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Evidence Review

ADDRESSING HARMFUL ALCOHOL USE TO REDUCE INTIMATE PARTNER VIOLENCE AND VIOLENCE AGAINST CHILDREN IN THE HOME

October 2024

INTRODUCTION

Alcohol use is one of the most consistent risk factors for intimate partner violence (IPV) and violence against children (VAC) around the world.[1, 2] Indeed, both the RESPECT and INSPIRE frameworks, which guide the global agendas around VAC and violence against women, now recognise reducing harmful alcohol use as an important prevention strategy.

While alcohol use is neither necessary nor sufficient for violence to occur, the evidence overwhelmingly suggests that addressing men's harmful drinking could reduce the frequency and severity of violence in the home and interrupt intergenerational cycles of abuse.[3, 4] **Yet addressing harmful alcohol use remains an underutilised strategy in the violence prevention field**; relatively few prevention efforts intentionally address harmful alcohol use or draw on effective strategies from the alcohol field. While alcohol has been implicated in multiple types of violence, this review focuses specifically on IPV and VAC in the home, the two most common forms of violence.

This review is written for violence prevention practitioners and researchers, as well as those working on alcohol use who are interested in addressing violence. It summarises what we know about the links between alcohol and violence in the home, describes the pathways through which they are linked, and explores how violence prevention interventions have incorporated alcohol reduction. It then describes a range of approaches to reduce harmful alcohol use at the policy, community, and individual levels. We conclude with implications for practice, highlighting the urgent need — and opportunity — for action (Go to page 26 for Definition of Key Terms).

CONTENTS

KEY MESSAGES

- Reducing harmful drinking can reduce the frequency and severity of violence and enhance the safety and well-being of women and their children.
- Research consistently demonstrates a strong link between men's harmful alcohol use and the risk of violence against women and children. Women frequently observe the same thing: violence is more likely when their partner is intoxicated.
- Various evidence-based strategies exist to reduce harmful alcohol use and address alcohol-related violence at the policy, community, and individual levels.
- Despite this, few violence prevention programmes intentionally address harmful alcohol use.
- Particularly promising (but underused) strategies include:
    - Integrating alcohol reduction strategies into (new or) existing violence prevention efforts (e.g., curriculum-based groups for couples);
    - Strengthening linkages with Alcoholics Anonymous or other mutual help/ peer support groups; and
    - Supporting community mobilisation around alcohol regulation and joining forces with groups advocating for stronger alcohol regulation.

Not addressing harmful alcohol use is a missed opportunity to reduce violence in the home!

UNDERSTANDING ALCOHOL USE

Around the world, alcohol is part of the social and cultural fabric of society. **Yet alcohol use is among the leading contributors to disease, disability, and mortality globally,** identified as a causal factor in more than 200 disease and injury conditions and resulting in 3 million deaths worldwide each year.[8] It is also associated with a range of negative social and economic outcomes, including violence. While the risk of negative health consequences is highest for those who are considered dependent on alcohol, the majority of alcohol-related problems can be attributed to the use of alcohol by non-dependent individuals — simply because they far outnumber dependent drinkers.[1]

Harmful alcohol use and other mental health concerns frequently co-occur. The relationship between poor mental health and alcohol use is complex: alcohol may be used to cope with psychological distress, or alcohol may actually increase the risk of other mental health conditions or exacerbate them. Both mental health and alcohol use may be a result of other risk factors, such as adverse childhood experiences. Learn more about pathways between, and interventions for, poor mental health and IPV here.

Alcohol use patterns differ consistently by sex, with men more likely to drink alcohol and to drink in more problematic ways, including drinking more frequently or

in larger quantities.[9] The WHO reports that men in low- and middle-income countries (LMICs) are twice as likely to drink alcohol as women, drink three times the amount that women do, and are more likely to binge drink.[10, 11] Men are also more likely to screen positive for alcohol use disorders than women.[12]

Gendered norms shape these patterns of alcohol use: in many settings, notions of masculinity are linked to frequent and heavy drinking.[11] A review of the masculinity and alcohol literature[13] reported that alcohol use was associated with masculine norms, including strength, stamina, aggressiveness, competition and dominance, risk-taking, power, and self-confidence; the desire to conform to such norms was a major motivator for men's drinking. Alcohol industry marketing efforts (and product options) are often designed to appeal to certain notions of masculinity (e.g., strength, financial and sexual success) and, increasingly, femininity (e.g., being attractive, sociable, and empowered).[14] The literature emphasises the ability to drink large quantities of alcohol and 'hold your liquor' as markers of masculinity and notes that alcohol is also used to lower inhibitions. These norms can be particularly powerful in certain social settings: research in the US and elsewhere demonstrates links between increased alcohol use/harms and male-dominated institutions like fraternities, athletic teams (and events), the military, and law enforcement.[13] At the same time, men often use alcohol to cope with shame or purposelessness related to their inability to achieve masculine ideals like providing for their family.[15] Social norms around women's drinking vary more widely, with greater stigma attached to women's drinking in many settings.[16] Of course, gendered norms interact with other factors: poverty, ethnicity, religion, and other context-specific norms shape drinking patterns and their consequences.[13]

Alcohol consumption levels are generally greater in higher- versus lower-income countries. However, emerging markets, young and urbanising populations, and targeting by the alcohol industry amid limited policy controls are creating a 'perfect storm' in LMICs that is driving increased alcohol use and related harms.[10, 17] Notably, traumatic legacies of colonisation and the importation of potent new forms of alcohol have resulted in disproportionate harm in some former colonies and among Indigenous peoples.[14]

There is an enormous unmet need for prevention and treatment.[18] A 2008 review found that globally, nearly 80 percent of people with alcohol use disorders did not receive treatment — the widest gap among all mental health disorders.[1,19] According to WHO data from 26 countries, only 7 percent of people with alcohol or drug use disorders across countries had received minimally adequate treatment — and only 1 percent of those in LMICs.[20] In addition to a lack of accessible services, gendered norms may pose barriers to accessing available services: men may be reluctant to seek help, and women who access alcohol treatment, especially mothers, may be stigmatised.[13, 21]

WHAT DO WE KNOW ABOUT THE RELATIONSHIP BETWEEN ALCOHOL USE AND VIOLENCE IN THE HOME?

Men's Alcohol Use and Intimate Partner Violence

Numerous studies show a strong and consistent association between men's use of alcohol and women's risk of experiencing IPV. [9, 11, 22, 23] This relationship has been demonstrated on every continent and across a range of study designs (e.g., longitudinal and cross-sectional studies, treatment studies, and experimental studies).[2, 24] For example, an analysis of nationally representative data from 28 LMICs found that male partner alcohol use was associated with women being 2.55 times as likely to have experienced IPV in the past year.[25] Alcohol use is also associated with increased perpetration of non-partner sexual violence[3] and other forms of violence and aggression.[10]

Heavy drinking is more strongly associated with IPV perpetration than more moderate use.[26] In particular, heavy episodic drinking (or 'binge drinking'), where multiple drinks are consumed over a short time, is linked to men's IPV perpetration. For example, a study across nine sites in Cambodia, Sri Lanka, Indonesia, and Papua New Guinea showed that men who reported having six or more drinks in one sitting at least once a month had 3.4 times the odds of using violence compared to men who abstained; there was also a less powerful association between alcohol and violence for occasional or moderate drinkers.[11] A 10-country study in Latin America also found this association between binge drinking and IPV, highlighting that the amount of alcohol consumed was more predictive of violence than the frequency of drinking.[27]

Alcohol use also leads to more severe episodes of violence. Studies suggest that violence is more severe and that injury is more likely when drinking or heavy drinking has occurred.[28] In a study across 13 countries, women consistently rated IPV incidents as more severe where one or both partners had been drinking.[29] Studies have also shown a temporal relationship — that is, that violence is much more likely to occur on days of drinking or after intoxication.[21]

Importantly, listening to women's experiences highlights the broad impact of men's drinking on women's lives. As Wilson and colleagues observe in a recent review: 'Almost 100% of the married women interviewed for a study in rural India blamed their husband's violence on alcohol. … In another study, a young pregnant Nepalese woman stated "It's only because of alcohol. There are no other reasons." … South African survivors of domestic violence described alcohol as a force outside of the man, the "demon of alcoholism" that must be cast out.[30] The same review highlights the multiple direct and indirect ways that husbands' alcohol use harms women, including negative effects on their physical, mental, and reproductive health; economic impacts; strain on their relationships; increased caregiving and domestic load; and social harms like shame, loneliness, and isolation.[30] Although the risk factors for IPV go beyond alcohol use, these studies demonstrate how male partners' drinking has broad ramifications for women's lives.

