

**A QUALITATIVE UNDERSTANDING OF THE SOCIO-CULTURAL
AND SITUATIONAL CONTEXT OF SUBSTANCE ABUSE AND
SEXUAL RISK-TAKING BEHAVIOURS IN WOMEN**

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Submitted to:

**NELSON R. MANDELA SCHOOL OF MEDICINE
UNIVERSITY OF KWAZULU-NATAL DURBAN
SOUTH AFRICA**

For:

**Submitted in partial fulfilment of the academic requirements for the degree:
Master of Public Health**

BY

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27 August 2008

ABSTRACT

South Africa is one of the six southern African countries where the HIV levels for childbearing women are 20% or higher. In South Africa, like most countries, behaviours such as multiple sexual partners, unprotected sex and drug use expose individuals to the risk of HIV infection and drive the HIV epidemic. Thus, research on sexual risk behaviours associated with HIV/AIDS is vital in identifying target groups at risk for HIV. Previous research has shown a link between substance use and sexual risk behaviour however in South Africa research within this field is still evolving. Furthermore, research on substance abuse among women in South Africa is limited. In the light of increasing HIV infection in women and the possible influence substance use has on sexual risk behaviours including HIV, exploring the association between substance use and sexual risk behaviours among women would provide valuable information. Socio-cultural and situational factors are explored within substance use and sexual risk behaviours as women's lives occur with realm of individual, family and community.

The sample was drawn from an Alcohol and Drug Rehabilitation Centre situated in the Durban area. Study participants included Black/African, White, Indian and Coloured women who were admitted to the treatment centre for alcohol abuse. One focus group discussion and six in-depth interviews were conducted with women to understand the socio-cultural and situational context of substance abuse and sexual risk-taking behaviours (including HIV/AIDS). Substance abuse emerged from women's lack of coping mechanisms to deal with poor relationships and lack of employment which led to financial dependence on their partners. Women reported that within their settings, alcohol can be related to sexual risk behaviours because alcohol tends to lead to unsafe sexual behaviours. Women reported that alcohol use facilitates intimacy and rapport between couples thus some women tended to consume alcohol. Women reported that knowledge of safe and unsafe sex is known however implementation is difficult because condom use requires her partner's co-operation. Women were financially and emotionally dependent on their partners, social norms which determine women's role in society and sexual relationships governed their behaviour. Partner violence was a common feature among women which impacted on women's ability to negotiate condom use.

The paper discusses the intrapersonal, interpersonal and contextual/ situational factors that influence substance use and sexual risk behaviours in these women's lives.

DECLARATION

This Master of Public Health dissertation is my own work and all primary and secondary sources have been appropriately acknowledged. The dissertation has not been submitted to any other institution as part of an academic qualification.

This Dissertation is prepared in partial fulfilment of the requirement of the Master of Public Health degree at the School of Family and Public Health Medicine, Nelson R Mandela School of Medicine, University of KwaZulu-Natal, Durban South Africa.

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August 27, 2008



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ACKNOWLEDGEMENTS

My grateful thanks to:

Dr. S. Knight - For your support, constant encouragement and guidance with expert advice. Thank you!

Dr. A Bhana – For your assistance and support and helping me begin this journey.

The participants – Thank you for allowing me into your lives and for sharing your thoughts and feelings with me. This study would not be possible without each of your contributions.

Dheeran, My Husband – For love, patience and support throughout the years! Thank you for being so understanding and for encouraging me with this endeavour.

My Parents - For your love, support and always encouraging me to achieve!

ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
AOD	Alcohol and other drugs
STI	Sexually transmitted infections
HIV	Human Immunodeficiency Virus

TABLE OF CONTENTS

ABSTRACT.....	ii
DECLARATION	iv
ACKNOWLEDGEMENTS	v
ACRONYMS AND ABBREVIATIONS	vi
TABLE OF CONTENTS	vii
1 CHAPTER ONE.....	1
1.1 INTRODUCTION	1
1.2 BACKGROUND	2
1.3 RATIONALE FOR STUDY.....	6
1.4 AIM OF THE STUDY.....	9
1.5 OBJECTIVES OF THE STUDY	9
1.6 DEFINITION OF CONCEPTS	9
2 CHAPTER TWO.....	11
2.1 HIV/AIDS IN SOUTH AFRICA.....	11
2.2 SUBSTANCE USE IN SOUTH AFRICA	14
2.3 SUBSTANCE ABUSE IN WOMEN	19
2.4 SUBSTANCE ABUSE AND SEXUAL RISK BEHAVIOUR.....	25
2.5 SOUTH AFRICAN DRUG-RELATED HIV RISK.....	31
2.6 HIV PREVALENCE AMONG DRUG USERS.....	34
2.7 HIV PREVENTION AMONG DRUG USING POPULATIONS	36
2.8 CONCLUSION.....	36

3	CHAPTER THREE	38
3.1	PURPOSE	38
3.2	PHILOSOPHICAL PERSPECTIVE	38
3.3	RESEARCH DESIGN	38
3.4	METHODOLOGY	41
3.5	STUDY PARTICIPANTS	42
3.6	PHENOMENOLOGICAL RIGOR	43
3.7	DATA COLLECTION	44
3.8	DATA ANALYSIS.....	48
3.9	ETHICAL CONSIDERATIONS.....	49
4	CHAPTER FOUR	51
4.1	PRESENTATION OF THE RESULTS.....	51
4.2	FOCUS GROUP DISCUSSION.....	52
4.3	IN-DEPTH INTERVIEWS.....	55
4.4	RESULTS OF IN-DEPTH INTERVIEWS.....	56
4.5	SUMMARY OF RESULTS	69
5	CHAPTER FIVE	71
6	CHAPTER SIX	81
6.1	INTRODUCTION	81
6.2	EVALUATION OF THE PRESENT STUDY	81
6.3	LIMITATIONS OF THE STUDY.....	81

6.4	RECOMMENDATION FOR FURTHER RESEARCH	83
7	REFERENCES.....	85
8	APPENDICES	114
8.1	APPENDIX 1: FOCUS GROUP DISCUSSION GUIDE	114
8.2	APPENDIX 2 INDIVIDUAL INTERVIEW GUIDE	117

1 CHAPTER ONE

INTRODUCTION

“Drug abuse causes worse problems for females. Drugs seem to be more functional in a sexual relationship for women than men...The lives of women who consume drugs regularly tend to become more absorbed and conditioned by the habit and increasingly isolated from those of non-users , especially if , by trading sex , women alienate themselves even more from their existence as wife or mother”

(World Drug Report, 1999)

1.1 INTRODUCTION

Substance use and dependence cause a significant burden to individuals and societies throughout the world. The World Health Report 2002 indicated that 8.9% of the total burden of disease emerges from the use of psychoactive substances (World Health Report, 2002). The report indicated that tobacco accounted for 4.1%, alcohol 4.0% and illicit drugs 0.8% of the burden of disease in 2000 (*Ibid*). Most of the burden is attributable to substance use and dependence resulting in a wide variety of health and social problems, including human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS).

The leading source of HIV transmission within developed countries is injecting drug use through the sharing of contaminated syringes and needles which has been well documented (Kral, Bluthenthal, Lorvick *et al.*, 2001). However, drug-related HIV risk is not confined only to injecting drug users. Research indicates that alcohol and cannabis users are at lower HIV risk than cocaine users, but were at a higher risk for HIV infection through risky sexual behaviours than non-drug users (Wang *et al.*, 2000; Caetano & Hines, 1995). Alcohol and other drug (AOD) users have been found to be more likely to engage in risky sexual practices such as non-use of condoms, having multiple sexual

partners, using drugs during sex and they appear to have an increased incidence of sexually transmitted infections (Wang *et al.*, 2000; Caetano & Hines, 1995).

The term 'drug' is used in accordance with the definition provided by the World Health Organization, as quoted in the World Drug Report (1997) of the United Nations Control Programme. It refers to all psychoactive substances, that is "any substance that, when taken into a living organism, may modify its perception, mood, cognition, behaviour or motor function", whether licit (e.g. alcohol, nicotine, cough mixture, appetite suppressants or sedatives) or illicit (e.g. cannabis, cocaine, heroin, LSD). This definition of drugs accords with both local and international evidence that various patterns of drug use, whether licit or illicit are interconnected. Therefore, the traditional tendency in social sciences to investigate the use of a particular group of substances in isolation from that of others obscures the dynamics of drug use (Rocha-Silva, 1998). Human consumption of alcohol, tobacco, cannabis and other psychoactive substances or drug use, is regarded as an established phenomenon. Drug use is also viewed as neither a random nor static activity, but socially regulated, complex and dynamic (Rocha-Silva, 1998; World Drug Report 1997). Therefore, drug use varies over time and place in the type of substances consumed (licit or illicit), manner of consumption and reasons for use.

1.2 BACKGROUND

Over the past 30 years, the public has become increasingly aware of the devastation that alcohol and drug abuse can bring to the individual, family and community life. Within developed countries, the extent of substance abuse among women and the unique factors that affect their ability to seek and receive treatment has evolved and this has been well documented internationally. However, in South Africa, limited research exists with women as a homogeneous target group.

Historically in drug use research, participants have been almost exclusively male; as a result, little data exists on the specific problems and issues concerning the effects of drug use on women. Rather, studies that have been conducted among women in the past have

centred on the impact of women's addiction on children and family life, particularly the effect of drugs on the foetus. These concerns have reflected the traditional view of women, namely a primary preoccupation with their reproductive capacity.

Since women have been traditionally underrepresented in research studies and drug abuse treatment groups, the effects of drug use are far less understood for women than for men. However, scientific evidence generated thus far has suggested that drug use and addiction present different challenges to women's health, progress differently in women in relation to men, and each group may require different treatment approaches and strategies. Research indicates that women substance abusers differ from men in their experiences of substance abuse, frequently initiating substance use as a result of traumatic life events such as physical or sexual violence, sudden physical illness, an accident or disruption in family life (Grella, 1997; Institute of Medicine, 1990; Nelson-Zlupko *et al.*, 1995). Furthermore, it has been demonstrated that women substance abusers are often drawn into substance use by partners (el-Guebaly, 1995; Hser, Anglin & McGlothlin, 1987) or are living within an environment of heavy drinking or drug abuse (Ramlow, White, Watson & Leukefeld, 1997).

Women demonstrate unique psychosocial characteristics associated with substance abuse. Women substance abusers have a higher probability than men to have poor self-concepts (low self-esteem, guilt, self-blame) and high rates of mental health problems, such as depression, anxiety, bipolar affective disorder, suicidal ideation, psychosexual disorders, eating disorders and posttraumatic stress disorder (Boyd, 1993; Brady, Grice *et al.*, 1993; Brad, Killeen, Brewerton *et al.*, 2000). Furthermore, social stigma, labelling, and guilt serve as significant barriers to women's receiving treatment (Grella, 1997; Institute of Medicine, 1990; Nelson-Zlupko *et al.*, 1995), and programmes that treat men and women patients together are less appealing to especially vulnerable women, such as lesbian women, women with a history of physical or sexual violence and those who have worked as commercial sex workers (Grella, 1997; Fullilove *et al.*, 1992; Copeland & Hall, 1992).

Entering, engaging and remaining in substance abuse treatment may require not only the availability of specialized treatment services but also an array of resources to help with specific issues, such as child care, physical and mental health (Kaltenbach & Finnegan, 1989). Furthermore, the interplay of gender-specific drug use patterns and sex-related risk behaviours creates an environment in which women are more vulnerable than men to HIV infection (Stevens *et al.*, 1998; Weeks *et al.*, 1998) because women are more likely than men to exchange sex for money or drugs, to use drugs with many partners and have difficulty negotiating condom use with their sexual partners (Stevens *et al.*, 1998).

Of the several factors that contribute to increased vulnerability of women to HIV/AIDS, it has been observed that substance abuse among women places them at an increased risk for HIV/AIDS (WHO, 2005)

Since the beginning of the HIV/AIDS epidemic, public health researchers have been trying to identify individual and situational factors associated with the behaviour that exposes individuals to HIV/AIDS. Since there is yet no cure for HIV/AIDS, health education and preventive efforts are crucial. One of the main factors that have been suggested as a contributor to sexual risk-taking is the use of alcohol or other drugs with sex (Leigh, 1990). Since alcohol and drugs are believed to interfere with judgment and decision-making, their use in conjunction with sexual activity might increase the probability that risky sexual behaviour will occur.

1.2.1 WHAT IS KNOWN ABOUT SUBSTANCE USE AND SEXUAL RISK BEHAVIOUR?

Substance use can play a critical role in mediating sexual risk behaviour, particularly as far as the transmission of HIV and other sexually transmitted infections are concerned (WHO, 2003).

Sexual behaviour is a key element in the transmission of HIV. As previously mentioned, because alcohol and drugs are thought to interfere with judgment and decision-making, it

has been suggested that their use in conjunction with sexual activity might increase the probability that risky behaviour will occur (Leigh & Stall, 1993).

In recent years, researchers have begun to explore the relationship of alcohol or drug use and sexual “risk behaviours”, activities that place people at increased risk for sexually transmitted diseases, unintended pregnancy and sexual violence. Risky sexual activities include inconsistent use of condoms, having multiple sexual partners over one’s lifetime, engaging in unprotected sex with a casual partner or trading sex for money or drugs. Studies indicate that drinking and illicit drug use often occurs in association with risky sexual activity (Leigh, 1990; Visser & Moleko, 1999).

A number of studies have suggested a link between substance use and sexual behaviour; people who drink more heavily are more likely to have multiple partners and they are less likely to use condoms for every sex act. However, because many of these studies have consisted of convenience samples or have suffered from methodological inconsistencies, they have resulted in contradictory findings (Leigh & Stall, 1993). This is attributable to the study populations having been recruited from a variety of sources, including bars and bathhouses, advertisements and gay organizations (Stall *et al.*, 1986; Martin, 1990; McKirnan & Peterson, 1989). The argument here is that such samples may not be representative of the general population of homosexuals or heterosexuals, therefore these studies are limited with respect to their generalizability, in terms of prevalence estimates of sexual behaviour or substance use, and the assessment of the relationship between the two. As an example, samples recruited from bars may contain a larger proportion of people who regularly combine substance use and sex, or who engage in more risky sex in general, thus leading to an inflated association between substance use and high-risk sex. Some studies have demonstrated a significant positive association between the frequency of bar-going and level of high-risk sex (Ruefli *et al.*, 1992). Research on substance use and sexual activity have been conducted in the general population; however only one study has included detailed measures of "safe" and "unsafe" sexual behaviour and substance use (Cottler *et al.*, 1992).

Research on substance use and high-risk sex has also used a variety of measurement strategies. Research studies have conceptualised risky sexual behaviour as the frequency of unprotected anal intercourse (McCusker *et al.*, 1989), the number of sexual partners (McKirnan & Peterson, 1989), the level of condom use (Hingson *et al.*, 1990) or a summary risk variable constructed from a number of types of behaviour (Biglan *et al.*, 1990). Whilst in some research studies alcohol use has not been distinguished from drug use (Kelly *et al.*, 1991), others have been defined as the number of substances used (Ostrow *et al.*, 1993) or has been measured using detailed quantity-frequency measures (Leigh, 2000).

1.3 RATIONALE FOR STUDY

Substance abuse and sexual risk behaviour are viewed as risk factors for major health and social problems among adults in developing countries (Morojele *et al.*, 2006; Morojele *et al.*, 2004). Rates of substance use in South Africa have been shown to be high in the latest findings of South African Community Epidemiology Network on Drug Use {SACENDU} (Plüddemann *et al.*, 2006). South Africa has one of the highest prevalence of HIV in the world (UNAIDS, 2006).

Similar to the rest of sub-Saharan Africa, the HIV epidemic in South Africa disproportionately affects women. Young women (15-24 years) are four times more likely to be HIV-infected than young men, in 2005, the prevalence among young women were 17% compared with 4.4% among young men (Shisana *et al.*, 2005).

The abuse of substances is increasingly being regarded as a key determinant of sexual risk behaviour, as well as an indirect contributor to HIV transmission in sub-Saharan countries (Fritz *et al.*, 2002; Morojele *et al.*, 2004; Morojele *et al.*, 2006). Research conducted among adults in South Africa have revealed consistently that substance use is associated with HIV infection (Campbell, Williams & Gilgen, 2002; Morojele *et al.*, 2006; Kalichman *et al.*, 2006; 2007) and other sexually transmitted infections and diseases (Morrison *et al.*, 1997). Furthermore, it can be associated with sexual risk

behaviours such as having multiple sexual partners (Trigg *et al.*, 1997). However, researchers have reported that the relationship between substance use and sexual behaviour and how it relates to sexual risk behaviour in different contexts is complex. Fritz *et al* (2002) found a significant relationship between substance use and sexual behaviour whereas others have not found a significant association (Mataure *et al.*, 2002).

A number of studies on drug-related HIV risk among adolescents and other vulnerable groups (men who have sex with men, youth, sex workers and women) at risk of becoming infected with HIV have been conducted in South Africa (Parry & Pithey, 2006). However, most studies exploring substance use and HIV risk factors have included mixed gender samples (Kalichman *et al.*, 2006; 2007), rather than only woman-focused samples (Wechsberg, Luseno, Lam, Parry & Morojele, 2006). Despite the vast body of research exploring substance abuse and sexual risk behaviours, currently there are only a limited number of qualitative studies that have been conducted in South Africa to uncover women's experiences and their perception of how their substance abuse impacts on their sexual behaviour and the reasons why substance use may be related to sexual risk behaviour.

Given an apparently consistent link between substance use and HIV infection, an understanding of the factors underlying this link is crucial for informing the development of effective interventions to reduce HIV risk among substance abusers, especially among women since they constitute the most vulnerable population for HIV infection. In a country such as South Africa, an urgent need exists to explore all the potentially valuable avenues for reducing risk of contracting HIV.

