

# Alcohol in the context of HIV among young women in South Africa

Consultancy services, Soul City (SC) South Africa

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**Leane Ramsoomar-Hariparsaad (PhD)**

*“Freedom cannot be achieved unless the women have  
been emancipated from all forms of oppression”*

*(Nelson Mandela)*

## **EXECUTIVE SUMMARY**

This report presents a broad overview of the impact of alcohol use and misuse on sexual risks, including HIV/AIDS among women aged 15-24 years in South Africa. It will analyse and review literature on the link between alcohol use, sexual risk, gender-based violence and HIV/AIDS among women in South Africa. The review will be presented against the backdrop of salient structural drivers (poverty, unemployment and gender inequality) that are understood to exacerbate existing vulnerabilities, particularly for black African women. This review is based on recent findings of the South African National HIV Prevalence, Incidence and Behaviour Survey (SABSMM), highlighting the high rates of HIV infection among 15-24 year old females in South Africa. This literature review will present a summary of policies and programmes that have been implemented in South Africa to mitigate these risks. Policy gaps to address the burden of alcohol use in the context of the burgeoning HIV/AIDS pandemic will be presented. This review highlights existing bottlenecks to effective population level implementation of policies and interventions and recommends practical considerations as a way forward (the appointment of an advisory group and suggestion of sectors as possible collaborators).

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## Definition of terms

**Adolescents:** 15–19 years old (WHO, 2014).

**Alcohol per capita consumption (APC):** is defined as the per capita amount of alcohol consumed in litres of pure alcohol in a given population (WHO, 2014).

**Alcohol dependence:** (also known as alcoholism or alcohol dependence syndrome) is defined as a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated alcohol use and that typically include a strong desire to consume alcohol, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to alcohol use than to other activities and obligations, increased tolerance, and sometimes a physiological withdrawal state (ICD-10; WHO, 1992).

**Heavy Episodic Drinking:** is defined as consumption of 60 or more grams of pure alcohol (6+ standard drinks in most countries) on at least one single occasion at least monthly (WHO, 2014).

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## List of abbreviations

<b>APC:</b>	Adult Per capita Consumption
<b>ART:</b>	Antiretroviral Treatment
<b>BAC:</b>	Blood Alcohol Content
<b>CCT:</b>	Conditional cash transfers
<b>DALY:</b>	Disability-Adjusted Life Years
<b>DDG:</b>	Deputy Director General
<b>GBV:</b>	Gender-based Violence
<b>GSHS:</b>	Global School-Based Health Survey
<b>HAPS:</b>	HIV and Alcohol Prevention in Schools
<b>HCT:</b>	HIV Counselling and Testing
<b>HIV/AIDS:</b>	Human Immunodeficiency Syndrome / Acquired Immunodeficiency Syndrome
<b>IMAGE:</b>	Intervention with Microfinance for AIDS and Gender Equity
<b>IPV:</b>	Interpersonal Violence
<b>LMIC:</b>	Low-and Middle Income Countries
<b>OMC:</b>	One Man Can
<b>MTF:</b>	Monitoring the Future
<b>MRC:</b>	Medical Research Council
<b>NDOH:</b>	National Department of Health
<b>NGO:</b>	Non-Governmental Organisations
<b>SABSSM:</b>	The South African Behavioural Seroprevalence and Mass Media Study
<b>STI:</b>	Sexually Transmitted Infection
<b>TB:</b>	Tuberculosis
<b>WHC:</b>	Women's Health Co-Op

**WHO:** World Health Organization

**YRBS:** Youth Risk Behaviour Survey

**YRBSS:** Youth Risk Behaviour Surveillance Systems

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## INTRODUCTION

Alcohol use and misuse presents a major risk factor for a range of leading causes of mortality and morbidity globally. The most recent Global Status Report on Alcohol and Health indicates that alcohol use alone accounts for 3.3 million deaths (5.9 %) of total deaths and 139 million (5.1 %) of total Disability-Adjusted Life Years (DALYs) (World Health Organization, 2014). As a risk factor, alcohol has been largely implicated in the epidemiology of both communicable and non-communicable diseases (Parry, et al, 2011; Lim et al, 2013; Kalichman et al., 2007; Fisher et al., 2007).

Moreover, alcohol has been increasingly recognised as an antecedent to many sexual risk taking behaviours (engaging in unprotected sex, incorrect or inconsistent condom use after heavy drinking, or engaging in sex with multiple partners, sex work and transactional sex), resulting in Sexually Transmitted Infections (STIs), including HIV/AIDS, interpersonal violence (including gender-based violence and sexual assault) (Jewkes, et al., 2002; Jewkes, et al.; 2010; Kalichman et. al, 2007; Dunkle et al., 2004; Scorgie, 2012; Magni et al., 2015). The association between alcohol and sexual risk is based on previous research that found alcohol use influences choices around sex, diminishes effective skills for consistent and correct condom negotiation and inhibits sound judgement (Chersich & Rees, 2010; Wechsberg et al., 2005; Morojele et al., 2006).

In sub-Saharan Africa, where heavy alcohol use co-exists with a devastating HIV burden, this intersection results in negative health outcomes-particularly for women. Sub-Saharan Africa accounts for approximately 69% of the global burden of HIV and AIDS (UNAIDS 2012). South Africa remains a heavily burdened country, with a prevalence of 17.9% (UNAIDS, 2013). Recently, the South African National HIV Prevalence, Incidence and Behaviour Survey (SABSM) 2012 estimated that 12.2% (6.4 million) of the South African population were HIV positive. Within this HIV infected population, young women (15-24 years old) have been disproportionately affected by the disease, with a reported incidence of 24.1% (Shisana, et al., 2014) and up to eight times higher HIV prevalence relative to their male peers (Dellar, et al., 2015).

The socio-economic, biological and behavioural factors cited as determinants of sexual risk and HIV infection for young women include unique biological risks, (larger mucosal surface areas), multiple and concurrent sexual partnerships, unprotected sex, alcohol

use in the context of sexual exchange, gender-based violence and transactional sex (Ackermann, et al., 2002; Morojele, 2006; Kalichman et al. 2009).

In the face of multiple and often complex cluster of risk factors, alcohol use has been consistently cited as a key determinant of sexual risk (Fisher et al., 2007; Shuper et al., 2010; Kalichman et al., 2007; Morojele et al., 2006; 2013). Furthermore, women are profoundly marginalised because these risks occur against the backdrop of a socio-economic context characterised by high rates of unemployment and poverty, low social status of women, and the lack of opportunities for education and economic progression in South Africa. Given this marginalisation, South African women concurrently face the colliding risks of early alcohol initiation, heavy alcohol use and gender-based violence (GBV) and HIV (Shisana, et al., 2014; Russell et al., 2013; Morojele et al., 2013).

This review is premised on ample evidence that illustrates alcohol consumption is associated with risky sexual behaviour resulting in STIs, gender-based violence and HIV infection. It asserts risks occur within the context of stark gender inequality, poverty and unemployment-which perpetuate women's marginalisation. While the review is unable to comprehensively address all issues related to alcohol, gender-based violence and HIV/AIDS, it provides broad brush strokes of the link between alcohol and sexual risk in the context of the structural drivers of HIV.

### **The link between alcohol use and sexual risks**

Alcohol is widely understood to be consumed along two dimensions, that is, volume of consumption (litres of pure alcohol consumed) and patterns of drinking (mainly binge drinking) (Rehm et al., 2004). Volume of consumption is understood to be related to chronic diseases such as cardiovascular diseases and cancer (Parry, et al., 2011), while drinking patterns (heavy episodic/binge drinking) are associated with acute effects, such as violence, unintentional injuries, and high-risk sexual behaviours (Rehm, et al., 2004). A considerable body of empirical evidence supports the association between alcohol use and sexual risk. In the absence of a causal link, several studies found strong associations between alcohol use and misuse as a behavioural risk factor for HIV incidence (Fisher et al., 2007; Kalichman, et al., 2007; Shuper et al., 2010). Findings from a recent review of the association between alcohol and HIV in sub-Saharan Africa indicate that adolescents who consume alcohol were more likely to engage in sex, early sexual debut and have multiple concurrent partners than their non-consuming counterparts (Morojele et al., 2013).

