Chisholm Health Ethics Bulletin

Vol 19 No 4 Winter 2014

Pastoral Care for School Students who Experience Same-Sex Attraction

Research shows that sexual orientation is neither well defined nor ultimately defining for adolescents seeking self-identity. Rather, the data on instability of sexual orientation among youth and young adults suggest that most of the time unquestioning affirmation of an adolescent's claimed same-sex attraction will do more long-term harm than good. This article explores this complexity and proposes more appropriate ways to provide excellent pastoral care in schools.

In its modern rebirth toward the end of the twentieth century, bioethics was defined as "the systematic study of the moral dimensions – including moral vision, decisions, conduct and policies – of the life sciences and health care."[1] Over time, it became clear that the moral dimensions of health care cannot be limited to purely clinical or empirical medicine any more than a complete picture of the human person can be restricted only to physiological functions. Over the last 150 years, we have come to value a more holistic concept of human health that must include psychological, social, spiritual, relational and other dimensions of well-being.

Sexuality is one of those dimensions. Because the total well-being of the developing adolescent invariably requires resolution of his or her sexual orientation, bioethics today can rightly embrace a discussion on pastoral care for students who experience same-sex attraction. This article will examine briefly some data on same-sex orientation among adolescents, review some assumptions in the research, and note some essential components of appropriate pastoral care in the educational setting.

The first hurdle, however, is to determine the precise meaning of 'same-sex orientation.' Some studies rely solely on self-reports of orientation, but most acknowledge that 'orientation' may or may not coincide with the individual's claimed sexual identity, erotic fantasies, sexual behaviours or romantic relationships.[2] That is to say, some young people self-identify as 'gay' or 'lesbian' (or 'unsure') on the basis of their romantic attractions rather than their actual sexual behaviours, while others count themselves 'gay' or 'lesbian' on the basis of sexual fantasies rather than either romantic attraction or behaviours. The data show that same-sex sexual experience, and even same-sex attraction, do not necessarily define same-sex orientation.[3]

Interpreting study results multiplies this confusion. Where one study attempts to distinguish carefully between these various 'components or markers of sexual orientation,'[4] another intentionally includes all of the variables under one heading.[5] A lack of commonality across studies makes comparison of results very difficult, and this must be remembered in the discussion that follows.

Interpreting the Data

Healthy development of school students who experience same-sex orientation is quite properly the subject of considerable attention today, particularly in research focused on student safety.[6] A review of the research reveals the dimensions of its complexity.

The first issue is the imprecision already noted around the definition of 'same-sex orientation,' but a second issue is the widely varying quality of the research itself. Some projects rely on participants to volunteer information, which creates the risk of self-selection bias. More rigorous research tends to produce more reliable data because it samples across the whole population. Much of the research commissioned or conducted by special interest groups tends to fall into the former category, while peer-reviewed and published academic research tends to be more rigorous, more robust and better controlled for confounders.

A third difficulty is the clear evidence of instability during adolescence in some or all of the 'markers of sexual orientation,' as well as considerable fluidity in self-reported sexual identity in the transition from adolescence into adulthood.[7] Some surveys claim that 10% of school students are same-sex attracted,[8] but other, more robust research reveals that fewer than 2.5% of adults self-report as gay, lesbian or bisexual.[9] This discrepancy merits closer examination.

Significantly, stability of sexual identity seems to be related not only to age and presumably emerging personal maturity, but also to the sexual identity itself: not only do over 97% of

IN THIS ISSUE

adults self-report as heterosexual,[10] but 97% of these maintain their heterosexual identity over time.[11] In contrast, reliable research suggests that one-third of gay males, and over two-thirds of lesbians and bisexual adults, change their identity label over time.[12] Such changes occur more commonly in early adulthood than in later adult life.[13] As one researcher states, "instability of same-sex romantic attraction and behaviour (plus sexual identity in previous investigations) presents a dilemma for sex researchers who portray non-heterosexuality as a stable trait of individuals."[14] The data show consistently that heterosexuality is a much more stable sexual identity, which may in part be why it is generally considered normative.[15]

…any pastoral conversation about sexuality and sexual orientation cannot be restricted to either the student's present sense of their sexual orientation or to merely physical aspects of their sexuality.... The person is a subject whose best interests can only be served by keeping their physical-spiritual-relational-social-developmental nature in full view. An adequate pastoral care relationship will be built upon and never lose sight of this more complete, more integral sense of the student's human dignity....

Non-heterosexual instability among adolescents also plays directly into the question of what appropriate pastoral care might look like. It is legitimate to challenge the proposition that school authorities should simply affirm a secondary school student in his or her self-reported sexual orientation.[16] Given the data, such un-nuanced affirmation risks inflicting more harm than good on many students by reinforcing what will ultimately be for most of them a fallacy. Appropriate pastoral care cannot be so undiscerning.

But none of this changes the fact that school students who (even temporarily) feel themselves to be same-sex oriented are often subjected to physical and psychological bullying precisely on the grounds of their perceived sexual orientation or gender identity. Bullying always causes harm, especially when it occurs in periods of personal vulnerability – and the adolescent's search for sexual identity is a time of great uncertainty and self-doubt. The incidence of bullying of lesbian, gay, bisexual, transgender and intersex (LGBTI)[17] students on these grounds is estimated to range from 55% to 90% (depending on the source); verbal abuse is most common (53-61%) followed by cyber bullying (23%), physical attack (18-20%) and even death threats (6%).[18] Compounding these are the harms that some same-sex oriented adolescents inflict upon themselves: nearly one-quarter of LGBTI students try to take their own lives at some point, and more than half engage in deliberate self-harm.[19] Clearly an appropriate pastoral care strategy must pay careful attention to the particular needs of this vulnerable cohort.

Pastoral Care

Complex questions require complex answers, and bullying on the grounds of sexual orientation is certainly complex. Numerous studies have contributed to a description of what 'adequate pastoral care' might look like.[20] Most agree that an adequate response must involve a 'whole-of-school approach,'[21] which refers to a structured process of forming the whole teaching and non-teaching staff of the school on the presence and particular needs of LGBTI students in the school community. It is led by the principal and assisted by specialised counsellors, and eventually extends to the student body. An audit of existing school policies, practices and curriculum, making amendments where necessary to minimise the risk of stigmatising students who experience same-sex attraction, is also indispensable. All agree that an effective response will also need to engage parents, external agencies, and Church leadership.[22]

The remaining discussion is limited to some practical issues for counsellors in Catholic schools. It describes pastoral care which is integral, developmental, affirming, professional, concrete, clear and accommodating.

The foundation of a response which truly reflects the Catholic identity and mission of a school is the Church's integral vision of the human person. In that context, any pastoral conversation about sexuality and sexual orientation cannot be restricted to either the student's present sense of their sexual orientation or to merely physical aspects of their sexuality. The Catholic tradition holds a view of the person that is both more holistic and more hope-filled than the static and fragmented view of some contemporary approaches. In that tradition, the person is both body and soul, a subject whose best interests can only be served by keeping their physical-spiritual-relational-social-developmental nature in full view.[23] An adequate pastoral care relationship will be built upon and never lose sight of this more complete, more integral sense of the student's human dignity.

