

Women who fall by the roadside: gender, sexual risk and alcohol in rural Uganda

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ABSTRACT

Aims To investigate community perceptions about the different relationship between alcohol consumption and sexual risk-taking for men and women in a high HIV prevalence African setting. **Design and setting** Participatory learning and action (PLA) activities were conducted in five rural villages in south-western Uganda in 2002. For each village, discussions and visualization activities over the course of 5 days explored local concepts of fun, drinking alcohol and HIV-related behavioural risks. Twelve focus group discussions (FGDs) investigated emerging themes. Analysis is based on visual outputs, observation notes and focus group transcripts. **Participants** Attendance at sex-segregated PLA sessions was open to all village residents. FGDs were purposively sampled from drinkers and general population groups. **Findings** For men, drinking is conducted invariably outside the home, usually at night in bars, emphasizing independence, masculinity and freedom from domestic responsibilities. For women, drinking outside male supervision challenges feminine ideals of domesticity and signifies potential sexual vulnerability. Accepting drinks from men was viewed as signifying assent to sex and refusal could justify men resorting to sexual coercion. Even though drinking is seen to promote sexual risk, HIV prevention campaigns were considered unwelcome in bars. Communities preferred seminars involving drinkers and non-drinkers alike. **Conclusions** Public drinking in this community serves as a marker for men willing to exercise privileges of independence (sexual and otherwise) and women willing to defy gender norms (and risk the sexual consequences). The social and symbolic context of drinking suggests why effective HIV prevention around alcohol should not be limited to drinking environments alone.

Keywords Alcohol, gender, sex behaviour, social norms, Uganda.

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INTRODUCTION

The HIV epidemic in Africa is distinguished by the predominance of heterosexual transmission and its sheer scale of magnitude [1]. HIV prevalence at antenatal surveillance sites, generally the most widely available approximation of prevalence among the general population, has been observed over 40% in several southern African sites, and commonly exceeds 10% in the East African region [2]. At such high levels, distinctions between 'high risk' groups and the general population cease to be meaningful and prevention efforts can be targeted appropriately across the spectrum of the sexually active population. Uganda is often hailed as an example of how such a broad-based approach can be successful [3–5]. According to antenatal surveillance data, national HIV prevalence in Uganda fell from a peak of 13% in the early 1990s to just

4.1% in 2003, one of the lowest in the region [2]. Longitudinal studies in the rural study site where the current study is based confirm significant declines in HIV incidence across all age groups over the 1990s [6].

Concern about alcohol consumption as a persistent risk factor for HIV transmission was heightened by survey analysis from the same rural Ugandan site, showing that those who drink were twice as likely to be infected with HIV compared to those who never drink, controlling for religion, marital status and other factors [7]. A recent population-based survey in Zimbabwe found similarly that both men and women whose partners had visited beer halls in the last month were significantly more likely to be HIV positive (OR = 1.4) compared to those who had not when controlling for sex, marital status and sexual behaviour [8]. Both results are consistent with numerous other studies, conducted in a variety of geographic and

cultural settings, that have found a positive association between alcohol use and sexual risk-taking, such as having multiple partners or using condoms inconsistently (see [9,10] for reviews). In countries as diverse as Thailand, Switzerland, South Africa and the United States, research participants have reported that being under the influence of alcohol led them to have unexpected sex or forget to use a condom [11–13].

Such evidence notwithstanding, the case for a direct causal connection between alcohol and sexual risk-taking has never been established conclusively. A systematic review of studies applying strict criteria of event-level correlations between specific drinking and sexual episodes failed to find any consistent relationship between the two [9]. Corbin & Fromme [14], for example, found the significance and even direction of effects of alcohol on risk behaviour depend whether global, situational or event-level data are used within the same sample. Where significant associations are found, they tend to be conditional. Leigh [15] found drinking alcohol led to significantly lower condom use only in the context of first sexual relationships. Experimental research in psychology has found support for the alcohol myopia theory, which holds that intoxication may either inhibit or disinhibit intentions to engage in sexual risk behaviour, depending on dominant cues in the environment in which alcohol is consumed [16].