A broad range of factors potentially influence substance abuse and sexual risk behaviours. To investigate these factors using quantifiable data arguably negates the potential usefulness of such data, since developing meaning out of such data requires a deductive application of theory that might fail to adequately shed light on the complex interactions between substance abuse and sexual risk behaviours. Whereas qualitative methods are inherently inductive and seek to discover rather than test explanatory

theories, this paradigm allows the researcher to interpret the data with much more depth and insight than quantitative methods (Hennink & Hutter, 2004).

Within the qualitative approach, the phenomenological framework is used. The phenomenological perspective embodies the importance of lived reality and the subjective experiences of the participants. To understand this 'realness' or phenomenon experienced within a lived context, it is necessary to interact and listen to information provided by the individuals concerned (Terre Blanche & Kelly, 1999). Phenomenology is interested in describing the variation of these experiences and to clarify their essential meanings through a reflective process, 'to make the invisible visible' (Kvale, 1996). The reflective awareness of the experience then leads to psychological meaning (Stone, 1986). This approach is not based on the assumption that we have an understanding of psychological reality. Rather, it provides us with the tool to identify the key features of an experience of a phenomenon.

The method of data collection considered suitable for this study is focus group discussions and in-depth interviews, since it would yield qualitative data that provide insight into the attitudes, perceptions, feelings and opinions of the participants. Chapter Three provides a detailed description of the methodological procedures used in this study.

A study on substance use and sexual risk behaviour is of great importance to South Africa. In addition to having one of the highest rates of HIV/AIDS in the world, there are also high levels of substance abuse with alcohol being reported as the primary substance of abuse in South Africa. Many of South Africa's social and health problems are attributable to the abuse of substances, with sexual risk behaviours considered to be one such problem. However, there has been a limited amount of research on the mechanisms through which substance abuse increases the occurrence of sexual risk behaviour within South African communities. Such research is crucial to inform the development of interventions to help communities recognise their increased vulnerability with respect to their engagement in and/or exposure to sexual risk behaviours in contexts where

substance abuse occurs. Hence, such research can conceivably be used to inform behaviour change interventions.

1.4 AIM OF THE STUDY

To understand the socio-cultural and situational context of substance abuse and sexual risk-taking behaviours (including HIV/AIDS) among women in treatment for substance abuse.

1.5 OBJECTIVES OF THE STUDY

1. To explore the historical and social context of these women's lives.
2. To determine factors which influence sexual risk-taking behaviours among these women in treatment.

1.6 DEFINITION OF CONCEPTS

The following concepts will be defined as they are significant in the study:

- **SUBSTANCE ABUSE / DRUG ABUSE / AOD**

The term 'drug' can be used to cover licit substances (tobacco and alcohol) and illicit substances, such as central nervous system depressants (opiates and opioids, e.g. heroin and 'street' methadone), stimulants (cocaine, crack, amphetamines and ecstasy) and cannabis. It also includes prescription drugs (such as benzodiazepines) that are taken in a manner that was not indicated or intended by a medical practitioner and the failure to use over the-counter preparations, such as codeine-based products (e.g. cough medicines, decongestants), in accordance with instructions. A working definition of 'substance abuse' is the use of substances that are socially, medically or legally unacceptable or that have the potential for harm. The terms 'substance' and 'drug' are used interchangeably.

- **SEXUAL RISK BEHAVIOUR / SEXUAL RISK:**

Sexual risk behaviour is defined as sexual behaviours, which increase people's chances of experiencing adverse health consequences, particularly HIV infection and sexually transmitted infections (STI). The behaviours may include unprotected penetrative sexual intercourse, unwanted pregnancies and multiple sexual partnerships.



2 CHAPTER TWO

LITERATURE REVIEW

'As the HIV/AIDS epidemic continues to spread, its association with drug use is becoming more apparent. However, in many countries, that potentially deadly link is still being ignored'

(UNAIDS, 2001)

2.1 HIV/AIDS IN SOUTH AFRICA

South Africa is experiencing one of the world's most devastating HIV epidemics and was estimated to have 5.54 million people (18.8% for adults aged 15 to 49 years) living with HIV in 2005 (Department of Health, 2006).

Several factors have been identified as potential causes of the rapid spread of the HIV epidemic in South Africa, which include the burden of sexually transmitted infections (STIs), poverty and income inequality, malnutrition, unemployment, gender inequality, the growing commercial sex industry, a long history of labour migration, inconsistent use of condoms and social norms that accept or encourage multiple sexual partners (Parry & Abdool-Karim, 2000; Shisana *et al.*, 2005).

With regard to HIV prevalence data in South Africa, three national South African HIV prevalence surveys have been conducted by the Department of Health, Human Science Research Council and Witwatersrand Reproductive Health Research Unit.

The South African Department of Health conducts annual, unlinked, anonymous surveys among women attending antenatal clinics to obtain an estimate of HIV prevalence among the general South African population (Parry & Pithey, 2006). Survey data from the Department of Health indicated that HIV prevalence is increasing and, in 2005, a sample

of 16,510 women across all nine provinces yielded a prevalence rate of 30% (Department of Health, 2006).

The projections from the antenatal data estimated that the number of people infected with HIV in South Africa at the end of 2005 were as follows: women aged 15 to 49 years (2.94 million); men aged 15 to 49 years (1.96 million); and children aged 0 to 14 years (235,060 million) (Department of Health, 2006). The survey data indicated varying rates in HIV prevalence rates among the different age groups which Parry & Pithey (2006) suggested might be reflective of different patterns of risk for each age group. The prevalence rate for teenagers (aged 15 to 19 years) was 15.9% and, for women aged between 25 to 34 years the rate was 38.0% (Department of Health, 2006). An increase in prevalence across most age groups occurred between 2004 and 2005, with the largest increase (24.5% to 28.0%) observed among women aged between 35 and 39 years (Department of Health, 2006).

Parry & Pithey (2006) compared the results from two surveys conducted by Human Science Research Council in 2002 and 2005 respectively. The comparative findings of the 2002 and 2005 survey indicated an overall HIV prevalence among persons aged 2 years and older was estimated to be 10.8%, which was slightly less than the 11.4% estimated in 2002 (Shisana *et al.*, 2005). For adults aged 15 to 49 years HIV prevalence increased slightly from 15.6% in 2002 to 16.2% in 2005. HIV prevalence among females aged 15 to 49 years was 20.2% in 2005, which was lower than the 29.5% found in the 2004 antenatal survey in which more than 90% of the participants were Black/African (*Ibid*). However, when the findings were restricted to Black/African females aged 15 to 49 years, the overall HIV prevalence was 24.4%, and, among those who were pregnant in the last 24 months, the figure rose to 26.8% (Parry & Pithey, 2006). Overall, females were more likely to be living with HIV and showed an increase in prevalence from 12.8% in 2002 to 13.3% in 2005, in contrast to males whose prevalence decreased from 9.5% in 2002 to 8.2% in 2005 (*Ibid*).

As mentioned previously the epidemic in South Africa disproportionately affects women. From the 2005 survey, young women (15-24 years) are four times more likely to be HIV-infected than are young men, which was reflected in 2005 survey data with the prevalence among young women as being 17% compared with 4.4% among young men (Shisana *et al.*, 2005).

Parry & Pithey (2006) reviewed the data from the three national surveys and they indicated that the results of a Human Science Research Council survey in 2005 confirmed the results of the Reproductive Health Research Unit survey conducted in 2003. Results from the survey conducted in 2005 found that youth aged 15 to 24 years, had a 10.3% HIV prevalence, which was slightly higher than the 2002 survey which was 9.3%. There was a significant increase in prevalence among females aged 15 to 24 years, which increased from 12.0% in 2002 to 16.9% in 2005. Conversely, the HIV prevalence for males in the group 15 to 24 years decreased from 6.3% to 4.4% in 2002, 2005 consecutively.

Parry & Pithey (2006) assessed the findings of three prevalence studies which provided an overview of the South African HIV/AIDS epidemic as opposed to seeing these findings in isolation. Furthermore, they noted “what is evident from each of these studies is that HIV prevalence is exceptionally high in South Africa and although it affects all segments of the population, women are more likely to be living with HIV/AIDS than men”.

Mortality data indicated that the total deaths (from all causes) in South Africa increased by 79% from 1997 to 2004 (from 316 505 to 567 488) (Statistics South Africa, 2006). A large proportion of the rising trend in death rates is attributable to the AIDS epidemic (Anderson & Phillips, 2006; Medical Research Council, 2005), and the increasing death toll has driven average life expectancy below 50 years in three provinces (Eastern Cape, Free State and KwaZulu-Natal) (Actuarial Society of South Africa, 2005).

In South Africa, similar to many parts of the world, gender inequality continues to impede human and social development. The HIV/AIDS epidemic disproportionately affects women's lives in respect of rates of infection and the burden of care and support they bear for those with HIV/AIDS related illnesses. Young women are more likely to be infected than men. A report conducted by the University of the Witwatersrand in April 2004 indicates that women make up 77% of the 10% of South African youth between the ages of 15 – 24 years who are infected with HIV/AIDS (Pettifor *et al.*, 2005)

Women's greater vulnerability to HIV/AIDS is partially attributable to the high levels of sexual and domestic violence reported across the country, which is amongst the highest levels reported anywhere in the world. As an example, almost one-third of sexually experienced women (31%) reported that they did not want to have their first sexual encounter and that they were coerced into sex (Pettifor *et al.*, 2005). Gender-based violence and gender inequality are increasingly being cited as important determinants of women's HIV risk. A cross-sectional study of 1366 women presenting for antenatal care at four health centres in Soweto, South Africa revealed that women with violent or controlling male partners are at an increased risk of HIV infection (Dunkle *et al.*, 2004).

Research studies have also explored the role of psychological factors as determinants of HIV risk and have revealed that individuals with low levels of self-esteem and self efficacy tend to be more likely to engage in unsafe sex (Eaton & Flischer, 2001; Kipp *et al.*, 1994).

2.2 SUBSTANCE USE IN SOUTH AFRICA

Unlike other sub-Saharan countries, South Africa is unique in that it has a well developed capacity for surveillance and research on drug-related problems. Established in 1996 the primary resource of this information is the South African Community Epidemiology Network on Drug Use (SACENDU) project which currently monitors alcohol and other drug use trends at six sentinel sites in South Africa. Four of these are large port cities (Cape Town, Durban, Port Elizabeth and East London and two are provinces [Gauteng, a

largely urban province that includes the cities of Pretoria and Johannesburg; and Mpumalanga, a mostly rural province that borders Mozambique, Swaziland, and Zimbabwe)]. South African Community Epidemiology Network on Drug Use primarily uses secondary data sources such as treatment demand data and information from the South African Police Service's Forensic Science Laboratories (Parry *et al.*, 2002; Plüddemann *et al.*, 2005).

South African Community Epidemiology Network on Drug Use meets every six months to provide community-level public health surveillance of alcohol and other drug use, trends and associated consequences. This is done through the presentation and discussion of quantitative and qualitative research data. Through this initiative, South African Community Epidemiology Network on Drug Use provides descriptive information on the nature and pattern of AOD use, emerging trends, risk factors associated with AOD use, characteristics of vulnerable populations and consequences of AOD use in South Africa.

An analysis of information from persons being seen by specialist treatment centres during Phase 20 (January – June 2006) of the South African Community Epidemiology Network on Drug Use project revealed the following (Plüddemann *et al.*, 2006).

Alcohol remains the dominant primary substance of abuse among patients across all sites except Cape Town, accounting for 55% of admissions in Mpumalanga, 64% of admissions in East London, 60% of admissions in Durban/Pietermaritzburg (PMB), 48% of admissions in Cape Town. The proportion of alcohol-related admissions remains fairly stable in Durban/Pietermaritzburg, Gauteng and Mpumalanga but decreased in Port Elizabeth and East London. In Cape Town, the proportion increased compared to the previous period (July – December 2005). The mean age of patients seen at treatment centres who had alcohol as the primary substance of abuse ranged from 38 years to 41 years across sites. This is substantially older than the mean age for other drugs. Such patients are also more likely to be male. The proportion of patients with alcohol as the primary substance of abuse who were female ranged from 12% in East London to 30% in Cape Town.

Cannabis was the second most common primary substance of abuse among patients seen at specialist treatment facilities in Durban/Pietermaritzburg, Gauteng, East London and Mpumalanga, ranging from 19% in East London to 25% in Mpumalanga. The proportion of patients with Mandrax as their primary substance of abuse has continued to decline or remains very low in all sites. Only one site (Port Elizabeth) has more than 5% of their patients reporting Mandrax as their primary substance. Persons seen in specialist treatment centres that had 'white pipes' (Mandrax) as their primary substance of abuse tended to be older than those who had cannabis alone as their primary substance of abuse. Cannabis is the most common primary substance of abuse for patients younger than 20 years in most sites except Cape Town where the primary substance of abuse is methamphetamine.

Data from specialist treatment centres suggests that the use of these substances remains a male phenomenon. Between 0% and 10% of patients whose primary substance of abuse was "white pipes" were female across the sites; however between 4% (Port Elizabeth) and 14% (Cape Town) of patients whose primary substance of abuse was cannabis were female.

The proportion of patients at specialist treatment centres whose primary substance of abuse was cocaine powder/crack increased to 21% in Port Elizabeth (significant increase) and to 10% in East London in the 1st half of 2006. However, proportions in the other sites remained fairly stable. Cocaine powder is primarily snorted and crack is smoked. Between 13% (Durban/Pietermaritzburg) and 31% (Port Elizabeth) of all patients had used crack/cocaine either as a primary or secondary substance. This indicates that cocaine is generally more common as a secondary substance of abuse. In Port Elizabeth, cocaine/crack is now consistently reported as the second most common primary drug of abuse after alcohol, replacing cannabis or Mandrax as observed in previous periods.

In all sites the mean age of persons in treatment whose primary drug of abuse is cocaine powder or crack was 27 to 31 years. In Cape Town, 25% of patients whose primary substance of abuse was cocaine were female compared to 7% in Durban/

Pietermaritzburg. The majority of the patients with cocaine/crack as their primary substance of abuse are still white in most sites, although about 40% in Port Elizabeth and Cape Town were Coloured. Generally, few adolescent patients report cocaine as their primary substance of abuse, the highest proportion being 12% in Port Elizabeth. In Cape Town, 41% and Gauteng, 36% of patients treated for cocaine dependence had been previously in treatment.

In Cape Town 14%, in Mpumalanga 10% and in Gauteng and Port Elizabeth 8% of the patients in specialist centres had heroin as their primary substance of abuse. The proportion in Cape Town, Gauteng and Mpumalanga remained stable compared to the previous period, with a slight increase in Port Elizabeth. The mean age of persons seen in treatment centres in Cape Town, Gauteng and Mpumalanga who had heroin as their primary substance of abuse was 23-25 years, which remained fairly stable. Heroin appears to be less of a male phenomenon than drugs such as cannabis and Mandrax. In Cape Town, 24% and in Gauteng, 27% of the patients with heroin as the primary substance of abuse were female. In Gauteng, heroin patients also exhibited a greater tendency to have received treatment before than patients treated for any other drug, with 50% reporting that they had previously been in treatment. In Cape Town 38% of heroin patients had been in treatment previously. Patients treated for heroin addiction for the first time in Cape Town had been using heroin for an average of three years.

Intravenous use by patients with heroin as their primary drug of abuse remains low in Cape Town, with only 10% reporting injecting use compared to 15% in the 1st half of 2005, and 24% in the 2nd half of 2004. This is linked to the changing demographic profile of heroin patients, most of whom are now Coloured and prefer to smoke the drug. Only 2% of Coloured patients reported injecting the drug compared to 31% of White heroin patients. In Gauteng, 37% of patients reported injecting, compared to 39% in the previous period. In Mpumalanga, 12% of heroin patients reported injecting, compared to 37% in the previous period, a significant decrease. In this site a change of mode of use seems to have occurred with 22% of the White patients reporting injecting the drug, compared with 47% in the previous period. A drastic increase in the proportion of Black heroin

patients has been noted in Mpumalanga, increasing from 11% in the first half of 2005 to 30% in the 2nd second half of 2005 and 37% in the 1st half of 2006. In Cape Town, 16% and in Gauteng and Port Elizabeth 11% of patients reported the use of heroin, as either their primary or secondary substance of abuse.

Between 1% (East London and Cape Town) and 5% (Durban/PMB) of patients seen at specialist treatment centres from January – June 2006 had over-the-counter (OTC) or prescription medicines (PRE) listed as their primary substance of abuse. This is fairly similar to the previous six-month reporting periods. In Gauteng 64% and in Cape Town 73% of patients who had over-the-counter or prescription medicine as their primary substance of abuse, were female. The average age of these patients ranged between 36 and 42 years. These substances are more common as secondary drugs of abuse with between 3% (East London) and 12% (Durban /Pietermaritzburg) of patients across sites reporting this drug either as primary or secondary substances of abuse. Substances abused included benzodiazepines, analgesics, Codeine products and sleeping pills.

The proportion of persons using specialist treatment services, whose primary drug of abuse was Ecstasy, remains low across all sites. No more than 1% of patients reported Ecstasy as their primary substance of abuse across all sites.

Ecstasy was however reported as a secondary substance of abuse by several persons attending specialist substance abuse treatment facilities across the sites with between 3% (Durban/Pietermaritzburg, Gauteng and Mpumalanga) and 6% (Cape Town) reporting Ecstasy as a primary or secondary substance of abuse. The patients in treatment where the primary substance of abuse was Ecstasy were mostly White. Overall, LSD was reported by very few patients. Thus, for example, only 24 patients reported it as a primary or secondary substance of abuse in Gauteng versus 13 patients in Cape Town.

