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Substance use, gender inequity, violence and sexual risk among couples in Cape Town

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Abstract

Alcohol and other drug use, gender power inequities, and violence are key contributors to sexual risks for HIV among South African men and women. Little is known about the intersection of these sex-risk behaviours among couples in established heterosexual relationships. We conducted 10 focus groups discussions with men and women in relationships of one year or longer recruited from shebeens (informal taverns) in Cape Town, South Africa. Participants described high levels of alcohol consumption at shebeens; low levels of condom use with main and casual sex partners; gender roles disfavours women's condom negotiating power that also promoted economic dependency on male partners; men often spending a portion of the household income on alcohol and other drugs and sex with others in shebeens; loss of household income driving women to trade sex to provide for their families; and sexual violence and the exploitation of women occurring in shebeens. Findings highlight how the social contexts of alcohol and other drug use, gender inequitable norms, and gender violence promote HIV risk within established heterosexual relationships in South African communities, and inform the design of HIV risk-reduction interventions tailored to heterosexual couples who drink alcohol in shebeens.

Keywords

alcohol; drug use; gender power; gender-based violence; HIV; sexual risk; South Africa

Introduction

HIV infection remains the single greatest threat to public health in South Africa, particularly for women because they are disproportionately affected by the disease (Shisana et al., 2009). To effectively prevent HIV among women, the interrelated HIV risk factors of alcohol and other drug use, gender-based violence, and gender inequality (Jewkes et al., 2010; Parry and Pithey, 2006; Wechsberg, Luseno, and Lam, 2006; Wechsberg et al., 2008) must be addressed within the context of heterosexual relationships, which is the primary context for HIV transmission in South Africa (Abdool Karim et al., 2009).

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Alcohol and other drug use is an important risk factor related to sexual risk for HIV transmission in South Africa (Morojele et al., 2006; Parry and Pithey, 2006), as it has been shown to lead to greater disinhibition and impaired judgement, which may result in inconsistent condom use and other sex-risk behaviours (Wechsberg, Luseno, and Lam, 2006; Wechsberg et al., 2012). The association between alcohol and other drug use and sexual risks for HIV is of particular concern for efforts to prevent HIV in the Western Cape Province of South Africa, which according to a nationally representative household survey has a significantly higher prevalence of lifetime alcohol and other drug use disorders (20%) than the national average (11%; Herman et al., 2008).

Alcohol and other drug use is also associated with other behavioural risks for HIV, including exposure to gender violence, such as physical and sexual violence against women. Several studies have reported significant associations between women's alcohol and other drug use and experiences of gender violence, as well as men's alcohol and other drug use and perpetration of gender violence (Dunkle et al., 2006; Jewkes, Levin, and Penn-Kekana, 2002; Townsend et al., 2011), including sexual/physical violence against and sexual coercion of a relationship partner (Abrahams et al., 2006). Additionally, men have reported that they engage women in alcohol and other drug use to make them less resistant to having sex, which facilitates the widely accepted practise of having multiple female sex partners (Sawyer-Kurian, Wechsberg, and Luseno, 2009; Townsend et al., 2011).

Exposure to gender violence is an independent HIV risk factor in South Africa, with studies reporting associations between both intimate partner violence (IPV) perpetration and victimisation (Dunkle et al., 2004; Jewkes et al., 2010) and HIV serostatus among men and women (Jewkes et al., 2011). Gender violence increases HIV risk in several ways. First, violent men may have a higher HIV prevalence because the traditional ideals of masculinity that emphasise dominance over women also demand exaggerated displays of male heterosexuality, such as having multiple sex partners and having unprotected sex (Jewkes et al., 2011). Second, violence (or the threat thereof) may prevent women from controlling the circumstances of sex, including condom use, and demanding male partners may insist on unprotected sex (Jewkes et al., 2006; Jewkes & Morrell, 2010; Kalichman and Simbayi, 2004). Third, at the societal level, gender violence is driven by a culture that supports inequities in relationship power and an idea of masculinity based on control of women (Jakupcak, Lisak, and Roemer, 2002; Wechsberg et al., 2008). South African women's economic vulnerability and dependence on male partners further contributes to gender power imbalances in relationships (Sawyer, Wechsberg, and Myers, 2006).

These inequities in relationship power also impact risk for HIV acquisition among men and women. For example, Kaufman et al. (2004) found that South African men's level of control within their relationships was linked to their negative attitudes toward women, and negative attitudes toward women were associated with HIV risk behaviour among men. A longitudinal study of South African women also found that women who experienced relationship power inequity had an increased risk of HIV infection (Jewkes et al., 2010).

Several studies have shown that Black African and Coloured¹ men and women in South Africa who live in disadvantaged communities are disproportionately affected by HIV compared with other ethnic groups (Abdool Karim et al., 2009; Shisana et al., 2009). Although earlier studies indicated that sexual risks for HIV among Black African and Coloured men (Sawyer-Kurian, Wechsberg, and Luseno, 2009) and women (Sawyer,

¹In South Africa, the terms 'Black African' and 'Coloured' (people of mixed race ancestry that self-identify as members of a particular cultural group) are demographic markers used to monitor racial disparities and improvements in access to health and social services.)

