



## Calling Communities to Address Stigma & Discrimination

Many of us who work among People Living With HIV/AIDS and addicts, probably feel comfortable with the knowledge and sensitivity we have developed to deal with their issues related to stigma and discrimination. But the alarming fact that we face even today is that of the reaction which comes from the educated community (both in rural and urban) towards the affected and the infected. Irrespective of any religion, communities find it difficult to relate normally with people who face such problems in their lives (whether self-created or due to circumstances). People have become self-centred, distancing themselves from those undergoing pain and suffering. The pain and suffering incurred due to stigma and discrimination is, many a times, much more painful than physical pain. As care-givers, what would be our role in such situations?

The two workshops we did at Durtlang, Aizawl, one with care providers and the other with church leaders and volunteers, taught us a lot about how different communities in Aizawl looked at the problems related to Substance Abuse and HIV/AIDS.

The sharing of experiences in these workshops helped us to understand that change in attitude can happen effectively at community level if



more opportunities are created to learn/understand the problem of stigma. We also learn how positive approach of community leaders and caregivers play a crucial role in responding to their problems.

Our gratitude to Mr Sundar Daniel whose insights challenge us towards addressing stigma head on.

Editor

*With HIV, it is not the condition itself that hurts most (because many other diseases and conditions lead to serious suffering and death), but the stigma and the possibility of rejection and discrimination, misunderstanding and the loss of trust that HIV positive people have to deal with.*

- Rev Canon Gideon Byamugisha, in 'What Can I Do?' Strategies for Hope

Trust

# Stigma and Discrimination



Mr Sundar Daniel

## What is stigma?

**W**e command certain respect in the society by the values and standards we follow in our life. The same way, we respect others for the good values and standards they hold onto in their lives. Respect, in turn determines the kind of relationships we will initiate or maintain. Most often, we tend to emphasise more on the respect that is due to us rather than what is due from us to others.

In the context of HIV, our moral values and standards appear to have played a major role in determining how we relate to those vulnerable to HIV, those infected by the virus and even those affected by it. Consequently, we believe that being infected and even vulnerability to the infection are the direct results of low or loose morals, and justify the dishonour that we mete out to the vulnerable and the infected. In the early stages of the epidemic when HIV was believed to be an infection that spread among homosexuals, Christians quoted from Romans 1 of Scripture saying if God Himself gave them up, why should we care. Stigmatisation is not just there in the society. It is within families too. We are quick to disassociate ourselves from those infected with the virus, in order to safeguard our respect in the society.

**Stigma is the shame, disgrace or dishonour that is meted out to individuals, through attitudes and behaviour of those who consider themselves to be of higher values and standards.** The consequence of stigma is discrimination. **Discrimination is the different, 'less than' treatment meted out to an individual, with little or no regard for the pain that the individual is already undergoing as a result of being broken and wounded.**

Quite often, our moral values and standards are guided by the culture of our milieu. This limits our understanding of grace and the responsibility that follows an experience of grace. To the extent that we allow culture, as against the Bible,

*“Therefore, like little children who, after dark, avoid the very place where they felt safe to play all day long, Christians too, despite being fully aware of how HIV spreads and how it does not, have stayed away from the HIV positive individual and even his innocent two-year-old child or tottering eighty-year-old parents”*

to guide our understanding of what is moral and what is not, we also lend ourselves to hypocritical behaviour, one that does not recognise our own fallen and sinful nature. Let us recognise our fallen and sinful nature, the grace that we have experienced, and consequently our roles as channels of grace.

## Why there is stigma?

Many a time, we may consider our moral values and standards as a protective shield. Naturally therefore, we believe the reverse to be true as well. Anything that does not adhere to our values and standards or withstand their test is a potential hazard and must be avoided at all costs. Surely drug users have not treated their bodies as the temple of the Holy Spirit; surely also the female sex worker has not had one faithful partner with whom she would share her life

'till death do us apart'. Are they therefore a threat that we must avoid? **For many drug users, their drug use is a desperate attempt to cope with life. For many sex workers, selling their bodies is the only means they know of to fulfil their responsibility as parents and feed three little mouths. Christ died to exemplify absolute, selfless giving, not self-preservation.**

Moral values and standards as a protective shield may not be applicable in all aspects of life. We believe that when we maintain our values and standards, we cannot fall prey to the consequences of immoral behaviour. The extent to which this principle can be applied in issues of health needs to be explored. Let us say, as an example, that we rightfully enjoy only the benefits of our hard work. Yet, all the good and greasy food that we gulp down cannot guarantee us protection against obesity. On the contrary, knowledge that we must eat healthy food in disciplined quantities has a better chance of providing us that protection provided, of course, that we apply this knowledge.

