

Alcohol's impact on the health and wellbeing of women in low- and middle-income countries: An integrative review

Anne-Marie Laslett^{1,2}, Megan Cook^{1,3}, Leane Ramsoomar⁴, Neo Morojele⁵, Orratai Waleewong⁶

¹ Centre for Alcohol Policy Research, La Trobe University, NR1 Building, Melbourne, Victoria 3086, Australia.

² Care Economy Research Institute, La Trobe University, NR1 Building, Melbourne, Victoria 3086, Australia.

³ Institute for Social Marketing & Health, University of Stirling, Stirling, United Kingdom.

⁴ South African Medical Research Council, Pretoria, South Africa.

⁵ University of Johannesburg, Johannesburg, South Africa.

⁶ International Health Policy Program, Ministry of Public Health, Thailand.

Abstract

In lower- and middle-income countries (LMICs), alcohol poses significant challenges to the health, well-being, and safety of women. This integrative review builds upon a previous rapid assessment conducted by Laslett and Cook in 2019, delving into the specific impacts of alcohol on women's health in LMICs while also shedding light on research gaps across different global regions. We advocate for further research endeavours and policy initiatives aimed at addressing these deficiencies. Additionally, we prompt discussions regarding the necessity of establishing distinct priorities for alcohol research, monitoring, policy, and evaluation tailored to women's needs in LMICs, as compared to those for men or the general population, particularly in high-income countries (HICs).

Introduction

Alcohol's harms to women have historically been understudied compared to research that has focused on men, and this imbalance continues in many basic areas (Holman & Armstrong, 1992; Rehm et al., 2021). Moreover, alcohol's harm to women in low- and middle-income countries (LMICs) is also neglected. While sharing biological and social consequences of alcohol use with women in high-income countries (HICs), alcohol's harm to women in LMICs arises and is managed in different contexts. Women (and men) experience more harms per litre of alcohol consumed in LMICs than in HICs (Room et al., 2022; Room & Rehm, 2023). There is also evidence that suggests there is more stigma linked to mental illness and alcohol use in LMICs than in HICs (Semrau et al., 2015; Sorsdahl et al., 2012), and towards women than men globally (Pauley et al., 2023; Sorsdahl et al., 2012), including in some LMICs (Slabbert et al., 2020). The norms and culture of drinking by women and related stigmatisation of women vary greatly across LMICs. Women may be treated worse (in terms of respect and in terms of availability, quality and tailoring of treatment) than men in communities and in health care settings as a result and may be less likely to seek treatment; indeed, men are much more likely to be in treatment than women (Slabbert et al., 2020; Sorsdahl et al., 2012). Although, in some ways

these norms have protected women from drinking like men (Holmila & Raitasalo, 2005). However, women are commonly more affected by others' drinking than are men, with this situation more often arising from men's drinking than women's drinking. This is especially true with women much more likely to be affected by men's than women's drinking in LMICs (Laslett et al., 2020; Laslett et al., 2019).

An Overview of Women's Alcohol Consumption Globally, Regionally and in LMICs

Globally, an estimated 312 million women drank harmful amounts of alcohol in 2020 (GBD, 2022). Alcohol is a major cause of ill-health and poorer wellbeing for women worldwide, including in LMICs, due to both women's own drinking, as well as men's drinking (Wilson et al., 2024). In HICs the gender gap in drinking is narrowing, and this trend is being mirrored in some LMICs (World Health Organization [WHO], 2018). Nevertheless, men continue to drink more heavily than women, particularly in LMICs (Grittner et al., 2020).

The global prevalence of drinking and per capita consumption, according to WHO, has increased since 1990 and is predicted to continue to rise until 2030, particularly in large LMICs such as India, China and Vietnam. The prevalence of women's and men's drinking and heavy episodic drinking (HED) in these large LMIC countries is

driving increases in alcohol consumption and harms in the Western Pacific and South East Asian Regions (Manthey et al., 2019). Models of per capita alcohol consumption developed by Manthey and colleagues (2019) show higher than global rates of consumption for women in many regions (comprising mostly LMIC countries) in East Asia, Eastern Europe, Southern Latin America, Tropical Latin America, Southern sub-Saharan Africa and Western sub-Saharan Africa.

A recent study of alcohol use disorder (AUD) prevalence (using DSM-IV criteria for “alcohol abuse” or alcohol dependence [American Psychiatric Association, 2000]) in 13 LMICs across four continents, found the prevalence of AUD among women to be 1.1% in low- to lower-middle income countries and 4.0% among women in Upper-middle income countries, ranging from 0.1% in Nigeria to 4.9% in South Africa (Glantz et al., 2020). Where detailed studies of women's drinking patterns have been undertaken, for example in Sub-Saharan Africa, 22.2% - 37.5% of women are current drinkers (compared to 38.9% - 55.4% of men), 32.2% – 71.3% of women who drink are heavy episodic drinkers (HED; Morojele et al., 2021) and consumption rates per woman who drink are high: between 4.74 litres (Central Africa) and 12.76 litres (Southern Africa; Morojele et al., 2021). Such HED has been associated with a range of non-communicable, communicable and neonatal diseases and injuries to oneself (Morojele et al., 2021), and to others, including both the frequency and severity of intimate partner violence (IPV; WHO, 2016, 2018).