Wechsberg, and Myers, 2006) who use alcohol and other drugs are often related to gender power differentials, gender violence and their alcohol and other drug use, they did not examine how alcohol and other drug use, gender inequities, and violence within the context of heterosexual relationships is related to sexual risk for HIV. This knowledge gap has limited the development of couples-based HIV risk-reduction interventions.

Research is therefore needed to understand the occurrence of these risk behaviours in established relationships within disadvantaged communities of colour. This study aims to address this gap in the science through providing preliminary qualitative data of factors underpinning sexual and other contextual and cultural risk factors for HIV among couples who drink alcohol. More specifically, it investigates how alcohol and other drug use, gender power, and gender violence are related to sexual risks for HIV among couples in established heterosexual relationships.

Methods

Focus group participation and protocol

Setting—Two large Cape Town township communities served as the setting for this study: Mitchell's Plain, a predominately Coloured township community; and Khayelitsha, a predominately Black African township community. These two communities were selected as focal points because of their high prevalence of HIV, alcohol and other drug use, and crime and violence. More specifically, Mitchell's Plain has one of the highest rates of gang-related crimes and also had the highest incidence of drug-related crime in Cape Town in 2006 (Caelers and Bailey, 2006). Another study found that a number of women in Mitchell's Plain who reported some type of sexual abuse were abused by a family member or their intimate partner (Statistics South Africa, 2000). Khayelitsha is the largest Black African informal settlement in the Cape Town metropolis, with high levels of violent crime, including homicide. It also has one of the highest rates of HIV prevalence in the Western Cape Province (Shaikh et al., 2006).

Recruitment and eligibility criteria—Project staff conducted street outreach in the two communities of interest, passing out fliers and approaching adults to describe the study and ask permission to screen for study eligibility. To help facilitate entry into each township community, outreach workers were indigenous to that particular community. Outreach workers operated in mixed-gender teams to ensure that potential male and female participants were only ever screened by a person of the same gender. To ensure privacy and prevent potential conflicts with partners, interested persons were screened individually, even if they were interested in being a part of the couples' focus group. To be eligible for the focus groups, potential participants had to (1) be in a heterosexual relationship for at least one year, (2) be 18 to 45 years old, (3) have used alcohol in a tavern or shebeen (a local term for an informal tavern) in the past year, (4) be able to communicate in English, (5) have been sexually active at least once in the past 90 days, and (6) like to talk in a group.

Participants—We conducted 10 focus groups comprising a total of 67 participants, of which 33 were recruited from Khayelitsha and 34 from Mitchell's Plain. Five focus groups were conducted in each community: a women-only group, two men-only groups, and two groups with women and their male partners (i.e., couples). Table 1 shows the number of participants in each focus group. Among the participants, 14 attended the men's or women's focus groups as well as the couple's focus group with their partner.

Focus group procedures—The focus group discussions were held in private rooms in community halls, recreation facilities, and libraries that are frequently used for community

meetings and workshops within the two target communities. Immediately prior to the start of each focus group, project staff informed individual participants of the objectives and format of the group discussion, provided assurance of confidentiality and anonymity, and obtained verbal and written consent for participation. To ensure protections for participants' confidentiality, participants were asked not to discuss their own personal information within the group, but rather to discuss what they see happening within their peer networks and community. The focus group discussions used an open-ended narrative interview strategy to encourage free-flowing discussion related to alcohol and other drug use, gender and relationships, violence, and sexual risk among couples in the target communities.

The Principal Investigator (PI) of the study, who is an American woman and has experience with focus groups and working with these communities, conducted the groups. Female facilitators have been found to be effective in facilitating sensitive discussions with both male and female interviewees (Lamb & Garretson, 2003; Pollner, 1998). However, during the men's and couples' focus group discussions, a South African male facilitator was always present and was actively involved in the discussions.

The PI attempted to establish rapport with participants through emphasising the participants' position as experts in their communities and by sharing what she had already learned about their communities. The focus group discussion probed for information related to community alcohol and other drug use, long-term relationship partners and sexual relationships with other partners (casual or trading partners), perceptions of STD/HIV risk, condom use with sex partners, violence, and gender influences on sexual risk taking. The discussion was guided by a set of questions developed and reviewed locally. Focus groups were facilitated in English; however, a translator was always available to translate the questions into Afrikaans or Xhosa (the two main local languages of the Western Cape Province) or the responses of the participants into English. Focus groups lasted between 90 to 120 minutes, and were audiotaped and transcribed verbatim. These transcripts were reviewed for accuracy against the recording. After completion of the focus group discussion, participants were provided with a resource list of local health, substance use, and violence-related services. As compensation for their time, participants received a ZAR50 (~5 USD) gift card and a health kit (containing male and female condoms, lubricants, and personal toiletries) valued at ZAR100 (~10 USD). The protocol for this study was approved by the Human Subjects Committee at RTI International and Stellenbosch University's Health Research Ethics Committee.

Data analyses

A content analysis approach (Ryan and Weisner, 1996) was used to analyse the transcripts. Content analysis involves generating and applying codes to sections of text, then reviewing the text by assigning various codes and 'code families' to identify recurring themes. The coding team created an initial list of codes based on key domains and used these to code discussions. To enhance coding agreement, data were individually coded by two researchers, and coding procedures and definitions were discussed and compared for agreement. Additions of new codes or changes in code definitions were determined via consensus among the research team. No new codes emerged after two-thirds of the focus groups were coded, suggesting that content saturation was achieved. For this particular analysis, we retrieved coded text regarding gender violence, gender-based power, gender roles, sex-risk behaviours (including condom use), alcohol and other drug use, and established relationships. Intercoder reliability checks were conducted to facilitate internal validity, with a Kappa score of 0.79 being achieved between the two coders.

