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

FINAL REPORT



**World Health Organization
MSD/MER**

***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)

Godfrey Woelk, Katherine Fritz, Mary Bassett, Charles Todd, Alfred Chingono.

**Department of Community Medicine,
University of Zimbabwe,
Box A178,
Avondale, Harare,
Zimbabwe.**

30 August, 2001

Table of Contents

Acknowledgements	4
1. Introduction	5
1.1 Project aim and objectives	6
1.2 Key areas of investigation	6
1.3 Study design	7
1.4 Study venues and Recruitment of study subjects	8
1.5 Time line	8
2. Results	9
2.1 Social mapping	9
2.2 Male Focus Group Discussions	10
2.3 Female Focus Group Discussions	25
2.4 Cross sectional quantitative survey	32
3. Discussion	48
References	51
Comments on the rapid assessment Approach and manual	52

Acknowledgements

We would like to acknowledge the project coordinator Agatha Dodo, and research assistants Gugu Ndimande, Shingirai Nhira, Edward Chigwedere and Tracy Kandeya. We would also acknowledge the contribution of the Project Advisory Board members: Dr. O.L. Mbengeranwa, SAfAIDS, Dr. L. Charimari. We are especially thankful to Dr. Tim Rhodes who developed the protocol. The project was funded under a contract (Project No: GL/GLO/ADT/002/FT/98.999.02) with a joint WHO/UNAIDS programme through the Policy, Strategy and Research department of UNAIDS.

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 non-drinkers	50	25	75
Structured Questionnaire with Female non-drinkers	20	7	27
Time-Line Follow-Back Interviews	4	2	6
Focus Groups	4	2	6

³ “Growth points” have been established across Zimbabwe by the government in order to stimulate commerce in rural areas. Once a growth point has been established, the government provides infrastructure development (roads, sanitation, and electricity) as well as incentives for businesses to establish themselves. Growth points typically develop into small market towns.

2. RESULTS

2.1 Social Mapping

Types of Drinking Venues

There are several overarching types of drinking venues in contemporary Zimbabwe. Perhaps the most widely patronized establishments are called “beerhalls”. Beerhalls are characterized by their large size. They may host several hundred patrons at a time. Spatially, they are organized such that a high wall (6-8 ft. high) surrounds the perimeter of the establishment. Entering the beerhall entrance, one finds large courtyard where there are benches and tables. At the center of this large yard is a concrete building. Inside the building, there is typically one large hall, again with tables and benches. The hall itself appears similar to a large school assembly room or cafeteria. The “bar” is at one end of this large room. The bar counter itself is encased by metal bars and is simply a place to purchase beer, not a counter at which one sits. At the bar, one can buy a variety of beers but one type of beer predominates, this is the so-called “traditional” African beer made from maize or other grains. This type of beer is thick and opaque. Often, it is simply called “opaque” beer and it contrasts with the “clear” beer known to European and American drinkers. Both opaque and clear beer are mass produced in Zimbabwe and marketed with advertising slogans on television and on billboards. There are several different brands of opaque beer but the leading one is called “Chibuku” and is brewed in Harare and at other locations around Zimbabwe by a commercial brewery. A variety of clear beer is also sold by the bottle at beerhalls. Overwhelmingly, however, the drink of choice by beerhall patrons is Chibuku. At beerhalls, Chibuku is bought by the two-litre “mug”. The mugs are large open containers and are shared among a group of friends, each taking a sip from the mug and passing it to the person seated next to him. In fact, the advertising slogan for Chibuku beer is “Hari Yemadzisahwira” [mug of friends]. Purchase of the beer happens in turns. Men who have more expendable income on a given day will purchase more of the beer but others usually return the favor in the drinking circle on another day. “Month’s end” is known to be the time when beerhall patronage soars. This is the time of the month when many people receive their paychecks. Sharing is the social norm at the beerhall and no one drinks alone. Aside from drinking, beerhalls offer other diversions for their patrons. There is often a snooker table or two, a jukebox, and dartboards. Some men bring their game boards with them to the beerhall. Draft (otherwise known as checkers) is a popular pastime. Gambling can also be popular at beerhalls. Dart or draft games may include wagers and some beerhalls even have off-track horse race betting. Beerhalls may also fulfill the role of community center by offering a place where groups can meet. On Sunday mornings, for example, one often sees banking cooperative members or funeral society⁴ members meeting at a beerhall to conduct business.

The central role beerhalls play, not simply as bars, but as community institutions has an interesting social history rooted in the legacy of British colonial rule in southern Africa. Early in the 20th century, British authorities started a campaign to control black African men’s drinking practices. The British, who relied on cheap African labor to maintain lucrative mining and commercial farming enterprises in southern Africa, were ostensibly concerned about over-drinking among men. They were also concerned about the large amounts of money female beer brewers made producing and selling beer to the male workforce. As a solution to both perceived problems, the British government made petty brewing illegal and took over the beer brewing industry. British authorities also passed laws making it illegal for black Africans to consume “European” liquor and relegated them to consuming the “traditional” opaque beer produced by

⁴ Funeral societies are a common phenomenon throughout eastern and southern Africa. A funeral society is a grass-roots mutual aid society in which individuals organize themselves such that each contributes a certain amount of money to a common fund from which funeral expenses can be paid out as needed.

national breweries. In order to control the timing and amount of beer consumed by blacks, the British authorities also established beerhalls. These were government owned and operated retail establishments where beer consumption was regulated.

Other types of drinking venues in contemporary Zimbabwe include nightclubs, bottle stores, sports bars, and hotels. Sports bars and hotels are venues patronized by wealthier Zimbabweans. In them, bottled “clear” beer is sold along with spirits of various kinds. Nightclubs and bottle stores are more ubiquitous and attract crowds of mixed socio-economic status. Bottle stores are establishments where alcohol is sold but which do not provide seating. Alcohol bought at bottle stores is technically meant to be consumed elsewhere, however, it is common to find large groups of men “hanging out” just outside the store drinking and socializing. In Harare, this activity (known as “public drinking”) is illegal but practiced nonetheless. In growth points, however, the ban of public drinking has been lifted, allowing large crowds of men to gather on the sidewalk outside of bottle stores. In the growth point that was used as a site for this study, the bottle store also played music and men crowded inside of it to dance, despite the highly constrained space.

Nightclubs are places where loud music and dancing prevails at night. Most nightclubs are only open at night. It is typical for many nightclub patrons to begin their evening at a bottle store (alcohol prices at bottle stores are less than prices at nightclubs) where they begin drinking. People often then migrate to a nightclub to finish the evening with dancing and more drinking. While sex workers solicit clients at all types of drinking venues, our informants identified nightclubs as the venues where commercial sex thrives best (see focus group discussions below).

2.2 Male Focus Group Discussions

Male groups: Demographics

<u>Venue</u>	<u>Age range</u>	<u>Marital Status</u>	<u>Employment</u>	<u>Drinking Habit</u>
Urban- A	24-43	Single=3 Married=8	S/employed=3 Unemployed=2 Unskilled=3 Semi-skilled=2 Other=1	Daily=7 3 x week=1 Every 3 days=1 Weekends=1 Whenever money=1
Urban- B	23-32	Single=3 Married=8	S/employed=3 Unemployed=2 Unskilled=3 Semi-skilled=2 Other=1	
Urban- C	20-45	Single=3 Married=8	S/employed=3 Semi-skilled=2 Other=1	
Rural	25-41			Daily=2 Weekends=2
Urban- A:	Spaceman Bottle Store and Night Club			
Urban- B:	Chitubu Beerhall			
Urban- C:	Mutomba Night Club			
Rural:	Guruve Hotel			

The ages of the male drinkers ranged from nineteen to about sixty years of age.

Role of alcohol, other substances and the bar setting in recreational activities

Men who participated in the focus group discussions strongly emphasized camaraderie among friends as being the most important reason they enjoy attending drinking venues. Men spoke of the congenial atmosphere at drinking venues and reported valuing drinking venues because of the opportunity to socialize. Participants indicated that going to the bar was attending a community centre, where you could spend time with your friends. As an informant from urban A group put it:

“There are some Christians in our community, they meet in church. We are also a similar group, we meet in the bar - pahusahwira. [We have something in common].”

In answer to the question why he liked his drinking place, another informant from urban group A gave the reason:

“People are so welcoming and brotherly, so even if they are not your usual drinking crowd, they will offer you a mug – they will offer something.”

Another informant from the same group further elaborated by saying:

“Also, at ... (the name of the bar), we all know each other, ... if anything happens to one of us, we all go there to assist. Even in death we are together. We have a soccer team.”

Another informant from the rural group stated that more bluntly:

“ I can’t drink beer alone, I need the company of other so as to enjoy my beer. It is just like eating sadza (the staple food of a stiff porridge made from maize meal), it is nice when you are many.”

Reciprocity among friends is an important element of the drinking culture. Friends take turns buying mugs of beer and even if one doesn’t have money (or has only a small amount), one can lean on the generosity of friends to buy beer. By pooling money, men also perceive that they are able to purchase more beer and thus enjoy themselves more.

“When you go to the bar, your aim could be getting drunk, but you might not be having that kind of cash, so you know that if you just have enough for one scud (a litre of opaque beer) and you meet your three friends who also have enough for one, you know you have four scuds and you can drink. Therefore you can get drunk, that is one reason why we go to the bar.” (Informant in urban group A)

Some men acknowledged that they typically visited a bar with the explicit intention of becoming drunk. One participant commented:

“When you drink water, you take the amount that you wish to, not that the water would have run out. The purpose of drinking beer is to get drunk”. (Informant from urban group C)

Concerning substances other than alcohol, the most commonly used ones were marijuana (*mbanje*) and (herbal) aphrodisiacs in the bar setting. Men reported using marijuana especially when they were doing

hard physical labor. Men also reported using marijuana as a substitute for beer, when there was no money for alcohol.

“We drink beer and we also take drugs because we want to get drunk. Recently with the rises of prices we could only afford to buy brandy, it was much cheaper. When you see others drunk, you will be forced to take mbanje in order to get drunk”. (Informant from urban group B)

“Mbanje is the best substance for one to get drunk”. (Informant from urban group B)

“When I have less money for scuds, I take mbanje”. (Informant from the rural group)

Men also reported using mbanje to help them forget about personal problems:

“I take it when I have a problem with someone, I use it to forget things that bother me”. (Informant from rural group)

Aside from seeking the company of friends and drinking to intoxication, men mentioned other benefits to patronizing a bar. These include exchanging information, borrowing money, and learning about and getting jobs.

“You get knowledge that you would never get anywhere else in your life, we grow up in different environments, some grew up in the rural areas, some in the urban areas, so when we meet it is a cross section”. (Informant in urban group A)

“Also, all the other things like information about jobs is heard at bars; where one person has left and another is needed, information is heard at the bar.” (Informant in urban group A)

“We socialise with others and thus we get jobs. When you are at home you keep socialising with the same people and they do not bring new information and sometimes they are not helpful. Yet people in the bar have been very helpful in our lives.” (Informant in urban group B).

“Again we are well known in the area and acquaintances also patronise the bar. This is where we organise all our things, its more like a reception, we get information about part time jobs if unemployed.”

“We get jobs, some of us depend on part time jobs. As an electrician, I have had an opportunity of being offered piece jobs by friends in the bar. Piece jobs are important because you get money and you will be able to get money off hand.” (Informant in urban group B).

“Also, it is at the bar where we lend and borrow each other money, either for bus fare to work or other things.”

“Yes, because if you do it [drink] at home, your neighbours will start knowing your life, and we don't want them to see that today you have no money, so we make such arrangements at the bar.” (Informants in urban group A)

As the previous quote suggests, another reason for finding recreation in the bar setting is the unwillingness to stay around at home. Life in the high-density neighborhoods of Harare is crowded. Houses are subdivided and space is rented out by the room. Most families occupy just one, two, or three

rooms. Escaping the cramped home quarters and household chores is a powerful incentive for men to spend long hours at a local beerhall where they can see their friends and enjoy the ample space available for socializing.