The relationship between alcohol consumption and sexual risks has been examined in relation to frequency of alcohol use (how often alcohol is consumed) and quantity of alcohol consumption (how much is consumed). Notwithstanding evidence that frequency of alcohol use is associated with sexual risks, (Kalichman et al., 2007), quantity of alcohol use, particularly heavy drinking, is consistently associated with an increased risk of sexually transmitted diseases (STIs) (Cook & Clark, 2005; Carrasco et al., 2015; Kalichman, et al. 2007; Chersich & Rees, 2010). In particular, Kalichman and colleagues (2007) found that the greater the quantity of alcohol, the increased likelihood of sexual risks. People with problem drinking have been found to have a two-fold higher risk for HIV than those who do not drink (Chersich and Rees, 2010). Similarly, a meta-analysis of global studies found an association between alcohol consumption and an increased risk of HIV infection (Balinaus, 2009). Zablotska and colleagues (2006) in their study in Rakai, Uganda found that using alcohol before sex increased the likelihood of HIV infection. Similarly, Fisher and colleagues found strong associations between alcohol use and HIV infection in South Africa (Fisher et al., 2007). Recently Townsend and colleagues, in a Cape Town based study found that alcohol misuse (problem drinking) was significantly associated with having any symptom of a STI; non-use of condoms due to drinking; and inconsistent condom use (Townsend et al., 2010).

Moreover, other studies found that unprotected sex among HIV infected populations is significantly associated with *any* alcohol consumption as opposed to *no* consumption, while greater quantities of alcohol use are strongly associated with HIV transmission (Kalichman, 2007) and incidence (Balinaus, et al., 2009). In essence, alcohol consumers are at higher risk of STIs, including HIV than their non-consuming counterparts (Kalichman et al., 2007; Morojele et al., 2013) though evidence highlights the salience of the quantity of alcohol consumed as a particular threat for sexual risk taking (Carrasco, et al., 2015).

Alcohol is also understood to indirectly impact on sexual risks, including HIV via behavioural factors such as heavy consumption prior to sexual activity, incorrect and/or inconsistent condom use and multiple concurrent partnerships (Fisher et al., 2007; Kalichman et al., 2007). Morojele and colleagues (2006) provide a convincing argument for the association between alcohol and sexual risks in Africa. They posit that the most distal predictors of alcohol-related sexual risk behaviours (societal/cultural/peer group/community/familial) are the key predictors of heavy alcohol consumption (See Fig 1). These predictors influence alcohol consumption which in turn influences sexual risk behaviours. Moreover, the model acknowledges that drinking environments, socio-economic,



societal and community contexts moderate the relationship between alcohol and sexual risk behaviour. Their research supports findings that individuals who are unemployed, poor, and exposed to social, cultural and community norms that promote heavy drinking are those that drink heavily (Morojele et al., 2006). They also argue that alcohol affects sexual risk behaviour via psychoactive effects (reasoning, judgement, and sense of responsibility). These psychoactive effects are moderated by the very conditions in social, cultural and community domains and drinking environments that serve to either promote or discourage alcohol and risky sexual behaviour. Furthermore, the model posits that psychoactive changes (sexual arousal, sexual desire and inhibitions) yield risky sexual encounters in the presence of these moderating factors. Notwithstanding the indirect effects of alcohol use on sexual risk behaviour, the model acknowledges that there may be direct predictors of sexual risk behaviour in the absence of alcohol use. In addition, they argue for a mutually negative reinforcing relationship between engagement in a sexual encounter and more drinking, as illustrated by the loop (dotted arrows) (See Figure 1) between alcohol use and sexual risk.

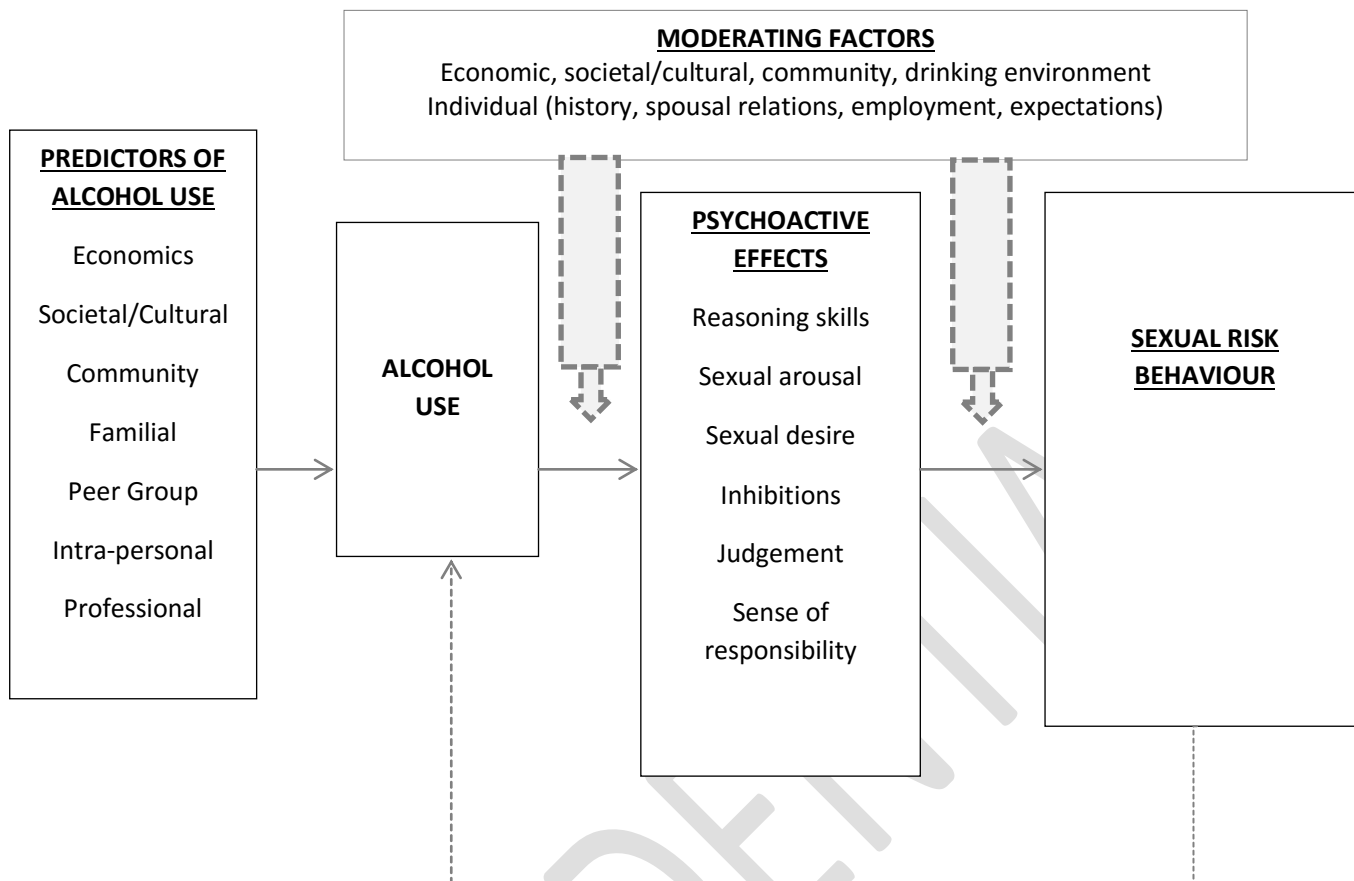


FIGURE 1: Conceptual model of alcohol use and sexual risk behaviour (Morojele, et al., 2006)

In South Africa where structural conditions such as poverty, unemployment, and gender and power imbalances prevail, the interrelationships between structural, behavioural and cognitive factors can have dire health consequences, particularly for key populations at risk for HIV infection. Moreover, the high volume of alcohol consumption and heavy drinking patterns (WHO, 2014) which co-exist with a massive HIV burden places poor and disempowered young women at particular risk.

