CASE REPORT

HIV in India: the Jogini culture

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SUMMARY

Jogini is the name for a female sexually exploited temple attendant and is used interchangeably with Devadasi in the state of Andhra Pradesh, India. Jogini are twice more likely than other women who are used for sexual intercourse in India to be HIV positive, and their rate of mortality from HIV is 10 times the total mortality rate for all women in India. The four states in India with the most Jogini also have the highest prevalence of HIV. The following case is unfortunately typical of the Jogini and sheds light on a potentially disastrous public health problem in rural South India.

CASE PRESENTATION

The patient is a 32-year-old woman from a small village in the state of Andhra Pradesh, India.[1 2] She is the only child of whom she describes as loving parents. She remembers playing in a field as a 7-year-old girl when her father came to her and said that she was to become a Jogini. The entire village attended her dedication ceremony. It seemed as if people were celebrating her and what she would become. She herself did not understand what was going on. All she knew was that her parents said that she was now a Jogini and she always obeyed her parents.

The patient's father had a serious dilemma. First, he was a Dalit. As a member of the lowest social caste (often called the untouchables in western literature), he believed that the options for his daughter were limited. He was unable to afford the dowry that would be expected of their family if he were to arrange a marriage for her, and he had no sons. It was his belief that only a son could light his funeral pyre (antyesti). Since he did not have a son he was in danger of becoming a ghost (bhoot) and would not be able to join his ancestors. His way out of the dilemma was to have his daughter dedicated as a Jogini. Then, because of her special relationship to the Goddess Yellamma, she would be able to light his funeral pyre when he died.

The patient never attended school. At menstruation, she awoke to a startling reality as she had her first sexual encounter in her parent's home. Jogini have attendant sexual responsibilities. Though the sex was brutal, it was not necessarily immoral to her. It was all she knew. Her parents taught her that it was acceptable and necessary. She began her life of working in the fields, begging and going to the temple. Every Monday, Wednesday, Friday, Saturday and Sunday she would work hard in the fields. If men harassed her while she was working in the fields or walking home she was obliged to comply. Every Tuesday and Thursday she would go house-to-house to beg. Men approached her and she performed her duty. If men came to her parent's home at night when her work was done or early in the morning before she went to work in the fields, again, she had sex with them. By the time she was 13 she was pregnant and at 14 she had a son. She has no idea who her son's father is because most of the men of the village have used her for sex.

She gave birth to her son at home. The same home that she had played in as a girl and been abused as an adolescent. She did not take advantage of the government subsidy to have her child in the hospital because she had no idea that it existed. She was illiterate, did not know her rights and lacked self-confidence. When her son was old enough to go to school she tried to convince him to attend but he refused. Her son does not obey her. The community has no respect for her.

In her 20s, the patient remembers that she began to get sick more often, and as she approached 30, she started to become very weak. It was at this time that her uncle died of AIDS. Her uncle had used her for a long time. He had been with her since she was an adolescent and before she had her son. Last year, the Operation Mercy India Foundation Anti-Human Trafficking Unit (OMIF AHTU) team in her village started working with her to help her leave her life as a Jogini. The process was not easy. How could she change the only life she understood when everyone in the village knew that she was a Jogini? OMIF AHTU advocated for her to the government and helped her to understand her rights to a pension and a home as legal entitlements of all former Jogini. They also brought her to the regional hospital where she learned that she was HIV positive.

GLOBAL HEALTH PROBLEM LIST

The life of a Jogini is determined by
The caste system;
A lack of educational opportunities;
A lack of independence in financial income and expenditure;
Criminal prostitution.

Literature review

The Jogini can be traced back to medieval South India. It appears that at that time a woman would become a Jogini in order to upkeep the services of the temple or because a donor appreciated their art. Their roles would include sweeping the temples, carrying the utensils for worship and dancing for the gods. Towards the end of this period, a schism appeared between the 'clean' and 'unclean' castes, and each group began to take on certain roles.

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It was this divided form of the Jogini practice that the British experienced in the 19th century. Some abolitionist tried to emancipate the Jogini from their servitude by passing acts such as The Madras Act V of 1929. While there was success in reforming the rights of the Jogini from the 'clean' castes, the Jogini from the 'unclean' castes were often pushed into the sexual exploitation that the Jogini are associated with today.

According to the state government of Andhra Pradesh, there are 16 799 Jogini. One-third of the districts across Andhra have no surveillance. It is estimated that 50% of the Jogini in Andhra are unreached by this data.[3]

In addition to Jogini in Andhra Pradesh, there are also 22 943 Devadasi in the state of Karnataka and 135 000 in all of India.[4] Many of these women are suffering from sexually transmitted infections due to high-risk sexual activity. Of all women used for sexual intercourse in India, Jogini are among the youngest (mean age of onset of sexual activity 15.7 vs 21.8 years). The onset of HIV correlates with the age of onset of sexual activity. Furthermore, Jogini average 2.6 more clients per week than the average sexually exploited woman. Both of these factors contribute to the fact that with an adjusted OR of 1.98 and p value of less than 0.001, Jogini are more likely to be HIV positive than the average woman used for sexual intercourse in India.[5 6] Furthermore, Jogini have an AIDS-associated mortality rate of 2.44/100 person-years, which is 10 times higher than the national mortality rate among women in India.[2 4 5]

Jogini are more likely to work in rural settings than other sexually exploited women,[6] and in rural regions, the prevalence of HIV is higher (OR of 1.5 in rural Karnataka).[7 8] In northern Karnataka's Devadasi districts, HIV prevalence at antenatal clinics is 2.6%, five times as high as the state average of 0.52%.[8 9] According to the National Aids Control Organization of India, 57% of all HIV infection is in the states of Andhra Pradesh (500 000cases), Maharashtra (420 000cases), Karnataka (250 000cases) and Tamil Nadu (150 000cases). Andhra Pradesh, Maharashtra, Karnataka and Tamil Nadu are also the four states with the most Jogini.