“Home is too routine and children are disturbing, you end up being involved in household chores like sending a kid to the toilet, there so many demands, so you would like to take a break sometimes.”
(Informant from urban group B)

In some cases, men even reported that their wife would encourage him to go and drink at the bar, so that he can be out of the way at home.

“Sometimes when I don’t have money these women make sure they give me money in order for me to go to the bar and they will be able to feel free. They enjoy being alone because they gossip a lot.”

“If you stay too much at home, you end up quarreling with your wife, you can even interfere with her cooking”. (Informants from urban group A)

Socialising, primarily with other men, at the bar is also reinforced by a common belief that a man who spends much time at home with his wife and family is “under the thumb” of his wife.

“Again, when you stay at home, people will think that you have been given traditional herbs by your wife not to leave home.” (Informant from urban group B)

Other reasons for socialising in the bar setting is the lack of other entertainment and leisure facilities. There is often a juke box, disk jockey, or live music at bars and beerhalls and this is appealing to men, particularly to younger men.

“Music. We don’t mean to say we don’t have good radios, we have radios but can’t buy all the music that we appreciate”. (Informant from urban group A)

The lack of other forms of entertainment was mentioned by a respondent as a reason why some people abused drinking.

“But the problem is that I have no other forms of entertainment. I don’t go to church. During the weekends I should rest. How? We have no tennis courts no boozers’ (soccer) clubs, we have no grounds do you hear? What do you think I should do?” (Informant from urban group C)

Role of alcohol, other substances and the bar setting in sexual activity

Focus group data indicates clearly that drinking venues are locations where many men expect to have the opportunity to socialize with women and in many cases to initiate a sexual relationship with a casual or commercial sex partner. According to one participant:

“The whole country is full of women, but at the bar, we get women for “instant satisfaction” – there we are assisted”. (Informant from urban group A)

“When I have money, I get a girlfriend for the night, that is if she has met my requirements. I am not married”. (Informant from urban group B)

Some men, however, insisted that they did not sleep with the women they met in the bar but only socialized with them.

“I agree, it is nice to have a woman by your side as you drink, but not to sleep with her. I even buy beer for them, but all in the name of socialization.”

The enjoyment of socializing with women in the bar was expressed as such:

“You enjoy yourself and really get drunk. The beer even tastes better and your rate of drinking is even increased”. (Informant from urban group A)

Others said that they were faithful to their wives and went home. For some, beer reportedly helped them to avoid sleeping with other women.

“I am a loyal husband. I sleep with my wife only.” (Informant from the rural group)

“I drink beer so that I do not get into the trap of sleeping with women”. (Informant from the rural group)

“I go home (after drinking) because I have my own wife whom I make sure I satisfy before I sleep. Even if I am drunk, I will do my best to satisfy my wife’s sexual desires. After satisfying her, she won’t falsely accuse me that I have been to a girl friend’s place. I might go home as late as 2 am and this creates room for suspicion from my wife’s side. I make sure she must know I am fresh.” (Informant from urban group A)

In the bar setting, herbal aphrodisiacs (*Shona: mishonga*) appear to be commonly used. They are linked together with helping to solve a problem of apparent impotence, or siring girls only and improving the home situation. It is a problem that friends would give advice and assistance on.

“Remember we said at the beginning that friends would help you to solve a problem at home – it is in this area – it could be that “moto amuna”, (there is no fire). You can meet an old man who might advise and also give you something [an herbal aphrodisiac] and he would say report tomorrow if there is any improvement or trouble you can be assisted. Also you could be having a problem of getting girls, you can talk about this and be told of where you can get assistance. So in the bar, you can find women, mishonga (medicines), jobs, witchcraft.” (Informant from urban group A)

“Most people take traditional herbs, mbanje and other substances to stimulate human feelings. The reason why men take them is that they may be weak and failing to satisfy their wives’ desires. But after taking vhuka vhuka [a particular type of herbal aphrodisiac], the men will be strong no matter how drunk they are, they will be able to satisfy their wives. The following day the man will be showered with praises by his wife because she will be satisfied. She won’t even need to go out and look for something else.” (Informant from urban group B)

Aphrodisiacs were also associated with casual sex.

Expectations of the effects of alcohol and other substances commonly used.

Alcohol was reported to give courage, and to provide entertainment and enable relaxation and refreshment. The following quotes illustrate these points.

“It gives me courage, if I can’t approach an offender⁵ sober I go for them drunk”. (Informant from the rural group)

An informant from urban group C, in mentioning that there were a number of different reasons that individuals expected from drinking put it thus:

“There is another who says to himself ‘if I don’t drink I won’t be able to talk to that girl (shyness). You see that? ...”

Alcohol also provided courage to even face enemies:

“You get courage even to face enemies. At times I’d be having an enemy who I want to tell something. I can only be able to do this when I am drunk, eg. to tell somebody that I hate them. So when I am drunk, I’m not shy to tell you that I don’t like what you are doing to me, I become courageous. I begin to think of so many things – even a girl that you have been wanting to propose love to for a long time and been afraid – you are no longer afraid. Beer makes you succeed in whatever you plan to do”.
(Informant from urban group A)

“So beer gives him courage to do what he was looking forward to doing”. (Informant from urban group C)

Informants in one of the FGDs felt that this “courage” could also mean loss of self-control, which could lead to unbecoming activities, such as spending all the money on alcohol, using commercial sex workers, and engaging in criminal activities:

“... some drinking leads to theft, some leads to committing murder, and others end up in prostitution”.
“My previous point was that beer is good: it is not bad. But CONTROL YOURSELF. ... Beer is not bad, but if you don’t restrain yourself from doing bad things ...”.
“... (after drinking beer), it is rare to think of our wives back home or our girlfriends elsewhere. We lose control to beer, and get overcome by the current surrounding, so much that what I desire for that very short time is what my heart desires and sees as suitable”.
(Informants in urban group C)

“Also, beer helps you to forget your problems because when you are drunk, you are not shy to say out your problems”. (Another informant from urban group A)

The “courage” enabled by alcohol included telling the truth when drunk:

“Also, when you are in the beer-hall, you don’t tell lies when you are drunk, that when you say all your truth”. (Informant from urban group A)

⁵ A woman

Informants stated that alcohol facilitated entertainment, relaxation and “refreshment of the mind”:

“... so beer gives them entertainment, some old men would say, beer gives me a ‘special kick’, they would do well after starting off with beer”. (Informant from urban group A)

“After drinking I relax easily”.

“To refresh my mind after my strenuous job. If I don’t drink and go home I am frustrated”. (Informants from the rural group)

The expectation from the use of marijuana was different to that from alcohol. Some informants felt that marijuana was the best substance to get drunk on, others felt that it made one more restrained (unlike alcohol). There was a more general perception that it facilitated hard work.

“It (mbanje) helps me to carry a good work load”. (Informant from the rural group)

“About mbanje, I witnessed something from my grandfather – when he went to chop logs and firewood, he would smoke mbanje first – you would be surprised at the amount of energy that he would have and the work load he would go through”. (Informant from urban group A)

“I take it when I have a problem with someone, I use it to forget things that bother me”. (Informant from the rural group)

“Mbanje is the best as compared to beer. When you get drunk you can perform but when you take mbanje you respect and behave. We will be afraid and shy”. (Informant from urban group B)

Marijuana was also said to make the user fearless:

“When you smoke mbanje and you get into town, you are unafraid of anybody, even a car itself, you don’t care about it, you just walk and say it will stop, you get very courageous”. (Informant from urban group A)

In answer to the question about the effect of marijuana in a bar, the same informant had this to say:

“You might step on anybody – you just get into a fighting mood with everybody. You feel stronger than anybody else around you – you lose respect even for older people”. (Informant from urban group A)

There was also discussion that effect of marijuana was variable and this depended on the season of the year the drug being currently consumed was harvested, and on individual reactions. The quotations are all taken from urban group A.

“With me, I become very conscious when I have taken mbanje and also very forgetful again”.

Another informant in the group stated that:

“It depends on the grade of mbanje that you will have taken”.

In answer to a question clarifying the grades of marijuana, this was said:

“For example, this time of the season, there is a very high grade”. “... (the mbanje is very dangerous), if you get drunk with it, you become literally mad. Then there is another grade, which is reaped during the farming season, even if you take in large doses, it has no effect – it can only make you cheeky”.

Another informant indicated that mbanje was smoked for the “sweet fantasy lie”. “All your plans just flow so smoothly, you feel on top of the world”.

Yet another informant stated that:

“Mbanje also takes away a sense of urgency. You can say, I want to go to town now, now – smoke mbanje and start fooling around”.

One informant in comparing mbanje and beer made the following statement:

“... I don’t know what others enjoy, but mbanje and beer are very, very different things. The difference is that you feel the effects of beer, but with mbanje I don’t know what those who take it say”.

Another emphasized that variability in effect:

“I think it depends on one’s blood”.

Beliefs concerning male and female sexual behaviour and condom use:

From the focus group discussions, it appeared that there was a considerable amount of sexual activity associated with the drinking establishments. The bar is where women for “instant satisfaction” are sought. The situation of casual and commercial sex is not only for young or single men:

“... In the bar, it is a mixed bag, the young, the old, everybody we meet in this respect”.

Also where couples were apart for any length of time, sexual solace would be sought with others:

“... It can happen that your wife has gone to the rural areas, and it is cold. I feel I can’t sleep alone, we want to tell the truth here”.

Informants however, mentioned that men were now more careful because of illness, so that sex would be sought with “somebody that you know”. Knowledge about her meant that:

“... You know where she lives, what her lifestyle is, who she has gone out with, that type of thing”.

However, the carefulness was often undone by pride, money and drunkenness.

“We just talk, but there are some people who just take women because that particular day they have money, and they want to show off to their friends that today she is with me This happens regardless whether you are drunk or not, but because it is you who has money on that day”.

“When we say we have our own ladies whom we know, you will still be sober and the month will be in the middle. When the month comes to an end, you would be aiming at something, you want to get her drunk, and say, when it is month end, I want to kill her with beer this is the person you would be waiting for all along”.

For many men, while they may not have had the intent to get a woman when they went to the bar, but just to drink, sexual encounters sometimes just evolved.

“... But you know eyes are deceitful, so you see a woman, get attracted to her and because you now you have to get home, you want to do it ‘chop-chop’ (with haste) and go home”.

In response to one of the group who insisted that if men look for women in the bar, it is because of problems at home, (with disagreement from the rest of the group), an informant put it this way:

“Asi ka, \$50 yawakanonga gore riya, wanga usingazive kuti ukafamba ne road iyoyo uchayinonga futi”. (Literally: *“But that \$50 you picked up that year, you did not know if you used that particular road you would have picked it up”.*) In other words, you were attracted to a woman without foreseeing it.

Lust was the reason for the casual and commercial sex encounters:

“We as men, are not afraid of anything. All women we see look like flowers, so I have lust whenever I see a woman”.

A number of men in the group felt that as they were unfaithful, so were their partners:

“Honestly, we men when we are drunk, we get this excuse of saying we did it because we were drunk, but in this case, when we talk of our wives at home, there is no woman who doesn’t have a boyfriend in private. [others laugh]. Yes, women (married) have secret boyfriends. Women are more careful than men, with us, we do it openly when we are drunk”.

Another informant agreeing with this statement said:

“Yes, these women have their own young men they love so dearly in private”.

This however created controversy within the group, with some saying that many women are faithful to their husbands, unlike men.

Condom use was related to a number of factors. These included whether the partner was casual or regular, and the length of time of the relationship. There was ambivalence toward condom use, as issues raised such as the safety of condoms, the risk of infection even if a condom was used, the reduction in pleasure with using a condom, and the need for children in a relationship, suggested that informants considered condoms not an optimal choice. There was also discussion of the non-use of condoms as a weapon to get back at women considered to be arrogant. There did not seem to be a consensus about who determines condom use, as in one group the view was that it was the woman, and in other, it was the man.