The Catholic tradition also recognises that the school will not be the only factor shaping the life of the young person, whose growth will continue for many years under the influence of other social and cultural factors. Pastoral care in the school setting will affirm those aspects of the LGBTI student's experience that favour openness to ongoing personal growth and stability, while gently challenging those which threaten to limit this possibility prematurely. In light of the evidence about instability of adolescent sexual identity, particularly non-heterosexual instability, pastoral carers will not take the easy option of simply affirming the student's self-perceived sexual orientation or same-sex activity which may be divulged. They will strive instead to establish a safe and trusting relationship with the student capable of sustaining a sensitive, mature and hope-filled exploration of future possibilities for growth, remembering that

> the overall goal in caring for youth who are or think they might be gay, lesbian or bisexual is the same as for all youth: to promote normal adolescent development, social and emotional well-being, and physical health.[24]

Recognising that LGBTI students often experience an overwhelming sense of fear – of isolation, of discovery, and of rejection or abuse – the carer will take pains to assure the student of their safety in the pastoral relationship. They will help the student think through their feelings carefully (reminding them that "strong same-sex feelings and even sexual experiences can occur at this age and do not define sexual orientation" [25]) and identify risky behaviours

(including sexual behaviours, use of alcohol, tobacco or other drugs), offering advice or referral for treatment. The carer will also discuss issues around fear of disclosure to parents, peers or significant others. A student's 'coming out' has the potential to cause immense discord in his or her family. The wider school community could have an important supportive role to play for student and family alike.[26]

The LGBTI student's sense of safety in the school community must not be confined to one-on-one pastoral relationships but should extend to the wider cultural and physical environment. Few commentators seem to advocate setting aside specific 'safe places' in the school for LGBTI students to gather – perhaps for fear of further stigmatisation – but at times it is necessary to make special arrangements for individuals or small groups of students. For example, an intersex student may be receiving professional treatment that includes trialling a short (or even a very long) period of life in the other gender. This may necessitate identifying or creating suitable toilet and change -room facilities for that student, and perhaps special arrangements for other aspects of the curriculum such as physical education. A whole-of-school approach will also require that school staff, as well as that student's peer group, are properly prepared for these changes: school leaders will remain in close contact with the student's parent(s), and will structure opportunities to communicate information to the school community with sufficient time for reflection, questions and conversation.

…Schools must not blindly affirm a student's felt same-sex orientation but should provide excellent pastoral care designed to both support and challenge the student to ongoing growth....

Careful communication and compassion are probably the most important elements in developing appropriate pastoral care for students who feel that they are same-sex oriented. Many commentators emphasise the need to pay close attention to the language we use to discuss sexual orientation.[27]

Consider for example the senior school student who asks whether he can invite a same-sex partner to the senior ball. As described, this simple scenario contains two assumptions: first, that it is the student who invites his partner to the ball; and second, that the other party is indeed the student's 'partner' – a word which when used in conjunction with 'same-sex' could imply active sexual behaviour. Schools can avoid any confusion by insisting that (1) it is the school, and not the individual student, that issues invitations to the senior ball; and (2) those who are invited are not 'partners' but 'guests', a word which avoids any unfortunate implications. (This approach also allows the school to establish an appropriate standard of dress and behaviour before, during and after the event.)

Many students feel that they are or may be same-sex oriented at some time during their school years. The data suggest that for the vast majority this is a passing phase in the normal development of their sexual identity, since 97.7% of people identify as heterosexual in adult life. But there is no way of knowing which individuals will constitute the 2.3% of school students who will later identify as same-sex oriented adults.

Schools must therefore provide safe environments for all students regardless of their real or felt sexual orientation, encouraging and not jeopardising their growth toward wholeness. Schools must not blindly affirm a student's felt same-sex orientation but should provide excellent pastoral care designed to both support and challenge the student to ongoing growth. Only in this way is the student's total human dignity properly respected, and the school's pastoral responsibility properly fulfilled.

ENDNOTES

[1] Albert R. Jonsen, *The Birth of Bioethics* (New York: Oxford University Press, 1998), vii.

[2] For a discussion of this complexity, see Ritch C. Savin-Williams and Geoffrey L. Ream, "Prevalence and Stability of Sexual Orientation Components During Adolescence and Young Adulthood," *Archives of Sexual Behaviour* 36 (2007): 385-394.

[3] See the findings of A. M. Smith et al, "Sex in Australia: sexual identity, sexual attraction and sexual experience among a representative sample of adults," *Australian and New Zealand Journal of Public Health* 27, no. 2 (2003): 138-145, Abstract online at National Center for Biotechnology Information, http://www.ncbi.nlm.nih.gov/pubmed/14696704

[4] Savin-Williams et al, 385.

[5] See, for example, Lynne Hillier et al, *Writing Themselves In 3: The third national study on the sexual health and wellbeing of same sex attracted and gender questioning young people* (Melbourne: La Trobe University, 2010), viii; online at Gay and Lesbian Health Victoria, http://www.glhv.org.au/report/writing-themselves-3-wti3-report

[6] See, for example, April Guasp (2012), *The School Report: The experiences of gay young people in Britain's schools in 2012* (*The Stonewall Report*) (Cambridge: Centre for Family Research, University of Cambridge, 2012); online at http://www.stonewall.org.uk/documents/school_report_2012(2).pdf; Tiffany Jones, *A Report about Discrimination and Bullying on the Grounds of Sexual Orientation and Gender Identity in Western Australian Education, prepared for the Equal Opportunity Commission of Western Australia*, 2012, Equal Opportunity Commission, Government of Western Australia, http://www.eoc.wa.gov.au/Libraries/GBTI_project/2012-GBLTI_-_Tiffany_Jones_report.sflb.ashx; Mental Health America (MHA), Bullying and LGBT Youth, (n.d.), MHA, http://www.mentalhealthamerica.net/bullying-and-gay-youth; and Australian Human Rights Commission (AHRC), Violence, Harassment and Bullying and the LGBTI Communities; (n.d.), AHRC, https://bullying.humanrights.gov.au/lesbian-gay-bisexual-trans-and-intersex-equality-1. The interpretation of data on 'gay bullying' in schools is challenged by David van Gend, "Is the gay bullying plague in schools a myth?" 29 July 2014, MercatorNet, http://www.mercatornet.com/articles/view/is_the_gay_bullying_plague_in_our_schools_a_myth

[7] See, for example, Savin-Williams et al; Steven E. Mock and Richard P. Eibach, "Stability and Change in Sexual Orientation Identity Over a 10-Year Period in Adulthood," *Archives of Sexual Behaviour* 41, no. 3 (2011): 641-648, Abstract online at http://link.springer.com/article/10.1007%2Fs10508-011-9761-1#page-1; Miles Q. Ott et al, "Stability and Change in Self-Reported Sexual Orientation Identity in Young People: Application of Mobility Metrics, *Archives of Sexual Behaviour* 40 (2011): 519-532, Abstract online at http://link.springer.com/article/10.1007%2Fs10508-010-9691-3#page-1

[8] Safe Schools Coalition Australia, *Safe schools do better: Supporting sexual diversity and gender diversity in schools*, 2013,

online at http://www.safeschoolscoalition.org.au/uploads/1dd74255c1091bb724ea0c7aa03292a4.pdf; see also Jones, 10.

[9] US Department of Health and Human Services, *Sexual Orientation and Health among U.S. Adults: National Health Interview Survey, 2013*. National Health Statistics Report 77 (15 July 2014), at 3, online at http://www.cdc.gov/nchs/data/nhsr/nhsr077.pdf; Smith et al. found that only 2.5% of adult men and 2.2% of adult women in Australia self-identify as gay, lesbian or bisexual.

[10] Ibid, 3,

[11] Savin-Williams et al, 387.

[12] Ibid.

[13] Ott et al, 12; Mock et al, 646.

[14] Savin-Williams et al, 393. This fluidity casts serious doubt on the strategy of the 'Safe Schools Coalition' that by-passes education authorities and appeals directly to secondary school students to promote what it claims to be a 'safe schools' agenda – see Safe Schools Coalition Australia, *Safe schools do better.* The data on non-heterosexual instability among adolescents suggest that this strategy is seriously misguided.

[15] Mock et al, 645 attributes the stability of heterosexuality to its normative status, but the data also support the alternative hypothesis: that heterosexuality is normative because it is the most stable sexual orientation for adults.

[16] This claim underpins the proposals of Jones and the Safe Schools Coalition.

[17] There seems to be no agreed objective basis for including all of these in a single amorphous category, yet the LGBTI designation is a commonplace in the literature. 'Intersex' refers to a range of recognised objective medical conditions which may require a variety of treatments up to and including surgery; 'gay', 'lesbian' and 'bisexual' are subjective self-reports which may be based on a range of shifting criteria as discussed in the text; 'transgender' can refer to an intersex person who has undergone a form of 'gender reassignment,' or one who deals with gender dysphoria of a more or less psychological nature by adopting the dress, behaviour and other characteristics associated with another gender. Despite this confusion, the 'LGBTI' designation will be retained here for the sake of convenience; it should be interpreted as referring to students who, at particular moment in their adolescent development, believe themselves to be same-sex oriented.

