/12/18

"... the point is not so much any more a sort of protection [against HIV/STD], but about not to get pregnant. I would rather say that it is so in several cases."

Jel_FB/7/12 (reply to the question about what risk they used condoms for)

"Of course against conception. It could also be without protection in a partner relationship but in such a case [in casual sex] not."

Regarding the possibility of unwanted pregnancy during casual sex, some soldiers would deny their responsibility or would not disclose their names. As far as they were concerned, unwanted pregnancy was the casual partner's problem.

Ba _FA/9/14

"These are one-night stands, they [casual partners] sometimes even don't know their names ... It's her problem [unwanted pregnancy]."

B_FB/12/18

"... if she would get pregnant, all are dressed in green ... He [soldier] doesn't care in fact. The soldier is clean, isn't he?"

J_FA/4/12

"... they don't know one another [soldier and casual partner]. Maybe they know each other's name, the first one, Peter or so. She has no idea. She probably knows his face ... as we now have half a year and I go with a girl now, and I will be in civil life and she, if she has a baby, till she finds me ..."

Very few soldiers are aware of their own risk of STD and HIV infection in casual sex. HIV/ AIDS in particular does not concern them. Since the number of HIV-positive persons is relatively low in Slovakia, the risk of HIV/AIDS infection is an abstract rather than a real threat.

B_FB/13/15

"One doesn't think that something might happen. One would be crazy to say that this would happen and that would happen ..."

"One doesn't admit that in our times ... still not much of it [AIDS], so one doesn't admit that one could get infected himself. If some foreigner, there one could think about it ... other diseases are curable."

R_FA/7/1

"... I will not have any kid. She will, it's her problem. I'm an unknown soldier."

"... in Slovakia, who has AIDS? Mostly drug users, some Africans, or Ukrainians, who screw with these African women–I don't know who they are. Or Arabs, and thus mostly those who have, who use needles in Bratislava. They all are there."

P_FB/7/12

"I know in the village, a village girl, she has never been anywhere, then what should I be afraid of?"

L_FB/11/18

"... it [STD/HIV] has not been seen by anybody yet, or nobody believes that some really ... that somebody really ...[would get STD/HIV]."

Insufficient information about the prevention of possible risks is another reason for the low perception of risk of contracting STD/HIV. The conviction of one soldier that if a casual partner

has had sex with several soldiers who are healthy till today—which means that there is no threat on her side—can serve as illustration.

L_FB/8/18

"I would say that we know one another and they [soldiers] know with whom has she [casual partner] been before. I think that this is also why he is not afraid of sleeping with [a casual partner]."

"And there is another thing, that sex need not be in a classical way, classical act, but there are various forms, e.g. oral sex, or ..."

P_FB/6/12 (reply to the question about what risk they use condoms for)

"Because of infection. Well, rather against the disease. Because who knows how many [sexual partners] has she had before you and who knows what disease she has ... A child isn't such a great problem, but to live one year and die, it is a rather great problem. With that AIDS, mainly, that syphilis and gonorrhoea ..."

J_FB/7/12 (reply to the question about what risk they use condoms for)

"Against AIDS disease. There [in casual contact] is no confirmation that I don't get a disease."

INFORMED CONSENT SHEETS

Consent form for key informant interviews

We have contacted you in order to carry out a personal interview for a study that aims to assess the relationship between alcohol use and sexual risk behaviour in order to devise interventions to reduce the risk. This project encourages community participation and partnership that should lead to an action plan for the development of interventions at the local level.

Before commencing, we require you to sign, if you agree to participate, this form of consent. Therefore please read the following carefully:

> *One of the issues that you must bear in mind is that your participation in the interview to follow is totally voluntary. We have taken all the necessary measures to maintain confidentiality, so that your name cannot be identified with what you have said. If, after reading this note, you decide that you do not wish to go through with the interview, you can indicate this to the person interviewing you and the interview will be discontinued and that will be the end of the matter. If you do however decide to go ahead, you should be aware that the interview data will be recorded on a computer for subsequent analysis without your name appearing at any moment. If you are in agreement, please sign this form of consent with a fictitious name that will be erased and changed into a number after the interview. The team will undertake all measures to prevent breach of confidentiality.*

The most important objective of the study that we are carrying out is to help us understand how the use of alcohol influences sexual behaviour. We need to collect data about this subject in order to be able to design prevention programmes to reduce alcohol use related sexual behaviour that leads to the acquisition of HIV and other sexually transmitted diseases.

The interview will take about half an hour (30 minutes) of your time.

Some participants may feel uncomfortable during the interview, since the topics to be discussed are sensitive. But it is important for you to know that your collaboration can help to reduce alcohol use related problems such as sexual risk behaviour that could lead to the acquisition of HIV infection. If something is unclear, or if you have any doubts whatsoever, you may contact any of the following people: XXXX.

I agree to participate in the study and my fictitious name (pseudonym) is:

_____

Date: _____

I certify that in my presence the participant has been informed about the possible benefits and risks of participation in the research and has been given the opportunity to ask any questions.

_____

Representative of the research team:

Date: _____

Place: _____

Consent form for focus group discussions

We have contacted you in order to carry out a group discussion for a study that aims to assess the relationship between alcohol use and sexual risk behaviour in order to devise interventions to reduce the risk. This project encourages community participation and partnership that will lead to the development of an action plan for intervention at the local level.

Before commencing, we require you to sign, if you agree to participate, this form of consent. Therefore please read the following carefully:

> *One of the issues that you must bear in mind is that your participation in the discussion to follow is totally voluntary. We have taken all the necessary measures to maintain confidentiality, so that your name cannot be identified with what you have said. If, after reading this note, you decide that you do not wish to go through with the interview, you can indicate this to the person interviewing you and the procedure will be discontinued and that will be the end of the matter. If you do however decide to go ahead, you should be aware that the interview data will be recorded on a computer for subsequent analysis without your name appearing at any moment. If you are in agreement, please sign this form of consent with a fictitious name that will be erased and changed into a number after the interview. The team will undertake all measures to prevent breach of confidentiality.*

The most important objective of the study that we are carrying out is to help us understand how the use of alcohol influences sexual behaviour. We need to collect data about this subject in order to be able to design prevention programmes to reduce alcohol use related sexual behaviour that leads to the acquisition of HIV and other sexually transmitted diseases.

The group consists of six to eight people. The group discussion will be co-ordinated by a member of the research team and will take about one and a half hour (1 hour and 30 minutes) of your time.

We know that not all members of the group will feel comfortable during the discussion, since the topics to be discussed are sensitive. But it is important for you to know that your collaboration can help to reduce alcohol use related problems such as sexual risk behaviour that could lead to the acquisition of HIV infection.

If something is unclear, or if you have any doubts whatsoever, you may contact any of the following people: XXXX.

I agree to participate in the study and my fictitious name (pseudonym) is:

_____

Date: _____

I certify that in my presence the participant has been informed about the possible benefits and risks of participation in the research and has been given the opportunity to ask any questions.

_____

Representative of the research team:

Date: _____

Place: _____

Consent form for in-depth interviews

We have contacted you in order to carry out a personal interview for a study that aims to assess the relationship between alcohol use and sexual risk behaviour in order to devise interventions to reduce the risk. This project encourages community participation and partnership that will lead to the development of an action plan for intervention at the local level.

Before commencing, we require you to sign, if you agree to participate, this form of consent. Therefore please read the following carefully:

> *One of the issues that you must bear in mind is that your participation in the interview to follow is totally voluntary. We have taken all the necessary measures to maintain confidentiality, so that your name cannot be identified with what you have said. If, after reading this note, you decide that you do not wish to go through with the interview, you can indicate this to the person interviewing you and the interview will be discontinued and that will be the end of the matter. If you do however decide to go ahead, you should be aware that the interview data will be recorded on a computer for subsequent analysis without your name appearing at any moment. If you are in agreement, please sign this form of consent with a fictitious name that will be erased and changed into a number after the interview. The team will undertake all measures to prevent breach of confidentiality.*

The most important objective of the study that we are carrying out is to help us understand how the use of alcohol influences sexual behaviour. We need to collect data about this subject in order to be able to design prevention programmes to reduce alcohol use related sexual behaviour that leads to the acquisition of HIV and other sexually transmitted diseases.

The interview will take about one hour (60 minutes) of your time.

Some questions may make you feel uncomfortable, since the topics to be discussed are sensitive. But it is important for you to know that your collaboration can help to reduce alcohol use related problems such as sexual risk behaviour that could lead to the acquisition of HIV infection. If any question makes you feel uncomfortable, please indicate it; you do not have to answer any unpleasant questions if you do not wish to.

If something is unclear, or if you have any doubts whatsoever, please tell me.

I agree to participate in the study and my fictitious name (pseudonym) is:

_____

Date: _____

I certify that in my presence the participant has been informed about the possible benefits and risks of participation in the research and has been given the opportunity to ask any questions.

_____

Representative of the research team:

Date: _____

Place: _____

References

Bianchi, G., Popper, M., Lukšík, I. & Supeková, M. (2000). *A Rapid Situation Assessment of Substance Use and Sexual Risk Behaviour in Slovakia*. Final Report. Geneva: WHO.

Bianchi, G. & Popper, M. (2000). Interaction of substance use and risks to sexual health in the Slovak army: General, sociocultural and individual behaviour patterns. *AIDS CARE*, 12 (6):757-766.

Glaser, B.G. & Strauss, A. L. (1967). *The discovery of grounded theory*. New York: Aldine.

Annex Two

QUESTIONS USED IN THE EMPIRICAL STUDY BY DATA COLLECTION METHOD

INTRODUCTION

In addition to what was presented in Chapter 3.2 of this publication, this annex indicates the main questions in respect of which data were collected in the project countries. The questions are sorted by research instrument (key informants, observations, focus group discussions, in-depth interviews and surveys), as well as in terms of subject matter (general issues, alcohol consumption, sexual behaviour, interaction between alcohol intake and sexual behaviour, entertainment venues). The sets of questions that were used in the respective research sites were largely identical—specifically to facilitate comparisons across sites—and are thus not sorted by country.

Apart from illustrating the range of research issues that were explored in the study, it is hoped that these questions will inspire further research.