While many of the effects of alcohol on men and women are similar, some of the physiological and pathological health effects of alcohol are worse for women (Erol & Karpyak, 2015). Although the underlying mechanisms will not likely differ in LMICs, most research on the differing biological effects of alcohol on the sexes is based on research largely undertaken in HICs (Erol & Karpyak, 2015). For instance, any drinking has been found to increase the risk of breast cancer (Shield et al., 2016), and women are more likely to experience medical problems like alcohol-related liver disease and cardiomyopathy after a shorter duration or a lower volume of consumption than men, and to die at an earlier age than men if they die of an alcohol-related cause (Erol & Karpyak, 2015). Recently, Rehm and colleagues (2021) reported that across alcohol-related conditions, in general women experienced a greater increase in relative risk per gram of alcohol consumed than men. Wilsnack and colleagues found globally that women's own drinking contributed to a range of different health problems, including cardiovascular disorders, liver disorders, cancer, brain and neurocognitive deficits, as well as physical injuries from the behavioural and social consequences of HED. These include alcohol-impaired driving, sexual assault, and IPV (White, 2020; Wilsnack et al., 2018). Currently, meta-analyses, have shown higher relative risks for women than men associated with alcohol consumption for HIV, hypertensive heart disease, ischemic heart disease, both stroke types, liver cirrhosis, and pancreatitis (Rehm et al., 2021). However, for many other conditions, research has been undertaken mostly on men (Holman & Armstrong, 1992; Rehm et al., 2021). Given the HED undertaken by women who do drink in

LMICs, the disease and injury sequelae they experience should be treatment, reporting system and policy priorities.

In addition to patho-physiological differences, there are gender differences in the socio-psychological harms that may occur in LMICs: women are less likely than men to experience problems from their own drinking, e.g., alcohol use disorders and dependence (Wilsnack et al., 2000), but more likely to experience alcohol-related intimate partner homicide and other harms from their partners and family members (Stanesby et al., 2018; United Nations Office on Drugs and Crime, 2019). A recent review by Wilson and colleagues (2024) of qualitative studies of men's drinking showed the many social harms (mental health impacts, quality of marital relationships, social isolation, impact on the family) that women face. This review found that 65% of these studies came from LMICs. This may be because of greater interest in qualitative research in LMICs than in HICs, or because funding of quantitative and biomedical research about the health effects of alcohol on women in LMICs is limited. While alcohol has been identified as a risk factor for more than 200 diseases, whether alcohol is responsible for the same proportion of all of these conditions experienced by men and women is less clear, as is whether the risk is similar across the world, with many studies still generating alcohol attributable fractions regardless of gender or country, despite evidence being based largely on men in HICs (Rehm et al., 2021).

Our Approach (Methods)

The aim of this integrative review is to summarise the multitude of ways in which alcohol adversely affects women's health, wellbeing and safety in LMICs and to encourage discussion on the priorities for research, monitoring, policy and evaluation that could be established to ensure women's alcohol-related harms are minimised and their wellbeing maximised in LMICs. First, we summarise harms to women in LMICs from their own drinking and secondly, we describe harms from others' drinking.

This summary is based on four information sources: (a) a rapid review by Laslett and Cook, 2019; (b) recent Global Burden of Disease (GBD) data (GBD Study Team Figure 1, produced by Jiang and Laslett, 2023 on 2019 data); (c) a small number of selected additional reviews (Kilian et al., 2023 ; Kilian et al., 2020; Rehm et al. (2021) identified in a recent review of reviews undertaken by Karriker-Jaffe et al. (2023); and (d) a pooled analysis of data across five studies in Africa (Ramsoomar et al., 2021).

