BEYOND SAFER SEX PRACTICES: CHRISTIAN PERSPECTIVES ON AIDS EDUCATION FOR PUBLIC HEALTH PROFESSIONALS

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INTRODUCTION

AIDS (acquired immunodeficiency syndrome) is an incurable, fatal, multi-faceted disease which presents society with a unique set of bio-medical, educational, public health, and social challenges. The advent of AIDS in an era of sexual freedom has fueled heated dialogue and bitter controversies on individual and collective sexual mores, treatment of persons with AIDS (PWAS), and the appropriateness of preventive educational interventions- both within the general population and specifically with individuals engaging in high risk behaviors.

Society's response to the AIDS pandemic has been characterized by fragmentation in education, leadership and public policies. The social consequences of AIDS, like many other epidemics preceding it, (smallpox, cholera, tuberculosis, polio, and the bubonic plague), are provoking significant social, cultural, and scientific changes within society (Ergas 1987).

AIDS has also altered the practices, responses, and attitudes of health care professionals. A recent survey among young physicians indicated that given the choice, more than 25% of them would not take care of patients with AIDS. In addition, it is not uncommon for health workers to direct blame toward persons with AIDS for the behaviors which lead to the disease. A guarded, almost adversarial mind-set has replaced the samaritanism of medicine. Rogers (1988) provides a poignant commentary on this shift of attitudes.

> About 80 years ago, a distinguished Boston physician, Francis Peabody, wrote that the secret of caring for the patient is to care for the patient. Given the awful reality of AIDS, it is hard to know how we can recapture this attitude. At present, a large chasm

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of fear separates many health care workers from some who come to them for care. The helping professions need to find their way around this canyon. (p. 1368)

As a result, two AIDS epidemics are often referred to within professional circles: one caused by a retrovirus, and the other caused as a result of societal oppression of persons afflicted with the syndrome (Chng and Roddy, 1987). It is against this socio-cultural backdrop of fear, anxiety, paranoia that all public health professionals must provide care, reassurance, as well as design, implement, and evaluate preventive interventions.

RESPONSES OF CHRISTIAN INSTITUTIONS AND HEALTH PROFESSIONALS

Communities of faith, including churches and church-based educational institutions, have been reticent to address the topic of AIDS. When addressed, there appears to be a lack of a common discourse or world view, especially across disciplinary lines, which guides the communal ethos, institutional policies and practical interventions.

While persons with AIDS tend to be affirmed as children of God, endowed with the divine image, and ultimately of inestimable value, there is often an uneasy unwillingness to become involved in preventive educational efforts, particularly to individuals who engage in high risk behaviors and to populations with increased prevalence of AIDS (Sider, 1988).

In the absence of a cure, the only way to prevent infection and transmission of the human immunodeficiency virus (HIV) is through educational efforts geared towards primary prevention (Scutchfield, 1987). Although knowledge is one of the greatest weapons in slowing the spread of the disease

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and creating supportive environments for individuals in crisis, it is almost impossible to discuss the topic within public or professional circles without confronting a large amount of hysteria, fear, and misinformation. This is often coupled with moralistic, unrealistic, and simplistic solutions for facing the complex challenges created by this disease.

Christian institutions of higher education have an influential role in shaping the minds and attitudes of future health professionals to meet the challenges and respond to the needs of AIDS. Public health professionals, more than any other group, must be prepared to assist individuals and their significant others who face the crises of this devastating disease.

Christian health professionals have a unique opportunity, not only to minister and share God's unconditional love, compassion, and faithfulness in the face of a terminal illness, but also to exert leadership and assume advocacy roles for AIDS prevention within their communities of faith, as well as in their agencies or institutions of employment. Their examples and efforts based on an understanding of the complexity of issues involved, the clarity of their roles and limitations, and most importantly, their picture of and relationship with God, can assist in combating the ignorance, fear, and paranoia that immobilizes effective efforts to eradicate this disease.

In this context, this paper will examine: 1) the challenges of AIDS education; 2) idiosyncratic features which distinguish AIDS educational interventions from others within the realm of infectious and/or chronic diseases; 3) responsibilities unique to Christian public health professionals; and 4) implications for teaching public health professionals, with a distinctive Christian perspective, for compassionate, effective, and appropriate educational interventions within the larger societal context.