Increasing attention to the social context of drinking is bringing a rare convergence of epidemiological and anthropological approaches to this subject (see [17]). Broad cultural variation in social pathologies (or the lack thereof) associated with drinking [18,19] and transformations of drinking behaviour with the commercialization of alcohol [20,21] have made many anthropologists wary of global generalizations. Rather, literature in this field tends to stress the socially embedded nature of drinking behaviour and the importance of local meanings attached to it by social actors. In relation to sexual behaviour, alcohol is often viewed not as an instigating factor, but as a pretext or cueing mechanism for socially scripted behaviour known well in advance to all participants. Ethnographic studies of drinking environments in South Africa and Botswana, for example, describe clearly understood rules of social engagement, enforced by threats of violence, where accepting drinks from others is tantamount to agreeing to sex [22,23]. The perceived association between drinking alcohol and having sex is so powerful in the popular imagination in many settings that individuals consume alcohol as a conscious strategy to facilitate sexual encounters [11,24,25]. Consequently, it is essential that any intervention strategies to reduce sexual risk behaviour in drinking environments must begin from a clear understanding of the social context in which both occur.

Against this backdrop, we conducted a qualitative study of the relationship between alcohol consumption and sexual risk behaviour in the same rural study communities in south-western Uganda, where a significant positive association between drinking and HIV status was found. This analysis has two main objectives. The first is to document the social context of sexual risk behaviour and condom use in and around drinking environments. The second is to elicit participatory community input into identifying solutions to reduce the perceived impact of drinking on sexual risk-taking and the spread of HIV in these communities. Because gender role definitions are central to both drinking and sexual behaviour, we construct our analysis around contrasting gender perspectives on this topic.

STUDY AREA AND METHODS

The study was conducted by the Medical Research Council (MRC) Programme on AIDS in Uganda based at the Uganda Virus Research Institute. Fieldwork was conducted in a rural subcounty of Masaka District, located in south-western Uganda that has been the site of a population-based cohort study since 1989. Residents rely on subsistence agriculture with some small-scale cash crops of plantain and coffee. Roughly a quarter of the population are Muslim, with the remainder predominantly Catholic or Anglican.

Complementary group methods of qualitative data collection were employed. A participatory learning and action (PLA) approach was adopted in the first stage of research because it offered the opportunity for local residents to engage with each other through discussion and analysis of issues related to alcohol use in the community. PLA activities strive to encourage community-led identification of priorities, and the sharing of local experience and indigenous knowledge [26–28]. This strategy relies on engaging community participants to produce visual outputs such as maps, diagrams and drawings as a way of collectively thinking through problems and identifying solutions. Visual approaches have been shown to maximize accessibility among groups with mixed literacy levels [29,30]. They have been used extensively in HIV prevention and education activities in a range of developing countries to stimulate discussion and engage communities in problem-solving [31–34]. In the context of the current study, participatory activities served a dual function of providing descriptive information on the social context and significance of drinking behaviours, while at the same time providing an enabling environment for local populations to devise their own solutions to identified problems [35,36].

Four ‘drinking’ villages and one predominantly Muslim ‘non-drinking’ village of roughly equal size (between

300 and 400 adults each) were selected purposively to provide a range of alcohol consumption. MRC staff members assisted by local council officials mobilized all interested adult residents to attend a series of participatory afternoon sessions. A total of 162 males and 239 females attended sessions, in groups of 30–50 participants meeting over 5–7 days in public spaces in each village between June and August 2002. The same set of participatory tools used in each village was designed to build on each other, including community maps, descriptive charts, ‘chapatti’ (Venn) diagrams, spider diagrams and problem trees (see [36]). Attendance in the groups was fluid, with individuals coming and going during the course of sessions, although core groups of regular attendees and cumulative visual outputs provided continuity over time. Research teams consisted of a moderator, to introduce each visual activity, and a note-taker and observer, who together documented the nature of discussions and any agreements and disagreements around the construction of visual outputs.