Women's Alcohol Use and Intimate Partner Violence

Among women, alcohol use appears to be both a consequence of and a potential risk factor for experiencing violence. Some longitudinal studies show a relationship between women's experience of IPV and subsequent (heavy) alcohol use.[31] Women who have experienced IPV may be using alcohol to cope with the psychological trauma of current or past violence or other traumatic experiences or to 'numb' themselves in anticipation of, or in response to, current violence.[32] There is also some emerging evidence, primarily from high-income countries, that IPV may impede women's access to substance use treatment and completion.[33] Women experiencing co-occurring IPV and substance use may also face challenges accessing IPV support services; some services exclude women with active substance use, for example, or may fail to understand and address both issues.[24, 34]

Heavy drinking also appears to increase women's risk of experiencing violence, though the evidence remains somewhat mixed.[31, 33] A 2014 meta-analysis[35] found that women's drinking increased the risk of both experiencing and perpetrating IPV.[31] However, a more recent review of studies that followed women forward in time and focused on violent episodes in the past 12 months found that the association was not statistically significant in either direction.[36] The authors of both reviews emphasise that the evidence is limited by methodological challenges, including differences in how different studies measure alcohol use and/or IPV and a failure to control for key factors that could account for the association, including her partner's alcohol use, her own prior alcohol use, or her previous experience of IPV. **It may be that the link between women's alcohol use and IPV victimisation actually reflects her partner's drinking**, as couples may drink together; alternatively, other factors, such as childhood trauma or mental health issues, could be driving both harmful alcohol use and experiences of IPV.[28, 31]

BOX A: DEBATE: WHY HASN'T THERE BEEN MORE COLLABORATION BETWEEN EFFORTS TO PREVENT VIOLENCE AND THOSE TO REDUCE HARMFUL ALCOHOL USE?

Given the links between alcohol and violence, it may seem surprising that there hasn't been more joint effort between feminist anti-violence activists and professionals in the alcohol field. Why is this the case?

A central point of contention has been the framing of the relationship between alcohol and violence, which is rooted in the historical and philosophical underpinnings of the two fields. Most of the work on violence against women emerged from the women's movement and focused on addressing gender inequality and the social and structural systems that drive violence; there was a strong emphasis on empowering women generally and survivors specifically. By contrast, while it has sought policy solutions to prevent alcohol-related harm, the alcohol field has not usually centred a gendered

analysis in understanding alcohol use. It has taken a more individualistic and 'medical' approach to treatment, often framing addiction as a disease or disorder in order to reduce stigma and encourage treatment. At the heart of the debate, then, is a concern that a focus on alcohol as a contributor to violence would undermine feminists' efforts to bring attention to how gender inequality and patriarchal power drive men's violence, and that it would allow perpetrators to evade responsibility and accountability for their choice to use violence against women and children and for the harm they cause.[24]

Increasingly, however, there have been impassioned calls to move beyond this debate, explicitly recognising the gendered ways in which alcohol affects violence and focusing on how to address both issues in order to develop effective prevention, response, and treatment options.[2, 9, 30, 37]

> ***Ignoring the presence of alcohol will neither eliminate its role in intimate partner violence nor prevent its being used as an excuse for violence. On the contrary, the more we know about how alcohol affects violence, including intimate partner violence, the better able we will be to develop effective prevention strategies and treatment responses.***
>
> **Graham et al., 2011[29]**

Alcohol and Violence against Children in the Home

Parents' or caregivers' harmful alcohol use has likewise been shown to have a range of detrimental consequences for children, including negative health, educational, and social outcomes.[38] It is also implicated in an increased risk of child maltreatment, including physical or sexual abuse and neglect.[38, 39, 40, 41, 42, 43] For example, one study in India found that 43 percent of men reported that as a result of their own or another adult's drinking, a child in their household experienced physical or psychological abuse or neglect in the past year.[44] The findings also suggest a dose-response relationship between the respondents' drinking patterns and reported harms to children: those reporting more drinking also reported more harms.[44] A similar study in eight countries — Australia, Ireland, Chile, Sri Lanka, Thailand, Vietnam, the Lao People's Democratic Republic, and Nigeria — also found that the presence of a heavy drinker in the home was strongly associated with reports of harm to children across all countries.[39]

Harmful alcohol use is linked to poor parenting practices. Caregivers who drink may be less responsive, be less involved, and have difficulty fulfilling their caregiver roles. They may be less able to provide financially for their children's needs and more likely to use harsh discipline.[40, 42, 45, 46, 47] Alcohol use is also linked to lower levels of parental monitoring and supervision, which may increase children's risk of experiencing sexual violence (from inside and outside the family).[43]

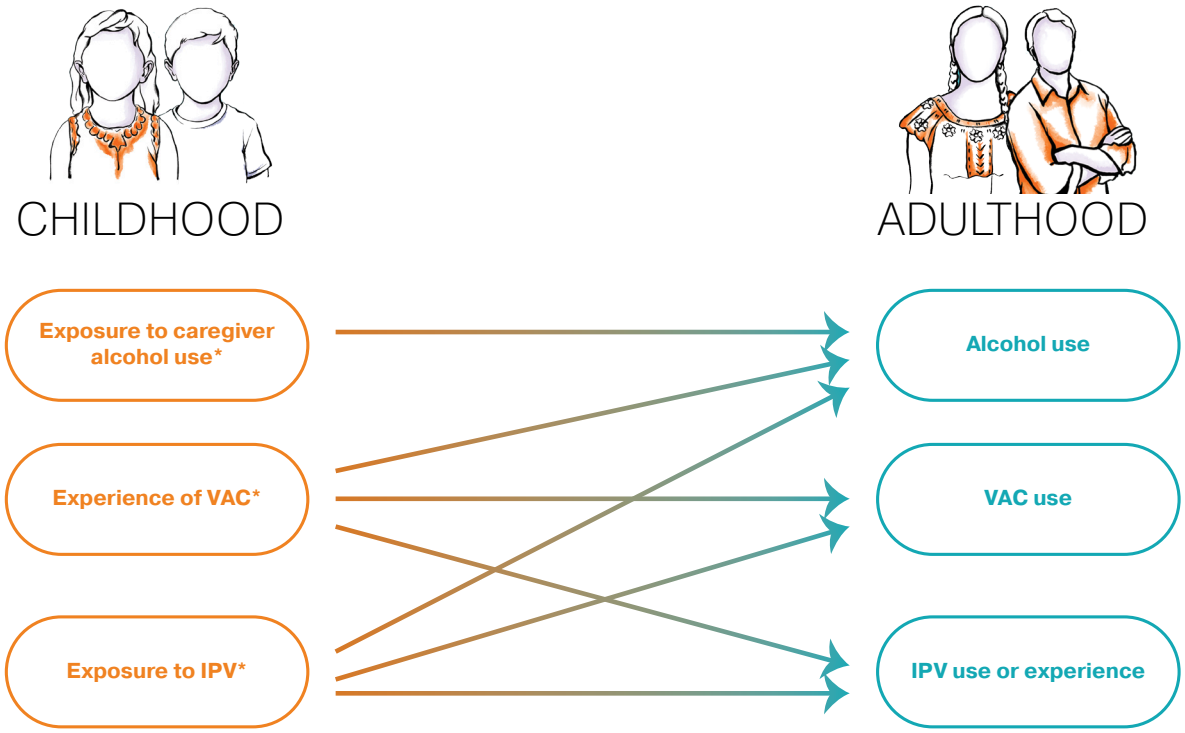
Parents and caregivers may use alcohol to cope with the stress and frustration of