### Alcohol and Gender

It is widely established that women (particularly young women) bear the brunt of the HIV pandemic in South Africa (Ramjee & Daniels, 2013; Shisana, et al., 2014; Magni et al., 2015). Of the almost six and a half million people in South Africa who live with HIV, 23.3% are women. The high incidence among young women aged 15–24 years is disquieting and highlights the need to address the associated socio-economic determinants. Concurrently, global evidence has consistently indicated that males outnumber females in frequency of

alcohol consumption, binge drinking, and alcohol use disorders (WHO, 2014). This is consistent with evidence from population based studies, such as the Youth Risk Behaviour Surveillance Systems (YRBSS), the European School Survey Project on Alcohol and other Drugs (ESPAD), the Monitoring the Future Survey (MTF), and the Global School-based Student Health Survey (GSHS) (Xuan et al., 2015; Hibell et al., 2012; Johnston et al., 2015; Reddy et al., 2013).

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**Table 1. Alcohol drinking status among South Africans by gender (%)**

	2002 YRBS		2008 YRBS		2011 YRBS		1998 SADHS		SABSMM 2005	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Ever used alcohol	56.1	43.5	54.4	45.1	53.8	44.9	35.5	15.9	32.4	15.4
Current alcohol use (past 30 days)	38.5	26.4	40.5	29.5	36.6	28.2	23.3	8.5	27.6	11.6
Past month binge drinking	29.3	17.9	33.5	23.7	30.3	20.1	17.3	5.8	0.5	0.2
Age of initiation <13 yrs	15.8	9.0	15.3	8.6	16.3	8.7				

Source: Reddy et al., 2002; 2010; 2013 (13-19 years old); Department of Health, 1998 sub-sample (15-24 years old), 2003; Shisana et al, 2005 sub-sample (15-24 years old)

Despite alcohol consumption in South Africa being characterised by high rates of abstinence (WHO, 2014) and lower alcohol consumption among women, (See Table 1) abstention co-exists with heavy episodic drinking, particularly over weekends (WHO, 2014; Parry et al., 2005). Since heavy episodic drinking is associated with acute effects such as unintentional injuries, sexual violence and risk taking, women (who themselves may drink heavily or whose partners do so) are placed at increased risk of several acute negative outcomes.

Women largely expose themselves to alcohol and its associated harms during their interaction with men, namely, as patrons of alcohol-serving establishments, via sex work, domestic and external contexts in which sex is coerced, transactional sex and as victims of interpersonal violence and gender-based violence (Fritz et al., 2010; Pitpitan et al., 2016). While men globally consume more alcohol more frequently and record higher levels of binge drinking and alcohol use disorders (WHO, 2014), women often find themselves at the receiving end of men's alcohol consumption and/or as victims of their own structural circumstances (poverty, unemployment and lower social status). This is supported by previous research indicating that women are more likely to drink with a sex partner than men (Morojele, et al., 2004), be victims of alcohol-related sexual violence (Phorano et al., 2005) and engage in transactional sex and sex work than men (Wechsberg, 2006; Jewkes et al., 2012).

In the context of a burgeoning HIV pandemic, multiple and often colliding factors increase women's vulnerability to acquiring sexually transmitted infections including HIV. These include, but are not limited to, biological, economic (transactional sex and sex work) and behavioural (alcohol use, multiple sexual partners, unprotected sex) and structural determinants (poverty, unemployment) (Chersich & Rees, 2008, Kalichman, et al., 2007; Morojele et al., 2006).

South African women face stark gender disparities including unequal power relations, limited opportunities for work and access to income, education, housing and health care (Wechsberg, 2008). In keeping with socio-economic conditions in most low-and middle income countries, South African women have access to fewer resources, fewer opportunities for gainful employment and/or to be educated. This stark reality is reflected in the 2011 Census figures which indicate that unemployment rates among South African women (34,6%) are higher than those among South African men (25,6%). Black South African

women are further marginalised by racial and gender differentials reflected in the low unemployment rate among white men (5,0%) versus the high unemployment rates (41.2%) among black African women (Statistics South Africa, 2012). The same report found that labour force participation is lowest among women in the black African population group and highest among men in the white population group. In terms of household income, the average female-headed household had approximately more than half the annual income in 2011 (at R67 330) compared to their male counterparts, who earn an average of at least R128 329 (Statistics South Africa, 2012). Similarly, women continue to lag behind men on overall opportunities for education. Previous research found that South African women often have to forgo education in favour of men (Dellar et al., 2015; Myers et al., 2015). Census data indicate that almost 10% (9.9) of South African women aged 20 years and older have no education at all with a small narrowing of the gap in the two latest reporting periods, that is, 2009 (12.1%) and 2011 (9.9%) (Statistics South Africa, 2012). This inequality in education, employment and economic opportunities exposes women to a range of risks, including sexual, violence and relationships that undermine efforts to prevent HIV. The constrained opportunities for education and employment result in economic dependence on men for resources, exchange of sex for money and resources and reinforcement of inequality. Wechsberg and colleagues found that poorer women may be influenced by their male partners to engage in risky behaviours, including both alcohol and other substance use and sexual risks (Wechsberg, 2008).

The prevailing patriarchal society in South Africa further heightens women's vulnerability, particularly as it relates to negotiating power within the context of sexual relationships. The hegemonic discourse of masculinity means that men are viewed as "in control of women" (Jewkes & Morell, 2010) and women lack the requisite power and agency to negotiate sex, condom use and fidelity. Previous research in South Africa reveals that gender power imbalances and intimate partner violence places women at increased risk of HIV infection (Jewkes & Morell, 2010), while other research indicates that individuals who consume alcohol prior to sex are at increased danger of engaging in high-risk sex (Dingle & Oei, 1997; Kalichman et al., 2007), hence more likely to be HIV positive (Woolf-King et al., 2013). In South Africa, heavy drinking patterns co-exist with sexual risks (Morojele et al., 2013) and heavy drinking patterns in turn affects sexual decision-making, including correct and consistent condom use and condom negotiation. Chersich and Rees (2008) found that heavy episodic drinking among women resulted in inconsistent condom use, sexual violence

and the acquisition of STI's including HIV. In short, alcohol use fuels an already unequal power relationship between men and women, resulting in several negative outcomes, including HIV/AIDS, STI's, teenage pregnancy and sexual assault (Chersich & Rees; 2008; Kalichman et al., 2007; Dunkle et al., 2004). Furthermore, perusal of the incident cases of HIV in the latest South African HIV surveillance report reveals that key affected populations are mostly concentrated within poor and marginalised groups (Shisana, 2014).

## **Drinking contexts**

A rapidly growing body of research has implicated drinking contexts as key contextual determinants of sexual risk. Given the characteristics of alcohol-serving establishments - many informal, unregulated and without sexual risk reduction strategies (e.g. access to condoms) - alcohol venues are seen as contexts in which the risk for both alcohol use and sexual risk coincide (Pitpitan et al., 2013). Additional research describes drinking establishments as meeting places where sexual initiation and multiple sexual partnerships commence and potentially sustained (Kalichman et al., 2007; Morojele et al., 2006).

