

FULFILLING OBLIGATIONS TO ONE'S MOTHERLAND: HIV/AIDS PREVENTION IN INDIA

A STORY BY PALLASSANA R. BALGOPAL
TOLD TO ROLAND MEINERT

Social work colleagues with a special interest in international practice invariably share stories about their work with one another. Drs. Balgopal and Meinert work closely on the CSWE Commission on accreditation and come together for extended meetings three times a year. During one of these meetings, Dr. Balgopal (BAL) shared the following story with Dr. Meinert (ROLAND). The story is presented in a question and answer format.

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and, too emotionally involved to share his experiences from a scholarly perspective.

ROLAND(R:) Since 1987 you have been going back to India every summer, but you've never said whether it was for family reasons. I know that during 1992-1993 you had a Fulbright and spent the time in India. What have you been doing?

BAL(B:) Well, I've been going back for both reasons. In recent years the professional activities have increased. In the beginning I spent a summer in Singapore in a program on HIV/AIDS awareness. The program was sponsored by the WHO (World Health Organization) to educate health service administrators and workers about its increasing magnitude in Asian countries. This took part of the summer and I wanted to spend the rest in India. My initial intent was to spend what remained of the summer relaxing with family and friends and to do some thinking about the upcoming semester back at the School of Social Work,

University of Illinois, Urbana-Champaign.

However, during the first summer back in India, a series of events drew me into contact with groups who are profoundly impacted by HIV/AIDS. One group was part of mainstream society and the other was very marginalized and on the fringes. At the time I wasn't conscious of it, but both these groups tapped into one of my needs that had been present for some years. Like many Asian-Indian social work educators raised outside the USA, I felt an obligation to give something back to the culture that nurtured me. My initial purpose for coming to this country was to obtain advanced training and then to return to India to work. However, my decision to stay created a sense of guilt for having abandoned my original mission. The opportunity to work in India gave me a sense of consolation that I was finally able to do something for the Motherland. As an Asian Indian immigrant, I carry with me the belief of adhering to "Dharma." Dharma

Dr. Balgopal noted that he avoided writing about his work in India until now: (1) he was not finished with the work yet (2)

is a set of beliefs and expectations which lay down a series of proper forms of behavior and steps in an individual's life. Loosely translated, *Dharma* means *duty* and distinguishes itself from conscience. While Indians may not always explicitly say that they adhere to *Dharma*, many of them implicitly follow its basic tenets. As a middle-class Indian immigrant, I have followed some of the fundamental tenets which include being a successful professional, raising and supporting a family, and being involved in my ethnic group's social and cultural activities. But at the emotional gut level, I feel a need to do something for my Motherland. One way of achieving this is by frequently visiting family and sometimes being involved in social welfare projects that are especially focused on helping the oppressed and vulnerable groups.

R: What were the two groups, and knowing of your long-standing commitment to HIV/AIDS prevention, how did they fit into this?

B: The two groups were cross-country truck drivers who are gainfully employed in what is considered a skilled occupation, and the other were Hijras who are institutionally marginalized and stigmatized in Indian society. However, both of these groups are directly involved in the spread of HIV/AIDS in India. Although efforts are being made in India to deal with HIV/AIDS, the level of awareness about it by the general population at large is not very high. In India there has never been an icon like Magic Johnson who has been HIV positive and received extensive nationwide publicity. The reason for this is the fear of stigmatization and of being ostracized by the public.

R: Tell me about the truck drivers, their involvement with HIV/AIDS, and the manner in which you began working with them.

B: My first contact with the truck drivers occurred when I visited the food stands, known as "*dhaba*," in the outskirts of Madras in south India. In the North Indian language, this term means a roadside eatery where homestyle food is served. Most of the truck drivers in India are

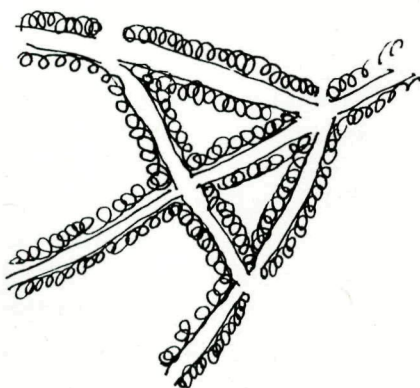
of north-Indian origin and they prefer to eat north-Indian style food, so *dhabas* are seen all over Indian highways. At the time of my visit to one of the *dhabas*, there were about 10 truck drivers who had stopped to have their evening meals. My contact with them began with exchanging pleasantries in the north-Indian language, Hindi. Most of the exchange was about the quality of food and whether it is as authentic as that which they are served at home, especially since this *dhaba* was located in the heart of south India. After discussing issues about adjusting to different environments with different languages, ethnicity, and customs, the conversation led to a discussion about their being away from home so frequently, for long periods of time, and what they



