KNOWLEDGE PARTNERSHIP PROGRAMME

Analytic Study on Alcohol and Violence Against Women: Desk Review

International Center for Research on Women (ICRW)

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Analytic Study on Alcohol and Violence Against Women

Desk Review

Draft report

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Contents

1: Introduction

1.1 Background

Alcohol consumption plays an important role in the perpetration of violence against women, particularly violence among intimate partners. Alcohol is an important risk factor to address in intervening to reduce violence against women. Evidence to explore the linkages between alcohol consumption and violence against women in public and private spaces is much needed. In particular evidence is needed to understand how is consumption of alcohol is buoyed by existing alcohol policies and its impact on lives of women as important structural factors to set an agenda for policy reform dialogue among diverse stakeholder. The following review synthesizes evidence from India, as well as across the globe on understanding the linkages between alcohol and violence against women and measures that address these linkages.

The following review was undertaken by sourcing and reviewing published literature, reports, program documents on topic of alcohol consumption, alcohol policies, programs to address violence, consequences and implications of alcohol consumption and publications on relation of alcohol and violence against women. A review of alcohol policies and implications on violence against women is separately presented in an accompanying report. The articles and publications for the desk review were sourced from open access journals, websites of various organizations and relevant government departments

1.1.1 Changing scenario of Alcohol consumption in India:

The National Family Health Survey -3 (NFHS-3) documents that about 32% of Indians consume alcohol of which 4-13% are daily drinkers. Compared to many other high-income countries, men in India consume less proportion of alcohol, however the usual pattern of alcohol use is one of heavy drinking of spirits, and drinking to intoxication, and the proportion of hazardous users among current drinkers is greater than in many high income countries[1] . Furthermore, what is disturbing is that the younger generations is initiating alcohol at earlier age as compared to earlier. For example, a study conducted by NIMHANS in

[1] Benegal V. (2005) India: alcohol and public health. *Addiction*, 100:1051–56.

the city of Bangalore documented the age of first drink to have decreased from 28 to 19 years. Another study in the north-east region of the country reported that more than half of the adult men interviewed reported to have started drinking alcohol before the age of 21 years[2] A recent population based survey of 1900 adult men who were current users of alcohol in Goa, revealed that one third of the surveyed men reported an adolescent onset of alcohol use. Based on retrospective data of current users in the study, the analysis revealed that the proportion of current users who reported adolescent drinking onset increased from 19.5 percent among those born between 1956-60 to 74.3 percent for those current alcohol users born between the cohort of 1981-1985. The study also documented a number of negative outcomes associated with adolescent onset of alcohol use such as alcohol related injuries, alcohol dependence, psychological distress and hazardous drinking[3]

The average age of first alcohol consumption has fallen from 28 years to 19 years in Bangalore (Benegal, 2005). According to the NFHS-3 about 32 percent of Indians consume alcohol of which 4-13 percent are daily drinkers-which is still considered not a very harmful pattern, but Indians also demonstrate 'binge drinking' patterns, which means that though people may not drink frequently, but when they do they are likely to 'binge drink' i.e.– consume more than five drinks at a time (Benegal). Recent analyses of the National Sample Survey Office (NSSO, 2010-11) showed that although only 15 percent of Indians drink alcohol, they consume 28.7 liters of alcohol per year-which is higher than even the world's biggest drinking country-Belarus.

[2] Hazarika N., Biswas D., Phukan R. (2000) Prevalence and pattern of substance abuse at Bandardewa, a border area of Assam and Arunachal Pradesh. *Indian Journal of Psychiatry*,42:262.

[3] Pillai, A., Nayak, M.B., Greenfield, T. K., et al (2014) Adolescent drinking onset and its adult consequences among men: A population based study from India. Epidemiology of Community Health,1–6. doi:10.1136/jech-2014-204058

2. Unpacking: relationship between alcohol on violence against women

2.1 Are alcohol consumption and violence against women related?

Globally, 30 percent of mortality caused by violence is attributable to alcohol, ranging from 8% in the Middle East and North Africa to 56 percent in Europe and Central Asia[4]. However not all men who consume alcohol engage in partner violence or commit violence against women in public space too. Though the llink between alcohol and violence against women is not casual, the relationship is complex and is mediated by individual, situational, and social factors such as income, education, and occupation; cultural factors, such as attitudes about violence, drugs, alcohol, and personality factors. The following are the various aspects of alcohol consumption that have found to be related to violence against women.

2.1.1 Theories of alcohol and violence against women

There are three main theories that explain the link between alcohol and IPV-the spurious effects theory, the indirect effects theory and the proximal effects model.

The spurious effects theory postulates that there is no causal link between alcohol and IPV and that there are other factors that co-vary with both IPV and alcohol consumption. Age, preclusion to deviance-related risk factors, socioeconomic status, race and drug problems are some of the possible intervening factors. The theory has been challenged as several studies have shown that the relationship between alcohol and violence remains strong even after controlling for factors such as age, ethnicity, education, soico economic status, occupation, hostility and normative views on aggression (Klostermann & Fals-Stewart, 2006)[5]

[4] Preventing violence by reducing the availability and harmful use of alcohol. WHO, (Series of briefings on violence prevention: the evidence).Geneva.

5 Klosterman KC, Fals-Stewart W. Intimate partner violence and alcohol use: Exploring the role of drinking in partner violence and its implications for intervention. Aggression and Violent Behavior. 2006;11:587–597 in Dating Violence and Substance Use in College Students: A Review of the Literature. Ryan C. Shorey, Gregory L. Stuart, and Tara L. Cornelius. Aggress Violent Behav. 2011 Nov-Dec; 16(6): 541–550.

The indirect effects model postulates a causal relationship between alcohol and aggression which is mediated by other factors such as marital conflict and dissatisfaction. The mediated effects of aggression may then in turn lead to IPV. The theory offers a partial explanation as research has shown that that IPV-alcohol association continued to be evident even after controlling for marital dissatisfaction (Klostermann & Fals-Stewart,2006)[6].

The proximal effects model suggests that individuals who consume psychoactive alcohol or illicit drugs are more likely to engage in partner violence due to the psychopharmacological effect of drugs on cognitive thinking or process leading to perceptual distortions and lowered inhibitions[7].

