Alcohol regulation and HIV in South Africa

Introduction

Decades into the AIDS epidemic, South Africa continues to have one of the world's highest rates of HIV infection, over 18%. (Watt 2012b 1009) It also has one of the world's highest levels of alcohol consumption per drinker (Rataemane 373). These two facts are not unrelated. Though it is unclear which biological, cultural, or incidental set of factors may account for this, there is a robust correlation between alcohol consumption and rates of HIV transmission, one which increases with levels of consumption per drinker (Baliunas 2010, 162). Drinking, an important and polarizing issue throughout South Africa's history, is even more critical if connected to HIV transmission. In 1999, the World Health Organization (WHO 1999) published its first Global Status Report on Alcohol. This report documented the health burden of alcohol, a burden that it described as "fallen since 1980 in most developed countries, [but] risen steadily in developing countries" (viii). The concern voiced here is joined by several other WHO publications (WHO 2004, Jerrigan 2002) as well as a significant body of academic literature (Mcintyre 2011, Parry 2005, Rataemane 2006, Woolf-King 2011). Much of this literature suggests that broad taxation of alcohol is the best way to reduce alcohol consumption and the health burden of alcohol (Doran 2010, 352). Other common recommendations are restrictions on advertising and limiting of sales outlets, bars, and other alcohol serving venues (WHO 2005, 24). Policies of this kind are common in developed countries, and South Africa has been the first country in Africa pursue a similar regulatory regime (Parry 2010, 66).

Of course, the use of alcohol is not only a medical problem but a widespread and longstanding social practice, with endlessly varied articulations around the world. As such, the problems faced by alcohol use and abuse differ throughout the world, and each alcohol culture faces its own issue. Alcohol, despite its ubiquity, remains a cultural product, and its practices and significance are to some extent culturally defined (Mandelbaum 1965, 281). And yet, WHO and academics generally advocate a kind of "one size fits all" policy, suggesting taxation and other technocratic regulation at the national level in almost every case. By taking a closer look at local conditions, practices, and history, regulators and public health advocates may be able to craft more idiosyncratic policies which reflect South African drinking culture and issues, as well as more effectively combat the specific problems facing them.

This paper will discuss the cultural and historical context which lies behind the connection between alcohol consumption and HIV transmission in South Africa, and its implications for regulations. This link is not necessarily inherent, but an aspect of South Africa's drinking culture and historical background. First, I will take a close up look at South African township shebeens, a place where the connection between alcohol and HIV transmission seems most clear. These shebeens are often centres of informal sex work, in which alcohol acts as a medium of exchange (Watt 2012b, 1005). Alcohol and risky sex here are symbiotic in ways which cannot be addressed simply by technocratic means. I will also discuss the long history of alcohol as a way to maintain racial boundaries in South Africa and its use in asserting control over Africans during the colonial period and apartheid. Alcohol was also an important means of resistance for Africans during apartheid. Regulations such as those proposed by the WHO, though

they appear to be entirely politically neutral and technocratic, have specific and local resonances in South Africa which cannot be ignored by South African regulators.

I will also question whether regulations on alcohol which focus on efficiency and economic interest is effective on an individual level. Academics and officials often assume that South Africans will respond as rational economic actors to regulation, reducing alcohol consumption, and therefore HIV transmission rates, as taxes rise. This view, of man as 'homo economicus,' often fails to predict how people behave in real life situations, in which desires, obligations, and cultural activities may be more important than economic interests. There may be a better way to reduce the harm caused by alcohol consumption in South Africa. Rather than solely applying large scale measures, chosen because of their efficiency, South Africa could choose to address its problems on a smaller, more local scale. By enlisting and supporting groups such as Alcoholics Anonymous, religious organizations, even workers and owners of Shebeens, South Africa may be able to address its problems more directly. These measures may not be as efficient economically, and they would not be under the direct control of the South African state. This kind of approach could address the real problems of South African citizens, helping individuals, rather than seeking to lower consumption statistics.

