
A Rapid Assessment in Relation to Alcohol and Other Substance Use and Sexual Behaviour in Zimbabwe

FINAL REPORT



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***A Rapid Assessment in Relation to Alcohol and Other Substance Use and
Sexual Behaviour in Zimbabwe***
(Project No: GL/GLO/ADT/002/FT/98.999.02)

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1. Introduction

The HIV epidemic in Zimbabwe currently ranks among the most severe in the world with an estimated 25% of the adult population or 1.4 million Zimbabweans age 15-49 already infected with HIV [1]. Data also demonstrate that the Zimbabwean epidemic is a generalized one, having spread far beyond high-risk core groups and into the general population of sexually active adults who currently make up 50% of Zimbabwe's total population. An average of 28% of pregnant women seeking antenatal services at surveillance sites nationwide were HIV positive in 1997 [1]. HIV prevalence varied from 7 % to 53% with the capital city, Harare, reporting 28%. In a more recent study of 14,112 pregnant women who gave birth in Harare clinics and hospitals, 33% were HIV positive. Prevalence increased with age, reaching a peak of 44% prevalence among women aged 30 to 34 years [2].

In countries such as Zimbabwe, where HIV is primarily sexually transmitted and prevalence is high, the use of alcohol and other psychoactive substances may assume particular importance in the transmission dynamics of HIV infection and other sexually transmitted diseases. Epidemiological data gathered in diverse countries around the world point to an association between alcohol/drug use, sexual activity and sexual risk behaviour. For example, six studies conducted with gay men in the U.S. and Australia show that individuals with higher levels of non-injection substance use at baseline were more likely to become infected with HIV over time [3-8]. In addition, epidemiological studies conducted in Zimbabwe, Tanzania, Kenya, Zambia, and Central African Republic have found significant associations between alcohol consumption and high-risk sexual behavior [9-12], prevalent STDs [12-14], prevalent HIV infection [12,15], and incident HIV infection [16,17].

In Zimbabwe, a survey of 2,691 male factory workers in Harare revealed that drinking in a beerhall in the preceding week was significantly associated with HIV infection in bivariate analysis ($OR = 2.27$) [12]. This relationship held in multivariate analysis controlling for several other risk factors including having more than two sexual partners in the last year and paying for sex in the last year. In another study conducted in Harare, male clinic attendees who reported drinking alcohol the day before or during the previous weekend were significantly more likely to report having been treated for an STD within the past six months ($OR = 7.1$) [14]. A recent Zimbabwe national health survey also reports that drinking alcoholic beverages is associated with higher rates of extramarital sexual activity, multiple sex partners for unmarried men, and paying for sex [18]. The survey found that 36% of married men and 15% of unmarried men reported having been drunk at least once in the past 30 days. Twenty four percent of married men who reported becoming drunk more than once in the past 30 days also reported extramarital sex in the previous year compared to 11% of married men who said they had not drunk alcohol in the prior 30 days. Among unmarried men, 5% of those who had not drunk alcohol had two or more partners in the prior 12 months compared to 33% of those who had been drunk more than once. In addition, only 3% of men who did not drink reported paying for sex in the last year compared to 14% of men who reported drinking to intoxication. The connection between commercial sexual encounters and alcohol use was also shown in a 1989 study of female sex workers in Bulawayo, Zimbabwe's second largest city. Sex workers reported that more than half their clients were drunk during sex [19].

In a context of drinking to intoxication, multiple partnering, concurrent extra-marital relationships, the widespread use of commercial sex workers, and female economic and social dependency, it is imperative to explore the relationship between alcohol/drug use and risky sexual behaviour, particularly with a view to intervention. While epidemiological studies conducted to date in Africa suggest a strong association between alcohol use, HIV risk behavior, and HIV infection itself, no study has attempted to explore the

social dynamics that link alcohol/drug use and HIV risk behavior. This research project was conducted in an effort to provide “on-the-ground” practical understanding of the relationship between HIV risk and alcohol/drug use such that HIV prevention programmes can be designed to address the important role alcohol and drug use may play in exacerbating sexual risk behavior.

1.1 Project Aim and Objectives

Aim

To increase knowledge and understanding of the relationship between alcohol and other psychoactive substance use, and sexual risk behaviour, in Zimbabwe, to be able to develop interventions to reduce the sexual transmission of HIV and to minimize other adverse health consequences linked to substance use and sexual behaviour.

Objectives

1. To characterize the relationship between alcohol and other substance use and high-risk sexual behaviour.
2. To identify key features of the social, cultural and structural context that influence sexual behaviour, substance use and sexual risk taking, including factors influencing relationship formation and the satisfaction of sexual and other needs.
3. To identify key factors influencing sexual risk and substance use reduction.
4. To use the data gathered from the assessment to develop appropriate intervention strategies.
5. To offer a constructive critique of the existing RAM methodology and to make suggestions concerning its improvement for use in Zimbabwe and elsewhere.