Findings

How do gender inequity and alcohol and other drug use fuel conflict, fear, and violence within relationships?

Participants revealed the multiple roles that alcohol and other drug use have in established relationships, describing couples that drink and ‘tik’ (a local term for methamphetamine) together and cultivate relationships that are grounded by alcohol and other drug use:

Some of the women start with their boyfriends. He gets her hooked on drugs so she must stay with him because he’s the one who provides her with drugs and she can’t go without drugs. (*Vusi*, male)

Yet, participants also commonly agreed with the traditional notion that a good woman protects the home and children. Because women are held accountable for maintaining their household responsibilities, they are stigmatised for trying to enact any social behaviour that is considered appropriate only for men, such as visiting shebeens alone or using alcohol and other drugs. Buhle, another participant, illustrated how the partner’s alcohol and other drug use can upset the balance expected in most households:

Especially when they use drugs together, maybe the man comes out of work, now he expects his food and his tea...but his wife...is drugged when the man comes home. (*Buhle*, male)

However, participants asserted that ‘men are supposed to drink.’ Still, alcohol and other drug use appeared to steer men’s behaviour away from cultural expectations and to introduce conflict by influencing their spending habits. Lesly-Ann expressed a widespread expectation women have for their male partners, asserting that ‘he must work for [her] and work for [her] children.’ However, participants often reported that increasingly women have had to find other ways to support their families as a result of men spending the income on outside girlfriends and on alcohol and other drugs for themselves and on their girlfriends and casual partners. Participants commonly reported that women often engaged in survival sex, having sex with other men for money and food.

While unmet gender role expectations create conflict within couples’ relationships, participants also expressed the presence of dissatisfaction in intimacy and sex. One female participant lamented:

Maybe I wake up in the morning, and I am not going to work. Maybe my husband’s going to work. He can’t kiss me and say bye-bye. Sometimes they don’t say, “I am going out.” They leave the door open like this.... (*Victoria*, female)

Another participant provided a direct link between alcohol and other drug use and barriers to intimacy and to the lack of sexual satisfaction from the male partner:

But when on tik, they want to have sex the whole night. They want to ‘pomp’ (i.e., have sex) the whole night. It’s terrible. (*Nandipha*, female)

One male participant explained that, depending on whether he has a car, a man can have more than 10 women available to him at the same time. Also, men felt that lack of sexual satisfaction with their main partner reinforces their right to have multiple sex partners. In explaining main relationships, another male participant asserted:

But the thing is, you see, if she’s not pleasing him, he’s got a right to go look for something else, you understand? (*Joel*, male)

A man’s frequent engagements with and the availability of sex partners outside the main relationship appear to feed a woman’s fear of the withdrawal of her partners’ affection and

support, often leading her to elect to submit to his wishes. In some instances, her feelings of powerlessness might even allow him to rape her children. One participant reflected:

When girl children are not yours, as they grow up, the man could see she is mature and fall in love with her. The mother cannot protect her because then he will not bring bread. (*Andile*, male)

Rape of children is happening. Those children don't belong to me. No charge of rape. You can't even tell the neighbour because the next day he won't be there to put bread on the table. (*Marcus*, male)

A woman's lack of sexual autonomy is aligned with participants' agreement that men want to have sex with more than one woman, and that women may have no power over their bodies. Male participants confirmed the risk a woman faces by refusing her partner, asserting that she might get raped by him. Female participants explained additional reasons for women's submissive behaviour:

[If she does not have sex when he wants it], she will get abused or [he will] go somewhere else, with another woman.... (*Amy*, female)

He is going to hit you, and he will go and sleep with another woman. (*Justine*, female)

Conflicts over money, jealousy, and excessive drug use also were cited as reasons why a woman or a man might abuse the other. However, participants agreed that male partners were more frequently abusive. Additionally, despite widespread acceptance of multiple partners for men, participants described relationship conflict often erupting into intimate partner violence when the female partner is suspected of infidelity. One female participant reported:

....because you are scared of your husband.... If your husband sees you [flirting] with other guys, he is going to kill you... (*Portia*, female)

When asked about the frequency of couples' fighting, one male participant confirmed:

A lot.then he is starting to be jealous and that's when the fight starts. (*Lizo*, male)

Additional relationship issues were cited as precursors to conflict and violence, including disagreements over drinking and spending money. Also, participants agreed that conflict arises when couples use alcohol and other drug with each other, especially when one partner wants to stop using alcohol and other drugs altogether or when partners are in disagreement over the appropriateness of use. One male participant said:

That is also where the fighting comes in. Not necessarily fighting, but verbal arguments. It happens when he drinks and she doesn't, or she drinks and he doesn't. That is where the arguments start, because I am not in the mood for drinking today, and she abuses it today. (*Thabo*, male)

Participants also described that a partner's altered state because of 'tik' use can lead to partner violence. A female participant noted:

Some of them get high on the tik...it doesn't give them the high as they initially thought. The thing is they get off that high, they abuse the alcohol and they go into a different drug to get them off. That is why I call it another kind of drug. Then they go on that trip, they call it a trip, and then that's when the issues, the fighting and the abuse starts. (*Nolundi*, female)

Sometimes men abuse their female partners because there is no money available for alcohol and other drugs. As one male participant described:

...especially if you don't have money to buy your tik or buy your alcohol, and maybe your partner has the money, and you are craving for this stuff and you get violent, because maybe...she doesn't want to give you the money to do it, and so you will get violent and start abusing your partner. (*Dumisani*, male)

Women who stayed with abusive male partners were viewed as having full agency. For example, Bongoni, a male participant, rationalised, '[They must like it]...because they don't want to stay away from their boyfriends.'