[18] A range of data on the incidence and effects of sexuality-based bullying are presented in Guasp, and Jones.

[19] Guasp, 4.

[20] Some notable contributions include: Peter Norden SJ, *Not So Straight: A national study examining how Catholic Schools can best respond to the needs of same sex attracted students* (Richmond, VIC: Jesuit Social Services, 2006), online at http://www.nordendirections.com.au/presentations/NSS.pdf; Education Commission of the Ontario Conference of Catholic Bishops, *Pastoral Guidelines to Assist Students of Same-Sex Orientation* (Ontario: Ontario Conference of Catholic Bishops, 2004, online at http://acbo.on.ca/englishdocs/Pastoral%20Guidelines.pdf; United States Conference of Catholic Bishops, *Ministry to Persons with a Homosexual Inclination: Guidelines for Pastoral Care*, 2006, online at http://www.usccb.org/issues-and-action/human-life-and-dignity/homosexuality/upload/minstry-persons-homosexual-inclination-2006.pdf; and Barbara L. Frankowski et al, "Sexual Orientation and Adolescents: Clinical Report – Guidance for the Clinician in Rendering Pediatric Care," *Pediatrics* 113 (2004): 1827-1832, online at http://pediatrics.aappublications.org/content/113/6/1827.full.pdf. These very considered, professional and highly nuanced contributions stand in marked contrast to those of Guasp, and Jones.

[21] Norden, Recommendations 6.2, 6.4, 6.5 and 6.6.

[22] Norden, Recommendations 6.3, 6.9, 6.14-6.17.

[23] See Second Vatican Council, *Gaudium et spes,* Pastoral Constitution on the Church in the Modern World (7 December 1965), nn. 12-18, online at Holy See, http://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_const_19651207_gaudium-et-spes_en.html

[24] Frankowski et al, 1828.

[25] Frankowski et al, 1830.

[26] For a fuller discussion of clinical issues, see Frankowski et al, passim, on which these considerations are based. On pastoral support for parents and families of students who 'come out', see Bishops Committee on Marriage and Family, United States Conference of Catholic Bishops (USCCB), *Always Our Children: A Pastoral Message to Parents of Homosexual Children and Suggestions for Pastoral Ministers, Origins 28, no. 7 (2 July 1998): 97, 99-102, online at USCCB,* http://www.usccb.org/issues-and-action/human-life-and-dignity/homosexuality/always-our-children.cfm

[27] See Norden, Recommendation 6.21; Jones, 35 & 38; Guasp, 13 -14, 27.

All online references accessed 3 September 2014

Joseph Parkinson ✠

Rev Dr Joseph Parkinson is the Director of the L. J. Goody Bioethics Centre in Perth.

Preventing the Sexual Transmission of HIV/AIDS

There was once a strong belief amongst global HIV/AIDS organisations that the key to the prevention of the sexual transmission of HIV was condom (C) use. Other measures such as abstinence (A) and being loyal (B) to one partner were seen as beneficial, but secondary. Thirty years later, the evidence is mounting that behavioural change (A and B) is much more effective in halting the spread of HIV than condoms.

Since the HIV/AIDS pandemic was declared in the 1980s, control of the spread of HIV infection[1] has been variable. In 2012, there were 2.3 million new infections recorded. HIV is spread through blood, semen, pre-seminal fluid, rectal and vaginal fluids and breast milk. It is mainly transmitted through sexual intercourse, exposure to infected blood or blood products,[2] and perinatally through pregnancy and breastfeeding. The predominant mode of transmission is sexual intercourse.[3] Factors which influence the risk of transmission include the frequency and type of sexual activity,[4] male circumcision, and some sexually transmitted infections (STIs). These in turn are impacted by social, cultural and environmental factors.[5] This paper will focus on the sexual transmission of HIV. It will argue that the key to addressing the HIV/AIDS pandemic is not solely nor primarily condom use, but changing perceived sexual behavioural norms.

There are essentially two competing views about sexual intercourse. The first holds that the only proper 'place' for sexual intercourse is within a lifelong committed relationship. Within that relationship, sexual intercourse expresses the total self-giving of each person to the other. It should also be open to procreation. The second view sees sex simply as a pleasurable activity, irrespective of the

relationship of the two individuals involved, as in the sex trade. These two different moral perspectives have led to different emphases in approaches to preventing HIV transmission through sexual intercourse.

The Sexual Act as an Expression of Total Self-giving Love

This view of sexuality was and is the cultural norm in many societies – including pre-colonial South Africa[6] and Uganda.[7] It is the vision of sexuality expressed in many of the religions of the world – including the Catholic Church. The Catholic Church teaches that sexual intercourse is the ultimate expression of union between a husband and a wife, who "become in a way one heart and one soul, and together attain their human fulfilment."[8] It is part of the spouses' total self-giving and faithful love of each other until death. This perspective calls for abstinence until commitment is made to another through marriage. It also calls for fidelity to one's spouse throughout the marriage.

This vision of sexuality honours and respects the dignity of the human being, and affirms the meaning and purpose of life as human flourishing. It calls for self-restraint and responsible behaviour resulting in the good of self, other, family and society.[9] Respecting the dignity of each person is not confined to Catholicism. Correctly understood, it is a moral imperative. This is why it was and is the cultural norm of so many societies.

Within this vision, there is no risk of spreading HIV if both partners are not infected. However, there may be a risk of spreading HIV when one partner is infected and the other not. From this perspective which recognises sexual intercourse as the expression of ultimate union, it is understandable that promiscuity is viewed as the 'banalisation of sexuality.'[10]

The Sexual Act as a Pleasurable Activity

When the sexual act is viewed solely as a pleasurable activity without moral constraints, there is no necessary call to abstinence and fidelity. Promiscuity may become the norm. Without respect for the other, the sexual act may become an act of power-over-another, and this in turn may lead to physical, verbal or psychological abuse.[11] Being trapped in a cycle of such violence can lead to loss of dignity and self-respect, and a sense of powerlessness. When such behaviours are entrenched in the culture, and promiscuity and abuse become the norm, it is hard to regain a sense of dignity and selfhood. Poverty may also lead to the use of one's body as a commodity rather than the sacred vessel it is.

HIV infection would not have reached such pandemic proportions if there was not already fertile ground to enable it to happen in the form of widespread promiscuity and the socio-economic determinants that support it. Fear of being infected with HIV may not be enough to stop sexual transmission. Indeed, the partial security of condom use (and other measures that mitigate the transmission of HIV) may instead encourage what Edward Green calls "risk compensation" behaviour: that is, increasing promiscuity with a false sense of security.[12]

Because their personnel tend to see sexual intercourse merely as pleasurable activity, some Western aid organisations and governments tend to think that the best approach to the prevention of HIV transmission is harm minimization. This explains the emphasis on condom use in their strategies.

Medical Approach

The medical management of disease begins with the diagnosis of an ailment based on a comprehensive history and examination. In the case of this 'ailment' which is HIV infection, the sexual transmission of HIV occurs predominantly outside the fidelity of a monogamous relationship. Those who become infected by HIV commonly have multiple and concurrent sexual partners. The prevalence of HIV infection is significantly higher in promiscuous and polygamous cultures, in men-who-have-sex-with-men (MSM), and in the sex trade. The likelihood of transmission is heavily affected by social, cultural, and environmental factors that often differ markedly between and within regions and countries. The obvious medical management is firstly, primary prevention according to the physical determinants of HIV transmission; and secondly, treatment with antiretroviral treatment (ART) for those who have become infected.