parenting, especially where they have limited support and skills.[48] Indeed, a recent meta-analysis of US-based studies found that interventions focused on parenting skills and reducing parenting stress in combination with alcohol treatment were more effective than those focused only on alcohol.[49] Importantly, parenting can also provide the motivation to stop or reduce drinking.[21, 49] Indeed, there is evidence that even brief interventions that include (or focus on) parenting-related content are effective at encouraging parents with drinking problems to seek treatment.[38]

Nonetheless, the relationship between caregiver alcohol use and VAC is difficult to disentangle. Harmful alcohol use often co-occurs with other factors that increase the risk of VAC, including parental mental health concerns; financial, housing, or food instability; inconsistent employment; stress; and IPV.[42, 45] As Laslett et al. (2017) note: 'Where problematic responses to children (e.g., physical discipline) are common in families and where few other strategies and supports exist to minimize stressful situations, heavy drinking is likely to precipitate and worsen child abuse and neglect.'[39]

Moreover, alcohol use, IPV, and VAC are deeply intertwined, including across generations. Much has been written about cycles of violence, where children exposed to violence between their parents and/or experiencing violence themselves are more likely to perpetrate or experience IPV as adults and to use violence against their children.[50, 51] Harmful alcohol use is an important part of these cycles: it is linked to both perpetrating and experiencing IPV and to using VAC, and children exposed to violence are more likely to use alcohol or drugs as adults.[9, 52, 53] Parental alcohol misuse is also linked to their children's subsequent alcohol and drug use.[10, 38] Studies also show that women actively protect children from alcohol-related (and other) violence in the home, including sometimes by using harsh punishment themselves to avoid more severe punishment from the father.[32, 54] We developed Figure 1 as a simplified illustration of key relationships among IPV, VAC, and alcohol; other factors, including other adverse childhood experiences and parental attitudes, shape children's adult behaviours.

Figure 1. Intergenerational links among IPV, VAC, and alcohol



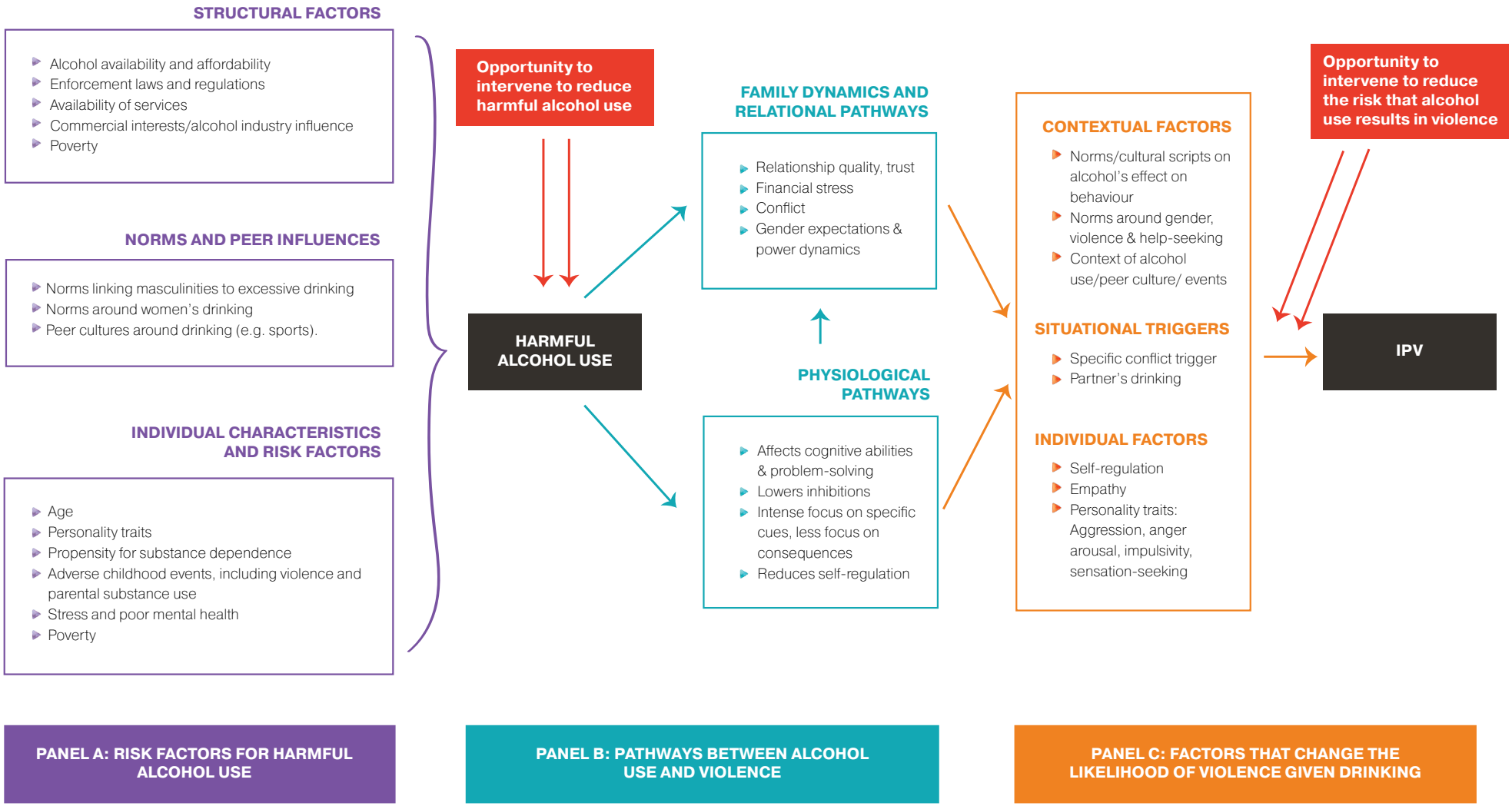
*Frequently co-occur, also with other adverse childhood experiences

BOX B: ALCOHOL INDUSTRY INFLUENCE

The multibillion-dollar alcohol industry is dominated by a handful of multinational companies that have expanded globally, focusing increasingly on LMICs.[55] The policies considered most effective in addressing harmful alcohol use are ones that limit the availability, affordability, and marketing of alcohol — in other words, policies that regulate the behaviour (and, therefore, limit the profits) of the alcohol industry.[56] Alcohol industry actors have been highly organised, strategic, and active around the world to obstruct and interfere with alcohol policymaking and enforcement, advocating for self-regulation rather than mandatory policy measures.[17, 56] The alcohol industry also works in other ways to increase exposure to their products, including through aggressive advertising and marketing and through sponsoring events such as sports and music festivals.[57]

Alcohol industry actors frame harms related to violence (and the appropriate policy responses) as related to consumers' individual responsibility, shifting the focus from structural, population-level interventions to individual behaviour change.[56, 58] While in some cases industry actors have sought to partner with and fund organisations working on violence, and supported campaigns against gender-based violence, we must view these efforts with scepticism given the industry's active opposition to broader efforts that might affect their businesses. Indeed, many public health groups recommend avoiding accepting funds from industry and industry-affiliated groups for health-related prevention, research, and educational activities.[17]

Figure 2. Pathways between harmful alcohol use and violence



HOW DOES HARMFUL ALCOHOL USE LEAD TO VIOLENCE?