How do gender inequity and alcohol and other drug use intersect to further drive HIV risk?

Participants reported that in some instances, men in established relationships trade their female partners for alcohol and other drugs. Men are able to initiate this by getting the woman 'hooked on tik.' Male participant Buhle explained:

The boyfriend finds a way to trick her....They throw the drugs in the water and when she drinks it, she feels this feeling, she feels better and then she wants...to do the real thing, wants to...do it right, not doing it through the water. (*Buhle*, male)

Once the female partner is dependent on alcohol and other drugs, they are 'sold' by their male partner for sex to drug dealers, shebeen owners, 'customers and between their friends' in exchange for alcohol or other drugs. Lwazi, one of the male participants, indicated, 'If I own you as my wife, I can sell you to that man [for money or alcohol].'

In situations where women engage in survival sex or are being traded for alcohol and other drugs, they may have little condom negotiating power. When discussing condom use during such transactions, male participant Dengani explained, 'If he prefers it without a condom, they will do it [have unprotected sex].' As Sizwe, a male participant, described, 'She is doing it because she was forced to do it, because she has been using the stuff of this man.... I don't think they can use the condom.' Nomvula, a female participant, confirmed, 'We need the money and we can do it without condoms.'

Participants indicated that men's condom use across all types of partnerships (main partner, casual partners, and one-night stands) is also inconsistent. Condoms are sometimes used to prevent pregnancy, but are least likely to be used when the couple is hurried. Male participants often reported that optimal sensation outweighed the risk of HIV, adding that achieving pleasure and using condoms were not simultaneously possible. Mandla, a male participant, expressed the general sentiment as, 'You can't eat the sweet with the wrapper, flesh to flesh.'

Participants cited additional barriers to condom use. For instance, some participants expressed suspicions around condoms. While participants reported that government-issue free condoms were available in the community, but because of the bad press surrounding the quality of these condoms, they were not often used when having sex with casual partners or one-night stands in these settings or people's because of heavy alcohol use. Drinking seems to impair judgement around condom use. As one participant explained:

To be honest, when you are drunk you don't think of the consequences. Sometimes when you are sober, you see that girl is beautiful, you don't think maybe HIV. (*Akhona*, male)

In general, participants suggested that condom use within established relationships was rare. One participant noted:

Couples around here don't even use condoms. Most of them, the longer they go out, they don't use condoms. If...he sleeps with her [another woman]... and then if he comes back to me, he doesn't use a condom. (*Amy*, female)

Additionally, participants linked condom use within established relationships with perceptions of ‘unfaithfulness’ and the occurrence of affairs. As such, the lack of condom negotiation with established partners was associated with concerns that their partner would suspect that they are being unfaithful and with fear that such suspicions could result in significant conflict with their partners. One female participant reported:

Ja [yes], but there are also those people who don’t use condoms because they are afraid that their partners are going to ask a lot of questions like why do you want to use condoms, are you having an affair? (*Lois*, female)

How do shebeen environments introduce HIV risk for women in relationships?

In multiple aspects, neighbourhood shebeens were characterised as easily accessible sites that have direct impact on sex-risk behaviour, leading indirectly to women’s vulnerability in heterosexual relationships. Participants widely agreed that in addition to alcohol and drug use, there are violent episodes between couples, casual sex partners, and men (e.g., because of jealousy over women) as well as consensual sex, rape, and sexual transactions (i.e., for survival and for exchange of alcohol and drugs) occurring in the hallways, toilets, and yards of shebeens. One male participant noted:

Sometimes (they) need to go to the toilet together, because women get raped through the whole night. (*Odwa*, male)

Similarly, participants reported that they have observed women high on drugs or alcohol and having impaired sex in shebeens. Participants suspected that condoms were not used in these situations.

Gang rape, particularly in the shebeen setting, was also reported by participants as a common occurrence. Women are often drugged and taken advantage of without their consent or knowledge, as noted by one male participant:

Sometimes they (women) don’t even know when they get awake that they had sex with that guy and that guy or whatever.... They don’t know what happened.... When you tell them, you slept with that guy, they say, ‘What?’ They didn’t even know about it. (*Dube*, male)

Even when condoms are used, use is inconsistent; and sex was often described as impaired by alcohol and other drug use. Fenyang, a male participant, asserted, ‘People using drugs do not use condoms’; another male participant Marcus reported, ‘If he’s drunk he wouldn’t use one.’