1. Key informant interviews

1.1 General

1 What are the customs/practices that prevail within the main groups in your community/ country?

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

3 Please tell me of other venues to visit in order to learn more about people's drinking behaviour.

1.2 Alcohol consumption

1 What stereotypes/customs regarding alcohol consumption exist (e.g. where, who with and when)?

2 What are the drinking patterns/habits here?

3 To what extent do people use alcohol?

4 Where do people drink alcohol and why do they go there?

5 What types of alcoholic beverages do people drink?

6 Can you name some of the alcoholic brands that people drink?

7 What are the main types of alcoholic beverages used?

8 How do people drink (e.g. how often and how much)?

9 When do people drink (e.g. what time of the day/week/month)?

10 Describe the differences in drinking patterns among males and females.

11 Why do people drink?

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

13 What do alcohol users think about their own drinking?

14 When do they see it as the abuse of alcohol?

15 What are the signs of alcohol abuse?

16 What kinds of personalities are susceptible to risky alcohol use?

17 What do people expect of alcohol?

18 When under the influence of alcohol, how do people characteristically behave?

19 How do you feel about alcohol use in this community?

20 What do people (generally) think about drinking?

21 What role does the culture or lifestyle of people play in their drinking?

22 Is alcohol used together with other psychoactive substances ("drugs")?

23 Do you see alcohol as a "drug"?

24 Can you tell me what people think about under-age drinking (i.e. the use of alcohol by persons younger than 18 years)?

25 What factors can reduce the use of alcohol in your community?

26 Can you tell me about alcohol advertising in this community?

27 What are the main positive/negative consequences of drinking?

28 What should be done to prevent alcohol abuse?

1.3 Sexual behaviour

1 To what extent do stable and casual partnerships in sexual relations feature in your culture?

2 What stereotypes/customs regarding sexual behaviour exist in your community (e.g. where, with whom, when, etc.)?

3 Is there a typical model of sexual behaviour among people living here?

4 Do people talk before/during/after intercourse?

5 What is "risky sexual behaviour"?

6 How does the youth understand "safe sex"?

7 What is your understanding of sexual risk and safe sex?

8 What risks and protective measures are taken during sexual encounters?

9 Do people use protective measures during intercourse? When?

10 To what extent are young people/adults aware of health risks in sexual encounters?

11 To what extent do people have the option to adopt protective measures in sexual encounters?

12 What factors affect the adoption of protective measures in sexual encounters?

13 What are the facilitators and barriers to practising safe sex?

14 What are the features of a personality susceptible to taking sexual risk?

15 What are people's attitudes towards taking sexual risks?

16 How do people respond to sexual problems?

17 What measures can be implemented to prevent risky sexual behaviour?

18 What kind of preventive information/ education should be given and how should it be given?

1.4 Alcohol and sexual behaviour links

1 What are the cultural and personal determinants of alcohol and sexual behaviour risks for sexually transmitted illnesses, including HIV infection?

2 What views do people have on the role of alcohol in risky sexual behaviour? Are they aware of a link between alcohol and risky sexual behaviour?

3 What cultural expectations exist concerning the role of alcohol in sexual encounters?

4 How does alcohol influence sexual behaviour?

5 Is alcohol related to seeking sexual partners and, if so, in what way?

6 What role does alcohol consumption play in commercial sex?

7 Where does alcohol-related risky sexual behaviour typically occur?

8 Are alcohol/other psychoactive substances used before/during intercourse?

9 Why do people drink alcohol before/during sex?

10 What are the advantages/disadvantages of drinking alcohol before/during sex?

11 In your opinion, what effects does drinking have on people's sexual behaviour?

12 Are there any visible changes in sexual behaviour after people have been drinking alcohol?

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

14 How do people feel about these effects?

15 Why do young people use alcohol before sexual contacts?

16 What are the positive/negative expectations that youth/adults have regarding the use of alcohol before/during sexual contacts? Are these expectations justified?

17 Does it happen that young people experience shame/embarrassment about their sexual behaviour after sobering up?

18 Do young people think about "safe sex" when intoxicated?

19 Who are the people most affected by risky sexual behaviour as a result of alcohol use?

20 Does the drinking environment contribute to a change in sexual behaviour after alcohol use?

21 How can risky alcohol use and sexual behaviour be prevented?

22 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 behaviour?

1.5 Entertainment venues (including drinking places)

1 What kind of things do people do here?

2 What do they take/drink?

3 About how many drinks do they have if their friends press them into taking alcohol?

4 Do all people who come here drink?

5 Those who do not drink, what are they like and what do they do?

6 Besides taking alcohol, do they use any other psychoactive substances ("drugs")?

7 Do they drink until they get drunk?

8 Does people's behaviour change after drinking?

9 Do men and women behave in the same way while/after drinking?

10 Where do you think kids go after they leave this place? And other customers?

11 What types of people come to this place?

12 Have there been instances where people have had sexual intercourse at this place?

13 Do you know whether they use a condom during sexual intercourse?

14 Can customers get any condoms on the premises? Are any for sale?

15 Do you have regular customers (people who come here often)?

16 What are regular customers like?

17 Do they behave differently when they are sober and when they are drunk?

18 What kinds of risks do alcohol/other psychoactive substance ("drug") users run?

19 Do you think kids who drink are more at risk than those who do not?

20 Do you think this place could facilitate/ stimulate risky behaviour with regard to contracting HIV/STI? Why?

21 Can this place help in preventing HIV/STI? How? What are the obstacles?

22 Is the use of alcohol and other psychoactive substances ("drugs") regulated/controlled here? And if so, in what way?

23 Have you heard of customers with HIV/ STI? How did it happen? Do you think this is related to their alcohol/other psychoactive substance ("drug") use? Why?

24 Do customers regularly use condoms? How do you know? When do they use/do they not use condoms?

2. Observations

2.1 General

1 What type of social hierarchy (including subordination/power structure) exists in the community?

2 Are there indications of spontaneous communication with people not belonging to the group under observation or with an observer/researcher?

3 What does the place look like in terms of security (e.g. bouncers), hygiene, means of protection against unsafe sex (e.g. condoms), injecting drug use, availability of sex workers, accommodation, transport services, communication services (e.g. public phones), type of music/food, etc.?

4 To what extent are health risks considered in this place?

5 What risk-reduction strategies are used?

6 Are there indicators of health promotion measures (e.g. messages) in the place?

2.2 Alcohol consumption

1 Who are the drinking partners (girl/boyfriends, wives/husbands)?

2 What kinds of drinks are taken?

3 About how much alcohol is consumed at a time?

2.3 Sexual behaviour

1 Who (e.g. age, socioeconomic status, race, gender) are the people involved in sexual behaviour/encounters?

2 What types of behaviour are they exhibiting?

3 What attitudes and behaviour do the proprietor exhibit?

4 What language/dialect is commonly used?

5 What language is used when a person is intoxicated (e.g. vocabulary, tone)?

6 What characterizes behaviour when a person is intoxicated?

7 What are the effects of intoxication on behaviour?

8 What non-verbal cues (signs, contact, provocative gestures, petting and pinching) prevail?

9 What are the features of interpersonal interactions?

10 What types of people interact (their age, gender, marital and social status, and style of dress)?

11 Are there indications/evidence that protective measures against unsafe sex are used?

12 How can the safety of sexual encounters be increased?

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

3. Focus group discussions

3.1 Alcohol consumption

1 What alcohol use patterns exist in the target population (e.g. who drinks, gender, age groups; frequency of drinking, kinds of drinks consumed, time of drinking, how alcohol is consumed (e.g. bottles or glasses or sponging), where does drinking take place)?

2 What factors (e.g. culture, availability, access, advertisement) encourage drinking?

3 Do people experience pressure to drink and, if so, what types of pressure?

4 What activities accompany alcohol use?

5 Is alcohol, or is alcohol not, associated with fun?

6 Are psychoactive substances (“drugs”) other than alcohol used?

3.2 Sexual behaviour

1 Who are sexually active?

2 What kinds of sexual partnerships (e.g. sugar daddy/mummy, homosexuality, casual sex) occur?

3 Do multiple sexual relationships/polygamous relationships occur?

4 What types of sexual intercourse (e.g. oral, anal) occur?

5 What do people say about the various kinds of sexual relationships (acceptable or unacceptable)?

6 What is risky sexual behaviour?

7 What is safe sex?

8 What are the implications of casual sex for sexual partnerships in the target population?

9 Do people find casual sex acceptable?

10 Do people accept premarital sex?

11 Does the number of sexual partners influence risky behaviour?

12 What are the facilitators and barriers to safe sex practices?

13 Are condoms used in sexual contacts and, if so, when?

14 In what circumstances do people experience sexual arousal/satisfaction?

3.3 Links between alcohol and sexual behaviour

1 Can you describe the situations in which the use of alcohol may be associated with sexual behaviour?

2 What types of sexual contacts occur and what, if any, is the role of alcohol use in each case?

3 Why do people use alcohol before sexual intercourse and what do they expect from this practice?

4 Can you list the typical features of a person who usually drinks before sex?

5 Is drinking alcohol before sex a common practice in the target population?

6 What are the advantages/disadvantages of drinking alcohol before sex?

7 What positive/negative expectations do people have of alcohol use before/during sex?

8 Do these expectations ever come true? When?

9 Is sexual performance better if accompanied by alcohol use, or is it frustrating?

10 Does a person feel ashamed of his/her sexual behaviour after sobering up?

11 What are your views on the issue of drinking-induced sexual disinhibition?

12 Why does some people's use of alcohol not lead to risky sexual behaviour?

13 Does a person in the state of alcohol intoxication give any consideration to safe sex?

14 What can you tell me about alcohol use among sex workers and their clients?

15 Does the use of alcohol affect the sexual behaviour of the clients of sex workers?

16 Does alcohol use affect condom use during sex between the client and sex workers?

17 What measures are likely to prevent risky sexual behaviour?

18 What can enhance the efficiency of (existing) preventive measures?

19 What opportunities exist for preventive interventions in the target population?

20 What types of "safe sex" strategies/ measures do people use?

21 Does psychoactive substance use (including alcohol use) affect decision-making about taking precautions against STDs/HIV/ AIDS/pregnancy?