In the recent rapid review conducted by two of the authors (Laslett & Cook, 2019) we found 275 publications on alcohol-related harms to women and children in LMICs. Laslett and Cook (2019) undertook a rapid review of all studies published in the Medline, CINAHL, PsycInfo and Web of Science databases between January 2008 and July 2018. Thirty-eight publications documented physical and mental health alcohol-related harms to women from their own drinking and 18 studies documented harms to women from others' drinking. Twenty-five described how women's drinking was related to progression to more serious drinking

problems. A total of 172 papers documented gender based and/or IPV-related harms (Laslett & Cook, 2019). Key sections from the review by Laslett and Cook (2019) on diseases, injuries, mental health and violence are reproduced and paraphrased here with permission from FORUT. FORUT is a Norwegian non-government organisation, working towards poverty reduction and for a fair and just world. Translated and abbreviated from Norwegian, FORUT stands for working for development and is owned by Norwegian peace- and sobriety organisations IOGT, Juvente and Juba. We have updated this information by including recent Global Burden of Disease (GBD) data and a small number of selected additional reviews identified in a recent review of reviews undertaken by Karriker-Jaffe and colleagues (2023). The additional review articles included Kilian and colleagues (2023; 2020), and Rehm and colleagues (2021) and a pooled analysis of data across five studies in Africa (Ramsoomar et al., 2021).

Findings

Effects from Women's Own Drinking

Deaths

In 2019, 374,000 deaths of women were attributed to alcohol globally (GBD Risk factor collaborators, 2020). In 2016, 26.1 million disability-adjusted life-years (DALYs) were

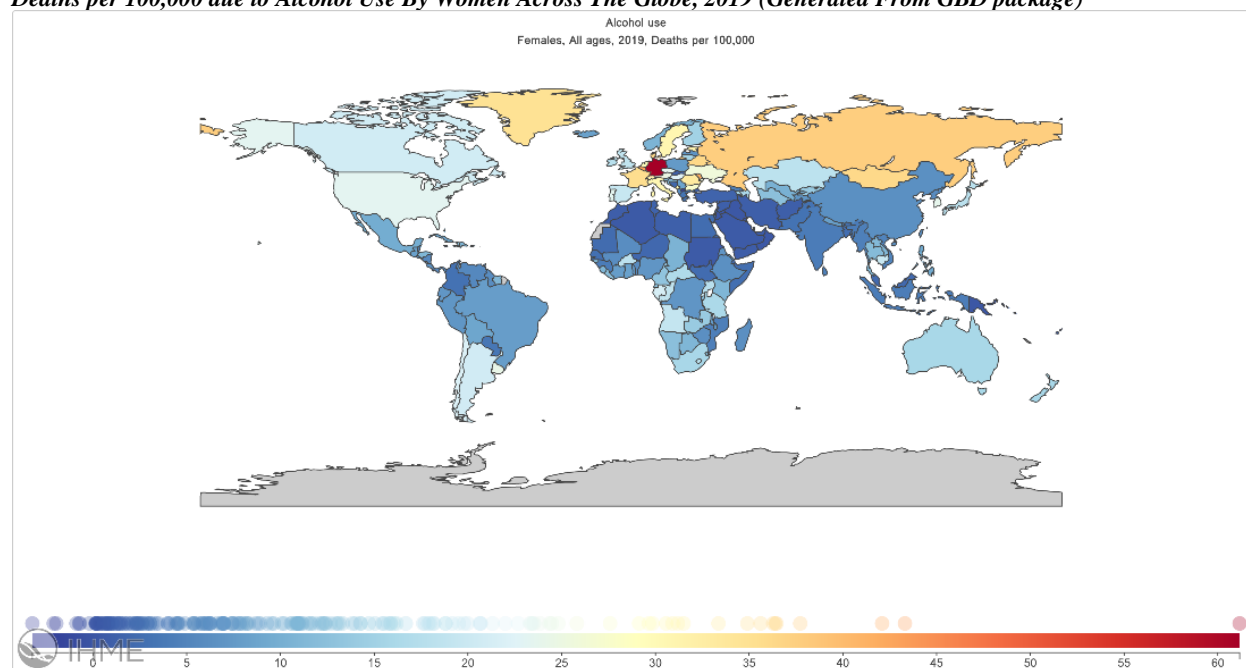
attributed to alcohol globally for women (WHO, 2018), and among women aged 15–49 years, 3.8% of deaths and 2.3% of DALYs were attributed to alcohol use (GBD 2016 Alcohol Collaborator, 2018). As depicted in Figure 1, women were identified as experiencing higher rates of deaths due to alcohol (pale-blue to orange colours) than the global average in countries in Sub-Saharan Africa: Angola, Burkina Faso, Central African Republic, Gabon, Lesotho, The Republic of the Congo, Uganda; in South America: Argentina, Chile, French Guiana and Uruguay; and in Azerbaijan, Cambodia, Kazakhstan and Mongolia in Asia. The LMICs with the highest rates are seen in Europe, in Belarus, Bulgaria, Estonia, Lithuania, Moldova, Romania, Russia and Ukraine (GBD Study Team Figure 1, produced by Jiang and Laslett, 2023 on 2019 data). Cohort studies provide stronger evidence on the associations between drinking frequency and all-cause mortality among women in LMICs and are described in [Table S1](#).