Shebeens and casual sex work

South Africa's alcohol culture, as well as the health issues it raises, is fairly unique throughout Africa. Though per capita consumption is fairly low, studies have indicated that per capita consumption per drinker is extremely high. (Parry 2005, 426) This points towards a drinking culture of binge drinking by a few, rather than occasional

drinking by a majority of the population. In fact, it is estimated that close to 70% of South Africans abstain from alcohol. Nonetheless, alcohol has been shown to be an influence in a significant amount of South Africa`s hospital visits, and in a majority of incidences of domestic violence and accidental deaths (WHO 2004, 94). Alcohol abuse has also been linked throughout Africa to infectious diseases such as Tuberculosis. (Mcintyre 2011) However, the most troubling aspect of South African alcohol consumption is without a doubt its tight connection with HIV transmission. This link, though real, has no obvious cause. One study which makes this connection speculates that the causal relationship may be biological, in which drinking makes it easier to contract HIV, cultural, in which drinking makes one more likely to engage in risky behaviour, or simply incidental, in which some third factor makes it more likely that someone will drink heavily and contract HIV. (Baliunas 2010) Detached, scientific research is unable to say more than this, but a more ethnographic approach may help illuminate the situation. Site observation and interviews conducted at South African alcohol serving venues, or shebeens, fill in this correlation with details from the lives and situations of real South Africans. (Watt 2012a, Wojcicki 2002)

The connection between alcohol and HIV transmission may be found most prominently in interactions at these shebeens. In many South African township shebeens, alcohol works to blur the distinction between casual sex, transactional sex, survival sex, and long term relationships. Alcohol allows these relationships to become ambiguous, both to observers and participants. Here, alcohol serves as a medium of exchange, with men buying drinks for women with the expectation that it will lead to sex. This exchange often begins by men simply buying a large amount of alcohol for them-

selves and spreading it around the table in order to appear wealthy, generous and attractive to women. This one sided display then becomes an exchange, where women accept alcohol under the implicit assumption that it will lead to sex (Townsend 2011, 45). Buying drinks for women in the hope of beginning a relationship with them is common throughout the world, but ethnographic research has shown that the exchange of alcohol for sex in the Shebeens is very formal and normalized, lying somewhere in between courtship ritual and sex work. Extended interviews in a recent study (Watt 2012b) suggested that this implicit assumption is made both by men and women at the bars. A woman remarked that "I don't have money...I am going to get a boyfriend for the evening," and a man that "you drink from me, and I also drink from you" (1008).

This reciprocal exchange, while sometimes discussed frankly by the participants, also leaves much room for ambiguity and disagreement. (Townsend 2001) Men sometimes couched the relationship as a simple exchange, and sometimes as romantic. Some men even reported taking part in the ritual as a way to find women to fall in love with (45). Likewise, women also sometimes described the relationship as one in which they were in control, and sometimes as one in which they felt powerless. Women came to the shebeen fully aware of the expected reciprocal relationship, and took part in it or attempted to subvert it for their own benefit, either to meet men they liked, or to get free drinks for themselves and their friends (Watt 2012b, 1009). Both men and women discussed the ambiguity of the relationship, the men seeking to separate "easy" girls, who would participate fully in the exchange, from "hard" girls, who are either unaware of the expected exchange, or seek to get out of fulfilling their side of the bargain (Townsend 2001, 45). Women, likewise, often travel in groups or with male friends in order to

protect themselves from men who feel they are entitled to what a women is not willing to give. (Watt 2012b, 1009) The unequal power dynamic between men and women implicit in this exchange relationship is not without its dangers. It is not uncommon for a women who has accepted alcohol to find that she is not free to refuse sex. Men discussed ways they had of dealing with women who would not fulfill their end of the bargain, claiming that “a guy who lets a girl who has used his money get away is stupid” (1009). Violence is not an uncommon response to this perceived slight, with another man saying of a woman who tried to get away “I would follow her and I would do things like raping her” (1009). Women, too, felt obligated to accept anything proposed by men, because of both a feeling of indebtedness and a fear of violence. (1011).

The most important line blurred by the use of alcohol in these situations is the distinction between casual sex and sex work. Though formal sex work does exist in South Africa, it is generally confined to more urban and Europeanised areas, such as Johannesburg. in contrast, the exchange of alcohol for sex in shebeens is never mistaken for sex work, in particular because these women do not act or dress in ways that are expected of sex workers. Instead, these relationships are much more fluid, and can last a few hours, a few days, or even longer. Women refer to these men as boyfriends, and see nothing unusual about relying on them for financial support. The exchange is much less formal and regulated than sex work, where prices are negotiated up front (Wojcicki 2002).