Also, during one focus group, multiple participants described the perceived value of condoms in the community apart from safe sex:

In the shebeen sometimes they do have the boxes. They have them there.... Sometimes the people take them for their children....(*Samuel*, male)

...and you just take it, you open it and blow it up like a balloon, you throw water in it.... (*Dube*, male)

...we have water bombs... (*Joel*, male)

Although women who drink, use other drugs, and spend money at the shebeens were ostracised and described as being irresponsible and neglecting the needs of their family, men in established relationships often go to the shebeens after receiving their paycheck. Conversely, the shebeen setting was also described as a place for meeting new partners that sometimes eventually become long-term partners, for using alcohol and other drugs with a main partner, or for exchanging a main partner’s sexual favours for alcohol and other drugs.

When asked if they knew of men who traded their girlfriends for drugs in shebeens, participants affirmed that ‘many of them [i.e., boyfriends]’ participated in such transactions.

Participants frequently reported witnessing violence in shebeens because of jealousy over flirting and suspicions of infidelity. Participants also noted that violence in the shebeens often spills over into violence in the home. In other instances, participants were able to make direct links between alcohol and other drug use in the shebeens to IPV and partner exploitation in established relationships:

Sometimes it happens because of drugs in the shebeens and such, sometimes men abuse the women because they can’t get money for tik or for buttons [methaqualone]) and take it out on the wife. They must go look [find money] for him money for drugs. (*Zoe*, female)

Male participants rationalised that, conversely, conflict in the home drives their need for escape and compels them to go to shebeens:

Sometimes here, this stressful environment at home, so you want to like just get out of here and just hang loose. (*Joost*, male)

Some go (to shebeens) because [they] fight [with their] wives. They go and then can go home to sleep. (*Sabelo*, male)

The shebeen environment was commonly described as a place for men to engage in casual and transactional sex with other partners. In discussing attempts to initiate casual sex with a woman in a shebeen, men explained that in some cases, rather than force a woman to have sex, they would capitalise on the ability of alcohol and other drugs to increase libido in women by buying them drinks or supplying them with drugs. When this strategy fails, men are strongly aware of their options to have sex with other women. As supported by Joel’s comments, men perceive themselves to have a wealth of options for having sex with another woman when efforts to have sex with the first woman are unsuccessful:

You just leave her. Then you go to the next girl. Then you just carry on the same process... attempting to use drugs or alcohol to have sex with the female. (*Joel*, male)

Participants reported that some men, despite having a main partner and a family to support, would share and spend their money on alcohol and potential casual sex partners and girlfriends they meet in shebeens. As one female participant noted:

...she must wait for him although he’s enjoying himself there and then the next morning he doesn’t even have a R10.00...and then the children are also hungry, he didn’t buy food, he just went straight to the shebeen and then these ladies are waiting for him there even to buy some beer for them and a chicken for them...and then his children didn’t eat. (*Noma*, female)

Participants explained that as these alcohol and other drug purchases impinge on the financial well-being of the household, when a man does not come home and there is no food, the woman will engage in survival sex at the shebeens. As one female participant noted,

His main partner needs some money, so instead she goes to the shebeen to trade [sex] to get some money to pay for the meat [for the household]. (*Nomhle*, female)

In the context of such economic urgency and women’s need to go to shebeens and rely on men other than their main partners for financial support, women’s capacity to negotiate condom use was reported as significantly reduced:

Some of them [women] would ask [to use a condom], and if the man...if that is the person that has got the money, and he prefers it without a condom, they will willingly. (*Winnie*, female)

Despite acknowledging the possibility that some women frequent shebeens because of needs that are unmet by their partners, women who go to shebeens without their male partners were perceived to be there to trade sex for drugs. As such, a woman frequenting shebeens opposes culturally prescribed gender expectations for women. In fact, male participants reported that they did not approve of their main female partners' going to shebeens because they are viewed as inappropriate environments for 'good wives.' Women who attended the shebeens unaccompanied by a male partner were seen as sexually available to all of the men. Andreis, a male participant, asserted, 'Then they're everyone's woman.'

How do couples view monogamy and main partner expectations?

When asked about their ability to remain faithful to their main partners, participants listed multiple temptations, including lack of trust with their main partners, desire for more money, desire for better sex, jealousy, to get attention, boredom in the main relationship, and a desire for better bodies:

Sometimes in the shebeens girls wear nice clothes and they are so cute. Sometimes I forget my wife as well. (*Siya*, male)

They also acknowledged that attending shebeens in general, and use of alcohol and other drugs in particular, were major barriers to monogamy.

Until the tik is (gone from the community), then we (couples) are not together. (*Patrick*, male)

Despite a lack of confidence that monogamy was possible, participants were able to share their perspectives on ideal roles for men and women in couple relationships. Generally, the idyllic couple relationship was described as one built on understanding, respect, open and honest communication, trust, and love. It was also characterised by a dedication to children by both female and male partners, sharing, and having fun. Participants commonly reflected that couples have enduring relationships because they do not entertain other options and acknowledge the value of the other partner such that they remain faithful. Women in strong relationships were specifically described as those who cared for the children and remained faithful to their partners. Male participants asserted that 'good men' are loving fathers and husbands, supportive of their children, and generally love their families and aid their families in living a balanced life.