In Cape Town the increase in patients reporting methamphetamine as their primary substance of abuse continued, with 37% reporting it as their primary substance of abuse in the first half of 2006. The mean age of patients presenting with methamphetamine use

as the primary substance of abuse was 22 years, lower than most other drugs. Most of the patients were Coloured (92%) and 73% were male. Most of the patients reported smoking the drug (99%) and only one person reported injecting the drug. 48% reported daily use of the drug and a further 28% reported using it 2-6 days per week. Overall, 46% of all patients reporting for treatment in Cape Town in the first half of 2006 reported methamphetamine either as a primary or secondary substance of abuse, a further increase from previous periods. In Gauteng the number of patients reporting methcathinone ('CAT') as their primary substance of abuse continues to increase, with 94 reporting it as their primary substance of abuse compared to 47 in the previous 6-month period. A total of 175 patients reported 'CAT' as either their primary or secondary drug of abuse. The effects of 'CAT' are described as being fairly similar to methamphetamine ('tik'), although considered not to be as potent.

2.3 SUBSTANCE ABUSE IN WOMEN

Until the early 1990s, the substance abuse treatment literature was based primarily on male samples, or mixed samples of men and women with the main focus on gender differences. Women were excluded from most studies due to their childbearing potential; as a result, findings about effective substance abuse treatments were not fully generalizable to women. Women who have problems with substance use differ from men in their patterns and onset of drug use (Zilberman *et al.*, 2002).

Among the most reproducible findings of studies focusing on women and substance use disorders is that of the heightened vulnerability of women to the adverse medical and social consequences of substance use, abuse and dependence (Chatham *et al.*, 1999; Gentilello *et al.*, 2000; Henskens *et al.*, 2005; Hernandez-Avila *et al.*, 2004). For substance use disorders, including alcohol, opioid and cannabis dependence, females advance more rapidly from use to regular use to first treatment episode than do their male counterparts (Dawson, 1996; Hernandez-Avila *et al.*, 2004; Johnson *et al.*, 2005; Orford & Keddie, 1985; Randall *et al.*, 1999). In addition, when they enter treatment, despite fewer years of use and smaller quantities of substances used, their substance abuse

symptom severity is generally equivalent to that of males (Hernandez-Avila *et al.*, 2004; Randall *et al.*, 1999). Even with fewer years of substance use, at treatment entry females tend to average more medical, psychiatric and adverse social consequences of their substance use disorders than males. Given the approximate equivalence of age of initiation of substance use between males and females in the younger age cohorts (Hernandez-Avila *et al.*, 2004; Holdcraft & Iacono, 2002, 2004; Johnson *et al.*, 2005), this heightened vulnerability of females of all age cohorts produces particular clinical and public health concerns (Greenfield, 2002). It also sets the stage for examining the information on predictors of treatment entry, retention and outcomes for women with substance use disorders.

While current evidence indicates that the proportion of women represented in substance abuse treatment facilities is lower than the population prevalence of these disorders in women relative to men, such data do not represent gender discrepancies in ever having received treatment for substance use disorders. Another area of research is gender differences in seeking or entering care for substance use disorders in different service sectors, such as specialty substance abuse treatment, mental health, or general health care (Weisner, 1993; Weisner & Schmidt, 1992). An example thereof is that the relatively low prevalence of women in substance abuse treatment programmes might be accounted for by women defining their substance-related problems as health or mental health problems and seeking care in physical or mental health sectors (Weisner & Schmidt, 1992).

Weisner & Schmidt (1992) ascertained that women with problem drinking were more likely than men to seek care in non-alcohol specific settings, especially mental health treatment services. In a separate study, Weisner (1993) demonstrated that there were gender differences in factors affecting treatment entry. In creating a model to explain reasons for this phenomenon, Weisner found that for women, lifetime general treatment history, ethnicity and employment were significant factors; however for men, social consequences, substance abuse treatment history and employment were most prominent. Mojtabai (2005) found that males were less likely to use mental health services, but not substance abuse services than females.

Data from a large multi-site prospective clinical epidemiological study revealed that women entering substance abuse treatment were younger and had a lower education and employment levels, health and mental health problems, greater exposure to physical and sexual abuse, and greater concerns about issues related to children compared to men (Wechsberg *et al.*, 1998).

Responsibility for children, lack of access to childcare services, and society's punitive attitude toward substance abuse by women as child bearers are barriers frequently reported by women who require help (Institute of Medicine, 1990; Allen, 1995; Coletti, 1998; Prendergast *et al.*, 1995). In the 1980s, legislated offences penalized chemically dependent mothers who used drugs during their pregnancies (Beck, 1990). Transportation to treatment sites has also been identified as an additional barrier for women (Coletti, 1998; Ayyagari *et al.*, 1999).

A few studies have identified the special needs of women. Thus for example, women substance abusers are more likely than their male counterparts to report greater dysfunction in the family of origin (Ayyagari *et al.*, 1999), and/or lacking adequate role models for parenting (Davis, 1990). Poor interactions with children can be a significant source of stress that interferes with treatment efforts (Davis, 1990; Greif & Drechsler, 1993). Women substance users also exhibit a greater tendency than male substance users to enter dependent relationships dominated by their partners (Woodhouse, 1992), which hinders their ability to perform basic life skills, such as managing money and planning for the future. Furthermore, women in treatment may need female role models for recovery. In fact, research in the 1980s found that structural factors of treatment facilities such as staff composition influenced use rates by women and impacted their entry and continuation in treatment (Beckman & Kocel, 1982).

Studies of the association between coping skills and substance abuse indicated that persons deficient in coping skills are more likely to use alcohol and other drugs as a way to handle stressful situations (Abrams & Niaura, 1987; Cooper, Russell, & Frone, 1990). Substance use in stressful situations has been described as emotion-focused coping, or an

attempt to manage the emotional distress engendered by the stressful situation (Abrams & Niaura, 1987).

Moreover, lack of coping skills contributes significantly to relapse (Marlatt, Barrett, & Daley, 1999). A history of victimization, especially childhood sexual abuse is frequently associated with substance abuse in women. Alcoholic women are 2.5 times more likely to report childhood sexual abuse than non-alcoholic women (Miller & Downs, 1995; Miller, Downs, Gondoli, & Keil, 1987). As many as 90% of women in treatment for substance abuse report a history of physical and sexual abuse (Ladwig & Andersen, 1989; Weiner, Wallen, & Zankowski, 1990). A recent qualitative study of alcohol dependency in rural women found that childhood and adult victimization were significant occurrences in the lives of alcoholic women (Boyd & Mackey, 2000).

Research has shown that substance abuse is associated with low self-esteem in women, and women may drink to compensate for feelings of inadequacy (Turner, 1995). Low self-esteem results in poor coping mechanisms in the presence of stress often leading to alcohol and drug use as an alternative coping strategy (Miller & Downs, 1995). Moreover, feelings of worthlessness and powerlessness encourage the pursuit of something that increases one's sense of being in control (Abbott, 1994). Because value is primarily determined by an outside force, a solution is sought in a source external to self. That external solution is often alcohol and other drugs (Abbott, 1994). This may be especially true for those women who have histories of childhood victimization (Miller & Downs, 1995). Victimized women experience feelings of worthlessness, powerlessness and loss of control (Abbott, 1994).

Women often describe their substance use as having a sudden and heavy onset, which often follows a traumatic event (Woolis, 1998). In contrast, men's patterns of substance use are often described as gradual and progressive onset (van der Walde *et al.*, 2002).

Women have reported that they use substances to numb emotional pain from issues such as abuse, sex work, grief over the death of loved ones or guilt over injury to loved ones,

especially children (Peterson, Berkowitz, Cart, & Brindis, 2002; Poole & Isaac, 2001; van der Walde *et al.* 2002). Substance use often increases in response to a life crisis, including loss of significant relationships, death of a loved one and children leaving home (AADAC, 2003; Poole & Isaac, 2001). For some women, such losses can also lead to treatment seeking behaviour (*Ibid*).

Relational issues are intricately connected with the onset and progression of substance use problems in women (Poole & Isaac, 2001; Zelvin, 1999). Families of women with substance use problems can either help or hinder treatment seeking, but they rarely have a neutral impact (Poole & Isaac, 2001). Women's substance use patterns are influenced by their partners or spouses and their children's functioning and well-being (Zilberman *et al.*, 2002). If problems in these relationships remain unresolved, it is difficult for women to sustain any progress gained through treatment (Poole & Isaac, 2001; Zilberman *et al.*, 2002).

Women are more likely than men to use drugs when they are alone and to be in a relationship with a partner who is a regular substance user (Woolis, 1998; van der Walde *et al.* 2002). Women with poor coping skills coupled with low self-esteem tend to have low self-efficacy in managing substance use (Poole & Isaac, 2001; van der Walde *et al.*, 2002; Zilberman *et al.*, 2002). Some women may find their roles as caregivers incompatible with treatment seeking (AADAC, 2003). One strong recurring theme in literature is that women forgo or postpone treatment entry because they do not have someone they trust to care for their children in their absence (Poole & Isaac, 2001). Women often fear that they will lose custody of their children if they indicate a need for substance use treatment. In some cases, women will enter treatment in an effort to try to regain custody of their children (*Ibid*).

Over-dependence on unhealthy relationships with men or women partners is central to the lives of substance-abusing women. Primary relationships are essential to identity development in women even more so than in men. Addicted women often develop learned helplessness. The concept of learned helplessness is the product of conditioning

and socialization. Addicted women have learned to believe that the outcome of a situation has little to do with their input. These misperceptions lead to dependency on others and upon substances (Cohen *et al.*, 2000).

Women have indicated that they use substances to cope with feelings of depression, devaluation and low self-esteem and to numb emotional pain from abusive encounters (Bush-Baskette, 2000; Yahne *et al.*, 2002). In addition, experiences of domestic violence can contribute to poor decision-making skills or reluctance to make decisions at all (Brown *et al.*, 2000).

Some women report that shame and guilt are factors that motivate them to continue to use substances and prevent them from seeking treatment (Tait, 2000; van der Walde *et al.*, 2002). Women, more often than men, use prescription drugs to address feelings of shame and discouragement (Vines & Mandell, 1999). Shame and guilt are often tied to their roles as mothers and caregivers (Poole & Isaac, 2001). Rural women cite feelings of shame as potential barriers given that anonymity may be more difficult to maintain in a small, closely knit communities (*Ibid*).

Women are strongly influenced by their peers, significant others and family members (Poole & Isaac, 2001; van der Walde *et al.* 2002; Zilberman *et al.*, 2002). Women who perceive that they have minimal support from significant relationships are less inclined to access or initiate treatment (Riehman *et al.*, 2000). In one study, women who had support only from other substance users experienced similar difficulties in accessing community services, which was similar to those who had minimal or no identified social supports (Nyamathi, Leake, Keenan, & Gelberg, 2000).

In some instances, a partner or significant other may not support women who try to access treatment and may actively seek to discourage such efforts (Zilberman *et al.* 2002). Resistance from male partners who use drugs has been identified as a major barrier for women who want to seek treatment. Resistance from a partner or significant

other may prompt women to withdraw from services after treatment has been undertaken (Poole & Isaac, 2001; Riehman *et al.*, 2000).

2.4 SUBSTANCE ABUSE AND SEXUAL RISK BEHAVIOUR

A growing body of work focuses on the intersection of substance use and sexual behaviour as they affect the risk of HIV infection. Research has shown that alcohol and drug use are strongly related to high-risk sexual behaviours such as inconsistent condom use and having multiple sex partners (Chesney *et al.* 1998; Leigh & Stacy, 1993; Ostrow *et al.* 1993).

Several studies have reported that drug and alcohol use is associated with high-risk sexual and drug use behaviours (Fitterling, Matens, Scotti, & Allen, 1993; Malow, Devieux, Jennings, Lucenko, & Kalichman, 2001; Rees, Saitz, Horton, & Samet, 2001; Stein *et al.*, 2000). People with heavy alcohol use tend to engage in riskier behaviours, such as sex with multiple partners, unprotected vaginal and anal intercourse, and injection drug use (Bagnall, Plant, & Warwick, 1990; Halpern-Felsher, Millstein, & Ellen, 1996; Leigh, Temple, & Trocki, 1994). Active drug and alcohol use is associated with increased sexual and drug using risk behaviours (Battjes, Pickens, & Brown, 1995; Booth, Kwiatkowski, & Chitwood, 2000; Rees *et al.*, 2001; Stein *et al.*, 2000). The relationship between alcohol and sexual risk taking is complex, and may be explained in a number of ways. Alcohol use may influence high-risk behaviors by affecting judgment and increasing disinhibition. Alcohol use may be a marker of a risk-taking personality; people with heavy alcohol use may also be more likely to engage in high-risk sexual behaviors (Leigh *et al.*, 1994). Thus, one critical approach to slow the spread of HIV among persons with alcohol problems is to change risky sexual behaviours.

Since the early years of the epidemic, needle and syringe sharing among injecting drug users has been recognized as a major vector for the spread of the human immunodeficiency virus. Sexual transmission among intravenous drug users, and from intravenous drug users to non-intravenous drug users' sexual partners, also formed a

longstanding concern, along with perinatal transmission to their children. The number of intravenous drug users diagnosed with HIV/AIDS continues to expand in the second decade of the HIV epidemic, also the number of related cases in intravenous drug users' sexual partners and their children. Approximately one-third of HIV/AIDS cases are associated with injecting drug use (Centers for Disease Control and Prevention, 1994).

The potential contribution of non-intravenous drug users to HIV transmission and disease progression has also been of concern. For example, drug intoxication may lessen inhibition and facilitate engagement in sexual risk behaviours. Involvement in drug-using social networks may promote sexual contact between non-injectors and intravenous drug users, therefore increasing risk of HIV exposure. Research has shown that some non-intravenous drug users engage in sex to obtain drugs or money to buy drugs. Recently, it has been recognized that crack cocaine users who engage in sex to obtain their drugs may be at higher risk for HIV infection (Inciardi *et al.*, 1993).

Despite the evidence of the range of high-risk sexual practices among non-injecting drug users, high-risk injection behaviour has dominated the attention of researchers, thus sexual transmission of HIV has received less attention. Research indicates that HIV infection is increasing among non-injecting drug users (Des Jarlais *et al.*, 1995).

Women with severe drug dependency problems are likely to be at greater risk of sexual acquisition of HIV than men (Ickovics & Rodin 1992). In most of the literature on chemically dependent women, initiation and continued access to drugs occurs mainly through male sexual partners (Worth, 1991). In samples of individuals in drug treatment, women have a faster transition from drug use initiation to addiction (Anglin *et al.*, 1987; Hser *et al.*, 1987) and greater severity of addiction as compared to their male counterparts (Anglin *et al.*, 1987; Hser *et al.*, 1987). When women decide to seek treatment, however, a drug-using sexual partner may obstruct access to treatment (Mondanaro, 1989).

Research that has focused on the relationship between alcohol use and sexual risk behaviour is very limited within the South African context. Most studies have involved

adolescents living in the Cape Town area, with the exception of two studies, one of which was a study of arrestees in three major cities and the other was a study conducted at a university in the Eastern Cape. Thus far, the findings revealed conflicting results. Therefore, further work needs to be done to clarify the nature and extent of the relationship between alcohol use and sexual risk behaviour. Each of the studies are described in turn. Flisher *et al.*, (1996a) conducted a study in 1990 to ascertain whether the notion of a syndrome of adolescent risk behaviour is valid for Cape Peninsula high school students. The sample consisted of 7340 high school students, from grades 8 to 12, from 16 schools in the Cape Peninsula. The relationships between the risk behaviours were demonstrated by means of unadjusted odds ratios. The alcohol risk behaviour variable (binge drinking) was defined as "having had 5 or more drinks on at least one occasion in the previous 14 days". The sexual risk behaviour variable was defined as "ever having had heterosexual vaginal intercourse". The research indicated a statistically significant relationship between alcohol bingeing and sexual intercourse, with a stronger correlation among boys than among girls.

Another study examined the relationship between drug use and sexual behaviour among students from four private schools in Cape Town (Morojele *et al.*, 2000). The participants comprised 92 (74%) males and 31 (25%) females, with a mean age of 14.33 years, enrolled in grades 8 to 11 with the majority (79%) being white. The measure for alcohol use was "had used alcohol in the past month" and for sexual behaviour two measures were included. These were (1) engagement in sex with a near-stranger (whether respondents' last sexual partner had been known to them for more than 7 days); and (2) failure to use family planning (whether they or their partner had used anything to prevent pregnancy or prevent disease on the last occasion that he/she had sexual intercourse).

This study showed that there were significant correlations between alcohol use and both sexual behaviour variables. It should be noted that the researchers of the study suggested caution in interpreting the results because of sample bias (mostly white males at private schools). Adolescent contraceptive use and its association with other risk behaviours (including alcohol use) was investigated in a study among 913 sexually active high

school students in Cape Town (Flisher & Chalton, 2001). Two measures of alcohol use were included: (1) ever used alcohol, and (2) used alcohol in the past month. Use of contraception was measured as "used contraception on the last coital episode". Contraceptive use was not found to be significantly associated with the use of alcohol.

A study conducted among 176 predominantly white, female second-year psychology students at Rhodes University, Grahamstown in the Eastern Cape, assessed students' alcohol use and sexual behaviour and their beliefs about how alcohol and other drug use would affect their sexual behaviour. There were significant associations between alcohol/drug use and the number of sexual partners (alcohol/drug users have more sexual partners) and knowledge of HIV transmission (alcohol/drug users have better knowledge) (Simpson, 1996). However, alcohol/drug use was not significantly related to frequency of condom use or respondents' perceived risk of HIV infection (*Ibid*). Although the students had high levels of knowledge regarding safe sex practices, only 15% of the sexually active respondents used condoms regularly (*Ibid*).

A study was conducted to examine the risk factors for teenage pregnancy among sexually active black adolescents in Cape Town; it was found that alcohol use was not associated with sexual risk behaviour which may lead to pregnancy (Vundule *et al.*, 2001). This finding would appear to support the finding of the study conducted by Flisher & Chalton (2001). Teenage pregnancy has been identified as one critical problem currently facing South Africa. Most teenage pregnancies in South Africa occur within the context of unstable relationships and are usually an unplanned or unwanted pregnancy. This has important implications for efforts to reduce other outcomes, such as the spread of sexually transmitted infections and HIV (Department of Health: National Framework for Contraceptive Services, 1998).