22 Is there an association between alcohol use, sexual behaviour and HIV/AIDS?

4. In-depth interviews

4.1 Alcohol consumption

1 Have you ever taken alcohol and/or other psychoactive substances ("drugs")?

2 How old were you when you first took alcohol and/or other psychoactive substances?

3 What did you take and how much?

4 Who were you with? What were you doing?

5 Were you pressed into doing it?

6 Was there any specific reason to take alcohol/other psychoactive substances?

7 Where do you go now to take alcohol/other psychoactive substances?

8 How often do you go to these places?

9 In the case of alcohol, what kind of drink do you take and about how many drinks?

10 Is there anything that helps you to know when it is time to stop drinking/taking other psychoactive substances?

11 Does your behaviour change when you drink/use any other psychoactive substance? In what way?

12 Is drinking, or is it not, a serious problem in your life?

13 Do you have any (positive/negative) family experiences related to alcohol use?

14 Do you think alcohol use should be controlled/regulated and, if so, how?

4.2 Sexual behaviour

1 What motivates the decision to enter into a sexual relationship?

2 Do sexual partners experience psychological/spiritual bonding before, during and after sexual contact?

3 How do people typically behave when building sexual partnerships?

4 What types of sexual partnerships (e.g. casual, permanent) commonly occur?

5 When do people experience sexual contact positively/negatively?

6 To what extent do changes in a person's sexual life correlate with changes in his/her social life (e.g. self-esteem, relations with people around him/her)?

7 What changes in sexual behaviour come about with changes in age, marital status, etc?

8 Can you please tell me about your present sex life (e.g. feelings about sex, level of satisfaction, use of contraception, reason for sex, risk protection, etc.)?

9 Can you please tell me about your personal history with regard to sexual intercourse?

10 What characterized your first sexual intercourse (e.g. age, feelings, risk protection, partner)?

11 How often does sexual intercourse currently occur? With whom?

12 What motivates intercourse?

13 Does communication occur before/during/ after intercourse?

14 What types of sexual relationships (casual, steady, combined) are you involved in?

15 How frequent do you have extramarital/ multiple sexual partners? In which circumstances, why, when, where?

16 Do you go to certain places in order to flirt?

17 What do you do to flirt?

18 Do you consider using protection during intercourse?

19 Do you feel satisfied with using a condom during intercourse? What about your partner?

20 What, if any, protection do you use in the various sexual relationships (casual, steady, combined) in which you are involved? When and why do you not use such measures?

21 Can and do you negotiate ways of taking precaution against unsafe sex with your sexual partner?

22 Are you embarrassed to talk to your partner about using a condom before sex?

23 Who decided to use a condom when you last had sex?

24 Do you use a condom when you have sex with clients, casual partners, extramarital partners, private regular partners, etc.?

25 How often does condom use occur? With whom? Why?

26 Are there any STI/HIV prevention posters at the (drinking) places you go to?

27 Have you received sex information/ education in your family and/or at school/ work and, if so, when?

28 How do you evaluate the level of your information/education about sexual risks with regard to HIV/AIDS, STDs? Have you ever had an STD?

29 Please tell me more about your health in general?

30 Have you ever suffered any sexually transmitted infection? Which one(s)?

31 Please tell me about your own sexuality (e.g. arousal, impotence, premature ejaculation, orgasm, rigidity, size, sexual aggression/passiveness, satisfaction with own sexuality/manhood/womanhood, etc.)?

32 What are your personal beliefs about condom use (e.g. initiation of condom use) and ability to negotiate safe sex?

33 How easy/difficult is it to change sexual behaviour?

34 What do you think can be done to prevent risky sexual behaviour?

4.3 Alcohol and sexual behaviour links

1 To what extent is alcohol used before sexual contacts?

2 What do people expect from alcohol use?

3 What expectations about alcohol do not come true and why?

4 Are psychoactive substances (including alcohol) used before/during intercourse? Why?

5 What are the real effects of using psychoactive substances (including alcohol) before/during intercourse?

6 Did you take any alcohol/other psychoactive substances before/during your first sexual encounter?

7 When you take any alcohol/other psychoactive substances, how often do you have sexual intercourse? How often do you use a condom in these instances? Where do you get the condoms?

8 How does alcohol use influence sexual activity?

9 After how many drinks do you start flirting?

10 Which sexual risk practices are most common amongst alcohol users?

11 How do you feel about sex when you have taken alcohol (e.g. satisfaction or dissatisfaction)?

12 To what extent are you able to obtain professional/medical help if needed?

5. Survey questions

5.1 Use of alcohol and other psychoactive substances

1 Are there recreational facilities in your community? What types of facilities (e.g. drinking places)?

2 Can you easily use the recreational facilities (e.g. drinking places) in your community?

3 Is it easy for you to buy alcohol in your community if you want to?

4 Are there people who drink heavily in your community? Many?

5 Does your community accept the abuse of alcohol?

6 Have you seen advertisements of alcoholic drinks in your community? Many?

7 Who among your family members has had an alcohol problem?

8 Have you ever taken alcohol?

9 Have you taken alcohol in the past 12 months?

10 In which types of venues or at which events do you usually take alcohol?

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

12 Have you ever used substances (“drugs”) such as cannabis, mandrax, cocaine, etc?

13 Have you ever used substances such as cannabis, mandrax, cocaine, etc. while drinking alcohol?

14 Remember THE LAST 30 DAYS. On how many days have you taken alcohol?

15 How many times did you use any of the following beverages: beer, champagne, alcopops, wine and hard liquor?

16 What type(s) of alcoholic beverages did you mostly take?

17 How many alcoholic drinks did you usually take on a typical occasion when you were drinking? (Please note that one drink is equivalent to one can or bottle of beer, cider or cooler, or one glass of wine, or one tot of hard liquor.)

18 With whom did you usually drink?

19 At what time of the day did you usually drink?

20 Remember the last day when you used alcohol. Where were you drinking, and when did you

drink?

21 Remember THE LAST 30 DAYS. How many times (if ever) did you have five or more drinks in a row? (A "drink" is a glass of wine (150 ml), a bottle or a can of beer (500 ml), a shot/tot of hard liquor (50 ml) or an alcoholic cocktail.)

22 How many times (if ever) have you been drunk?

23 How many drinks do you need to get drunk?

24 Did you have sex when BADLY DRUNK?

25 Why do you usually drink? (Personal, social, economic, cultural, religious reasons?)

5.2 Sexual behaviour and related alcohol use

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?

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

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)?

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)?

5 How old were you when you first had sex?

6 Was it with your spouse?

7 What was the age of the person with whom you had first sex? Was there an age difference between you? If so, what was the difference?

8 What was the reason for your first sexual contact? (Marriage, love, curiosity, violence, state of alcohol or other drug intoxication?)

9 Did you use a condom during your first sexual contact?

10 How long did you stay with your first sexual partner?

11 How many partners have you had?

12 Have you ever had occasional sex contacts?

13 Did you have occasional sex contacts in the last 12 months?

14 Did you usually use a condom?

15 Under what circumstances did you use a condom? (Always, if your partner agreed to use it, if your partner insisted, with your constant partner, with casual partners, in paid sex, never, if a partner seemed unreliable to you?)

16 You USE a condom because …?

17 If you DO NOT USE a condom, why don't you?

18 Does alcohol influence condom use?

19 Where do you get condoms?

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

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

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

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

24 Have you had venereal diseases?

25 Have you passed/not passed an AIDS (HIV) test?

26 How many contacts did you have during the last 12 months? (With one regular partner, with several regular partners, with occasional partners, with regular and occasional partners?)

27 Did you use a condom during sex with a REGULAR partner during the last 12 months?

28 Did you take alcohol before sex with a REGULAR partner during the last 12 months?

29 Did your REGULAR partner use alcohol before sex during the last 12 months?

30 How many drinks did you have before sex with your REGULAR partner?

31 Did you use a condom during sex with OCCASIONAL partners in the last 12 months?

32 Did you take alcohol before sex with OCCASIONAL partners during the last 12 months?

33 Did your OCCASIONAL partners take alcohol before sex during the last 12 months?

34 How many drinks did you take before sex with your REGULAR partner(s)?

35 Did you have ORAL SEX during the last 12 months?

36 Did you use condoms during oral sex?

37 Did you take alcohol before oral sex?

38 Did you have ANAL SEX during the last 12 months?

39 Did you use a condom during anal sex?

40 Did you take alcohol before anal sex?

41 Did you have GROUP SEX during the last 12 months?

42 Did you use a condom during group sex?

43 Did you take alcohol before group sex?

44 How many drinks did you take before group sex?

45 Did you have PAID SEX (sex for money, food or shelter) during the last 12 months?

46 Did you use a condom during paid sex?

47 Did you take alcohol before paid sex?

48 How many drinks did you take before paid sex?

49 Did you have sex with a person infected with venereal diseases?

50 Did you have sex with HIV-infected persons?

51 Did you have sex when you were infected with venereal diseases yourself?

52 How often have you had sex under the influence of alcohol in the last three months?

53 How often have you had sex under the influence of illicit substances such as cannabis, mandrax (methaqualone) or cocaine (crack or powder) in the last three months?

54 How often have you had sex that you regretted having had it in the last three months?

55 When was the last time you used a condom?

56 How frequently did you use condoms with your spouse or regular partner(s) in the last three months?

57 How frequently did you use condoms with casual partners in the last three months?

58 How do you evaluate the level of your own knowledge about alcohol, venereal diseases and AIDS/HIV infection?

59 What does "safe sex" mean to you?

60 What does "unsafe sex" mean to you?

61 How do you feel, or would you feel, about having more than one sex partner in your life?

62 What may happen if you do or do not have sex with your sex partner?

63 Which is safer: sex with an older woman or sex with a younger woman?

64 Which is safer: sex with an older man or sex with a younger man?

65 How likely are you to become infected with HIV?

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

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

68 Do you know any places where alcohol use facilitates occasional sex contacts?

5.3 Commercial sex workers

1 How many (total) paying/non-paying clients did you have in the last seven days?

2 How many (total) sexual partners did you have in the last seven days (including spouse)?

3 On the last day that you worked, how many clients did you have?

4 The last time you had sex with a client, how much money did you receive? (Cite amount of money in local currency.)

5 The last time you had sex with a client, did you take drinks?

6 Did you take an intoxicant other than alcohol to enhance sexual pleasure?

7 The last time you had sex with a client, did he/she take drinks?

8 Did your partner force you to take drinks?

9 Why did you take drinks before/during the sexual act?

10 The last time you had sex with a client, did you and your client use a condom?

11 Who suggested condom use then?

12 Why didn't you and your client use a condom then?

13 How many times did you and all your clients use condoms over the last 30 days?

14 How many times did you drink before/ during the sexual act with your clients during (a) the last month, and (b) the last 12 months?