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CHALLENGES OF AIDS EDUCATION

Many public health professionals involved in AIDS education, especially those with a Christian perspective, reflect the perplexity found in the larger society about the complex issues raised by this disease.

There is often a conflict between personal values and professional practices, especially in regards to educational interventions. Some Christian health professionals believe that the messages and media utilized and promoted by public education and health practitioners, encourage behaviors and values which conflict with those espoused by the scriptures.

A cognitive dissonance may exist between the provision of accurate knowledge and promotion of behaviors needed to prevent transmission of the virus, and a belief that promotion of these less than ideal options, will not only condone, but encourage individuals to continue the behaviors which put them at risk for AIDS.

Current scientific knowledge documents HIV transmission through three primary behavioral routes: 1) heterosexual and homosexual activity, with special concerns about receptive anal intercourse; 2) parenteral transmission which occurs by accident, through IV drug use and administration of blood products prior to 1985; and 3) perinatally - through maternal-child contact in utero, at birth, or during lactation (Becker and Joseph, 1988).

While risk-avoidance techniques are clearly preferred in most public health interventions, the reality of AIDS dictates that risk-reduction activities must also be promoted, given the pluralistic bases for lifestyle choices by individuals in our society. Nonetheless, promotion of some of these activities often pose ethical dilemmas if they conflict with one's value system.

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Examples of potential conflict include: the use of distribution of condoms among adolescents or the general population; distribution of free, clean needles or disinfection of needles for intravenous drug users (IVDUs); use of preventive measures that describe explicit types of sexual behaviors within gay and heterosexual communities; promotion of risk reduction intervention curricula within the gay community directed toward promoting gay identity and self-esteem; negotiation skills for communicating condom use and/or safer sex techniques with a new or potential sexual partner; eroticizing safer sex techniques through the use of educational sessions or videos; and distribution of brochures in which sexual activities are discussed and/or promoted according to the degree of risk for HIV transmission.

Some of the behaviors, while at lower risk for HIV transmission, fall outside of the comfort zone, familiarity, or value system of the health professional. The health professional is often faced with candid discussions of sexual practices, and/or confrontation of personal biases regarding sexual behaviors and orientation - homosexual, bisexual, and heterosexual (Shernoff, 1988).

There is also continued debate surrounding the role of sex education in schools. Before the advent of AIDS, it may have been possible for schools to avoid sex education entirely or dismiss potentially controversial subjects within the curriculum as non-relevant or appropriate. However, these unresolved issues are intensified with the urgent need for AIDS education.

Consequently the issues of level, content, explicitness, and appropriateness of AIDS education continue to be debated at all levels of

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curriculum, as well as within and between local, state, and federal public health and education agencies (Koop, 1987).

IDIOSYNCRATIC FEATURES OF AIDS EDUCATION

AIDS also poses some unique challenges to health education. Health educators are professionally trained to develop, implement, and evaluate behavioral change interventions to populations at high risk. However, despite the cumulative experiences with other chronic or infectious diseases, they are often ill-prepared to deal with the problem of HIV infection for several reasons.

1. **Transmission is associated with behaviors traditionally considered deviant or private.** The mechanisms for HIV transmission include sexual, reproductive, and addictive behaviors. These are areas which are viewed as more appropriate for private decision-making than for public consensus due to considerable heterogeneity in underlying social values (Becker & Joseph, 1988). Due to the highly stigmatized social context in which AIDS occurs, public health professionals have a difficult task designing messages which are socially acceptable to the general population, but specific enough for individuals involved in high-risk behaviors.

2. **There is an erosion of faith in the accuracy of scientific expertise or truthfulness.** For many, the authority of scientific expertise is eroded, due to the conflicting nature of "expert" information, as well as gradual changes in the knowledge base for medicine and public health. Despite significant evidence that HIV is not casually transmitted, public fear is high.

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3. **Moralistic attitudes and simplistic solutions have impeded educational efforts.** AIDS has reinforced attitudes held by some individuals about homophobia, or is taken to be proof of a moral order. Moralistic messages have not been well received within high risk groups, as they are often interpreted as a rejection of the individual. Solomon and DeJong (1986) emphasize: "When people feel they are being castigated, they are less likely to attend to new information; the bearers of that information will simply lack credibility" (p. 307).