Physical Determinants

As HIV is transmitted through contact with infected body fluids in the sexual act, abstinence guarantees non-transmission. Only one contact with infected body fluids is needed to be infected. Being faithful to one partner, who is HIV negative and faithful as well, guarantees that there will be no sexual transmission of HIV. Even when the number of sexual partners is small, the risk of contact with infected body fluids increases as the number of infected people within the community rises. Concurrent multiple partners, whose HIV status is positive or unknown,[13] increase the likelihood of transmission. There may be some genetic predisposition to increased risk of HIV infection. When someone is exposed to infected body fluids, the presence of other STIs increases the chance of infection.[14] Abstinence guarantees non-transmission of STIs, as does monogamy in non-infected individuals. Male circumcision is associated with a decrease in HIV transmission of approximately 60%.[15] Early and effective ART that results in undetectable viral load, significantly decreases the risk of sexual transmission but does not eliminate it.[16]

ABC

Based on the science of HIV transmission, the *ABC* prevention strategy was proposed in the early management of the HIV pandemic. *A*bstinence,[17] *B*eing faithful[18] to one partner and, if these are not possible, consistent and correct *C*ondom usage, have effectively decreased the spread of HIV. While it is unclear whether one component is more effective than the others, it is obvious that condom use alone cannot be *the* answer to HIV prevention. Shelton et al determined that in almost every country where there was a decrease in HIV incidence, there was an associated reduction in the number of sexual partners.[19] For example, a programme in Thailand which required sex workers to use condoms certainly reduced HIV transmission. This intervention also led to a two-fold decline of men engaging in commercial and casual sex.[20]

In contrast to this, until recently the strategies of what is

sometimes called the AIDS Establishment[21] have emphasised the promotion of condom use and other prophylactic devices as primary prevention, alongside voluntary counselling and testing (VCT) and the treatment of STIs. These strategies are either unproven or disproven.[22] It is only in recent years that the need for a combination approach has been acknowledged by the AIDS Establishment.[23] However, even though behavioural change, especially partner reduction, has been shown to be a most effective component,[24] condom use, despite its variable success rate,[25] continues to be flagged as the most significant method.[26]

… The long-term strategy for the prevention of HIV transmission…. surely requires extensive (and probably intensive) education about HIV/AIDS, sexuality, and the reasoning behind attitudinal and behavioural change. It also necessitates ongoing support. Such a strategy is most effective when planned and executed at grassroots level involving the local leaders and the whole community....

The long-term strategy for the prevention of HIV transmission would involve different emphases according to the situations, urgencies, cultures and moral stances of the target population. It surely requires extensive (and probably intensive) education about HIV/AIDS, sexuality, and the reasoning behind attitudinal and behavioural change. It also necessitates ongoing support. Such a strategy is most effective when planned and executed at grassroots level involving the local leaders and the whole community, and resourced by multinational non-governmental and governmental organisations.

The question as to whether behavioural change is an effective and feasible measure is addressed by Hanley and de Irala in *Affirming Love, Avoiding AIDS: What Africa Can Teach the West.* They argue for the urgency of behavioural change - abstinence and fidelity - as very effective and feasible means of prevention, whilst highlighting the inadequacies and dangers of condom promotion, VCT and treatment of STIs[27] as promoted by the AIDS Establishment. Citing numerous articles, they argue that there has been a strong association between the reduction in prevalence of HIV and behavioural change in countries such as Kenya, Zimbabwe, Haiti, Rwanda and Ethiopia.[28] It is only when *A* and *B* cannot be acceded to that *c*ondom use, male circumcision and other proven strategies might be considered at least in the short term. This may be, as Benedict XVI said, "a first step in a movement towards a different way, a more human way, of living sexuality."[29] Even if this is granted, however, it must be emphasized that if long-term prevention is the aim, condom use is not the answer. Why?

Condoms

Condoms have been shown to be an ineffective long-term solution in the prevention of the sexual transmission of HIV. For one thing, the inability to ensure consistent and correct use of condoms makes them an unreliable method of preventing HIV sexual transmission.[30] Their effectiveness is dependent on the material of the condoms (latex is most effective), the quality of their manufacture, consistent and appropriate use (avoiding breakage and slippage), and accessibility. Even then, condoms do not guarantee full protection. Their use may also imply a questioning of the fidelity of the partner. Condoms are also associated with HIV, which carries a stigma of disgrace and abhorrence, and can lead to prejudice and discrimination. This may discourage their use. Whilst their use may have been effective in the sex trade as a 'stop-gap' measure, it is obviously more effective to stop the sex trade through behavioural change, thus not only preventing the transmission of disease but also remedying the abuse, indignity and exploitation of people, along with the significant human trafficking[31] that often accompanies the sex trade. Risk compensation is also a reality. And whilst the evidence is not strong, the question as to whether concentrating on condoms hinders the success of other more effective strategies[32] also needs to be considered.

Socioeconomic Determinants

A holistic medical approach would also assess the socioeconomic context of HIV transmission. The challenges involved in changing the behaviour of a society are enormous. In societies where sexuality and fertility is inherent in people's identity, self-esteem, and socio-acceptability, change is difficult. Where polygamy, sex regarded as pleasurable recreation, and pregnancy as indicative of one's fertility and hence marriageability, are accepted cross-generational norms, it is difficult for many to accept the teaching that promiscuity is wrong. Even if infection with HIV and death is a possibility, some will still choose promiscuous sex, perhaps out of a mistaken idea that they will be loved for having done so. Further, whilst HIV infection remains a social stigma, there is little encouragement to be tested for it. Poverty, food insecurity, years of drought, low levels of education, unemployment, illness, abandonment and abuse issues, poor self-esteem and distrust of foreign aid are significant issues that can impede the acceptance of behavioural change.[33] It is through loving fidelity, respecting the dignity of individuals, being inclusive and non-judgemental, providing integrative, comprehensive services which address social, physical, mental and spiritual health, and "reuniting and strengthening families who have been overwhelmed by sickness, death and loss,"[34] that change can eventually happen.

Conclusion

UNAIDS approximates[35] that 35.3 million people are living with HIV worldwide.[36] The impact of this goes beyond the infected individual, to the family and community. Children are orphaned and possibly infected themselves; grandmothers become the sole parents; life-expectancies are shortened, resulting in a limited workforce, and communities without food. If we are serious about preventing the sexual transmission of HIV infection, we must first address the foundational issue of human sexuality and its expression in sexual intercourse. Our sexuality is integral to who we are as human beings and how we relate to each other. Ultimately, the choice lies in whether we

relate to each other with respect and love, intending the good of self and others, and ultimately reach our highest good; or instead seek limited and short-term often insatiable self-fulfilment, without moral constraints, that result in the destruction of self and society. The HIV pandemic is an example of the effect of promiscuity and the banalisation of sexuality. The evidence is strong that pre-lifetime-commitment abstinence and mutual fidelity in a monogamous relationship is the key to the prevention of sexual transmission of HIV.

Changing entrenched behaviour and attitudes can be both a short- and long-term endeavour depending on the individual and society. Where it becomes a long-term endeavour, shorter term responses to the HIV pandemic may become necessary. These might involve such strategies such as ABC, VCT, treatment of STIs, male circumcision, and early and continued ARTs.[37] If the ABC strategy is considered, evidence now strongly indicates that the emphasis must be not abC but ABc – that is, that the greatest priority must be to promote the behavioural change of abstinence and fidelity.

Whilst education is key, it is only possible and effective if the conditions are right for its reception, integration and application. Gender inequality, social stigma, alienation, discrimination, partner abuse,[38] poverty, unemployment, racism, inadequate nutrition, poor access to health services, and cultures and traditions that reinforce physical, psychological and sexual abuse, powerlessness and poor self-esteem, all mitigate against behavioural change.

…The evidence is strong that pre-lifetime-commitment abstinence and mutual fidelity in a monogamous relationship is the key to the prevention of sexual transmission of HIV….

Ultimately it is people at grassroots who work with the community, and who have gained an understanding of their philosophies and values, who will effect the greatest change. Through loving fidelity, they gain the trust of the people. Resourced by multinationals, not demanding unreasonable conditions, they are able to not only treat those infected with HIV but also address the social determinants that mitigate healing. In doing so, they provide the fertile ground in which necessary behavioural change can happen and so prevent the transmission of HIV.

ENDNOTES

[1] Infection with the Human Immunodeficiency Virus (HIV) can eventually lead to the development of the Acquired Immunodeficiency Syndrome (AIDS). Anti-Retroviral Treatment (ART) introduced in the 1990s has improved the life expectancy of infected individuals from a few years to a nearly normal life expectancy if diagnosed and treated early. For further information on the basics of HIV infection, see Centers for Disease Control and Prevention (CDC), "About HIV/AIDS," CDC, February 12, 2014, http://www.cdc.gov/hiv/basics/whatishiv.html.