15 When you were sober (had not taken drinks) how many times did you use condoms, during (a) the last month, and (b) the last 12 months?

16 Do you enjoy sex when you are drunk?

17 Do you use condoms when you have sex and why?

18 Who decides on the use of condoms?

19 Do you personally insist on the use of condoms during sex and why?

20 Under what circumstances would you agree to have sex with a client without using condoms?

21 Where do you usually get your clients?

22 What things do you look for in a client?

23 What class of clients do you usually target/attract?

24 How do you manage to attract your clients?

25 Do you have any agent/person who organizes clients for you and takes care of your safety?

26 How much do you usually make from each client?

27 How many clients do you usually handle per outing?

28 Do you negotiate the amount with the client?

29 When is payment made?

30 Do men demand/request sex without condoms?

31 What do you do in such cases?

32 In which way does your use of alcohol affect your sexual behaviour?

33 What kind of behaviour do you engage in when you have taken alcohol?

34 What do you like/enjoy about what you do?

35 What don't you like about what you do?

36 What would it take for you to stop what you are doing?

37 Is it possible for you to tell whether or not a client has HIV/AIDS?

38 Do people consider you a prostitute/sex worker?

39 How do you feel about it?

40 Do you consider yourself a prostitute/sex worker?

41 If your answer to the above question is NO, whom do you consider to be a prostitute/sex worker?

42 Have you ever heard of diseases that can be transmitted through sexual intercourse?

43 Can you describe any symptoms of STDs in women/men? Any others?

44 Have you had a genital discharge during the last 12 months?

45 Have you had a genital ulcer/sore during the last 12 months?

46 Did you take any measure to prevent STDs in the last 12 months?

47 Does alcohol enhance sexual pleasure?

48 Does alcohol lead to risky sexual behaviour (casual, commercial, unprotected sex)?

49 How does alcohol influence sexual behaviour (casual, commercial, unprotected sex)?

50 Does alcohol have an effect on sexual behaviour in the following circumstances:

o Casual sex (relatives, neighbourhood or other acquaintance)?

- o Commercial sex?
- o Man to man?
- o Unnatural sex (with a minor, other types of gratification)?
- o Sexual frenzy (a group activity, changing of partners)?
- o Sexual assault (unwilling partner, impulsive sex)?

51 Have you ever heard of HIV or the disease called AIDS?

52 Do you know anyone who is infected with HIV/AIDS?

53 Can you go out with a client you suspect has HIV/AIDS and why?

54 If you were to be diagnosed with HIV/AIDS, what changes would you make to your sex life?

55 How many of your friends who were doing what you do have died of AIDS?

56 How many of your friends who do what you do, do you suspect of having HIV/ AIDS?

57 HIV/AIDS is transmitted through:

- o Unprotected sexual contact?
- o Kissing?
- o Sharing razors?
- o Sharing meals?
- o Sharing towels/clothes?
- o Sharing injections?
- o Pregnancy?
- o Childbirth?

58 Does alcohol use increase the risk of STDs and HIV/AIDS?

59 Does alcohol use affect condom use?

60 Is it possible in your community for people to get a confidential test to find out if they are infected with HIV?

61 Have you ever had an HIV test?

62 Did you voluntarily undergo the HIV test, or were you required to have the test?

63 Do the following measures prevent HIV/ AIDS:

- o Abstaining from sexual intercourse?
- o Having an uninfected faithful sexual partner?
- o Not sharing needles/injection tools?
- o Cleaning with soap and water after sex?
- o Applying an antiseptic solution after sex?
- o Cleaning with alcohol/spirits after sex?
- o Cleaning with urine after sex?
- o Applying cream/medicinal preparation?

- Finishing the sexual act quickly?
- Ejaculating "outside"?
- Condom use?
- Taking medicines before/after sex?

5.4 Clients of commercial sex workers

1 What type of alcoholic beverage do you usually take, if any?

2 What type of alcoholic beverage do you prefer? Why?

3 Why do you drink?

4 How often do you drink? (Daily, weekly, monthly, etc.?)

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

6 How many drinks do you need to get drunk?

7 How often do you get drunk? (Daily, weekly, monthly, etc.?)

8 When do you usually drink and why?

9 Where do you usually drink and why?

10 Where would you prefer to drink and why?

11 Do you use the services of sex workers/ prostitutes?

12 How often do you use the services of sex workers and why? (Daily, weekly, monthly, etc.?)

13 At what age did you have your first sex with a sex worker and why did it happen?

14 Was a condom used?

15 Was money/gifts involved?

16 How did you feel afterwards?

17 Do you have a regular sexual partner?

18 How often do you have sex? (Daily, weekly, monthly, etc.?)

19 With whom do you usually have sex?

20 Under what conditions (under the influence/ sober)?

21 When do you enjoy sex more: when drunk or when sober?

22 Do you usually remember what happens during sex when you are drunk?

23 Where do you usually have sex?

24 Who decides on where to have sex?

25 Have you always used condoms when having sex with sex workers?

26 If the answer to the above question is NO, under what circumstances haven't you used condoms when having sex with a sex worker?

27 Under what circumstances would you have sex with a sex worker without using condoms?

28 Where do you usually get sex workers?

29 What things do you look for in a sex worker?

30 What class of sex workers do you usually target?

31 What class of sex workers do you usually manage to get?

32 How do you manage to attract sex workers?

33 Do you negotiate payment with the sex workers?

34 When is payment made?

35 How much do you usually pay sex workers?

36 How often do you have the desire to seek the services of a sex worker when you go out drinking? (Every time, sometimes, etc.?)

37 How often do you have the desire to seek the services of a sex worker when not drinking?

38 In what way does your use of alcohol affect your sexual behaviour?

39 Have you heard of HIV/AIDS?

40 Are you scared of contracting HIV/AIDS?

41 Do you know your HIV status?

42 Would you like to know your HIV status? Why?

43 Is it possible for you to tell whether a sex worker has HIV/AIDS?

44 Can you go out with a sex worker you suspect has HIV/AIDS? When?

45 If you were diagnosed with HIV/AIDS, what changes would you make to your sex life?

46 How many of your friends who have died of AIDS do you suspect contracted the disease from their involvement with sex workers?

47 Do you think your drinking puts you at risk of contracting HIV/AIDS? Why?

Annex Three

DETAILED FINDINGS ON (1) ALCOHOL USE, (2) SEXUAL BEHAVIOUR AND (3) INTERACTIONS BETWEEN STI/HIV, ALCOHOL USE AND SEXUAL BEHAVIOUR

INTRODUCTION

The core findings of the research conducted in the eight sites in this study are reported in Chapters 3.4 to 3.7 of this publication. However, an extensive pool of additional data was collected in the project countries on the issues concerned, namely alcohol intake, sexual behaviour and interactions between alcohol use and sexual behaviour. In view of completeness, and on behalf of those readers who may have a special interest in the additional data, this annex lists these data by project country and research topic.

1. Specific findings on alcohol use

1.1 Belarus

1 The official consumption figure was 9*l* per capita of pure alcohol per year. The total consumption, including illegaly produced and/or distributed alcohol, was estimated at about 13*l*.

2 An overwhelming majority of the population, including young people, were *regularly intoxicated by alcohol*.

3 During 2000

o 17 100 people died of trauma and poisoning related to alcohol intake.

o Of all "narcologically supervised" persons (18 613), 10.1% were women.

o Of crimes under investigation, 30% were committed under the influence of alcohol.

o Anti-alcohol legislation was violated 880 831 times (e.g. appearing in public in a state of intoxication, alcohol use in public places, at the workplace, being put into a medical sobering-up station, driving under the influence of alcohol).

o There was a high incidence of "alcohol-caused" incidents, traumas, diseases and STI transmission.

4 Substance use was *increasing*, especially among women and teenagers.

5 People with alcohol dependence problems were mainly those with low *education*—working-class people, vocational students (students from lower secondary education schools).

6 Those who *believed in God* drank alcohol significantly less frequently.

7 Alcohol **"***initiation***"** mostly took place at home—with parents.

8 Initiation into alcohol and other substances "through curiosity" was reported by between 62 and 72% of 14-16 year olds. Peer pressure was another important reason for starting to take alcohol.

9 The most *preferred drinks* were vodka, then wine and beer among boys, and "champaign", then wine and then beer among girls.

10 *Beer* was mostly considered *a non-alcoholic drink.*

11 *Places* where young people used alcohol were mainly those where supervision was impossible—parties, sport events, discos and bars.

12 "No holiday without alcohol" was an *established slogan* in Belarus.

13 "Binge for three" was a new form of the traditional binge drinking and was engaged in at every possible "celebration" (personal, family, public). "Celebration" had become an important aspect of the sociocultural context of alcohol use and a synonym for bingeing together. This may have much to do with alcohol use patterns in the context of weakened social and moral values.

14 Alcohol intoxication was *not considered scandalous* by most people and therefore nobody stopped to consider the risks associated with sex under the influence of alcohol.

15 At *student hostels* all celebrations occurred over weekends and were accompanied by alcohol use.

16 *Discos* were predominantly attended by students from vocational schools. Alcohol was much more used by those who showed up single at parties and were looking for a partner than those who came with a partner.

17 Among *homosexual* men there was little intravenous drug use; instead, the use of soft psychoactive substances, including alcohol prevailed.

1.2 India

1 Alcohol use was common among *men*, but very rare among *women*, except for tribal/ traditional folk artists and sex workers.

2 The degree to which alcohol was *accepted* varied across socioeconomic and cultural group, and might be linked to an overall *lifestyle* that includes the consumption of non-vegetarian food and liberal sexual attitudes.

3 The complementary occurence of alcohol use and group sex or homosexuality should be seen as an indicator of strong cultural barriers to any *sexual "otherness"*, which could only be broken under the *facilitating effect of alcohol*.

4 All participants from risk groups were alcohol drinkers.

5 The majority drank alcohol alone at home or at the workplace in the evening.

6 Cannabis/other psychoactive substances was used by half the participating transport workers and by 15% of the FCSWs. Opiates were used by 3% of the general population sample but by 13% of the transport workers.