“When you pick a woman, and you are drunk, you don’t want to use a condom, but a woman can force you to use the condom”. (Informant from urban group A)

The reason for this is that the women come to the bar to look for men and consequently money, therefore it is their responsibility to protect themselves, as this quote illustrates:

“Women who come to the bar to get drunk, they look for money to look after themselves. These women know that it is your business to pick women, it is not that you are starting with them, so they want to protect themselves and they also know that for some of the women, you don’t use a condom”. (Informant from urban group A)

However, informants in the rural group felt that it was the man that initiated condom use, as most women did not like them. The women did not like them because:

“They say they can’t eat a sweet in a paper”, according to a rural informant. In general, the rural informants seemed more reluctant to use condoms than the urban informants. An informant from the rural group indicated that he only used a condom if the woman insisted on it:

“With me, I tell my girl that I do not want to spoil you, if there is no condom, do not accept me, if she refuses, I leave her alone”.

Condom use will be forgone under a number of circumstances, one of which is if the man is prepared to pay enough.

“In all truth, if take out \$100 and say to a woman, I am not used to a condom, she is torn between using the \$100 and taking a risk. She then eventually agrees. In this case, you are on top of the situation. Then there is another type of woman who will refuse completely to sleep without a condom. But also she might have has 10 or so short times, she would have made her buck (money) for the day and only needing somewhere to finish off the morning - it could be around 4 am usually if you see a woman doing that. But most of them don’t refuse to sleep without a condom if you give them \$100”. (Informant from urban group A)

This was also mentioned by an informant in urban group B:

“Girls from town will ask you if you have a condom first. If you do not have, she will provide (sex) and you will be charged more, instead of paying \$300 for the night, you will pay six hundred. The other \$300 is for ‘risk’ allowance or ‘danger’ allowance”.

Another circumstance where condoms are not used is where there is the opportunity for commercial sex and both partners have no condoms, and insufficient money to purchase them:

“The other problem is that the man will have agreed with a woman to go and sleep together, it is during the month. The man offers \$50 when they get to the gate, the women starts saying, I have no condoms at home, so what shall we do - please buy yourself. She counts the \$50, if she changes it is short. They then proceed to the home and they have no condoms. Then they ask each other ‘are you alright?’ The other says ‘yes I am alright’, but are you both doctors to say that? This is another big problem. Then they sleep without the condom”. (Informant from urban group A)

The lack of condoms at the time that they might be needed is another circumstance for their non-use:

“People leave the bar, those women who hunt for men - have a ‘short-time’ system; the fees are different, so they just buy one packet of Protector condoms. The man buys one packet, they go to their place of sleeping. Some men will use 2 at a time and do their job and finish. In the morning, the man might want to do it again, and there would be no condoms. Then the man would start saying: ‘asi iye uyu, nemasimiro ake aya angave nechirwere?’ (But this one, the way she dresses [smartly], would she have the disease?) Giving himself confidence to go into the woman without the condom...”. (Informant from urban group A)

The type of relationship obviously affects condom use. Once a single sexual encounter develops into a recurrent activity with the same person (a relationship), condoms are less likely to be used. This is the situation of a “permanent girlfriend” as the following quotation illustrates:

“People are killing each other, especially the idea of ‘permanent girlfriend’ and ‘permanent boyfriend’. I don’t know what this means - is this a person you take home every Friday when you have money? (Others agree) What happens with these permanent girlfriends is that the first day you use the condom, and maybe the second day, on the third day, you start saying you are mine and I am yours. But the permanent girlfriend doesn’t wait for one man only, who usually is someone’s husband, they are picked by others”. (Informant from urban group A)

An informant from urban group B supported this practice, with the following statement:

“When you fall in love with a prostitute and she comes to stay with you for a while, you will use the condom for five days only. But after that you find yourself having sex without a condom. Because it’s boring to use a condom continuously and you will tell the prostitute that you need a baby with her”.

The issue of apparent trust in a relationship is extremely pertinent to the use of condoms. An informant from urban group A related that he was misled by his brother into not using a condom which led him to contract a sexually transmitted infection:

“... My brother said that if you are going to use a condom on a woman, it means you don’t trust her, so what’s the point. Then I stopped using a condom. Then I met her the following day and told her what I had discussed with my brother and asked her if she trusted me. She said she did, so I rendered the condom useless, I also trusted her. After that, it was me the victim who remained bothering doctors, after I fell sick”.

An informant from the rural group also indicated that the more frequently one slept with a particular woman, the less the likelihood that condoms would be used. In fact the woman would refuse to use a condom.

“If you have trust in the woman you get to know her as time goes on in your relationship”.

Condoms are perceived as for use with commercial sex workers, as another informant from urban group A related:

“I stayed for two years without my wife, I was out of the country. When I came back, I told her I wanted to use the condom, but you know our wives are understanding and very obedient. I couldn’t explain myself any better, I tried but couldn’t be more open. She said condoms are for prostitutes”.

On the other hand, one informant believed that condoms were used more in marriage than out of it:

“...the husband comes home at 3 am in the morning on consecutive days. Then the woman can tell that he has been with another woman. Then she refuses him to sleep with her without a condom. Also after that, you are broke for a week, and you are a good boy. Then you go back to each other, you will be coming home at 6 pm. This time you might even have a baby”. (Informant from urban group A)

The same informant supported his argument that condoms were used more in marriage than out of it by saying that condoms were not used in first encounters, even in casual sex:

“... It never happens during the first time, never. She would like to taste first, before she can settle for the condom. So condoms are used in homes”.

The ambivalence towards condom use is also seen in the a ready belief that there is a risk of getting a sexually transmitted infection even though a condom was used:

“We also hear of people who caught an illness, but were using condoms. The issue here is that - I heard a friend saying that when you pick these women, some live in shacks, and they have no lights at all, so when you go into their routes, it would be dark. But a condom, like socks, is not a problem to wear even in the dark. So you can use it. At the end the woman, since she will be drunk, she forgets where she has put the ‘cloth’ for cleaning, and it is dark. Then she takes her underwear, she cleans herself with it, first before she cleans you, then, the protection that had been there to start with is compromised.” (Informant from urban group A)

The ambivalence towards condom use and the resentment of having to pay more for sex when the price of the condom is included has lead to apparent practices of piercing the ends of the condoms. Bravado is also an issue in condom non-use:

“Some men will pierce the condom themselves after feeling the pinch of paying \$100. They know there is an illness. Men deceive each other, one will laugh at another and say, ‘so you used a condom - I did it ‘fare-fare’ (without a condom). So this man is ??? than the one who did without a condom. This is why we pierce them at the end”.

The reason for piercing the condom was put in this way:

“So that the sperms flow right inside, and make her pregnant.”

The intention being not to make her pregnant as such;

“... but to fix her for making me eat a sweet in a plastic”. (Informant from urban group A)

An informant from urban group had a similar statement about this practice:

“Sometimes males do not want to use condoms because they want the girl to fall pregnant so that she will become useless, she might be too boastful about herself. You may want five to ten women to sleep with without condoms so that they will be useless when they get pregnant”.

Condom piercing is used then as a punishment for women considered arrogant, and probably indicates the ambivalence towards condom use.

Condom use was also conditioned by the need for children:

“When you want to marry someone going for tests is very expensive. Consequently, you just commit yourself into the marriage because all you need is the child. And maybe you may want to make the woman pregnant for her to come to your place. Hence you are forced to have sex without condoms”. (Informant from urban group B).

Beliefs concerning alcohol, other substance use and sexual activity:

Alcohol was perceived to increase sexual desire and sexual performance:

“When some people get drunk they need to have sex with women”. (Informant from urban group B)

“But to tell you the truth, when you go to the bar, you will see women as they are, but at the end of the day, when you are drunk, you see them in different light, they all become beautiful and you want to take them to bed without condoms”.

“...there is a certain type of beer that will cause a difference, when you take it, you don't sleep at home – your wife will be thinking that you have taken some herbs of some sort to increase your sexual activity. In fact, you will not be enjoying as much as she could be, you would be in trouble because of this beer, even this opaque beer is a problem, if you take it, your sexual activity lasts longer”. (Informants from urban group A).

Unlike beer, there was a perception that beer had more of an effect on sex than marijuana:

“Me, as a person who once tried mbanje and didn't get any joy from it, when I take opaque beer, I do work very well (meaning sexual intercourse). [Others laugh] To me it will be delaying, but the person I'll be with will be enjoying herself, thinking that I have taken some herbs somehow. I do feel like a woman when I take beer rather than when I take mbanje”. (Informant from urban group A)

Factors inhibiting and enabling reductions in alcohol use

It was almost unanimous that the cost/lack of money/poverty reduced alcohol consumption, as three out of the four male focus groups mentioned this:

“All drinkers want to drink every day. Money is the problem, the most common inhibiting factor”. (Informant from the rural group)

“Nhamo ishamu. If one has no money, they avoid a lot of problems ...”.

Another factor was religion. As an informant in urban group A put it in answer to the question on factors inhibiting alcohol use:

“If you commit yourself to Jesus in these hard time, you defend yourself from a lot of problems – times are bad”.

Other factors that inhibited alcohol use were illness (health reasons) and if the spouses complained a lot. However, both these factors were challenged in another focus group discussion:

“You could be given orders not to drink by your wife or by the doctor. ...But doctors orders – it’s a lie, I see some people who have TB, but drink the scud until they fall. Some go to the extent of dying, having failed to obey the doctor’s orders not to drink”. (Informant in urban group A)

“... Even your wife can scare you – because some men wet the bed at night – then the woman would say, ‘I can’t wash blankets everyday’. If he is a serious drinker who has his money to drink everyday, he may say, ‘you can go, I will look for somebody else’. ...”. (Another informant in urban group A)

Taking medications was another reason for reducing alcohol consumption:

“Some people may be under medication or they may be told to stop for a while, while they take a prescribed medicine. But afterwards they stop drinking forever and even smoking. That is how the majority stop drinking beer”. (Informant in urban group B)

From the discussions in the male focus groups health reasons and spousal concerns seem to be less effective in reducing alcohol use. Another factor mentioned was the fear of AIDS in the rural group. Drinking is a group activity as reported earlier, so that drinking alone would tend to enable a reduction in consumption.

Factors inhibiting and enabling condom use

Cost and availability at the time of need inhibited condom use. Ignorance and drunkenness were also stated as factors in their lack of use.

“There used to be a nice/good system of buying condoms – there would be a machine with a slot for \$2 and it would drop a condom, but now condoms are sold through the counter. Now this system is bad, there could be somebody that you respect sitting by the counter there. Now can you buy a condom in these circumstances?

Secondly, there could be some at the council bar, but in some of the indigenous bars, you might not find condoms. Then you try to borrow from friends and they might not have anything. So some people are prepared to use condoms but they are not necessarily available when needed”. (Informant in urban group A)

An informant from the rural group stated that:

“If only condoms can be made freely available, even if one buys them a sweet it would be good to be given a condom”. Another said:

“Avail condoms in abundance”.

Some participants in the focus group discussions felt that ignorance inhibited condom use. Others however disagreed. This excerpt from the rural group illustrates this point:

Informant A: *“Most do not know (about AIDS in this rural area). It is like if I sleep with a woman without a condom, that person is not aware of AIDS, what it means”*.

Informant B: *“They will be knowing, especially drinkers, but when drunk we tend to forget that there is AIDS”*.

Informant C: *“People know. When they get drunk they hide behind their fingers”*.

Other factors mentioned inhibiting condom use were beauty and trust, and having sex with a virgin.