A research study conducted by the Medical Research Council and the Institute for Security Studies examined the relationship between alcohol and other drug use and respondents' HIV status (Parry *et al.*, 2001). The study aimed to investigate the links between drug use and crime among 827 arrestees in three surveys in three major cities

over three time periods: August/ September 1999, February/March and August/ September 2000. With respect to data collected for Phase I of the study (August to September 1999), it emerged that 20% (166 out of 827) of the arrestees tested positive for HIV, with a greater prevalence among females (30%) than males (18%). The highest prevalence was found among the African respondents (25%), followed by Indian (19%), White (10%) and Coloured (5%) respondents. No age differences were found with regard to HIV status. It emerged that 19% of those who reported using alcohol in the past month were HIV positive, whereas 15% of those who reported not having used alcohol in the past month were also HIV positive. Contrary to expectations, these results suggest that HIV prevalence rates were higher among non-drinkers during the past year than they were among drinkers. The same unexpected direction of results emerged with respect to the correlation between use of various illicit drugs and the arrestees' HIV status. The researchers speculate that under-reporting of alcohol/drug use by the respondents could be a cause of their failure to find a strong relationship between HIV status and drug/alcohol use, and to find a relationship between the two variables in the expected direction.

Among the approximately 40 million people in the world who are infected with HIV, two out of three live in sub-Saharan Africa; nearly one in five South African adults are living with HIV/AIDS (UNAIDS, 2006). Coinciding with one of the world's worst HIV/AIDS epidemics, South Africa has among the world's highest levels of alcohol consumption per drinker: 16.6l of pure alcohol per year (Parry, 2005). Similar to elsewhere in the world, alcohol use among South Africans is associated with risks for sexually transmitted infections including HIV/AIDS (Cook & Clark, 2005). Cognitive factors, such as the expected outcomes from drinking, have demonstrated important effects on sexual risk behaviours in South Africa. Thus, for example, expectations that alcohol will increase sexual desires and sexual pleasure are related to HIV risk behaviours among STI clinic patients in Cape Town (Kalichman, Simbayi, Jooste, Cain, & Cherry, 2006). In addition, sexual enhancement expectations have been related to greater numbers of sex partners and regret with some feeling after having had sex (Morojele *et al.*, 2006). There is also evidence for gender differences in how alcohol expectancies are related to sexual risk

behaviour. In qualitative research, men are more likely to expect that alcohol will increase their sexual desires, whereas women expect the opposite effects of alcohol on sexual desires (Simbayi, Mwaba, & Kalichman, 2006). Alcohol expectancies may also differ for men and women in relation to whether the individual and his or her partner were drinking before sex. However, to my knowledge, no studies that have quantitatively examined the association of alcohol outcome expectancies and alcohol use by sex partners within sexual contexts in South Africa.

Previous research in South Africa is limited by uni-dimensional representations of alcohol expectancies (Kalichman *et al.*, 2006; Simbayi *et al.*, 2004). Theories propose that alcohol outcome expectancies are multidimensional (Goldman & Darkes, 2004). In addition to sexual enhancement expectancies, drinkers may expect alcohol to have a more generalized behavioural dis-inhibiting effect; acting out and doing things one would not ordinarily do. In addition, alcohol may be expected to facilitate non-sexual social interactions such as easing conversation and increasing friendliness.

Another aspect of alcohol use that may vary is the sexual context of drinking, whether individuals drink before sex and whether their partners drink before sex. In the current study, they tested the associations between drinking in sexual contexts and three alcohol outcome expectancies: sexual enhancing, behavioural disinhibiting, and social facilitating expectancies. Based on previous qualitative research in South Africa (Morojele *et al.*, 2006; Simbayi *et al.*, 2006), they hypothesized that sexual enhancement and behavioural disinhibition outcome expectancies would be related to drinking before sex and that sexual enhancement and social facilitation outcome expectancies would be related to having partners who drink before sex. They also hypothesized that men and women would differ in their associations between alcohol expectancies and drinking; men were predicted to have stronger associations between sexual enhancement expectancies and their own drinking before sex, whereas among women the associations between behavioural dis-inhibition and social facilitation, alcohol outcome expectancies were predicted to be stronger for partners drinking.

Persons experiencing alcohol and other drug addictions appear to be more likely than non-addicted persons to be infected with a sexually transmitted infection (STI). Cook & Clark (2005) conducted a systematic review of published literature on the association between problematic alcohol consumption and STIs, and they reported that 8 of the 11 studies found a significant association between alcohol consumption and at least one STI. Evidence regarding the association between HIV and drug abuse can also be found (Aceijas *et al.*, 2004). Much of this evidence comes from patients who have engaged in sharing of injection needles and other drug use paraphernalia. Fewer studies have examined the relationship between HIV (and other STIs) and abuse of non-injectable drugs. However, several studies suggest an increased vulnerability to HIV and other STIs among persons who use non-injectable drugs (Bachmann *et al.*, 2000; Poulin *et al.*, 1999; Shoptaw *et al.*, 2003). Given associations between STIs and alcohol/drug abuse in *developed* countries, it is plausible to surmise that such associations may also exist in *developing* countries.

2.5 SOUTH AFRICAN DRUG-RELATED HIV RISK

In South Africa, there have been several studies focused on drug-related HIV risk among adolescents and other vulnerable groups at risk for HIV infection. Parry & Pithey (2006) in their review of local studies on drug-related HIV risk in South Africa, discussed studies conducted on drug use and sexual risk behaviour among adolescents of both genders, studies conducted among female commercial sex workers, a survey study that investigated factors associated with HIV risk behaviour and STIs among African women, and the nature and extent of heroin use in Cape Metropole. Furthermore, they discussed the International Rapid Assessment, Response and Evaluation (I-RARE) study of drug use and sexual-HIV risk patterns among three vulnerable drug-using populations in three South African cities. Parry & Pithey (2006) found that although some studies have indicated an association between the use of substances and high-risk sexual behaviour among adolescents, the causal links between the two behaviours, access to drugs and other people's drug use still need to be explored further.

A study in 2002 conducted by Morojele, Brook & Moshia (2002) examined the relative importance of adolescents' access to drugs, self-drug use and drug use of family members, partners and peers in their sexual activity. A significant relationship was found between having engaged in sexual intercourse and self drug use, drug use by the father of the participant and greater accessibility to such substances (Morojele, Brook & Moshia, 2002).

Currently sex work is criminalized in South Africa under the Sexual Offences Act 23 of 1957. However, sex work still occurs and is steadily growing. Parry & Pithey (2006) postulated that the multi-faceted sex industry reflects the many gender-based social and economic inequalities that are the legacy of the apartheid era (Pauw & Brener 2003, cited in Parry & Pithey, 2006). The circumstances surrounding women initiation into sex work generally involves financial support for survival. Research studies have shown a link between sex work and sex-related violence; also women are more likely to use alcohol and drugs, thus placing them at risk for unprotected sex and acquiring HIV (Wechsberg, Luseno & Lam, 2005).

A study was conducted with commercial sex workers to identify barriers to HIV risk reduction. The study identified a number of barriers to sustained safer sex practices or factors that could possibly lead to an increased risk of contracting HIV (Parry & Pithey, 2006). Risk factors identified in the study was the resistance by some clients to the use of condoms, client violence and forced unprotected sex, low rates of condom use in their personal relationships and substance abuse among sex workers (Pauw & Brener, 2003). Data revealed that commercial sex workers reported that the reasons for continuing substance use was related to the sex work whereby substances were used to reduce levels of anxiety and fear linked with sex work, to stimulate a feeling of happiness, to increase their enjoyment of sex, to increase their self confidence and to help them cope with their job (*Ibid*). However, some of the participants perceived that the use of drugs increased their vulnerability to violence and abuse (*Ibid*).

The intersection between high-risk sexual behaviour, substance abuse and victimisation was explored in a pilot study with a sample of Black/African commercial sex workers in Pretoria. Results of the study indicate that cannabis is the most common first substance ever used with other substances respectively: alcohol, crack cocaine, and heroin. Furthermore, women [44%] reported drug use with their clients. Women reported that one or more of their last 10 clients had been violent; also women reported that these clients were often intoxicated with alcohol or other drugs. The findings of the study reinforce the need for focused, comprehensive interventions that address issues around substance abuse, sexual risk and violence as well as recognise that these are interconnected (Wechsberg, Luseno & Lam, 2005).

Parry & Pithey (2006) reviewed existing studies on drug-related HIV risk which indicated that the studies established a large degree of high-risk sexual behaviour, violence and substance abuse (especially alcohol, cannabis, crack cocaine and some heroin) among female street sex workers in South Africa. In addition, drug use often occurred in conjunction with sex work. Recent research indicates that the levels of sexual and physical violence against women in South Africa are prevalent. A study conducted among women attending antenatal clinics in Soweto revealed that women with violent or controlling partners were at an increased risk of HIV infection (Abrahams, Jewkes, Laubscher & Hoffman, 2006; Dunkle, Jewkes, Brown, Gray, McIntyre & Harlow, 2004)

Similar findings were found by Kalichman & Simbayi (2004) among women residing in an African township in Cape Town. Results indicate that women who experienced sexual assault were more likely to have STIs, multiple male sex partners, greater rates of unprotected vaginal sex, lower rates of anal sex with condom use, to have used alcohol, 5 times more likely to exchange sex for money and nearly 5 times more likely to have shared needles to inject drugs than women without a history of sexual assault.

A study was conducted in three South African sites in late 2005 by Parry, Plüddemann, Achrekar, Pule, Koopman, Williams & Needle (2006) which focused on drug-related HIV risk in South Africa and explored drug use and sexual HIV- risk patterns among

vulnerable groups as mentioned earlier. Data was collected using key informant interviews and focus group discussions. Results indicate that cannabis, ecstasy, crack cocaine and heroin were used extensively by all subgroups. Results on the effects of heroin use on sexual behaviour were not clear as some indicated that it decreased a person's sexual drive while others reported that heroin use prolonged sex. The majority of participants felt that the use of heroin increased the chance of unsafe sexual behaviour (Parry *et al.*, 2006).

Several participants admitted to sharing needles (mostly with a single regular partner, but occasionally in groups) and most intravenous drug users reported using the same needle several times even when they were aware of the risks associated with these practices (Parry *et al.*, 2006).

2.6 HIV PREVALENCE AMONG DRUG USERS

Currently there are a few studies that have investigated HIV prevalence among drug users in South Africa. Parry & Pithey (2006) provided a brief overview of the studies that were conducted to date. They noted that the studies conducted were on a small scale or may have been included as part of a wider research undertaking. One of the earliest studies to document the prevalence of HIV infection among intravenous drug users in South Africa was a retrospective analysis of Wellconal abusers admitted to one of two hospitals in Johannesburg over an 18-month period (July 1991 and December 1992). The study analysed the case records of 86 patients (median age of 24 years) with a total of 121 admissions presenting for complications from Wellconal abuse. Of the 72 patients tested for HIV, two (2.8%) were found to be positive (Williams, Ansell & Milne 1997, cited in Parry & Pithey, 2006). The study revealed that between the months of August and September 1999, the HIV prevalence rate was assessed among a sample of 827 arrestees from Cape Town, Durban and Johannesburg as part of a broader project which was investigating the link between drug use and crime in South Africa. The overall HIV prevalence rate was 20% and was higher among females (30%) than among males (18%). Among Black/ African arrestees HIV prevalence was assessed to be 25%, followed by Indians (19%), Whites (10%), and Coloureds (5%). Even though only a very small

number of arrestees reported injection drug use (1.3%) or needle sharing (0.8%) in the previous 12 months, intravenous drug users were established as having higher rates of HIV infection than non- intravenous drug users (45% versus 22%). An unexpected finding was that arrestees reporting substance use in the past 12 months (excluding alcohol) were significantly less likely to be HIV positive than non-users (17% versus 25%) (Parry, Vardas & Plüddemann 2001, cited in Parry & Pithey, 2006).

Parry & Pithey (2006) discussed three other studies which contributed significantly to HIV prevalence data among drug users. In 2001, a study was conducted by Leggett (2001) which postulated that there was a positive association between hard drugs (drugs other than alcohol and cannabis) and HIV among commercial sex workers in South Africa. Results indicated that ethnicity was highly associated with HIV, but not with hard drug use. Black/African sex workers had the highest HIV prevalence of 66% compared to 17% in Coloureds and 18% in Whites. However, the results show that hard drug users were less likely to be HIV positive (27%) than non-users (56%) (Leggett, 2001).

HIV prevalence data from the community survey conducted in 2004 among heroin users revealed an overall prevalence of 3.2% of the total sample of 250 participants. Of these that tested HIV positive, two participants reported sharing needles (Plüddemann, Parry, Flisher & Jordan 2004 cited in Parry & Pithey, 2006).

The I-RARE study, which was conducted in 2006, provides the most recent HIV prevalence data among HIV-risk related drug use. Parry *et al.*, (2006) found that of the 92 participants who tested for HIV, 28% were HIV positive [34% among commercial sex workers, 35% among men who have sex with men, 20% among intravenous drug users and none among non-Intravenous drug users]. From the data, it was identified that some participants', especially commercial sex workers, were not well informed about safe sex practices or aware of voluntary testing and counselling centres and treatment services (Parry *et al.*, 2006).

Parry & Pithey (2006) noted that there are gaps in research on HIV prevalence among drug users and these need to be addressed in order to assess susceptibility and risk.

2.7 HIV PREVENTION AMONG DRUG USING POPULATIONS

There has been an increase in the number of programmes aimed at the prevention of HIV or substance abuse in South Africa; however few programmes focused specifically on the prevention of HIV among drug using populations (Parry & Pithey, 2006).

Parry & Pithey (2006) in their review of studies outlined some of the government's strategies to ensure an integrated response to the substance abuse problems in South Africa. These included the establishment of a multi-sectoral co-ordinating body (Central Drug Authority) in 2000 to oversee the implementation of the National Master Plan which implemented various strategies to reduce supply and demand for drugs, especially among youth. Two pilot studies conducted in Pretoria and Cape Town contributed to our body of knowledge of HIV prevention among drug users. The studies focused on women at risk using a woman-focused HIV prevention intervention. Baseline data from pilot study in Pretoria indicated high levels of sexual risk and violence however at follow-up visits; participants reported a decrease in the proportion of unprotected sex and daily use of alcohol and cocaine (Wechsberg, Luseno, Lam, Parry & Morojele, 2006). Results from the study in Cape Town indicated significant decreases in the proportion of unprotected sex acts and rates of physical and sexual abuse in follow-up visits compared to baseline data (Wechsberg, Luseno, Myers & Parry, 2006).

2.8 CONCLUSION

Substance use among women in all parts of the world continues to be a significant health problem. An understanding of the risk factors related to substance use by women in different countries and in varying cultural groups will assist culturally relevant prevention programmes aimed at individuals living in different parts of the world. Investigators have made important advances in identifying the predictors of substance use in the United

States and other industrialized nations; nevertheless, much remains to be learned about the risk factors in developing countries, like South Africa.

3 CHAPTER THREE

RESEARCH METHODOLOGY

3.1 PURPOSE

A qualitative phenomenological research study was designed to explore the essential elements of the lived experience of substance abuse among South Africa women recovering from substance abuse. The researcher conducted a qualitative research study with individuals as a unit of analysis. The researcher selected this approach because it was appropriate for gaining in-depth information on the lives of these women.

3.2 PHILOSOPHICAL PERSPECTIVE

The perspectives of Frankl (1984) provide the conceptual orientation for this study, whereas direction for data analyses was provided by the procedural steps of Giorgi's (1985) method. Frankl (1984) states that the meaning of life differs from man to man, from day to day, and from hour to hour. Frankl (1984) proposed that the chief dynamic behind the addictive behaviour is "existential frustration", created by a vacuum of a perceived meaning in personal existence, and manifested by the symptom of boredom. The underpinnings of Frankl's work stress the individual's freedom to transcend suffering and find meaning in life regardless of his circumstances. The substance abuser often looks on his existence as meaningless and without purpose. Frankl's (1984) work is based on empirical or phenomenological analysis, which was described as the way in which man understands himself, and how he interprets his own existence.

3.3 RESEARCH DESIGN

3.3.1 QUALITATIVE RESEARCH

"All good science begins with description". Within the study of human behaviour, much of the initial description takes the form of observations and information documented qualitatively, not quantitatively (O' Reilly, 1995). The use of qualitative data has become

more common and has recently grown in acceptance within the scientific community, particularly in the field of public health. Some of this recent change is due to the increasing sophistication of qualitative research methods and data processing techniques (*Ibid*). However, the change is attributable to new questions about relationships between human behaviours and the public health problems of HIV, AIDS and drug abuse. With the emergence of these public health problems, traditional quantitative data collection methods have become recognised as insufficient to meet informational requirements about human health and behaviour (O' Reilly, 1995). Researchers have shown that the increased use of qualitative methods provides a more holistic approach to understanding risk behaviours and their contexts, in order to develop more effective prevention interventions for curbing the epidemic. Appropriately applied, qualitative research methods are neither a soft science nor the mere journalistic reporting of values, beliefs and behaviours (Carlson, Siegal & Falck, 1995). Rather, qualitative methods have the capacity to expose the 'hidden' worlds of drug users and those close to them in their holistic contexts (*Ibid*).

Qualitative research recognises the importance of understanding the meaning of experience, action and events as these are interpreted through the eyes of participants, researchers and sub-cultures, therefore adopting sensitivity to the complexities of behaviour and meanings in the contexts where they typically or 'naturally' occur (Richardson, 1996). With qualitative research, we are seeking to discover knowledge, to develop or reformulate theory from the authentic source; we are looking at the whole within context. Therefore, the interest in qualitative methods is directed toward discovering or uncovering new insights, meanings and understandings rather than testing pre-existing theories (Brink and Wood, 1998). Hence, qualitative research is an inherently inductive process.