[2] Examples include intravenous drug use, reception of intravenous blood and blood products and organ transplantation not screened for HIV.

[3] Worldwide, sexual intercourse accounts for approximately 80 percent of infections. See Ian Askew and Marge Berer, "The Contribution of Sexual and Reproductive Health Services to the Fight against HIV/AIDS: A Review," *Reproductive Health Matters* 11, no. 22 (2003): 51–73. Sexual intercourse accounts for more than 90 percent of infections in sub-Saharan Africa.

[4] Anal intercourse is the highest risk with receptive anal sex riskier than insertive anal sex. In penile-vaginal intercourse, male-to-female transmission is more likely than female-to-male transmission. See Centers for Disease Control and Prevention, "HIV Transmission," CDC, February12, 2014, http://www.cdc.gov/hiv/basics/transmission.html and Rachel Royce et al., "Sexual Transmission of HIV," *New England Journal of Medicine* 336, no. 15 (1997): 1072-78.

[5] Poverty, for example, impacts on the nutritional status of the individual and access to health care, food, clean water and sanitation; socio-cultural "enforcement" of polygamy encourages promiscuity for social acceptability.

[6] Philippe Denis, "Sexuality and AIDS in South Africa," *Journal of Theology for Southern Africa* 115 (March 2003): 63-77 at 68 and 74; Peter Delius and Clive Glaser, "Sexual Socialization in South Africa in an Historical Perspective," *African Studies* 61, no. 1 (July 2002): 27-54.

[7] In a speech to the 1991 International AIDS Conference, President Yoweri Kaguta Museveni of Uganda called his people "to return to the time-tested culture of no premarital sex and faithfulness." For this, see Matthew Hanley and Jokin de Irala, *Affirming Love, Avoiding AIDS: What Africa Can Teach the West* (Ballan, VIC: Connor Court Publishing, 2011), 35. Also, one limited study found that while polygamy is currently accepted as a cultural norm in middle Africa, the practice of monogamy is more widespread. For this, see James Fenske, "African Polygamy: Past And Present," Centre for the Study of African Economies Working Paper, University of Oxford, 2012), http://www.economics.ox.ac.uk/materials/papers/12544/csae-wps-2012-20.pdf

[8] Paul VI, *Humanae Vitae*, Encyclical Letter (1968), #9. The encyclical teaches that sexual intercourse is both unitive and procreative, and that these two ends cannot be separated.

[9] *Humanae Vitae,* #10.

[10] Benedict XVI, *Light of the World: The Pope, the Church, and the Signs of the Times,* trans. Michael J. Miller and Adrian J. Walker (San Francisco: Ignatius Press, 2010), 119.

[11] This is especially so in situations of gender inequality where women are subordinate to men including their husbands who in turn may also have other sexual partners.

[12] Edward C. Green, *Broken Promises: How the AIDS Establishment Has Betrayed the Developing World* (Sausalito, CA: PoliPointPress, 2011), 51.

[13] HIV antibodies can be detected as early as 2 weeks in a few people and by 12 weeks in more than 99.9% of people. A final test 6 months after exposure is recommended to ensure a negative status for those whose risk of infection is greater. Hence it is difficult to determine an individual's HIV status at the time of the sexual act especially if multiple partners are involved.

[14] Although the evidence is mixed, it is likely that the presence of genital ulcers and syphilis chancroid increases the risk of the virus entering the blood stream of the individual through breaks in the skin. See Centers for Disease Control and Prevention, "HIV Transmission," CDC, April 12, 2014, http://www.cdc.gov/hiv/basics/transmission.html.

[15] In one meta-analysis, uncircumcised males were twice as likely to have HIV infection. For this, see Helen A. Weiss, Maria A. Quigley, and Richard J. Hayes, "Male Circumcision and Risk of HIV Infection in Sub-Saharan Africa: a Systematic Review and Meta-analysis," *AIDS* 14, no. 15 (Oct 2000): 2361-70. For a report on three randomised controlled trials which included prevention counselling, see Helen A. Weiss et al., "Male Circumcision for HIV Prevention: From Evidence to Action?" *AIDS* 22, no. 5 (March 2008): 567-574. These trials showed that "male

circumcision reduces the risk of HIV acquisition by approximately 60%," 567. A total of 10,908 uncircumcised HIV-negative men were randomised to intervention and controlled arms and followed up for 2 years. The study was stopped after two years by independent Data and Safety Monitoring Boards, when it became clear that HIV seroconversion was significantly less in those circumcised.

[16] Centers for Disease Control and Prevention, "Effect of Antiretroviral Therapy on Risk of Sexual Transmission of HIV Infection and Superinfection," CDC, September 2009, http://www.cdc.gov/hiv/pdf/prevention_art_factsheet.pdf.

[17] Abstinence education counsels people either to postpone their first sexual act until they are committed to another for life or to abstain entirely from sexual intercourse.

[18] Education in fidelity counsels people to be committed and faithful within a monogamous relationship – or at least to reduce the number of their sexual partners and to avoid high-risk partners. For this, see James D. Shelton et al.,"Partner reduction is crucial for balanced 'ABC' approach to HIV prevention," *British Medical Journal* 328 (10 April 2004): 891-3.

[19] Ibid.

[20] Ibid., 891.

[21] The AIDS Establishment is the term Edward Green uses for "global authorities like the World Health Organization and UNAIDS (the Joint United Nations Program on HIV/AIDS) and governmental donor agencies like USAID (the U.S. Agency for International Development) and its European counterpart." See Hanley and de Irala, *Affirming Love,*1. Critique of the AIDS Establishment's focus on condom promotion, voluntary counselling and testing, and treatment of STIs, includes noting the profiteering in a multibillion dollar industry which manufactures condoms and tests. For this, see Ibid., 36-7.

[22] David Wilson and Daniel T. Halperin, ""Know Your Epidemic, Know Your Response": a Useful Approach, If We Get It Right," *The Lancet* 372, no. 9637 (August 2008): 423-6, http://dx.doi.org/10.1016/S0140-6736(08)60883-1.

[23] In a 2009 press release, for example, UNAIDS stated: "Condoms are an essential part of combination prevention which includes among other elements: access to information about HIV, access to treatment, harm reduction measures, waiting longer to become sexually active, being faithful, reducing multiple partners and concurrent relationships, male circumcision, ensuring human rights and the reduction of stigma." For this, see UNAIDS. "Press Release," UNAIDS, March 18, 2009, http://www.unaids.org/en/Resources/PressCentre/Pressreleaseandstatementarchive/2009/March/20090318ComprehensivePrevention. See also The White House Office of National AIDS Policy, "National HIV/AIDS Strategy for the United States," July 2010, http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf, viii.

[24] Malcolm Potts et al., "Reassessing HIV Prevention," *Science* 320, no. 5877 (May 2008): 749-750; James D. Shelton, "Confessions of a Condom Lover," *The Lancet* 368, no. 9551 (December 2006): 1947-8.

[25] A meta-analysis by Davis and Waller estimated the latex condom effectiveness of reducing HIV transmission to be 87%, but varying from 60% to 97%. See Karen R. Davis and Susan C. Weller, "The Effectiveness of Condoms in Reducing Heterosexual Transmission of HIV," *Family Planning Perspectives* 31, no. 6 (Nov/Dec 1999): 272-279. Pinkerton and Abramson suggested that with consistent use condoms are 90-95% effective. See Steven D. Pinkerton and Paul R. Abramson, "Effectiveness of Condoms in Preventing HIV Transmission," *Social Science and Medicine* 44, no. 9 (1997): 1303-1312.

[26] UNAIDS, *Press Release*, xxi. As Hanley and de Ira highlighted in *Affirming Love*, this is also evident in many of the documents and websites of the AIDS Establishment, where condom use is highlighted and emphasized. Other measures are recommended but arguably without the same emphasis as condom use.

[27] Hanley and de Irala, *Affirming Love*, 23-35.

[28] Ibid., 40-41.