Following the participatory sessions, a series of moderated focus group discussions were conducted to explore emerging themes in greater depth. This method was adopted as smaller group size and the presence of a research moderator in focus groups give researchers comparative control over discussion content and ability to probe on particular issues while retaining social interaction useful for assessing social norms [37]. A total of 12 focus group discussions were conducted among men and women selected purposively to represent the views of youth (aged 18 to 29 years), adults (aged 30 to 49 years) and elderly people (aged 50 years and over) in the general population. Four additional focus groups were conducted among men and women who regularly frequent bars. Throughout the text below, excerpts from PLA field-notes are included in italics while direct quotes from focus groups appear in italics and quotation marks.

Analysis of PLA data is based on visual outputs created on flipcharts by community members and combined field-notes from note-takers and observers. Focus group analysis is based on transcribed texts of discussions that include both original Luganda and English translations. Overview charts were created to allow systematic comparison of themes emerging from PLA and focus group data across different groups [38]. Because it is typically the discussion and debate around the construction of PLA visual outputs, rather than the charts themselves, that provide most analytical insight (at least for outsiders), we rely primarily on textual data from field-notes in this analysis, although we have included a Venn or ‘chapatti’ diagram for illustrative purposes (see Fig. 1).

The study received ethical approval from the Uganda Virus Research Institute Science and Ethics Committee. Informed consent procedures were administered verbally

to assembled groups, with emphasis placed on participants’ right to leave the activity at any time and to refrain from answering questions or contributing to discussions and interactive activities.

RESULTS

From both PLA and focus group discussions, a general consensus emerged that drinking was a normal social activity embedded in local culture and tradition. The main exception was abstinence from drinking for religious reasons by a significant minority of Muslims and smaller numbers of evangelical Christians. For this reason we exclude data from the one primarily Muslim non-drinking village from this analysis. A variety of alcohol beverages is available for consumption in drinking villages, including *mwenge omuganda* (a mixture of fermented bananas and sorghum), *kwete* (fermented maize), *waragi* (distilled spirits from bananas or sugarcane, available legally in bottled form and illegally in locally distilled form) and *kasese* (illegal extra-strength waragi). Alcohol is sold and consumed in a variety of settings that typically mark the social class of drinkers. Those with disposable income favour small bars in trading centres that serve bottled beers and commercially distilled spirits. The majority with less income favour informal village bars, often an individual brewer’s home, where less expensive locally fermented and distilled beverages are usually shared in plastic cups or gourds among multiple drinkers. Men are more common in public drinking venues, although groups report that women are also found wherever alcohol is served. Social gatherings provide more equal opportunities for drinking for both men and women. In particular, traditional *mwenge omuganda* is valued by both sexes for its role in traditional celebrations and observances such as traditional *okwanjula* (betrothal) ceremonies, church weddings, burials and last funeral rites:

‘Alcohol is something that binds culture together. In the past, they could tell you “take some beer because it is even what was used to marry your mother”. Alcohol has been in use since the past. They would take it to the in-laws for marrying a woman and if you had not taken it, you did not get the woman.’ (Adult women FGD)

Gender and acceptability of drinking

In this society, it is acceptable for both men and women to drink and socialize together. However, there are clearly defined roles for *how* men and women consume alcohol, and differences in social meaning behind drinking. For men, drinking is simple recreation. It offers opportunities to relax, meet friends, share sorrows or catch up on the latest news; drinking alone at home was seen not so

much as unacceptable as illogical. Going out to drink for men presupposes independence, and emphasizes freedom from the household and its duties:

'Men enjoy themselves because men have a lot of time to enjoy. After digging, the man washed his legs and joins his friends while a woman is at home doing domestic work.' (Women drinkers FGD)

Furthermore, among the opportunities for leisure at bars was the chance to compete for and win sexually available women, which both men and women identify as natural and expected for men.