Research conducted in alcohol-serving establishments in Cape Town, South Africa found that sexual and alcohol-related risks with partners outside of primary relationships commonly occurred in alcohol-serving venues (Kalichman et al., 2013). Similarly, a rural South African study found that frequenting alcohol outlets was associated with increased sexual risk among young women, particularly after they consumed alcohol (Rosenberg et al., 2015). Specifically, the authors found that young South African women who frequented alcohol-serving outlets reported more sexual partners, engaged in more unprotected sex and transactional sex compared to young women who did not frequent such establishments (Rosenberg, et al., 2015). It is important to note the assertion that alcohol-serving establishments promote risky sexual behaviour given the often clandestine environment and characteristics (lighting, music and lack of condoms) (Rosenberg, et al., 2015). The study concluded that frequenting alcohol-serving establishments in rural South Africa was associated with increased sexual risk, particularly among alcohol consuming women (Rosenberg, et al., 2015). This is in keeping with previous research (Kalichman, et al., 2007; Morojele et al., 2004), that found drinking establishments such as bars, taverns, and private homes where alcohol is served and consumed, are associated with HIV and other sexual risks. Morojele and colleagues (2006) reported that alcohol-serving establishments are often sex venues, underlining the co-existence of alcohol consumption and risky sexual behaviours. Pitpitan and colleagues (2013) demonstrated that alcohol use among female bar patrons in South Africa was associated with gender-based violence and sexual risk, while Weir and colleagues (2003) found that drinking venues across rural and urban areas were common spaces where people met sexual partners. Worryingly, these establishments often did not supply or make available condoms (Weir, 2003). A study in Tanzania on women, bar and hotel workers found that alcohol use before sex was associated with condom failure, which was five times more likely to occur when compared to those who did not consume alcohol.



Furthermore, prior alcohol consumption was associated with engaging in sexual encounters with casual, first time, or transactional partners (Fisher et al., 2010).

### **Sex work**

Sex work has long been recognised as a structural driver of the HIV epidemic. The very nature of sex work is symptomatic of social and economic vulnerabilities that face many women (Scorgie et al., 2012). Sex work places women at risk for unprotected sex, re-use of condoms and alcohol abuse (Campbell & Mzaidume, 2001), resulting in sexually transmitted diseases, violence and substance abuse (Wechsberg, 2006). A systematic review and meta-analysis of data from low income and low-middle income countries revealed that women who engage in sex work are at an increased likelihood (13 fold greater than women in the general population) of being HIV positive and having other STI's. (Baral, et al., 2013). This is unsurprising given that, multiple and changing partners among sex workers, their partners and clients result in rapid transmission of HIV and other STI's (Chen et al., 2007).

Alcohol compounds the risk that many sex workers face. Wechsberg and colleagues found that almost a quarter of sex workers (25%) in their South African study drank on a weekly basis (Wechsberg et al., 2005). In another study, 60% of sex workers reported using alcohol with clients in the past month, 62% reported using alcohol before sex and almost half (48%) of their clients who were violent, were drunk half the time (Wechsberg, 2005). Recently, Pitpitan and colleagues established that there was an increased likelihood of alcohol and drug use among men and women "sellers" of sex in a Cape Town based study (Pitpitan et al., 2013).

### **Transactional Sex**

Previous research has tended to use the terms transactional sex and sex work interchangeably. For the purposes of this review, transactional sex is understood to be the exchange of sex for cash, material goods (e.g. groceries, gifts), or services such as accommodation or transport. It is differentiated from sex work, whereby the individual in sex work identifies him/herself as a sex worker, price is often negotiated beforehand and sex is usually solicited in public spaces (Jewkes et al., 2012). The multiple and concurrent nature of partnerships that characterise transactional sex, often with no or low condom use, predisposes (Leclerc-Madlala; 2005; 2008) particularly young women in age-disparate relationships to STI's (Hawkins et al., 2009; Zembe et al., 2013).

Furthermore, in transactional sex, young and often poor, women exchange sex for material goods and to meet basic survival needs (Kalichman et al., 2007; Zembe et al., 2013). Research in South Africa has shown that transactional sex is inextricably linked to prevailing socio-economic and gender power imbalances (Leclerc-Madlala, 2005; Zembe, et al., 2013), where men view sex as an entitlement (Jewkes et al., 2012) and women possess very little negotiating power in the occurrence and nature (protected/unprotected) of the sexual act. Indeed, Zembe and colleagues (2013) found that transactional sex is seen as a manifestation of impoverished socio-economic contexts, in which many young women in South Africa live. As a result, transactional sex is viewed as a driver of sexual risks, particularly HIV and STI's among many young South African women (Zembe et al., 2013).

Alcohol is linked to transactional sex as a commodity for exchange. For example, alcohol is often cited as one of the "goods" exchanged for sex with men (Mataure, 2002; Zembe et al., 2013). Other research indicates that sex partners buy women drinks (Maganja et al., 2007) in exchange for sexual encounters, often under conditions determined by the man (Dunkle et al., 2004). Findings from a mixed method Tanzanian study found that alcohol used in the context of transactional sex reduced shame, induced relaxation among individuals exchanging sex for material goods and consequently increased the chance of acquiring a STI (Norris, et al., 2009).

Alcohol use is also directly associated with transactional sex, particularly as it relates to quantities of alcohol consumed. Previous research has found a dose-response relationship between heavy alcohol consumption and sexual risk (Weiser, et al., 2006). In South Africa, Townsend and colleagues discovered that men drank to excess as part of a deliberate strategy to "attract women to them and, subsequently as a currency in transacting for sex" (Townsend et al., 2010). This strategy was based on the fact that excessive alcohol use a.) decreased men's inhibitions and increased self-assurance in proposing sex and b.) supported no, inconsistent or erroneous condom use, even in the presence of knowledge about HIV risks, placing women partners at risk for HIV infection (Townsend et al., 2010).

Results from a recent nationally representative survey in South Africa indicate that transactional sex is a risk factor for HIV infection and that alcohol may increase the risk for transactional sex (Magni et al., 2015). Specifically, binge drinking and alcohol dependence was shown to increase the likelihood of engaging in transactional sex, which placed women at risk for HIV infection (Magni, et al., 2015).

## **Gender-based violence**

Intimate partner violence and the risk for HIV infection have become a major concern for public health practitioners in South Africa (Jewkes & Morell, 2010; Jewkes, et al., 2010; Dunkle et al., 2004). In sub-Saharan Africa, a region with high rates of under-reporting of sexual violence, the prevalence of sexual violence ranges between 5-46% (Stockman, et al., 2013) and is associated with risk for HIV infection. Violence is overwhelmingly gendered. South African studies among men found that 27.5–31.8% enact violence toward partners (Dunkle et al. 2006), while Seedat and colleagues found that half the female victims of homicide are killed by their intimate male partners. In addition, South Africa has a particularly high rate of rape of females (Seedat et al., 2009). A strong evidence base exists demonstrating that gender-based violence is associated with high-risk sexual behaviour, including multiple and concurrent sexual partnerships, alcohol and other drug use, transactional sex and sex work, and irregular or low condom use (Dunkle et al., 2004; Jewkes et al., 2006; Wingood, & DiClemente, 1998). Although the relationship between gender-based violence and HIV infection has (deservedly) been the focus of many recent studies, this association is further complicated by alcohol use. Pitpitan and colleagues found that alcohol use was associated with gender-based violence and sexual risk among women in drinking venues in Cape Town (Pitpitan et al., 2013). In addition, Phorano and colleagues found that the link between violence in the context of relationships is in part accounted for by consumption of alcohol (Phorano et al., 2005).