The ambiguous kind of casual sex practiced by men and women in these shebeens is particularly likely to result in sex which has a high risk for HIV transmission. The clandestine nature of the exchange blurs the distinction between casual and regular

partners. Condom use is thought to be appropriate for casual partners, but not necessarily for regular ones. Exploiting this distinction, where a man is not necessarily a casual partner, and not yet a regular one makes it much less likely that women will insist on using a condom (Gysels 2002). Furthermore, the undefined nature of the alcohol for sex relationship, in which a man spends money up front with the expectation that they will recieve something in return, causes many women to feel indebted to men, and thus obligated to have sex with them on their terms, often without a condom (Watt 2012b, 1011). Difficulties in condom negotiation is one of the most frequently discussed issues by women in shebeens, with one saying “what can you do? After all, you did use their money” (1009).

Alcohol, besides acting as a medium of exchange, also has a direct effect on the participants. Unsurprisingly, alcohol made it difficult for men and women both to exercise good judgement about condom use, forgetting or deciding to forgo it. Without the detachment of a professional sex worker, the passion felt in the heat of the moment allowed women and men both to ignore condoms. Alcohol plays multiple roles in this exchange, and in each case reinforces decisions to engage in risky sex. (Watt 2012b 1011)

This practice fleshes out to some degree the strong relationship between alcohol and HIV transmission in South Africa. Alcohol is clearly very important for cultural practices which reinforce risky sex. However, it is also clear that the two do not stand in a one to one relationship. Alcohol enables risky sex practices, and in particular it enables them to remain clandestine and ambiguous. However, simply raising the price of alcohol through taxation or banning advertisement is unlikely to break this relationship. Even if

it does make alcohol more expensive for those who go to the Shebeens, Its not necessarily true that a reduction of alcohol consumption in these Shebeens will change Shebeen culture. It may simply alter the "rate of exchange," as it were. Furthermore, since buying alcohol for women does act as a status symbol for me, more expensive alcohol may have just the opposite effect, with people buying more in order to appear more wealthy and generous. If shebeen culture is an important part of why alcohol and HIV are linked in South Africa, measures which engage with this culture are needed in order to make a difference. Personal, persuasive, and small scale measures which connect with the people in the shebeens are likely to be more effective at breaking the connection between alcohol and risky sex practices. This, rather than simply attempting to reduce alcohol consumption across the board is necessary to affect change.

Alcohol and Alcohol regulation in South African history

The use of alcohol in risky sex practices as a sign of status, generosity, and wealth, is not an isolated co-incidence. Through the history of colonial and apartheid South Africa, the regulation of alcohol has been used as a way to control the majority African and mixed race population, both by supplying it to them and denying it. The consequences of this history remain a part of South African culture, and form the political landscape of alcohol regulation. Alcohol regulation has never been politically neutral. The technocratic, national scale approach advocated by the WHO, though argued for in terms of efficiency and effectiveness, also has its political resonances. Any discussion

of how alcohol should regulated by the South African state must keep this in history in mind.

Already in the late 19th century, access to alcohol, via state regulation, was an instrumental part in establishing a racial hierarchy in South Africa. African, white, and mixed race populations were defined in part by their tolerance and ability to drink, and laws were drafted to reinforce these categories. Africans were denied alcohol, as they were thought to be unable to drink with temperance, and worse, did so with "no feeling of shame." This was done in part to "civilize"" the blacks, and help them achieve "native sobriety," and in part as a measure of control. A supply of sober, cheap African labour in the fields and in the mines was also necessary to support the colonies. Alongside denying alcohol to the African masses, it was also used to placate and earn the support of a few prominent black leaders and educated people. By Co-opting black leaders, and encouraging them to see themselves as colonial leaders, the state was able to exercise more effective control over this subject population (Mager 736).

The mixed race, or coloured population of South Africa was treated entirely differently. Rather than the rhetoric of sobriety and civilization, coloured farmworkers were kept under control by dispensing wine as a portion of their wages. This strategy, known as the "dop" system, gave farm owners control of coloured labour in a much different way, by limited the mobility of its workers, making it more difficult for them to seek other opportunities, and also making them dependent on the alcohol that was supplied by farm owners. Though this practice began on wine farms, it spread throughout the agricultural industry (London 1999, 1409). This practice has something to do with the very

high volume of alcohol consumption in South Africa today. It also continues to this day in some rural areas, though it is much less often than in the past. For their part, European colonists saw no particular need to regulate or prohibit alcohol consumption for themselves. They were presumed to be temperate and fully in control.