All participants agreed that after taking alcohol men want to show their manhood. They do this most especially when drinking in places with women. (Field-notes, women, descriptive chart activity)

While drinking may enhance masculinity, it threatens norms of femininity embodied in a conservative code of behaviour for women's 'dignity' (*ekitibwa*). At the simplest level, dignity for rural women is tied to marriage and fulfilment of the expected roles of being a dutiful wife and good mother. To attend bars requires access to disposable income, freedom from domestic responsibilities and mobility outside the home, all of which take women away from spousal or maternal roles. While most groups insist that women are as free as men to drink alcohol, socially acceptable drinking for women is limited to the home or social events and ceremonies, where women go by invitation. Objection to women spending time in bars with men had as much to do with incompatibility with their domestic duties as the moral or sexual dangers.

'It is because God created them [men] to show their superiority (okusajjalaata) by leaving home to drink in town. They drink, while women have to stay at home.' (Adult men FGD)

It is the men who are supposed to drink because their responsibilities at home are few yet women have so much to do. Like looking after the family, cooking for the children and most important of all, women have to protect their dignity. (Field-notes, women, descriptive chart activity)

At a deeper level, dignity for women also implies conformity to the standards of chastity or fidelity. Although women report feelings of sexual stimulation from alcohol, acting on these feelings transgresses acceptable behaviour and is morally equated with 'prostitution'.

'In fact, after taking beer, a woman can accept to go with someone she had refused. She accepts because she now no longer feels ashamed because they say that beer takes away shame.' (Adult women FGD)

The sexual threat to women's dignity from alcohol appears in two forms. On one hand, alcohol exposes

women's perceived weaknesses, rendering them vulnerable to sexual advances by men. On the other hand, alcohol is seen to unleash women's own potential for sexual aggression, similar to men, but stripped of any admiring or sympathetic undertones. Men may also lose their dignity from drinking, but more from physical loss of control, such as falling down or wetting themselves, and the consequences are generally less socially ruinous. The social construction of drunken behaviour is demonstrated by descriptions of men and women at the point when they 'lose all control'. Men seek sexual contact with women they would not otherwise choose, and not finding a willing sexual partner is seen as one of the causes behind rape:

... when men drink waragi [local gin], it provokes them to have sex. If a man does not control his sexual desire he can rape any woman he comes across. (Field-notes, women, problem tree activity)

By contrast, women who drink too much revert to the passive role of victim. Women who have also been drinking are seen to become easy targets when walking home alone and are believed to be susceptible to becoming disorientated, weak, and to falling unconscious. These women are described as 'falling by the roadside' and pose a source of temptation that men cannot be expected to resist, whether drunk or sober:

Some women drink a lot and fall on the roadsides and men are forced to rape them there. [Local saying]: 'If I meet her falling alongside the road, it is as if I have come across money.' (Field-notes, men, chapatti diagram activity)

Participant 1: *'They [the men] have not committed any crime.'*

Participant 2: *'She is the one who has caused it. No one told her to drink the alcohol. She is the one who will have caused it. She would have given herself away.'* (Women drinkers FGD)

Interestingly, while participants were adamant that rape after 'falling by the roadside' occurs, it was always portrayed as something happening in *other* villages, not locally. Such stories bear the hallmarks of cautionary tales to warn women of the dangers of drinking in public.

Sexual negotiation and risks

Although the ideal suggests women drink under male supervision at home or at social events and ceremonies, in reality women do frequent public drinking places both as customers and sellers. Visiting a bar does not automatically imply sexual intentions for women, and all groups mention that such outings generally come and go with-

out event. However, bars are recognized as the easiest place to negotiate sexual relationships, where clear terms of exchange are recognized. Either men or women can initiate the process. Interest has to be expressed discreetly with a glance, wink or a message passed through the person serving alcohol. Accepting a drink from a man establishes an obligation for the woman to 'pay back', usually by agreeing to have sex. If a woman does not uphold her side of the bargain, a man is justified in using force.