Coerced sex and/or sexual assault have been associated with alcohol use, although the temporality of this association remains unclear (Balinaus, et al., 2009). A global systematic review of intimate partner violence in low-and middle income countries established an association between sex which was coerced and HIV/STIs, multiple and high-risk sex partners and no condom use (Stockman, et al., 2013). The risk profile of male perpetrators of violence indicates that they are likely to have a history of physical aggression, engage in multiple concurrent sexual partnerships, use condoms inconsistently and engage in alcohol misuse (Dunkle et al., 2006; Abrahams et al., 2004; Jewkes et al., 2002), and engage in transactional sex (Hoffman et al., 2006). Not surprisingly, previous research found that men who perpetrate violence against women were more likely to have STIs, multiple concurrent partners and therefore more likely to be HIV positive (Garcia-Moreno, et al., 2006).

Moreover, relationships in which IPV exists are usually characterised by stark power differentials (Morell & Jewkes, 2010; Dunkle et al., 2004), which limit the ability to negotiate

safer sex. Biologically, the often aggressive act of sexual coercion may result in genital tearing and facilitating the spread of HIV into the blood stream (Campbell, 2002). The causal pathways between gender-based violence, alcohol use and sexual risk are multifaceted and complex, consequently requiring responses that are multi-level and ecological in nature.

## **The response**

The interrelatedness of sexual risk taking and alcohol use within the context of structural factors, such as gender inequality, in South Africa highlight both behavioural and structural determinants that place young women at risk. Addressing alcohol-related sexual risk behaviour in the context of a burgeoning HIV epidemic requires multi-level, intersectoral interventions that go beyond the health sector, which is necessary in order to address the structural drivers that directly and indirectly increase girls' HIV risk. Consequently, these interventions can (and should) focus on primary prevention, but not to the exclusion of structural interventions and empowerment of women through investments in education, economic empowerment, and access to income and property.

A few, but important, efforts in the field of sexual and alcohol risk reduction have been undertaken to mitigate the risks for HIV and alcohol abuse respectively. These include venue-based interventions (STI-clinic and bar studies) (Kalichman et al., 2007; Morojele et al., 2006), sex worker setting studies (Wechsberg, et al. 2008), school-based programmes (Karnell et al., 2006, Wechsberg, 2005; 2006; Smith et al., 2008; Cupp et al., 2008; Deveau et al., 2009) and community based programmes (Jewkes et al., 2008; Letsela, 2012; Wechsberg et al., 2014; Pronyk, et al., 2006; Letsela, 2012; Nkosi et al, 2009; 2015). Table 2 below details studies, campaigns and interventions that have addressed alcohol-related sexual risk and HIV in South Africa

**Table 2: Studies/Campaigns/Interventions of alcohol-related sexual risk and HIV in South Africa**

<b>Study name/author</b>	<b>Year</b>	<b>Geographic location</b>	<b>Duration</b>	<b>Type</b>	<b>Impact</b>
<b>Stepping Stones</b>	2002	35 communities in Eastern Cape Province, South Africa	3 years	Community based RCT	33% reduction in HSV-2 incidence at 2 year follow-up Lower % of men reporting perpetration of IPV across two years of follow-up Less transactional sex and problem drinking at 12 months
<b>Women Focused HIV Prevention Intervention</b>	2006	Pretoria, South Africa	5 years	Pre-Post Intervention	Significant increases in past week condom use, but not general use
<b>Wechsberg 2008</b>	2008	Cape Town, South Africa	3 years	Pre-Post Intervention	Women in the WHC area were 1/3 less likely to become HIV infected Twelve months post intervention, HIV positive women in the intervention arm were significantly more likely to be abstinent from alcohol than HIV positive women in the nutrition or HCT arm
<b>One Love Campaign</b>	2009	Lesotho, Malawi, <b>South Africa</b> , Swaziland, Tanzania, Zambia and Zimbabwe	3 years	Mass Media campaign	Greater likelihood of HIV testing compared to control group Greater likelihood of condom use among exposed group compared to control group Reduction in sexual partners among exposed group in Namibia and Zambia

					only (See also pg.34 below)
<b>IMAGE</b>	2001	Limpopo Province, South Africa	5 years	Cluster randomised trial	A 55% reduction in IPV among women in the intervention arm relative to controls. Significant increases in communication about sex or HIV in the homes of IMAGE sample
<b>One Man Can</b>	2006	Limpopo, Eastern Cape, Kwa-Zulu Natal, Mpumalanga, the Free State, Gauteng and North West, South Africa	Ongoing	Public campaign	Increased participation of men, youth and traditional leaders/healers in workshops. Increased public dialogue, awareness and shift in public attitudes around HIV, stigma and the problems of gender-based violence. Improved parenting and more involved and responsible fathering
<b>HealthWise</b>	2008	Cape Town township based schools, South Africa	3 years	School-based RCT	Reduction in onset of sexual activity among males and females  Reduction in the mean no. of partners in the past 30 days, past 6 months
<b>Women's Co-Op</b>	2014	Western Cape, South Africa	5 years		One third reduction in likelihood of intervention population becoming HIV infected 12 months post intervention, HIV+ women were significantly more likely to be abstinent form alcohol than

					women in the nutrition or HCT arm
<b>DREAMS</b>	2014	National, South Africa	2years/current	Multiple interventions	Ongoing
<b>PREPARE</b>	2013	After-school programme, Western Cape, South Africa	3 years	RCT	Significant Reduction in IPV among teenagers
<b>HAPS</b>	2006	Pietermaritzburg township based schools, South Africa		Pre-post quasi-experimental	No effect
<b>HAPS</b>	2008	Pietermaritzburg township based schools, South Africa		Cluster randomised controlled trial	Reduction in onset of sexual activity among males and females
<b>STI-Clinic Study</b>	2007	STI Clinics in Cape Town, South Africa	3 months	RCT	Significant Reduction in unprotected vaginal sex, % of condom use and condom use at last sex. Significant reduction in alcohol use in sexual contexts.

## **Community based programmes**

Community based efforts in South Africa that are notable in addressing the problem of HIV, alcohol and sexual risks and violence are outlined below:

### **1.) Stepping stones**

Stepping Stones is a participatory community based intervention designed to guide people through the process of attitude and behaviour change with an overall objective of promoting sexual health, improving psychological wellbeing and HIV prevention (ACCORD, 2007; Shai & Sikweyiya, 2015). Stepping Stones was to be found successful in reducing HIV risk factors such as genital herpes and perpetration of IPV. At the two year follow-up, men from the intervention arm reported a 38% reduction in perpetration of SIPV (Shai & Sikweyiya, 2015).

The Creating Futures project, which is an adaptation of the Stepping Stones process, bears particular relevance to the current review. It aims to reduce HIV risk behaviour and victimisation and perpetration of different forms of IPV (Misselhorn et al, 2012) and was implemented among young people (18 years and older) living in informal settlements.

The findings from the Creating Future's project indicate a reduction in the experience of sexual and intimate partner violence, significant improvements in gender attitudes among both men and women and more equitable relationships at 12 months follow-up (Shai & Sikweyiya, 2015).

### **2.) One Love campaign**

In 2009 SC: IHDC (Soul City Institute for Health and Development Communication) launched the OneLove HIV prevention campaign aimed at reducing multiple and concurrent partnerships (MCPs) as a contribution to reducing new HIV infections (Letsela, 2012). The campaign sought to address the determinants of MCPs, as identified by the formative research, intergenerational sex, transactional sex, lack of communication and dissatisfaction in relationships, alcohol abuse, and cultural and gender norms (Letsela, 2012). The campaign was implemented in nine Southern African countries: Lesotho, Malawi, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe.