[29] Benedict XVI, *Light of the World,* 119. The Catholic Church accepts that condom use "with the intention of reducing the risk of infection, can be a first step in a movement towards a different way, a more human way, of living sexuality." At the same time, the Church insists that "the provision of condoms does not constitute 'the real or moral solution' to the problem of AIDS," for this problem can ultimately be solved only by embracing a more human and life-affirming vision of sexuality. For this, see Congregation for the Doctrine of Faith, "Note on the Banalization of Sexuality Regarding Certain Interpretations of 'Light of the World'," December 27, 2010, Holy See, http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20101221_luce-del-mondo_en.html

[30] High rates of sexual transmission of HIV have been reported despite high rates of condom use. Hearst and Chen suggest that "inconsistent use…, low use among those at highest risk, and negative interactions with other strategies, such as partner reduction" may decrease the impact of condom use. See Norman Hearst and Sanny Chen, "Condom Promotion for AIDS Prevention in the Developing World: Is it Working?" *Studies in Family Planning* 35, no. 1 (March 2004): 39-47 at 39.

[31] UN GIFT, "Human Trafficking - The Facts," United Nations Global Impact, 2008, http://www.unglobalcompact.org/docs/issues_doc/labour/Forced_labour/HUMAN_TRAFFICKING_-_THE_FACTS_-_final.pdf.

[32] Giuseppe Benagiano et al., "Condoms, HIV and the Roman Catholic Church," *Reproductive BioMedicine Online* 22 (June 2011): 701-709, http://dx.doi.org/10.1016/j.rbmo.2011.02.007.

[33] Cabrini Ministries Swaziland, *Program Report 2012-2013* (Manzini, Swaziland: Cabrini Ministries Swaziland, 2013), 1-64.

[34] Ibid., 13. This report is an example of the importance of grassroots planning that is specific to a particular culture, tradition and place. It involves gaining the trust of the people. I am very grateful to Cabrini Sisters Diane DalleMolle MSC and Barbara Staley MSC for sharing the wisdom and insights they have gained from personal experience in Swaziland.

[35] It is impossible to accurately determine the number of HIV-infected people in many parts of Africa and other remote regions in the world, especially those places with poor infrastructure.

[36] UNAIDS, "AIDS by the Numbers" UNAIDS, 2013, http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2013/JC2571_AIDS_by_the_numbers_en.pdf.

[37] Provision of ART to HIV-1 infected patients could be effective in reducing HIV sexual transmission. Its effect in vertical transmission between mother and baby has been shown. HIV transmission from mother to baby declined from an estimated 1,650 a year in 1991 to fewer than 200 per year by 2004. See Deborah Donnell et al., "Heterosexual HIV-1 Transmission After Initiation of Antiretroviral Therapy: a Prospective Cohort Analysis," *The Lancet* 375, no. 9371 (June 2010): 2092-8.

[38] "There is a 50% increase in likelihood of acquiring HIV among women who have experienced intimate partner violence." UNAIDS, *AIDS by the Numbers,* 6.

All online resources accessed 15 May 2014

Caroline Ong RSM ✠

I am very grateful to Cabrini Sisters Diane DalleMolle MSC and Barbara Staley MSC for sharing the wisdom and insights they gained from personal experience as the Executive Director and Deputy Executive Director of Cabrini Ministries Swaziland, respectively.

Problem Drinking in Australia

The widespread over-consumption of alcohol in Australia has shaped its high tolerance to drinking culture. Australia has a complex socio-cultural relationship with alcohol and it is challenging to reduce high alcohol intake when it is so ingrained in our society. The substantial harms associated with over-consumption not only affect the drinker, but also impact upon the wider community. This article discusses the available evidence about the health and social harms for individuals that may result from an over-consumption of alcohol and how these impact on society. More so, it discusses how effective alcohol policy strategies such as decreasing the availability of alcohol, increasing its price as well as promoting public awareness of the associated risks may help to reduce these harms.

Worldwide, alcohol consumption is the fifth largest cause of preventable death and injury. The World Health Worldwide, alcohol consumption is the fifth largest cause of preventable death and injury. The World Health Organisation (WHO) reports that approximately 3.3 million deaths are attributable to its use per year.[1] A recent report of alcohol usage by the Australian Bureau of Statistics (ABS) states that alcohol consumption in Australia, though having fallen slightly over the last few years, now sits at an average of 9.9 litres per capita,[2] making Australia one of the heaviest drinking nations in the world.[3]

In 2010, approximately 88% of Australians aged over 14 had tried alcohol in their lifetime with more than half of the population (60.4%) consuming it at a 'low level' of risk.[4] However, there is still a significant proportion of Australians (20.1%) who consume alcohol at a 'high risk' level. One in five Australians 14 years or over place themselves at an increased health risk over their lifetime due to their drinking.[5] Those living in remote areas are more likely to drink at 'risky' or 'high risk' levels than those living in urban areas.[6]

The propensity for an individual to drink results from a complex interactional process. Genetic predisposition, personality traits (for example, impulsivity) and contextual factors (such as family and peer drinking habits) all contribute to this process.[7]

The likelihood of drinking to excess often begins at adolescence when drinking is 'normalised' as part of the social group culture. This is shaped by the influence of peers as well as family members.[8] For a proportion of individuals in this age group, this process becomes problematic as they develop through to young adulthood and establish their drinking habits. They may progress to episodic bouts of heavy or 'binge drinking'[9] leading to intoxication.[10] The literature highlights that these drinking patterns often lead to health and social problems at the time of drinking excessively as well as later on in life.

A. HARMS TO INDIVIDUALS

Health status and physiological effects

The literature paints a vivid picture that excessive exposure to alcohol contributes to adverse health outcomes. Alcohol has been causally linked to over 200 different medical conditions including cardiovascular problems, liver cirrhosis, some types of cancers, sleep disorders, and alcohol dependence.[11] The physiological effects of an increase in alcohol consumption also impact upon mental co-ordination, judgement and reaction time. Alongside these effects, impairments in conflict resolution and problem solving are evident.[12]

In self-reported studies, moderate drinkers usually report better health status as opposed to those who report being abstinent[13] - an effect which is arguably related to their subjective appraisal of wellbeing. This subjective perception of health status can also be identified in risky drinkers, with a large proportion (78.3% for males, 64.8% for females) not being aware of the risk of harm due alcohol intoxication[14] and only likely to reduce their intake when faced with a chronic health diagnosis such as diabetes and/or hypertension.[15] A lack of appraisal may also increase the likelihood of undertaking risky behaviours such as engaging in driving whilst intoxicated and being involved in physical altercations, leading to an increased risk of injury, hospitalisation and crime.

Emergency department data is often used in the literature to provide statistical evidence for alcohol's involvement in injury and death.[16] Research has shown that the risk of injury is greater in patients who consume alcohol as opposed to those who do not.[17] Co-morbidity with mental illness and other forms of drug use increases the risk further.[18] Additionally, police data indicate that alcohol is a leading contributing risk factor in crimes such as road and traffic offences and assaults.[19]

Alcohol-related harm

A vast majority of research has focused on the negative consequences of consuming alcohol to excess and how it impacts upon individual health and the wider community.[20] These have been characterised as alcohol-related harms - a broad range of events occurring as a consequence of drinking to excess.[21] These are highlighted in conflicts that arise when an individual fails to acknowledge and consider the negative impact their drinking has on broader society, leading to physical, emotional and associated monetary costs.

B. IMPACTS ON TO SOCIETY

Societal costs

It has been estimated that up to 70% of individuals are affected by someone else's drinking behaviour.[22] From Indigenous Australians, to first time mothers, to children and the elderly, most Australians experience some sort of consequence as a result of someone's excessive drinking.[23] One of the main negative consequences examined in the literature is the relationship between alcohol and violence.