1.3 Mexico

1 Families encouraged *children* to drink alcohol at the young age of 10-12 years (boys were being more encouraged than girls).

2 The main *drinking pattern* was excessive drinking on weekends, none or little during weekdays.

3 The *average intake* in beer halls was ten beers, which is very high.

4 *Peer group pressure*, which was typical of the adolescent environment, was particularly

strong in the venues frequented by young people.

5 *Social gatherings* constituted an excuse to drink.

6 The *social construction of masculinity* involved drinking—male status depended on ability to drink. Therefore any *male* behaviour under the influence of alcohol tended to be excused. A man was expected to drink whenever he was offered a drink so as to prove his masculinity and social independence.

Men also had higher *expectations of alcohol* as concerns the facilitation of social interaction, sexuality and feelings of power. Furthermore, men expected women to experiment with alcohol in order to stimulate sexual behaviour. Another specific justification for male alcohol use in heterosexual relations was disclosed: "Women do not need alcohol to cry and feel melancholic, but men do." Therefore a man "had to" drink in order to get in tune with his partner.

1 There was strong social stratification, almost segregation, in *venues* for entertainment and alcohol consumption; the stratification was also expressed by the type of music played in the venues. (Some venues catered for high income and "nice" young people who listen to rock and pop music while taking beverages; others catered for low income young people who listen to folk music while drinking beer.)

2 *Teenagers* drank beer—mainly because it was cheap—in groups, often at parties in one of the parents' houses. A common party saying was: "Where no one drinks or gets drunk there is no fun" and "If there is no beer or other alcoholic drink, that's a reunion, not a party". Young people consistently competed to see who could drink more and remain standing longer.

3 While visiting *reggae* concerts, young people frequently smoked *marihuana*, which was associated with reggae music.

4 *Other substance use* was tolerated in most of the venues (in beer halls mainly inhalants, in discos and bars cocaine, LSD, marihuana, acid, ecstasy).

5 Young people agreed that the most important reason for young people to start drinking was (1) lack of attention from their families and parents, and (2) conforming with other young people who drank.

6 Young people were being "*bombarded with alcohol advertisements*".

7 *Homosexual environment*: Drinking facilitated socialising/meeting and talking to acquaintances. In other words, here alcohol was an instrument.

1.4 Romania

1 More than one-fifth of people claimed that psychiatric clinics were there for alcohol-related problems.

2 More alcohol was used in rural than urban areas.

3 More men than women used alcohol.

4 Men drank beer and spirits, women wine and sweet liquor.

5 Young people usually drank spirits and poor people usually drank beer and cheap wine.

6 No formal control policy concerning sales, availability, consumption and advertising was being applied.

7 Home-made (illicit) alcohol was considered more healthy than alcohol sold legally.

8 The Romanians had the following national saying: *"Tell me what kind of alcohol you drink and I will tell ymu who you are."*

9 Alcohol use was not expected to have any *negative effect***.** Expected positive effects were happiness/a "high"; relief from problems, frustrations and worries; and gaining power and potency (not in a sexual sense).

10 There were gender-specific *expectations* concerning the influence of alcohol upon behaviour: Men were expected to be more rude and aggressive than women, and stopping drinking may result in a man becoming more gentle in his sexual behaviour.

11 There was a belief that women had *"a stronger censor than men and for this reason women's behaviour under alcohol is not so disturbed"*. This myth placed the responsibility for all safety/health issues on the shoulders of female partners.

12 Frequently the *wife accepted anything as long as her husband brought money*.

13 Another belief was that the type of behaviour following drinking depended on the *quantity* of alcohol used; this encouraged "easy" drinking.

14 Alcohol drinking had social labels/ meanings: Drinking alcohol was a *sign of maturity*, omnipotence, happiness, humour.

15 Alcohol use accompanied *all important events in life*.

16 *"Normal drinking"* meant knowing your own limits of drinking.

17 The "abnormal drinker" was seen to be a person who had developed a medical illness or had legal problems. Moreover, these consequences were often seen as *"bad luck"* or the result of sin.

18 Alcohol use was only perceived as a vice when the person was in the later stages of developing alcoholism.

1.5 Russia

1 The most frequent *place for using alcohol* was reported to be "in the street", followed by "on a visit"; only 9.5% of the 88 respondents indicated drinking alcohol in clubs, restaurants etc.

2 Young people in discos preferred *beer* because it was cheaper and because spirits was diluted by bar tenders.

1.6 South Africa

1 Alcohol was used mostly on *weekends*, except for the unemployed who drank on weekdays, mornings or afternoons.

2 Drinking alcohol was a kind of *lifestyle,* mainly in the urban environment.

3 Enjoying a party meant using alcohol.

4 Monday was a day for hangovers and Tuesday a day for cleaning by vomiting induced by drinking salt water.

5 *Drinking alcohol was proof of "maleness"*. Some women stated that partners who did not drink, tended to complain and nag around the house, or "had a problem".

6 *Men* tended to drink from 17:00–22:00, *women* from 17:00–05:00, and in some instances women drank more than men. (Applicable to men and women who frequent shebeens and

bars very often, spend much of their leisure time drinking, are regular and heavy drinkers, and sometimes are unemployed.)

7 Among the identified *risky drinkers*, there seemed to be a higher proportion of women than men. However, this might have been an artefact produced by the particular type of research; other forms of male alcohol use might have remained hidden. Moreover, the concept of "risky drinkers" might have been a problematic category per se.

8 Some women started drinking after experiencing *violence* from their heavy drinking partners because they felt that the drinking would help them cope with the violence. Another group of women reported that since drinking together, their lives with their partners had improved as it meant that they spent more social time together and visited drinking venues together. However, men often spoilt the flow of social interaction during outings by their jealousy and mistrust of their partners.

9 Only half of the women in the survey reported ever having drunk alcohol. This put in question the reliability of all the data.

10 Younger men reported enjoying *drinking competitions* (the "last man standing" was awarded).

11 The younger *women* who were reporting drinking from early morning till sunset tended to be those who were unemployed and heavy drinkers, and were recruited from shebeens and other drinking venues.

12 *Police* in uniform took alcohol at drinking venues.

1.7 Zambia

1 The alcohol used most frequently by sex workers and their clients was *mosi*. It was used on a daily basis "*because they mainly like it*".

2 Sex workers drank because they had to "*earn a living*" and to forget problems.

2. Specific findings on sexual behaviour

2.1 Belarus

Statistical data from previous studies

1 There was an increase of children born to minor mothers.

2 The proportion of abortions in families with fathers who were dependent on alcohol was 2–2.5 times higher than in other families.

Sexual debut

1 The most frequent motives for engaging in sex for the first time were: (1) sexual drive and desire; (2) love, feeling of being in love; and (3) curiosity and desire to get sexual experience.

2 Age of first intercourse among 14–17 year olds:

At age 14: 15%

At age 15: 25%

At age 16: 20%

Other data showed that 19% of sexually active young people started their sexual life *before age 16* (data from 189 medical school students aged 17–25 years).

1 Extremely early sexual debut (under age 13), as well as other negative parameters (alcohol use, rape), was much more frequent among the *rural population*.

Conceptualization of sexuality

1 The behaviour of teenagers has been changing significantly in recent years. A more *liberal* sexual outlook and increased sexual activity were also combined with low contraceptive use, leading to numerous teenage abortions and deliveries, as well as the spread of STIs.

2 In spite of the more liberal approach to sex, one-fifth of women and one-third of men expressed aversion to their future husband/ wife's engagement in premarital sex.

3 Typical comments of key informants on sexual promiscuity among young people:

Reason for promiscuity: The media supported and the youth accepted promiscuity, fashion stimulated sexual desire, commercial advertisements were based on sexuality and affected attitude to sexual behaviour significantly, familial relations were unsatisfactory, and sexual debut was frequently associated with violence.

There was a lot of free time and unspent energy which were vented through sex.

The decision to have sex was often made under the influence of alcohol or under pressure of the partner.

Promises of rewards in the form of money, clothes etc might persuade young people to have sex.

The majority of teenagers were spoiled, had few interests and hobbies, and read little.

Sex was therefore satisfying one's desires.

It was considered prestigious to have several partners, especially for a man.

Girls often associated sex with material hardship.

1 The parishioners in the focus group discussions expressed rejection of premarital sex, but whereas *men often blamed their wives for their premarital sexual relations* women did not do the same in connection with their husbands.

2 *Irresponsibility in sexual relations was typical among young people in Belarus.*

3 The majority of young people engaged in sexual intercourse under the influence of *psychoactive substances***,** mainly alcohol.

4 *Young girls often yielded to psychological pressure* from their young male partners in fear of jeopardising their relationship.

Places where people had intercourse

1 Wherever possible—apartments, hostels, parks, public gardens, benches, night clubs, basements, porches, disco bars.

2 *Apartments were leased for 24 hours or less*.

3 In student hostels almost all sexual activity occurred between 19:00 and 21:00, the time when visits were allowed; the remaining roommates had to leave the room.

4 Discos were seen as places for meeting "sexually loaded" acquaintances (sexually willing partners).

5 Bars were less perceived as places for meeting intimate acquaintances.

Homosexuality

1 The prevalence of homosexuality among people younger than 14 years in boarding schools was about 10%, which rate increased 100% for young people 14 years and older. They ususally had sex with mates from the same boarding school.

STI/HIV

1 Belarus had the third highest *syphilis* morbidity rate in Europe. In 1996, 2 per 1 000 of the population were infected with syphylis; in 2000, 1 per 1 000 were.

2 STI/HIV prevalence was the highest among women aged 18–19 years. In the age group 15-19 years, syphylis morbidity was three times higher among women than men.

3 In January 2001, 3 857 cases of HIV infection were registered, but only 23 of them were acknowledged as homosexual cases. This small figure might reflect a general rejection of homosexuality and fear of disclosing sexual orientation.

Condom use

1 Condom use was not looked upon as a steady safety precaution: 29% of respondents never used it and 44% used it quite frequently.

2 Survey data collected from young people showed *severely insufficient knowledge* of STD, HIV and sexual risk taking.

3 Condoms were available in shops, but were *expensive* for young people and residents of boarding schools, who were seldom given money and had many other financial needs.

4 Condom use was highly inconsistent, even in casual sex. If condoms were used, *prevention of pregnancy* was the chief reason, and was offered as motivation when women requested men to use condoms.