“Some ladies are too beautiful to use a condom, for you feel weak”. (Informant in urban group B)

“Trust also causes people not to use condoms. One trusts a girlfriend but that girlfriend will have betrayed you way back. She may have been infected before, but because you are in love on a formal basis you trust her”. (Informant in urban group B)

Fear of AIDS has enhanced condom use. Also there are certain beliefs that encourage condom use. One such belief is that the condom lubricating fluid is therapeutic:

“ – some people think that the fluid in the condom will help to ‘straighten’ their penis, this is the belief most men have – not that they use condoms to prevent AIDS, they think condoms are therapeutic, ...”. (Informant in urban group A)

Experiences on STIs/HIV/AIDS and sexual activity

The majority of informants in the male focus groups acknowledged having had a sexually transmitted disease (STD), some of them a number of times. STDs were considered to be a very common occurrence, and until recently almost a desirable experience in order to demonstrate that a man would know how to have sex with a woman. However, with the HIV/AIDS epidemic, STDs had become stigmatized and it seemed that men had become more careful:

“Zvagara zvichirwariwa izvi. People always suffer from these (STDs)”. (Informant in the rural group)

“... During our time, if you didn’t suffer from a STD, we would say that you don’t know how to make love to a woman. But it was that time and STD could be well treated people at that time had different views altogether – we would show off to each other ‘these days I have got drop’. If you say that these days, people will start avoiding you and say, we don’t have much of him left. ... Even those types that make you fail to walk, you would still show off – you would be getting into a bus and limp in a fashionable way – to alert other people of your condition”. (Informant in urban group A)

“These days STDs are no longer there. When you find yourself infected with a STD you must know that you will die”. (Informant in urban group B)

From a comment in one of the focus groups, it seemed that STDs were associated with having sex during the woman’s monthly period and were thus the woman’s fault:

“Most women are cruel that’s why most are witches. Most of them do not even disclose that they are on monthly period, they let you have sex with them. By the end of the day you will be ill. To add on that, when one is drunk he may refuse to put on a condom and force the girlfriend saying he was to find out on his own if the woman is on. Which is dangerous”. (Informant in urban group B)

The informants in the focus groups knew about HIV/AIDS, with some of them having cared for sick relatives. Others had friends and relatives who were suffering or had died from AIDS. The awareness of the AIDS deaths was high. The stigma associated with AIDS was because of how wasting people with HIV/AIDS became.

“I had a female relative who suffered from AIDS. When I visited, she wanted just to breathe fresh air, but she was hastily restrained. ‘Can’t you see that you are just bones, you are embarrassing, go back inside the house’. People are embarrassed to be associated with sufferers. People will start saying this is so and so’s wife husband, brother or whoever, and it is embarrassing”.

2.3 Female Focus Group Discussions

Focus Group Discussion with Rural Female Sex Workers

Participants (pseudonyms):

Peace, 26 years, form 2 education

Nyasha, 19 years, grade 7 education

Anna, 23 years, form 3 education

Ratidzo, 26 years, form 3 education

While some women in the group said they drink for reasons similar to those we found among men (simple enjoyment), several also indicated they use alcohol for self-medication for depression, or as Nyasha told us, *“to comfort myself and become less ashamed with the activities I do.”*

Becoming less ashamed with the activities of sex work also allowed the women we spoke with to have the courage to carry on with sex work. Like some men, Anna said that alcohol gives her *“courage to do something.”*

For men, alcohol helped build courage to buy sex while for women sex workers, alcohol confers courage to sell sex. In both cases, alcohol is the social lubricant needed to sustain commercial sex.

Similarly, women reported that alcohol helps them to overcome shyness or become more social, allowing them to conduct their work more effectively. Ratidzo commented that,

“I can’t move alone, I need company to start the soliciting because at first I will be shy. I need to drink beer and get drunk, then the shyness can disappear.”

Nyasha added, *“I started drinking beer by imitating others and what makes me continue drinking beer is that where we go to solicit, if you do not drink, you won’t be able to understand drunk people. So if we all drink, we are able to understand each other.”*

Anna added that, *“...when drunk, people seem to understand each other easily.”*

For women, like men, drinking beer is preferably a social activity. Women mentioned three reasons for this.

First, drinking at a bar, in the company of others, simply makes drinking more pleasurable: *“Beer needs other people. As for myself, I can’t drink where there are not many people. The large number of people makes it good to drink.”* (Nyasha)

Second, because you can meet people who buy beer for you: *“I want to drink among others. You could meet some people who will buy beer for you.”*(Ratidzo)

Third, drinking with many others allows one to meet sex clients: *“You could meet some ‘uncles’ from home”* [uncles being a euphemism for clients] (Anna)

For the women we spoke with, drinking beer bought for them by potential clients is an important precursor to the actual negotiation of the sexual service.

“Helping [men] spend their money” as Peace put it, is a major role women said they played at the bars. Women assisted men to spend money on both beer and in the final instance, sex. It is interesting to note that sex workers may then play a pivotal role in the business success of the bars they patronize as they encourage men to spend money on alcohol. It is possible, although we didn’t investigate the possibility, that bar owners at the growth point tacitly encourage the activities of sex workers for just this reason.

Ratidzo described the process by which she and her clients typically agree on an arrangement:

“He will ask you to go outside and negotiate, he will indicate that he wants to put up at my place and wants to know the charges. We would then continue drinking until such a time when we go home.”

According to the women who took part in the focus group discussion, the charges for sex vary depending on the amount of time a man seeks to spend with the sex worker. What is called “short time” are brief encounters that take place most often in the bushes outside, in a car, back alley, or at times, at a man’s home or the sex worker’s home. These encounters cost from \$70.00 to \$100.00. For longer periods of time, women charge from \$150 to \$200 and for a whole night (until about 6am. the following morning) they charge \$300.00 [the exchange rate at the time was Zim \$32 to 1 USD]

More long-lasting relationships can flower between women and their clients. Growth points are crossroads for both migrant men and men who are farmers in nearby communal areas. Women who sell sex can often also offer a place to sleep and other domestic services for men who are on the road and don’t want to stay in a hotel. Ratidzo, Anna, and Nyasha reported the following:

Anna: *“Some take you today and when they return they look for you, so you wake them quite early for extra sex.”*

Facilitator: *“What is extra sex?”*

Nyasha: *“You add more. You could go as far as 7am or 8am. We cook for them so that when they come next time they give us more money. We give them water to bath or roast meat served with sadza.”*

Ratidzo: *“And if he wanted to leave \$100, he will leave \$200”*

Anna: *“It’s just like those who come to stay for a while, they don’t want to change partners everyday so that’s how a relationship develops. If he returns next time he will definitely look for you.”*

The women in the focus group were knowledgeable about condoms and acknowledged the important role they play in HIV prevention. At first, they emphasized the importance of using condoms every time they had sex regardless of whether they knew or trusted the man in question. Ratidzo, said:

“You choose to use a condom or not to use a condom not that because you are used to each other. Staying together for a long time cannot stop us from using a condom.”

Anna disagreed, however, saying that condom should be used when you don't know the “background” of the person you are sleeping with. But, she added:

“There is one called a permanent boyfriend, the one who pays rent, who gives me money, I accept without a condom.”

Ratidzo then agreed that, *“It is usual to have a permanent boyfriend and agree not to use a condom and at the same time have one who agrees to using a condom.”*

All the women reported that they negotiate condom use before having sex, and usually before taking the man home or going to his hotel room or home.

Nyasha: *“If he has already paid me, I just give him back the money and ask him to look for someone who can take it without a condom.”*

Ratidzo: *“I normally ask when I am being given the money whether he uses a condom or not. If he refuses I still take some of the money already given.”*

Peace: *“As for me, I seek his consent to use a condom first. If he later changes, we share his money by half, for having wasted my time.”*

The women also reported taking some responsibility for making sure that condoms were on hand when they needed them. Nyasha reported that

“What we do is when we get home we get condoms and keep them under the pillow. When he comes to you without attempting to take them you tell him to take them.”

Anna stated that if she knows she doesn't have them at home, she asks the man if he has them and tells him he will have to buy them if he doesn't.

All women reported that condoms are sold at the bars for \$5 per packet [Protector condoms come in packets of 3 for \$5].

Drinking excessively, however, can seriously impair women's capacity to effectively negotiate:

Ratidzo: *“What happens is sometimes you get too drunk and a boyfriend takes you home by car. You may be too drunk to know what happens. He could have sex with you without a condom. You'll be too drunk to be conscious. Some drink to the point of sleeping unconsciously, ending up being carried home.”*

Nyasha: *“This usually results from taking mbanje [marijuana] and beer at the same time.”*

Although women reported using condoms fairly consistently with their clients, it became apparent that they are at risk for STDs and HIV. Several women has disturbing stories to tell regarding STDs they have had in the past. These stories indicate that despite the women's efforts to enforce condom use, they are made vulnerable by the untrustworthy behavior of their clients:

Anna: *"I suffered in early January. I was drunk. I had short time with an elderly man. He pretended to be putting on a condom but removed it. When I looked later I noticed he did not have it on. When I asked him why he had done it he said "I've got a wife and children. What do you fear?" After about a month, I became sick with gonorrhea."*

Nyasha: *"I once suffered from it [gonorrhea], when I had just joined this trade, without knowledge of what a permanent boyfriend could give. I went out with this guy and he said since I was his girlfriend it was not necessary to use a condom. He said he wanted a child. I didn't know much about this trade. We went for 3 months and after that I suffered from a disease "of wounds". From there I learned a good lesson."*

Ratidzo: *"I had this gonorrhea when I just started the trade, because I didn't know that condoms are important. Then I didn't even know the actual person I got it from."*

Anna: *"At one time I had to force someone to wear a condom. When he had finished I saw the condom covered in blood."*

Nyasha: *"Some tell you that they have no STD and if you are not careful, you will get it, because some are so used to it and having sex is not painful anymore."*

Some women have developed interesting strategies for identifying men who may have an STD:

Peace: *"No, I haven't [had an STD]. I use condoms. I also inspect whether the man has an STD by holding firm his private parts. He jumps [if he has an STD]. Especially with gonorrhea, if you hold and press him you see something whitish coming out of him."*

Enforced condom use by itself, however, is an insufficient protective measure, however, when faced with deceptive men. Women were especially concerned about the risk associated with "short time" sex:

Nyasha: *"With short times some wear condom and some don't. Some have sex while standing, others while lying down. Here in most cases, standing is the problem because he will be behind you and when he inserts he can pretend to be putting the condom in place.... And in most cases men want to use their own condoms so you have to tell him to use the one you will provide."*

Anna: *"Short time is risky in terms of diseases, they would entice you with \$1000 to have sex without a condom. You will think only for a short time! You won't be facing him so he could take advantage and remove it."*

Nyasha: *"What he does is he takes his penis out as if by mistake, slips off the condom and then reinserts without a condom. So he holds you fast."*

Urban Female Focus Group Discussion

Participants (pseudonyms):

Rita, 29 years

Lime, 34 years

Harriet, 35

Kuyedza, 31

Note: All four participants were in some stage of mild to moderate intoxication during the discussion.

All participants said that they seek clients at drinking places. Nightclubs are preferable to other types of drinking places and the women said they chose to patronise nightclubs that were “hot”. Harriet described what they meant by this:

“A hot place is one patronised by many men who have money and can buy me beer until I am drunk. It is also a place where men can admire me when I get to the bar smartly dressed and ask to join them in spending money.”

For these women, appearing smart and attending smart bars was very important, not only to their trade, but to their sense of self-esteem. They also expressed an appreciation for drunken socializing:

“I enjoy seeing drunk people and for people to see me drunk.” (Kuyedza)

“People can entertain you with jokes when they are drunk.” (Rita)

“You get to see the behaviour of drunk people. Some will be taking off clothes and doing all sorts of funny things” (Lime)

In addition, inebriated men are good for business. Lime had this to say:

“With those who drink beer, once they are drunk, it’s always very easy to get part of their change when they send you to buy beer. You can actually get more money if hooked to a man who drinks beer. Those who don’t take beer are very difficult to cheat for they always know how their money is getting spent.”