1.2 Key Areas of Investigation

The study emphasized the following key areas of investigation:

- (a) What is the relationship between alcohol use and sexual behaviour?
The extent and nature of:
 - alcohol use and other substance use
 - sexual activity and relationships
 - associations between alcohol use and sexual activity
 - associations between alcohol use and sexual risk
 - associations between alcohol use and HIV/STDs
- (b) How does socio-cultural and economic context influence alcohol and other substance use and sexual behaviour?
Perceived social norms influencing:
 - patterns of alcohol and other substance use
 - patterns of sexual behaviour
 - alcohol and other substance use and sexual activity
 - alcohol and other substance use and sexual riskSocial and physical settings influencing:
 - alcohol and other substance and sexual activity
 - alcohol and other substance use and sexual risk

Economic factors influencing:

- alcohol and other substance use and sexual activity
- alcohol and other substance use and sexual risk

(c) What are the factors that enable and inhibit sexual risk reduction?

- levels of knowledge and awareness of potential health consequences
- individual and contextual factors enabling and inhibiting levels of alcohol use
- individual and contextual factors enabling and inhibiting sexual safety
- potential for individual and community-based behaviour change strategies

In addressing each of these key areas of investigation, the following key analytical comparisons are likely to be important:

Potential differences between:

- urban and rural settings
- “low density” and “high density” areas¹
- drinking venues (bars, beerhalls, “shebeens”², clubs)
- sexual relationships (marriage, concurrent, casual, commercial)
- men and women
- age groups
- socio-economic groups
- educational levels
- individuals with reported HIV positive and HIV negative antibody status

1.3 Study design

Overview

The study utilised a rapid assessment methodology based on the WHO/PSA Rapid Assessment and Response (RAR) Guide on Substance Use and Sexual Risk Behaviour (1998). Both quantitative and qualitative methods were used. This enabled the study to gain both an epidemiological assessment of the relationship between alcohol use and risky sexual behaviour, and a descriptive understanding of the social contexts in which alcohol use and risky sexual behaviour occurs. The following research methods were employed:

- (a) Review of existing Zimbabwe data and research
- (b) Social and geographic mapping
- (c) Focus group interviews (n=6)
- (d) Cross-sectional quantitative surveys (n=452)
- (e) Time-line follow back (TLFB) interviews (n=6)
- (f) Ethnographic observations

¹ Harare is a city divided by race and class, with lower-income and working-class people living in “high-density” neighborhoods. These neighborhoods were originally established during British colonial rule in order to segregate black residents of Harare from white residents. The majority of Harare residents today reside in the crowded high-density neighborhoods.

² Shebeens are illegal liquor outlets, typically operated from someone’s house. They are reputed to be places where prostitution thrives.

1.4 Study Venues and Recruitment of study subjects

The study was carried out in two geographic locations: 1) Glen Norah, a high-density neighborhood in Harare, and 2) a rural “growth point” called Guruve³. A total of 452 individuals were interviewed using the structured questionnaire. Table 1 below presents the numbers of individuals who participated in the different aspects of the study, by the different sites. Of the 6 focus groups carried out, two were with commercial sex workers (one each in the urban and rural sites) and four were with men recruited at drinking venues. The average number of respondents in the focus group discussion was seven. Projected sample sizes were achieved for all the various components of the study.

Study participants were selected from four venues in the urban site (Glen Norah) and two venues in the rural site (Guruve). In Glen Norah, the research sites included one bottle store, two nightclubs, and one beerhall (see section D.1. for full descriptions of drinking venues), as well as two clinics. In Guruve, the sites included a hotel, bottle store/night club. Convenience sampling was used to recruit study participants for the questionnaire, focus groups, and in-depth interviews. Only those who were over the age of 18, willing to participate, assessed to be able to understand the nature and purpose of the study, and were not inebriated were invited to take part. Participants were invited to participate on the basis of verbal informed consent, and they were free to refuse to answer any question, or withdraw at any time. They were assured that their responses would be confidential.

1.5 Timeline

This study began in July 1999 and concluded in December 1999. July and August were devoted to intensive ethnographic data collection. In September, the quantitative questionnaire was constructed and pre-tested. In October through December, the questionnaire was administered, focus groups and in-depth interviews were conducted and ethnographic observations continued.

Table 1: Overview of Study Participants Recruited by Site

	Urban Site	Rural Site	Total
Structured Questionnaire (total)	308	144	452
Structured Questionnaire with STD Patients	60	40	100
Structured Questionnaire with Male sex drinkers	50	25	75

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