2.1.1 Level of intoxication, frequent alcohol consumption and consumption of alcohol just before committing violence against intimate partners

Frequent alcohol consumption is associated with violence. Alcohol frequently acts as a dis-inhibitor, reduces self-control and affects cognitive and physical functioning, thereby reducing the ability of an individual to negotiate non-violent conflict resolution[8]. Strong links between alcohol use and intimate partner violence has been found in many countries suggesting that frequent alcohol consumption increases the occurrence and severity of domestic violence[9]. Several studies indicate that between a third and a half of perpetrators of violence had consumed alcohol prior to assaults taking place (United States of America, 35%; South Africa, 44%; England and Wales, 45%; China,50%)[10]. Further, a study of wife assault, in an alcohol rehabilitation program for military veterans found more than one-third of the patients had reported assaulting their wives or partners in the previous year prior to the survey, their wives reporting even higher rates[11].

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[6] Ibid.
[7] Violence against Women: An International Perspective . Holly Johnson, Natalia Ollus, Sami Nevala. Springer, 2008.
[8] Room R, Babor T, Rehm J**:** Alcohol and public health**.** *Lancet* 2005, **365:**519-530.
[9] Intimate partner violence is defined as any behavior within a relationship which causes physical, psychological or sexual harm to those in that relationship. It includes acts of physical aggression (slapping, beating, kicking or beating), psychological abuse (intimidation or humiliation), forced sexual abuse or any other controlling behavior (isolating a person from family and friends, monitoring their movement and restricting access to information).
[10] Preventing violence by reducing the availability and harmful use of alcohol. WHO, (Series of briefings on violence prevention: the evidence).Geneva.
[11] Gondolf EW, Foster RA. Wife assault among VA alcohol rehabilitation patients. Hosp Community Psychiatry. 1991;42(1):74-9.

However the relation of alcohol consumption and intimate partner violence is not just associated by frequency of drinking, but is also with harmful use of alcohol, binge drinking, heavy/habitual drinking as compared to mild or no alcohol use[12]. Women who live with heavy drinkers run a far greater risk of physical violence and that men who have been drinking inflict more serious violence at the time of an assault.[13].

A multi-country study in Chile, India, Egypt and the Philippines identified significant associations between several risk factors such as regular alcohol consumption by the husband/ partner and life time physical IPV against women across the four countries[14]. A study in the UK found that 32% (or one third) of IPV related events in UK occurred when the perpetrator was under the influence of alcohol[15].

Studies of alcohol treatment populations, addicted to alcohol and drug use in the US show high rates of perpetration among treatment populations. In one study, Schumacher et al found that 44% of men (n=658) used one or more acts of physical violence in the year preceding treatment. Further, the American Medical Association estimated that nearly 75% of all wives of alcoholics have been threatened, and 45% have been assaulted by their partners[16].

There is strong empirical evidence to support the role of alcohol as a correlate in acts of IPV (Leonard and Jacob, 1988)[17]. Alcohol-related violence is associated with more severe injuries and its consumption has been found to increase the occurrence and severity of domestic violence[18]. Substance use (by the perpetrator, the victim or both) is involved in as

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[12] Gil-Gonzalez, D.,et al., Alcohol and intimate partner violence: do we have enough information to act? European Journal of Public Health, 2006. 16(3): p.278-284.

[13] World Report on Violence and Health. WHO . 2002. Geneva.

14 Jeyaseelan L, Sadowski LS, Kumar S, Hassan F, Ramiro L, Vizcarra B: World studies of abuse in family environment: risk factors for intimate partner violence**.** *Injury Control and Safety Promotion* 2004, **11:**117-124.

[15] Mirrlees-Black C: *Domestic violence: findings from a new British Crime Survey self-completion questionnaire*. Home office, London; 1999:1-10.

[16] Grasping the nettle: alcohol and domestic violence, Revised edition, 2010, Sarah Galvani, University of Bedfordshire

[17]Leonard K.E and Jacob T. Alcohol, alcoholism, and family violence. In: Van Hasselt, V.B., ed. *Handbook of Family Violence*. New York, NY: Plenum Press, 1988. pp. 383-406. in Caetano R, Schafer J, Cunradi CB: Alcohol-Related Intimate Partner Violence among White, Black and Hispanic Couples in the United States. *Alcohol Res Health* 2001, 25(1):58-65.

18 Reider EE, Zucker RA, Noll RB, Maguin ET, Fitzgerald HE: Alcohol Involvement and Family Violence in a High Risk Sample. In *The Annual Meeting of the American Psychological Association: 96th Annual convention*. APA, Atlanta, GA; 1988:1-30.

many as 92% of reported episodes of domestic violence [19]. In a study researching characteristics of domestic violence offenders, 73% of perpetrators had been drinking at the time of the assault.[20] A study in the USA found that alcohol plays an important part in IPV. 30 to 40% of the men and 27 to 34% of the women who perpetrated violence against their partners were taking alcohol at the time of the event[21].

2.1.2 Evidence from India

Studies conducted in India on understanding the relationship between alcohol and violence against women, also mirror similar findings from global evidence. For example, a cross-sectional household survey (500 households) carried out in Thiruvananthapuram district of Kerala showed a clear association between husband's alcohol consumption and reported physical violence. More than 61 percent of the women whose husbands had got drunk at least once a week and were educate less than class 10 reported that their husbands had hit, kicked, slapped or beaten them. However the study findings also suggest that men who were not habitual drinkers , but were less educated were also perpetrators of violence[22]. Similarly another study in Goa with 821 women aged 18–49 found that excessive drinking predicted partner violence[23]. The study also found that excessive alcohol use for partner increased the risk for common mental disorders among their female partners.

International Centre for Research on Women (ICRW) in partnership with the International Clinical Epidemiologists Network (INCLEN) conducted a study (10,000 households in seven sites) on the prevalence of domestic violence as well as its correlates (INCLEN, 2000). Respondents were women of 15-49 years of age with at least one child less than 18 years of age currently living with them. The study found that domestic violence was

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[19] Brookoff D, O'Brien KK, Cook CS, Thompson TD, Williams C. Characteristics of participants in domestic violence. Assessment at the scene of domestic assault. JAMA. 1997;277(17):1369-73 in Domestic violence, alcohol and substance abuse Monica L ZilbermanI; Sheila B Blume in Rev. Bras. Psiquiatr. vol.27 suppl.2 São Paulo Oct. 2005.

[20] Gilchrist, E., Johnson, R., Takriti, R., Weston, S., Beech, A. and Kebbell, M. (2003) *Domestic violence offenders: characteristics and offending related needs*, Findings, 217, London, Home Office in Grasping the nettle: alcohol and domestic violence, Revised edition, 2010, Sarah Galvani, University of Bedfordshire

21 Caetano R, Schafer J, Cunradi CB: Alcohol-Related Intimate Partner Violence among White, Black and Hispanic Couples in the United States**.** *Alcohol Res Health* 2001, **25**(1)**:**58-65.