With the exception of Botswana, the OneLove Campaign messages were conveyed in a mix of materials, media and community action, which have been uniquely researched and developed by each country partner. The programme includes TV and radio drama series, talk shows and public service announcements broadcast by national and community broadcasters;



billboards; social mobilisation and community dialogues; as well as community capacity-building through training.

The outcomes of the campaign reflect:

## 1. Changing behaviours related to preventing HIV

1.1. HIV testing: Exposure to the OneLove Campaign regionally was associated with a greater likelihood for HIV testing among exposed respondents compared to unexposed respondents. Fifty nine percent of respondents were likely to test for HIV if they were exposed to at least two media.

1.2. Safer sexual behaviour – Condom Use: As a result of exposure to the OneLove Campaign, there was a greater likelihood of condom use among exposed respondents compared to unexposed respondents. Seventy six percent of males in Malawi, who were exposed to a radio drama, were more likely to report on condom use at last sex among those with multiple partners in the past year compared to 59% of unexposed males. In Mozambique, 28% of young women (15–24) exposed to two or more media were more likely to report on condom use during last sex compared to 16.1% of unexposed women.

It is noteworthy that the OneLove Campaign was associated with the reduction of sexual partners in Namibia and Zambia, but not in other countries. Only 3.6% of women in Namibia and 4.4 % in Zambia, who were exposed to two or more media, were more likely to have multiple partners in the past 12 months.

1.3 Safer sexual behaviour – Intergenerational Sex: There was an association between reduced intergenerational sex and exposure to the OneLove Campaign among young women (aged 15–24) in Lesotho, Swaziland and Malawi however in Namibia the reverse was true.

Safer sexual behaviour – Transactional Sex: In Namibia (5.5%) and Zambia (24.4%) of men exposed to the OneLove Campaign were consistently less likely to report giving gifts or money in exchange for sex.

1.4 Knowledge and Awareness: In Lesotho, Malawi and Zambia the evidence was consistent that the OneLove Campaign contributed to raising awareness around the increased risk of HIV infection in the context of having multiple partners, even with low levels of

exposure. In Lesotho, 95% of men exposed to the campaign through two or more media channels knew that having multiple sexual partners increases the risk of HIV compared to 89.5% of unexposed men ( $p < 0.05$ ).

1.5 Attitudes: The OneLove Campaign had a positive impact on eroding notions of masculinity in most countries.

2. Intermediate behaviour (discussion, debate)

2.1. Discussing sexual satisfaction: An important part of the campaign was to encourage discussion between sexual partners (spouses or cohabiting partners) about sexual satisfaction thereby decreasing the need to have other sexual partners. The results in Zimbabwe and Malawi were consistent, but in the other countries the results were inconsistent or even negative (Namibia).

2.2. Discussing HIV: Generally, the OneLove Campaign contributed to stimulating discussion about HIV at an interpersonal level among partners, friends and with children.

2.3. Attitudes toward discussing sex: With the exception of Namibia, there is clear and consistent evidence that the OneLove Campaign contributed to shifting attitudes around the role of communication in sexual relationships. This indicator was not measured in Zimbabwe.

### **3.) Women's Co-op Health**

This study tested the woman-focused Women's Health Co-Op (WHC) intervention relative to both a nutrition intervention and HIV counselling and testing in a randomised field trial of young women from 14 communities who were engaging in substance use and risky sex behaviours (Wechsberg et al., 2014). The study sought to increase condom use, decrease substance abuse, and prevent intimate partner violence, and thereby stem the spread of HIV. The WHC is a two session group intervention grounded in feminist and empowerment theory.

Results revealed that:

- 1) The WHC revealed that women in the WHC area were 1/3 times less likely to become HIV infected.
- 2) Post 12 months, HIV positive women in the intervention arm were significantly more likely to abstain from alcohol than HIV positive women in the nutrition or HCT arm.

#### 4.) One Man Can programme

The One Man Can (OMC) campaign, a rights-based gender equality and health programme to prevent both violence against women, and HIV and AIDS in Southern Africa. The programme was implemented in 2006 by Sonke Gender Justice, a South African NGO. OMC has featured as an example of best practice by the World Health Organization, UNAIDS, and the UN Population Fund and translated into nearly a dozen languages and implemented all across Africa (van den Berg, 2013). The OMC campaign encourages men to become actively involved in advocating for gender equality, preventing gender-based violence and responding to the spread and impact of HIV/AIDS (Nkosi et al, 2009). This model is based on the premise that changing deeply held gender and sexuality-related beliefs and practices require comprehensive, multifaceted strategies.

1. During the period of July 2007 and June 2009, the OMC objectives were to:
2. Use formative research and monitoring and evaluation strategies to increase knowledge and understanding of how to engage diverse groups of men in urban and rural area, including traditional leaders, and engage in ongoing dissemination of project findings.
3. Strengthen the commitment and capacity of civil society organisations to work with men to reduce gender-based violence, HIV/AIDS and promote gender equality through the use of rights-based approach activism.
4. Develop communications strategies that shift social norms about men's roles and responsibilities in achieving gender equality.
5. Educate traditional leaders on how to address gender-based violence, promote gender equality, reduce HIV/AIDS and support them to take decisive action.
6. Increase men's use of HIV services such as STI treatment, VCT and support groups.

The impact evaluation results indicate that:

25% of men who access OMC interventions will subsequently access VCT services (Colvin et al., 2009)

1. 25% increase in reported incidents of GBV through SAPS during the project period
2. 25% increase in estimated condom use. (Colvin et al., 2009)

27% of participants got an HIV test soon after the OMC workshop. (Colvin et al., 2009)

3. 53% of participants reported witnessing an act of gender-based violence in their community after the workshop and of these people 86% said they reported the incident to police, NGOs or other community structures

Two thirds of participants reported increasing their use of condoms after the workshop. (Colvin et al., 2009).

### **5.) IMAGE Micro Financing Study**

The Intervention with Microfinance for AIDS and Gender Equity (IMAGE) study is the first of its kind that used a cluster- randomised trial design. The intervention combined a microfinance based poverty alleviation program with participatory training on HIV risk and prevention, gender norms, domestic violence, and sexuality. The premise of this unique intervention was that it can improve the economic wellbeing, empower women, and lead to reductions in Intimate Partner Violence (IPV) (Pronyk et al, 2006).

The IMAGE study was conducted between September 2001 and March 2005 in South Africa's rural Limpopo province. This province is burdened by high levels of poverty, unemployment and migration to neighbouring cities for employment. Loans were provided to poor women who enrolled in the intervention. A participatory learning and action curriculum was integrated into fortnightly loan meetings. Effect estimates were generated for outcome measures among direct programme participants (Cohort 1) and 14-35 year old household (Cohort 2) and community members (Cohort 3), alongside matched controls (Pronyk et al, 2006).

The results indicate that:

1. Over a two year period, levels of IPV were reduced by 55% among women in the intervention arm relative to controls (Pronyk et al, 2006). This study provides encouraging evidence that a combined microfinance and training intervention can have health and social benefits, including reducing levels of violence experienced by participants, though indirect effects, if any, on young people's HIV risk over the short term are more limited (Pronyk, 2006).
2. Significant increases in communication about sex or HIV within the homes of IMAGE participants compared with controls [aRR 1.46 95% confidence interval (CI) 1.01–2.12] (Pronyk et al, 2008).

3. Significantly higher proportion of intervention participants reporting they had undergone VCT relative to those in the comparison group (aRR 1.64, 95% CI 1.06–2.56).
4. At baseline, only 77/220 (35%) women were married, and few women (3%) in either group reported having had more than one sexual partner in the last year. There was no difference in numbers of reported partnerships between intervention and comparison groups at follow-up. Qualitative data suggested that whereas multiple partnerships for both men and women might be part of the broader social context, few personal accounts of changes in such relationships emerged. Qualitative data suggested women readily acknowledged the challenges faced when using condoms with sexual partners. Despite these challenges, focus group discussions and key informant interviews indicated a sense of enhanced bargaining power among intervention participants, which in a number of instances was expressed as increased confidence in negotiating safer sex and the successful introduction of condom use with male partners.