The women also said they even feel distrustful of men who don’t drink:

“We also don’t trust men who get into the bar and don’t take beer. We at times get suspicious that we even think they are robbers. It is very abnormal to get into a beerhall/nightclub from 6p.m. to 3a.m. without taking beer. Such people can be robbers. They can also over use you. Most such people never rest when they start making love.” (Harriet)

“Most of these are also very rude. They can criticise almost everything about you so much that you end up offended.” (Rita)

The sexual incompetence of drunk men can be a real advantage for sex workers. Since drunk men are likely to fall asleep quickly, it relieves the sex worker of having sex multiple times in one night, or leaves her the opportunity to have more clients in one night and thus make more money:

“My friend was telling me yesterday that she can take up to 5 men. You know when men are drunk they do not perform for long.” (Lime)

For these women, becoming intoxicated is a strategy for forgetting about personal problems, most notably, their own marital problems:

“Beer makes me forget some of my problems, for example, the fact that at my age I can’t get a man who can marry me.” (Harriet)

“Beer also makes me forget some of my problems. My husband passed away and once I drink I don’t think much about him. When my younger sisters come home with their husbands I at times start thinking about my lost husband and start crying. However once I drink beer, I don’t think about all that.” (Lime)

All the women expressed enthusiasm about condoms and the importance of their use:

“Nowadays, sex without a condom is a non-starter. Without a condom, I’ll never agree to have sex, I always make sure they put on a condom or I’ll do it myself because at times some men are cruel and will perforate the condom while you don’t know.” (Lime)

“I use condoms even with my permanent boyfriend. We often use male condoms.” (Rita)

“No matter how drunk I am, I will never forget protecting my body.” (Harriet)

The women preferred the male condom over the female, which, they said, caused discomfort:

“I have only used a female condom once since they were introduced. We often use and prefer male condoms. With male condoms, you won’t even feel he’s putting on something and with female condoms you always feel this pain in the womb.” (Harriet)

“At times when you meet men who say they don’t want to use a condom then you can just put on a female condom. If he says he can feel something you can always tell him he is too drunk and no longer knows what he is doing.” (Rita)

Rita also had heard of a condom alternative:

“Some clever women now insert cotton into their private parts when a man refuses using a condom. This cotton blocks whatever comes out of a man from getting into the woman.”

Like the rural women we had a focus group discussion with, the urban sex workers told us that it is rather common for a client to become a steady partner or regular client for whom sex can be given without charge.

“With some men they give a lot of money when they have it, buy you some groceries and even pay rentals for you. If such a regular client comes, I’m always willing to have sex without money. Such men will be more or less friends and we always understand them.” (Rita)

“Some of the guys we call permanent are very clever, though. They only make themselves available when they know you are not in financial problems. Some permanent clients never make themselves available

when they know we are towards paying rental. These guys, they should always pay whenever they want to use my body.” (Harriet)

Lime told us (and Rita agreed) that she prefers married men to be her permanent partner:

“I often prefer married men because they are not so possessive and they don’t want too much attention. If I don’t impress him today he can always go to his real or permanent wife.”

At the same time, Rita acknowledged her belief that married men are the worst “culprits” in spreading AIDS:

“I think married men are one of the worst culprits in spreading AIDS within married couples. Some of them come to nightclubs to drink beer and have sex without a condom and go back to their wives whom they also have sex with without a condom. At the end of it all, married women end up catching diseases as well.”

Speaking about the allure of sex workers, all agreed that sex workers had something special to offer to men—most notably the special treatment sex workers give to their vaginas in order that they will be tight and dry for their clients:

“These medicines tighten our private parts or make them contract so much that you will be more or less like a virgin. We apply these medicines so that when we meet men they will enjoy sex. Our private parts will be dry.” (Lime)

“It is not enjoyable for men to insert their private parts into a woman’s private parts which are just like a wide open mouth. They won’t feel anything. He should feel like he has slept with a woman whose parts are still intact.” (Rita)

“We also have another medicine called mutundo wegudo (lit. baboon’s urine). With this type of medicine, once a man makes love with you for the first time he will keep on coming to you only—just like the baboon always goes to one place to release its urine.” (Lime)

“I don’t usually like this idea of using these medicines as others are saying. What we women should be doing is just putting Dettol (an antiseptic) or salt into our bath water. It also tightens your private parts or drains fluids from our private parts so much that you will be more or less like a virgin.” (Rita)

“I think it’s because married women are not very concerned about their private parts. They just leave them expand like that. So when a man comes to me after I have used my lemon-salt solution he is bound to feel the difference or enjoy more.” (Harriet)

Aside from using vaginal preparations, the women also cited their skill at love-making as an attraction for men:

“Besides taking good care of our private parts, we also know the difference styles of making love. Lovemaking should never be through one style always. You should use different styles. However most married women always want to use just one method so that their husbands perceive them as decent women. At the end of the day he will leave such a woman for better styles.” (Lime)

“Using one style of making love everyday will be like having sadza, stew, and vegetables everyday. This is what married women are doing to their husbands. With us we try giving the chips, chicken, and sausage today, another meal tomorrow, and so on. It should not be just one style everyday.” (Harriet)

2.4 Cross sectional quantitative survey

A total of 452 individuals completed an interviewer-administered questionnaire. The questionnaire consisted of five parts: demographic information, alcohol and drug use, sexual behavior connected to alcohol consumption, and sexual behaviors generally (see Appendix for a sample questionnaire). Presented here are data from each segment of the questionnaire with an emphasis on sexual behavior connected to alcohol consumption.

The questionnaire was administered to 376 men and 76 women. 308 participants (68% of the sample) were sampled in the urban site while 144 (32%) were sampled in the rural site. In addition, 85 of the participants (19% of the sample) were drawn from STD clinics (52 from an urban clinic and 33 from a rural clinic).

The mean age of the respondents was 32.7 years. Among men, this was 33.2 years, compared to women who were on average four years younger, 29.8 years. Urban and rural respondents were similar in age, 32.6 and 32.8 years respectively. The average age of respondents drawn from the STD clinics was 30.6 years, compared to the age of 33.1 of the non-clinic sample. The majority of respondents (68%) had at least two years of secondary education (nine years of education). Women had lower education levels relative to men (nine versus eleven years), and as did rural versus urban respondents (seven as against ten years).

Concerning marital status, about half of the men and the rural women were married, (see Table 2). Among the urban women, nearly a third were separated or divorced. About 11% (22) of the married men were in polygamous marriages, 12 of these were urban men.

Respondents were asked about the type of work they did. About a quarter of the rural men said that they were unemployed, and over a third of the urban men worked in trade or industrial occupations. Over 20% of the urban women and 17% of the rural women acknowledged to being sex workers.

There was a wide differential in the reported mean monthly (regular) income between rural and urban respondents. Urban subjects earned considerably more than rural ones. Urban men (n=216) earned twice as much as those in the rural areas (n=84), (Z\$7 155 versus Z\$3 874) and urban women (n=30) twice as much as rural women (n=11), (Z\$4 597 versus Z\$1 650).

Table 2: Demographic characteristics of the sample interviewed using a questionnaire.

	Men		Women		Total	
	Urban	Rural	Urban	Rural	Men	Women
Marital status (N)	255	121	53	23	376	76
Married/ Cohabiting (%)	50.6	62.0	22.7	52.2	54.2	31.6
Single (%)	39.6	22.3	28.3	26.1	34.0	27.6
Separated/ Divorced (%)	6.3	10.7	32.1	17.4	7.7	27.6
Widow(ed) (%)	3.5	5.0	17.0	4.3	3.9	13.1
Type of work¹						
Unemployed (%)	11.4	25.0	17.0	26.1	15.7	19.7
Trade/industry (%)	36.2	17.5	9.4	0.0	30.0	7.1
Services (%)	6.7	9.3	13.2	26.1	7.4	17.1
Professional (%)	17.3	13.3	5.7	0.0	18.6	3.9
Clerical (%)	6.8	0.0	11.3	0.0	4.5	7.8
Business (%)	7.5	0.0	0.0	0.0	5.0	0.0
Farming (%)	0.0	15.8	0.0	0.0	5.0	0.0
Informal trade (%)	0.0	0.0	0.0	17.4	0.0	5.3
Sex work (%)	0.0	0.0	17.0	21.7	0.0	18.4

¹Reported only for at least 5% in a particular occupation

Table 3: Frequency of alcohol use.

	Men		Women		Total	
	Urban	Rural	Urban	Rural	Men	Women
Do you drink?	N=255	N=121	N=53	N=23	N=376	N=76
Yes (%)	75.7	78.5	64.2	21.7	76.6	51.3
Type of alcohol consumed in last 30 days	N=193	N=95	N=34	N=5	N=288	N=39
Opaque beer %	67.4	83.2	55.9	(4)	80.2	58.9
Clear beer %	88.1	88.4	91.2	(5)	88.2	92.3
Spirits %	40.4	44.2	58.8	(4)	41.7	61.5
Freq. Of consum.	N=193	N=95	N=34	N=5	N=376	N=76
Daily (%)	38.3	34.7	35.3	(4)	37.1	43.6
3 x per week (%)	11.4	3.2	0.0	(0)	8.7	0.0
Weekends only (%)	16.6	16.8	23.5	(0)	15.6	20.5
Whenever \$ (%)	31.6	41.1	20.6	(1)	34.7	20.5
Rarely (%)	2.1	4.2	20.6	(1)	2.8	20.5
Regular place?	N=193	N=95	N=34	N=5	N=288	N=39
Yes (%)	75.6	76.8	52.9	(4)	76.0	56.4
Type of place	N=146	N=73	N=18	N=4	N=219	N=22
Beerhall (%)	40.4	39.7	44.4	(2)	40.2	45.5
Nightclub (%)	24.7	26.0	44.4	(2)	25.1	45.5
Bottlestore (%)	29.5	21.9	5.6	(0)	26.9	4.5
Bar (%)	3.4	1.4	0.0	(0)	2.7	0.0
Hotel (%)	1.4	11.0	0.0	(0)	4.6	0.0
Other (%)	0.7	0.0	5.6	(0)	0.5	4.5
Freq. Of drunk	N=193	N=95	N=34	N=5	N=288	N=39
Always (%)	25.4	32.6	17.6	(3)	27.8	23.1
Often (%)	27.5	20.0	20.6	(0)	25.0	17.9
Sometimes (%)	31.6	26.3	32.4	(1)	29.9	30.8
Rarely (%)	7.3	7.4	14.7	(1)	7.3	15.4
Never (%)	6.7	10.5	11.8	(0)	7.9	10.3
Missing (%)	1.6	3.2	2.9	(0)	2.1	2.6
When last drunk	N=193	N=95	N=34	N=5	N=288	N=39
This week (%)	81.9	86.3	52.9	(5)	83.3	58.9
>1week ago (%)	9.3	11.6	20.6	(0)	10.1	17.9
> 1 month ago (%)	5.7	2.1	17.7	(0)	4.5	15.4
Can't remember(%)	3.1	0.0	5.8	(0)	2.1	5.1
Missing (%)	0.0	0.0	2.9	(0)	0.0	2.6
How often drink to get drunk?	N=193	N=95	N=34	N=5	N=288	N=39
Always %	25.4	32.6	17.6	(3)	27.8	23.1
Often %	27.5	20.0	20.6	(0)	25.0	17.9
Sometimes %	31.6	26.3	32.4	(1)	29.9	30.8
Rarely %	7.3	7.4	14.7	(1)	7.3	15.4
Never %	6.7	10.5	11.8	(0)	7.9	10.2
Missing %	1.6	3.2	2.9	(0)	2.1	2.6
Last time drunk	N=193	N=95	N=34	N=5	N=288	N=39
This week (%)	81.9	86.3	52.9	(5)	83.3	58.9
>1week ago (%)	9.3	11.6	20.6	(0)	10.0	17.9
>1 month ago (%)	5.7	2.1	17.7	(0)	4.5	15.4
Don't remember(%)	3.1	0.0	5.8	(0)	2.1	5.1
Missing (%)	0.0	0.0	0.0	2.9	0.0	2.6

More than three quarters of the men and two thirds of the women drank, (Table 3) and their drinking debut tended to be early. Out of a total of 306 responses, the mean age of drinking debut was 15.5 years for urban men, 17.1 years for rural men, 14.2 for urban women and 17.4 for rural women. There were 17 missing values and 4 did not know the age at which they started drinking. Clear beer was the alcoholic beverage most commonly consumed, with opaque beer being consumed in equal proportions among the rural respondents. Respondents tended to drink often, with over a third drinking daily. Availability of money was related to the frequency of drinking. The men tended to have a regular drinking place (more often a beer-hall), while the women tended not frequent the same place as often, and tended to patronise beer-halls and nightclubs. There was a high frequency of drunkenness, with rural women reporting the most drunkenness. More of the rural women reported being commercial sex workers. Urban men and women were drunk 2.8 times in the past week, rural men twice in the past week and rural women were drunk 4.6 times in the past week. There were 316 responses to the question on the number of times an individual had been drunk in the past week, with 1 who did not know and 10 missing values. In general, respondents drank to get drunk, with more rural respondents reporting that always drank to get drunk, compared to urban respondents. The majority of the respondents had been drunk in the past week, more than 80% of the men and 50% of the women.