missed about it. One of the truck drivers said that due to the *dhabas* being located in southern India, one could find north-Indian food, but one could not get women. "Food, which one is used to, can be replicated, but when it comes to women, it is a different story." In time, our conversation led to a discussion about the increased numbers of prostitutes and road-side sex workers (who are frequently housewives and village women who engage in commercial sex to subsidize their family income). Initially, the drivers jokingly asked me whether I was looking for women. When I said "no," they wanted to know why I was so curious about their roadside activities with the village women. I was frank and told them about my involvement in doing HIV/AIDS awareness work. My frankness seemed to facilitate the drivers in opening up and having an honest discussion. We talked about the risk factors associated with such casual sex and contracting sexually-transmitted diseases (STDs). One of the drivers, referring to his own

contraction of gonorrhea, chuckled and said, "You have a lot of heat in your crotch." Ultimately, this led to our discussion about HIV/AIDS.

As an outgrowth of my work with WHO in Singapore, I began to visit schools of social work in India with the purpose of imparting information and increasing the students' awareness about HIV/AIDS. As I traveled from school to school, I became aware of the extent to which HIV/AIDS was being transmitted by cross-country truck drivers. It occurred at rest stops along the highways where women from nearby villages, invariably poor, would have casual sex with the drivers. The women at the rest stops would meet the drivers and their apprentices for a quick encounter, which in India is called "ejaculatory sex"

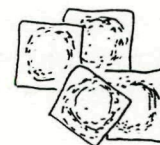


for pay. Some of the women and drivers are now HIV positive, resulting in the virus being spread throughout the country along the highway network. Initially, I was at a loss as to how

to approach the problem, but decided to use the time-honored principle of beginning where the client is. I simply began hanging around the rest stops where the truck drivers had stopped for a meal and for quick sex. I soon became a familiar face at some of these rest stops where I struck up conversations with both the owners of the *dhabas* and the drivers. I had two objectives for the contacts. The first was to pass out condoms to the drivers and information as to why it is important to use them. Second, if they seemed interested, I provided as much information as they were willing to listen to about HIV/AIDS itself and how it was spread. When I left at the end of last summer, I, along with the other local social workers, had become known as the "rest stop condom men." Probably anyone who did what I did would achieve some degree of effectiveness, but I had one major advantage. My

ability to speak both "north" and "south" Indian languages, without a discernible accent, helped tremendously in establishing short-term focused conversations with the truck drivers at all the rest stops that I visited.

However, what has been most difficult for me emotionally is the plight of the poor village women. They must give up their dignity to engage in transient sex with the truck drivers to help support their families. These women rightfully claim that prostitution is not by choice but to supplement their income. They are able to



make more money in an evening prostituting than in a whole month of farm work. There is nothing I can do to change the circumstances within which they live and that force them to sell their bodies. On the one hand it is important that I do whatever I can to stop the spread of HIV/AIDS. On the other hand I feel guilty of depriving the village women of the meager money they get which is desperately needed to help support their families and children. My own observations of this culture and its economic disparity lead me to conclude that the real solution for these women rests in better employment opportunities. But this is unlikely to become a reality during their lifetime.

In addition, because of the cultural values, it is not easy for me as a male to work with these women on sexuality issues. After recognizing this limitation, I shared my concern with some professional colleagues. They, in turn, worked with the local public health officials which resulted in their recruiting female para-professionals to work with these village women at grass-root levels. Additionally, during my visits to the schools of social work, I met with female students and other professional social workers. We discussed ways of passing on the HIV/AIDS information to the village women and they (the female social workers) are being encouraged to design approaches using a social development perspective. In this regard, some very innovative and bold work is being done by Dr. Sunderraman and his colleagues in Madras

and Mr. Akash Gulalia in Delhi. Through their initiatives, "block" field placements have been developed. These placements include social work students living for a period of time in the villages. Their actual stay in the village has helped facilitate their acceptance by the village community.

R: Bal, the truck drivers and village women are certainly high-risk populations in terms of HIV/AIDS; however, you also told me about another high risk group. They are the Hijras. Tell me something about them.

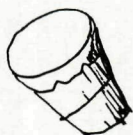
B: The Hijras are also highly at risk in terms of contracting HIV/AIDS and ultimately spreading it. Unlike the truck drivers, the Hijras live in a state of institutionalized marginality and stigmatization. They have been in India for centuries. Some of them speak with a great deal of pride about giving up their male genitals as a homage to their patron Goddess to achieve spiritual transcendence. Not all Hijras are homosexuals, but they all dress in drag. Some Hijras undergo sexual surgery and engage in commercial sex.