Global health problem analysis

Caste system

The Jogini system is socially accepted and a common practice in South India. In order to understand how the Jogini system is illegal yet sanctioned, it is important to acknowledge the social demographics of the Jogini system. While the Dalit caste represents 18% of the general population of India,[10] all Jogini are Dalit.[11] One-third of visits to Dalit homes are refused by public health workers. Over 48% of 560 villages across 11 states in India deny Dalits access to water sources such as wells, hand pumps and pipelines.[12] Police reports show that an anti-Dalit crime is committed every 18 min.[13] Even so, 27.6% of village police stations refuse entrance to Dalits.[12]

Compared with women of other castes, Dalit women suffer from 17% more illiteracy, 3.4% more unemployment, a 17.4% higher infant mortality rate and 7.8% more anaemia.[10] They are also expected to contribute more to the family's income and often have to take on jobs that put them at a greater risk such as night sweeping of the streets or manual savaging.[14]

> Dalit women are at the bottom of Indian society. Within the women's movement, Dalit issues have not been taken seriously. Within the Dalit movement, women have been ignored. Caste, class, and gender need to be looked at together.[4]
>
> Ruth Manorama, the head of the National Federation for Dalit Women.

Lack of educational opportunities

The patient, like 92.8% of Jogini,[5] is illiterate. She did not attend school. For those in employment, there is an 8% wage increase for every extra year of education.[15] Perhaps even a few years of primary school would have provided her with literacy skills and the confidence necessary to seek an alternative way to earn a living. Basic education also increases opportunities for women by increasing the likelihood that they will have an independent income. In India, literate mothers have lower rates of severely stunted (40% compared with 44%) and severely underweight (7% compared with 9%) children when compared with illiterate mothers.[16] For every 10% increase in female literacy in India, there is a 9/1000 decrease in the child mortality rate as well as a decrease in the total fertility rate and female child disadvantage (female child disadvantage refers to how in India baby girls are less likely to survive to the age of 5 than boys. The established trend in medicine is that girls have a survival advantage under the age of 5. China is the only other country in the world that has this reversed trend).[17] Literate mothers also have a greater spacing between pregnancies,[16] the more education that a woman has, the more likely she is to understand contraceptive methods taught by health workers including condom usage.[18] Literate women better utilise healthcare institutions. They spend more time discussing health and disease with healthcare professionals, are more likely to take advantage of village child health development centres and their children benefit more from the centres.[16 17]

This patient's lack of education made her vulnerable and more in need of help and protection from *outside* her community. OMIF AHTU offered her on-the-job training as a seamstress, so that she was able to earn a living while learning a skill. Access to healthcare is a pervasive problem for illiterate women. A community health worker brought this patient to the hospital where she learned that she is HIV positive. In rural Andhra Pradesh, antiretroviral medication is only dispersed at the regional infectious disease hospital in Hyderabad. It takes at least 6 h to travel there and buying the bus ticket there leaves no money for food for a week.

Jogini prostitution

Eighty three per cent of Jogini had their first sexual experience with a benefactor who paid for their dedication ceremony (92% of sexually exploited women in India did not have their first sexual experience for compensation, $p<0.001$).[19] Additionally, Jogini are less likely to see their clients as perpetrators of violence than the average sexually exploited woman in India (13.3% vs 35.8%).[5] In fact, Jogini are more likely to say that they find emotional intimacy and succour in clients.[14] However, the incidence of mental health problems among Jogini women is high—92% of Jogini women report depression and 57% report that they have attempted suicide.[20]

There have been many attempts to stop Jogini practice. The states of Karnataka and Andhra Pradesh enacted the Devadasi (Prohibition of Dedication) Acts during the 1980s. The Karnataka Devadasis Act was adopted by the State Legislature in 1982 and made it illegal to dedicate a Jogini (Andhra Pradesh Act was adopted in 1988). There is a fine of 5000 rupees (US $82) and up to a 5-year prison sentence. The fine and jail sentence are applicable to any person found to be involved in dedications.[13] As of 2009, there have been 45 cases and one conviction in Karnataka. In Andhra Pradesh, there have been seven cases and no convictions.[21]

As with all complex cultural and social determinants of health, interventions need to be culturally acceptable and avoid stigmatisation.[22] One strategy to decrease HIV infection has

been to 'sanction' the Jogini profession while protecting women by increasing their knowledge of sexual health.[8] A strategy in combating prostitution is to focus on the control structure that keeps women powerless. Corrupt police and pimps have to lose their hegemony as women become free. However, Jogini are not under the control of these men. They are bound by social norms that take their independence and exhort them to perform a cultural function that most Indians recognise as exploitative and abusive.[23] The formation of sexually exploited female collectives has provided some social and economic structure towards peer education and outreach programmes, so that discourse on alternatives to sexual servitude is still possible within a cultural framework.[24] Such collective approaches correlate with effective education as demonstrated by safer sex behaviours such as the use of condoms.[25] Other initiatives are to train Jogini for work in a different profession—the temple priest might perform a cleansing ritual and village leaders may support Jogini by taking an active stance against the discrimination within the community. Peer educators such as former Jogini or community health workers may help to educate the women about sexual health and their basic rights as individuals. This can be coupled with programmes currently working with Jogini to alter the tradition of induction or to stop induction before the age of sexual consent (18 in India).[5 26]

Learning points

- Social systems are complex determinants of health.
- Social and cultural attitudes may be entrenched.
- A lack of education and financial independence is intrinsically related to access to healthy lifestyles and access to healthcare.

Competing interests None.

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