Stigma proceeds from a lack of knowledge. What we don't know about is something to be feared. And what we fear is best avoided. Therefore, like little children who, after dark, avoid the very place where they felt safe to play all day long, Christians too, despite being fully aware of how HIV spreads and how it does not, have stayed away from the HIV positive individual and even his innocent two-year-old child or tottering eighty-year-old parents.

Our awareness appears limited to the extent of our moral values and standards. Despite the rigour with which we maintain them, any one of us can get infected; it could happen at the hospital when blood is transfused. While we avoid those who are obviously engaged in risk behaviour, it continues to happen to faithful housewives. HIV in some states of North East India was in the very initial stages related to Intravenous Drug Users (IDUs). But by

mid 90s, the trend had shifted and now, in these states, HIV is spread more through immoral sexual activities.

We continue in our confusion about unlawful and unsafe sex. Is all lawful sex safe? No. The number of legally wedded and faithful wives who have contracted the infection from their husbands is too large to be ignored. I am sure there are many sad stories of 'first night, first sex, infection'. Unfortunately, campaigns of 'be faithful' are misplaced and addressed to the victims rather than the predators. Is unlawful sex unsafe? No. The consistent and proper use of condoms will disapprove this notion. Yet we disapprove of promotion of condom usage. Our messages on safe sex should talk not only about adultery, prostitution and fornication but also murder and suicide. Our messages need to emphasise life before moral values and standards.

We also persist in our denial that an epidemic of a quarter century is still not a part of us. However, there could well be many in our congregations who are HIV+. In our eagerness to hold onto our values to maintain a respectable position in the society, we overlook our basic duties as a Christian towards those who are suffering. First we need to respond positively to prevent it from spreading. For example, we can arrange activities to empower a faithful wife having sero positive status, to stand up against her abusive husband. We are happy to live within our own circle, we fear our happiness will be disrupted if we involve ourselves with the problems of the broken and the wounded.

Our knowledge of moral values and standards that we hold so dear is limited. We hold onto an unbiblical view of sin that seems to say that the unlawful sex is a big sin, or that the drug user is a bigger sinner but a corrupt bureaucrat or politician who contributes ill-gotten money to the church is favoured. Therefore, we need to maintain 'the sanctity of the pulpit' and not modify the administrative systems of our church to suit human need. We do not stop to think that our position runs contrary to that of our Messiah, who was pierced for our transgressions, was crushed for our iniquities; the punishment that brought us peace was upon Him, and by His

wounds we are healed (Isaiah 53:5).

Let us learn more about HIV in our context. Let us gain a biblical understanding of sin and grace, of sex and sexuality, of death. Let us consider the ways we can contribute to those who are broken. Let us bring the missionary zeal into our lives. Let miracles happen once again.

### **How are people stigmatised?**

In the days when people knew less about HIV and AIDS, stigmatisation was more open. Over the years that our knowledge of the virus grew (with little effect on our attitudes and behaviour towards those vulnerable, infected and affected) as also some legal protection for the infected, we appear to have adopted more ingenious ways of stigmatising and discriminating against those who need healing for their brokenness and woundedness. Isolation in life and ignominy in death are common ways of stigmatising and discrimination. Vulnerable individuals who engage in risk behaviour are isolated in the family, in the community including the church and at the workplace. Although unhelpful, we blame, judge, label and gossip about such persons. We neglect them, their needs and their rights. Often confidentiality is not maintained, because they are considered to be less than others. Institutional assistance is offered, more for the purpose of distancing the person from our environment rather than out of a conviction that institutional assistance will actually help him/her. And where none of these work to distance the person from us, the individual is harassed, violently treated and abused. The stigma continues even after death; communities where the dead were buried with much honour, adopted newer practices of burial with minimal community participation. In other places, the street on which the dead was carried through are washed and purified before the community can use the road.