## 6.) DREAMS

This PEPFAR funded programme aims to reduce new HIV infections in adolescent girls and young women in ten sub-Saharan African countries, including South Africa. The programme seeks to address the structural drivers that directly and indirectly amplify girls' HIV risk, including poverty, gender inequality, sexual violence and lack of education (PEPFAR fact sheet, 2014: <http://www.pepfar.gov/partnerships/ppp/dreams/>). There are no evaluations currently available as the programme was launched in December 2014. However, DREAMS is described as a comprehensive package of evidence based approaches that seeks to ensure that girls are developed into "**D**etermined, **R**esilient, **E**mpowered, **A**IDS-free, **M**entored, and **S**afe women" (<http://www.pepfar.gov/partnerships/ppp/dreams/>).

## **The Policy environment**

Policy environments function to either facilitate or hinder positive behaviour change. Existing policy efforts in South Africa require appraisal within the context of high rates of alcohol use and misuse and the pandemic proportion of HIV/AIDS.

### **Policy Gaps**

As a WHO member state, alcohol policy strategies in South Africa are aligned to the Global Strategy to reduce the harmful use of alcohol (World Health Organization, 2010). Notwithstanding significant advances in alcohol policy development in South Africa over the past two decades, early alcohol initiation, binge drinking and increasing rates of alcohol per capita consumption indicate that regulatory and control policies are inadequate. The absence of a standardised alcohol policy that is equally applicable across South Africa emphasises the need for an unequivocal national alcohol policy to be implemented.

Despite the existence of minimum alcohol purchasing and drinking laws in South Africa (18 years old), the high rates of underage drinking nationally require:

- Stricter enforcement of existing minimum alcohol purchasing, selling and drinking age laws, age enforcement checks at point of sale, age checks of workers at outlets, adults purchasing alcohol for minors (Paschall, Grube, Black, & Ringwalt, 2007) and age enforcement checks at point of sale (Babor et al., 2010).
- Stronger monitoring of existing laws for minimum purchasing, selling and drinking age (e.g. through identification checks, routine checks on public drinking, spot checks of sellers and purchasers at outlets).

The current policies governing alcohol availability and accessibility, in the face of high rates of heavy episodic drinking (HED), fall short of reducing harms associated with binge drinking itself and its associated risks. A recent (unpublished) analysis of alcohol policy effectiveness in South Africa reveals that the rating of the implementation of measures to address availability of alcohol (e.g. restrictions for on/off premise serving to intoxicated persons, national legal minimum age for sales of alcohol beverages) was overwhelmingly "weak".

The total ban of alcohol advertising is supported by consistent and credible evidence in international literature that highlights exposure to alcohol through media and other

communication channels is associated with increased likelihood of drinking. Yet the ban in South Africa has been marred by long delays. Furthermore, the feminisation of the alcohol industry is an indication of the industry's concerted efforts to reach a previously underserved market (Johnston, 2015). This is evident in marketing of "alcopops", sweetened and fruity drinks to women and further objectification of women through media portrayals and adverts, associating alcohol with "being sexy", successful and romantic.

The prevalence of *binge drinking* and its associated harms requires decisive and improved public health action in the areas of:

- Decreased accessibility, by reducing the number of alcohol outlets in close proximity to schools, universities and residential areas;
- Introduction of laws prohibiting the sale of large quantities of alcohol (including communal drinking); and
- A total ban on alcohol advertising and media portrayals linked to excessive drinking, romance and glamour.

With regard to reducing the *negative consequences of drinking* and alcohol intoxication (including sexual risks), there is no documented co-ordinated national effort in place in South Africa to address this. In addition, a designated authority to monitor and report alcohol-related harm is non-existent. This must be addressed in a bid to ensure that alcohol-related harms are documented and used as a leverage point for planning interventions, funding and advocacy efforts.

*Visible and effective policing* is a non-negotiable link in the chain of effective enforcement. Similarly, stronger implementation of existing laws for minimum purchasing, selling and drinking age (e.g. through identification checks, routine checks on public drinking, spot checks of sellers and purchasers at outlets) are largely absent.

When the intersection between alcohol use and sexual risk is considered, there is a potential for overlap between alcohol and sexual risk reduction programmes and interventions. These include: integrating alcohol education, awareness and its association with sexual risk into sexual risk reduction programmes in settings across schools, universities, communities and venues where populations most at risk are a captive audience (bars, shebeens, STI clinics and schools). Similarly, where alcohol prevention programmes

are implemented, the potential exists for heightened awareness and education regarding the associations between use and sexual risk.

The HIV epidemic is particularly gendered. In addition direct and indirect causal pathways have been established between alcohol and sexual risks. This necessitates that alcohol policies and sub-policies be gender specific, targeted and tailored to the needs of key populations at risk for HIV infection, including age-specific (e.g. 15-24 year old women, sex workers, bar patrons/workers). Although men are disproportionately affected by high rates of alcohol consumption and heavy episodic drinking, women are indirectly harmed by their alcohol use via unprotected sex, HIV infection and gender-based violence (Fritz et al., 2010). Therefore, cross-disciplinary research and intervention efforts must occur between gender and substance use researchers and practitioners. This remains an opportunity for joint collaboration that is largely unexplored and under-utilised in South Africa. Potential gender specific policy development discussions should include:

1. acknowledgement that women need comprehensive intervention programmes that address not only alcohol use but associated determinants (unemployment, poverty and low social status);
2. alcohol and other substance using women in discussions about the alcohol policy;
3. prioritisation of an agenda for women in alcohol prevention programmes and policy development processes;
4. education, job and income generating skills development which ensure that women can meaningfully contribute to society and poverty alleviation and empowerment;
5. education and economic policies discussions that aim to ensure that more women gain control over educational choices, economic income and access to housing and land;
6. evidence base of alcohol's harm to others (specifically) women; and
7. reduction in the legal BAC limits for women, given the hormonal and metabolic differences between men and women

Policy efforts are slow, often messy and fraught with nuances. However, a useful starting point would be to make explicit the links (albeit associative) and/or causal between alcohol, HIV infection, and gender-based violence and sexual risk behaviours more generally. Policy



briefs that provide concise and unequivocal evidence of alcohol-related sexual risk associations remain accessible information "bites" for policy makers and key stakeholders.

A strong evidence base documenting these links can be a very useful leverage and advocacy tool advocating for:

1. Integrated HIV and alcohol risk reduction programmes.
2. Retraining and/or reorientation of health care, community based and treatment centre staff to address risks for both alcohol use and HIV infection.
3. Routine screening for HIV in alcohol treatment programmes and screening for alcohol use in primary health care settings.
4. Responsible beverage service (not serving to intoxicated patrons, making available condoms in bars, shebeens and taverns).
5. Public Service Announcements displaying the effects of alcohol on gender-based violence and sexual risk behaviours.

6.