5 Both dominant *churches of the country* (the Catholic and the Orthodox Church) *were against condom use*.

Sex business

1 Sex workers preferred to attend private medical services where the approach/ attitude of the personnel was more humane and anonymity was ensured. Self-treatment of gonorrhoea occurred frequently.

2 Prostitutes working in hotels and call girls refused unprotected sex. However, street prostitutes might agree to *unprotected sex***,** especially with regular customers.

3 *"Covert"* or hidden *prostitution* occurred.

Pertinent survey findings

[The sample consisted of 300 participants (200 men, 100 women, average age 22 years, 70% practising Christianity—90% were from the Orthodox Church—and 21% were atheists).]

1 The average value (on a scale of 1–5) for *"importance of alcohol in sexual relations"* was 2.01, the value for "importance of religion in sexual relations" being 1.73.

2 In recent years 16.3% of the sample had had venereal disease.

3 Condoms were never used by 19.4% and seldom by 25%, which totalled almost *45% for seldom to never use of condoms* (for women only the figure was 58%). These figures differred little from the figure for the question on whether a condom was used in the last intercourse under the influence of alcohol: 50% of the respondents answered "No". Thus alcohol seems to have influenced condom non-use only marginally. One feasible

explanation might be the high non-use figure (45%), pointing to the fact that those who finally did use a condom, habitually did so.

4 Condoms were always used by 18% of the respondents (for women only the figure was 8%).

5 Having or not having had an STD differentiated significantly between the respondents on the following items: STD was related to a significantly higher frequency of having had more than five sex partners, to a higher divorce rate, to lower condom use (overall as well as during the last intercourse), and to lower overall satisfaction.

6 Inverted correlations between "inclination to risk" and "satisfaction level" occurred among respondents who had and who did not have an STD. Among those with STD, the higher their inclination to risk, the lower their satisfaction; among those with no STD, *the higher the inclination to risk, the higher the satisfaction.*

2.2 India

1 General population sample (alcohol users)

2 Alcohol at first intercourse: 20%

3 Premarital sex: 20%

4 Man-to-man sex (lifetime experience) among 8.5% of general population, and 9% among transport workers

5 Non-regular non-commercial sex among general population: 18%

6 MSMs in general population frequently engaged in anal sex, always without condoms

7 Condom use during last intercourse with regular sex partners: 11-15%

8 Condom used during last intercourse with non-regular partners: about 66.6%

9 Condom use was low except among FCSWs (79% during last intercourse), although they reported *low condom use during sex with non-paying clients*, who were partners for whom intimacy was reserved. Condom use with commercial clients ensured FCSWs of a sort of psychological protection.

10 Some people still believed in the traditional myth that *HIV transmission could be prevented* by cleaning the genitalia with alcohol, urine or antiseptic solutions, finishing the sexual act quickly, or ejaculating "outside".

2.3 Kenya

1 *Conceptualisation of male sex*: "As a man I still have to go out with other women. You cannot stick to one woman, and this is true of other men." This pointed to promiscuity and casual sex. Nevertheless, not everyone engaged in it.

2 People *who looked fat were believed not to have HIV*.

3 "People have stopped talking about pregnancy**.** *We fear HIV the most*."

4 *Condom use* was estimated to be very low—5% of sexually active people.

5 *Condoms were sold* at almost all visited hotels/bars. Unfortunately, sales were low.

6 *Safe sex* was often conceptualised as "mutual trust", which conceptualisation exposed one to risk in a country with a high HIV prevalence, as was the case in Kenya. Condom use was seen as proper for casual sex and commercial sex, though.

7 There was also a tendency to *substitute caution with trust*: "We should learn to trust our

partners and stick to the trusted one instead of introducing condoms." This attitude militated against the promotion of sex health.

2.4 Mexico

1 Heterosexual venues

2 Sexual intercourse occurred on the floors and in rest rooms (e.g. a restaurant bar in the south of Mexico City).

3 Oral sex was tolerated in semi-dark areas of a bar in the north of Mexico City (even though this was officially forbidden).

4 Homosexual venues

5 A fitness centre in Mexico City was being used on Saturdays/Sundays for sexual encounters—entrance was allowed only for those in underwear and with a towel.

6 Condoms were seldom offered for free or sold (only in homosexual venues) and were seldom promoted in bars and discos.

7 Homosexual men expressed their wish to use condoms openly, whereas partners in heterosexual relationships attached symbolic meaning to their encounters and therefore *could not negotiate condom use directly*. Nevertheless, the dominent route of HIV transmission in Mexico was through MSMs.

8 The *repressive male-dominated culture* prevented safe sex:

9 Many young people were shy to buy condoms.

10 Girls had or pretended to have little experience of sexual issues and therefore did not insist on condom use or did not carry condoms.

11 Young men did not stop to get condoms as they did not want to "sexually scare" their partners (who could change their minds).

12 Condoms were rarely used in casual sex among MSMs, not even in "dark rooms". It seems that *overall safety* was more important than safety during sexual intercouse (friends wrote down the registration number of a taxi in which someone was leaving for a sexual adventure).

13 Young women perceived *STI/HIV as a homosexual and prostitute problem*—they themselves associated unsafe sex with unwanted pregnancy.

14 The main perceived reason for using a condom was to prevent *unwanted pregnancy*, not STI/HIV. Family members who instructed young people to use condoms did so out of aversion to pregnancy, not fear of STI infection.

15 All the interview participants had practised at least some *unprotected anal or oral sex*, mainly in the early stages of their sexual life, in spite of prevention campaigns and the promotion of condom use.

16 Condoms were believed to *reduce sexual sensitivity*.

17 Condoms were *expensive* for young people.

18 Moreover, some MSMs claimed that sex without a condom induced a "*surge of adrenalin*", and the risk involved in unprotected casual sex gave additional pleasure.

19 *Chichifeo* occurred frequently, that is, older men paid for drinks and gave gifts to young men in exchange for sex.

20 Even *with steady partners* MSMs engaged in sex without condoms.

2.5 Romania

1 Young people had superficial and inconsistent knowledge of sexual risks and STIs.

2 Informants were unable to distinguish particular "models" of sexual relations, but the following *trends* manifested:

3 The differences between urban and rural sex life were disappearing among young people.

4 Gender relations were becoming more liberal, and extramarital relationships were more frequent.

5 "Marriage is not a norm for living together anymore."

6 Marital values like honesty and chastity were declining.

7 Engaging in sex frequently and having multiple sex partners were considered as masculine characteristics, although both sexes showed stronger sex-oriented behaviour.

8 Unwanted pregnancy was seen as the major risk in sexual relations. STI was denied and seen as fate or bad fortune.

9 Men's and women's perceptions of sexual risks differed: Men were more superstitious and women more realistic. ("Young men are very detached and consider it fate or bad luck if things go wrong. On the contrary, girls have condoms with them at many occasions.")

10 Young people used condoms much more than older people, probably because of their greater exposure to the mass media and campaigns. However, statistical data showed that condoms were used infrequently (in 1996 only 2.4% of the population used condoms).

11 *No sex education* was provided at school or at home, and talking about sex at home was tabooed and punished:

12 "My mother avoided discussing this subject with me."

13 "My mother never stopped threatening me if I should have sexual contacts with boys."

14 "I think my mother was afraid of my becoming homosexual or practising masturbation."

15 "When my father was drunk he was rude and pushed my mother into having sex, neglecting that his children were there. I first learned popular and vulgar language about sex and then what were appropriate and civilised words for that."

16 Reasons for engaging in first sex:

17 Woman: An uncle who lived in the village where she spent her summer vacations with her grandparents *forced* her to have sex when she was 14, rewarded her with new clothes, which she appreciated as she would not get such presents from her parents, and this happened regularly every summer vacation thereafter.

18 Woman: "To have sex in our breaks at school meant *glory*. Thus I was ready to say yes to the first solicitor." (She was 17.)

19 Man: He went for walks in the town and an *"experienced" girl took him by the hand* into the darkness under the trees and they had sex. She never spoke to him after that, even when they met again. (He was 17.)

20 Man: When he was 16, an *older friend took him to a woman* for commercial sex. She taught him "all-inclusive" oral sex, and they used condoms consistently.

21 Condoms were sold in every shop, but people were ashamed to buy them, and refused to use them because they would reduce pleasure and hamper spontaneity. However, young *women* were more and more *carrying condoms with them***.** Women were apparently more aware of sexual risks than men.

22 The main barrier to safe sex was the insistence on "*preserving the natural way of doing it*".

23 There seems to have been a wide range of individual *strategies* for lowering sexual risk, but the local culture was also influenced by the level of exposure to the world outside:

24 Some people relied on traditional beliefs and thus ignored risk, saying that "AIDS is very infrequent here" and "I heard that in Africa or the US there are a lot of AIDS cases ... here it is not often ... maybe children of the street ... *I could recognise a person with AIDS*, a vagabond, a homeless person, dirty and ragged, a wreck ... I never read something about such illnesses." The participants never used condoms even though they had sex with several unknown partners. (A taxi driver allowed his clients to pay him by having sex with him.)

25 Another participant expressed a *risky attitude but used a condom*: "I avoid having sex with unknown girls; all girls I have, frequently visited my disco or were introduced by one of my friends. Anyway, I used condoms when intuition told me to do so, because I am aware of the risk of STDs."

26 People who were *careful and used condoms* for casual sex had *experience of other countries, cultures and travelling*.

27 *Types of sex workers* in Romania:

28 Call girls;

29 Girls at motorways working in association with pimps, the latter being called "fish";

30 Girls at low-budget bistos and bars (considered to be the most risky sex partners);

31 Girls at markets being directly sold by "fish" to farmers from the rural areas who were seeking casual sex with an anonymous person (a "drink ritual" always accompanied negotiations on this type of sex).

32 Taxi drivers and older men frequently bought sex, and at railway stations customers bought sex from young girls (*street children*); sex was performed in toilets or in dark places.

2.6 The Russian Federation

1 Out of the 88 interviewees (university students and graduates; sub-group 1 aged 22 years and younger, sub-group 2 aged 23–30 years):

2 Sexual debut occurred before 16 years among 26.2% and 49.9%.

3 Condoms were used by 57.1% and 30.4% at first intercourse.

4 9.5 % and 2.2% indicated interest in both hetero and homosexual intercourse.