[22] Domestic violence against women in Kerala. Discussion Paper no 86. Pradeep Kumar Panda. Centre for Development Studies. Thiruvananthapuram.

23 Nayak MB, Patel V, Bond J, Greenfield TK: Partner alcohol use, violence and women's mental health: population-based survey in India. *Br J Pychiatr* **2**010**,** 196**:**192-199

positively associated with women's childhood experience of family violence and alcohol consumption of husband.[24]

2.1.3 socio-demographic characteristics associated with alcohol-related violence

Review of evidence suggests socio-demographic factors that are associated with alcohol-related violence are low education among women, women who are not in any gainful employment. Whereas research from India suggests that men with lower education and history of violence in childhood were socio-demographic factors associated with alcohol-related factors. Studies also pint out to childhood experiences of family violence, mental illness of the spouse as correlates of alcohol-related violence faced by women. similarly couple related factors such couples who are younger and belong to low socioeconomic status report higher prevalence of IPV[25]. Similarly, younger males and females (16 to 24 years) belonging to lower socioeconomic positions and living in urban areas with poor housing were more likely be victims of alcohol-related assaults that was beyond the domestic sphere.[26]

2.1.4 Socio-cultural norms that affect alcohol related partner violence

Evidence from cross cultural research has shown that though alcohol use may be associated with intimate violence it is not the primary cause of violence. Bennett (1995) suggests that majority of men who use alcohol and drugs are not violent toward their female partners, and most episodes of violence do not involve substance abuse[27].

Kaufman Kantor and Straus [28] using nationally representative sample of 5,159 families show that excessive drinking is associated with higher wife abuse rates but alcohol

[24] Ibid.

[25] Intimate Partner Violence and Contribution of Drinking and Sociodemographics : The Brazilian National Alcohol Survey. Marcos Zaleski, Ilana Pinsky, Ronaldo Laranjeira, Suhasini Ramisetty-Mikler and Raul Caetano. J Interpers Violence 2010 25: 648 originally published online 2 June 2009

[26] People and places: Some factors in the alcohol violence link. Journal of Substance Abuse 7(4) 207-213. Plant, M and C. Thornton (2002)

[27] "Association is Not Causation: Alcohol and Other Drugs Do Not Cause Violence". Gelles, Richard J. and Mary M. Cavanaugh. 2005. in *Current Controversies on Family Violence*, 2e. Donileen R. Loseke, Richard J. Gelles, and Mary M. Cavanaugh (eds.). Thousand Oaks, CA: Sage Publications. pp. 175–189

[28] The 'Drunken Bum' theory of Wife Beating, Kaufman Kantor and Straus. Presented at the National Alcoholism Forum Conference on 'Alcohol and the Family,' San Francisco, CA, April 18, 1986

use is not an immediate cause of violence in majority of the families. The research examined drinking behavior at the time of the violent incident and showed that alcohol was not used immediately prior to the violent conflict in the majority (76 percent) of the cases and that the violent male was drinking at the time of the incident in 14 percent of the cases.

Societal beliefs and norms against violence can affect the risk of alcohol related partner violence. In some societies, heavy drinking and violent behavior is associated with masculinity[29].One of the risk factors for alcohol related IPV is the association between heavy drinking and anti-social personality disorder[30]. According to DeKeserdey and Schwartz (1998), societal patriarchal belief systems can be attributed to intimate partner violence. The 'male peer support' provide guidance, support and advice in dealing with the opposite sex which can include the use of psychological, physical or sexual abuse (Dekeserdey and Kelly 1995, DeKeseredy & Schwartz, 1998)[31].

In the context of alcohol and IPV, negative attitudes towards women and male peer support for abusing female partners is often associated with heavy drinking within the context of male social groups. A woman's risk to violence is reduced through establishment of support networks, economic networks and connections with other people. Consequently, a woman most vulnerable to male violence is isolated and finds herself alone against a husband who has extensive support from others in the social network (Baumgartner, 1993)[32].

Deeply rooted societal beliefs and conditioning about alcohol consumption, factors of normalized violence and men's power and control plays a fundamental part and can contribute to the risk of alcohol related violence. A general acceptability of violence against women in a society may reflect deep seated patriarchal bias, gender inequity and a culture

[29] Johnson H. The role of alcohol in male partners' assaults on wives. Journal of Drug Issues, 2000, 30:725-740 in WHO Facts on Alcohol and Violence: Intimate partner violence and alcohol.Geneva.

[30] Fals-Stewart W, Leonard KE, Birchler GR. The occurrence of male-to-female intimate partner violence on days of men's drinking: the moderating effects of antisocial personality disorder. Journal of Consulting and Clinical Psychology, 2005 73:239-48 in

[31] Intimate partner violence on campus.: A test of social learning theory. Keith J. Bell. Indiana University, Pennsylvania.

[32] Baumgartner, M. P. (1993). Violent networks: The origins and management of domestic conflict. In R. B. Felson & J. Tedeschi (Eds.), Violence and aggression: The social interactionist approach (pp. 209-231). Washington, DC: American Psychological Association in Risk Factors for Abusive Relationships: A Study of Vietnamese American Immigrant Women. Merry Morash, Hoan Bui, Yan Zhang and Kristy Holtfreter Violence against Women, 2007; 13; 653

of valuing men over women. In the Indian context, research in the area of violence against intimate partners as a result of male subculture of peers, whose value system justifies or condones it, needs to be explored in further detail.

2.1.5 Sexual violence and alcohol

Beyond the domestic sphere, consumption of alcohol has been strongly associated with sexual assaults against women especially in instance of rape. For example recent analyses of a five country study, including India on men and their gender attitudes and violence – the IMAGES found that in India any alcohol use was associated with sexual violence perpetration, this was particularly found in the case of binge drinkers then men who did not binge drink and thus is an important contributory factor to sexual violence-though not causal[33].