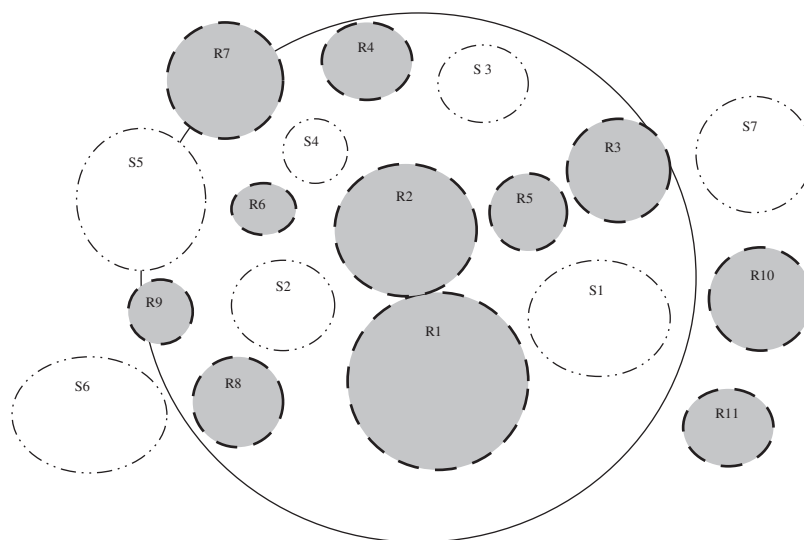
... the women ask for alcohol from the men and in the end they are asked to pay for alcohol bought, in sexual satisfaction. In this case she has to accept and if she refuses, then men have to use force to pay themselves by raping ... (Field-notes, women, descriptive chart activity)

In spite of the risks, women also admitted to eliciting drinks from men with no intention to engage in sex afterwards. Known as 'detoothing', this practice was described as a frivolous adventure in which women use their feminine wiles to exploit men, although it was also described in a language suggesting it involves taking risks and carries no guarantee of success:

... when I went to that place [outside the community], I enjoyed. I met a guy who bought me some beer and

chicken. But I didn't pay back! [Laughter] ... But here in my area, if you really accept to drink ... you must be ready to pay back because [local men] know you very well and he is always around and if you refuse, he might even beat you! (Female drinkers FGD)

Figure 1 shows an example of a typical 'chapatti' or Venn diagram taken from women in Village A in which participating women were asked to rank sources of HIV risk (shaded circles) and possible solutions (unshaded circles) in proportion to their size and centrality to the community (represented by the large solid circle). Factors placed inside the solid circle represent 'central' concerns to the community. Factors placed on the solid circle represent 'marginal' concerns that may originate outside but sometimes affect the local community, while those placed outside the circle represent problems perceived to exist outside local communities, literally 'other people's problems'. Note that while women considered alcohol as a risk for HIV within the local community, it was ranked only fourth of six among internal risk factors, and fourth of four solutions. Note also the elision of 'rape' and 'falling by the roadsides' reflecting central narratives of male aggressiveness and female vulnerability in response to drinking. The placement of these on the margins probably reflects a



Risks in order of position and size	Solutions in order of position and size
Inside	Inside
R1 Promiscuity	S1 Using of condoms
R2 Fun things	S2 Avoiding fun things like wedding parties and discos
R3 Separation	S3 Treating oneself if you know you have AIDS
R4 Getting drunk	S4 Reducing alcohol taking
R5 Serial marriages	
R6 Home breakdown	
Edge	Edge
R7 Falling by the roadside	S1 Marital faithfulness
R8 Raping	
R9 Walking home at night	
Outside	Outside
R10 Defiling children	S1 Caining those who drink with young girls
R11 Drinking alcohol with young girls	S2 Those who rape / defile kids should be killed