I think it depends on if they love each other or stay together because of their children. Some people stay in their relationship..., the guys who are battling to because they do it, think of the children. (*Cebo*, male)

A woman has a husband or has a boyfriend that's living with them but they are both working with the children in school, they help the children. (*Vuyane*, male)

Discussion

Previous studies have reported that alcohol and other drug use, gender power differentials, and gender violence contribute to sexual risk behaviour for HIV among men and women who use alcohol and other drugs in Cape Town, South Africa (e.g., Sawyer-Kurian, Wechsberg, and Luseno, 2009; Sawyer, Wechsberg, and Myers, 2006). However, these earlier studies did not explicitly examine how these risk factors intersect to influence sex-risk behaviour within the context of established heterosexual relationships. To the best of our knowledge, this study is among the first to explore alcohol and other drug use and

gender-related factors that contribute to sexual risk for HIV among heterosexual couples who attend shebeens in Cape Town. As such, the study findings potentially deepen current understandings of the risks for HIV for couples who use alcohol and other drugs, and informs the development of interventions to reduce these risks.

First, the findings suggest that HIV risk among heterosexual couples who use alcohol is influenced by societal norms of gender inequity that underpin gender violence and male dominance in sexual relationships, and reinforces women's financial dependence on male partners. For men in established relationships, gender norms promoting traditional masculinities (e.g., male dominance, greater access to and power over money, sexual prowess, and risky behaviours that include alcohol and other drug use) appear to influence men's sexual risk-taking. For men in established relationships, the findings suggest that this sexual risk-taking often occurs with other casual sex partners when alcohol and other drugs are used in the context of shebeens. Participants described how alcohol and other drug use in shebeens facilitated men's acquisition of additional sex partners and that these casual sexual encounters often did not involve condom use because one sex partner was impaired by alcohol and other drug use and did not consider the risks associated with unprotected sex. They also described how alcohol and other drug use facilitated forced sex in or around shebeens, which also occurred without condoms. These findings are in keeping with previous studies examining violence against women as it relates to alcohol and other drug use (Sawyer, Wechsberg, and Myers, 2006; Sawyer-Kurian, Wechsberg, and Luseno, 2009).

Second, sexual risk-taking among men (such as having unprotected sex when using alcohol and other drugs and having multiple sex partners) also increases risk for HIV among their female main partners because of reportedly low rates of condom use within established heterosexual relationships. Yet, gender inequities in established relationships make it difficult for women to refuse sex if her male partner refuses to use a condom (even if he has other sex partners) or to challenge her partner's sexual decision-making because she is seen to 'belong to the man.' This is also in accord with findings from previous studies (Sawyer, Wechsberg, and Myers, 2006).

Third, gender inequities in established relationships that result in women having less control over financial decision-making and the household income than men have contributes to women's vulnerability to HIV, particularly when their main male partner spends much of the household income on alcohol and other drug use or casual sex partners in shebeens. Out of economic urgency, this sometimes forces women in established relationships to trade sex for food or money or to seek additional male partners for further financial support. In addition, women's reliance on male partners (whether main, casual, or trading partners) for economic support decreases their power to negotiate condom use and safer sex practices.

Fourth, alcohol and other drug use among heterosexual couples not only exacerbates gender inequities and associated risks for HIV, but at times results in gender role disruption. Participants provided several examples of how female partners were unable to fulfil their relationship responsibilities (such as taking care of the children) because of alcohol and other drug problems, and male partners were unable to fulfil their financial responsibilities to their families because they had spent their money on alcohol and other drugs at shebeens. This gender role disruption appears to lead to relationship dissatisfaction, which may drive people to seek sex partners outside of the main relationship. Although both men and women in established relationships believed that monogamous relationships were possible, they relayed a sense of hopelessness around monogamy given the presence of societal and traditional cultural norms supporting multiple partners for men and high levels of relationship dissatisfaction among both men and women. However, participants articulated culturally prescribed roles that potentially can fortify relationships and reduce partner

temptation to frequent shebeens and enact behaviours that increase HIV risk. Consequently, more work is needed to understand how gender role disruption in the context of established heterosexual relationships impacts sexual risk for HIV, how to help couples overcome conflict caused by role disruption, and how to help couples embrace both the traditional and more contemporary behaviours that strengthen the main partnership.

In addition, HIV risk among heterosexual couples who use alcohol seems to be influenced by the social and environmental contexts of alcohol and other drug use. More specifically, the shebeen was identified as a key recreational place in these communities where people met to relax, socialise, drink alcohol, and meet new sex partners. Both men and women in established relationships reported frequenting shebeens to drink alcohol and meet new sex partners; although the reasons for meeting new partners often differed by gender. Participants also identified several negative aspects of the shebeen environment. For example, female participants reported that men spent large amounts of their household income on alcohol and other drugs in shebeens and participants confirmed that gender violence (particularly sexual violence against women), partner conflict, cheating (infidelity), and sex trading for alcohol and other drugs, money or other resources occurred within shebeens. This finding is in keeping with previous work that has also shown that shebeens validate and propagate violence against women (Chersich and Rees, 2010; Watt et al., 2012) through supporting gendered hierarchies that legitimise male social and economic dominance over women (Chersich and Rees, 2010; Watt et al., 2012) and facilitate sexual risk-taking behaviour such as trading sex for other resources (Kalichman et al., 2008). These findings add to the literature in that couples seem to be aware of their inability to problem solve and communicate and are aware that violence escalates.