2.2 Costs of alcohol to women and families

The social costs of alcohol consumption are well known, however fewer studies have calculated the costs of alcohol consumption to families and women in particular. The effects of men's drinking on other members of the family is often particularly on women in their roles as mothers or wives of drinkers. The risks include violence, HIV infection, and an increased burden in their role of economic providers. A study comparing two groups of families within the same community in Delhi, India (one group of families with one adult consuming alcohol and vice versa), found that families with at least one person who used alcohol, on an average, spent almost 14 times more on alcohol per month compared with those who did not use alcohol. Moreover, families with alcohol users reported significantly more debt and were more likely to use health services. Thus implications of alcohol consumption on the family means that families' resources that are used for alcohol, and related expenses, renders the family unit deprived of financial resources for food and education of children and fewer resources for purchasing daily living consumables.[34]

[33] Heilman, B., Hebert, L., & Paul-Gera, N. The Making of Sexual Violence: How does a Boy Grow Up to Commit Rape? Evidence from five IMAGES Countries. Washington,DC : International Center for Research on Women (ICRW) and Washington, DC:Promundo. June 2014

[34] WHO global status on Alcohol (2004)

At a macro level, few studies conducted show that alcohol-related problems account for over a fifth of hospital admissions[35]. At a household level, families with alcohol and tobacco users are more likely to be pushed into impoverishment arising out of distress selling and hospitalization (Bonu at al., 2005)[36]. A study from the state of Karnataka in South India estimated that direct and indirect costs attributable to people with alcohol dependence alone was more than three times the profits from alcohol taxation and several times more than the annual health budget of that state [37]

The available literature suggests that costs of alcohol consumption to families and women have been operationalized in a varied manner like physical violence, abuse, deprivation of the household and also burden on women support the family as a care giver and bread winner as a consequence of men's alcohol consumption. Therefore, apart from understanding violence as being 'physical violence' comprising of 'obvious acts' of manifestation of men's aggression. It would be helpful to broaden our conceptualization of violence against women in relation to alcohol consumption as also being a form of 'economic abuse' that 'deprives' women of resources – a lack of which triggers a vicious cycle of borrowing, violence and additional role of being a bread winner for her family.

2.3 Alcohol Reduction Interventions

Alcohol interventions generally fall into four categories : 1) Brief interventions involving screening in primary health care settings and using a brief verbal inquiry during history taking; 2) Community-based interventions that aim at changing the drinking environment through social norms, campaigns, education in schools etc. 3) Venue-based alcohol reduction interventions; 4) Structural interventions restricting access to alcohol by developing laws and policies to make alcohol more expensive and less available;

2.3.1 Brief interventions, treatment and self-help support systems:

[35] Sri, E. V., Raguram, R. & Srivastava, M. (1997) Alcohol problems in a general hospital—a prevalence study. *Journal of the Indian Medical Association*,
95 , 505–506.

[36] Bonu, S., et., (2005) Does Tobacco or alcohol contribute to impoverishment from hospitalization costs in India? Helath Policy and Planning, 29 (1), 41-49.

[37] Benegal, V., Velayudhan, A. & Jain, S. (2000) Social costs of alcoholism: a Karnataka perspective. *NIMHANS Journal* , **18**, 6–7.

Treatments associated reductions in alcohol abuse help in reduction of alcohol related harm and violence. These are therapeutic interventions that are designed to address alcohol and substance abuse problems in an individual. They play a critical role in a patient's abstinence from alcohol and substance abuse and relapse after treatment. The Behavior couple therapy (BCT) is a behavioral approach treatment program that aims to build support for abstinence and to improve relationship and communication among married or cohabiting individuals seeking help for alcoholism or drug abuse. BCT works directly to increase relationship factors. The patient and the spouse, are seen together in BCT, typically for 12-20 weekly outpatient couple sessions over a 3-6 month period. BCT has been effective in several populations by targeting a reduction in alcohol and substance abuse and improving skill deficits. The treatment shows a rapid reduction in maladaptive methods of conflict resolution through 'sobriety contracts' and active listening skills[38].

O Farrell et al (2003), examined partner violence in the year before and after in individually based outpatient alcoholism treatment for male alcoholic patients. Participation in the program resulted in significant reductions in interpersonal violence39. The results were compared to a demographically matched non-alcoholic comparison group. In a year before the treatment 56% of the alcoholic patients had been violent towards their female partners compared to 14% in the comparison group. In the year after treatment, violence decreased significantly to 25%.

2.3.2 Community-based interventions

Community interventions aimed at changing the community environment can reduce alcohol use and related problems; though multiple community-level changes may be needed to reduce the same. In Sweden, the Stockholm Prevents Alcohol and Drug Problems (STAD) project, established partnership between the licensing board representatives, police, county administration and the national health board, It reported a 29% reduction in violent crime

[38] Behavioral Couples Therapy for Alcoholism and Drug Abuse. Timothy J. O'Farrell and Abigail Z. Schein. J Subst Abuse Treat. Jan 2000; 18(1): 51–54.

[39] O'Farrell TJ et al. Partner violence before and after individually based alcoholism treatment for male alcoholic patients. *Journal of Consulting and Clinical Psychology*, 2003, 71:92–102.

through a combination of interventions like beverage service training, community mobilization and strict enforcement of existing licensing legislation[40].

The Sacramento Neighborhood Alcohol Prevention Project (SNAPP), was implemented between 2000 and 2003, in two low-income, predominantly ethnic-minority neighborhoods, with the Sacramento community. It aimed to reduce alcohol access, drinking, and related problems among underage youth and young adults (ages 15 to 29) Five intervention components were selected- community mobilization, community awareness, responsible beverage-service training, underage-access law enforcement, and intoxicated-patron law enforcement. Significant reductions were reported in assaults as reported by police and emergency medical services and in motor vehicle crashes through this intervention[41]

In India, the RISHTA program, operative in various poor communities in the outskirts of Mumbai since 2001, integrates programming related to harmful alcohol use into their ongoing work on men's sexual and reproductive health. The project includes sexual and reproductive health services for men, community mobilization, shifting social norms, and encouraging men to seek treatment and support for sexual health problems. Alcohol abuse was tackled through the use of street dramas and follow-up community meetings. An evaluation of the project demonstrated that men in the panel study who were drinkers at baseline but not at end line showed a significant drop in overall alcohol use and reported more gender equitable attitudes, less risky behavior and reduced extra marital sex[42].

Other programs in India that have employed community level interventions like the "community mobilization in treatment of alcoholism" program in Chennai that employs a successful approach to engaging the entire rural community in identifying, treating village men who have alcohol addiction, including family counseling, violence against women being one of the issues is addressed explicitly in the program. However majority of these programs

[40] Preventing violence by reducing the availability and harmful use of alcohol. WHO, (Series of briefings on violence prevention: the evidence).

[41] A Review of Environmental-Based Community Interventions T**raci L. Toomey** and Kathleen M. Lenk. Alcohol Research & Health, Volume 34, Issue Number 2

[42] What Works to Prevent Partner Violence? An Evidence Overview. Working paper (version 2.0). Lori L. Heise. December 2011. London School of Hygiene and Tropical Medicine

that are de-addiction oriented, community-based initiatives that have documented success of their programs have not been evaluated and hence a barrier to scale-up.