Alcohol-related violence is one of the most significant issues faced by Australia today. This is particularly due to alcohol's dis-inhibitive properties, resulting in a rise in aggressive tendencies and a reduction in impulse control.[24]

Alcohol-related violence causes substantial negative consequences to society including injury, death and hospitalisations. Toxicology reports indicate that it is the most reported substance found in homicides[25] and increases in per capita consumption are correlated positively with homicide rates.[26] Furthermore 'king hit' (single blow, traumatic brain injury) fatalities have been shown to be largely attributable (73%) to alcohol intoxication.[27]

Excessive alcohol use has also been known to cause intimacy and relationships problems resulting in domestic violence, child abuse and neglect. These relationship problems impact upon the quality of care for children as well as the ability of caregivers to protect children from harm.[28] Australian research has shown that alcohol intoxication is a risk factor in almost 20,000 cases of child abuse.[29] As the Victorian Child Protective Services (CPS) has identified, a large proportion of children whose caregivers abuse alcohol, experience either single or repeated incidents of maltreatment.[30] This pattern of abuse negatively impacts upon the developing child, causing further negative consequences later in life to him/her and to others.[31]

Economic costs

Further to interpersonal violence, it is estimated that in 2010 the financial cost in Australia associated with the harmful effects of alcohol was approximately $36 billion.[32] This estimate is based on the expenditure of both tangible (e.g. out-of-pocket expenses, loss of productivity at workplaces) and intangible (e.g. lost quality of life) costs. Inversely, the economic gains for reducing alcohol intake by 3.4 litres per capita include a possible one third reduction in the cases of disease and premature death, and an increase of $789 million towards the healthcare sector.[33] Furthermore, other resources (i.e. time, police/hospital staff presence) that could otherwise be used for other needs would not be wasted.

C. STRATEGIES TO REDUCE HARM

Alcohol guidelines established by the National Health and Medical Research Council (NHMRC) highlight the importance of regulating alcohol intake in order to minimise risk to individuals and communities.[34] In the same way, Catholic healthcare guidelines promote a sense of moderation, which permits the legitimate use of alcohol but which regards its abuse as "reprehensible."[35] Harm minimisation and risk reduction approaches towards excessive alcohol consumption are important to lessen its negative impact upon society. Government legislation and policy could provide the framework for this.

Restriction of access to alcohol

One of the policies recognised in the literature as being effective is restricting access to alcohol. Clearly, easier access to alcohol exacerbates the level of risk. In 2008, legislation passed in Newcastle required 14 establishments in the CBD to close at 3.30 am and not to admit any new patrons ('lockout') after 1.30am. Analysis of this intervention showed a 37% decrease in assaults.[36] A further analysis showed that this intervention had had a sustained effect in the area.[37] However, this was not the outcome when the 'lockout' intervention was applied to other areas of Australia such as Ballarat (VIC)[38] and Brisbane (QLD),[39] indicating that lockouts alone cannot be the sole strategy for reducing the rate of alcohol-related assaults.

In a broader perspective, Livingston[40] argues that an examination of alcohol outlet densities around suburbs provides a clearer view of the social impact of the problem and its subsequent harms. He argues that previous research has indicated that stand-alone bottle shops are positively associated with higher rates of assault, domestic violence, chronic disease and heavy episodic drinking.[41] Reducing their numbers and proximity within neighbourhoods would subsequently lessen the impact of alcohol-related harms within the wider community. This notion ties in with the fact that most Australians (73%) prefer drinking at home or at a friend's home[42] and that parental supply of alcohol at home aids in initiating sensible drinking habits in adolescence.[43]

Public awareness of supposed health benefits and risks of alcohol consumption

While some studies have found some health benefit from moderate alcohol consumption, these benefits are questionable, as meta-analyses of findings are unclear about the validity of these claims.[44]

These possible health benefits in turn are far outweighed by the clear and insidious dangers of high-risk alcohol consumption, with the evidence of harmful effects far stronger than any proposed beneficial effects.[45] Abstinence from alcohol is the recommended guideline for young people under the age of 15,[46] pregnant women[47] and those with a mental illness.[48]

… There is a current problematic social 'normality' associated with excessive alcohol consumption in Australian culture. In order for effective behavioural change to occur, there must be a direct and clear message to the government to change alcohol access policy, by restricting its availability and increasing its price....

Similarly to the public being aware of NHMRC alcohol guidelines, education about the dangers associated with drinking alcohol to excess is important. Some strategies may include promoting school-based programs which educate about the risks of excessive alcohol consumption as well as those which help to develop decision-making skills. More so, parental participation in explaining the associated dangers of alcohol use to their children is vital, as they influence the development of drinking habits within families. These in turn will promote widespread attitudinal change which may help in leading to behavioural change.[49]

Furthermore, Australia at present has no mandatory health warning label requirements for alcohol products,[50] making it more difficult for individuals to make an informed decision about alcohol consumption. This is despite public opinion polls indicating high levels of support for warning labels on alcoholic beverages.[51]

Increasing the price of alcohol

Increasing the price of alcohol may cause risky drinkers to reduce their alcohol consumption[52] and may thereby also

have an impact on the rates of assaults and violence. A recent longitudinal study in England and Wales found that a decrease in alcohol affordability led to a reduction in per capita alcohol consumption and a subsequent decrease in violent attacks.[53]

More so, recommendations by the National Alliance for Action on Alcohol (NAAA) have highlighted the importance of pricing and taxing alcohol based upon the respective percentage of alcohol found within the product (in effect a volumetric tax).[54] Compared to other interventions such as drink- driving campaigns and treatment for alcohol dependence,[55] this has been recognized as the most cost-effective measure to reduce alcohol-related harm.

Whilst an excise on all alcoholic beverages does exist in Australia, it is applied and calculated differently based on whether the product is beer, wine or spirits. It is recognised in the literature that changing the tax per volume of alcohol content is a politically sensitive issue. There are clearly vested interests which seek to influence these policies, with the alcohol industry seeking to modify or delay any such regulation.[56]

Conclusion

Whilst some may find the notion of an alcohol-free society tempting due to the major economic and social benefits, prohibiting the use of alcohol is not the answer, if only because it is not a practical strategy at the present time in Australia. The contentious issue then is to try to limit intake of excessive amounts of alcohol while still achieving a balance which permits sensible use of alcohol. Even this goal, however, may only be achieved with widespread societal change. There is a current problematic social 'normality' associated with excessive alcohol consumption in Australian culture. In order for effective behavioural change to occur, there must be a direct and clear message to the government to change alcohol access policy, by restricting its availability and increasing its price. More so, the modest health benefits associated with alcohol consumption should not be as strongly emphasised in the marketing of alcohol, while associated risks should be displayed to allow individuals to make a proper and informed decision in regards to their alcohol consumption. Changing attitudes and behaviours at the societal level will undoubtedly be a long and arduous process. Even so, the progress which has been made in changing societal attitudes toward smoking and tobacco use remind us that change is indeed possible.