Women's Drinking and Non-Communicable Diseases

[Table S1](#) outlines the many increased risks of a range of non-communicable diseases (NCDs) associated with women's drinking found in LMICs. These diseases include breast cancer, oesophageal cancers, stroke, acute pancreatitis, reproductive disorders, genitourinary problems and gout. Much of the research on NCDs is undertaken in HICs, with few studies of many of these conditions identified in LMICs.

Figure 1

Deaths per 100,000 due to Alcohol Use By Women Across The Globe, 2019 (Generated From GBD package)



Infectious Diseases, including Sexually Transmissible Infections

Studies of infectious diseases, including sexually transmissible infections (STIs) in LMICs and alcohol consumption by women were relatively commonly identified and summarised in [Table S1](#). Alcohol,

particularly HED, is associated with sexual risk-taking by men and women, for instance unprotected sex and sex with multiple partners (Scott-Sheldon et al., 2016). In turn these risky behaviours are associated with increased prevalence of HIV, with the risk for women influenced by their own and men's drinking behaviours (Kalichman et al., 2007). Women

reported that their own alcohol consumption was a factor contributing to the failure by men to use of condoms and engaging in unprotected sex in some countries, and that men's drinking was also a factor (discussed later). Studies of drinking and adherence to HIV treatment and the consequences of not doing so for HIV are also described in [Table S1](#). Recent estimates indicate that 7,000 or 2.2% of HIV cases in women in South Africa are attributable to alcohol (Rehm, Probst, et al., 2017). It is important to note that the GBD factors one's own alcohol consumption into estimates of sexual-risk taking and consequential impacts on HIV and other STIs, however the way harms from others' (particularly men's and partners') drinking affects women, is not included in current GBD estimates. Moreover, many studies of infectious diseases and STIs in LMICs are undertaken in high-risk groups, e.g., female sex workers (FSWs), pregnant women and women living with HIV, where there is stigma and heightened surveillance and testing of women at risk and who come into treatment (compared to women in the general population).

Injury

High risk drinking, consumption of four or more drinks in a day or eight or more drinks in a week, by women increased the risk of violent injury, specifically, the risk of being hit or stabbed in China, Ghana, India, Mexico, Russia and South Africa (Clausen et al., 2015). In an emergency department study in the Dominican Republic, Guatemala, Guyana, Nicaragua and Panama, the reported drinking of alcohol by women at the same time of the injury but in the prior week increased the likelihood of intentional and unintentional injuries more than fivefold (Borges et al., 2013).

Mental Health

Studies in several LMICs, for instance, Brazil, China, Colombia, India, Mexico, Mongolia and South Africa, reported links between women's own drinking and alcohol-related mental health problems (See [Table S1](#)). These included associations between women's drinking and a range of mental health disorders such as: borderline personality and antisocial personality disorder, severe psychological distress, suicidality, self-harm, major/severe depressive symptoms and chronic pain. Again, among women at higher risk of a range of health and social harms, for instance FSWs or caregivers of children with HIV/AIDS, or women who had recently given birth, alcohol along with other risk factors has been linked to poorer mental health outcomes. This was particularly evident where intersections between alcohol use, mental health problems, partner violence, HIV and illicit drug use were evident. Many studies found maternal alcohol consumption to be significantly associated with postnatal depression (Ahmed et al., 2018; Matos et al., 2009; Póo et al., 2008; Savarimuthu et al., 2010) although the direction of the association was not clear.

Self-Rated Health

Self-rated poor health was associated with being both a current drinker or a former drinker, with females more likely to rate their health as poor than males in Malaysia (Chan et al., 2015). Surprisingly little information was found linking

women's own alcohol consumption and quality of life or personal wellbeing in LMICs.

GBV, IPV, and Women's Consumption of Alcohol

In sub-Saharan Africa, women who reported higher frequency and consumption of alcohol were more likely to report experience of gender-based violence (GBV), including courtship, dating violence and rape (see [Table S1](#)). However, among women in these settings, alcohol alone did not significantly account for the joint experience of GBV and these sexual risk behaviours, although alcohol use partially accounted for women's sexual risk behaviours (Pitpitan et al., 2013). While recognising that women's drinking may increase the risk of GBV victimisation, this type of study can be problematic. Such studies do not consider the perpetrator's drinking or other perpetrator characteristics (as discussed below). Nevertheless, in conjunction with other evidence, these studies can highlight that men may be likely to target women who have been drinking, or target women because they have been drinking, and that men's drinking may also be associated with greater reported perpetration of GBV and IPV. Women were at greater risk of GBV where there was evidence of significant intersecting oppressions, e.g., poorer health, alcohol consumption, HIV and IPV (Jiwatram-Negron et al., 2018; Wilson et al., 2016). In South Africa, hazardous drinking was reported as an outcome of IPV, associated with six times the odds of experiencing physical, sexual abuse and emotional abuse (Jina et al., 2012). Fewer studies were identified in LMICs outside of Sub-Saharan Africa.