Trotter & Medina-Mora (2000) noted that qualitative methods are ideal tools for exploring the many facets of drug use and drug abuse cross-culturally and within special populations in a single culture. They explained that these methods tend to be used as exploratory techniques: for identifying and exploring complex behaviours within their

natural context, approaching hidden or difficult to reach populations, addressing sensitive issues, gaining knowledge of new or not sufficiently understood problems and conducting formative analysis of the socio-cultural and psychosocial context in which drug use occurs. Furthermore, they identified these techniques as invaluable in the identification of emerging issues such as changes in substances used, the circumstances of use, routes of administration, the subgroups using drugs, and for discovering sensitive information that would be inaccessible through quantitative methods. Therefore, qualitative methods are of special importance when substance abuse occurs in highly variable and context-specific cultural environments, each of which may have a different impact on drug use and its consequences (Trotter & Medina-Mora, 2000).

Wiebel (1990) identifies two reasons why qualitative methods are significant for drug abuse research. First, the construction of meaningful structured questionnaires amenable to statistical analysis requires that the researcher is familiar with the way in which targeted respondents perceive their world. Hence, it is important to conduct qualitative research in the early phases of a research project. Second, 'qualitative research is often the only means available for gathering sensitive and valid data from an otherwise elusive population'. Therefore, qualitative research is necessary not only for the designing of the questionnaire but also to formulate meaningful research questions, conduct appropriate statistical analyses and interpret the results.

Few would argue with the assertion that drug abuse and the increased frequency of HIV risk behaviours sometimes associated with it, are deeply enmeshed in peoples' daily routines. However, qualitative methodologists assume that they form systematic patterns to the way drug abusers create meaning in their lives, perceive their place within society and behave (Carlson *et al.*, 1995). They also assume that such knowledge may be patterned by gender, ethnicity, class, geographic context, etc. Through qualitative methods, it is possible to gain an understanding of the meanings people attribute to their actions as well as delineate the wider socio-political and ecological context in which drug use and HIV risk behaviours occur (*Ibid*). Researchers explained that such an understanding is crucial not only for designing and evaluating questionnaires but for

designing locally and culturally sensitive intervention and prevention programmes and formulating meaningful research questions (*Ibid*).

This research was motivated by the paucity of studies that explore the subjective experience of female substance abusers, with respect to socio-cultural and situational factors that influence substance abuse and sexual risk-taking behaviours in these women. Specifically, the phenomenological method was used as it allows for a meaning-centred and discovery-orientated approach to the problem. This will enable the researcher to explore the life-world of participants as it is experienced by them.

3.4 METHODOLOGY

Phenomenology was chosen as the methodology for this study, because it enables one to describe the world as it is experienced before any theories are devised to explain it. Phenomenology seeks meanings from appearances and arrives at essences through intuition and reflection on conscious acts of experiences, leading to ideas, concepts, judgements, and understandings.

The core processes included in the phenomenological methodology are bracketing, phenomenological reduction (intuiting), imaginative variation (analyzing), and synthesis of meanings and essences (describing). Bracketing involves refraining from judgment, abstaining or staying away from the everyday or ordinary way of seeing things. In our natural attitude we tend to hold knowledge judgmentally, we presuppose that what we perceive in nature is actually there and remains there as we perceive it. Giorgi describes this process as setting aside one's own presuppositions or knowledge about a particular phenomenon. Intuiting involves the task of describing in textural language what one sees, not only in terms of the external object but also the internal acts of consciousness. The reduction is strictly a methodological move to temporarily strip the world of the multitude of implicit presumptions about its existence as 'real', thereby allowing aspects of the world to occur as pure phenomena for consciousness. The term 'imaginative variation' or 'analyzing' means "to arrive at structural descriptions of an experience, the underlying

and precipitating factors that account for what is being experienced” (Moustakas, 1994), p. 98. Giorgi refers to this process as the delineation of “meaning units” and that by freely changing aspects or parts of a phenomenon or object one is able to see if the phenomenon remains identifiable or not. Characteristics that describe a phenomenon are imagined or condensed thoroughly by the researcher and those elements that clearly describe and are characteristic of the phenomena are considered essential. Describing involves the integration of textural language into a unified statement of the essences of the experience of the phenomenon under investigation. It is describing the central characteristics of the phenomenon by using analogy, negation, and metaphor.

3.5 STUDY PARTICIPANTS

The study population comprised of adult female patients in treatment for substance abuse at the Rehabilitation Treatment Centre situated in Newlands area, Durban. At any one time, the total number of women in treatment at the Centre ranged from between six to eight patients. At the beginning of the study, four participants had been admitted to the treatment centres. As a consequence only one focus group (n = 4) was conducted. Over the next two months six in-depth interviews were conducted. The total sample size: four women participated in the focus group discussion and six in the in-depth interviews, therefore a total sample of n = 10 women participated in the study. Study participants included Black/African, White, Indian and Coloured women who were admitted to the treatment centre for alcohol abuse. Participants' ages ranged from 29 years old to 52 years old.

Because qualitative research stresses depth more than breadth and insight more than generalization, sample sizes are relatively small compared to survey research. The sample size depends on the number of people needed to answer the research question. As Glaser & Strauss (1967 cited in Ulin *et al.*, 2005) described, “When little new information is coming from the observations, interviews or focus group discussions, you can be reasonably confident that you have saturated that source of information to the point of

redundancy”. This was the case with the data collected from the in-depth interviews, thus saturation point was reached.

3.5.1 CRITERIA FOR PARTICIPATION

Four criteria are suggested by Stones (1985) in selecting participants suitable for phenomenological research:

1. They should have had experiences relating to the phenomenon under investigation.
2. They should express a willingness to speak openly to the researcher about the experience.
3. They should be verbally fluent and able to communicate their feelings and thoughts with regard to the research phenomenon.
4. They should be naïve regarding psychological theory to avoid working off implicit assumptions. This facilitates direct access to their feelings and emotions.

The participants of the study fulfilled the above criteria as they were all in treatment for substance abuse, and were willing to participate in the research. They were comfortable to speak about their experiences and did not participate in any previous psychological study, which might have caused them to formulate implicit assumptions about the study. All women who participated in the study had been at Rehabilitation Treatment Centre for a minimum of seven days.

3.6 PHENOMENOLOGICAL RIGOR

Guba (1981) suggests that credibility, dependability, confirmability and transferability be used to support rigor in qualitative research. Although Giorgi’s (1985) phenomenological analysis does not rely on participant review or inter-subjective agreement by expert judges, peer debriefing or returning to participants to validate findings to establish qualitative rigor, some aspects of rigor drawn from Lincoln & Guba’s (1985) work were applied to increase trustworthiness of the interpretation. Streubert and Carpenter (1995) state that rigor or trustworthiness in qualitative research can be achieved through the

researcher's attention to and confirmation of the information discovered. The goal of maintaining rigor is to accurately represent what those who have been studied experience. Credibility involves activities that increase the probability that credible findings will be produced (Lincoln & Guba, 1985). One of the best ways to establish credibility is through prolonged engagement with the subject matter. For this, Giorgi (1985) considers the process of bracketing, phenomenological reduction, and concern for essences as evidence of reliability and validity. Bracketing in this study was achieved through "journaling" throughout data collection and analysis. Notes regarding beliefs, presuppositions, and past experiences with spirituality and recovery from substance abuse, as well as thoughts after interviews, were recorded and discussed with my supervisor. These entries were useful in achieving bracketing and in rendering non-influential this researcher's prior experiences and presuppositions on the phenomenon. Dependability is met through credibility (Streubert & Carpenter, 1995). Confirmability is the way one documents the findings by leaving an audit trail. An audit trail is a recording of activities over time, which can be followed by another individual (Streubert & Carpenter, 1995). The objective is to clearly illustrate the evidence and thought process that led to the conclusions. The use of journals also serves to establish confirmability. In this study, presenting the data from the beginning where naive meaning units were identified, to clustering, and finally to themes and the essential descriptions achieved this end. Transferability is the probability that the findings of the study have meaning to others in similar situations.

3.7 DATA COLLECTION

3.7.1 STRATEGY

This study used the focus group discussion to generate key questions for the in-depth interviews. Due to the small number of women in treatment at the Centre at any one time, only one focus group was conducted. After the focus group discussion, key questions were generated and six in-depth interviews were conducted with the women.

3.7.2 FOCUS GROUP DISCUSSIONS

In order to gain an understanding of the women's interpretation of their substance abuse, the precipitating events leading to their substance use and rehabilitation, a focus group discussion was used to gain insight into these salient issues. The focus group produced qualitative data that provided insights into the attitudes, perceptions, feelings and opinions of the women. By using open-ended questions, it allowed women control of the discussion but also placed the researcher in a position to facilitate the use of observation of women in the group discussion, which was useful for analysis of the data (Kreuger, 1994).

According to Kreuger (1994) a focus group presents a more natural environment than that of an individual interview because participants are influencing and being influenced by others; just as they are in real life, thus providing socially orientated research capturing real life data. One of the unique elements of focus groups is that there is no pressure by the moderator to have the group reach consensus. Rather, attention is placed on understanding the thought processes of participants as they consider the issues under discussion. With regard to the concerns about validity of the focus group, Kreuger (1994) suggests that they have high 'face validity', which is due to the believability of responses from participants to a large extent. People tend to 'reveal' their views in focus groups which may not be available from individual interviews, questionnaires, or other sources of data.

Similar to other information gathering techniques, focus group discussions have their limitations. Firstly, the researcher has less control in the group interview as compared to individual interviews. Kreuger (1994) suggests that focus group discussions allow the participants to influence and interact with each other and, as a result, group members are able to influence the course of the discussion. Second, since group interaction provides a social environment, comments must be interpreted within the context and care must be taken to avoid lifting comments out of context and out of sequence. Researchers need to be fully aware that participants occasionally modify or reverse their position after interacting with others. In addition, participants tend to hold back especially about

sensitive information, for example concerning risky sexual behaviours within a group setting. Therefore, the method requires carefully trained interviewers, using techniques such as pauses, probes, and the ability to know when and how to move to new topics. Finally, the discussions must be conducted in an environment conducive to conversation.

While there exists excellent resources on the use of focus groups for research (Kreuger 1994; Morgan 1993), only a few articles have been published which refer to their use with high-risk behaviour groups involved in alcohol and other drugs (O' Brien, 1993). Well known to drug abuse treatment professionals and researchers is that most individuals involved in drug and alcohol abuse have no difficulty in discussing their drugs, drug use, or lifestyle in a conducive environment. This is especially clear in group discussion where one participant's comments prompt others to provide examples and add depth and detail (Shedlin & Schreiber, 1995).

Focus group sessions have great potential in AOD and HIV/AIDS research. When careful consideration of their methodological and situational appropriateness is made, focus groups can provide data important to the development of research instruments, prevention education materials and public interventions (Shedlin and Schreiber, 1995). Therefore because of the nature of the group format, focus groups are also uniquely effective in obtaining information from hard-to-reach populations who are traditionally hard to interview (*Ibid*).

3.7.3 IN-DEPTH INTERVIEWS

The single most important way that either individual or group interviews can contribute to a project is to build around the other method when devising the interview schedule (Morgan, 1997). For example, preliminary focus groups can provide a useful starting point for individual interviews that involve unfamiliar or sensitive topics, for instance sexual risk-taking behaviours. The basic idea is to use one or two exploratory focus groups to reveal the range of the future informants' thoughts and experiences prior to the first individual interview (*Ibid*).

A final way to combine focus groups with individual interviews is to conduct one as a follow-up to the other. When individual interviews are used as a follow-up, it can help provide depth and detail on topics that were only broadly discussed in focus groups (Morgan, 1997). Hence, my study entailed a focus group session, followed by in-depth interviews in order to explore issues raised in greater detail.

In-depth interviews were conducted with six women, all of whom were in treatment at the Centre for alcohol as their primary substance of abuse. The semi-structured interview was considered appropriate because it provides rich, spontaneous information. The nature of in-depth interviewing assumes that the interviewer and the respondent engage in a dialogue in which both partners are co-equals (Oakley, 1986). Female drug users are not accustomed to being asked about their opinions, their behaviours and the meaning of their actions (Sterk-Elifson, 1995), therefore in-depth interviewing allows them to express themselves.

The semi-structured method was considered most appropriate for this study since the data was systematically collected and provided the opportunity for analyzing both verbal and non-verbal responses. In addition it allows one to probe when participants are uncertain or unwilling to discuss issues, to check honesty of responses, the exact meaning of the participant's reply, as well as to stimulate further discussion.

In general, interviews as a method of data collection set up a structural power relationship which has to be acknowledged by the researcher (Ribbens, 1989). Considering this, the initial explanation of the objectives and motivations of the study assisted in establishing rapport and a comfortable relationship with participants. The interviews provide the opportunity for spontaneous dialogue and expression of opinions and experiences not likely in a quantitative approach.

3.8 DATA ANALYSIS

Within phenomenological methodology there are several schools of thought, and various methods for collecting and analyzing data (Omery, 1983; Spiegelberg, 1982). The types of method are closely associated with the philosophical/theoretical perspectives. For this study, Giorgi's (1985) phenomenological method was used. Selecting Giorgi was based on three factors: Firstly, for its well-defined method which was influenced by the works of Husserl (1913/1931) and Merleau-Ponty (1962), secondly, the ability to use psychological analysis of interpretation in formulating meaning units with greater clarity, and thirdly, the researcher is able to analyze the descriptions with a special sensitivity to the perspective of his or her discipline.

When analyzed from within a disciplinary framework, Giorgi defines the meaning units as the scientific essences. Giorgi makes clear that it is critical to distinguish between the use of philosophical phenomenology, which is universal and foundational, and the use of the empirical phenomenological approach that seeks to disclose and elucidate the phenomena of behaviour as they present themselves. This study followed the core processes of phenomenology and the four steps outlined in Giorgi's (1985) method, which are as follows: (1) The researcher reads the entire description of the learning situation obtained from the participants to acquire a sense of the whole statement; (2) next, once a sense of the whole has been grasped, the researcher rereads the same description more slowly with the specific intent of discriminating "meaning units" from within a psychological perspective and with a focus on the phenomenon of interest; (3) once the "meaning units" have been delineated, the researcher then goes through all of the "meaning units" and expresses the psychological insight contained in them more directly. This is especially true of the meaning units more revelatory of the phenomenon under consideration; (4) finally; the researcher synthesizes the transformed meaning units.

3.9 ETHICAL CONSIDERATIONS

The study was approved by University of Durban-Westville Ethics Committee, Durban, South Africa. Once ethical clearance had been granted, the Superintendent of the Rehabilitation Centre was contacted for approval to conduct the study at the Centre. Two meetings were held with the Superintendent covering issues about the protocol, aim and objectives of the study and benefits and risks of the study. Ethical issues regarding confidentiality, voluntary participation, feedback and anonymity were discussed with the Superintendent prior to approval. After these issues were covered to the satisfaction of the Superintendent, permission was granted to recruit female participants from the Centre.

The researcher explained the purpose of the study, benefits and risks, issue of confidentiality, voluntary participation and the right to withdraw from the study at any time to the potential participants. Women were asked to provide verbal consent prior to data collection. Permission to record the interview was sought and the participants provided verbal consent prior to recording. The transcripts were given unique identifiers in order to protect anonymity of the participants. The tapes and transcripts are stored in a lockable cupboard with access only to the researcher.

Ethical considerations for focus groups and in-depth interviews are the same as for most methods of social research (Homan 1991, cited in Gibbs, 1997). For instance, when selecting and involving participants, researchers must ensure that full information about the purpose and uses of participants contributions is provided (participants were fully informed about the nature of the study). A particular ethical issue to consider will be the handling of sensitive material and confidentiality given that there will always be more than one participant in the focus group (participants were assured concerning the anonymity of their individual responses). Participants were also encouraged to keep confidential what they hear during the sessions with respect to disclosure of information about other participants within the group. Before the interview process the benefits and risks of participating in the study were discussed. Participants were informed that some

questions being asked may be sensitive in nature and this may make them feel uncomfortable but they are not forced to respond.

4 CHAPTER FOUR

RESULTS

In this chapter the results of the study are presented. The results aim to answer the main research question of the study which is to understand the socio-cultural and situational context of substance abuse and sexual risk-taking behaviours (including HIV/AIDS) among women in treatment for substance abuse.

Due to paucity of research in the understanding of South African women's experiences of substance abuse and sexual risk behaviours, the study was designed to explore women's perspectives of becoming and being substance dependent and its impact on sexual risk behaviour.

4.1 PRESENTATION OF THE RESULTS

The results of the focus group discussion and in-depth interviews are presented separately outlining the primary objectives, sample characteristics, with the data being presented in three key categories: reasons for initiating alcohol and drug use, mediating factors reinforcing continued alcohol and drug use, and consequences of alcohol and drug use. For the in-depth interviews, the three key categories are further explored within the intrapersonal, interpersonal and situational/contextual factors which influence substance use and sexual risk behaviours in these women.

At the end of this chapter a summary of the results in terms of substance abuse and sexual risk behaviours is presented.

4.2 FOCUS GROUP DISCUSSION

4.2.1 PRIMARY OBJECTIVE

The primary purpose of the focus group discussion was to determine group norms and behaviours related to substance use and sexual risk behaviour.

The main themes of the focus group discussion were substance use, sexual behaviour and links between substance use and sexual risk behaviour. The focus group discussion lasted approximately one and a half hours. Each group member provided verbal informed consent prior to participation.

4.2.2 SAMPLE CHARACTERISTICS

One focus group discussion was conducted with four women which was the maximum number of women in treatment at the facility at that point in time. Women's ages ranged from 29 to 45 years old. The group consisted of Black/African and White women. There were no Indian women in treatment at that point in time. Their primary substance of abuse was alcohol. All women were living with their current partners. Three women reported previous admission to a treatment facility in the last two years. Two women were currently employed.