ENDNOTES

[1] World Health Organization (WHO), *Global status report on alcohol and health* (Geneva: World Health Organization, 2014), 2.
[2] Australian Bureau of Statistics (ABS), *Apparent consumption of alcohol, Australia, 2012-13,* 2014, http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4307.0.55.001main+features12012-13.
[3] WHO, 296.
[4] Australian Institute of Health and Welfare (AIHW), *2010 National Drug Strategy Household Survey Report* (Canberra: Australian Institute of Health and Welfare, 2011), 53.
[5] Ibid., 45.
[6] Ibid., 59.
[7] Keriann Little et al., "The longitudinal prediction of alcohol consumption-related harms among young adults," *Substance Use and Misuse* 47 (2012): 1303-1317 at 1304.
[8] Mike Reid et al., *Drinking related lifestyles: exploring the role of alcohol in Victorian's lives* (Melbourne: Victorian Health Promotion Foundation, 2013), 13; Little et al., 1305.
[9] There is no standard definition of what constitutes 'binge drinking', because everyone is different in their ability to breakdown and metabolise alcohol content, making it difficult to quantify. As a general rule according to the NHMRC guidelines, drinking more than 4 standard drinks per occasion is considered to be an episode of 'binge drinking'.
[10] Rebecca McKetin et al., "The role of off-licence outlets in binge drinking: a survey of drinking practices last Saturday night among young adults in Australia," *Drug and Alcohol Review* 33 (2014): 51-58 at 51; National Health and Medical Research Council (NHMRC), *Australian Guidelines To Reduce Health Risks from Drinking Alcohol* (Canberra: Commonwealth of Australia, 2009), 149.
[11] WHO, 2.
[12] Australian Medical Association (AMA), *Alcohol Use and Harms in Australia,* 2009, AMA, https://ama.com.au/alcohol-use-and-harms-australia-2009-information-paper.pdf.
[13] AIHW, 66.
[14] Ibid., 67.
[15] Liang Wenbin and Tanya Chikritzhs, "Reduction in alcohol consumption and health status," *Addiction* 106 (2010): 75-81 at 75.
[16] Kirsten Vallmuur et al., "A comparison of methods to identify alcohol involvement in youth-related emergency department presentation data," *Drug and Alcohol Review* 32 (2013): 519-526 at 519.
[17] Mandy Williams et al., "Alcohol consumption and injury risk: A case-crossover study in Sydney, Australia," *Drug and Alcohol Review* 30 (2011): 344-354 at 344.
[18] Cheryl Cherpitel et al., "Risk of injury from alcohol and drug use in emergency department: A case-crossover study," *Drug and Alcohol Review* 31 (2012): 431-438 at 431.
[19] Josh Sweeney and Jason Payne, *Drug use monitoring in Australia: 2009-2010 report on drug use among police detainees* (Canberra: Australian Institute of Criminology, 2010), 9.
[20] Anne-Marie Laslett et al., *The range and magnitude of alcohol's harm to others* (Fitzroy: AER Centre for Alcohol Policy Research, Turning Point Alcohol and Drug Centre, Eastern Health, 2010), 113.
[21] Little et al., 1303. [22] Laslett et al., 47. [23] Ibid. [24] AMA, 2009.
[25] Shane Darke, "The toxicology of homocide offenders and victims: A review," *Drug and Alcohol Review* 29 (2010): 202-215 at 202.
[26] Mats Ramstedt, "Population drinking and homocide in Australia: A time series analysis of the period 1950-2003," *Drug and Alcohol Review* 30 (2011): 466-472 at 466.
[27] Jennifer Pilgrim, Dimitri Gerostamoulos, and Olaf Heino Drummer, "'King hit' fatalities in Australia, 2000-2012: The role of alcohol and other drugs," *Drug and Alcohol Dependence* 135 (2014): 119-132 at 119.
[28] Anne-Marie Laslett et al., "Alcohol's involvement in recurrent child abuse and neglect cases," *Addiction* 107 (2012): 1786-1793 at 1786.
[29] Laslett et al., *Range and magnitude,* 171.
[30] Laslett et al., *Addiction*, 1786.
[31] Laslett et al., *Range and magnitude,* 95.
[32] This combined total of 36 billion dollars was calculated from Laslett et al., *Range and* Magnitude, 178; and David Collins and Helen Lapsley, *The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/2005* (Canberra: Commonwealth of Australia, 2008), 65. Laslett et al. identified 20 billion dollars of costs, while Collins and Lapsley identified a further 15.3 billion. To estimate the total cost in 2010, the latter figure from 2004/5 was modified to account for inflation.
[33] Anne Magnus et al., "The economic gains of achieving reduced alcohol consumption targets for Australia," *Research and Practice* 102, no. 7 (2012): 1313-1319 at 1313.

[34] NHMRC, 1.
[35] Pontifical Council for Pastoral Assistance to Health Care Workers, *Charter for Health Care Workers* (Boston: Pauline Books and Media, 1995), 88.
[36] Kypros Kypri et al.,"Effects of restricting pub closing times on night-time assaults in an Australian city," *Addiction* 106 (2010): 303-310 at 303.
[37] Kypros Kypri, Patrick McElduff, and Peter Miller, "Restrictions in pub closing times and lockouts in Newcastle, Australia five years on," *Drug and Alcohol Review*, 2014: 1-4 at 1.
[38] Peter Miller et al.,"The long-term effects of lockouts on alcohol-related emergency department attendances within Ballarat, Australia," *Drug and Alcohol Review* 31 (2011): 370-376 at 370.
[39] Lorraine Mazerolle et al.,"Violence in and around entertainment districts: A longitudinal analysis of late-night lockout legislation," *Law & Policy* 34, no. 1 (2012): 55-79 at 55.
[40] Michael Livingston, "To reduce alcohol-related harm we need to look beyond pubs and nightclubs," *Drug and Alcohol Review* 32 (2013): 113-114 at 113.
[41] Ibid.
[42] Foundation for Alcohol Research and Education (FARE), *National Alcohol Poll: Attitudes and Behaviours* (Canberra: The Foundation for Alcohol Research and Education, 2014), 8.
[43] Conor Gilligan et al., "Parental supply of alcohol and adolescent risky drinking," *Drug and Alcohol Review* 31 (2012): 754-762 at 754.
[44] Michael Roerecke and Jürgen Rehm, "The cardioprotective association of average alcohol consumption and ischaemic heart disease: a systematic review and meta-analysis," *Addiction* 107 (2012): 1246-1260 at 1246.
[45] Hans Fekjær, "Alcohol - a universal preventative agent? A critical analysis," *Addiction* 108 (2013): 2051-2057 at 2051.
[46] NHMRC, 4.
[47] Ibid., 5.
[48] Ibid., 96.
[49] AMA, *Alcohol consumption and Alcohol-Related Harms,* 2012, AMA, https://ama.com.au/position-statement/alcohol-consumption-and-alcohol-related-harms-2012.
[50] Rebecca Matthews, Michael Thorn, and Caterina Giorgi, "Vested Interests in Addiction Research and Policy - Is the alcohol industry delaying government action on alcohol health warning labels in Australia," *Addiction* 108 (2013): 1889-1896 at 1889.
[51] Lisa Thompson, Brian Vandenberg, and John Fitzgerald, "An exploratory study on drinkers views of health information and warning labels on alcohol containers," *Drug and Alcohol Review* 31 (2012): 240-247 at 240; FARE, 47.
[52] AIHW, 80.
[53] V. Sivarajasingam et al., "Violence in England and Wales in 2013 - An Accident and Emergency Perspective," 2014, 1-15 at 6, http://www.cardiff.ac.uk/news/resource/12846.35244.file.eng.pdf.
[54] National Alliance for Action on Alcohol (NAAA), "Reducing harm from alcohol - creating a healthier Australia," 2012, 1-7 at 2-3, http://www.vichealth.vic.gov.au/~/media/ResourceCentre/PublicationsandResources/alcohol%20misuse/naaa%20position%20statement%20final%20201210.ashx; Linda Cobiac et al. "Cost-effectiveness of interventions to prevent alcohol-related diseases and injury in Australia." *Addiction* 104 (2009): 1646-1655 at 1650.
[55] Elizabeth Manton, "The diverse drivers of relative changes in excise taxes on beer and spirits in Australia, 1902-2012," *Drugs, education, prevention and policy* 21, no. 3 (2014): 197-204 at 197.
[56] Sally Casswell, "Vested interests in addiction research and policy - Why do we not see the corporate interests of the alcohol industry as clearly as we see those of the tobacco industry," *Addiction* 108 (2013): 680-685 at 680; Geoffrey Munro, "Why the Distilled Spirits Industry Council of Australia is not a credible partner for the Australian government in making alcohol policy," *Drug and Alcohol Review* 31 (2012): 365-369 at 368.

All online resources accessed 30 May 2014

Emanuel Nicolas Cortes Simonet ✠

Caroline Chisholm Centre for Health Ethics

Suite 47, 141 Grey Street, East Melbourne Vic 3002

Tel (03) 9928 6681 Fax (03) 9928 6682 Email: ccche@svha.org.au

www.chisholm.healthethics.com.au

Subscription fees: Single $30.00 + GST; Overseas [single] AUD $40.00

Director/Editor: *Rev Kevin McGovern Dip Ap Sc (Optom) (QIT), STL (Weston Jesuit School of Theology)*

Senior Research Assistant: *Dr Caroline Ong RSM M.B.,B.S. (Melbourne University), FRACGP, Dip Obs RANZCOG, MA Bioethics and Health Policy (Loyola University, Chicago)*

Research Assistant: *Dr Dilinie D Herbert BSc, M BMedSc, PhD (Monash University)*

Research Assistant: *Mr Emanuel Nicolas Cortes Simonet B Psych (Hons) (Victoria University) B Sci (Victoria University)*

Sub-editor: *Ms Sofia Mehreen MA Business (Prof. Accounting) (Victoria Uni) MA (English Literature) (Punjab University) BA (Mathematics and Economics) (Punjab University)*