Stigma and discrimination add to the brokenness and woundedness of the suffering. Let us include the broken and the wounded and respond to their needs; they are our own.

Let us practice confidentiality. Where

there is a need to share confidentiality, let us ask, 'who needs to know and why?' Let us not reveal the sero-status of individuals while sharing points for prayer. Let us reach out to those who, ashamed of their brokenness and woundedness, would rather deny themselves an opportunity for healing. Let us think of community-based responses.

*Sundar Daniel is a Consultant for HIV/AIDS and Substance Abuse Issues. This article is an adapted version of the author's presentation on 'Healing the Broken and Wounded', a workshop for church leaders of Aizawl, Mizoram on March 2, 2007*

"In the phase of the drama of so many bodies walking, seeking a home, a shoulder, and embrace, a meaning that helps to understand this pain, to face it and go beyond resignation... and then integrate it as a part of life experience of exercising the limits imposed, daring to advance and extend the margins imposed by illness...

- Ernesto Barros Carlos

## Workshops at Durtlang, Aizawl

### i. Three day workshop for Counsellors

A three-day workshop on Qualitative Approaches to Addiction Therapy was organised at Presbyterian Hospital, Durtlang from February 26 - 28, 2007, bringing together



30 counsellors from different parts of Aizawl. This was an initiative to identify training needs of counsellors involved in addiction treatment in Aizawl for giving quality care and treatment as well as to promote the need for a training centre in Addiction Therapy in Mizoram. The proactive support and initiative taken by Dr Lalremthanga, Director of the hospital and his dedicated team in organising the workshop was indeed praiseworthy. The sessions were conducted by Mr Bappa Mukherjee, Consultant and Incharge, De-addiction Centre of Kailash Hospital, Noida; Mr Sundar Daniel, Consultant; and Fr Thomas Ninan, PCSA, CMAI. Participants appreciated the contents and felt they are relevant to their area of work. Similar training workshops will be organised at a regular basis in Mizoram in future.

### ii. Two day workshop for Church leaders and volunteers

A two-day workshop on 'Healing the Broken and the Wounded' was organised at Presbyterian Hospital, Durtlang from March 1 - 2, 2007, which brought together 45 participants from different churches in Aizawl. Participants were from the three major churches in the area namely the Presbyterian Church, the Baptist Church and the Salvation Army. The Moderator of Presbyterian Church, Rev Vanlalchunga, inaugurated the workshop and Rev Sharath David, Mr Bappa Mukherjee, Mr Sundar Daniel and Fr Thomas Ninan led the workshop. The participants were challenged to commit their lives to healing ministry focussing mainly on PLWHAs and drug addicts.

## Visit to Community Health Project at Bukpui Village, Mizoram

A one-day interaction with church volunteers and community health volunteers from five villages in Mizoram was organised at Bukpui village at the Presbyterian church campus. The visit brought together 95 participants from 5 villages to interact with Dr Sanghluna and Dr Chama, Presbyterian hospital; recovering addicts from Halfway Home, Durtlang; Rev Sharath David and Fr Thomas Ninan, CMAI. The participants were encouraged to identify various problems that they as a community face in living a healthy and wholesome life and how they could actively participate as a community in Healing Ministry to overcome these obstacles.

Programme to Combat Substance Abuse desk of CMAI (PCSA) strives to facilitate and promote Christian involvement and participation towards addressing various issues of Substance Abuse in India since 1992. It coordinates the activities of national network of committed Christians named CACSAN which has been active in India since 1994. For details contact Fr Thomas Ninan.

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## Announcement

Dear Reader,

We appreciate your interest in our newsletter and would like to record our gratitude for the same. However, with the steep increase in production costs, bringing out each edition is an uphill task. We would therefore, appreciate your support by donating Rs 50/- for a year's supply of *Addiction News*.

Please send the amount by Demand Draft in favour of *Christian Medical Association of India*, New Delhi.

## Addiction News

A CMAI publication on  
*substance abuse and alcoholism*



Christian  
Medical  
Association of  
India

### Published by

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Printed at: Seema Printing Press