5 23.8% and 50% practised sex while under the influence of alcohol.

6 Sexual intercourse with unfamiliar persons was reported by 14.3% and 45.7%.

7 Casual intercourse occurred among 38.1% and 78.3%.

8 "Always used" a condom was reported by 24% and 13%.

9 "Always used" a condom during casual sex occurred among 43.5% and 70%.

10 "Never used a condom" was reported by 43% and 26.7%.

11 "Never used condom in oral sex" was reported by 88.6% and 66.7% (oral sex was reported by 57.1% and 69.6%).

12 Anal sex was reported by 14.3% and 19.6%; out of these, condom use was reported by 22% consistently always, and by 18% "sometimes", thus allowing for about 60% who presumably never used a condom with anal sex.

13 Group sex was reported by 45% and 47.8%. Of these participants, 89.5% and 54% "never used" a condom.

14 Commercial sex (reported by about 7.3% and 11%) was always performed with a condom and with alcohol.

15 Ever having had an STI was reported by 11.5% and 28.3%.

16 Having been *tested for HIV* was reported by 58.5% and 65.9%.

17 An *HIV-positive status* was reported by one participant in each group.

18 Alcohol intake before sex was reported by 90.5% and 89.1%.

19 In sub-group 2 *heavy drinking* (6–10 drinks) *before sex* was reported by 15.6%.

20 *The "older" group seems to have been consistently more at risk, although they also had more developed risk-preventing skills* (mainly condom use in casual and group sex) and had less liberal attitudes.

21 *Alcohol* was believed to remove pressure, inhibition and "*complexes induced by wrong norms of sexual behaviour in the family*". Alcohol was a cultural tradition, relaxed a person before sex and made sexual contact easier.

22 The *meaning of sex* was changing and sexual pleasure was greatly superseding all other pleasures (multiple partners, casual partners and sex with alcohol were the norm).

23 The two age groups had *different conceptualisations*:

24 The 14–22 year olds used condoms, expected a high number of partners, expected group sex and expected to relax and have pleasure when they combined sex with alcohol.

25 The 23 year old and older group were conservative about condoms—they did not use them except for casual sex. Pleasure was placed above health, and they were not afraid of STI because they were sure that it was curable. Pleasure and emotions were the chief concerns.

26 According to expert key informants, sexuality was getting more aggressive in Russia, mainly among groups of young people living "on the edge" of criminal circumstances. *"Condom-protected rape*" occurred.

27 In "Disco 1" in Moscow no sex was allowed in dark places or toilets—these were watched by security. "Casual" couples left the facility usually soon after some dances in order to find an appropriate place for sex. Condoms were sold from machines in toilets in this disco and boys used to buy them.

28 In another disco there were 14 "individual video telephone relaxation" booths where sex was being performed, and on another floor there was a long corridor with dark rooms (illuminated by screens with porno films) where any sexual activity was tolerated.

2.7 South Africa

1 Young men seemed to *divide sex* into:

2 Sex for procreation

3 Love-making, involving emotions

4 Having sex for recreation.

5 *For a man it was acceptable to have many sex partners*, for a woman it was not. Men having many sex partners was perceived as "normal". However, for a woman to have multiple sexual partners was considered to be morally wrong. The term "nava" was used to describe

an uncontrollable desire to have sex or being strongly aroused sexually. (The „condition“ of having nawa was mentioned by women in one focus group to describe a very specific group of women in a very specific township.)

6 *Women* were socialised to please men sexually.

7 Women were expected *to satisfy their male partners sexually* whenever the man wanted this. Some women reported on the use of antiseptics and a white stone to tighten their vaginas (i.e. engagement in so-called dry sex). However, in the long term this resulted in less friction and discouraged men from sexual relations with them. (The reference to dry sex was made by women during the focus groups mainly about other women and did not refer to their own behaviour.)

8 *Sugar daddies and sugar mummies* were older people who engaged in heterosexual relations with young people by providing them with benefits (expensive presents). The older people were supposed not to have HIV/AIDS, so youngsters believed they would not get infected through intercourse with their older sex partners.

9 Condoms might be used in casual sex but in sex with a regular partner people (mainly men) were more likely to want "*flesh-to-flesh*" sex. They believed that regular partners were safer because previous experiences of unprotected sex with them had not resulted in health problems, such as infection with HIV.

10 *Safe sex* seemed to be associated with condom use, but knowledge about the interconnectedness between STI, HIV and sexual intercourse seemed to be quite basic, almost superficial.

11 *Knowledge* about HIV, HIV status and related issues was apparently quite restricted. (A participant argued that, as he had a three year old child, he could not be HIV positive.)

General population data (questionnaire)

1 There seemed to be less *satisfaction* with the sex partner in the highest income cohort.

2 More women than men reported sometimes engaging in *unwanted sex* because of fear to refuse (27% versus 15%), fear of financial consequences (15% versus 11%), emotional consequences (12% versus 8%), verbal abuse (26% versus 17%) and physical consequences (9% versus 5%). More men than women (42% versus 37%) reported having sex with a partner "because the partner expected it". The above data on fear of refusing sex point to data "contamination" by the male construction of sex—"doing it whenever I want to". The fear of refusing sex was higher in the high-income cohort (33%) than the medium and low-income cohort (both 18%). Fear of the financial consequences of refusing sex dominated in the low-income cohort (18%, compared to 9% and 12%).

3 Surprisingly, the same frequency of *violence in the relationship* was indicated by men and women (13%), which might "prove" the reliability of this figure, particularly as it differs little from the violence frequency in other countries. The highest frequency of violence occurred, not surprisingly, in the lowest income cohort (17%) as compared to the 9% and 13% for the medium and high income cohorts. However, in the lowest income cohort the cultural acceptance of spousal abuse was the lowest (13%) and 18% among the medium and high income cohorts. The cultural acceptance of spousal abuse was much higher among men (26%) than women (9%), which acceptance found expression in their actual behaviour.

4 Trust in the partner was reported by about 78% of the participants, which figure may account for an overall low level of condom use.

Attitudes to condom use and safety

1 More than *five sex partners in the lifetime* was reported by more men (38%) than women (26%), and more often in the high than the low-income cohort (37% average for both sexes in the high-income cohort versus 29% in the low and medium income cohorts). Having multiple sex partners was reported to be "healthy" more by men (18%) than women (7%), and mainly by the high-income cohort. It was also much more culturally acceptable for men (46%) than for women (14%). Both sexes, however, saw it as a significant HIV risk (95% of women and 91% of men).

2 Not surprisingly, data on multiple sex partners differed strikingly between the qualitative and quantitative set. This is likely to be due to the difference in the sample, since the target groups of the qualitative assesments involved risky drinkers and their partners only, while the quantitative study sampled members of the general population. In addition, the difference could also be due to a social desirability bias in the survey data.

3 Some of the data on *condom use* were difficult to interpret as they were derived from a question about "last year's condom use", which was vague. However, two questions asked about condom use with a regular and casual partner in the past three months. Male condom use was higher than female condom use, and a strong linear gradient occurred in increased "consistent" condom use with a casual partner from the low (40%) to the high-income cohort (92%), indicating an *economy-related* interpretation of this item (condoms were expensive).

4 Actual condom use was reported consistently less among women than men, with both regular and casual sex partners, despite the differences in attitudes described above.

5 Excuses for not using condoms, based on the qualitative assessments:

6 "You get pushed into sex and you forget condoms."

7 Not going to get a condom was frequently motivated by fear of losing "the catch" while chasing a woman, or losing the opportunity to have sex with her.

8 Men (35%) perceived themselves more at risk of acquring HIV than women (29%). However, men "feared" infection from their stable partners more than infection from their casual partners; among women the opposite was true.

9 Survey data supported women's conception of sugar daddies as being less risky partners, but did NOT support the qualitative information on men's perception of sugar mummies as less risky partners. (This pattern was the strongest in the medium-income group.) This inverted relationship (*interaction between sex and risk perception*) between men and women was highlighted in the responses to the question on the importance of condom use with regular and casual partners: With regular partners condom use was considered important by more women than men (61% versus 49%), whereas with casual partners condom use was seen to be important by more men than women (92% versus 82%). The same distinction also occurred in respect of cultural acceptance of condom use in casual sex (condom use was accepted by fewer women than men). In other words, women feared their stable partners more than men did; but women feared casual partners less than men did.

2.8 Zambia

1 Age at *first sex* among female sex workers occurred mainly between 14 and 15 years.

2 The myth that *men could not be satisfied with only one partner* prevailed among 33.3% of women.

3 *Knowledge* about HIV/AIDS and condoms was lower among sexually active young people than among adults.

4 *Self-accepting sex workers* (willing to publicly acknowledge their profession—82% of the sample) were distinguished from *self-rejecting sex workers* (18% of the sample) by the first group's more consistent use of condoms. However, in contrast to other countries, the self-accepting sex workers walked the streets, and the self-rejecting sex workers worked in the night clubs.

5 *Condoms were used in commercial sex* by 15% to 22% to 66% of sex workers (as indicated by sex workers at different occasions); 48% of clients admitted condom use.

6 The main reason for *accepting unsafe sex* was the additional pay to be obtained from the client, which indicated the exploitation of sex workers.

7 *Places for commercial sex* were mostly rest rooms (not toilets, but brothel-like rooms that were rented for a few hours).

8 Of sex workers, 44% believed *they could spot a person with HIV/AIDS* simply by looking at the person.

9 *STI* occurred among 37% of sex workers**.**

10 *"Any lady was picked for sex"* according to 35% of clients.

3. Specific findings on the interaction/synergy of risks related to alcohol and sex

3.1 Belarus

Culture-related behaviour in general and partner selection

1 *Alcohol was the third most frequent reason for girls to have sex the first time*. An incomplete family seems to have correlated strongly with early sexual engagement.

2 Psychoactive substance users preferred *non-users of substances as sex partners,* which posed a significant potential health risk**.**

3 At discos *alcohol was much more consumed by those who showed up single* and searched for a partner than by those who came with a partner.

Sexual intercourse per se

1 There were significant differences between high and low alcohol use: *High alcohol use was related to having had more sex partners.*

2 "High" alcohol users had significantly *"worse" parameters* for the following risky sex indicators: age of sexual engagement (16 years for "high" alcohol users compared to 17.5 years for "low" alcohol users), assessing importance of alcohol for sex, assessing importance of love for sex, and assessing importance of morals for sex.