Abstinence is also promoted to teen populations, but dialogue on how to deal with sexual feelings is far from adequate. Educational campaigns which have as their main theme the "Just Say No" approach have been extremely pervasive and popular in recent years. While the message may be timely and refusal skills appropriate in an adolescent's communication repertoire, an analysis of the approach yields a simple answer to complex behaviors. This approach, rather than encouraging critical thinking skills and value clarity, reduces the decision-making process to a simplistic one; overlooks the complexity of human behavior; and may ultimately be detrimental to problem-solving skill development (Sharpe, 1988).

Educators must be aware of the balance between facilitating necessary behavioral changes related to transmission of HIV, and decrying or denying human sexual expression. AIDS has firmly linked sex and death in the minds of the public. It has insidiously undermined healthy concepts of sexuality. Positive messages are needed, which reaffirm human sexual expression (in the broad sense of the term), and confirm a sense of maleness, femaleness, love and intimacy. This is critical for adolescents who are in the process of forming core concepts on sexuality.

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Sexual intercourse with multiple partners has also been linked to an increased risk of HIV infection. While increasing the number of sexual partners does increase risk of exposure to HIV, unprotected sex once with only one partner could also lead to infection. Unless testing has established that both partners have not been exposed to HIV at the initiation of a sexual relationship, there is no guarantee that the relationship is virus free. This has significant implications for individuals who are maintaining long-term relationships, but have potentially been exposed to the virus, even once, through a variety of ways.

4. **Some behavioral changes for AIDS prevention are strongly linked with personal identity.** In populations which have organized their lifestyles around certain behaviors at high risk for HIV, the removal of the behavior constitutes a significant loss of self. For both the heterosexual and homosexual populations, sexual behavior is strongly linked to self-identity. It is a source of personal meaning and definition.

The same parallel can be made with the culture surrounding IV drug users. Therefore, the targeted behaviors have low changeability and high importance for these groups, making behavior change difficult.

5. **Prior educational efforts may have heightened anxieties and unwarranted fears of infection.** Some misinformed. individuals have structured educational interventions primarily around the fear of infection and stigma associated with the disease. This orientation, historically has yielded short-term behavioral changes, but is generally ineffective in sustaining them over a period of time. "Research has shown that people are more likely to deny the validity of a message, dismiss its applicability to themselves, or adopt a fatalistic attitude if they are not presented with concrete steps

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they can take on their own behalf." (Solomon & Dejong, p. 308) One must balance fear arousing information with constructive suggestions for purposeful action.

6. **Captive audiences eager for education for the most part do not exist.** AIDS can be viewed on a health-illness continuum that includes: 1) individuals at risk due to high-risk behaviors; 2) individuals who are HIV positive but asymptomatic; 3) individuals who are diagnosed with AIDS or AIDS-related complex (ARC); and 4) individuals who are at low risk due to behaviors (Moynihan, Christ, and Silver, 1988). These categories present a complex matrix for intervention design.

Additionally, a large majority of the target group is well, and denial or underestimation of personal vulnerability may be considerably easier than significant behavior change. This is particularly true with teens or sexual partners of IV drug users.

7. **No personal incentives related to behavior change exist for individuals who are seropositive.** Due to the incurable nature of the disease and its consequences, individuals at risk for infection or already infected are asked to make lifetime behavioral changes. For those individuals already seropositive, there are few personal incentives to adopt new behaviors since they may not change the ultimate outcome of the disease. The appeal for behavior change, in this instance, resides primarily on altruistic motives-- motives which may not be operational in the individual.

8. **The public health professional may have inadequate knowledge or familiarity with the target group.** Health professionals working in AIDS prevention target interventions with groups exhibiting high-risk behaviors. These groups may be distinguished either by extremely close knit or loosely

formed social networks. Group members may come from a variety of races, socio-economic backgrounds, or cultural groups, and often operate outside of traditional or established norms. The health professional may have little contact with the group or knowledge of its norms. This may lead to suspicion, distrust, lack of credibility or common grounds for discourse, and may interfere with the creation of optimum learning conditions for educational interventions.

