

## **Broaden the vision**

### **A Reflection on HIV and the churches in North East India**

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Over the years that North East India (NEI) has gradually caught the attention of national media, it has been, not for the breathtaking beauty of the land and its peoples, but for conflict and guns, poor development and drugs and HIV. The region is also known for its Christian ethos and it was probably this that led a senior government official to ask, 'Where there is a Christian majority, there is also conflict, drugs, and HIV. What is it about the Christian faith that brings this about?' Compare this remark with the appreciation that Khushwant Singh once expressed for Christians whom he acknowledged were responsible for some of the best educational and health institutions in the country. To be relevant, the Christian community and churches must once again contribute effectively to social change and development.

In the context of HIV, the states of NEI can be classified into two groups. In the first group - Manipur, Mizoram and Nagaland – which are in the high prevalence category, the responses are more intense. The second group – Arunachal Pradesh, Assam, Meghalaya, Sikkim and Tripura – falls into the low prevalence category. The responses to the epidemic in these states range from persistent denial as in Meghalaya to a limited coverage of services as in the case of Arunachal or Sikkim. Common to all eight states, as also across the country, is a growing epidemic and the inadequacy of appropriate responses to 'halt and reverse' it.

HIV in NEI began as an injecting drug use related epidemic but was soon identified in the general population. As of 2004, three – Manipur, Mizoram and Nagaland - of eight states in NEI had transited to a generalised epidemic situation. However, only two of these states have been officially notified as HIV high prevalence states.

After more than a decade of informing, educating and communicating about HIV, the levels of awareness of the infection in the region as a whole, and among its rural population in particular, are very low. Where people are aware, as in the first group of states, it has not resulted in optimal behaviour change whether towards prevention or care. In prevention, behaviour change should be reflected in safer injecting and sexual practices. While there is a marginal reduction in the prevalence of HIV among IDUs, it continues to be an area of concern. Awareness should also change stigmatising and discriminatory behaviour towards those infected and affected, resulting in greater acceptance of those infected and affected, and fairness in access to opportunities and services for them.

What is needed for behaviour change is an environment that will, at the least, not hinder it. Safer injecting practices focus on preventing the spread of HIV. In other words, the focus is not on drug treatment towards abstinence. Often, as in Mizoram, such interventions are not even tolerated. Organisations which ventured to intervene to protect the lives of IDUs faced hurdles regarding the location of their centres/ outreach points. Condom programming is also aimed at preventing the spread of the infection and not on addressing the morality of the sexually active.

With over fifteen years of the epidemic in NEI, the number of AIDS-related deaths is steadily increasing. Consequently issues of infected and affected women, widows and children are visible more than ever before. While there is some data available on women, there is less on widows. Data on orphans and other vulnerable children (OVC) is almost non-existent. The efforts to address the HIV-related needs of OVC across eight states can be counted on the fingers of one hand.

Churches in NEI are widespread. Almost every village in Manipur's hill districts, Meghalaya, Mizoram and Nagaland has at least one church. In these states, churches are powerful. They have often been looked up to, and responded to address conflict-related issues. Churches in NEI have reached out to distant corners within the region with health services delivered through the mission hospitals and small health units, since long.

Given their reach, the overall response of the churches to HIV has been less than adequate. This inadequacy has its reasons, some of which relate to the churches themselves and some which relate to those more actively involved in the field of HIV. On their part, churches understood their mandate to be the spiritual nurture of their congregations and were being faithful to this responsibility. Therefore, they viewed (and many do even today) HIV as an issue beyond their boundaries. However, with HIV rampant in their hinterland, churches could not remain insulated from the virus. In the Christian-dominated states, many of whom were, as mentioned above, in the high prevalence category, there were daily reminders about HIV-related issues. Churches must pay attention to these reminders.

Those actively in the field of HIV have also contributed to the limited response of the churches. In their enthusiasm to mobilise communities to HIV, state AIDS programmes on HIV and NGOs in the field appeared to target churches to convert them to a public health view of preventing HIV. Most states did not consistently seek the active participation and partnership of the churches. It was also not uncommon for groups of Christian NGOs at the end of their workshops or conferences to call on churches to respond to HIV. Churches were and continue to be criticised for their position on harm reduction and condom programming. Despite their long history in health service provision the churches' resources were not sought and drawn on, until very recently, for initiatives of care.

Without a doubt, the need of the hour vis-à-vis HIV in the region, as also the rest of the country, to prevent the spread of HIV. But HIV prevention is not only about harm reduction through needle and syringe exchange or the more expensive oral substitution therapy. It is not just about addressing the symptoms – drug use and HIV – but also about addressing the environment in which these symptoms are nurtured and manifested. It is about ensuring that children learn how to cope with life's challenges so that when the choice of drug use presents itself, they can decide wisely. All those involved in the field of HIV need not be sold out on harm reduction, in just the same manner that all Indians need not speak one language to contribute to nation-building.

Surely, there is also a growing need for care initiatives. HIV and AIDS care includes the management of opportunistic infections and anti-retroviral therapy commonly known as ART. But caring for the infected is not only medical support. This requires specialists trained for the purpose. Home-based care and community-based care have been recognised internationally as means of ensuring quality care with minimal burden on the health delivery system. This is ideally delivered through a system of trained volunteers. With appropriate training, churches are best placed to provide this volunteer force.

The challenges of the HIV epidemic in North East India are manifold. Thankfully, the potential to address these challenges is also present within the region, much of it within the churches. Compartmentalised thinking has restricted the realisation of this potential. Our proscribed roles are less sacro-sanct than the lives we are mandated to save, whether in church, government or NGO. Let us broaden our vision and perspectives. Let us unite with all our diversities.