The recognition of alcoholism as a disease by the WHO in 1952 (Mager 737) led to increased medical treatment and action from mental health professionals, but even then limited to white, and occasionally coloured populations. African 'alcoholics,' if that term could be said to have any meaning for the racialized apartheid regime, received no treatment. Instead, Africans were thought to naturally be heavy drinkers, and not capable of being alcoholics in the true sense. Unlicensed and illegal shebeens, which defied the prohibition of selling European liquor to Africans, were patronized by Africans as a subtle act of defiance to the apartheid state. Shebeens, though they encouraged a sense of African solidarity, also became centers of excessive drinking. Many Africans believed that they were reviving a pre-colonial drinking culture, social and communal, but drinking remained heavily integrated into colonial oppression, as a soporific for the pain, desperation, and labour which came with colonial rule (740). WHO calls for intervention in alcohol related problems only led the government to further criminalize African drinking, through arrests for drunkenness and shutting down of Shebeens (741).

Following African drinking legalization in the 1970s, during student unrest and protest came to a head, liquor again became a heavily politicized issue. Students burned down and boycotted shebeens, and campaigns were initiated to turn bars into milk bars. As these campaigns became more heated, SAB, South Africa's largest brewery, fought back by identifying themselves with the struggle for black rights. Advertise-

ments, brand names, and sponsorship of black political and musical events wedded the SAB to the African cause against the government, and made beer drinking an explicitly political act (743). Campaigns against liquor advertisement, couched in medical terms, and criticism of "Shebeen queens" by African elites also played a role in this new politicization of alcohol (744)

The fall of the apartheid regime in the 1990's did not lead to an end of political machinations surrounding alcohol and alcohol regulation. Political uncertainty and infighting, as well as electioneering, has led to contradictory and incomplete regulation (Parry 2010, 1340). The liquor industry, having played a significant political role during apartheid, assumed this role afterward as well. Particularly close links were forged between the SAAC, an advocacy group for the alcohol industry, and the youth league of the African National Congress political party (Mager 747). This ensured that the alcohol industry too would be intimately a part of the actions taken by the South African government to regulate alcohol.

The relationship between the South African brewing industry, especially SAB, its largest brand, is complex and intricate. SAB made a political stand for equal rights for Africans in the final decades of apartheid, a stance which sustained and possibly even increased the subversive sense of drinking in the Shebeen for Africans. In this way, SAB encouraged the Shebeens as a source of African culture, and a place apart from the apartheid regime, as well as encouraging African entrepreneurship.However, commercialization and industrialization of beer brewing, over which SAB presided, also had negative effect on African drinking culture. As in many other places in Sub-Saharan Africa, small scale home brewed beer production, dominated by women and often made

with Sorghum or millet, was an important, if controversial, cultural institution. However, in South Africa, industrial production, led by SAB, largely displaced these women in the 1970's (Willis 2005, 3). What's more, this mass produced, clear beer, usually made with barley or maize rather than Sorghum, was markedly deficient in nutrients compared to nutritious sorghum beer, often considered a food. (Mager 738). Africans, unaccustomed to this low nutrient, high alcohol beer, drank more, and to worse effect. SAB, and the alcohol industry in general had a complex, ambiguous relationship to the public that it served. It supported Africans while also undermining important drinking traditions for South Africans. This relationship continues until the present, as after apartheid, SAB took a more direct role in policy discussions and political machinations.

After Apartheid, and especially after it was made a WHO priority after 2005, South Africa began to take action on alcohol regulation (Parry 2010 1340). However, this regulation was often piecemeal and incomplete. SAB and the rest of the south Africa alcohol industry always played an important role in drafting and passing this legislation. This overwhelmingly took the form of Brewers attempting to funnel policy into actions they did not perceive as harmful to their interests, such as warning labels on products (1344). Many other competing interests also served to scuttle or redirect regulation. Competing layers of government, different alcohol producers and vendors, and different public interest groups each played their part to shape alcohol regulation.