In this section, we describe the pathways through which alcohol use may lead to perpetrating or experiencing violence (see Figure 2). We first describe risk factors for harmful alcohol use, then turn to how alcohol use is linked to violence. Finally, we look at factors that affect the likelihood that violence will occur in the context of alcohol use. These pathways are complex and involve an interplay among physiological processes, relationship and situational dynamics, and broader contextual and environmental factors.[28]

Risk Factors for Harmful Alcohol Use (Panel A)

Factors operating at the societal, community, and individual levels interact to shape drinking patterns. **Structural factors** include greater availability and affordability of alcohol (including, for example, alcohol outlet density, operating hours, and pricing), which is associated with greater alcohol use; the implementation and enforcement of alcohol policies, which can reduce use; as well as levels of gender inequality and economic development.[8] **Norms and peer influences** around drinking (including those related to masculinity and the acceptability of both normative drinking and intoxication) are also important in shaping drinking behaviours.

Individual characteristics and risk factors include being male, being young, being poor, experiencing adverse events in childhood (including violence), and a family history of harmful alcohol use.[8] In addition, personality or psychological traits (e.g., impulsiveness, low self-esteem), as well as genetic factors, make some individuals more vulnerable to harmful patterns of alcohol use.[59, 60] Poor mental health, including anxiety, depression, and post-traumatic stress disorder, are also associated with alcohol use.[60]

Harmful alcohol use, IPV, and VAC share several important risk factors, including (but not limited to) poverty, unemployment, adverse childhood experiences, and mental health concerns.[32, 61] As with violence, no one risk factor predicts harmful alcohol use; the presence of more vulnerabilities and stressors increases the risk of experiencing problems related to alcohol consumption.[59, 60]

Pathways between Alcohol Use and Violence (Panel B)

Research shows that alcohol use can result in violence through several related pathways that influence both the perpetration and experience of violence. These pathways are gendered: Men globally are more likely to drink and to drink in problematic ways that cause harm to others. In addition, women's drinking is more stigmatised in many contexts, and they are more often blamed for the violence they experience while drinking. We emphatically reject victim-blaming but aim to describe how alcohol use, together with other factors, can increase women's vulnerability to violence.

Family dynamics and relational pathways: Alcohol use can erode relationship quality in the family, an important protective factor against abuse.[62, 63] For example, in a programme to reduce harmful drinking in Kenya (see Box H), women and children

described how drinking made men inattentive to and neglectful of family issues. Prior to the programme, women said their partners' spending on alcohol led to mistrust, conflict, and violence in the relationship. After the programme, women and their children reported more positive family relationships, including better communication, more transparency around finances, and more time spent together.[64]

Men's alcohol use can increase conflict in family relationships, including arguments over drinking behaviours and over the diversion of family income to alcohol. Qualitative studies of families in Zambia and non-cohabitating young adults in South Africa also found that respondents strongly associated drinking with male infidelity, with men sometimes responding violently if challenged about their behaviour.[65, 66] In addition, in the South African study, many men perceived women's drinking in public as a challenge to their authority and a sign of infidelity — both of which could trigger violence.[66]

Physiological pathways: Most directly, alcohol's pharmacological properties affect people's thinking, their behaviour, and their ability to solve problems and resolve conflict.[9,67] Alcohol use, particularly intoxication, makes people more likely to focus their attention on — and misinterpret — specific social cues, narrowing in on what they experience as provocations or 'misreading' sexual interest or consent.[9, 67, 68] It reduces people's capacity to self-regulate, lowers their inhibitions, and increases risk-taking.[21, 68] Alcohol may make it more difficult for individuals to think through the consequences of their actions.[16] It can also 'impair a victim's judgment, making them less able to de-escalate situations of conflict; reduce their capacity to implement safety strategies; [and] increase their dependence on a violent partner'.[24] Taken together, these effects can contribute to violence perpetration or victimisation.

Factors That Change the Likelihood of Violence Given Drinking (Panel C)

Alcohol's physiological effects alone are not sufficient to explain the relationship between harmful alcohol use and violence.[2] Alcohol is 'neither a necessary nor sufficient cause of violence, and its role is not uniform.[69] A balance of contextual, situational, and individual factors — those factors that may instigate violence and those that may inhibit it — combine to affect the probability of violence in any given situation.[2, 28]

Contextual factors, including the physical drinking environment (such as alcohol outlet density and location, lighting, and operating hours)[70] and social and gender expectations around what happens or is acceptable when drinking, may affect whether intoxication results in violence. As noted earlier, gender norms often equate masculinity with risk-taking, physical and sexual aggression, and the ability to drink heavily, which may shape behaviours.[11] For example, in a qualitative study in Australia, women reported that in a context where 'everyone drinks', men's excessive drinking was accepted as 'normal' and their problematic drinking went unaddressed and was made 'invisible'.[52] Alcohol-heavy, male-dominated sporting events often create such permissive environments.[71] Similarly, norms that 'excuse' intoxication and alcohol-related violence may lower inhibitions around violence or lead perpetrators to drink deliberately to have an excuse for being violent.[72]

Perpetrators may use women's alcohol use as a justification for violence, seeing female drinking and/or intoxication as unacceptable and/or transgressing gender norms.[31, 73] More broadly, norms around family privacy and against help-seeking may lower support for victims and increase the risk of violence recurring. As noted earlier, norms, together with practical barriers, can result in less support and less access to services for both men and women.[24, 72] **On the other hand, social norms that condemn alcohol-related violence and support survivors may inhibit the use of violence**.[72]

Situational triggers, the immediate events or circumstances that can cause conflict in a relationship and precipitate an episode of violence, are particularly relevant in the context of alcohol use. As noted earlier, drinking contributes to and exacerbates conflict within couples — related to drinking behaviours and to spending, adultery, or an inability to perform or adhere to expected roles.[66] This conflict can be ongoing, but it can also trigger aggression in the moment, especially if a person is intoxicated. Indeed, research has shown IPV is both more likely and more severe when both partners have been drinking.[74]

Individual factors, including personality characteristics such as antisocial traits, high anger arousal, and impulsiveness, have been found to be associated with aggression while drinking, while self-regulation skills and empathy may reduce the risk of acting violently when drinking.[2]

In summary, Figure 2 shows the complex and intersecting pathways between alcohol use and violence. Importantly, it also highlights the need and opportunity for interventions to both reduce alcohol use and interrupt the relationship between drinking and violence, which are explored in the next section.

WHAT WORKS TO ADDRESS VIOLENCE AND HARMFUL ALCOHOL USE?

Despite the links between alcohol and violence, few violence prevention interventions explicitly address harmful alcohol use, and few alcohol reduction approaches specifically address violence prevention.[28, 75] In this section, we explore alcohol-related content in existing IPV prevention programmes, highlight examples of programmes that have successfully addressed both alcohol and violence, and delve in greater detail into what works to prevent harmful alcohol use.