The findings from this study should be considered in light of a few limitations. First, we intended for all data to be garnered from audio-recordings of focus groups. However, in one case, a focus group was not properly recorded and analysis of that discussion was based only on the careful notes taken during the session. There were also instances where participant responses were unclear and could not be transcribed, and pulling information from the notes taken was required during the data cleaning process. While in most cases the meaning of the discussion was clear, this limited direct connection with the ‘voices’ of the participants.

Second, the focus group discussions with men, women, and couples were led by the study’s PI, a white American woman. While this may have had an impact on participant responses, the PI attempted to assuage potential effects by emphasising the participants’ position as experts on couples in their communities and by establishing rapport with participants by indicating what she had learned by engaging with others in the community. Also, during the men’s focus group discussions, a South African male facilitator was always present and actively involved in the discussions.

Third, the presence of both men and women might have limited the candour of participants, especially women, to speak about sensitive issues. In particular, having focus groups in a male-dominated setting, especially one in which gender violence is normalised, may have caused some women to be less willing to share their sexual and relationship experiences with a mixed-gender group. However, having separate and multiple focus groups with men and with women decreases the risk that particular common experiences and perspectives within each gender group were not expressed at some point during the study.

Finally, the selection criteria for these focus group discussions, and particularly the ability to speak and understand English, may have limited the variability of our sample and consequently the extent to which these findings are generalisable to the general population. However in Cape Town, the vast majority of the population understands and speaks English

and therefore it is unlikely that many people were excluded from participating in the study on the basis of language.

Conclusion

To the best of our knowledge, this study is among the first to describe cultural and contextual HIV risks in South African township communities for heterosexual couples who drink alcohol. The findings suggest that HIV risk within established heterosexual relationships is heightened by the intersection of alcohol and other drug use, gender power differentials, and gender violence on sexual risk.

Overall, HIV risk-reduction interventions are needed with couples to target these multiple sexual risks in addition to building communication and negotiation skills related to sexual expectations and general problem solving. Interventions focused on reducing alcohol and other drug use among couples and reducing time spent in shebeens may yield positive outcomes, particularly because the findings note that shebeens are risk environments for alcohol and other drug use and risky sex, and that alcohol and other drug use within relationships entrenches gender inequities, results in gender role disruption, and leads to relationship dissatisfaction and searching for other partners. Finally, in order to reduce the occurrence of sex-risk behaviours outside of established relationships, interventions that can begin to identify long-term relationship needs and expectations may be useful.

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References

- Abdool Karim SS, Churchyard GJ, Karim QA, Lawn SD. HIV infection and tuberculosis in South Africa: An urgent need to escalate the public health response. *The Lancet*. 2009; 374:921–933.
- Abrahams N, Jewkes R, Laubscher R, Hoffman M. IPV: Prevalence and risk factors for men in Cape Town, South Africa. *Journal of Violence and Victims*. 2006; 21(2):247–264. M.
- Caelers, D.; Bailey, C. How tik scourge fuels gang violence. *iOL News*; Sep 29. 2006 Retrieved from: <http://www.iol.co.za/news/south-africa/how-tik-scourge-fuels-gang-violence-1.295663>
- Chersich MF, Rees HV. Causal links between binge drinking patterns, unsafe sex and HIV in South Africa: It's time to intervene. *International Journal of STD & AIDS*. 2010; 21(1):2–7. [PubMed: 20029060]
- Dunkle KL, Jewkes RK, Brown HC, Gray GE, McIntyre JA, Harlow SD. Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *The Lancet*. 2004; 363(9419):1415–1421.
- Dunkle KL, Jewkes RK, Nduna M, Levin J, Jama N, Khuzwayo N, Duvvury N, et al. Perpetration of partner violence and HIV risk behaviour among young men in the rural Eastern Cape, South Africa. *AIDS*. 2006; 20(16):2107–2114. [PubMed: 17053357]
- Herman AA, Stein DJ, Seedat S, Heeringa SG, Moomal H, Williams DR. The South African Stress and Health (SASH) study: 12-month and lifetime prevalence of common mental disorders. *South African Medical Journal*. 2008; 99:339–344. [PubMed: 19588796]
- Jakupcak M, Lisak D, Roemer L. The role of masculine ideology and masculine gender role stress in men's perpetration of relationship violence. *Psychology of Men & Masculinity*. 2002; 3(2):97–106.
- Jewkes R, Dunkle K, Nduna M, Levin J, Jama N, Khuzwayo N, Koss M, Puren A, Duvvury N. Factors associated with HIV sero-status in young rural South African women: Connections between intimate partner violence and HIV. *International Journal of Epidemiology*. 2006; 35:1461–1468. [PubMed: 17008362]