2.3.3 Venue-based alcohol reduction interventions

Venue based alcohol reduction interventions have been tried in several parts of the world. These interventions entail raising alcohol risk awareness in places where people drink ,like at bars, pubs. It can include the use of popular opinion leaders, use of a trained facilitator to impart group sessions. In the context of HIV and alcohol, a more comprehensive version of the bar-based intervention was recently concluded as a demonstration project by ICRW through AIDStar One. Through formative work, this project identified multiple-levels at which interventions can be directed to reduce alcohol-related HIV vulnerability in Namibia. These are i) creating an HIV risk-averse bar environment, ii) mobilizing the community for self-regulation, and iii) decreasing the total number of bars in a community by making available alternative livelihood options[43]. This approach showed promising results in the context of HIV could also be adapted to address issues of violence related to alcohol.

2.3.4 Structural interventions

Several structural interventions have been tried to affect the alcohol policies to control alcohol consumption. Though there have been very scanty studies on the effect of structural level-policy interventions on reduction on violence against women, these interventions suggest a positive effect on decreasing alcohol consumption and influences drinking patters. Some of the structural interventions are presented below:

Regulation of alcohol availability is one way for governments to control alcohol consumption of the population. In Brazil, implementation of municipal law to curb sales of alcohol after 11 p.m showed a significant reduction in alcohol related violence[44]. In the

[43] Namy, S., H. Lantos, J. Haufiku, H. Shilongo, and K. Fritz. 2012. Reducing Alcohol-related HIV Risk in Katutura, Namibia: Results from a Multi-level Intervention with Bar Owners, Servers, Patrons and Community Members. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

[44] The Effect of Restricting Opening Hours on Alcohol-Related Violence. Sergio Duailibi, William Ponicki, Joel Grube et al. Am J Public Health. 2007 December; 97(12): 2276–2280

former Soviet Union, strict alcohol regulation was implemented in 1985 which included measures such as reduced state production of alcohol and alcohol outlets, increase in alcohol prices and restrictions on service hour timings. The measures taken produced a considerable impact on alcohol consumption and alcohol related violent deaths. However, the restrictions had to be lifted due to increased production of illegal alcohol which led to reduced state taxes. Similarly in Australia, ban on sale of alcohol during the day in aboriginal communities successfully curtailed alcohol misuse and harm[45].

Extended alcohol serving/selling hours and its effect on reducing violence have shown mixed results. In Australia, a cohort study examining police data on changes in assault rates after drinking outlets were permitted extended service hours, found a higher number of assaults related to alcohol compared to those that were not permitted extended service hours. Similarly, in England and Wales, increasing service hours in outlets serving alcohol showed no increase in associated violence[46]. Further, studies indicate that ban on alcohol sales in areas where alcohol related violence is common can help prevent alcohol related harm and violence. A before and after study on the impacts alcohol ban on consumption and sales in a college stadium in the USA found a significant reduction in number of assaults and arrests[47].

Reducing densities of alcohol outlets show a positive correlation with higher levels of incidence of violence. Neighborhoods that have more bars and alcohol outlets per capita experience more violence[48]. In a Norway Study between 1960 and 1995, increased outlet density (measured as number of public drinking places per 10,000 inhabitants) was found to be associated with higher numbers of violent crimes investigated by police. An increase of one alcohol outlet corresponded to an increase of 0.9 assaults investigated each year[49]. In

[45] Preventing violence by reducing the availability and harmful use of alcohol. WHO, (Series of briefings on violence prevention: the evidence).
[46] Ibid.
[47] Ibid.
[48] Scribner RA, Cohen DA, Kaplan S, Allen SH. Alcohol availability and homicide in New Orleans: conceptual considerations for small area analysis of the effect of alcohol outlet density. J Stud Alcohol. 1999;60: 310–316
[49] Outlet density and criminal violence in Norway, 1960-1995. Norström T. J Stud Alcohol. 2000 Nov;61(6):907-11.

another study, DiIulio (1995), found that the density of alcohol-selling establishments in urban neighborhoods was positively related to crime in Milwaukee's inner neighborhoods.[50]

Increased alcohol taxation through state controlled monopolies, minimum prices for alcohol and bans on drinks promotions. There is strong evidence to support that changes in alcohol taxes influence rates of problem drinking and that price of alcohol and levels of alcohol consumption are linked. A reduction in alcohol taxation in Finland in 2004 was associated with an increase in alcohol-related sudden deaths and mortality, criminality and hospitalizations. In contrast, an increase in excise duty in Alaska, United States in 1983 and 2002 were associated with substantial reductions in alcohol-related disease mortality[51].

In Australia, the Queensland Safety Action Projects used community mobilization, code of practice for licensed premises, increased enforcement of licensing laws and safety measures (e.g. lighting and public transport) to reduce alcohol related problems in nightlife environments. A controlled before and after study found reductions in arguments (28%), verbal abuse (60%) and threats (41%) in drinking premises where the intervention was implemented.[52]

[50] Stadium Alcohol Policies: A Comparison of Policies Available on College Athletic Department Web Sites. Brian E. Menaker and Daniel P. Connaughton. International Journal of Sport Communication, 2010, 3, 151-162.
[51] Pricing of alcohol. Esa Österberg at http://www.euro.who.int/__data/assets/pdf_file/0004/191371/11-Pricing-of-alcohol.pdf
[52] Ibid.

3. India alcohol policies: Gaps in policies and programs

3.1 Introduction

Indian constitution has enshrined the value of abstinence in it. Traditionally, India cannot be called as a "dry" culture and mention of use of substance including alcohol is present in various mythological stories of Shiva and use of alcohol by gods. There are extensive records of diverse fermented and distilled beverages produced from fruits, grains and flowers[53]. The emergence of values upholding "dry culture" can perhaps be traced to the colonial era with the rise Nationalist movement and Gandhian values for the need of temperance for the middle class into mass movement against drinking as a symbol of colonial oppression[54]. The value of abstinence from alcohol has been enshrined in Article 47 of the Constitution of India in its Directive Principles of State Policy, lays down that it is the duty of the State to raise the level of nutrition and the standard of living and to improve public health: *The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavor to bring about prohibition of the consumption except for medical purpose of intoxicating drinks and of drugs which are injurious to health.*

3.1.1 Understanding the policy structures for alcohol

In India the State Legislature has exclusive powers to make laws and policies and levy taxes on the production, distribution, sale, taxation of alcohol. Alcohol is a state subject and different state ministries and departments regulate different aspects of alcohol. For example, the Ministry of Social Justice and Empowerment oversees alcohol use prevention programs, capacity building for alcohol prevention and treatment and in some states runs de-addiction centers. The ministry of Health and family Welfare mostly is concerned with funding and running de-addiction, rehabilitation centers in individual states. Other aspects of alcoholic

[53]Acharya, K. T. (1998) *Indian Food: A Historical Companion* . Delhi: Oxford University Press.
[54] Saldanha, I. M. (1995) 'On drinking and drunkenness': history of liquor in Colonial India.*Economic and Political Weekly* , 16 September, 2323–2331.

beverages like regulation, taxation, are in the ambit of the ministry of finance and the state excise departments. There is an apparent lack of systematic coordination between these various ministries and thus no comprehensive national data on the production, sale, consumption and other related health and social harm of alcohol-use in the country[55].