9.   **Individuals progress toward permanent behavioral changes in incremental steps.** It is highly unusual for an individual or group to adopt a new or alter a pre-existing behavior without "trying it on" in a stair-step methodology. Recidivism is common in the initial phases of behavior change. This demands that health professionals repeat interventions at planned, successive stages over time; and offer realistic alternatives and support for individuals during phases of behavior change.

10.   **Knowledge regarding the determinants of AIDS relevant behavioral changes is scarce.** The ability to perform accurate community descriptions and analysis on selected variables within the target population at risk is a foundational prerequisite to the utility of several behavioral change paradigms.

Given the paucity of information about salient behavioral and psycho-social variables crucial to adoption of short or long-term behavioral changes, it is difficult to design appropriate interventions within certain target populations with a high incidence of HIV. More research is needed about the relationship of knowledge and attitudes to risk reduction, as well as the magnitude of behavioral changes required to reduce the spread of the disease (Becker and Joseph, 1988).

11. Education, alone, will be ineffective in solving the problem of AIDS. AIDS, in some groups, is a symptomatic response to greater social ills within society, such as impoverishment and institutional racism. As such, communities must be empowered to seek radical social changes. If the problems are addressed solely on an educational level, changes will be impotent and ineffective, and victim blaming will be perpetuated. Public policies must be restructured to provide viable alternatives to chronic unemployment, inadequate income, and reduced educational experiences.

RESPONSIBILITIES OF CHRISTIAN PUBLIC HEALTH PROFESSIONALS

Public health professionals trained within Christian institutions of higher education should be adequately prepared, not only to respond appropriately on a professional level to the complex and diverse issues inherent in AIDS education, but also to demonstrate a full celebration of faith and ministry within professional practice. God's continuing care and responsibility for his creation as exemplified in the scriptures, becomes pivotal in the way they relate to others. Arthur Simon (1987) speaks poignantly to this:

> Christians have dual citizenship. We are citizens of God's kingdom and citizens of an earthly country. That may sound abstract and academic, but it is not. It touches on our purpose in life and the way we plan and conduct our lives. It has immediate bearing on each one of us every day - what happens to us, what we decide to do, and how we feel about what we do. Our dual citizenship is, therefore, a powerful life-shaping reality (p. vii).

Christ's strong identification with the poor, outcast, and despised members of society calls us to embrace those who are the most vulnerable with good news of God. Christians have a scriptural mandate to minister to those in need. However, there is also a corresponding responsibility to work even harder to prevent God's creation from experiencing unnecessarily the consequences of brokenness and alienation resulting from disease.

IMPLICATIONS FOR TEACHING S.D.A. PUBLIC HEALTH PROFESSIONALS

Christ encapsulated the ultimate truth of the gospel by stating, "I have come that you may life, life in all its fullness" (John 10:10 TEV). AIDS education is, fundamentally, education for life in the midst of death and despair. When combined with the truth about God, it is good news for a dying world! Seventh-day Adventist public health professionals have the privilege, honor, and responsibility to provide hope in the midst of an epidemic of fear and moral self-righteousness, often promoted by religion.

Given the complexities of the social context and educational challenges of AIDS, how can Christian instructors adequately prepare future public health professionals for a unique ministry as caring, compassionate individuals who demonstrate the personhood and truth about God?

The following components should be included in a comprehensive training model for all Christian public health professionals working in AIDS prevention: 1) courses in religion, including a theology of creation, sexuality, death and dying; 2) an overview of human sexuality, including sexual dysfunctions; 3) a comprehensive overview of AIDS, including: virology, epidemiology, treatment and screening modalities, ethical implications, legal issues, and psycho-social considerations; 4) basic

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counseling techniques, with special emphasis on crisis counseling skills; 5) in-depth study of the determinants and models of health behavior change as well as health education program design; 6) overview of theoretical models of moral education, with practice in values clarification strategy development as well as affective teaching and learning styles; and 7) structured internships or experiential activities which allow guided integration and practice of the previously mentioned elements.

What distinguishes the training of Seventh-day Adventist public health professionals from colleagues who are comptetently trained in all of the previously mentioned areas? First of all, a belief in the reality of the great controversy view of the cosmic struggle between God and Satan, and its implications on the human family. This is a unique contribution from Adventist theology, and one which has significant implications for personhood.