However, it would be incorrect to suppose that each of these competing groups is simply looking out for the bottom line. Alcohol regulation has always been more than economics and public health for South Africa. It was an important part in the construction of Apartheid ideology, as well as an important part of the rhetoric of the inferior, un-

civilized, African. Alliances between black civil rights groups and SAB brewers enabling Africans one of their few acts of defiance and organization against the Apartheid regime. The slow, piecemeal pace of alcohol regulation after apartheid is not simply a matter of obstruction and corruption between industry and government. Today, too, alcohol regulation is a political act, with the political alliance of African National Congress, SAB, and Shebeen owners still important today. As the South African government seeks to craft a new regulatory regime, it must consider the implications of their decisions.

Tackling South Africa's HIV epidemic through alcohol regulation is not simply a matter of applying simple, technocratic fixes, such as alcohol taxes, closing of unlicensed shebeens, and advertising bans. Just as regulation was used in the past to oppress and control poor black South Africans, this new regulatory scheme, as politically neutral as it may seem, must not do the same. Regulations which close down Shebeens, important meeting sites for resistance to Apartheid, or ban advertising, some of which once doubled as clandestine slogans for equal rights, will not be able to hide behind their supposed political neutrality.

Intervention to control alcohol, especially in attempts to reduce HIV transmission, needs to take this history into account. This is not simply a matter of "sensitivity,"" or worrying about offending South Africans, but about crafting regulation and interventions to the local situation, not according to one size fits all recommendations by the WHO

Neoliberalism and alcohol regulation

Over the last decade, The WHO has addressed the issue of alcohol and alcohol regulation in Sub-Saharan Africa and South Africa in a series of reports, surveys, empirical studies, and recommendations (WHO 2005, WHO 2001. WHO 2004). This has been supplemented by a substantial amount of academic work on this subject as well (Chersich 2009, Doran 2010). Most of these admit that "promotion of safer behaviour...is more effective than promotion of total abstinence" (Chersich 2009, 4). Another common theme is that, though educational and persuasive approaches seem attractive, "few substantial and long-lasting effects have been found." They also lament that, for many approaches which have been effective in other parts of the world, "states may lack the capacity to police or the willingness to devote sufficient resources to render deterrent measures effective" (WHO 2001, 21). Under these constraints, reports often offer a recommendation which bypass the question of enforcement or allocation of resources altogether. Most commonly, excise taxes on alcohol, and banning of alcohol advertisements are recommended.

Taxes and advertisement banning on alcohol are attractive to governments for several reasons. The first is that taxes raise revenue for the state, rather than spend it. The rhetoric of alcohol taxes often emphasize "'correcting' for the negative externalities created by alcohol misuse." Despite this rhetoric, however, excise taxes rarely make up a large percentage of these costs, and, in the case of South Africa, are not necessarily allocated for this purpose (Ataguba 68). South Africas alcohol taxes are also highly regressive, with the very poor paying much more than the middle class or the rich. What's more, the health benefits gained by the tax's reduction of alcohol consumption went mostly to the middle class. Though the poor were most likely to pay alcohol taxes, and

more likely to face health problems and HIV infection due to alcohol, they were the least likely to receive treatment and health benefits. (Mooney 2008, 637) Private medical treatment in South Africa has greatly outpaced public spending, with the government paying a much lower amount of health care spending than even ten years ago. (639) This extreme inequality has a racial dimension as well, with Africans much more likely to be poor, pay more excise taxes and see no health care benefits. Unlike during apartheid, when regulation of alcohol black South Africans directly on the basis of race, it now does so indirectly, on the basis of class or wealth.

The sole use of excise taxes, advertisement bans, and other similar measures also ensures also that, rather than enforcing laws, regulations, and licensing on a daily basis, the South African government only needs to negotiate with corporate interests, such as the brewing industry, to pass and ensure compliance with its laws. South African Breweries have been heavily involved in the negotiation of liquor regulation laws since the end of apartheid. Warning labels and advertising controls is one area where the government and the alcohol industry could find agreement (Parry 2008, 1344). These method reduces the need to expend state resources by doing things like issuing licenses and running harm reduction, treatment, and education campaigns. With this in mind, it's no wonder that empirical studies generally show that taxes and advertisements are shown to be most effective in reducing alcohol consumption. Governments who are unable or unwilling to devote resources to running these programs effectively will not see any results from them. Nevertheless, just because South Africa has been unwilling to devote resources to these kinds of programs in the past is no reason that

they may not be able to do so in the future if they take a wider view of how a program can be made effective.