Alcohol Content in Existing IPV Prevention Programmes

While a scoping review of 40 group-based IPV prevention curricula (from 31 distinct programmes) in LMICs found that many curricula mention alcohol use, **less than a quarter of the curricula had specific activities or sessions dedicated to discussing alcohol or ways to reduce or manage its use**.[76] The curricula that did have such content generally included a discussion about the connection between alcohol (and drug use) and stress, and provided tips on avoiding or reducing alcohol use (e.g., tell your friends and family that you are trying to drink less and ask them to support you,

drink slowly and drink water between alcoholic drinks, or only carry enough money for one or two drinks). None focused on community action or policy advocacy to limit access to alcohol.[76, 77]

Interestingly, several IPV prevention programmes have been shown to affect **both alcohol use and IPV** despite not being intentionally designed to reduce harmful drinking.[3]

BOX C: PROGRAMME EXAMPLES

- The Stepping Stones and Creating Futures (SS-CF) intervention in South Africa, a group-based gender-transformative and livelihood strengthening programme for young men and women, found significant reductions in men's overall alcohol use and perpetration of physical IPV despite the curriculum having no specific content on harmful alcohol use.[78] SS-CF had no impact on young women's use of alcohol or on their experiences of IPV. The authors hypothesised that this lack of impact may have been due to the high levels of trauma these women experienced prior to the intervention, making it difficult for them to engage in the programme.[3] An earlier Stepping Stones trial in South Africa similarly found reductions in both alcohol use and IPV perpetration. Zindagii Shoista, an adaptation of SS-CF for couples and extended families in Tajikistan, showed continued declines in men's reported alcohol use and less IPV 30 months after the intervention.[79]

- Couples participating in the Change Starts at Home programme in Nepal, which included a session on alcohol, recounted in a qualitative study that male participants reduced their use of alcohol (and spending on alcohol), which resulted in improved communication, greater conflict resolution, and less violence.[80]

- The Bandebereho programme for parents in Rwanda also showed sustained differences in alcohol use between the intervention and control group at both 21 months and six years after the intervention. In further analysis of the 21-month follow-up, alcohol use emerged as an important mechanism through which the intervention reduced violence, accounting for nearly one-quarter of the treatment effect on IPV.[81] Only one of Bandebereho's 15 sessions was on alcohol use, with this men-only session focused on 'discussing reasons for drinking, consequences of excessive drinking and drug use, and how men can help each other in reducing the harm caused by drugs and alcohol'.[82] The analysis indicated that there is enormous untapped potential to integrate additional alcohol reduction strategies within this and other IPV prevention interventions, which could lead to greater reductions in violence.

While their content on alcohol was limited, these group-based IPV interventions employed some of the elements routinely used in alcohol interventions: they supported participants in strengthening self-regulation, building stronger social ties (with their partners and children, and also with group members), developing alternatives to drinking, and providing aspirational goals for men and couples to strive for. In addition, the broader focus on masculinities and gender norms, the building of relationship skills and family bonds, sessions on economic development and joint financial decision-making that made visible the costs of alcohol consumption, and the participatory reflection and discussion-based modality may have contributed to these changes.[3] These findings suggest that **there are opportunities to further incorporate and strengthen alcohol reduction strategies within violence prevention in LMIC contexts to mutually strengthen and reinforce positive outcomes**.

In addition, there are some promising examples of integrated programmes that intentionally address both alcohol and violence in the family.[37] Existing examples of integrated interventions (see Box D) are often implemented with people with more severe cases of alcohol abuse or violence (e.g., men enrolled in batterer intervention programmes) and may function differently for other populations.

BOX D: PROGRAMME EXAMPLES: ADDRESSING BOTH VIOLENCE AND ALCOHOL USE

- The **Violence and Alcohol Treatment (VATU) intervention in Zambia** adapted the Common Elements Treatment Approach (CETA) to work with families experiencing at least moderate levels of IPV and harmful alcohol use. CETA is a flexible therapeutic intervention that combines treatment strategies common to many mental health issues, including harmful substance use, into a single model that can be delivered by trained and supervised lay providers. CETA was modified to specifically address IPV and alcohol use, including discussions of safety planning and behavioural or situational modifications to help prevent violence.[83] Couples received separate individual CETA sessions (six to 12 weekly one-hour sessions). A trial found significant reductions in women's reports of IPV and men's alcohol use, with sustained impacts after two years.[4, 84] A qualitative study of the mechanisms driving the changes in violence included reductions in men's or women's alcohol use, participants' use of de-escalation strategies that they learned about (e.g., walking away or staying quiet), fewer sources of conflict related to alcohol and money, and increases in trust and communication between the couple.[65]

- The **Women's Health Co-Operative** (WHC) is a gender-focused two-session intervention to address HIV, violence, and alcohol use among sex workers and non-sex workers in South Africa. A six-month follow-up study found that compared to participants in a standard HIV prevention intervention, non-sex workers participating in WHC were less likely to drink and to meet diagnostic criteria for alcohol dependence,

more likely to report condom use at last sex, and less likely to report sexual abuse by their main partner. Sex workers reported less physical abuse by a main partner.[85] To better address risk factors for HIV and violence, the **WHC intervention was adapted to also include either couples together or sex-separated groups**. A trial comparing three intervention configurations (women-only with male partners receiving usual HIV testing and counselling, couples together, and sex-separated men's and women's groups) found that after six months heavy drinking among men decreased in all three arms; however, men in the couples' group were half as likely to report heavy drinking than men in the sex-segregated group. Heavy drinking decreased among women in both the women-only and couples' interventions, but not in the sex-segregated women's group.[86] Women in both of the arms that engaged men were more likely to report improvements in gendered power dynamics and relationship quality than those in the women-only group, though the specific outcomes varied between the couples' and sex-segregated groups. For example, women in the sex-segregated group were more likely to report no IPV victimisation in the previous three months compared to women in the other two intervention arms.[87]

- In South India, men recruited from in-patient alcohol dependency treatment who had perpetrated IPV in the past six months participated in an eight-session **integrated cognitive behavioural intervention** (ICBI). The sessions addressed the relationship between alcohol and IPV, triggers for alcohol use and IPV, and the consequences, and participants learned cognitive behavioural techniques such as relaxation, anger management, assertiveness, and cognitive restructuring. A trial three months post-intervention found that while both the integrated intervention and a one-session 'treatment as usual' approach reduced alcohol consumption, the integrated intervention also showed reductions in IPV and improved mental health reported by the participants' wives.[88]

INTERVENTIONS TO REDUCE HARMFUL ALCOHOL USE

The alcohol field has its own set of approaches and interventions to reduce harmful alcohol use. Alcohol interventions can generally be broadly categorised as:

- Structural or policy interventions, widely seen as the most effective approaches to reducing harmful alcohol use;
- Community interventions that aim to reshape the drinking environment;
- Group-based/peer support systems like Alcoholics Anonymous; or
- Individual psychological or behavioural interventions, including brief interventions, structured psychological or behavioural interventions, and pharmacological treatments.

Importantly, interventions at different levels are complementary and necessary. Individuals and families need programmes to prevent and/or treat alcohol and its related harms; at the same time, population-level reduction in harmful alcohol use requires structural interventions. **This review focuses in large part on individual- and community-level interventions,**

in part because these are common in the violence prevention field and provide a ready opportunity for collaboration. However, policy and structural approaches are necessary to achieve true population-level change.