Fundamental to this is an understanding of the meanings of creation and of man and woman made in the image of God. The human race has the capacity to exhibit one of the most fundamental characteristics of God - the ability to create after our own image. Our sexuality, in a relational sense, underscores the difference between man, angels, and other orders of created beings. For animals cannot procreate through love, and angels cannot love through procreation. However, through expressions of our sexuality, mankind has the capacity to rise above angels and experience the very nature and purposes of God, or degrade self below the level of animals.

Sexuality, in a broad sense, is part of our self-definition as male and female. It is not limited to genital expressions of sensuality, although these certainly are a distinctive part of our nature. Through sexuality,

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human beings have the opportunity to reflect the oneness, uniqueness, totality, and symbolism of a loving relationship in Jesus Christ. Sexuality gives us the opportunity to demonstrate on a human level (regardless of our marital status) ethereal and theoretical principles which are the essence of God's character from age to age - faith, long-suffering love, commitment, compassion, forgiveness, and freedom from condemnation.

The capacity to share in the creative purposes of God was a point of contention between Christ and Satan at the onset of the Great Controversy. As such, it should come as no surprise that Satan would be determined to destroy all vestiges of this unique characteristic and powerful symbolism between God and man.

This is done at four levels: (1) the orientation through which our sexuality is expressed (homosexuality versus heterosexuality); (2) the body, used physically to express our sexuality, (3) the mind, used to conceptualize our sexuality; and (4) human relationships, which demonstrate the integration of all of the above.

With the advent of AIDS, all of the following can be effectively accomplished. Even if an individual never comes in contact with the virus or develops the disease, but internalizes a distorted view of sexuality which cripples the capacity for genuine human relationships, a similar insidious effect can still be achieved.

Wolterstorff (1984) proposes that the religious beliefs of the Christian scholar operate as control beliefs, and function internally to scholarship. Not only should they assist in the choice, devise, and control of basic operational theories, but they should also be contained within the actual Christian experience.

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The Christian instructor training future public health professionals must wrestle with the complex interplay of personal values, morality, and professional ethics. The challenges of AIDS education from a Christian perspective consists of assisting the student to discover or develop a moral point of view from which personal and professional ethical decisions can be made, and developing critical thinking strategies which allow ample opportunities for consideration and articulation of religious and spiritual life experiences into professional practice. The basis and essential nature of Christian education demands that students develop the capacity to think and make choices consistent with their faith. AIDS education in Christian settings must involve a consideration of God's purposes in creation expressed through human relationships.

In addition, experiential learning situations must be designed where both student and instructor can interact intimately with individuals affected by AIDS. These experiences assist in discovering or developing values and feelings. Human-hearted concern for others which results in action cannot develop in a cognitive oasis. Ellen White (1902) elaborates:

The greatest work to which human beings can aspire is the work of winning men from sin to holiness. For the accomplishment of this work, a broad foundation must be laid. A comprehensive education is needed - an education that will demand from parents and teachers such thought and effort as mere instruction in the sciences does not require. Something more is called for than the culture of the intellect. Education is not complete until the body, the mind, and the heart are equally educated. (p. 398)

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CONCLUSION

Christian public health professionals have powerful opportunities to demonstrate, proclaim, and celebrate the love and lordship of Christ. By virtue of their profession, they are in a position of special responsibility to exercise care and compassion towards individuals who are broken- physically, mentally, relationally, and spiritually.

An old colloquialism states: "It is better to build a fence at the top of a cliff than to provide an ambulance at the bottom." Christian public health professionals must move beyond ambulance services at the bottom of cliffs, so to speak, in the crisis of AIDS. Although this will not be easy, or even comfortable, and the road this points us to sometimes resembles a mine field, "yet a full celebration of faith and our ability to make our lives count for others are overriding considerations. Although we run the risk of making mistakes, we do well to remember that the biggest mistake of all is to take no risks for others - not exactly the kind of life that followers of Jesus should aspire to. We are free to fail. We are not free to do nothing" (Simon, p. viii).

While calling for behavioral changes conducive to life, Christian public health professionals also have the privilege to point towards the source of eternal life. "And this is eternal life: for men to know you, the only true God, and to know Jesus Christ, whom you sent" (John 17:3 TEV).

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