World Health Organization

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Programming Idea 16: Addressing the intersections of violence against women, harmful alcohol use and HIV risk

What it involves: Addressing the intersections of violence against women, harmful use of alcohol and HIV risk is an emerging area of programming. It can include:

- policies to reduce alcohol availability, such as restricting hours and days of sale, implementing a rationing system, introducing minimum purchase-age policies and reducing the density of retail outlets;
- policies to regulate the prices of alcohol and increase taxes;
- policies to ban alcohol advertising and marketing (e.g. in movies, through merchandise, events, internet, podcasts, mobile phones);
- early identification of problem drinking and counselling interventions in health care settings.

Summary of the evidence: The relationship between harmful use of alcohol and violence is complex. Alcohol is not considered to be a cause of partner violence, but rather a contributing factor. Not everyone who drinks is equally at risk of committing violence. In many cultures there are high rates of violence against women even though alcohol is considered taboo. Studies show that drinking, especially binge drinking by men, may increase the frequency and severity of intimate partner abuse, and that the risk of partner violence is elevated on days when men drink *(28,66)*. Studies show that excessive alcohol use by male partners is strongly associated with HIV infection. A systematic review of 86 studies in sub-Saharan Africa found that alcohol consumption is consistently associated with unprotected sex, multiple partners, coercive sex, and transactional sex. The meta-analysis showed that drinkers have 1.57 times the risk of acquiring HIV compared to abstainers, and problem drinkers have 2.04 times the risk compared to abstainers *(33)*.

A meta-analysis of 112 studies shows an inverse relationship between high prices and taxes on consumption of alcohol and heavy drinking *(159)*. A meta-analysis of 23 interventions involving early identification (i.e. screening) and brief counselling by health care providers, implemented in primary care settings from the USA, also shows promise in reducing men's problem drinking *(160)*. However, these two meta-analyses did not include impact on partner violence or HIV outcomes. Other studies from Australia and the USA show that policies to reduce availability of alcohol (e.g. to curb density of alcohol outlets, reduce opening/selling hours) can potentially lead to fewer alcohol related problems, including domestic quarrels and assaults *(66)*. Community interventions to change drinking norms are an emerging area, with ongoing interventions in sub-Saharan Africa (e.g. Namibia, South Africa) *(161,162)*. See Annex 1.14 for examples of interventions for this programming idea.

Conclusion: Addressing the intersections of alcohol use, violence against women and HIV is an emerging area for programming. Evidence from high-income countries suggests that policies to reduce access to and availability of alcohol can reduce problem drinking, and may reduce situations that trigger violence (e.g. domestic quarrels). However, evidence on impact of these strategies on actual reductions in violence against women and on HIV-related outcomes is lacking.

Annex 1.14. Good practice examples, programming idea 16: Addressing the intersections of violence against women, harmful alcohol use and HIV risk

Policies to reduce availability of alcohol: In Australia, the population of Halls Creek, a small town in the remote Kimberley region of Western Australia, is predominantly Aboriginal. After many years of high alcohol consumption, a number of measures were taken in an effort to redress its negative influence on the community. Key among these was a restriction on the trading hours when 'take-away' alcohol was available. The effects of this intervention were monitored by examining longitudinal patterns of alcohol consumption, incidence of crime, and outpatient data at the local hospital. The data were compared with equivalent periods prior to the restricted trading hours. A decrease in alcohol consumption was observed for each of the two years following the intervention. Overall, incidence of crime declined. Alcohol-related presentations to the hospital and presentations resulting from domestic violence decreased relative to the equivalent quarterly period prior to the intervention. There were short-term fluctuations observed, particularly with domestic violence, where presentations (of less severity) became more frequent during several quarters. Emergency evacuations as a result of injury showed a marked decrease. The consistency of trends across a variety of health and social data showed a positive effect after the implementation of restricted trading hours. While a direct effect is likely, a multitude of concurrent programmes promoting health in the community place limitations on this conclusion. The process in achieving change, supported by statutory measures, has however, been successful in curbing the morbidity and mortality experienced by the community *(198)*.