The Impact of Alcohol via Others' Drinking on the Health of Women in LMICs

While women drink and may affect their own health, alcohol also causes a range of harms to others, i.e., to those other than the drinker, and women bear a substantial burden of the harms from men's drinking. In analyses of alcohol's harm to others survey data from Sri Lanka, India, Nigeria, Viet Nam and Thailand, 3.4% to 30.3% of women reported any drinking, yet 33.5% to 77.1% of women reported experiencing harm from others' drinking (Laslett et al., 2019). Moreover, in a study of ten countries, predominantly LMICs, for women the most harmful drinker was often a male partner, friend or relative (Stanesby, Callinan et al., 2018). Men's drinking in LMICs is a key risk factor for a range of conditions that affect women, and these are subdivided below into physical and mental health outcomes, GBV and IPV, and then a range of problems that intersect to worsen women's health and wellbeing. Supporting details for each section from specific studies are summarised in [Table S2](#).

Physical and Mental Health Outcomes for Women associated with Men's Drinking

For many conditions, only women's own drinking has been studied in terms of its relationship to physical and mental health outcomes in both HICs and LMICs. However, where a partner's drinking has been considered, there is evidence that a partner's heavy drinking has the potential to affect women's physical health as well as their mental health (See [Table S2](#)). In biomedical studies, alcohol's relation to risky

behaviours has been linked to the increased prevalence of injuries and infectious diseases like tuberculosis and STIs, with the risk for women often influenced by men's drinking behaviours rather than their own (Kalichman et al., 2007). For instance, when men's drinking is associated with aggression, it may affect women, increasing the stress and strain women experience in their lives as they react to their partner's behaviour (Callinan et al., 2019), including by having to care for them due to their drinking (Jiang et al., 2022). A number of individual studies (See [Table S2](#)) in India, Malaysia and Uganda identified how a husband's alcohol use was associated with an elevated risk of common mental disorders (CMD) and suicidality (Shidhaye & Patel, 2010) and partners' alcohol use was found to affect postnatal depression in women experiencing IPV in Malaysia (Ahmed et al., 2018) and India (Savarimuthu et al., 2010).

Gender-Based Violence (GBV) and Intimate Partner Violence (IPV)

Studies of women's partner's drinking and its association with GBV and IPV were published more often than studies on other health and social harms. Men's drinking was a commonly identified factor in studies of IPV across several LMICs including in Nigeria, Kenya, Malawi, Tanzania, South Africa, Russia, Turkey, Bangladesh, Philippines, Nepal, India, Peru and Brazil. Studies in 14 countries in sub-Saharan Africa found partner alcohol use was associated with a significant increase in the odds of reporting IPV for all 14 countries and that the relationship between alcohol use and IPV, although largely explained at the individual level by partner alcohol use, was also attributable to the overall prevalence of alcohol use in a given country (Greene et al., 2017). Pooled analysis of the association between alcohol use and violence against women from four GBV prevention studies in Africa (South Africa [two studies], Ghana, and Rwanda), found that harmful alcohol use among men was associated with a substantially increased odds of perpetrating physical IPV (adjusted OR [aOR] = 3.45) and non-partner sexual violence (aOR = 2.64), and that women who had seen their partner frequently drunk were almost six times more likely to experience physical IPV (Ramsoomar et al., 2021). Individual studies also demonstrate that women in many LMICs reported that their partner's (synonymously in these contexts, the man's) use of alcohol is quantitatively associated with physical IPV (See [Table S2](#)).

The WHO Multi-country Study on Women's Health and Domestic Violence surveyed women aged 15-49 years from Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Republic of Tanzania, Samoa, Serbia and Montenegro, and Thailand, between 2000 and 2003, and found that men's drinking consistently increased the risk of IPV; this risk was elevated when both the woman and the spouse drank. In five of the 14 sites, women's drinking was significantly associated with increased risk of IPV, but the odds of increased violence were lower than when men drank problematically (Abramsky et al., 2011). Based on population-attributable fractions for IPV perpetration reported by men, this study showed factors related to gender and relationship practices to be most important in accounting for IPV perpetration, followed by experiences of childhood trauma, alcohol misuse and depression, low education,

poverty, and involvement in gangs and fights with weapons (Fulu et al., 2013). In a study of 13 HICs and LMICs, severity ratings were significantly higher for IPV incidents in which one or both partners had been drinking compared to incidents in which neither partner had been drinking (Graham et al., 2011).