4.2.3 RESULTS OF THE FOCUS GROUP DISCUSSION

The focus group gathered data around reasons for alcohol and drug initiation, payment and source of drugs, context of drug-taking, circumstances around drug use, sexual behaviour and women-focused treatment needs. The results of the focus group are categorized and discussed according to: - A) reasons for initiating alcohol and drug use, B) mediating factors reinforcing continued alcohol and drug use and C) consequences of alcohol and drug use.

A. REASONS FOR INITIATING ALCOHOL AND DRUG USE

Facilitator: Are there any particular reasons why women take drugs?

D: A lot of women are feeling insecure in their marriages and everything that's why they turn to substance anyway, it happens.

C: Problems, financial, family and all the other problems...

B: I think I started to drink, I had no problem I think it was the people we joined, just wanted to be a part of their world and the need to be accepted because they seemed so happy.

A: You probably feel that by drinking, it will take all the problems away; you can deaden the unhappy feelings.

Multiple factors accounted for alcohol and drug initiation among women. Women reported seeking and using alcohol and drugs because of their relationship problems with their partners, the need to be accepted by their peers and to alleviate stress related to financial problems. Women reported using alcohol as a coping mechanism with their daily stressors, such as family and relationship problems and also partner violence.

B. MEDIATING FACTORS REINFORCING CONTINUED ALCOHOL AND DRUG USE

Women initially did not consider alcohol to be a drug. Women felt that alcohol and drugs were normalized in the general community. Women felt that the heavy use of alcohol is facilitated by social acceptance of heavy drinking as well as the easy access to alcohol in the community. Women reported that alcohol is easily available to those who have money. Women reported engaging in different activities in order to obtain money for alcohol which included either stealing; borrowing money from loan clubs; prostitution or hanging around friends who had money or alcohol.

Women reported continued use of AOD because it helped them escape their problems. However, over time they needed to use substances more often and at high doses in order for the 'good' feelings to have a long-lasting effect.

Women felt that alcohol use could be related to unsafe sexual behaviour, with some women reporting that it was easier to have sexual intercourse after consuming alcohol. Women felt that drinking with a partner helps to increase rapport and intimacy between couples and eventually facilitates compliance with sexual propositions.

Other reasons for the link between alcohol and sexual behaviour emerged. Women reported that alcohol consumption stimulates sexual arousal and desire, and reduced inhibitions, and this was further enhanced by the socially acceptable drinking environment. Women reported that they observed that after drinking alcohol people become more inclined to engage in sexual acts that they would not ordinarily find appropriate, such as engagement in sex with casual partners, sex in unusual locations and at times and places that they would normally consider to be unacceptable.

Women seemed to be aware of differences between safe sex and unsafe sex but generally did not practice safe sex. Women who were in long-term relationships did not practice safe sex with their husbands and boyfriends because they did not consider themselves at risk even though they were aware that their partners had other sexual female partners.

A. CONSEQUENCES OF ALCOHOL AND DRUG USE

Facilitator: Once women start taking drugs, what do you think are the most serious problems that they face?

B: Money problems, getting into trouble trying to pay the bills

D: Finances to fund my habit

C: Money maybe relationships became violent, can't trust everyone, even people who say they love you, but you must doubt them because they are the ones who hurt you the most.

D: for me, I think gaining trust of my friends who don't drink as well as my children because they never want to see me; they probably just embarrassed to be near me.

A: Financial, just those people who don't need to drink to forget, they seem to make you feel bad for drinking, they don't understand why you drink but all they see is a terrible woman.

Women felt that once they started using alcohol regularly to deal with their problems, over time the problems became worse. Women reported that their continued use created problems in which they had difficulty in gaining trust from friends and family. Furthermore, existing problems were exacerbated by their continued alcohol use such as more money problems, and partner violence became more frequent.

Women reported that they did not object to or in some cases were in favor of their male partners' heavy drinking. However, women reported that such alcohol use usually resulted in violent behaviour among partners. Women appeared to be more accepting of a lack of control in their sexual relationships. Some women reported that male partners were more likely to force them to have sexual intercourse when their partners were under the influence of alcohol than when they were sober. Women felt the need to satisfy their partners sexually, so they were not likely to resist strongly to unwanted requests by their regular or casual partners. Women feared that rejection of their partners would lead to their partners leaving them for another woman.

OUTCOME

The focus group discussion was conducted prior to the in-depth interviews in order to generate key questions also for further exploration of the key issues raised in the focus group discussion. From the focus group discussions, data related to partner violence, societal gender roles and community perceptions of women's alcohol use emerged. These issues were further explored in the in-depth interviews.

4.3 IN-DEPTH INTERVIEWS

4.3.1 PRIMARY OBJECTIVE

To explore and understand the socio-cultural and situational factors that underlies the relationship between substance use and sexual risk behaviours.

Each in-depth interview lasted approximately one to two hours. Each participant provided verbal informed consent prior to participation.

4.3.2. SAMPLE CHARACTERISTICS

Six women were interviewed. Women's ages ranged from 30 to 52 years old. The group consisted of 2 Whites, 2 Indians, 1 Black and 1 Coloured. Their primary substance of abuse was alcohol with occasional tobacco use. Four women were living with their current partners and two women were divorced or separated from their partners. Four women reported previously being admitted to a treatment facility in the last two years. Of the 6 women, one woman was employed.

4.4 RESULTS OF THE IN-DEPTH INTERVIEWS

4.4.1 FACTORS RELATED TO ALCOHOL USE

A. REASONS FOR INITIATING ALCOHOL USE INTRAPERSONAL

At the intrapersonal level, women's accounts of their experiences with alcohol use began because they were unable to handle stress in their daily lives. Women reported feeling worthless and unable to control the events of their daily lives. Alcohol helped them escape from their daily problems, thus, alcohol use became their coping mechanism.

Some women reported feeling alone and abandoned in their lives, therefore, they started consuming alcohol:

Participant C: From the time my mummy gave birth to me, I don't know her, so my hardship started from the time I was born. I was found and placed for adoption; a couple who couldn't have children adopted me.

Participant C: "...So I went to the adoption agency, so from the time I was born, I had a very hard life, and I think alcohol was inherited because when we did the group therapy, there is a 50 percent chance since my mother was using alcohol."

Participant F: I am okay for a while. But when I think about my husband then I feel terrible. I feel why he left me, who this girl is, it worries me a lot.

INTERPERSONAL

At the interpersonal level, women reported problems with their partners to the extent that partners were verbally and physically abusive. Women reported that problems with partners never changed but became unbearable over the years; therefore, they began drinking regularly to forget their problems. Most women reported abusive relationships and felt unable to control their circumstances since they were financially dependent on their partners. Some women reported having nowhere to go whilst other women stated that they 'love' their partners. Women reported that their partners introduced them to alcohol and that as a couple they frequently consumed alcohol together.

The main reason reported for initiating alcohol use was related to relationship problems with their partners. Women felt abandoned, lonely and neglected by their partners, which contributed to women's negative view of themselves and their low self-esteem.

One woman expressed her unhappiness and how her partner's neglect contributed to her alcohol use:

Participant A: "...He doesn't worry about me. It was carrying on and carrying on, you see I don't have any family to even talk to and don't have anybody. That's why my husband took advantage of me. You know there is nobody that I can go to..."

Another woman expressed her feelings of hopelessness and wanted to understand why her partner left her which resulted in her abusing alcohol:

Participant F: "...You see I started drinking heavily, when he left me. He was part of my life, but he just went away, not telling me the problem or anything"

Another woman expressed her difficulty with adjusting to her marriage, husband and in-laws. The problems were overwhelming and she found herself consuming alcohol to cope with these problems:

Participant B: "...Well, that's how it all started as the years went by I never really had an easy good marriage. There were lots of problems, you know you just get married and stay with in-laws and go straight to a new family and then I had bit of a problem marriage, ups and downs, but the real problem started about 6 to 8 months ago, when the stress got too much for me. I couldn't manage, and the only solution I could find was drinking, and if I drank it made me forget about the problems but the problem never really went away. I realise now, that it makes matters worse"

All women reported that they were introduced to alcohol by their partners and that they would generally consume alcohol together.

Participant E: My boyfriend use to take it, you see and I was just taking to get high, and we kept on fighting and all, not getting on, when we use to drink cough mixture, everything was fine.

One woman reported being forced by her partner to consume alcohol because he felt that she was "*frigid in bed*" and that the alcohol use enhanced their sexual relationship. From her account, refusal to have alcohol usually led to violence which appears to be a key feature in the relationship.

Participant D: "When I was married to my first husband, he said that I was very frigid in bed and you know men talk to each other, so I heard about it. What he use to do was, he use to bring wine everyday home. He manages a bottle store, when he came home, he use to bring the wine, use say have some, and take the wine glasses out, I was very afraid of him because he was a very forceful person. I use to tell him you know I don't drink, because I suffer from epilepsy. But he said 'a little won't do anything to you'. If I never use to give him sex, he use to kick me under the blanket..."

SITUATIONAL /CONTEXTUAL

Most women reported that alcohol use was acceptable in their social networks and that they usually consumed alcohol with their partners.

Participant C: "All his friends and their wives were all mixed – Coloured and Indian and White and they all use to drink and I never knew what alcohol was about because I came from an orthodox family until I came to Durban, that's where I even picked up the habit of

smoking. Just 'try it' for a toast, taste the champagne, so that's how I got the taste. So, by socialising eventually it was progressive and I never realised the seriousness and never knew the end result would be being an alcoholic and it could be fatal."

Five of the six women interviewed reported some form of verbal, physical and/or sexual abuse by their partners. Women explained that partner abuse was a usual occurrence and most women felt helpless during these episodes of violence.

Participant D: "At the beginning everything was fine, but he became physically and mentally abusing. He would run me down in front of friends and say you are a stupid idiot, things like that. You know in front of friends, he use to tell me that I don't know what the hell I am saying and I must go and make some coffee."

One woman reported that alcohol and abuse was part of her childhood experiences and from her account it appears that she believed that this behaviour was a normal occurrence.

Participant E: "Well, not really, when I was younger and stuff, you see my mum and dad use to only drink on weekends, then sometimes my dad use to hit my mum but only on weekends, it was fine then."

B. MEDIATING FACTORS REINFORCING CONTINUED ALCOHOL USE

INTRAPERSONAL

At the intrapersonal level, women reported that the alcohol helped them to cope with their daily problems, thus alcohol became their coping mechanism. Women reported that alcohol use elevated their mood and made them feel 'good' about themselves and helped them to temporarily forget about their problems. Women experienced a positive change in their mood after they consumed alcohol, and women reported that they did not feel depressed or stressed. Consequently, they continued drinking to maintain their altered state of mind.

Women reported that after they started using alcohol as a coping mechanism, they found it difficult to stop because they were still experiencing problems with some problems becoming uncontrollable. Thus, women found themselves consuming alcohol more regularly at increased levels to cope.

Women's accounts of their experiences after they consumed alcohol:

Participant B: "I felt calm, happy, not stressed."

Participant C: "I use to be very; very jovial I was never vulgar. I've never laid a finger on any of my children, so I can't be accused of child abuse, but eventually when I felt the drink was coming down, I'll have the next and the next to be happy."

Most women reported initial alcohol use was with their partners. However, over time their relationship problems escalated, and most women revealed that they preferred drinking alone at home.

Participant B: "Nobody knew I was drinking, drink alone, always drink alone. The problems started over and over again."

Participant C: "I was a binge drinking, I can stop when I wanted to stop but I can't promise when I am going to drink again and when this depression is going to set in. I wasn't able to promise my children anything, they didn't know when I was going to start again. I wasn't an every day drinker or habitual drinker, or dependent to have the two drinks before my meal. I could go for 2 or 3 months without drinking but the minute that depression hits me, I would start... but I drank alone at home, just me and my problems."

INTERPERSONAL

At the interpersonal level, women reported that their relationship problems were ongoing but when they consumed alcohol with their partners, the alcohol helped couples to feel closer to each other and their problems appeared non-existent. Women reported that alcohol facilitated intimacy with their partners. Women wanted to use alcohol more frequently since alcohol use made them feel loved and they felt closer to their partners during these episodes.

Interviewer: You use to take it with your boyfriend?

Participant E: "Yes, well he just spoke too much, but we use to talk to each other, listen even. When we use to do it we were very close, never use to argue, nothing, everything was fine. But when you take for long, it doesn't make you feel so good, you don't talk so much, you get quieter."

The following consists of extracts from one woman's account about how her initial relationship problems with her husband resulted in her seeking another partner.

Participant A: It has been carrying on for years. I have been married for 15 years and I don't even have a ring or anything. Then I spoke to my friend, and she said why you don't find a job or something. She told me why you worried about that man, you wasting your time.

Participant A: I started drinking, my husband too pushed me to another man, neglected me, that's why I turned to another man. This man was so caring, and he helps me.

Participant A: "...My husband is an alcoholic, he was drinking anything, as soon as I come home from work, and he was already drunk..."

SITUATIONAL / CONTEXTUAL

Most women reported being financially dependent on their partners which made it difficult for them “to go against his wishes” as one woman very clearly stated. Women also displayed a certain degree of emotional dependence on their partners which rendered it difficult for them to leave their partners.

One woman’s declaration of love for her partner but also her financial dependence on him:

Participant E: “I loved him, and I had no where else to go. I thought about it a million times but you see I have five children, where can I possibly go.”

As mentioned earlier, partner abuse was central to these women’s lives however they did report an increase in the severity of the abuse when the frequency of alcohol use increased.

Women’s experiences when their partners would physically, emotionally or verbally abuse them:

Participant C: “When I use to confront him, he would assault me. Its either I’m getting a blue eye or a slap or something and the abusive language you know, and he threaten me that he is going to take the children away and give someone to look after them. I didn’t question him about it until the summons came to me, it was a shock.”

Participant E: No, never. I just took it because, you know it’s there one day and next day you forget about things like that. So I use to drink, forget it all. But the feeling doesn’t last very long so I had to take more and more.

Four of the six women reported being previously admitted to a treatment facility.

One woman had been sober for 11yrs and she had relapsed because her ex-husband was remarrying.

Participant C: "So when I finally got divorced, I knew what wine did to me, it makes me feel a bit you know, happy, jovial so in order for me to feel happy, I started to drink the wine. While the divorce was being finalised I moved on to whisky, something stronger because it use to give me temporary relief, help me to forget. I couldn't come to terms with the loss; the whole divorce was still a shock. The fear of being without him, fear of being on my own, living with two children, what am I going to do, nothing occurred to me that I got a profession, I can work, which is what I did when I got out of treatment the first time. I been sober for 11 years, just for him to remarry and remarry, every time he was remarrying the pain you know, the emotional pain because he was the one and only man in my life"

Some women who had relapsed felt that they may have not been committed or may have not possessed the necessary requirements to overcome their circumstances. For this woman, there was no place for her to go to and she ended up on the streets again which led to her continued alcohol use after treatment:

Participant E: "You see, when I got out the first time, didn't have really anywhere to go. I had to fetch my kids from school. I didn't know where to take them, so you know the four season's hotel, we sat outside there. Some of the guys were there, drinking so we sat there, we stayed over the night, so maybe that was one of reasons why, but I'm not blaming that but maybe...."

Women reported maternal responsibility as a stress factor since partners were either away from home on a regular basis or partners refused to assist with child-rearing.

Women were expected to take care of the children, maintain the household and maintain the stability within the family. This became too stressful for women because of their multiple roles with minimal assistance from their partners.

Participant D: "Well it started with my husband forcing me but as time went on I acquired a taste for it. In my life I have moved around a lot because of my husband's jobs or not having a proper place to stay. With my first husband, he worked in lots of different places, so eventually we stopped moving around with him but we only saw him on weekends. I had to take care of the children, do their homework, wash, clean and sometimes it all got too much to handle."

C. CONSEQUENCES OF ALCOHOL USE

INTRAPERSONAL

At the intrapersonal level, the basic psychosocial problem faced by these women in becoming alcohol dependent is alienation from self and others. Alienation from self and others refers to the silent, all-consuming, continuous and escalating meaninglessness of their existence. The women's experiences of alienation were reflected in their descriptions of painful feelings in conjunction with living their everyday lives.

Alienation from self was reflected in women's descriptions of painful feelings that seemed to go to the "*core of their being*", "*feelings of being seen as flawed and having no purpose in life*". Alienation from self also meant denying one's feelings and accepting the perceptions of others, especially partners. Women described feelings of despair, hopelessness and self-loathing. One woman captured the essence of alienation from self: "*I didn't know what my purpose in life was...I didn't know why I was born. I didn't know why I was living.*"

Feelings of being unloved became feelings of being unlovable as these women blamed themselves for their partners' inability to love and care for them. The women believed that there was something inherently wrong with them that prevented others from loving them. One woman reflected her negative feelings towards herself with the following comment: "*I felt like I was a mistake*".

Another woman described her alienation from self with agony and despair:

Participant C: "Because it [alcohol] defined me, it helped me find myself, who I was. You know I could be tough and stand on my own and take care of myself. But inside I was really just a nothing, a nobody and to see the pain in other people's eyes. The pain makes me ask myself who am I..."

Alienation from others was reflected in women's descriptions of intensely painful feelings that were associated with being disconnected from significant others. Women

expressed their feelings of alienation as they discussed being lonely, depressed, hurt, angry, ashamed, guilty, unloved and neglected by their partners.

INTERPERSONAL

When women were asked about the consequences of their alcohol use, they mentioned that their relationship with their children and family [parents, siblings] were non-existent because of their alcohol use.

Participant D: "Not so good, I can't blame them, because I was doing the wrong thing. My son sees me and takes care of me from time to time. My daughter got married and moved, but I think she is still angry with me because I wasn't around for her. I don't even see my grandchildren. I got four, all ages I don't even know their ages. It hurts but what can I do."

Participant D: "Like I said, problems with my children really hurt me. They don't trust me anymore. This makes me feel terrible. It got so bad that they weren't talking to me. I didn't even know where they were, they just disappeared."