Respondents were asked about drug use. Tables 4, 5 and 6 present these data. About 42% of the respondents took drugs. Relatively few women compared to nearly half of the men, used drugs. Marijuana was the drug most commonly used; over 60% of the rural and 40% of the urban men had used it in the past month. Those who used drugs tended to take them daily or whenever they had money, (Table 6), including four of the nine women who responded to this question.

Most (66%) of the drug users took alcohol together with the drugs, with more rural men tending to use these substances together, ($X^2=8.74$, $p=0.003$), (Table 7). Six of the twelve women who used drugs, also used them together with alcohol.

Alcohol and drug use and sexual behaviour

Respondents were asked about their sexual behaviour in relation to alcohol and drug use. Tables 8-11 present these data. Nearly 90% of the respondents had recently (within the past 2 weeks) had sex when drunk (Tables 8 and 9). Over half of the men had had sex with a casual or commercial sex worker at this time, mostly without a condom (Tables 10 and 11). None of the women admitted to having sex with a client; 43% of them said that they had had sex with a casual partner when drunk, and 30% either did not know or had missing responses.

Respondents were asked why they had not used a condom the last time they had sex whilst drunk. Of the 15 women (one rural woman) to whom this question applied, eight said that they had had sex with their steady partner or spouse (1), four, including the rural woman, said that their partner does not like condoms, and two said that they were too drunk. Data were missing for one respondent. For the men, the responses to this question are presented in Table 12. Excluding those who had sex with their spouse or steady partner, more common responses were that condoms were not accessible at the time (9.8%), they were too drunk (8.4%) and sex was less pleasurable (6.2%).

When asked the reason for not using a condom when having drunk sex with a casual partner, the most frequently reported answers by the men were that condoms were not accessible at the time (21.2%) and that they trusted their partner, (21.2%). (Table 13). For the three women for whom this question applied, two said that their partner did not like condoms, and one admitted that she had been too drunk.

Table 4: Have you ever used drugs? (n=452)

	Yes	No	Missing	Total
Urban Men (n=255)	43.1%	56.1%	0.8%	100%
Rural Men (n=121)	55.4%	44.6%	0.0%	100%
Urban Women (n=53)	17.0%	81.1%	1.9%	100%
Rural Women (n=23)	13.0%	82.6%	4.3%	100%
	n=189			

Table 5: What drugs have you used in the past 12 months? (n=189)

	Marijuana 12 mo.	Marijuana 30 days	Inhalants 12 mo.	Inhalants 30 days	Other 12 mo. ♦	Other 30 days
Urban Men (n=110)	94.5%	40.0%	2.7%	0.0%	6.4%	0.0%
Rural Men (n=67)	97.0%	61.2%	0.0%	0.0%	0.0%	0.0%
Urban Women (n=9)	(9)	(4)	(1)	(0)	(3)	(0)
Rural Women (n=3)	(3)	(2)	(0)	(0)	(0)	(0)

♦ cocaine, LSD, heroine, mandrax

Table 6: How often do you take drugs? (%) (n=189)

	Urban Men n=110	Rural Men N=67
Daily	30.9	31.3
3x per week	0.9	4.5
Weekends only	7.3	7.5
Whenever have money	20.0	26.9
Occasionally	5.5	1.5
Rarely	12.7	1.5
when I can get them	12.7	11.9
only used once	1.8	0.0
no longer take them	5.5	4.5
Other	1.8	10.4
Missing	0.9	0.0
Total	100	100

Table 7: Do you take drugs and alcohol together? (%) (n=189)

	Yes	No
Urban Men (n=110)	59.1	40.0
Rural Men (n=67)	80.6	17.9
	n=119	

The more frequently mentioned reasons for not using a condom for drunk sex with a commercial sex worker (Table 14) were that condoms were not accessible at the time, (22.3%), they were too drunk (22.3%) and sex was less pleasurable (19.4%). Table 15 presents the responses to the question on the perception as to whether alcohol improves sexual performance. Though more than half said that it did not

improve sexual performance, about one in three believed that it did, more rural than urban men feeling this way.

Respondents frequently thought of sex when drinking. Over a third of urban men always thought about sex when drinking, as did 20% of women, and 14% of rural men, (Table 16). Except for rural women, over 20% of respondents admitted getting a partner drunk in order to have sex with them, and this proportion could be higher, as for about 10% of the men and 30% of the women, this information was missing (Table 17).

Around half of the rural men and urban women said that they used drinking establishments to meet sexual partners. Table 18 presents these data. Nevertheless, one in five rural women and nearly 40% of the urban men used drinking establishments to meet sex partners.

Table 19 presents the answers to the question how often respondents found it difficult to use condoms when drunk. Over 20% of the urban men and 30% of the rural men found it difficult to use a condom at least occasionally. More rural than urban men found it difficult occasionally to use a condom when drunk ($X^2=4.68$, $p=0.030$). Of those that had ever found it more difficult to use a condom when drunk ($n=129$), half of the urban men occasionally found it difficult with a commercial sex worker (Table 20). About 20% of the rural men said that they often found it difficult to use a condom with a commercial sex worker when drunk.

Alcohol was intimately associated with sex. About 70% of the men said that they were more likely to engage in sex when under the influence of alcohol (Table 21). However, only 44% of the women said they are more likely to engage in sex when under the influence of alcohol, though for two women (5.1%), the response was missing on this variable. Most of the women in the drinking places in this study were likely to be commercial sex workers.

For the men, sex was more pleasurable with alcohol. Many of the men (61%) found sex to be more pleasurable when under the influence of alcohol (Table 22), compared to less than half of the women. However, being under the influence of alcohol made it more difficult for majority of rural men (57%), and 41% of urban men (Table 23). A third of the women said that alcohol made it more difficult for them to use condoms. About 30% of the respondents said that being under the influence of alcohol made them forget to use condoms (Table 24). A majority of the men found it difficult to refuse sex when under the influence, as did about two out of five of the women (Table 25).

Respondents were asked if they drink to give themselves courage to approach a partner for sex. Table 26 presents these findings. Over 60% of the men said that they did not drink to get courage to ask for sex, but only 38% of the women. However, there was a high proportion of missing responses on this question among the women.

The majority (60%) of the men found themselves wanting to have sex when drinking alcohol, in contrast to a minority (40%) of the women, $p=0.004$, $X^2=8.25$, (Table 27). Many of the men had had sex with commercial sex workers, much of which was sex while drunk (84%), even though over 80% said that they had ever used a condom when having drunk sex with the commercial sex workers. Tables 28-30 present these findings.

Sexual behaviour

Respondents were asked questions about their sexual behaviour. The findings are presented in Tables 31-33. A high proportion of the sampled population had had extra marital partners in the past 30 days. Out of 198 married respondents, 126 (63.6%) had had non-spousal partners. Over 60% of the men and urban women had had sex with a non-spousal partner in the past 30 days, (Table 31). In the past 30 days, urban men had a mean number of non-spousal partners of 1.13, rural men 2.96, urban women 6.38 and rural women 4.30, (n=285, 16 missing, 8 did not know). Nearly 40% of those who had had sex with a non-spouse partner had not used a condom the last time they had sex. Table 32 presents these findings. The reasons for not using a condom are presented in Table 33. The most frequently stated reason among urban men was that sex was less pleasurable (28%), and among women was that their partner does not like them (26%). For rural men, condoms were not accessible at the time (24%), or they were too drunk (20%).

Respondents that were sampled from drinking places were asked whether they had ever had an STD, and if so, had they experienced this disease in the past 12 months. These findings are presented in Tables 34 and 35. Nearly 50% of the sample had ever had an STD. This ranged from about 36% of rural women to 69% of rural men. Of those that had had an STD, a third had had this experience within the past year.

Comparisons between STD and non-STD patients

The responses to various questions comparing STD and non-STD patients are presented in Tables 36 - 43. There was no difference in the proportions of respondents with STDs and those without who drank alcohol, both about 70%, (Table 36). However, the STD patients appeared to drink more often; nearly half drunk daily, compared to about a third for the non-STD patients, (Table 37). The STD patients were on average drunk three times in the past week (n=58), while the non-STD patients (n=258) were drunk 2.3 times in the same period. About 70% of the STD patients always or often drank to get drunk compared to 47% of the non-STD patients (Table 38, $p=0.002$, $X^2=13.3$)

Significantly more of the STD patients overtly acknowledged using a drinking establishment as a place to meet sex partners, (60% as against 40%), ($p=0.001$, $X^2=10.12$), Table 39. The STD patients (n=62) had a mean of 4.1 non-spouse sex partners in the past 30, compared to 3.1 for the non-STD patients (n=224). Most of the STD patients (62%) did not use a condom the last time they had sex with a non-spouse partner, as against 33% of the non-STD patients, (Table 40, $p<0.000$, $X^2=16.27$). More of the STD patients (85%) had had sex with commercial sex workers, compared to 62% of the non-STD patients (Table 41, $p=0.0009$, $X^2=10.93$). Of these nearly all of the STD patients had had drunk sex with a CSW, compared to 80% of the non-STD patients, (Table 42). Both these groups reported using a condom on such an occasion (Table 43).

Table 8: Ever Had Sex when Drunk (n=327)

	Yes	No	Missing	Total
Urban Men (n=193)	89.1%	10.9%	0.0%	100%
Rural Men (n=95)	93.8%	6.3%	0.0%	100%
Urban Women (n=34)	76.5%	20.6%	2.9%	100%
Rural Women (n=5)	(5)			
	n=290			

Table 9: If Yes, When was Last Time Had Sex when Drunk? (n=290)

	Yesterday	w/in last 2 wks	w/in last mo.	> 1 mo. ago	Missing	Total
Urban Men n=171	15.2%	55.0	8.8%	10.5%	10.5%	100%
Rural Men n=89	22.5%	64.0	4.5%	3.4%	5.6%	100%
Urban Women n=25	40.0	36%	8.0%	4.0%	12%	100%
Rural Women n=5	(1)	(3)	0.0%	20.0%	0.0%	100%

Table 10: With whom had last sex when drunk? (n=290)

	Spouse	Steady	Casual	CSW	Sex Client	Don't Know	Missing	Total
Urban Men n=171	22.7%	15.7%	25.0%	30.8	N/A	2.3%	3.5%	100%
Rural Men n=89	20.0%	10.0%	15.6%	54.4	N/A	0.0%	0.0%	100%
Urban Women n=25	3.7%	33.3%	33.3%	N/A	0.0%	11.1%	18.5%	100%
Rural Women n=5	(0)	(0)	(4)	N/A	(0)	(0)	(1)	

Table 11: Did you use a condom last time you had sex when drunk? (n=290)

	Yes	No	DK	Refuse	Missing	Total
Urban Men (n=171)	43.3%	55.0%	0.0%	0.0%	1.8%	100%
Rural Men (n=89)	42.2%	57.8%	0.0%	0.0%	0.0%	100%
Urban Women (n=25)	48.1%	48.1%	0.0%	0.0%	3.7%	100%
Rural Women (n=5)	(4)	(1)	(0)	(0)	(0)	
		N=158				

Table 12: Reasons for lack of condom use with drunk sex (%) (n=143)

	Urban Men n=93	Rural Men n=50
Had sex w/ spouse	39.8	34
Had sex w/ steady	20.4	14.0
Condoms not accessible at the time	8.6	12.0
Too Drunk	5.4	14.0
Had no money for condoms	1.1	6.0
Sex is less pleasurable	5.4	8.0
Partner doesn't like them	3.2	0.0
I don't like condoms	2.2	0.0
I trusted my partner	3.2	10.0
I don't trust condoms	1.1	2.0
Missing	9.7	0.0
Total	100	100