Regulations, such as advertising bans and increase of excise taxes, are part of a Neoliberal program that has become common throughout Africa in recent years. Though much of Africa was forced into adopting these kinds of policies by the World Bank (Foley 2010, 32), South Africa did so of its own accord (Lesufi 2002, 287). This program requires that the state relinquish control of many of its functions to regional governments, or private interests. In South Africa, as elsewhere, this program led to greater economic inequality, while simultaneously reducing the services which could combat the resulting poverty and health problems. Ellen Foley argues that neoliberal policies encourage the decentralization of responsibilities, health care in particular, without distributing resources to deal with these problems. As a result, ordinary health care needs are often forgotten. Development money, unable to work with decimated local systems, is allocated only for large scale projects, such as battling HIV/AIDS. However, because there is often very little health-care infrastructure on the ground, these large scale projects are not very effective or well-coordinated. They bypass local institutions and hierarchies, and are ignorant of local conditions (Foley 2010, 143-157). Something similar takes place in the context of neoliberal reform in South Africa. Regulation takes place only on the national scale, where local institutions need not be consulted or negotiated with. Money is allocated for anti-retroviral drugs (Mooney 2008, 638) or taken for excise taxes, but the kinds of behaviors which link alcohol to HIV scale are ignored or considered unworkable, unpractical, or ineffective.

Regulations such as excise taxes also depend heavily on the "Homo economicus" view of human nature, which suggests that humans always act in order to maximize utility, (Foley 2010, 96). This view assumes that, if taxes are increased, alcohol consumption will decrease, almost automatically. However, the experience of South Africa shows that this is not always the case. For example, despite increasing excise taxes in South Africa, the level of alcohol consumption per drinker has remained nearly constant (Ataguba 2012, 73). The ethnographic work done on South African drinking culture gives some clue as to why this might be the case. As shown earlier, the link between alcohol and HIV in South Africa, is not simply a matter of people drinking heavily and then becoming infected with HIV. A complex culture of conspicuous consumption, risky sex, domestic violence, and youth risk taking is responsible. It is very difficult to say what effect higher taxes will have on this volatile mixture. What's at stake is not merely reduction of alcohol consumption, but of risky sex and HIV transmission. There is no reason to believe that a higher price on alcohol will have any effect on binge drinking, or the shebeen culture of sex for alcohol exchange and the threat of sexual violence. There is even less reason for it to have an effect on condom negotiation at Shebeens. Regulators, having discovered a link between alcohol and HIV transmission, seem to think that they can attack one straightforwardly through the other. However, this link may be incidental, or more tightly integrated into the culture than regulators imagine. The connection between alcohol prices and alcohol consumption may be much more flimsy than they imagine.

Recent work by the Anthropologist Christian Groess-Green has reinforced the notion that human beings do not straightforwardly respond to stimuli as the "Homo

economicus" view of human nature suggests. He writes, speaking of risky behaviors in nearby Mozambique, that "unsafe sex may be alluring to marginalized youngsters, when illness and death are abstract dangers" (Groes-Green 2012, 46). Despite full knowledge of the risks involved, the subjects of Groes-Green's ethnography participated in risky sex and drug use, perhaps even because of the danger, the heady risk and possibility of loss involved. Though higher alcohol taxes may convince middle class families, or those on a strict budget to reduce consumption, for the Shebeen patrons, those who go to the bar to binge drink or look for sexual partners, the excess and the wild, uncertain risk of the situation may be exactly what they are seeking. Appealing to the pocketbook of such a group is unlikely to be a winning strategy.

My aim is not to claim that excise taxes and bans on advertising have no use at all in dealing with South Africa`s alcohol problems. Indeed, as part of a well-functioning system, they may play an integral part. However, regressive alcohol taxes along with an increasingly privatised medical system does much to hinder this system, taking money and health care away from those who need it the most. It is also a mistake to think that taxes have a straightforward effect on consumption, especially for patterns of drinking which are seen as transgressive and a sign of conspicuous consumption. These large scale initiatives must not be the only measures taken against alcohol abuse as it pertains to HIV transmission in South Africa. A small scale approach, community led and based, not directly under government control must also be tried.