Pregnancy, Men's Drinking, and IPV

Several studies consider how pregnant women are affected by IPV and how this risk is increased due to alcohol (See [Table S2](#)). In a review of 19 African studies of women attending health care services in South Africa conducted between 2000 and 2010, including a meta-analysis of 13 studies, 15% of women experienced IPV while they were pregnant. In five of these studies a partner drinking too much (OR = 4.50, CI [2.49, 8.00]) was significantly associated with physical partner violence in the past six months (Matseke et al., 2012) and partner alcohol use was identified as a risk factor for IPV during pregnancy (Clark et al., 2009). In Vietnam, India, and Brazil women who lived with a partner who drank alcohol, relative to those living with non-drinking partners, were more likely to report postpartum IPV (Moraes et al., 2011; Tran et al., 2012; Wagman et al., 2018) and antenatal IPV in Jordan (see [Table S2](#)).

Women Living with HIV and FSWs

These women are at often even greater risk of experiencing intersecting harms from violence and men's drinking, and report increased rates of physical violence and sexual coercion (see [Table S2](#)).

Qualitative Studies of the Intersections between Men's Drinking, Harms to Others, and Other Intersecting Oppressions

Several qualitative studies (see [Table S3](#)) have expanded on the primarily quantitative evidence to explicate the harms and ways in which alcohol is entangled in experiences of IPV and intersects with many problems, prejudices and oppressions, with for instance gender inequity and alcohol combining to worsen IPV. For example, working women in India reported being exposed to IPV because of husbands' insecurity and jealousy of their empowerment. When also exposed to a male partner's harmful alcohol use ("alcoholism" in the study itself), this increased the IPV they experienced (Biswas, 2017). The relationship between alcohol use and IPV was moderated by socioeconomic status (SES) within LMICs. For example, among women with a partner who used alcohol in Sub-Saharan Africa, those with lower SES had higher odds of experiencing IPV than women with higher SES (Greene et al., 2017).

War, Poverty, Violence, and Men's Drinking

Our review showed that in some LMICs, drinking, war and poverty intersect to complicate and worsen situations. Quantitative studies of the intersection between war, poverty, drinking and IPV are described in [Table S2](#). [Table S3](#) includes qualitative studies, in war-affected areas of Kenya, Liberia, Uganda and Thailand, and describes the interrelationship of men's drinking with a range of health, social and protection problems, GBV and STIs for women,

revealing emergent alcohol-related harm, with the relationship between IPV and alcohol complex and gendered (Ezard, 2014). Other studies in South Sudan, Kenya and Iraq revealed interrelated factors that triggered and perpetuated IPV, including alcohol, and described individual, family, community and societal processes that exacerbate women's risk of IPV in extreme conditions created by displacement (Wachter et al., 2018).

Sexual Violence (not IPV) and HIV

Men's drinking was commonly described in studies of LMICs women's experiences of sexual violence. The studies showed that women were forced into unprotected sex, that alcohol led to coercion in terms non-use of condoms, with men plying women with alcohol leaving them vulnerable to rape and multiple unwanted partners and increasing the risk of HIV infection. For FSWs external pressures to drink during sex work undermined their capacity to negotiate safer sex (Goldenberg et al., 2018). More detail of these studies is included in [Tables S2 and S3](#).

Discussion

Summarising the Evidence

This review, including the GBD analysis, identifies many ways in which the death, disease and injury of women across the world, including in LMICs is attributed to alcohol (Gakidou et al., 2017; Rehm et al., 2003; Rehm et al., 2003; Wang et al., 2012; Wang et al., 2016). The health of a disproportionately high percentage of women in LMICs is affected by alcohol. Among women worldwide in 2016, the leading causes of alcohol-attributable deaths and DALYs were cardiovascular diseases, digestive diseases and injuries (WHO, 2018). These figures relate largely to harms from women's own drinking. However, there are still gaps in our understanding of alcohol's impact on women's health. Holman and Armstrong (1992), and Holman and English (1995) developed alcohol attributable fractions that they noted were mostly based on middle aged, English speaking men, and in 2021, Rehm and colleagues noted that there are still not enough studies available to adequately separate risk curves between the sexes (Rehm et al., 2021). As authors, we add that this limitation is particularly true for women (and men) from LMICs. We note that the GBD and comparative risk assessment (CRA) studies produce estimates for many countries and by gender and region. A limitation of the GBD and CRA meta-analyses is that while extensive detail by country and region is provided regarding women's drinking, the underlying association is still mostly drawn from global literature that is largely based on HIC studies, apart from an increasing number of studies from China (Bahji et al., 2023)..

Harms from others' drinking are also incompletely factored into the burden of disease estimates (Rehm, Gmel Sr, et al., 2017), harms are not analysed by gender often enough, and this is especially the case in many LMICs. For example in health and social settings such as hospitals and emergency departments in LMICs the impact of others' drinking is rarely assessed and recorded (Laslett et al., 2016). Women living with a heavy drinker in LMICs and HICs have been

shown to experience reduced wellbeing and health-related quality of life (Laslett et al., 2020; Stanesby et al., 2018).