- Jewkes R, Dunkle K, Nduna M, Shai N. IPV, relationship power inequity, and incidence of HIV infection in young women in South Africa: A cohort study. *The Lancet*. 2010; 376(9734):41–48.
- Jewkes R, Levin J, Penn-Kekana L. Risk factors for domestic violence: findings from a South African cross-sectional study. *Social Science and Medicine*. 2002; 55(9):1603–1617. [PubMed: 12297246]
- Jewkes R, Morrell R. Gender and sexuality: Emerging perspectives from the heterosexual epidemic in South Africa and implications for HIV risk and prevention. *Journal of the International AIDS Society*. 2010; 13:1–11. [PubMed: 20205768]
- Jewkes R, Sikweyiya Y, Morrell R, Dunkle K. The relationship between IPV, rape and HIV amongst South African men: A cross-sectional study. *PLoS ONE*. 2011; 6(9):e24256. doi:10.1371/journal.pone.0024256. [PubMed: 21935392]
- Kaufman MR, Shefer T, Crawford M, Simbayi LC, Kalichman SC. Gender attitudes, sexual power, HIV risk: A model for understanding HIV risk behavior of South African men. *AIDS Care*. 2004; 20(4):434–441. [PubMed: 18449820]
- Kalichman S, Simbayi L, Vermaak R, Jooste S, Cain D. HIV/AIDS risks among men and women who drink at informal alcohol serving establishments (shebeens) in Cape Town, South Africa. *Prevention Science*. 2008; 9:55–62. [PubMed: 18264762]
- Kalichman SC, Simbayi LC. Sexual assault history and risks for sexually transmitted infections among women in an African township in Cape Town, South Africa. *AIDS Care*. 2004; 16(6):681–689. [PubMed: 15370057]
- Lamb ME, Garretson ME. The effects of interviewer gender and child gender on the informativeness of alleged child sexual abuse victims in forensic interviews. *Law and Human Behavior*. 2003; 27(2):157–171. [PubMed: 12733419]
- Morojele NK, Kachieng'a MA, Mokoko E, Nkoko MA, Parry C, Nkowane AM, Moshia KM, Saxena S. Alcohol use and sexual behaviour among risky drinkers and bar and shebeen patrons in Gauteng province, South Africa. *Social Science & Medicine*. 2006; 62(1):217–227. [PubMed: 16054281]
- Parry C, Pithey A. Risk behavior and HIV among drug using populations in South Africa. *African Journal of Drug and Alcohol Studies*. 2006; 5:139–156.
- Pollner M. The effects of interviewer gender in mental health interviews. *Journal of Nervous and Mental Disease*. 1998; 186(6):369–373. [PubMed: 9653422]
- Ryan G, Weisner T. Analyzing words in brief descriptions: Fathers and mothers describe their children. *Cultural Anthropology Methods Journal*. 1996; 8(3):13–16.
- Sawyer KM, Wechsberg WM, Myers BJ. Cultural similarities and differences between a sample of Black/African and coloured women in South Africa: Convergence of risk related to substance use, sexual behavior, and violence. *Women & Health*. 2006; 43(2):73–92. [PubMed: 17000612]
- Sawyer-Kurian K, Wechsberg WM, Luseno WK. Exploring the differences and similarities between Black/African and Coloured men regarding violence against women, substance abuse, and HIV risks in Cape Town, South Africa. *Psychology of Men & Masculinity*. 2009; 10(1):13–29.
- Shaikh N, Abdullah F, Lombard CJ, Smit L, Bradshaw D, Makubalo L. Masking through averages – intraprovincial heterogeneity in HIV prevalence within the Western Cape. *South African Medical Journal*. 2006; 96(6):538–543. [PubMed: 16841139]
- Shisana, O.; Rehle, T.; Simbayi, LC.; Zuma, K.; Jooste, S.; Pillay-van-Wyk, V.; Mbelle, N., et al. South African national HIV prevalence, incidence, behaviour and communication survey 2008: A turning tide among teenagers?. HSRC Press; Cape Town, South Africa: 2009.
- Statistics South Africa. Quantitative research findings on rape in South Africa. Pretoria: *Statistics South Africa*. 2000. www.statssa.gov.za/publications/rape/rape.pdf
- Townsend L, Jewkes R, Mathews C, Johnston LG, Flisher AJ, Zembe Y, Chopra M. HIV risk behaviours and their relationship to intimate partner violence (IPV) among men who have multiple female sexual partners in Cape Town, South Africa. *AIDS and Behavior*. 2011; 15(1):132–141. [PubMed: 20217470]
- Watt MH, Aunon FM, Skinner D, Sikkema KJ, MacFarlane JC, Pieterse D, Kalichman SC. Alcohol-serving venues in South Africa as Sites of Risk and Potential protection for violence against women. *Substance Use & Misuse*. 2012; 47(12):1–10. [PubMed: 22017286]
- Wechsberg WM, Luseno WK, Lam WK. Violence against substance-abusing South African sex workers: Intersection with culture and HIV risk. *AIDS Care*. 2006; 17:55–64.

- Wechsberg WM, Luseno W, Riehman K, Karg R, Browne F, Parry C. Substance use and sexual risk within the context of gender inequality in South Africa. *Substance Use & Misuse*. 2008; 43(8): 1186–1201. [PubMed: 18649238]
- Wechsberg WM, Myers B, Kline T, Carney T, Browne FA, Novak SP. The relationship of alcohol and other drug use typologies to sex risk behaviours among vulnerable women in Cape Town, South Africa. *Journal of AIDS and Clinical Research*. 2012; S1:015. [PubMed: 23403403]

Focus Group Participants**Table 1**

Focus Group	Community	
	Khayelitsha	Mitchell's Plain
Women	10	7
Men, group I	7	6
Men, group II	3	9
Couples, group I	6	14
Couples, group II	9	10