Figure 1 Chapatti (Venn) diagram for perceived risks and proposed solutions for HIV risks in the community: women, village A

combination of their relative rarity and the tendency of groups to ascribe morally repugnant activities to outside influences. The leading source of risk (promiscuity) and leading solution (condom use) were both considered male prerogatives by this group, suggesting that women believe men ultimately have more control over the course of the epidemic. It is interesting to note what was not highlighted by groups. For example, 'moving at night' was discussed in this session primarily as a risk for women, even though it is precisely men's relative freedom of movement and ability to initiate concurrent sexual partnerships that form a consistent backdrop for discussion of risk across all groups analysed here.

Community suggestions for the way forward

Perhaps due to the equanimity with which communities viewed drinking, participatory sessions produced few actionable strategies for reducing alcohol-related problems. Two categories of solutions emerged from group discussions with both men and women. The first was punitive, including suggestions to close bars by 10 p.m. and fining those caught drinking afterwards, and punishing or even executing rapists. The second involved raising general awareness about HIV risks from drinking. All groups agreed that awareness-raising would be most effective if targeted at entire communities rather than drinkers alone. The latter were assumed to be uninterested if not hostile to such interventions, as drinkers generally come to forget their problems (*mwerabizza nakku*) and would be too drunk to benefit from health messages or to use condoms correctly even if available. Resistance to AIDS awareness campaigns in bars was confirmed emphatically by focus group discussions among drinkers themselves.

Participant 1: '*Unless you call us together as you have done today, but not just entering into a bar for that purpose [sensitization about HIV/AIDS].*'

Participant 3: '*It is quite impossible in a bar.*'

Participant 6: '*Even if you come with a loud speaker and start teaching, they won't listen to you, they will only mock you.*' (Male drinkers FGD)

DISCUSSION

In this qualitative study we set out to describe the gendered social context of drinking behaviour in a rural Ugandan setting where earlier survey results showed a significant association between alcohol consumption and HIV risk. Group methods of data collection including participatory learning and action (PLA) and focus groups were employed to describe social context and shared

meanings attached to alcohol and its relationship to sexual risk behaviour, while helping communities identify appropriate and socially acceptable solutions to identified problems.

Our findings indicate that the relationship between drinking and 'high risk' sexual behaviours in rural Uganda is closely linked to the social construction of gender identities and sexuality. Participants described how drinking alcohol contributes to risk-taking in ways that enact and reinforce prevailing gender norms. For men, drinking represents a social activity that demonstrates their independence and freedom from the household and its responsibilities. Consuming alcohol is seen to heighten masculinity, whereby men become aroused, aggressive and 'in need' of sex. For women, however, drinking in public is less socially acceptable as it conflicts with the conservative rural ideology of female 'dignity' that emphasizes fidelity and devotion to domestic duties. The prospect of women drinking raises opposing anxieties of, on one hand, unleashing women's potential for sexual aggression, and on the other hand of exposing their inherent weakness and sexual vulnerability captured in the image of 'falling by the roadside'. Bar environments, where most recreational drinking occurs, are particularly associated with opportunities for sexual risk-taking, with buying or accepting drinks serving as widely understood cues for initiating sexual relations. Drinking in public thus becomes a marker for men who want to exercise privileges of independence (sexual and otherwise) and women willing to defy feminine ideals of domesticity (and risk the sexual consequences).