The possibility of small scale intervention

Reports by the WHO and others do not immediately rule out a community based approach to dealing with alcohol abuse. Indeed, the WHO`s report on approaches to alcohol abuse in developing countries claims that social and religious movements have "been among the most powerful catalysts in developing societies...in reducing rates of alcohol-based problems" (Jerrigan 2002, 25). However, the WHO's does not recommend that governments support or rely on these kinds of organizations. Instead, they suggest that what is necessary is a "global perspective on alcohol policy" (26). This implies that leadership and policy will be set on an international scale, and will require an integration of several vertical and horizontal levels of government to be effective. Yet, conditions and drinking cultures differ widely from area to area. Even national regulations often fail to take into account the specific conditions which give rise to problem drinking, and the specific problems which arise from it, such as the South African link between HIV and alcohol abuse. The WHO does not recommend that local groups lead the way on alcohol abuse because, in their view, "most commonly, such movements have arisen spontaneously," and "a perception of official co-option or manipulation tends to undercut the strength of such movements" (25). Though these concerns merit consideration, they are hardly a reason to abandon support for these organizations in favor of top-down solutions.

Alcoholics Anonymous is one of the first groups that comes to mind when considering small scale community organizations set up to battle alcohol abuse specifically. Though deeply rooted in an American protestant ethic, AA has shown itself to be exceptionally flexible in its over 75 year history and has spread throughout the world. AA "does not advocate any theological or ontological beliefs," and "speaks of this life" only

(Makela 1991, 1405-1406). It has had an almost unprecedented level of success and resiliency (White 2010, 1). South Africa has had AA chapters for over 60 years (D 2010, 3). Much of their work consists in trying to spread their message to those who need it across South Africa, translating AA literature into Zulu and Xhosa, and sponsoring outreach to youth and in prisons. What AA lacks is any kind of guarantee. Members are free to join and leave whenever they desire, and remain completely anonymous. As such, actions taken by the group are not easily measured, their efficiency and effectiveness cannot be assessed. Their anonymity also extends to politics, where they pledge to "remain forever non-professional," "never endorse any.....outside enterprise," and "ought never be organized" (Gross 2010, 2362). Rather than avoid this group, for fear of being seen as manipulating them, The South African government and the WHO should empower them, giving them support and information to help them do what they do more effectively. Funding groups such as this, allowing them to increase their scope while remaining outside of government or WHO control may be more effective than regulation in reducing alcohol abuse problems as well as the HIV transmission problems that they are linked to. Furthermore, AA and other organizations like this are cultural institutions. Rather than working indirectly, these groups may be able to have an impact on the culture of binge drinking and sexual violence at the heart of the problem. These kinds of groups work on a personal level, by persuasion and listening rather than by adjusting price levels.

Ethnographic studies focusing on the specific conditions of South African drinking culture also recommended small scale local efforts which could be very helpful. One study, looking at Shebeen culture, suggested that Shebeens, although a site where

much abuse takes place, may also be an important place to look to combat the problems associated with drinking. (Watt 2012a). Rather than shut down these unlicensed venues as an attempt to diminish alcohol consumption in South Africa, these venues could be sites of persuasion and change. Providing condoms and encouraging owners of Shebeens to support campaigns against sexual violence and risky sex. The problem of HIV transmission could be addressed directly, rather than indirectly through attempts to reduce alcohol consumption. Once again, knowledge of local culture can lead to support of individualized programs, rather than blanket ones. Enlisting interested parties and people actually living in these communities could likely build a more effective response. In order to do this, though, South Africa would need to spend money rather than raise it. Groups would have to be funded, and liaisons supported, laws enforced. However, measures such as these may be necessary to reduce the rate of HIV transmission and dangerous drinking in South Africa

Works Cited

Ataguba, John Ele-Ojo. "Alcohol policy and taxation in South Africa." *Applied health economics and health policy*. no. 1 (2012): 65-76.

Baliunas, Dolly, Jurgen Rehm, Hyacinth Irving, and Paul Shuper. "Alcohol consumption and risk of incident human immunodeficiency virus infection: a meta-analysis." *International Journal of Public Health*. (2010): 159-166.

Chersich, Matthew, Helen V. Rees, Fiona Scorgie, and Greg Martin. "Enhancing global control of
alcohol to reduce unsafe sex and HIV in sub-Saharan Africa." *Globalization and Health*. no. 5 (2009).

D, Ady, “AA in SA from the General Service Office of AA in South Africa,” AA’s General Service
Office. no. 1 (2010)

Doran, Christopher M., and Thameemul A. Jainulldeenabu. "Economic Efficiency of Alcohol
Policy." *Applied Health Economics and Health Policy*. no. 5 (2010): 351-354.