While the alcohol field has paid increasing attention to alcohol's harm to others, and some work has been done around combined substance use and perpetrator programmes in high-income countries,[89] there is a continued lack of attention in alcohol interventions to outcomes related to violence against women and children.[75, 90]

Structural or Policy Interventions

Structural policy interventions are key to reducing alcohol consumption and its related harms at a population level.[28, 90, 91] The WHO recommends the following policy interventions as 'best buys' for reducing harmful alcohol use, based on their cost-effectiveness and feasibility to implement:[92]

- **Regulating the availability of alcohol:** Evidence suggests that regulating or reducing the number and types of places that sell or serve alcohol, for example, or changing the hours they are open has an important impact on drinking patterns, as well as on alcohol-related harms that include injuries and homicides. Additional regulation includes restricting the concentration of outlets that sell alcohol, and establishing age minimums.[28, 93, 94]

  Some recent reviews have found only weak evidence of a direct association between policies that restrict alcohol accessibility and IPV.[28, 95] However, **other studies — particularly those examining IPV's impact on COVID-related alcohol bans — found much stronger associations**. For example, a study of a COVID-related alcohol ban in South Africa found that 77 fewer homicides, 790 fewer assaults, and 105 fewer rape cases were reported weekly during the ban period compared to the preceding five weeks, reflecting a drop in each outcome of 21 percent, 33 percent, and 19 percent, respectively.[96] Similarly, a ban on alcohol sales in Mexico during COVID found a reduction of 2.1 domestic violence crimes per 100,000 people (from a pre-pandemic mean of 13.2 per 100,000) in municipalities that passed alcohol sales bans.[97] While such pandemic-era bans may not be feasible or desirable in the long term, the evidence suggests that restricting alcohol availability can reduce or change patterns of alcohol consumption and have a dramatic impact on violence in the home.

BOX E: ALCOHOL POLICY AND VIOLENCE IN INDIA: EVIDENCE FROM NATURAL EXPERIMENTS OVER 30 YEARS

India provides an interesting case study on the effectiveness of policy changes, as its decentralised structure and changes in alcohol policy allow for 'natural experiments' over time and between states/settings.[95] An analysis of policy changes from 1980 to 2010 in India found that alcohol prohibition was associated with an 8 to 9 percentage point decrease in the likelihood of a man beating his wife, **a nearly 50 percent reduction**.[98,99] Another study on a policy that shut down bars serving hard liquor in Kerala found that it 'resulted in a decline in incidence of sexual assaults against women, which was not offset by an increase in domestic violence. … The most conservative results show a reduction in sexual assault cases by approximately 10 per cent after the regulation was implemented.'[100]

- **Reducing the affordability of alcohol through taxation or price regulation:**[101] A meta-analysis of over 100 studies, while quite dated (2009), found that a 10 percent increase in alcohol prices decreased alcohol consumption by approximately 5 percent.[102] Higher prices were also found to reduce the harms of alcohol, including assault, traffic accidents, and health consequences.[92]

  Taxes and pricing policies may affect different population groups — and even types of drinkers — differently. Heavy drinkers, for example, may be less likely to change their drinking behaviours in response to price changes and may end up spending less on essential goods like food or housing,[92] potentially leading to more economic hardship and family conflict.[95] Price changes can also push people to buy illegal or informal sources of alcohol;[92] this may be particularly relevant in LMICs, where a larger proportion of the alcohol consumed is home-brewed or informal.[103]

- **Regulating or banning alcohol marketing**[104] to counter alcohol industry efforts to promote positive attitudes towards alcohol and alcohol use, which associate it with success, social status, and fun and often appeal to gendered stereotypes:[28] Recent research suggests that exposure to alcohol marketing, initiation of drinking, and binge drinking are strongly related. The WHO strongly encourages marketing restrictions, though these are admittedly difficult to enforce, especially across new digital media.[28]

Implementing **a suite of policy interventions** (and effectively enforcing them) may have an even larger impact on alcohol use than any single intervention. A simulation model of 10 potential policy options across 48 countries[105] found that a package that included raising alcohol taxation, minimum unit pricing, regulation of alcohol advertising and statutory bans on advertising to children, sobriety checkpoints to counter drink-driving, and alcohol counselling in primary care would be the most effective in reducing the harms of alcohol, preventing 6 million cases of dependence and 1.8 million cases of injury every year.[92] This package of interventions also showed a positive impact on employment, productivity, and reducing countries' predicted health expenditures.

The evidence that such policies are effective at reducing harmful drinking is stronger in high-income countries than in less advantaged ones — potentially because fewer studies have been done to evaluate alcohol policies in LMICs. Indeed, there is a notable scarcity of policy studies that explore how alcohol regulation affects patterns of drinking and violence in LMICs.[91, 101, 106] The evidence linking reduced alcohol availability to reductions in violence is also stronger for assaults, homicide, and sexual assault than for violence in the home.[72, 90, 94, 107] This may be an artefact of researchers' reliance on crime data for conducting such studies. It is important to test how different alcohol policies specifically affect violence in the home, especially since some policies may shift drinking from public places into the home.

Additional policies may be particularly relevant to preventing alcohol-fuelled violence, as highlighted by Karriker-Jaffe et al (2023):[90]

- **Individual-level bans**, which aim to prevent harms caused by specific drinkers: For example, in South Dakota, United States, alcohol consumption bans and consequences for people who were convicted of drunk driving found that IPV-related arrests dropped by nearly 10 percent in the implementing counties.[108] Similarly, in Canada and in Australia's Northern Territory, individuals can apply to ban a particular person from purchasing alcohol.

- **'Dry zones', or 'rationing'**, which restrict alcohol availability or limit an individual or household's ability to purchase alcohol: While there are questions about whether dry zones have actually improved women's safety, Karriker-Jaffe et al. (2023) write that a recent study found the 'introduction of local dry zones in Western Australia was associated with decreases in substantiated child abuse and neglect cases'.[90] Similarly, studies in Sweden and Greenland demonstrated associations between rationing and reduced alcohol consumption as well as fewer alcohol-related crimes and reports of violence. Karriker-Jaffe and colleagues emphasise that 'it remains to be determined whether alcohol rationing may be an acceptable approach for controlling alcohol consumption in the current era, but evidence suggests it may be broadly impactful if adopted and may be a policy option for certain communities'.[90]

Advocating for alcohol policies has not generally been a priority for violence prevention practitioners. However, historically, women's movements have responded to how men's drinking harms women and children by advocating for policies and programmes to reduce alcohol use (e.g., efforts among Australian Indigenous populations, on Pacific Islands, and in India).[109] Closer collaboration between the violence and alcohol fields may provide additional support and rationales for key decision-makers to take on issues of alcohol and develop a more nuanced understanding (and evidence base) on policy interventions to reduce alcohol use and violence in the family.

Community and Civil Society Interventions to Change the Drinking Environment

Environments characterised by high availability, affordability, and acceptability of

alcohol increase the risk for alcohol consumption, especially among young people.[57] **Community-based interventions to change the drinking environment and drinking-related social and gender norms are therefore needed to support and sustain both individual-level change and alcohol control policies.** Yet relatively few examples of such community-based interventions from LMICs have been documented or evaluated.[110]

A set of case studies compiled by the WHO highlights community and civil society efforts to support alcohol regulation or contest alcohol industry influence.[57] For example, in Uganda, alcohol was traditionally sold in small plastic sachets that were inexpensive and accessible to young people. Civil society organisations advocated for many years to ban sachets by raising awareness about the problem and collecting and sharing evidence of its harms. The government banned the sale of alcohol sachets in 2016, though it took several years to effectively implement the ban and alternative products, like small bottles, are now available.[57] Similar bans were instituted in other countries, including Tanzania, Ivory Coast, Senegal, Malawi and Rwanda.[111]