Evidence that does exist from LMICs and HICs, shows that women are at increased risk of severe problems from their male partners' alcohol consumption (far more than men are from female partners' drinking), including homicide and severe IPV (Leonard & Quigley, 2016; United Nations Office on Drugs and Crime, 2019). Men's drinking significantly impinges upon the rights of women, and this is clearly seen in the threats to women's safety demonstrated in our related review (Laslett & Cook, 2019). Here, we document multiple examples of ways in which alcohol use by women and/or their partners intersected with violence and other harms women experienced, amplifying these harms. For example, women are put at increased risk of HIV infection as a result of the intersection between alcohol and IPV or GBV. In many of these studies, identified power imbalances left women vulnerable to harms particularly when alcohol was involved.

Women also experience harms from alcohol that extend beyond the health sector to many of the Sustainable Development Goals (SDGs; Laslett & Cook, 2019; Sperkova et al., 2022; Wilson et al., 2024) from their own and others' drinking in LMICs (with this usually from men's drinking; Laslett et al., 2020; Stanesby et al., 2018) and HICs (Kilian et al., 2023; Laslett et al., 2023; White, 2020). Financial harm from others' drinking is one example (Laslett et al., 2020). A recent global review by Wilson and colleagues (2024) of the qualitative literature of harm to women from men's drinking, found that harmful alcohol-related actions by men, including but not limited to violence (physical, verbal, sexual, intimidation), economic abuse, social and controlling behaviours and sexual jealousy, impacted women in a myriad of ways. These effects result in adverse outcomes for women's physical, reproductive and mental health, harmful effects on relationship quality and family life, and social harms such as shame, loneliness and social isolation (Wilson et al., 2024). Wilson and colleagues (2024) reported that while these problems were noted, health and wellbeing, social, housing and financial impacts particularly those that affect women, were generally not analysed with a view to examining alcohol's contribution.

Are Alcohol's Impacts on Women's Health Considered in Government Policies in LMICs?

Men's drinking affects women, yet alcohol-related health conditions experienced by women are seldom considered by government policy makers and health system planners, nor are harms to women part of the public debate on alcohol's place in LMICs (Karriker-Jaffe et al., 2023). The alcohol industry argues that responsible alcohol production, marketing and sales add substantially to national economies by providing employment and stimulating retail and entertainment and service industries (Pettigrew et al., 2018). Countering this, WHO and Movendi summarise how alcohol can impact sustainable human development and note that alcohol is a significant obstacle to achieving 14 out of the 17 SDGs (Sperkova et al., 2022). Cultural arguments about alcohol's place in many societies and lifestyles also continue, with the alcohol industry lobbying governments to

ensure profits are not threatened (McCambridge et al., 2018). Moreover alcohol is embedded in masculine social norms in LMICs and HICs, often part of masculine privilege, evident in government and public life and reinforced by marketing and advertising to increase men's drinking, often supporting forms of masculinity that perpetuate harm to women (Atkinson et al., 2022; Sørensen et al., 2022).

The prevalence of alcohol use by women is also increasing globally, particularly in many LMICs and women's consumption patterns are influenced by corporate and economic determinants. Marketing is extensive, often in the face of little regulation (Walls et al., 2020) and action is needed to ensure women are informed of the increased health and social risks that result from alcohol use in their lives.

What Policies Work to Reduce Harm to Women in LMICs?

Given women are substantially harmed by alcohol, we question whether existing policies, like WHO's SAFER strategy, will reduce alcohol-related harm to women? Theoretically, reductions in heavy drinking by women in LMICs should effectively contribute to improvements in women's health and wellbeing (i.e., to achieving SDG3), both by acting on women's own and others' drinking. However, women are increasingly being targeted as consumers of alcohol in LMICs, despite few resources and historical norms of abstinence (Walls et al., 2020). When governments do act, they tend to adopt blanket policies that are not tailored to the needs of more vulnerable groups, such as women and children (Karriker-Jaffe et al., 2023).

However, if the SAFER strategy can have an impact on men's drinking, we could expect positive effects for women. Theoretically, a reduction in overall consumption could causally improve health, wellbeing, and women's overall quality of life, resulting in fewer women spending time or living with heavy-drinking men, but this has not been shown or tested. The mechanisms regarding how alcohol is related to women's health and well-being have not been studied closely in LMICs, although reducing alcohol consumption, particularly by men, appears to be a cogent way to improve women's health, particularly with regard to reducing GBV and IPV. As noted by Room and colleagues (2022), women's movements in response to problematic drinking and harms from men's drinking have historically sought to reduce levels of drinking, including in low-and middle-income populations – for instance, among the Australian Indigenous population (Brady, 2019), on Pacific islands (Marshall & Marshall, 1990), and in states in India (Larsson, 2006).