Table 13: Reasons for lack of condom use with drunk sex with a casual partner (%) (n=36)

	Men (n=33)
Had sex w/ steady (note: this is an inconsistent answer)	15.2
Condoms not accessible at the time	21.2
Too Drunk	12.1
Had no money for condoms	6.1
Sex is less pleasurable	9.1
Partner doesn't like them	6.1
I don't like condoms	3.0
I trusted my partner	21.2
Other	6.1
Total	100

Table 14: Reasons for lack of condom use with drunk sex with commercial sex worker (%) (n=31)

	Men (n=31)
Had sex w/ steady	3.2
Condoms not accessible at the time	22.3
Too Drunk	22.3
Had no money for condoms	6.5
Sex is less pleasurable	19.4
I don't like condoms	3.2
I trusted my partner	3.2
I don't trust condoms	6.5
Missing	12.9
Total	100

Table 15: Do You Believe Alcohol Improves Your Sexual Performance (%)? n=327

	Yes	No	Depends	DK	Missing	Total
Urban Men (n=193)	34.7	49.7	14.0	0.5	1.0	100
Rural Men (n=95)	44.2	48.4	7.4	0.0	0.0	100
Women (n=39)	28.2	48.7	15.4	0.0	7.7	100

Table 16: When Drinking, How Often Do You Think About Sex (%)? n=327

	Always	Sometimes	Uncertain	Never	Missing	Total
Urban Men (n=193)	35.2	43.5	10.4	9.3	1.6	100
Rural Men (n=95)	13.7	56.8	20.0	7.4	2.1	100
Women (n=39)	20.5	30.8	23.1	17.9	7.7	100

Table 17: Have you ever got a woman/man drunk in order to have sex (%)? (n=452)

	Yes	No	Missing	Total
Urban Men (n=255)	26.3	62.0	11.8	100
Rural Men (n=121)	20.7	67.8	11.6	100
Urban Women (n=53)	20.8	49.1	30.2	100
Rural Women (n=23)	4.3	60.9	34.8	100

Table 18: Do You Use a Drinking Establishment as a place to Meet Sexual Partners? (%) (n=452)

	Yes	No	missing	Total
Urban Men (n=255)	38.4	56.1	5.5	100
Rural Men (n=121)	56.2	42.1	1.7	100
Urban Women (n=53)	49.1	47.2	3.8	100
Rural Women (n=23)	21.7	60.9	17.4	100

Table 19: How often have you found it difficult to use a condom when you were drunk? (%) (n=376)

	Never	Once only	Occasionally	Often	Always	N/A don't get drunk	Missing	Total
Urban Men n=255	39.2	10.2	12.2	7.1	3.1	24.3	3.9	100
Rural Men n=121	27.3	9.1	20.7	6.6	5.0	28.9	2.5	100

Table 20: If you have ever found it difficult to use a condom when you were drunk, how often has this happened with a sex worker? (%) (n=129)

	Never	Once only	Occasionally	Often	Always	Missing	Total
Urban Men n=78	11.5	16.7	50.0	10.3	5.1	6.4	100
Rural Men n=51	9.8	21.6	37.3	19.6	3.9	7.8	100

Table 21: Are you more likely to engage in sex when under the influence of alcohol? (%) (n=327)

	Yes	No	DK	missing	Total
Urban Men (n=193)	67.4	30.1	1.0	1.6	100
Rural Men (n=95)	73.7	26.3	0.0	0.0	100
Women (n=39)	43.6	51.3	0.0	5.1	100

Table 22: Is sex more pleasurable when under the influence of alcohol? (%) (n=327)

	Yes	No	DK	missing	Total
Urban Men (n=193)	60.6	35.2	1.6	2.6	100
Rural Men (n=95)	63.2	36.8	0.0	0.0	100
Women (n=39)	48.7	46.1	0.0	5.1	100

Table 23: Does being under the influence of alcohol make it difficult for you to use condoms? (%) (n=327)

	Yes	No	Don't use condoms	DK	missing	Total
Urban Men (n=193)	40.9	49.7	3.1	4.1	2.1	100
Rural Men (n=95)	56.8	32.6	5.3	5.3	0.0	100
Women (n=39)	33.3	48.7	5.1	5.1	7.7	100

Table 24: Does being under the influence of alcohol make you forget to use a condom? (%) (n=327)

	Yes	No	Don't use condoms	DK	Missing	Total
Urban Men (n=193)	25.4	65.8	3.6	2.6	2.6	100
Rural Men (n=95)	36.8	51.6	5.3	5.3	1.1	100
Women (n=39)	25.6	58.9	5.1	5.1	5.1	100

Table 25: Do you find it difficult to refuse sex when under the influence of alcohol? (%) (n=327)

	Yes	No	DK	missing	Total
Urban Men (n=193)	52.3	44.6	0.5	2.6	100
Rural Men (n=95)	58.9	40.0	0.0	1.1	100
Women (n=39)	46.2	46.2	0.0	7.7	100

Table 26: Do you drink to give yourself courage to approach a partner for sex? (%) (n=327)

	Yes	No	DK	Missing	Total
Urban Men (n=193)	27.5	70.5	0.0	2.0	100
Rural Men (n=95)	37.9	62.1	0.0	0.0	100
Women (n=39)	23.1	38.5	2.6	35.9	100

Table 27: Do you find yourself wanting to have sex when drinking alcohol? (%) (n=327)

	Yes	No	DK	Missing	Total
Urban Men (n=193)	60.6	36.8	0.0	2.6	100
Rural Men (n=95)	66.3	32.6	1.1	0.0	100
Urban Women (n=39)	38.5	53.8	0.0	7.7	100

Table 28: Have you ever had sex with a commercial sex worker? (%) (n=376)

	Yes	No	Missing	Total
Urban Men (n=255)	63.5	34.5	2.0	100
Rural Men (n=121)	71.9	28.1	0.0	100
	n=249			

Table 29: Have you ever had drunk sex with a commercial sex worker? (%) (n=249)

	Yes	No	N/A never been drunk	Total
Urban Men (n=162)	81.5	6.8	11.7	100
Rural Men (n=87)	87.4	2.3	10.3	100
	n=208			

Table 30: Have you ever used a condom when having drunk sex with a commercial sex worker? (%) (n=208)

	Yes	No	Total
Urban Men (n=132)	87.1	12.9	100
Rural Men (n=76)	86.8	13.2	100

Table 31: Have you had a non-spouse sexual partner in the past 30 days? (%) (n=452)

	Yes	No	Missing	Total
Urban Men (n=255)	68.6	27.5	3.9	100
Rural Men (n=121)	75.2	24.0	0.8	100
Urban Women (n=53)	64.2	28.3	7.6	100
Rural Women (n=23)	39.1	56.5	4.3	100

Table 32: The last time you had sex with a non-spouse partner, did you use condoms? (%) (n=389)

	Yes	No	Missing	Total
Urban Men (n=229)	50.7	37.1	12.2	100
Rural Men (n=101)	54.5	40.6	4.9	100
Urban Women (n=44)	50.0	40.9	9.1	100
Rural Women (n=15)	33.3	33.3	33.3	100
		n=149		

Table 33: Reasons for not using condom with last non-spouse sex partner (%) (n=149)

	Urban Men n=85	Rural Men n=41	Women n=23
Condoms not accessible at the time	12.9	24.4	4.3
Too Drunk	8.2	19.5	4.3
Only have sex w/my spouse	0.0	0.0	4.3
Condoms are too expensive	1.2	7.3	0.0
Sex is less pleasurable	28.2	9.8	8.7
Partner doesn't like them	11.8	2.4	26.1
Had sex w/ my steady	11.8	7.3	21.7
I don't like/trust condoms	5.9	4.9	0.0
I trusted my partner	10.6	14.6	8.7
I paid money for sex	0.0	2.4	0.0
Wanted to conceive	1.2	0.0	0.0
Was Raped	0.0	0.0	8.7
Other	2.4	4.9	4.3
Don't Know	1.2	0.0	0.0
Missing	4.7	2.4	8.7
Total	100	100	100

Table 34. Number and proportion of respondents from drinking places who had ever had an STD (%) (n=367)

	Yes	No	Missing	Total
Urban Men (n=214)	41.6	57.0	0.9	100
Rural Men (n=97)	69.1	28.9	2.1	100
Urban Women (n=42)	47.6	50.0	2.4	100
Rural Women (n=14)	35.7	57.1	7.1	100

Table 35. Number and proportion of respondents from drinking places who had had an STD in the past 12 months (%) (n=181)

	Yes	No	Missing	Total
Urban Men (n=89)	25.8	73.0	1.1	100
Rural Men (n=67)	38.8	61.2	0.0	100
Urban Women (n=25)	40.0	56.0	4.0	100

Some Comparisons between STD Patients and non-STD patients

Table 36: Do You Drink? (%) (n=452)

STD patient	Yes	No	Total
Yes (n=85)	71.8	28.2	100
No (n=367)	72.5	27.5	100
	n= 327		

Table 37: Frequency of Drinking (%) (n=327)

STD patient	Daily	3 x per week	Weekends Only	Whenever I have money	Rarely	Other	Missing	Total
Yes (n=61)	47.5	6.6	11.5	34.4	0.0	0.0	0.0	100
No (n=266)	35.3	7.9	18.4	32.7	5.6	0.0	0.0	100

Table 38: How often do you drink to get drunk? (%) (n=327)

STD patient	Always	Often	Sometimes	Rarely	Never	Missing	Total
Yes (n=61)	34.4	36.1	16.4	0.0	8.2	4.9	100
No (n=266)	25.6	21.4	33.1	10.2	8.3	1.5	100

Table 39: Do you use a drinking establishment as a place to meet sex partners? (%) (n=452)

STD patient	Yes	No	Missing	Total
Yes (n=85)	60.0	37.6	2.4	100
No (n=367)	39.8	54.8	5.5	100

Table 40: The last time you had sex with a non-spouse partner, did you use a condom? (%) (n=389)

STD patient	Yes	No	Missing	Total
Yes (n=74)	35.1	62.2	2.7	100
No (n=315)	54.6	32.7	12.7	100

Table 41: Have you ever had sex with a CSW? (%) (n=376) (Men only)

STD patient	Yes	No	Missing	Total
Yes (n=65)	84.6	15.4	0.0	100
No (n=311)	62.4	36.0	1.6	100
	n=249			

Table 42: Have you ever had drunk sex with a CSW? (%) (n=249)

STD patient	Yes	No	Never been drunk	Total
Yes (n=55)	96.4	0.0	3.6	100
No (n=194)	79.9	6.7	13.4	100
	n=208			

Table 43: If you have ever had drunk sex with a CSW, did you ever use a condom on such an occasion? (%) (n=208)

STD patient	Yes	No	Total
Yes (n=53)	83.0	17.0	100
No (n=155)	88.4	11.6	100

4. Discussion

In summary, the findings from the research further reinforced what has been written on the relationship between alcohol and risky sexual behaviour. Alcohol is associated with sex and particularly risky sex. From the findings of the focus group discussions, patrons of drinking places expected to meet women there. Some men went with the explicit intention of getting drunk to be able to have casual or commercial sex with the women there. For others, as they became inebriated, their thoughts turned to sex and their judgment became clouded, so that the women in the bar became attractive enough to have sex. We did not explore characteristics associated with this behaviour, but it is likely that there is an age differential. A recent study in India found that younger men were more likely to drink in order to have commercial sex [20]. Older men were more likely to engage in risky sexual behaviour as part of the process of getting drunk and consequently amorous. Respondents also indicated that they found it more difficult to refuse sex when under the influence of alcohol. Alcohol was associated with increased sexual desire and performance. The use of (herbal) aphrodisiacs probably increased risky sex, and the use of vaginal drying agents by commercial sex workers probably increased the risk of the transmission of sexually related diseases, including HIV.