Community-based interventions that aim to holistically address both alcohol and violence offer promising models. **In South Africa, Sonke Gender Justice developed a community mobilisation approach** (now expanded but not yet used by another organisation, ADAPT) to increase community awareness about, and strategies for community-led advocacy on, the full enforcement of alcohol regulations to address alcohol-related harms.[112] **In Sri Lanka, the Foundation for Innovative Social Development's Happy Families programme is a comprehensive community engagement and empowerment model** that works with women, children and youth, and men to challenge harmful social norms and expectations around drinking, strengthen family ties, provide alternative activities, and promote community action and advocacy for better policies to prevent alcohol use and its harms.[113]

Studies of interventions to change the drinking environment to address violence have focused on drinking in public settings and included elements such as bystander training for bar staff and enhanced policing and enforcement of drinking restrictions. While these are promising, however, relatively few evaluations have been done, especially in LMICs.[90]

Group-Based/Peer Support Systems

Group-based mutual support systems, most notably Alcoholics Anonymous (AA), may be an especially promising strategy to address harmful alcohol use in LMICs. AA is a non-professional, community-based mutual help system that works to provide long-term, free, ubiquitous, and easily accessible support through a network of gatherings. Developed in the 1930s and 1940s in the United States out of a religious/spiritual tradition, AA has both a social component that includes peer support, role modelling, and mentorship through a sponsor and a structured 12-step programme intended to help participants initiate and maintain abstinence from alcohol, strengthen interpersonal and coping skills, and improve well-being.[114] AA now has more than 123,000 groups in approximately 180 countries and an estimated membership of over 2 million people.[115] In some countries where AA is easily accessible, it 'is part of the de facto system of care for [alcohol use

disorder]'.[116] Indeed, professional, manualised '12-step facilitation' interventions now exist to facilitate referral to and engagement with AA or similar programmes.[116]

Studies have found that AA works through multiple mechanisms, many of which are similar to professional therapeutic approaches. These include changes in participants' social networks (towards social relationships that support recovery) as well as through strengthening coping skills, motivation for recovery, self-efficacy, psychological well-being, and skills to manage impulsivity and cravings.[116, 117]

Evidence from high-income countries shows that AA/12-step facilitation interventions work better than other treatments for facilitating ongoing abstinence/remission and are at least as effective as other treatments in reducing the intensity of drinking, the severity of addiction, and drinking-related consequences.[116, 118] AA has been shown to benefit a wide range of populations: for example, men and women, racial and ethnic minorities, young and old, and religious and non-religious people.[116]

Given its structure, AA is also far less costly than other interventions, and as such, is especially promising for LMIC contexts, though limited research has been done on its effectiveness there. AA can provide 'free, long-term, easy access and exposure to recovery-related common therapeutic elements, the dose of which can be adaptively self-regulated according to perceived need'.[114] It may also be particularly appealing in contexts where religion or spirituality are important.[16]

Individual Psychological or Behavioural Interventions

A range of individual psychological and behavioural interventions is commonly used to address alcohol use. These interventions vary in length and therapeutic approach, and they are often geared towards, and differ in their effectiveness for, different groups or types of drinkers. Individual treatments need to take into account the drinker's substance use patterns and severity.

Brief Interventions

Brief interventions typically aim to reduce harmful alcohol use among drinkers who are not specifically seeking help for alcohol problems. They are not particularly effective for people with more severe alcohol use disorders, though they can be used to encourage the initiation of more specialised treatment. They are considered promising interventions recommended for use in low-resource settings because they do not require extensive resources or specialisation.[119]

Effective brief interventions typically include:

- Feedback on the person's alcohol use and the potential harms and benefits of reducing drinking;
- Identification of high-risk situations for heavy drinking;
- Advice on how to cut down on drinking;

- Strategies to increase motivation to change drinking patterns; and
- Development of a personal plan or goals to reduce drinking.[120]

When delivered as part of a regular consultation with a health or social service provider, they tend to be quite short — one or more five- to 15-minute sessions — and fairly directive, aiming to prompt behaviour change by providing participants with information on their own drinking behaviours and the harms of alcohol use.[121] On the other hand, many other brief interventions use a motivational interviewing approach, which explicitly avoids giving directive advice and instead focuses on uncovering and building on existing motivation for change. These interventions are typically longer — several sessions, usually between 20 and 40 minutes but sometimes up to an hour.[120, 121]

The evidence for brief interventions in high-income countries, accumulated over 40 years, is considered fairly robust. A recent systematic review and meta-analysis of brief interventions, primarily from high-income countries, found that men and women participating in brief interventions drank less than the comparison group (which received minimal or no intervention) one year after the intervention.[120] The reduction was equivalent to a pint of beer or a third of a bottle of wine less per week. Longer counselling seemed to provide little additional benefit over the brief interventions.[120]

The evidence on brief interventions from LMICs is both more limited and more mixed. Several recent reviews suggest that brief interventions (as well as other psychosocial interventions) are promising, but there is substantial variation in intervention features, high levels of uncertainty, and small effect sizes.[1, 18, 122] Nevertheless, several programmes have demonstrated effectiveness: for example, a brief motivational interviewing intervention in India consisting of up to four 30- to 45-minute sessions delivered by lay counsellors found positive effects on alcohol use that were sustained over one year; notably, the study did measure IPV perpetration but did not find a reduction.[123, 124] Similarly, a review of alcohol interventions in Kenya found five evaluations of brief interventions that were reported as feasible, acceptable, and effective in reducing alcohol use; one study also found a reduction in IPV. There is likewise preliminary evidence that brief digital interventions may be effective in reducing alcohol consumption (for example, in Brazil, Korea, and Kenya).[125, 126]

BOX F: WHAT DO BRIEF INTERVENTIONS LOOK LIKE?[127]

The WHO's brief interventions in primary care manual outlines the following steps for brief interventions. These steps would be followed once a person's drinking is identified as risky or hazardous using a screening questionnaire such as the Alcohol Use Disorders Identification Test (AUDIT):[128]

- Inquiry: Asking clients whether they would like to see their questionnaire scores;
- Feedback: Offering personalised feedback on scores;
- Advice: Providing advice on how to reduce the risks associated with substance use;
- Responsibility: Allowing clients to take responsibility for their choices;
- Concerned: Getting feedback from clients on how concerned they are about their scores;
- 'Good' and 'less good' things: Weighing what is good about using the substance against what is less good;
- Summarise and reflect: Going over clients' feedback on substance use, emphasising the 'less good things' and how clients feel about these; and
- Take-home materials: Providing clients with materials they can use to complement the brief intervention.

Structured Psychological or Behavioural Interventions

More intensive or longer-term psychological or behavioural interventions are also commonly used to prevent and treat harmful alcohol use and alcohol use disorders. These interventions aim to strengthen coping skills, modify responses to triggers, and reinforce abstinence or reduced drinking.[18] **While these interventions vary in their duration, frequency, and provider, they typically consist of longer sessions over a longer period compared to brief interventions and are appropriate for people with a wider range of harmful drinking**.[119] They also include inpatient treatment in specialised settings, which in some LMICs is still the main treatment option, though it typically is not very accessible and focuses on the most severe cases.[18]

Research on different psychological approaches to addressing alcohol use disorders in high-income settings suggests these approaches are roughly interchangeable, resulting in comparable outcomes — perhaps because of factors common across approaches.[129] A recent review examined studies of effective psychological treatments to assess which core components or strategies were commonly used. These included assessment, personalised feedback, motivational interviewing, goal setting, homework setting and review, problem-solving skills, and relapse prevention/management.[129] Emerging evidence also shows that other types of interventions used for other mental health conditions (e.g., mindfulness practices) might also help reduce harmful alcohol use.[130, 131]