3.1.2 Alcohol policies: Total or Partial Prohibition-what does history tell us?

State excise policies cover multi-dimensional issues of alcohol control, possession, production, manufacture, selling, buying, and transport of liquor. Broadly India follows two types of alcohol policies: i) total prohibition and ii) Partial prohibition.

Total prohibition-total prohibition alcohol policy means that there exists a complete ban on all aspects of alcohol like production, possession, manufacture, selling, buying and transport of alcohol. States of Gujarat, Manipur, Nagaland and the Union Territory of Lakshadweep have imposed total prohibition. Gujarat is the oldest and the most consistent in imposing alcohol ban since 1960. There has been a history of other states that have imposed complete prohibition and then revoked the same prohibition to a partial prohibition, however in Gujarat, In Gujarat, non-resident Indians and overseas nationals are allowed to buy liquor using the permits issued by the government. Many Indian states have imposed total ban on alcohol but have eventually revoked the ban citing multiple reasons, the primary reason being loss of revenue to state along with of increased incidence of illicit liquor, bootlegging, increase in hooch tragedies etc. to cite a few examples, Andhra Pradesh imposed a complete ban on alcohol in 1952 which was then revoked in 1995 citing reasons of liquor trafficking from neighboring states. Haryana imposed a total ban on alcohol in 1996. To offset the loss of revenue for the state due to the alcohol prohibition, the state government increased taxes and fees for various state-provided services - power tariff were increased by 10-50%, bus fares by 25%, and the petrol sales tax by 3%. New taxes were levied on businesses and self-employed people. However despite all the measures, smuggling and brewing of illicit liquor increased in the state and Haryana tourism faced problems. Consequently Haryana revoked

[55] Public Health Foundation of India (2013). *Alcohol Marketing and Regulatory Policy Environment in India.* A report. Public Health Foundation of India, Health Promotion Unit, New Delhi.

the ban on alcohol in just two years of imposing. The two most recent examples in the country are those of the state of Mizoram and Kerala. Mizoram until recently was under the total prohibition under the Mizoram Liquor Total Prohibition (MLTP) Act 1995. This act was amended to allow to brewing of wine from guavas and grapes in 2007 with restriction. In July 2014 the state Legislative Assembly replaces the MLTP Act with the Mizoram Liquor Prohibition and Control Bill which introduced partial prohibition in the state allowing opening of breweries and liquor shops in the state, citing the need to lift the ban as the previous complete prohibition was ineffective and a partial prohibition with control was needed to curb sale of spurious alcohol and provide people with good quality liquor. On the other hand the state of Kerala has recently introduced a ban on sales of alcohol in 2 and three starred restaurants and has discontinued licenses of bars and restaurants-it remains to be seen whether the contentious ban in Kerala repeats the history of revoking bans as mentioned above.

Partial Prohibition- partial prohibition of alcohol is practiced in all states in India, with the exception of states that are under total prohibition. There is a significant variation in the manner in which states operationalize the partial prohibition. However there are certain common parameters that are used to implement the partial prohibition[56], these are:

- Restrictions on advertisements, promotion and sponsorships of alcoholic drinks
- Ban on drinking in public space
- Restrictions on opening of liquor shops at certain places such as educational institutions
- Regulating density of alcohol outlets in a particular district/state
- Regulating availability through restrictions on time and place of sales
- Declaring dry days
- Prescribing minimum legal drinking age
- Printing health warning on alcohol bottles
- Levy of excise duty on alcohol

[56] Sanjeeta M. Essay on Prohibition in India 2012 retrieved from http://www.preservearticles.com/201104105191/prohibition-essay.html on 20th November 2014 on 20 November 2014

The policy measures to regulate alcohol in the states are decided by every state and there is a big variation in the operation of the parameters described above. These regulations if implemented accurately aim at regulating access to alcohol to people.

3.2 Gaps in alcohol regulations

Alcohol control policies in most states have failed. A closer examination of the state alcohol policies reveal a wide variation in the states in the regulatory mechanisms that render the purpose of 'regulation' of alcohol useless and leaves plenty loop holes as pointed out below.

Variations in the minimum legal drinking age of drinking creates loopholes facilitating access to alcohol. The prescribed varies from 18-25 years across all states in India. The inconsistent and varied minimum legal drinking age are loopholes in the policies. For example in the state of Delhi the minimum legal drinking age is 25 years; whereas in the neighboring Uttar Pradesh this age is 21 years; similarly Maharashtra has a legal drinking age of 25 years but it has easy access to Goa with a minimum legal drinking age of 21 years and is in close proximity to the Union Territory of Diu and Daman where the legal drinking age is just 18 years which is still physically easily accessible to obtain alcohol.

Systems to distribute/sell liquor greatly vary from state to state for example Uttar Pradesh follows a lottery systems to provide rights to vendors to sell alcohol, whereas on states like Chandigarh, West Bengal follow a licensing system where the Excise Commissioner grants a license to sell liquor after a payment of fee for a period of time. Whereas Haryana, Arunachal, and Assam follow the bidding/auction system to grant liquor license to vendors with the highest bid of the year, as per provisions and conditions laid by the respective state excise policy. Whereas states excise departments of Andhra Pradesh, Bihar, Delhi and Chhattisgarh have a monopoly over wholesale distribution of alcohol and states of Jharkhand, Karnataka, Odisha, have monopoly over retail sale of alcohol. Only states of Tamil Nadu and Rajasthan have a monopoly over both whole sale and retail of alcohol distribution. It is very important to understand these systems due to its potential to generate revenue as alcohol taxes are the second major revenue-source for most state governments, after sales tax, alcohol taxes

comprise up to 90% of state excise duties in most cases [57]. A comparison of all states in India on state excise policies for alcohol control is presented in Appendix: 1.[58]

Revenue generation is therefore at the core of most alcohol policies and alcohol-related harms such as violence against women in public and domestic sphere is not a part of discourse of alcohol policy makers in India.