To the extent that alcohol and the environments in which it is consumed were seen as particular catalysts for unsafe sexual behaviours including multiple partnerships, lack of condom use and rape, popular perception would support conclusions of earlier survey research showing alcohol to increase risk of HIV infection [7]. However, the social and symbolic context of drinking shows why alcohol consumption cannot be interpreted as a simple 'risk factor' for HIV transmission in itself. As long as access to drinking environments and sexual exchanges that take place within them are in any way socially 'scripted', which this study suggests they largely are, the (intentional) social cueing effects of alcohol cannot be separated from (unintentional) physiological or psychological mechanisms at work. Community narratives highlight, at least to an outsider, the importance of gender norms that grant men relative freedom of movement and license to initiate concurrent sexual partnerships, while restricting 'respectable' women to the confines of home and marking others as subjects for sexual speculation and even violence. From this reading of our data, bar environments might be better understood as a forum for expression of such norms and the risk behaviours they

encourage, rather than an actual cause of such behaviours.

Such an interpretation has important implications for intervention strategies. If drunken behaviour itself is the primary problem, the solution would be to target drinkers and the environments in which they drink. This is precisely the approach proposed in a number of recent publications [8, 39–41]. Unlike findings by Fritz *et al.* [39] in Zimbabwe, however, participants in rural Uganda were adamant that such interventions would not be welcome in drinking contexts, but would welcome more broadly targeted efforts including drinkers and non-drinkers.

If sexual behaviour around bars were viewed as primarily a symptom of deeper social issues, then behaviour interventions targeted at such areas would ultimately have limited effect. Psychological strategies to place awareness-raising 'cues' in drinking environments suggested by MacDonald [16] and colleagues seem to underestimate the extent to which such risks are undertaken knowingly. Widely observed lack of association between drinking and sexual risk at event-level shown by Weinhardt & Carey [9] suggests that those who take risks while drinking also take risks when sober. While we do not analyse event-level data in this study, our conclusions would lead us to expect that the same is true in this setting, as gender norms that enable sexual risk are clearly not limited to drinking environments or drinkers alone. Even if drinking settings attract a core group of risk takers, we would still argue that the priority for interventions should not be the drinkers or their moods while drinking, but the *ideas* that help inspire, script and validate risk behaviours so often attributed to alcohol. As our data show, these start at home, and should rightfully also be addressed there.

Group methods on which these results are based may be criticized for encouraging socially acceptable responses and suppressing divergent or individually sensitive information (see [42]). Participants in PLA activities are self-selected and their contribution typically unequal, so the views expressed are unlikely to come from a representative sample of the surrounding communities. However, qualitative research is typically less concerned with representation than providing focused answers to the 'why' and 'how' behind observed behaviours that are harder to obtain with statistically generalizable methods. Because the social norms around drinking behaviour that are the focus of this study are a matter of shared public knowledge, sampling issues are arguably less relevant here in any case. The same element of social interaction in group interviews that may introduce social desirability biases is particularly good at eliciting social norms and shared meanings that would be more difficult to obtain from individual interview methods [37]. Meanwhile, no individual was asked to

report about personal sexual behaviour in these discussions, and communities appeared quite comfortable in discussing issues of drinking, sexual behaviour and even rape at a general level. The general consistency of results from 10 PLA sessions in each of five villages, reinforced by 15 focus group discussions, suggests that this approach yielded a fairly robust cultural perspective on drinking behaviour.

A recommendation for future research, unoriginal but worth repeating, would be to pay due attention to both social and ideological contexts of drinking behaviour [43] and be wary of universal principles that do not take the situated nature of social behaviour into consideration. Similarly, from an intervention standpoint, we would argue that attempting behaviour change without understanding the context or more importantly without community consent and involvement is a well-documented path to failure [44]. Community proposals for interactive seminars in our own study, while appearing at first to be a minimal gesture, may actually represent a good starting place for broad-based change, as they would provide time and space to begin collective discussion and critical evaluation of problems perceived to emanate from drinking. They also concur with the conclusions of our own analysis that risk behaviour in drinking environments ultimately reflects broader social norms that will require cooperation of both drinkers and non-drinkers alike to change. The experience of Uganda in reversing its own AIDS epidemic suggests that such behaviour change is possible with the involvement of broad community participation and less so, we would argue, with targeted risk factor approaches to prevention.

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