Foley, Ellen. Your Pocket Is What Cures You: The Politics of Health in Senegal. New Jersey:
Rutgers University Press, 2010.

Groes-Green, Christian. "Ambivalent Participation: Sex, Power, and the Anthropologist in
Mozambique."*Medical Anthropology*. no. 1 (2012): 44-60.

Gross, Michael. "Alcoholics Anonymous: Still Sober After 75 years." *American Journal of Public
Health*. no. 12 (2010).

Gysels, Marjolein, Robert Pool, and Betty Nnalusiba. "Women who sell sex in a Ugandan trading
town: life histories, survival strategies and risk." *Social Science and Medicine*. (2002): 179-192.

Haworth, A, and M Grant. "A perspective on alcohol studies in Africa." *Alcohol Health & Research World* . no. 3 (1993).

Jerrigan, David. Alcohol in developing societies : a public health approach. Summary. World
Health Organization, 2002.

Lesufi, Ishmael. "Six Years of Neoliberal Socioeconomic Policies in South Africa." *Journal of
Asian and African Studies*. (2002): 286-298.

London, Leslie. "The ‘dop’ system, alcohol abuse and social control amongst farm workers in
South Africa: a public health challenge." *Social Science and Medicine*. (1999): 1407-1414.

Macintyre, Kate, and Emily Bloss. "Alcohol Brewing and the African Tuberculosis Epidemic."
Medical Anthropology: Cross-Cultural Studies in Health and Illness . no. 2 (2011): 126-135.

Makela, Klaus. "Social and cultural preconditions of Alcoholics Anonymous (AA) and factors
associated with the strength of AA." *British Journal of Addiction*. (1991): 1405-1413.

Mager, Anne. "White liquor hits black livers': meanings of excessive liquor consumption in
South Africa in the second half of the twentieth century." *Social Science and Medicine*. (2004): 735-751.

Mandelbaum, David G. "Alcohol and Culture." *Current Anthropology*. no. 3 (1965): 281-293.

Mooney, Gavin H., and Diane E. McIntyre. "South Africa: a 21st century apartheid in health and
health care?."*Medical Journal of Australia*. no. 11/12 (2008): 637-640.

Parry, Charles D. H. "Alcohol policy in South Africa: a review of policy development processes
between 1994 and 2009." *Addiction*. (2010): 1340-1345.

Parry, Charles D. H. "South Africa: alcohol today." *Addiction*. (2005): 426-429.

Rataemane, Solomon, and Lusanda Rataemane. "Alcohol in South Africa." *International Journal
of Drug Policy*. (2006): 373-375.

Townsend, Loraine et al. ""Taking Care of Business": Alcohol as Currency in Transactional Sexual
Relationships Among Players in Cape Town, South Africa." *Qualitative Health Research* . no. 1 (2011): 41-50. 0.

Watt, Melissa et al. "Alcohol-Serving Venues in South Africa as Sites of Risk and Potential
Protection for Violence Against Women." *Substance Use and Misuse*. (2012): 1271-1280.

Watt, Melissa et al. "“Because he has bought for her, he wants to sleep with her”: Alcohol as a

currency for sexual exchange in South African drinking venues."*Social Science and Medicine*. (2012): 1005-1012.

White, William. "Commentary on Kelly et al. (2010):Alcoholics Anonymous, alcoholism recovery, global health and quality of life."*Addiction*. (2010): 637-638.

Willis, Justin. "Drinking Power: Alcohol and History in Africa."*History Compass*. (2005): 1-13.

Wojcicki, Janet Maia. "Commercial Sex Work or Ukuphanda? Sex-for-money Exchange in Soweto and Hammanskraal area, South Africa."*Culture, Medicine, and Psychiatry*. (2002): 339-37

Woolf-King, Sarah E., and Stephen A. Maisto. "Alcohol Use and High-Risk Sexual Behavior in Sub-Saharan Africa: A Narrative Review." *Archives of Sexual Behavior*. (2011): 17-42.

World Health Organization. Alcohol use and sexual risk behaviour : a cross-cultural study in eight countries. World Health Organization, 2005.

World Health Organization . Surveys of Drinking Patterns and Problems in Seven Developing Countries. World Health Organization, 2001.

World Health Organization. *Global status report on alcohol 1999*. World Health Organization, 1999.

World Health Organization. *Global status report on alcohol 2004*. World Health Organization, 2004.