3.3 Alcohol policies in Bihar, Odisha and Tamil Nadu

The three study sites of Bihar, Odisha and Tamil Nadu have similar minimum legal age of drinking of 21 years. All three states have direct state control over alcohol distribution like of retail distribution of alcohol in Bihar and Odisha, whereas Tamil Nadu through TASMAC has complete monopoly over retail and wholesale distribution of alcohol in the state.

A quick review of excise policy in the three states reveals that all the three states have seen an increase in sales taxes and state revenue from sales of alcohol. While excise policies of all the three states provide details on the systems of distribution of alcohol, licensing, and outlet density parameters for opening of alcohol (only in Tamil Nadu); l whereas state excise policies for Bihar and Odisha do not mention the restrictions on opening of alcohol shops. The Tamil Nadu state excise policy mentions, *"no shop shall be established within a distance of 50 meters and in other areas 100 meters from any place of worship or educational institutions."* Thus the excise policy seeks to regulate the access of alcohol to students and protects sanctity of religious places. However the other two states of Bihar and Odisha do not mention such parameters. The excise polices of all the three states do not mention the social harms of alcohol and do not take any cognizance of these. All the state excise policies are geared towards curtailing sale of illicit and spurious liquor and this has been projected as the excise department's rationale for imposing control and any mention of social harm, social evils, attributed to alcohol use are attributed to illicit alcohol. To quote from the 2014-2015 Tamil Nadu State Excise policy, " *With the avowed objective of improving social and economic welfare of those classes of people whom the evils of illicit drinking were afflicting most adversely, the government have formulated a pragmatic policy implemented by*

[57] Gururaj, G., Murthy, P., Girish, N., & Benegal, V. Alcohol related harm: Implication for public health and policy in India. Publication No. 73. Bangalore, India: NIMHANS, 2011

58 Alcohol Marketing and Regulatory Policy Environment in India: A report Public Health Foundation of India (2013), New Delhi

Prohibition and Excise Department" (Pg.1,)[59]*.* This excise policy also stipulates an amount of Rs 1 crore from its own fund to conduct awareness campaigns against the consumption of liquor – a mention that is otherwise missing in the state excise policies of Bihar and Odisha. Another feature of the state excise policies of these states is that though all three states have tribal populations that traditionally brew home-based liquor, the excise policy of Odisha grant concession in tribal areas to brew liquor for personal use and not for sale with approval from *Gram Sasan* (Gram Panchayat)[60].

3.4 Alcohol policies and the unresponsiveness to violence against women

While some of the gaps in alcohol policies have been mentioned earlier like lack of consistent enforcement of minimum legal age, alcohol policies are largely revenue oriented and therefore are not cognizant of harms of alcohol to the society. The wide variation in taxation regimes in states show that the pricing of alcohol is solely driven by profit motive. The fact that none of the excise policies reviewed even mention the words "violence, "women", health" is illustrative of a total apathy toward public health. Structurally since the alcohol is a state subject and a subject that is spread across departments, the departments concerned with public health related aspects of alcohol like the Ministry of Social Justice and Empowerment's (MoSJE) roles are limited in their scope due to a lack of dialogue and even a conflict of interest between these. With the MoSJE is geared towards rehabilitation of "addicts" epidemiological data suggests that habitually Indian drinkers are "binge drinkers"[61] who do not get diagnosed as "addicts" and are therefore outside the ambit of rehabilitation and treatment programs. Whereas literature across the world shows that binge drinking is associated with instance of 'violence'[62] . even within alcohol treatment and de addiction programs that are either residential or delivered in outpatient basis, the focus of treatments seems to be focused on pharmacological De-addiction supported by counseling (peer counseling and professional) and faith-based interventions such a 12-step programs.

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[59] *Home, Prohibition and Excise Department Demand 37. Prohibition and Excise, Policy Note 2014-2015)*

[60] Excise guidelines for year 2014-2015-Odisha

[61] Benegal, V., Velayudhan, A. & Jain, S. (2000) Social costs of alcoholism: a Karnataka perspective. *NIMHANS Journal* , 18, 6–7.

[62] Gil-Gonzalez, D.,et al., Alcohol and intimate partner violence: do we have enough information to act? European Journal of Public Health, 2006. 16(3): p.278-284.

While these treatments would be effective in dealing with “alcoholism”, we do not know if service providers in these rehabilitation and de addiction facilities address/explore the issue of “violence against women” as an issue as a consequence of alcohol consumption.

4. Conclusion

The relationship between alcohol and violence against women is not linear. Inclusion of alcohol is a significant factor that programs and policies need to consider in framing a comprehensive response to violence against women. The reviewed literature and policies highlight that alcohol consumption is a complex phenomenon that comprises of multiple factors that determine alcohol-related violence against women. Understanding of violence against women in the context of alcohol cannot be limited at an individual-level alcohol-looking at alcohol consumption levels. Macro level structural issues like alcohol-policies contribute in providing individuals with an environment that makes alcohol affordable and accessible. Similarly norms around masculinity and associated norms that normalize alcohol consumption and violence against women are rarely addressed in interventions. Moreover promising community level-interventions that implement multi-level programs to address alcohol and violence are not evaluated thus limiting our understanding of their effectiveness in influencing, pathways between alcohol and violence against women. An ecological approach to understanding and addressing alcohol-related violence is needed to comprehensively address micro and macro-level factors that have a bearing on alcohol consumption and violence. Some specific findings from the review are highlighted below:

- *Not all types of alcohol consumption is linked to violence*

Certain patterns of alcohol consumption like heavy drinking, binge drinking are associated with violence against women; compared to occasional or non-drinkers.

- *Alcohol consumption of men do not uniformly affect all women*

Reviewed research has thrown light on the varied correlates of violence specially in intimate relationships. Correlates like lower status of women in terms of lack of employment, low levels of education and exposure to childhood family violence are sone indicators.

- *Alcohol outlet density is closely related to violence against women in public spaces*

Given the close links between proximity of alcohol outlets to communities, research has pointed out the need to review, reform alcohol policies to reduce accessibility of alcohol.

- *Structural interventions on Alcohol policy are effective*

The review shows that structural interventions like increased taxation, decreasing availability, access to alcohol are perhaps the most effective and have far reaching consequences on multiple putcomes of alcohol including decreasing violence against women.