The evidence base on psychosocial interventions in LMICs is increasing and suggests that these types of interventions have the potential to reduce harmful alcohol use and are feasible in LMICs. However, a 2023 systematic review concluded that while promising, **there is currently insufficient evidence to determine the efficacy of psychosocial interventions on reducing harmful alcohol use in LMICs**, due in large part to substantial differences between interventions and studies.[18]

Pharmacological Interventions

A handful of pharmacological treatments have been approved to address alcohol use disorder and dependence: disulfiram, naltrexone, and acamprosate. Each works in a different way: promoting abstinence and preventing impulsive drinking, reducing cravings, or supporting the maintenance of abstinence. One evidence review has found that in LMICs, combined pharmacological and psychosocial interventions may reduce alcohol use compared to psychosocial interventions alone, but the evidence's level of certainty remains low.[18]

BOX G: PROGRAMME EXAMPLE: LEAD, ENGAGE, ACT, DEDICATE (LEAD)

LEAD was a five-session individual treatment programme for men in Kenya to address harmful alcohol use, depression, and family challenges. Recognising how social norms and failure to meet gendered expectations (for example, of being a provider) contribute to men's harmful drinking, LEAD incorporated discussions of gender and masculinities, and a focus on men's roles in and goals for their family, into a more typical brief therapeutic intervention. The first session used *motivational interviewing* to explore and enhance men's readiness to change their drinking behaviours. The following four sessions focused on replacing 'drinking and isolating behaviours triggered by negative emotions with healthy, value-based behaviours for self and family'; participants also learned refusal skills and communication techniques to help them manage social pressures to drink.[54] LEAD was framed as a leadership programme to help people reach their goals and values and reduce the things that get in the way of these goals, like drinking.[132]

A very small quantitative and qualitative pilot study found that in the month following treatment, participants were more than five times as likely not to drink, and when they did drink, they drank 50 percent less.[133] The study also found improvements in depression; couple and father-child relationships; and the mental health of the participant, their partner, and their children. In a follow-up study, partners and children also described 'men's reduced drinking, reduced spending, increased family-focused effort (e.g., coming home early), as well as increased emotion regulation, and openness to and communication with family', contributing to women's and children's well-being.[54] While larger-scale implementation and evaluation are needed, these initial findings suggest this may be a promising approach.

IMPLICATIONS FOR PRACTICE

Addressing the harmful use of alcohol is an important — and underutilised — strategy to reduce and prevent violence against women and children. There is enormous potential to reduce violence by explicitly and intentionally addressing harmful alcohol use — particularly by men — at multiple levels of the social-ecological model. Such efforts may enhance the impact on both violence and alcohol outcomes, and importantly, acknowledge women's (and children's) lived experiences. In this final section, we highlight the implications of this evidence for practitioners — primarily for those working on violence prevention, although these may also be useful for those focusing on alcohol reduction.

- **Take action on alcohol use:** As the violence prevention field, our limited efforts to date to address alcohol use are a missed opportunity and a failure to listen to women's voices. It is time for more intentional action on alcohol and violence in the home.

- **Strengthen collaboration and co-learning across the fields of violence prevention and alcohol (and mental health more broadly):** Both violence and alcohol practitioners can benefit from greater understanding and expertise on the strong links between alcohol and violence in the family, their common risk factors, and the existing strategies to reduce alcohol use and prevent violence. This is an important first step that can support thoughtful innovation and improve outcomes in both fields.

- **Build on the most promising approaches and seek opportunities for integration and innovation:** Existing approaches offer a solid starting point. However, new approaches and strategies for integrating these approaches with violence prevention — especially in individual-, family-, and community-level programming — are both needed and feasible:

    - **At the individual level, more intentionally and explicitly address alcohol use, and integrate effective alcohol reduction elements or approaches** (such as building on existing motivations, setting goals, and strengthening self-regulation skills) into existing violence prevention models, such as couples' and parenting programmes. Programmes like CETA offer a useful therapeutic model to start from.

    - **At the group or community level, develop connections with local peer/mutual support groups, such as AA**, where they exist and/or support these groups' establishment. AA is highly effective, simple to set up, and essentially free, and it may be particularly appealing in LMIC contexts.

    - **Use community mobilisation** to raise awareness of the harms and costs of alcohol use and to involve communities in advocating for policies and their enforcement.

- **Join advocacy efforts for gender-informed alcohol regulation:** Violence prevention groups can join forces with the groups advocating for alcohol regulation in their context and globally to promote better policies (informed by community needs, stronger implementation of existing policies, and careful evaluation from a

gender perspective). More research is also needed on how alcohol policies affect violence in the home, including specifically in LMICs.

- **Ensure that programming addresses the contextually gendered and relationship/family dimensions of alcohol use:** for example, by including discussions of infidelity and alcohol in couples' programming, working with men on their perceptions and response to women's drinking, or addressing parenting stress and skills.

- **Measure both alcohol use and violence when evaluating programmes or policies:** To expand our evidence and understanding on integrated programmes — or even just programmes focused on substance use in LMICs — more programmes should consider measuring their impact on IPV and child maltreatment as well as on alcohol use.[1]

- **Select, train, and support practitioners to address both alcohol and violence:** In both the alcohol and violence prevention fields, the success of interventions depends on the workforce implementing them. Effective psychosocial support interventions to reduce alcohol use depend on the skill of the provider or facilitator, and evidence from LMICs suggests that lay counsellors are effective. This suggests that it is feasible to train and support the (typically lay) providers from violence prevention programmes on incorporating alcohol reduction strategies, though additional research and testing are necessary.

- **Recognise the need for specialised support and establish referral pathways:** Not all alcohol use is the same — it may not be appropriate to include people with severe alcohol use disorders or dependency in violence prevention programming without additional support. Similarly, alcohol programmes need to consider the risk for violence in the family. It is important to train facilitators/providers to recognise this, and at minimum, programmes should develop and share referral options and pathways to existing resources.

ACKNOWLEDGEMENTS BOX

This brief was written by Ruti Levtov. It builds on a 2011 review by Lori Heise (What Works to Prevent Partner Violence? An Evidence Overview). At the Collaborative, it was reviewed by Crystal Dicks, Kate Doyle, Tania Ghosh, Lori Heise, and Erin Stern. External reviewers include Ali Giusto, Dean Peacock, Leane Ramsoomar-Hariparsaad, and Ingrid Wilson. It was edited by Jill Merriman and designed by Ana Lucia Ñustes.

The **Prevention Strategies Series** highlights a range of diverse — and sometimes underutilised — approaches that can prevent violence in the home. We focus on information useful to violence prevention practitioners and researchers, as well as those working in other fields who are considering addressing violence prevention in their programming.

DEFINITION OF KEY TERMS

In this review, we primarily use the term **harmful alcohol use** to refer to 'drinking that causes detrimental health and social consequences for the drinker, the people around the drinker and society at large, as well as the patterns of drinking that are associated with increased risk of adverse health outcomes'.[5] **Alcohol use disorder** is an umbrella term that encompasses a range of problematic drinking behaviours (including harmful use); it is a medical diagnosis based on specific criteria (for example, those laid out in the International Classification of Diseases, where it is classified as a mental health disorder). **Alcohol dependence**, sometimes referred to colloquially as alcoholism, is considered a severe form of alcohol use disorder and is characterised by both a strong desire to drink and difficulty controlling use despite negative consequences.[6]

This review focuses on **intimate partner violence (IPV)**, defined by the World Health Organization (WHO) as 'behaviour within an intimate relationship that causes physical, sexual, or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse, and controlling behaviours' by current or former partners.[7] We also focus on **violence against children (VAC) in the home**, which refers to all forms of physical, sexual, and emotional violence — including neglect, maltreatment, exploitation, harm, and abuse — towards a child under the age of 18, happening in the context of their home or family relationships.

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