A recent review by Karriker-Jaffe and colleagues (2023) of the harms women experience, indicates that there is insufficient analysis of how alcohol use and gender-based inequalities intersect to produce violence. This gap identifies that these factors together are not understood and incorporated when interventions are planned. More intention in planning is needed to prevent alcohol use and GBV to ensure interventions are undertaken in intersectional, rather than "siloeed", ways. For example: interventions to transform

masculinities can help to reduce men's harmful use of alcohol as a risk factor for IPV perpetration as demonstrated by the Stepping Stones (and adapted Stepping Stones and Creative futures - SSCF) studies in South Africa (Eastern Cape and Durban; Gibbs et al., 2015; Gibbs et al., 2020; Gibbs et al., 2017) and the Zindagii Shoista intervention in Tajikistan (Mastonshoeva et al., 2020; Mastonshoeva et al., 2022). This is likely a result of the gender-transformative nature of the interventions, which gives men the knowledge and abilities to reframe their lives as men, alter their relationships, and reduce their use of violence and other behaviours, such as heavy drinking (Ramsoomar et al., 2019). Other research in Zambia has shown that it is possible to substantially reduce women's experiences of physical and sexual IPV in couples with complex overlapping problems of IPV and harmful alcohol use through psychotherapeutic interventions for couples (Murray et al., 2020).

A number of studies on IPV reviewed highlighted that "programs for the prevention and reduction of partner violence against women need to address high levels of hazardous drinking in men as well as women's prior traumatization" (Saile et al., 2013). Although the evidence regarding the relationship between drinking and male perpetration of IPV is overwhelming in many LMICs, researchers discussed the potential for solutions in South Africa with some hope, suggesting that, "*alcohol and sexual relationship skills may be useful levers for future violence prevention efforts, and that intimate partner violence may be a tractable issue as men learn new skills for enacting masculinities in their household and in intimate relationships.*" (Hatcher et al., 2014, p.1023)

More recently, there have been increased calls among researchers and policy makers in LMICs for evidence-based programming that addresses alcohol, GBV and mental health synergistically (Karriker-Jaffe, et al., 2023; Ramsoomar et al., 2019). For example, a key recommendation that emerged from the global *What Works to Prevent Violence against Women and Girls* programme that generated evidence on the drivers of IPV in 13 LMICs across Africa, Asia and the Middle East is that, given the inextricable links between alcohol, poor mental health and GBV, addressing them through a variety of intervention modalities (gender transformative programming, couples psychotherapeutic interventions, and community based programmes) is critical to prevention (Ramsoomar et al., 2019).

Research Gaps

For many physical and mental health outcomes, only the woman's own drinking has been studied as a contributing factor. However, evidence considering partners' and others (particularly men's) heavy drinking shows the potential pathways through which women's physical health as well as their mental health is affected. For instance, when it is associated with aggression which can increase the stress and strain women experience in their lives as they react to their partner's behaviour. Additionally, GBV and IPV attributed to others drinking also affects women physically and mentally in a range of ways (Leonard and Quigley 2016). More research is needed in LMICs on harms to others, with

a focus on the harms experienced by women and children, if others' drinking is to be reduced and evaluated in relation to the component of SDG3 that seeks to improve women's and children's health and wellbeing.

Limitations

This review is based on a systematic search of the literature undertaken in 2019. The review was not pre-registered, a quality score was not undertaken and only one person reviewed each paper although AML and MC consulted each other if there were inclusion or quality queries. With the approach used to update the review in 2023, a total of 275 research publications were identified for the review, but a number of studies and findings may have been left out.

Conclusions

Researchers, NGOs, and governments pay insufficient attention to the ways in which women's health issues are affected when alcohol is involved. Capacity building of research and policy-making infrastructure in LMICs is crucial if academia, NGOs, and governments are to listen to, and respond to, the concerns of women affected by their own and other's drinking. In moving forward to address these research gaps specific attention needs to be paid to decolonizing alcohol research. This means not only increasing the number of studies done in LMIC settings, but also dismantling and disrupting the euro-centric normative epistemologies. Research should include authors from LMICs to increase accountability and inclusivity (Bahji et al., 2023), and include LMIC researchers in conceptualising, planning and conducting the research, i.e., in all stages of the research enterprise. Moreover, we note that there are insufficient evidence-based policies implemented to limit the production, sale and consumption of alcohol in LMICs (Sperkova et al., 2022) which will impinge on the health of women in the many ways outlined in this review. Within the context of LMICs we further emphasize the necessity to regulate industry interference and to reduce expansion in LMICs which is likely to increase harms and inequalities from alcohol (Esser & Jernigan, 2018), again particularly to women. Crucially, LMIC and global evidence suggests that to decrease health-related harms to women from alcohol, reductions in not only women's drinking but also, very importantly, men's drinking are required.

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