For commercial sex workers, alcohol was central to their activities. Alcohol gave them the courage to sell sex and was therefore the lubricant for casual and particularly commercial sex. In turn, casual and commercial sex probably facilitated the consumption of alcohol! It is likely that some bar owners might tacit support commercial sex work, as it is good for business!

A limitation of the study includes the fact that as respondents were conveniently sampled, the findings may not be representative of the areas studied. Also, the information depended on self-reports, with all the attendant biases. However, as much of the data was triangulated, focus groups with the survey, the main findings appear to be validated.

Factors characterizing alcohol and risky sexual behaviour in this population were that there was a high frequency of drunkenness, a high frequency of sex when drunk and a high frequency of drunken sex with commercial sex workers, *without* condoms. Knowledge about HIV and other sexually transmitted diseases was high, as was awareness of the protection afforded by condoms. Aside from some degree of lack of accessibility of condoms among the rural population, drunkenness inhibited condom use, probably both through impairment of the skill to put them on, and in reducing the awareness of the risk of unprotected sex. Respondents also indicated that sex with condoms was less pleasurable, and the women indicated that their partners did not like condoms. Altogether, there was ambivalence towards condoms as evidenced by the discussion in the focus groups. Another factor in the use of condoms was their availability at the time of need.

An important factor influencing the lack of use of condoms results from the setting of single episode commercial sex encounters, "short-times". As these often took place in the bushes or dark alleyways, the power of the commercial sex worker to insist on condom use was limited, and she often ran the risk of untrustworthy clients.

The role of other substances in risky sexual behaviour was less clear. Marijuana was the most commonly reported drug and a surprisingly high proportion of the respondents seemed to have used it. However, perceptions of the effect of marijuana is that it made one "work hard", and did not seem to be strongly associated with sex, or sexual arousal.

What seems to have come out clearly from the study is the social centredness of drinking places. Their importance is to some extent because of the lack of alternative entertainment and leisure facilities. Bars are community centres, providing opportunities for recreation, but also for information, gossip and jobs. Most of the respondents had regular drinking places. The bar setting also provides an opportunity for male bonding and escape from cramped, overcrowded homes and household chores. Social drinking in the bar is also linked to men being free from subjugation of their wives and therefore also generates solidarity among the participants. As drinking among men is a very social activity, it is a key feature generating risky sexual behaviour because of the social support. As men will share their resources to enable another to get drunk, so they support each other in having casual or commercial sex. Previously, experiencing an STD was a badge of honour, it demonstrated sexual prowess, though in recent years this is less the case with the fear and stigma of HIV/AIDS. However, the solidarity among drinking partners could afford an opportunity to reduce risky sexual behaviour through encouraging them to look out for each other. This may be in the form of cueing one's friend on the need for a condom at a relevant moment or a reminder on the risk of casual sex.

Other factors in the reduction of risky sexual behaviour include improving the accessibility and availability of condoms at the time of need, for example, from vending machines in drinking places, decreasing the number of drunken episodes and changing the norm of drinking to get drunk and avoiding drunken sex. A potentially important intervention to encourage full condom use with commercial sex workers is decriminalizing commercial sex work. This might allow for the provision of better facilities and allow for commercial sex workers to demand condom use.

In conclusion, alcohol is strongly associated with sexual risk. Potential interventions need to take into account the following factors found in this and associated studies:

- Drinking and drinking places have been at the centre of male social life in many parts of Africa and Zimbabwe for many years. Beerhalls particularly play a key role in male social activity Zimbabwe. Men living in the low-income and crowded neighbourhoods of Harare and other towns continue to depend on their neighbourhood beerhall as the only convenient and affordable venue for recreation.
- Drinking places are also valued community institutions, with loyal clientele. Men who patronize drinking places, do so frequently, usually in places near their homes.
- Drinkers either go with their close friends, or meet them there. Drinking is a social activity undertaken with friends in a drinking venue, rather than at home.
- These friends (peers) influence sexual risk behaviour in the drinking venues. The peers sometimes actively contribute to each others' risk, and sometimes tacitly condone the risky activities of their friends. In some circumstances, however, peers provide support for HIV risk reduction by discouraging risky sex.
- Patrons of drinking establishments recognize a link between alcohol use and engaging in casual and commercial sex. They are also ready to participate in a risky reduction strategy.
- Men are driving the HIV/AIDS epidemic, yet to date they have been inadequately targeted with intervention activities.

Given these issues, a possible strategy would be to develop a behavioural intervention designed to increase HIV prevention knowledge, skills and social support among groups of peers who drink together. The basis of this strategy is the bonds of friendship among men, facilitated through the use of drinking together, affords an opportunity to influence men to avoid risky sex or to use condoms through cues and reminders from their friends. Inherent in this approach is social support among friends, specifically the expectation that men will promote the sexual safety of their drinking friends by intervening with them when they are about to engage in sexual risk, especially sex while intoxicated.

Another potential intervention strategy is the use of popular opinion leaders to lead a change in the norms of drinking to get drunk and pleasures of drunk sex. The popular opinion leader strategy has been used successfully among gay men in bars in the USA leading to a reduction in risky sexual behaviour. The basis of this approach is that opinion leaders can influence certain attitudes, values and practices, and that at a certain point enough people would have changed, leading to a change in the group norms. It is likely that these opinion leaders provide role models for the desired behaviour change.

Both of these approaches involve men in a strategy to reduce sexual risk associated with alcohol. Another approach engages commercial sex workers. In this strategy, sex work would be decriminalized and the sex workers would be strongly encouraged to group themselves so that they can have enhanced security and solidarity to enable them to demand condom use every time. At the same time, the commercial sex workers would be required to undergo regular health checks and screening for sexually transmitted diseases. However, given the prevailing norms and attitudes in Zimbabwe, it is unlikely that this strategy could be implemented on a wide enough scale to make a measurable impact. The strategy involves a change in the law, something that normally takes years. The likely legal changes would probably face considerable opposition, particularly from the churches and women's groups.

Whatever approach is undertaken, there is an urgent need for an effective intervention. HIV/AIDS is an enormous problem that threatens to overwhelm Zimbabwe and indeed the whole of southern Africa.

REFERENCES

1. UNAIDS/WHO. Report on the global HIV/AIDS epidemic. Geneva: UNAIDS; December 2000
2. Humphrey J, Iliff P, Nathoo K. Rationale and design of the ZVITAMBO trial (Zimbabwe Vitamin A for Mothers and Babies). XIII International AIDS Conference. Durban, South Africa 2000.
3. Burcham J, Tindall B, Marmor M, Cooper D, Berry G, Penny R. Incidence and risk factors for Human Immunodeficiency Virus seroconversion in a cohort of Sydney homosexual men. *Medical Journal of Australia* 1989;150:634-639.
4. Chesney M, Barrett D, Stall R. Histories of substance use and risk behavior: precursors to seroconversion in homosexual men. *American Journal of Public Health* 1998;88:113-116.
5. Ostrow D, DiFranceisco W, Chmiel J, Wagstaff D, Wesch J. A case control study of human immunodeficiency virus type 1 seroconversion and risk-related behaviors in the Chicago MACS/CCS cohort, 1984-1992. *American Journal of Epidemiology* 1995;142:8754-8883.
6. Page-Shafer K, Veugelers P, Moss A, Strathdee S, Kaldor J, van Griensven G. Sexual risk behavior and risk factors for HIV-1 seroconversion in homosexual men participating in the tricontinental seroconverter study, 1982-1994. *American Journal of Epidemiology* 1997;146:531-542.
7. Penkower L, Dew M, Kingsley L, Becker J, Satz P, Schaert F, Sheridan K. Behavioral health and psychological factors and risk for HIV infection among sexually active homosexual men: the Multicenter AIDS Cohort Study. *American Journal of Public Health* 1991;81:194-196.
8. Silvestre A, Lyter D, Valdiserri R, Huggins J, Rinaldo C. Factors related to seroconversion among homo- and bisexual men after attending a risk-reduction educational session. *AIDS* 1989;3:647-650.
9. Mnyika KS, Klepp K, Kvale G, Ole-King'ori N. Determinants of high-risk sexual behavior and condom use among adults in the Arusha region, Tanzania. *International Journal of STD and AIDS*. 1997;8:176-183.
10. Ndinya-Achola JO, Ghee AE, Kihara AN, Krone MR, Plummer FA, Fisher LD, Holmes KK. High HIV prevalence, low condom use and gender differences in sexual behaviour among patients with STD-related complaints at a Nairobi primary health care clinic. *International Journal of STD and AIDS*. 1997;8:506-514.
11. Somsé P, Chapko MK, Hawkins RV. Multiple sexual partners: results of a national HIV/AIDS survey in the Central African Republic. *AIDS*. 1993;7:579-583.
12. Bassett MT, McFarland WC, Ray S, Mbizvo MT, Machezano R, van de Wijgert JH, Katzenstein DA. Risk factors for HIV infection at enrollment in an urban male factory cohort in Harare, Zimbabwe. *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology*. 1996; 13:287-293.
13. Morrison CS, Sunkutu MR, Musaba E, Glover LH. Sexually transmitted disease among married Zambian women: the role of male and female sexual behaviour in prevention and management. *Genitourinary Medicine*. 1997;73:555-557.
14. Gwati B, Guli A, Todd CH. Risk factors for sexually transmitted disease amongst men in Harare, Zimbabwe. *Central African Journal of Medicine*. 1995;41:179-181.
15. Mnyika KS, Klepp KI, Kvale G, Ole-King'ori N. Risk factors for HIV-1 infection among women in the Arusha region of Tanzania. *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology*. 1996;11:484-491.
16. Allen S, Tice J, Van de Perre P, Serufilira A, Hudes E, Nsengumuremyi F, Bogaerts J, Kindan C, Hulley S. Effect of serotesting with counselling on condom use and seroconversion among HIV discordant couples in Africa. *British Journal of Medicine*. 1992;304:1605-1609.
17. Kapiga SH, Lyamuya EF, Lwihula GK, Hunter DJ. The incidence of HIV infection among women using family planning methods in Dar es Salaam, Tanzania. *AIDS*. 1998;12:75-84.
18. Zimbabwe Central Statistical Office. 1999 Zimbabwe demographic and health survey. Harare: Zimbabwe 1999.
19. Wilson D, Sibanda B, Mboyi L, Msimanga S, Dube G. A pilot study for an HIV prevention programme among commercial sex workers in Bulawayo, Zimbabwe. *Social Science and Medicine*. 1990;31:609-618.
20. National Institute of Mental Health, USA. Preliminary Findings from the Ethnographic Study of the Collaborative HIV Prevention Trial - Chennai Site, 2001. Unpublished report

Comments on the Rapid Assessment Approach and Manual

The rapid assessment approach used in this study was based on the manual developed by the PSR unit of WHO. The manual collated rapid assessment/appraisal approaches used in many other areas and fields of study. The rapid assessment approach is not new, but in this particular application it was encouraged to enable intervention strategies to be developed at local community level.

However, there was divergence in the application of the rapid assessment approach. We endeavoured to have an Advisory Committee as an attempt to engage stakeholders in the process, ultimately to be able to develop a locally tailored intervention. A difficulty that we faced is that our study sites were not enclosed communities or institutions. They were suburbs in Harare and a growth point in a rural area. Our approach was to generate information that could be "generalized" to the country as a whole. We were not particularly interested in the situation in a specific institution, group or area. This created problems in engaging the stakeholders, for in Harare we did not know which stakeholders to invite, as the areas were somewhat dispersed. The result of this situation was that the Advisory Committee met only twice, as it was difficult to get attendance at meetings.

In addition, if the intent was to begin to develop an intervention strategy with the stakeholders, then the resources were insufficient. The funds were barely enough to ensure that the fieldwork was carried out.

In terms of the actual technicalities of the data collection methods and techniques, our experience was that the rapid assessment approach was somewhat useful. However, it may be more useful for inexperienced researchers. We also believe that the data from this study, as well as the Harare Beerhall, will be used to develop and test an intervention. If the intervention is shown to work, the intent is to publicize it so that the strategy can be taken up at national level.

In conclusion, we found this approach useful to a limited extent, but probably not in what was seen to be its particular strength.