3 Some parishioners claimed that, after their conversion, they regretted all physical motivations/desires that featured before their conversion.

4 However, the social life of these parishioners was presumably harsh: "There was no sex without alcohol. Alcohol use was conventional. Alcohol was an essential part of sexual relations." Other parishioners revealed a completely opposite pre-conversion personal history of alcohol consumption: "I have never used alcohol before, during or after sexual intercourse" or "I have never tried alcohol". Whether previous risky sex or religious conversion was the determinant of change was unclear.

5 The venereal disease patients revealed a much less dramatic connection between alcohol intake and sex: "I do not always use alcohol before sex", "Alcohol before sex is not a must", "If you know a person well already, you are bettter off without drinking" and "Use of alcohol is acceptable but it is not a rule".

6 One female participant mentioned the following expectation of alcohol in relation to sex: "I become more attractive. As the saying goes, there are no women who are not beautiful enough, but it can so happen that there is not enough vodka."

7 Teenagers who started early with sex usually started drinking alcohol and using other psychoactive substances the year after their sexual debut. This mainly occurred among women. Also, those who started using alcohol and other psychoactive substances more frequently got sexually active as well. This might indicate a mutual "facilitative" effect between sex and substance use—in this particular context a *facilitation of initiation into these behaviours.*

Condom use

1 Fifty-nine percent (59%) of persons addicted to psychoactive substances from a project in the town of Vitebsk reported an STI.

3.2 India

Sexual intercourse per se

1 *First sexual intercourse was connected to alcohol* use among 12% of the alcohol users in the general population.

2 *Casual sex* was frequently connected with alcohol use

3 In non-regular, non-commercial sex, women never used alcohol; condoms were used in two-thirds of such "last intercourses".

Condom use

1 *Condom use among FCSWs was high (70–100%) despite alcohol use*. The study did not answer the question on amount of alcohol being drunk and thus actual condom use might be related to a relatively low dose of alcohol. Nevertheless, this indicated a pattern dominated by a focus on risk prevention.

2 Transport workers and people from the general population reported that they were more inclined to *use condoms when they were under the influence of alcohol than when they were sober*. Again, the amount of alcohol consumed was not established.

3.3 Kenya

Culture-related behaviour in general

1 Culturally, alcohol served as an excuse for any incorrect behaviour, a warranty for irresponsibility.

Sexual intercourse per se

1 A man reported taking alcohol in order to stay focused on sex with his partner. Another believed that *alcohol gives you extra power for sex*. "You only do what your mind tells you, you do not think twice."

2 Alcohol was commonly taken before or during sex *to encourage one to do risky things and*

to reduce fear of possible consequences.

3 Sex workers reported using alcohol in order to stand the *smell and dirtiness of some clients.*

3.4 Mexico

Partner selection

1 The *best seats* in bars/discos (near the dance floor) were bound to purchasing a whole bottle of alcohol, not just a drink.

2 The *sex-alcohol connection in homosexuals/MSMs* was partly due to lack of places other than bars where these people could meet and have sex, and to society's rejection of the homosexual way of life.

Sexual intercourse per se

1 When young people asked about possible risks of alcohol intake, *sexual risks were rarely mentioned.*

2 *Older visitors to night bars and discos generally bought alcoholic drinks for younger visitors* in order to persuade them to have sexual intercourse.

Condom use

1 A real threat for safe sex was *ecstasy*, a much more potent sexual stimulant than alcohol and thus significantly reducing the chance that a condom would be used.

3.5 Romania

Culture-related behaviour in general

1 The public was aware of the connection between alcohol and deviant sexual behaviour and that family violence (mainly by men) occurred under the influence of alcohol. However, the core interest of the study was "standard" rather than deviant behaviour, and in standard behaviour alcohol-induced problems were presumably hidden to the public.

2 It was believed that women had a stronger censor than men and for this reason women's behaviour under alcohol "was not so disturbed".

3 These myths need to be addressed, because it *took responsibility for safety/health issues from men* and placed them on the shoulders of women.

Partner selection

1 Alcohol was involved *in sexual debut almost as a rule***,** but not purposively to make sex easier; alcohol was taken as a "socialiser", and only during that socialisation the decision was taken to have sex (facilitated by alcohol use).

3.6 Russia

Partner selection

1 According to a patient in an alcohol treatment clinic in Russia "*it is typical to invite a woman to a restaurant and to treat her with alcoholic drinks*". She always had three to five alcoholic "portions" before any sexual contact to make her forget her problems and relax.

Sexual intercourse per se

1 The belief that a person without alcohol was incapable of making sexual contact had become established.

2 Pornographic films promoted alcohol use before sex.

3 Casual sex was strongly associated with alcohol use (significant amounts of alcohol among young people).

4 In Disco 1 in Moscow sex was not allowed in dark places or in toilets—these places were watched by security. "Casual" couples usually left the facility soon—after some dances—in order to find an appropriate place for sex.

5 In another disco there were 14 individual "video telephone relaxation" booths where sex was being performed, and on another floor there was a long corridor with dark rooms (illuminated only by screens with porno films) where any type of sex activity was tolerated.

Condom use

The extent of alcohol consumption and risky sex was directly related to socioeconomic status: *The lower the social status, the more the alcohol use and the less safe the sex.*

3.7 South Africa

Culture-related behaviour in general

1 In the urban site there was some *visibility of drunken people* performing sexual activities (kissing, fondling, making love in cars, pubs, parks).

2 Men perceived *drunken women as stupid*, meaning to be unable to control their actions.

Partner selection

1 Although *female partners of drinking men* were averse to their partners' drinking, it was convenient to stay with them for other reasons. Some refrained from having sex with their drunken husbands, indicating that "ownership" of a woman by a man could thus be challenged and deconstructed.

Sexual intercourse per se

1 Sex was reportedly practised under the influence of alcohol during the previous three months by 28% of the respondents (2% reported being under the influence of illegal substances). *Alcohol use during sex* increased significantly from the low to the high-income cohorts (18%, 31% and 35%) in the general population sample.

2 There was a strong positive correlation between *satisfaction with a partner* and frequency of sex under alcohol.

3 Alcohol seems to have been a *facilitator of male casual sex*—45% of men reported increased desire for casual sex when they had taken alcohol (18% of women did so) and 19% a decreased ability to "resist" (versus 7% of women) in the general population sample.

4 *According to the qualitative assessments, brandy, dry gin or milk stout mixed with milk* was believed to boost sexual performance. Sometimes rum was considered a sexual booster. Some women believed that drinking Black Label beer helped both women and men to become more sexually aroused and satisfied.

5 Young men considered *alcohol as the main driver of sex*. "When you are drunk you need it [sex]." Some even stated that "you could not have sex without alcohol" or that "alcohol and sex are a match made in heaven, you cannot separate these two".

6 *More women than men* in the general population sample (46% compared to 37%) *reported increased sexual pleasure after taking alcohol*.

7 Some women and men enjoyed sex in particular *when they were sober*.

8 Drinking helped or urged some participants to *experiment* with different styles of sexual intercourse.

9 When both partners were drunk, *oral sex* was more likely to occur.

10 Drinking made the participants *focus more on their own pleasure* than that of their partners.

11 Women frequently reported drunken men to be *abusive during sex*. One participant reported that her husband sometimes forced her to sleep on the floor while he was having sex with another woman in the same room. (Although she did not mention alcohol use, it was presumably used during such incidents.) Another woman was forced to have sex but "there is nothing I can do because he will tell me that he takes care of me".

12 In certain city pubs and drinking venues *sexual intercourse was performed on balconies, in toilets, even in the company of other visitors sitting at the same table and bench*. During none of these incidents were condoms used. Moreover, the research team was denied access to many venues that presumably offered even more unrestrained sex.

Condom use

1 Correlational analysis showed a strong positive association between "alcohol use indicators" (frequency, quantity, problems) and risky sex indicators (regretted intercourse, number of partners). However, condom use was not consistently associated with these risky sex indicators; condom use was presumably "determined" by a complicated set of factors, which calls for more profound research.

Correlational analysis also showed a significantly positive association between two risky sex indicators: frequency of sex under the influence of alcohol and alcohol-increased sexual desire on the one hand, and recency of condom use on the other hand. In other words, *the higher the frequency of alcohol-based sexual desire and sex, the more recently condoms had been used*.

3.8 Zambia

Partner selection

1 Men sometimes bought beers in bars just to *show* women that they had money.

Sexual intercourse per se

1 Between 30% and 80% (due to two different questions to sex workers in the report) of intercourse did NOT occur under the influence of alcohol. At the same time only 30% of the respondents stated that they had sex while sober.

2 *Sex was paid for with* money/gifts, but also with *drinks* (mostly) beer—this was the case among almost 40% of sex workers. This was confirmed by respondents who declared that they attracted sex workers mainly with money (39%) and lots of beer (35%). Thus the double dependence problems (to sex and alcohol) was a vicious circle.

3 Moreover, 40% of *sex workers felt "sexy" after taking alcohol*.

4 Over 70% of *sex workers indicated that they felt "nice" after (commercial) sex*. This contributed to their continued engagement in sex work despite the threat of HIV/STI. However, 60% of the sex workers and 56% of the clients indicated that *they enjoyed sexual intercourse most when they were drunk*. Also, almost 40% of the sex workers enjoyed "doing nothing" the most, and 40% enjoyed "making money" through sex the most (which 70% of them enjoyed, and 60% out of these 70% *enjoyed the most when drunk*).

5 Sex workers sometimes *pretended being drunk* to seduce clients.

6 For *commercial sex clients* beauty (48%) and neatness (22%) of the sex worker were the chief concerns, much less than sex itself (13%). Other international data on expectations of commercial sex greatly supported this finding—neatness was usually the dominating concern.

The link between alcohol use and sexual behaviour has serious implications for the health of populations particularly due to the advent of HIV infection. WHO coordinated a multi-country study to identify factors related to risky sexual behaviour among alcohol users in diverse cultural settings. The countries involved included: Belarus, India, Mexico, Kenya, Romania, the Russian Federation, South Africa and Zambia. The results of the study presented in this report are likely to be useful to respond in specific and appropriate ways to the problem of alcohol use and sexual risk behaviour.

ISBN 92 4 156289 7