Participant F: "Sometimes good and sometimes bad, well good when I was with my friends because we use to drink, laugh, cook and eat. But when I came home, I can say that make me feel bad, once I got drunk and everyone, my mother was making so much of noise."

One woman explained that her continued use of alcohol led to her being physically abused by her husband:

Participant B: "Sometimes when my husband would come home, I use to be sleeping because I was drunk. He uses to get mad, we use to end up arguing, having a fight, he use to end up hitting me. It carried on for quite some time like that. I kept on denying it that I had an alcohol problem, I should tell people I was on medication and I had tablets and all. I use to have medication, I was not using it."

SITUATIONAL / CONTEXTUAL

Women reported being admitted to the treatment facility either through the court or a family member.

One woman lost custody of her baby and was admitted to a treatment facility.

Participant A: "Drinking, all the problems, and then the court took the baby away so I had to tell the judge everything. I am not going to shield him because he made me like this"

One theme that arose throughout the interviews was the community's perception of women who consume alcohol. However, for this, there was a contrast between the women's opinions which could be linked to difference in socio-cultural and social norms within their communities. Women who abuse alcohol tends to be viewed negatively by the general community and this is captured in one woman's account of her experience:

Participant B: "Yes, being Indian, you know you are not supposed to smoke or drink unlike the other races where it is acceptable. Times are changing doesn't mean we have to change, but you show me one person who doesn't drink or smoke, who hasn't tried it. What I learnt is that alcohol only helps for a while, it causes more stress by drinking and it doesn't really solve anything"

Participant B: "Other people must mind their own business, they act as if they don't have problems, and they probably have worse problems. You know society is always unfair, they always want to know what you doing, if you do anything they just want to put you down, because they feel they are perfect"

Participant B: "...Because I come from an Indian community, it's not acceptable for an Indian woman to drink or smoke and if you do something like that it is totally unacceptable"

One woman reported trading sex for money and the reason reported was that she was homeless and was staying with her relative who had introduced her to sex work.

Interviewer: Did you ever take drugs or ask for drugs in exchange for money sex or a place to stay?

Participant E: Yes that I did about four times. I didn't like it much.

Interviewer: Could you describe the situation to me?

Participant E: One night my aunt told me come on, we going to make some money, at that time I didn't really know what she meant, at that time I was staying with her, so I had to go. We use to be at this hotel and men use to come to us for sex.

4.4.2. FACTORS RELATED TO SEXUAL RISK BEHAVIOUR

INTRAPERSONAL

Women reported feeling neglected, lonely and abandoned which made them feel unloved by their partners, thereby having a negative impact on how they viewed themselves. Women displayed certain characteristics that could classify them as having a low self esteem or self-worth. However, women's view of themselves was a mirror image of their partner's view of them which contributed to their poor self worth.

Most women had a low HIV risk perception even though they were aware that their partners had other sexual partners. Women reported never using condoms with their partners however one woman reported condom use with casual partners.

Interviewer: Have you ever had a HIV test?

Participant E: No.

Interviewer: How likely are you to contract HIV in the future?

Participant E: Unlikely.

Interviewer: Why?

Participant E: Cos, now I am going to be more careful, oh gosh well now I'll know not to do anything stupid.

INTERPERSONAL

Violence seemed to be a strong feature in most of these women's relationships. This included violence in both current and previous relationships. Women appeared to remain in unsatisfactory relationships for financial support. Due to women's financial

dependency on their partners for survival, women found it difficult to negotiate condom use with their partners. Furthermore, some women reported that condom use was not discussed with partners as they were in long-term stable relationships. Women appeared to have basic HIV/STI, condom use and safe sex practices knowledge; however, most women reported that engaging in safer sex practices required their partner's co-operation which was usually difficult to attain.

One woman's experience of the relationship between alcohol use, unsafe sex and condom use:

Participant E: "Well my boyfriend you know, we use have stuff together. So sometimes we use to carry on for a while, things happened and we forgot to use [condom]. But we very seldom use to, use protection. But yes, it's happened a few times, sometimes you can't even remember stuff..."

SITUATIONAL/CONTEXTUAL

Women's financial dependence on their partners' acts as a barrier for condom negotiation, also, some women reported that partners refuse condom use.

Women's main reason for not using condoms was fear of their partner's reaction if they initiated condom use. Women felt that by asking their partners to use condoms, it would be perceived as a lack of trust and love in their relationship. In explaining why they did not use condoms with their partners, women clarified that they "*did not dare*" or were "*not allowed*" by their partners. Most women were receptive to using condoms if their partner initiated it: "*If he wanted to use condoms, it would be good for me*".

For most women, forced sex with their partners became acceptable over time and most women reported being unable to negotiate condom use in this context.

Interviewer: Do you and your partner use condoms when you engaged in sex?

Participant E: No, never.

Interviewer: Did you want too?

Participant E: Yes, but you see he didn't believe in it.

Interviewer: Did you ask him to?

Participant E: Yes, he uses to say he didn't like it, he wasn't comfortable using it.

Interviewer: Where you ever forced to have sex under the influence?

Participant E: Yes, lots of times.

Interviewer: How did this make you feel?

Participant E: Well, I didn't like it so much, it was stupid but everybody was doing that sort of thing. My boyfriend was quite forceful, push himself onto me and stuff.

Interviewer: So you saying, he would physically force you?

Participant E: Yes, sometimes.

Interviewer: Did you talk to him about it?

Participant E: He knew I didn't want it, oh yes, because I use to try to get him off but I couldn't, he was much stronger than me

4.5 SUMMARY OF RESULTS

In order to understand the relationship between substance use and sexual risk behaviour, I needed to understand them individually and thereafter examine how these behaviours overlap in these women's lives. In order to understand this, I looked at sexual behaviour norms, values and sexual practices i.e. condom use; substance use norms, values and practices and the setting in which substance use and sexual behaviour occurs within sexual relationships.

From the data, substance abuse emerged from women's lack of coping mechanisms to deal with poor relationships and lack of employment which led to financial dependence on their partners. Social acceptance of alcohol in the general community facilitated alcohol use as well as partner's alcohol use. For most women, alcohol became a coping mechanism which helped them escape their problems.

From the data, sexual risk behaviour was related to substance abuse in this sample of women. However, substance abuse was not directly related to sexual risk behaviour at a particular time point. Women reported that, within some settings, alcohol can be related to sexual risk behaviour because alcohol tends to lead to unsafe sex however women tend

to drink in social networks with their partners. Women reported that alcohol facilitates intimacy and rapport between couples. Women reported that knowledge of safe and unsafe sex is known. However, implementation is difficult because condom use requires her partner's co-operation. Most women reported not using condoms consistently with their partner; however, non-condom use can be linked to partner's refusal to use condoms. Women were financially and emotionally dependent on their partners, social norms which defined women's role in society and sexual relationships governed their women's behaviour. Partner violence was a common feature in all the women's lives which impacted on a woman's ability to negotiate condom use.

It can be noted that there is a strong association between substance abuse and sexual risk behaviours from the data. However, the nature of the association appears to be complex, in that histories of substance abuse increase the risk for sexual risk behaviours, also, sexual risk behaviours increase the risk for substance abuse. From the data, it can be highlighted that intrapersonal, interpersonal and situational / contextual factors play a significant role in the association between the two conditions being explored.

In this sample of women, the socio-cultural factors that facilitated the relationship between the two conditions was social acceptance of alcohol use especially linked to initiation of alcohol use by partners and the sexual norms within the community linked to gender inequality, the acceptance of multiple partnering, and the lack of consistent condom use within long-term relationships. The situational factors included lack of employment which led to financial dependence on their partners, maternal responsibility with no assistance from their partners and severity and frequency of partner violence. For these women, no one factor can be viewed in isolation to their substance abuse and sexual risk behaviours, however, the type of partner relationships is the common thread in these two conditions.

5 CHAPTER FIVE

DISCUSSION

A growing body of work focuses on the intersection of substance use and sexual behaviour as they affect the risk of HIV infection. Research has shown that alcohol and drug use are strongly related to high-risk behaviours such as inconsistent condom use and having multiple partners (Chesney *et al.*, 1998).

The data from the present study suggests that among substance abusing women, the association between alcohol use and sexual risk behaviours may not be straightforward. However, the study findings indicate that factors that influence substance use/abuse may directly or indirectly impact on sexual risk behaviours.

Previous research indicates that women are more likely to initiate substance use as a result of traumatic life events such as physical or sexual violence, sudden physical illness, an accident or disruption in family life (Grella, 1997; Institute of Medicine, 1990; Nelson-Zlupko *et al.*, 1995). The results of the study are consistent with these findings as all women reported violence in their lives in conjunction with disruption in their nuclear family.

Furthermore, the results support previous research that demonstrated that women substance abusers are often drawn into substance use by their partners (el-Guebaly, 1995).

Along with the increasing concern about the potential for HIV spread among drug using populations, there also exists a growing awareness in sub-Saharan Africa of the relationship between alcohol use (particularly misuse and abuse of alcohol) and HIV risk (Campbell, 2003). Sexual risk-taking behaviours associated with alcohol use are highly prevalent in many African countries severely affected by HIV/AIDS (Fritz *et al.*, 2002; Simbayi *et al.*, 2004). Women in the study were aware of HIV risk factors, however, their

HIV risk perception was low. However, their accounts of their lives reflected factors which contribute to HIV risk such as multiple partnering, sex work and lack of condom use.

Condom use was determined by their partners and most often partners refused condom use. Most women reported that their partners have other sexual partners, and women appeared to be accepting of this circumstance since they considered themselves as their partner's primary sexual partner. This acceptance of multiple partnering places women at increased risk for experiencing violence and possibly contracting STIs and HIV.

Numerous cross-sectional studies conducted among adults in this region have shown consistently that alcohol use is associated with HIV infection (Campbell, Williams & Giglen, 2002; Fritz *et al.*, 2002), as well as with sexual risk behaviours, such as having multiple sexual partners (Trigg *et al.*, 1997). In addition, some studies have demonstrated that alcohol consumption is related to higher levels of unprotected sex (Fritz *et al.*, 2002), although other studies failed to demonstrate the presence of such a clear relationship (Mataure *et al.*, 2002). Condom use among women in the study was inconsistent which was linked to partner's refusal to use condoms as the main reason for not using condoms which increased women's HIV risk. This however does show a direct link between substance use and unprotected use but there is an association between the two conditions. Women reported lack of condom use in their lives and not specifically to episodes of alcohol consumption however this sample of women were abusing alcohol on a daily basis and sexual activity occurred within this context, therefore, a causal link could be interpreted from the data, provided other factors are considered.

Focus group discussions and in-depth interviews were used to explore the life circumstances and experiences of substance abusing women in treatment. Findings from the focus group discussion and the in-depth interviews reinforce the perception of an intersection between substance abuse and sexual risk-taking behaviours. Partner violence was identified as a key contributing factor for substance use and sexual risk-taking among women in the study. However, the information gathered provided us with a better

understanding of some of the socio-cultural and situational factors substance-abusing women may experience. Most women reported that they used alcohol as a coping mechanism to help cope with daily stress. Women were aware that their steady partners had multiple sexual partners and that they were dependent on men to use protection during sex and were sometimes susceptible to violence, especially forced sex when they were intoxicated. The study ascertained that the circumstances of alcohol and drug initiation, and AOD risk behaviours at initiation for women are deeply rooted in social relationships. However, social persuasion, whether stemming from a sexual relationship or other peer influence, may have increased women's likelihood of AOD risk-taking behaviours.

In the previous chapter, results from the study were discussed. In this chapter, common factors contributing to substance abuse and sexual risk behaviour among participants are discussed. It is beyond the scope of this study to discuss all the factors contributing to substance abuse and sexual risk behaviour of women extensively. The researcher will attempt to discuss only those that emerged from the present study and compare the factors to findings of other studies. These factors are discussed below.

Kandall (1996), in his historical analysis of women and addiction noted, "we must acknowledge that women use drugs in large part in response to the stresses they face in their lives – minority status, reduced economic, social and political expectations, disproportionate experience of physical and sexual abuse." The findings of the study are aligned to the concepts in the above study with women's alcohol use in response to daily stress in their lives and a lack of coping strategies to deal with these stressors.

Research by Incardi *et al.*, (1993) supports the role that gender asymmetry and related stress play in women's substance abuse behaviours; research indicates that women substance abusers have fewer social supports and far greater family responsibilities than non-addicted women or addicted men. Furthermore, women are much less likely to use drugs for pleasure and more likely to use drugs as a coping mechanism for dealing with childhood life events, situational factors and depression (Hser *et al.*, 1987; Incardi *et al.*,

1993). Women in the study indicated that they used alcohol as a coping mechanism because of prolonged abuse and feeling neglected by their partners.

Family circumstances, stigma, community environment, social status, and the nature of their primary relationships all affect the treatment of substance use in women. Several studies suggest that women drug users are more socially isolated, depressed and dependent upon partners than male counterparts (Sanders-Phillips, 2002). Women who have experienced violence, whether sexual or physical, are more likely to use alcohol, as well as marijuana or crack cocaine (Fullilove *et al.*, 1992; Miller *et al.*, 2000). These women, often due to imbalances concerning power in their relationships, as well as a past history of abuse, are less likely to insist on condom use, placing themselves at risk for HIV and other sexually transmitted infections (Fenaughty, 2003; Amaro, 2000). Prior research on characteristics of women who abuse alcohol which places them at increased risk for unsafe sex can be identified within the sample; therefore this study supports local and international research on characteristics of women substance abusers.

Women have reported that they use substances to numb emotional pain from issues such as abuse, sex work, grief over the death of loved one or guilt over injury to loved ones, especially children (Poole & Isaac, 2001; van der Walde *et al.*, 2002). Some women reported that their maternal responsibility contributed to their substance use since partners were not involved or responsible for the well-being of their children. Women's role as a mother and gender roles in society was reflected in their accounts of their reasons for substance use which directly impacted on their initiation and continued use of alcohol.

Relational issues are intricately connected with the onset and progression of substance use problems in women (Poole & Isaac, 2001, Zelvin, 1999). Most women reported relationship problems with their partners which resulted in women abusing alcohol on a regular basis.

Patterns of substance abuse among women are influenced by their partners or spouses and their children's functioning and well-being (Zilberman *et al.*, 2002). Women's problems were reflective of the problems within their nuclear family thus women's lives were a mirror image of their partners and their children's lives. Women are more likely than men to use drugs when they are alone or to be in a relationship with a partner who is a regular substance user (Woolis, 1998; van der Walde *et al.*, 2002). This was reflective of the sample in the study. Experiences of neglect, violence and abuse among women contribute to their likelihood of developing problems with alcohol use (Jarvis, Copeland & Walton, 1998). Violence in these women's relationships was the main contributing factor to continued use of alcohol.

Women have indicated that they used substances to cope with feelings of depression, devaluation and low self-esteem and to numb emotional pain from abusive encounters (Yahne *et al.*, 2002). The findings of the study show that over time women's self esteem levels decreased and this was influenced by their partner's and society's view of the women and their acceptable or unacceptable alcohol use.

For many women financial, material or socially determined dependence on men implies that they cannot control when, with whom and in what circumstances they have sex. Nor can they make demands on men to minimise risky behaviour.

Unfortunately, some women who are at risk are dependent upon their male partners for economic security (Kane, 1991). In this study, some women feared that they would lose their desired partners if they insist on condom use, since this may be interpreted as an indication that women have been unfaithful to their partners.

The sub-ordinate position of women stems from our socialization which is influenced by cultural norms, religious beliefs and traditional morals, and this provides a rigid frame for the role of men and women in intimate relationships and in the broader society. All three organizing sets of principles across cultural groups emphasize the dominance of men over women. Gender norms that create unequal balance of power between men and women are

enforced by social institutions such as schools, workplaces and families. The acceptability of multiple partnering by the general community whereby women are expected to be faithful whilst men are expected and encouraged to have multiple sexual relationships. This double standard has resulted in the HIV infection rate of women, although aware of their partner's infidelity, being restrained by a number of factors, such as economic dependence to negotiate safer sex practices. Women in the study experienced similar circumstances whereby socio-cultural norms around sexual relationships and gender inequality were deeply rooted in their abuse of alcohol and engagement in sexual risk behaviours.

Gender based violence is one of the factors that predispose women to HIV infection.

Kistner (2003) argues that although the link between gender-based violence and HIV/AIDS has not been well-articulated, however, the link is strong. Violence is a key factor which increases women's risk of contracting HIV. Studies suggest that the first sexual experience of a girl will often be forced (Garcia, 2003). Women are two to four times more likely to contract HIV during unprotected vaginal intercourse than men (UNAIDS, 2001) since sexual physiology places them at higher risk of injury (especially in the case of young women) and because they are more likely to experience violent or coerced sexual intercourse (*Ibid*). Reporting of violence in this study was extremely high, with 8 out of 10 women reported experiencing physical, sexual or verbal abuse on a regular basis with their partners being the primary abuser.

There are physical, behavioural and social effects on the link between gender-based violence and HIV. Violence is associated with high numbers of sex partners, unprotected sexual intercourse, earlier sexual debut, and excessive drug and alcohol use. Gender-based violence is consistently linked with heavy drinking patterns and women who experience sexual or physical violence are at increased risk. One study found that women who were physically or sexually abused were 50% more likely to be HIV positive than women who had not been abused (Dunkle *et al.*, 2004). A key explanation for the link was that women's ability to successfully negotiate condom use becomes compromised when women are in relationships involving violence. These findings can be confirmed

within the present study because of high levels of violence and low levels of reported condom use.

Maman *et al.*, (2000) examined 29 studies from the United States of America and sub Saharan Africa to study links between HIV and gender-based violence. Two of these studies (Wood *et al.*, 1998; Abdool Karim *et al.*, 1995) were conducted in South Africa, although the samples were small. They argue that there are four mechanisms linking HIV and violence. Firstly, violence can increase the risk of HIV infection where a woman is forced to have sexual intercourse. Secondly, violence may mean that a woman is less able to negotiate the use of preventive measures such as a condom. Thirdly, links have been found between physical and sexual abuse during childhood and high levels of risk-taking behaviours in adolescence and adulthood. Lastly, women who are infected and disclose their HIV status may be at increased risk of violence. Violence is thus a determinant and potential consequence of HIV infection. Due to the high levels of violence reported in the study, it can be postulated that substance abusing women may be at increased HIV risk because of their exposure to substance use and violence.