In the Indian context, where alcohol policies seem to be drive by the "revenue" earning paradigm rather than a "public health" paradigm, coupled with a lack of national alcohol policy, engaging with multiple stakeholders is utmost important. The following are some suggestions:

- *Advocacy for Alcohol Policy reforms*

To make alcohol less accessible to men by decreasing alcohol outlet density, increasing the prices of alcohol [63]to dissuade drinking with effective implementation of alcohol control laws and make alcohol less attractive by imposing ban of alcohol advertising. Additionally a national policy on alcohol control is warranted to guide a seamless design and execution of alcohol policies that address the harms due to alcohol to people and women in particular

- *Engagement with women's' groups*

While alcohol use is not directly linked to violence against women, several studies have pointed out that alcohol use is an important factor in understanding domestic violence, similarly research shows that violence against women in public spaces and especially in cases of sexual violence alcohol is strongly associated with such crimes [64] . Women's groups have dealt with issue of men's alcohol use and violence in India. The most famous example of which is the Anti-Arrack movement of 1992 in Nellore Andhra Pradesh where activism by

[63] Outlet density and criminal violence in Norway, 1960-1995. Norström T. J Stud Alcohol. 2000 Nov;61(6):907-11

[64] Heilman, B., Hebert, L., & Paul-Gera, N. The Making of Sexual Violence: How does a Boy Grow Up to Commit Rape? Evidence from five IMAGES Countries. Washington,DC : International Center for Research on Women (ICRW) and Washington, DC:Promundo. June 2014

women resulted in the state banning sale of Arrack in Andhra Pradesh- even though this ban was eventually reversed, this movement was the first of its kind that put the issue of alcohol as an issue that affect the lives of women. A greater engagement where women's groups, other stakeholders like MoSJE and excise departments is needed to understand how harms to women from men's alcohol use can be addressed in a manner that is sustainable and protects the rights of the women-through a dialogue aimed at assessing change in policies of alcohol, change in the welfare programs run for alcohol prevention and treatment, so that costs of alcohol borne by women and families especially violence is put on the agenda of policy makers, program implementers and womens' groups.

APPENDIX 1

APPENDIX 1											
Source: Alcohol Marketing and Regulatory Policy Environment in India: A report **Public Health Foundation of India (2013), New Delhi**											
State/UT	**Ban on sales and drinking in Public Places**	**Licensing places for sale/ consumption**	**Licensing of days and hours of sale**	**Min Sales price**	**Outlet density**	**Quota for retail/personnel limit**	**Minimum legal drinking age**	**Warning/ hologram**	**Distribution system for alcohol**	**State regulation for advertising**	**Prohibition on point of sale advertising**
Andhra Pradesh	√	√	√	√	–	√	21 Years	Excise adhesive hologram	Distribution by Govt. corporation Andhra Pradesh Beverages Corporation Ltd (monopoly on wholesale distribution)	–	–
Arunachal Pradesh	√	√	–	–	√	√	21 Years	–	Auction*** System	–	–
Assam	√	√	–	–	–	√	21 Years	–	Auction System	–	–
Bihar	√	√	√	√	–	√	21 Years	Excise adhesive hologram	Distribution by Govt. corporation	–	√

									Bihar State Beverages Corporation Ltd (monopoly on retail sale)		
Chhattisgarh	√	√	√	√	–	–	21 Years	√	Distribution by Govt. corporation Chattisgarh State Beverages Corporation Ltd (monopoly on whole sale)	√	–
Goa	√	√	√	√	√	√	21 Years	√	Open System*	√	–
Haryana	√	√	√	√	√	√	25 Years	√	Bidding through tender***	√	–
Himachal Pradesh	√	√	√	√	√	√	18 Years	√	Lottery** System	Ban on direct and surrogate ads	–
Jammu and Kashmir	√	√	√	√	√	√	21 Years	–	Licensing System***	√	–
Jharkhand	√	√	√	√	–	√	21 Years	√	Distribution by Govt. corporation Jharkhand State Beverages Corporation Ltd	–	–

									(monopoly on retail sale)		
Karnataka	√	√	√	√	–	√	21 Years	√	Distribution by Govt. corporation Karnataka State Beverages Corporation Ltd (monopoly on retail sale)	√	–
Kerala	√	√	√	–	√	√	21 Years	–	Distribution by Govt. corporation Kerela State Beverages Corporation Ltd (monopoly on both retail and wholesale)	–	–
Madhya Pradesh	√	√	√	√	–	–	21 Years	Excise adhesive hologram	Licensing System	√	–
Maharashtra	√	√	√	–	√	√	25 Years	–	Open System	√	√
Meghalaya	√	√	√	–	–	√	21 Years	–	Licensing System	–	–
Odisha	√	√	√	√	√	√	21 Years	Excise adhesive hologram	Distribution by Govt. corporation through Odisha State	√	–

									Beverages Corporation Ltd (monopoly on wholesale distribution)		
Punjab	√	√	√	√	√	√	25 Years	Excise adhesive hologram	Lottery System	√	–
Rajasthan	√	√	√	–	√	√	18 Years	√	Distribution by Govt. corporation through Rajasthan State Beverages Corporation Ltd (monopoly on both retail and wholesale)	√	Point of sale advertisement is prohibited
Tamil Nadu	√	√	√	–	√	√	21 Years	Hologram restricted to foreign liquor	Distribution by Govt. corporation-TASMAC (monopoly on both retail and wholesale)	–	√
Uttarakhand	√	√	√	√	√	–	21 Years	√	Licensing System	–	–
Uttar Pradesh	√	√	√	√	√	√	21 Years	√	Lottery System	–	–
West Bengal	√	√	√	–	–	√	21 Years	–	Licensing system	–	–

Andaman & Nicobar	√	√	√	√	√	√	18 Years	_	Licensing system	_	_
Chandigarh	√	√	√	√	√	√	25 Years	Excise adhesive hologram	Licensing system	_	_
Delhi	√	√	√	√	√	√	25 Years	Health Warning	Retail by Govt. Corporation and Licenses to Distilleries/Bottling(monopoly on wholesale distribution)	Ban on direct and surrogate ads	√
Sikkim	√	√	√	√	√	√	18 Years	_	Licensing System	_	_
Tripura	√	√	√	√	√	√	21 Years	√	Licensing System	_	_
Dadra and Nagar Haveli	√	√	√	Prescribes Maximum Retail Price	√	√	21 Years	√	Licensing System	_	_
Puducherry	√	√	√	√	√	√	18 Years	Health warning along with a picture of a full human skeleton	Licensing System	√	_
Daman and Diu	√	√	√	√	√	√	18 Years	√	Licensing System	√	_