## SWOT ANALYSIS

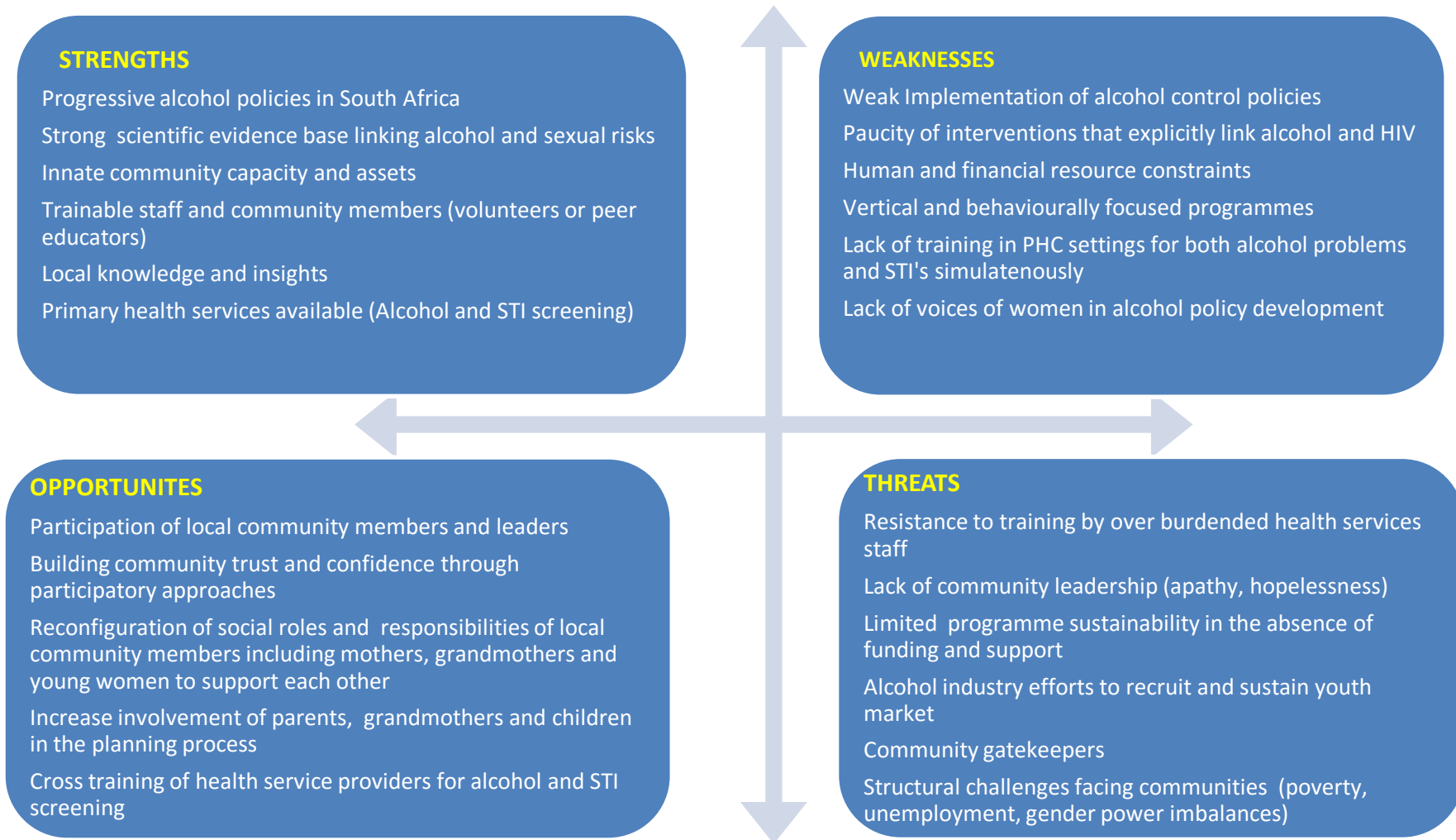


FIGURE 2: SWOT Analysis

## Stakeholders

Given the complex web of determinants that place young women at risk for HIV infection including biological, behavioural and structural drivers, efforts to mitigate risks require strong intersectoral collaboration. Key stakeholders that could potentially comprise a think tank group include, but are not limited to (individuals and groups) representing the public health interests of women.

**Table 3: List of proposed stakeholders serving an advisory/think tank function**

<b>Individual</b>	<b>Organisation</b>	<b>Sector</b>
Dr Mzikazi Nduna	Women's sector: SANAC	Government
Ms Lesego Tlhwane	Sex Workers Education and Education Taskforce (SWEAT)	Advocacy
Ms Palesa Mpapa	People Opposing Women Abuse (POWA)	Feminist rights advocacy organisation
Prof Rachel Jewkes	Medical Research Council, SA	Gender Research
Prof Neo K Morojele	Medical Research Council, SA	Alcohol Research
Mr Mbuyiselo Botha	Sonke Gender Justice/ Commission for Gender Equality	NGO

<b>Individual</b>	<b>Organisation</b>	<b>Sector</b>
Dr Marlise Richter	Sonke Gender Justice	NGO
Ms Savera Kalideen	Soul City	NGO
Dr Leane Ramsoomar-Hariparsaad	Independent/Wits	Alcohol Research
Prof Leickness Simbayi	Human Sciences Research Council	Alcohol and HIV Research
Ms Patience Mpani	Tshwaranang Legal Advocacy Centre	NGO
Dr Granville Whittle	DDG: Care and Support, Department of Basic Education	Government
Ms Vimla Moodley	Director: Health Promotion, NDOH	Government
Ms Sarah Magni	Anansi Health Consulting	Private
Faith Based Organisation/s	To be determined based on communities selected	Community
Youth Groups	To be determined based on communities selected	Community
Prof Vasu Reddy	University of Pretoria	Gender Researcher

## **Recommendations on possible high level objectives for interventions/campaigns**

The available evidence indicates that, at a minimum, addressing alcohol-related sexual risk behaviour in the context of a devastating HIV epidemic requires efforts in several areas:

### **Policy**

1. Develop integrated alcohol-sexual risk reduction policies;
2. Develop youth-specific gender sensitive policies and sub-policies; and
3. Effectively implement education policies that keep girls in school (e.g. CCT's).

### **Institutional**

- Garner political support for women as "at risk" groups;
- Make available "ring fenced" human and financial resources to empower women (through education and entrepreneurial investments);
- Advocate for more age-appropriate services and sustainable funding for prevention programmes;
- Implement school-based alcohol and sexual risk reduction programmes including life skills that link alcohol use and sexual risk;
- Monitor and evaluate programmes targeting women's health and reproductive rights with a view to rolling out best practices.

### **Partnerships**

- Coordinate multi-sectoral and inter-institutional and cross-disciplinary research, governance and responses

### **Lobbying and Advocacy**

- Lobby and advocate for women's sexual and reproductive health and human rights; and
- Availing and facilitating access to health care services for women (VCT, PREP, female condoms).

## **Community**

- Implement information and awareness campaigns in communities, highlighting the alcohol/HIV link;
- Providing clear, concise and accessible informational material that is culturally sensitive;
- Design and implementation of community partnered/ led, and peer education clubs, e.g. Soul Buddyz that are gender specific;
- Engage communities and families about rights, responsibilities and attitudes toward sex and sexuality; and
- Engage men in activities that foster respect for women, their reproductive health and rights.

## **Conclusion**

The established association between alcohol use and misuse and sexual risks for women has led to a call for integration between HIV-alcohol risk reduction interventions (Carrasco et al., 2015). This is merited given that the determinants of both sexual risk and alcohol use and misuse largely overlap. Moreover, reliance on solely vertical and behaviourally focused interventions for both sexual and alcohol risk reduction may be inadequate in bringing about positive behaviour change. Scientific literature on both sexual risks, including HIV and alcohol use has highlighted the structural nature of the determinants of these epidemics which is particularly pronounced for women. Consequently, complementary efforts that address the structural nature of sexual risk behaviours (e.g. poverty, unemployment, and gender power imbalances) are required to create environments in which healthier choices can become easier choices. Key learnings from previous work indicate the need for multi-level, gender sensitive programmes that address both the behavioural and structural determinants of alcohol misuse and sexual risk taking behaviours.



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