Women were significantly more likely to report multiple sexual partners and significantly less likely to report consistent condom use if they had high levels of depression or low levels of social support (Mazzaferro *et al.*, 2006). Women in the study reported 'being intimate with a partner' involved agreeing not to using condoms which as a result increased women's risk to HIV infection.

Alcohol consumption has been identified as an important determinant of HIV risk in South Africa. This occurs because much of the sex work occurs in "shebeens" since alcohol consumption is likely to lead to inconsistent condom usage and other unsafe sex behaviours (Williams *et al.*, 2000). The results of the study demonstrate that alcohol use does lead to inconsistent condom use.

The role of psychological factors as determinants of HIV risk should not be ignored. Studies show that individuals with low levels of self-esteem and self-efficacy tend to be more likely to engage in unsafe sex (Eaton & Flisher, 2001). Our data suggest that low self-esteem is associated with alcohol use; however, assessment of self-esteem was not rigorous across the sample. However, future research could include questions to assess self-esteem levels.

Another possibility is that experiencing sexual abuse early in life has a negative effect on sexual development or overall interpersonal functioning, increasing the likelihood that women will engage in sexual risk behaviours or become involved with risky and violent partners. For example, women who have experienced sexual abuse may rely on sex as a way of coping with distress or use sex in an attempt to gain intimacy (Cinq-Mars, Wright, Cyr, & McDuff, 2003; Luster & Small, 1997). Women who have been sexually abused also may not be able to be assertive in sexual situations, such as insisting that their partners use a condom (Cinq-Mars et al., 2003; Luster & Small, 1997). In this study, sexual abuse was identified as a barrier for women to negotiate condom use with their partners.

A recent study found that women who had a history of sexual abuse during childhood were more likely to become involved with a risky partner, which was defined as a partner with a history of multiple partners or who has been unfaithful (Testa *et al.*, 2005). This was consistent with the circumstances of one participant.

While no causal links exists between alcohol and HIV/AIDS, there is a clear association between the abuse of alcohol, especially when associated with intoxication, and engagement in risky sexual behaviours which substantially increases the risk of STIs including HIV/AIDS. Strunin (1999) suggests that the influence of alcohol on unsafe behaviour may not be generalizable, but rather is limited to specific populations and may not apply only to specific types of risk situations.

This study extends previous research conducted in Africa that has linked alcohol use and sexual risk behaviour (Mnyika *et al.*, 1997; Trigg *et al.*, 1997). This research complements qualitative studies conducted in Zimbabwe (Fritz *et al.*, 2002; Mataure *et al.*, 2002) and helps to further understand the relationships between substance use and sexual risk behaviours in which individuals who have consumed alcohol are more likely to engage in unprotected sex.

A pilot study was conducted in Cape Town with a sample of Coloured and Black/African women, to develop an understanding of the intersections of substance abuse, sexual behaviour and violence. The study found that both groups of women reported using cannabis, methaqualone and alcohol, although they differed on other drugs (Sawyer, Wechsberg & Myers, 2006). They also found that, for participants in both groups, relationships with men affected sexual and substance use risk behaviours, with both groups reporting high rates of violence. Our study findings are consistent with the above study as high rates of violence were reported by most women and male partners influenced women substance use and sexual risk behaviours.

In South Africa women's vulnerability for contracting HIV is characterized by sexual and physical violence (Wood, Maforah & Jewkes, 1998), disempowerment due to economic dependence on men, cultural norms which hinder condom use (Ackermann & de Klerk, 2002), and alcohol and drug use (Wechsberg, Luseno & Lam, 2005). In this study, women's everyday lives were characterised by these factors, therefore, women who abuse substances are more likely to be at risk of HIV infection through risky sexual behaviour. Previous research in this field has found that women who abuse substances are more likely to engage in risky sexual behaviour (Dunkle *et al.*, 2004a; Wechsberg, Luseno & Lam, 2005) and be exposed to intimate partner violence (Jewkes, Levin & Penn-Kekana, 2002).

The findings of the study indicate that women who abuse alcohol and other drugs are at risk of HIV infection through various socio-cultural and situational factors. Socio-cultural factors include gender roles of women within society which includes women's economic

dependence on men, their submissive behaviours within sexual relationships, which is regarded as acceptable behaviour, in combination with the situational factors of partner violence, trading sex for money and being homeless directly impacts on their risk and exposure to HIV. It is, therefore, important that HIV interventions be multi-faceted for women substance users and it should include increasing their HIV/AIDS knowledge which would help them reduce sexual risk behaviours, provide them with some coping skills to protect themselves from violence, increase their skills in condom negotiation and to empower women to recognize their self-worth and build their self-esteem.

6 CHAPTER SIX

RECOMMENDATIONS AND CONCLUSION

6.1 INTRODUCTION

This chapter will evaluate the present study in terms of strengths and limitations as well as provide recommendations for future research.

6.2 EVALUATION OF THE PRESENT STUDY

The aim of the study was to provide women with the opportunity to voice their experiences of becoming and being alcohol dependent and its association to sexual risk behaviours. Each participant's unique social context and personal history was explored. It has been noted from the available literature on substance abuse among women in South Africa, that there is little research conducted with women as a unique group with their personal narratives as a method of inquiry.

It is believed that the research aim was achieved, as the participants provided their stories and explained their subjective views on their substance abusing behaviours. Each participant provided their life story, which allowed the researcher to gain an understanding of the participant's social context and personal history, and how this influenced the meaning derived from each participant's experience. Understanding how each participant was influenced by their interactions with others, and the events occurring in their life, allowed the researcher to appreciate the value and importance of context in shaping the participant's way of experiencing their world.

6.3 LIMITATIONS OF THE STUDY

According to Plummer (cited in Mouton, 2001), the main limitations of qualitative studies relate to a lack of generalizability, 'questionable' reliability and validity, and selection bias. However, while Plummer's limitations are considered crucial in terms of quantitative studies, qualitative studies such as the present one have different aims and

utilize different methodologies. These 'limitations', therefore, are not regarded as central to the qualitative research process, since its aim is not objective measurement and subsequent generalisation of results to a larger population. In line with the phenomenological perspective, which proposes that reality is multi-faceted and comprises multiple selves, multiple meanings and multiple contexts (Dickenson & Zimmerman, 1996), this study offered an interpretation of how women perceive their substance use, in order to shed light on their experiences. The credibility, dependability, conformability and transferability were, nevertheless, achieved and were discussed in Chapter Three within phenomenological rigour. Finally, in terms of bias, as the researcher, my presence was made explicit from the beginning of the study. In the qualitative research process, the self of the researcher is regarded as the 'main instrument' (Babbie & Mouton, 2001) and meaning is co-constructed through interaction with the research participants. Another limitation that should be noted is that the results represent self-reported data, and therefore it is possible that social desirability may have influenced participants' responses.

Although I gathered rich data that gave me insight into the socio-cultural dynamics of the groups, the study had certain limitations. The accepted minimum number of focus groups is two (Kreuger, 1994), and I recognize that a larger sample of focus groups would have enriched the understanding of the life experiences of these women. Although participants were a convenience sample and met the eligibility criteria, I recognize that the sample may not be completely representative of the population of all community women who use alcohol and drugs. Also, because this was not a quantitative study and random sampling was not used, the sample may not have been representative of the population of substance-abusing women in these communities. Therefore, I do not know if these patterns of drug use apply to other substance-abusing women in the communities or if these patterns can be generalized to substance-using women in similar communities.

6.4. RECOMMENDATION FOR FURTHER RESEARCH

The findings of the study indicate that HIV interventions for women in communities need to be multi-faceted and encompass ways for women:

- (a) Empower women to protect themselves from gender-based violence,
- (b) to increase skills in condom negotiation and HIV/AIDS knowledge to reduce sexual risk behaviours,
- (c) to control substance abuse and eventually stop abusing substances,
- (d) to increase self awareness by providing women with information on self worth and strategies to increase mental wellness in women, and
- (e) to understand risk behaviours within their sexual relationships.

Future research studies need to explore the socio-cultural factors that affect women's risk, which could focus on their understanding of use of different drugs and the context within the different racial groups. A deeper understanding about the drug culture within the groups could provide further insight into prevention and intervention strategies which would be beneficial to all groups of women.

Furthermore, research needs to explore the influence of socio-cultural factors, life experiences and circumstances for substance-abusing women with substance abusing partners as they relate to violence and sexual risk behaviours. The study indicated that women's self-esteem and self worth were contributing factors to their substance use and abuse, thus this should be explored in order to provide how socio-cultural factors shape their substance use and sexual risk behaviours. Women's HIV susceptibility is linked to their mental health and how mental health affects their substance use and sexual risk behaviours. This needs further investigation especially the onset of mental health problems before and after onset of substance use.

The current results present important implications for future research. It is apparent that longitudinal studies are necessary to develop a clearer understanding of the complex relationships between abusive experiences and adult sexual risk behaviours, given that thus far only one such investigation has been conducted, and this study focused on high

risk women only (Zierler et al., 1991). It is also important that future work examines how multiple forms of abuse including physical, sexual, and emotional abuse occurring at different developmental stages affect sexual risk behaviours. In addition, future work should examine potential mediators of these relationships including social support, sexual schemas, relationship factors and psychopathology. Finally, there is a clear need for the development, assessment and refinement of interventions targeting women who engage in chronic sexual risk behaviors that take into account both contextual and historical influences on these behaviours. To conclude, results suggest that the relationships among abuse experiences and sexual risk behaviours are complex. The current study found that sexual risk behaviours among adult women were most closely associated with experiences of physical abuse by romantic partners. In contrast, intra-familial physical and sexual abuses were not associated with sexual risk behaviour, with the exception of an association between intra-familial sexual abuse and having had multiple sexual partners. Finally, while binge drinking is associated with sexual risk behavior, it does not mediate the relationship between abuse and sexual risk behavior.

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8 APPENDICES

8.1 APPENDIX 1: FOCUS GROUP DISCUSSION GUIDE

TITLE OF RESEARCH:

A qualitative understanding of the socio-cultural and situational context of substance abuse and sexual risk-taking behaviours in women

FOCUS GROUP DISCUSSION GUIDE

My name is Jessica Phillip, you can call me Jessi.

I am studying for my Masters in Public Health.

One of the requirements of the degree is that I have to undertake a meaningful piece of research.

Very little is known about the context and experience of women who take drugs and various substances. This research is meant to help me understand your context and experiences because it is also likely to be helpful to others like yourself who may seek help from treatment centers.

I will help guide the discussion, but you are free to talk about anything that you feel is relevant. There are no right or wrong answers but rather differing points of view. Please feel free to share your point of view, even if it differs from what others have mentioned. I will be tape recording the sessions because I need to go back and listen carefully to what you all have said. The tapes and all the information you provide is confidential. You are free to withdraw from participating at any point you wish. I hope, however, that by helping me I am able to also help you in talking about the issues related to substance use.

Time frame: one & half to two hours.

Informed consent process

Facilitator needs to introduce the study and verbally consent each participant individually prior to data collection. Facilitator to consent participants and ensure participants understand their rights as participants.

Introductory Question:

Facilitator to ask participants to introduce themselves and probably how long they have been at the centre and how they have come to be at the centre.

QUESTIONS

1. How do you think women usually start using drugs?
2. What sort of drugs do women start taking?
3. Do they continue taking these drugs, or do they move to other drugs?
4. What effects do women look for in taking these drugs?
5. Are there any particular reasons why women take drugs?
6. How do the women pay for the drugs they use?
7. Do you think that drugs are easily accessible?
8. From whom do they obtain drugs?
9. Where do women usually take the drugs and with whom?
10. When you take drugs, do you always feel safe or have there been instances when you felt unsafe?
11. Have women been attacked while under the influence of drugs?
12. Who do you think is most likely to attack these women?
13. Once women start taking drugs, what do you think are the most serious problems that they face?
14. Are you aware of other women who take drugs, but who are not in treatment? Can you tell me about these women?
15. Do women have special needs and circumstances that need to be taken account of?
16. How do you think we can address these needs?
17. Are women more willing to do things they would not ordinarily do while

under the influence of drugs? (Probe: examples)

18. Have you ever engaged in sex, whilst using drugs?
19. When you do engage in sex, do you use protection? At all times? Is it with a regular partner?
20. Is there any occasions when you felt “forced” to do drugs or engage in sex?
21. For women to stop using drugs, what do you think needs to change?
22. What circumstances do you think would keep these women off the drugs?
23. What are the things in your lives that can make it easier for you to be? Probe healthy and independent in the future?

Probe:

- Activities – sports, church/religion, music, hobbies
- Supportive family / adults
- Job Opportunities
- Community service opportunities

24. Is there anything that we have missed?
25. Do you have any questions?

Thank you for participating in this focus group discussion.

TITLE OF RESEARCH:

A qualitative understanding of the socio-cultural and situational context of substance abuse and sexual risk-taking behaviours in women

INDIVIDUAL INTERVIEW GUIDE

My name is Jessica Phillip, you can call me Jessi.

I am studying for my Masters in Public Health.

One of the requirements of the degree is that I have to undertake a meaningful piece of research.

Very little is known about the context and experience of women who take drugs and various substances. This research is meant to help me understand your context and experiences because it is also likely to be helpful to others like yourself who may seek help from treatment centres.

I will help guide the discussion, but you are free to talk about anything that you feel is relevant. There are no right or wrong answers. Please feel free to share your point of view. I will be tape recording the sessions because I need to go back and listen carefully to what you have said. The tapes and all the information you provide is confidential. You are free to withdraw from participating at any point you wish. I hope, however, that by helping me I am able to also help you in talking about the issues related to substance use.

INTRODUCTORY QUESTIONS:

Their name and when they came to the Centre.

In your own words, why did you come to the Centre?

How do you feel about being here?

[A] Circumstances around drug initiation

Tell me when did you first start using drugs?

Can you remember how old you were?

Can you tell me how you got introduced to it (using drugs)?

Did you start doing it alone?

Where did you start using drugs?

Were there any reasons at that point that you felt you started?

So, how old were you?

And what drugs did you take? How often?

1. Are you using any other drugs beside (mentioned above)? (Tell me more) What is your most frequently used drug / used in combination.
2. Do you think that you take drugs for different reasons now than when you first started? (Ask for further explanation...)
3. Do you enjoy taking drugs? Why?

[B] Payment and source of drugs

4. Do you find drugs expensive?
5. How do you pay for them?
6. Where do you get the drugs from?
7. Did you ever take drugs /ask for drugs in return for money , sex or a place to stay?
8. Where do you take drugs?
9. Is this place safe?
10. Do you take drugs alone?
11. When you take the drugs, how does it make you feel?

[C] Context of Drug-taking

12. Has there been times when you felt unsafe or threaten when under the influence of drugs?
22. Have women been attacked while under the influence of drugs? Do you know of anyone? (...could you tell me about them)
23. Who do you think is most likely to attack these women?
24. Does your behaviour change when under the influence? How?

25. How do you feel when you don't take drugs?

[D] Circumstances around drug use

26. Once you started using drugs , what was the most serious problems you faced? (Ask them to elaborate on what they say ...give examples ...how it made them feel)?

27. Did you ever try to stop using drugs? How did you go about that?

28. Have you been in treatment before?

If yes, what happened? What were the reasons for not succeeding? How is the last time different to now?

If no, what prevented you from seeking treatment?

29. Do you know or are you aware of other women who take drugs , but are not in treatment? How do you feel about them not being in treatment?

[E] Needs of women in treatment

30. How long have you been here?

31. Do you think its helping you?

32. Do you feel a woman you get the respect you deserve?

33. What do you do at the Centre?

34. Is there anything that you need but feel you are not getting?

F] Risky sexual behaviour

31. At what age did you become sexually active?

32. How many sexual partners have you had in the last two years?

33. Did drug taking start off with friends or did you start on your own?

34. Where you in a sexual relationship with any of the people that were using drugs with you?

35. Did anyone ever influence you into using drugs during sex?

36. Are you in a committed / intimate relationship?

37. Do you have any sex partners other than your committed partner?

38. When you have sexual intercourse, do you use protection? At all times? (probe)

39. How often did you use condoms with a casual partner?

40. How often did you use condoms with a committed partner?
41. How often do you use a condom whilst under the influence of drugs?
42. Are you able to insist on the use of a condom, whilst under the influence?
43. What effect did it have on your sexual performance?
44. Have you ever forgotten to use condoms whilst under the influence of drugs?
45. Are you in a committed / intimate relationship?
46. How do you feel about your relationship?
47. How important is trust to you in your relationship?
Do you have trust in your partner that he will be there when you need him?
Do you have trust in him that he does not have other partners?
48. How would your partner feel (what would he do) if you told him you wanted to use a condom?
49. If you suggested he use condoms, would he think you did not trust him? Would his reaction matter to you?
50. Have you ever had sex without a condom when you really wanted your partner to use one? Can you describe the situation?
51. Have you tried to get your partner to use condoms? what did you say to persuade him?
52. Did you ever take drugs or ask for drugs in return for money, sex or a place to stay?
53. Have you ever been treated for a sexually transmitted disease?
54. How worried are you about being HIV positive? Why?
55. Have you ever been for a HIV test?
56. How likely are you to contract HIV/AIDS now?
57. How likely are you to contract HIV/AIDS in the future?

[G] Availability of personal and contextual resources for change

58. Do you think the treatment has been helpful?
59. What are the chances of you starting to use drugs again? (Probe: What needs to change?)
60. Do you feel like you are ready to quit? (Probe why?)

61. Do you feel like you would need a support group or follow –up sessions to help you stay clean?

Thank you for participating in this discussion.