R: Would you say they are similar to transvestites, cross-dressers, or those who undergo sex change operations in the United States?

B: There may be some superficial resemblance, but psychologically, behaviorally, and culturally they are totally different. The Hijras are a distinct community with a specific organized, hierarchical social structure. One of their most important

functions in Indian society is, for example, to act as community entertainers during celebrations such as weddings, the birth of a child, and other holidays and festivals. They sing, dance, play the *dholak* (sacred drum), and give a

blessing. Through such entertainment activities, they earn alms for their "community." In addition, because of recent economic depression, Hijras are increasingly engaging in prostitution.



R: How does an Indian male become a member of the Hijra community?

B: It is a matter of individual choice usually made during late adolescence and the young adult years. Some males are attracted to the prospect of living as a woman rather than as a man and to a lifestyle of institutionalized homosexuality.

R: What enabled you to become involved with the Hijras and how did it actually come about?

B: Via their prostitution activities, the Hijras are emerging as one of the major high-risk groups to be infected with STDs and HIV. They are often solicited for clandestine homosexual activities, mainly by married men. For some time I tried to achieve a degree of acceptance within the Hijra community, including through my contacts with their "*Naik*" or leader. Then a fortuitous incident took place. A colleague from the Delhi School of Social Work, Akash Gulalia, arranged for me to go to the neighborhood where Hijras hang out at dusk to procure "customers." At that time, we came across a Hijra who was being harassed by a motorcycle policeman. I was able to stop the harassment, which was escalating, by using a mild form of intimidation. One of my relatives had been a high police official in the area, and when I began dropping names, the policeman backed off and left. This rescuing incident facilitated my establishing confidence with this young Hijra. At that juncture, I also told her that I did not want to interfere with her "business activities" but would enjoy getting to know her.

R: Bal, you told me that you feel more confident about creating more extensive changes in your work with the Hijras than with the truck drivers. Why is that?

B: With the truck drivers and village women, the only positive results came about on a person-by-person basis with little chance of impacting the total population. On the other hand, even though it is an ambitious undertaking, by following the principles of social development practice, it may be possible to have an impact on the spread of

HIV/AIDS throughout the entire Hijra population.

There are structural and socio-economic changes that can take place within their communities and connections can be made with police, public health, and educational resources. By working with the Hijras on their turf, especially in their own neighborhoods, and by



developing an indigenous willingness, it is conceivable that basic institutional changes can come about. In my next meeting with the Hijra whom I rescued from the police harassment, I greeted her as *thangachi*, an enduring Tamil (south-Indian language) term meaning "little sister." I used the Tamil term because it was easy to identify her as south Indian due to her distinct Hindi accent. She looked at me with surprise, as it is uncommon for Hijra to be treated with such acceptance. I apologetically added that I did not want to encroach on her business hours ("*dhandha*"), but that I would like to talk. She became receptive, stating, "You are a very unusual person," and invited me into her home where she served tea and southern Indian snacks. We spent more time talking about her life than about prostitution and AIDS. The Hijra preferred

that her clan members did not know that she prostituted. This would be a shameful experience for her, if it became known. Also, due to my referring to her in the feminine gender, she seemed content by my acceptance of her lifestyle; I could tell by her insistent smiles. The norm is for the Hijras to be treated and stigmatized as "whores." But this norm was broken for the brief moment when I referred to her as my *tangachi*, younger sister.

In closing, I must clarify that in my recent trip, I learned how professional colleagues working with the truck drivers have been successful in getting the drivers to come to the roadside clinics for treatment of STDs. Most drivers infected with a variety of STD's stop to get medications, are informed about HIV/AIDS and the risks in contracting it from unprotected sex, and are given condoms.

R: As I listen to your story, it seems to me that you are optimistic and enthusiastic about your work in India. It also seems to me that there is something involved here that goes beyond the application of professional skills.

B: Yes, I am enthusiastic but not optimistic. It seems that for every progressive move forward, many more problems arise. The incidence and prevalence of HIV/AIDS all over India is increasing at an alarming rate. In fact, it has become the epicenter of this epidemic.

Like many academics, I sometimes wonder whether what I teach students actually works and makes a difference. My work with the truck drivers and the Hijras has re-confirmed for me that it does. However, my work in India has philosophical, spiritual, and psychological meaning for me. I find great value in being able to help my Motherland and to give back something to the people and culture who gave me so much. This is one way of fulfilling my *dharma*, a never-ending conflict.

Roland, as you are aware, I was reluctant to talk about my work. I appreciate your encouragement and enticement to share my story. □

ENDNOTE: Dr. Balgopal wishes to thank two persons who provided information and assistance in working with the two groups. Dr. Sunderraman, a UCLA-trained psychiatrist, assisted in developing contacts with truck drivers, and Akash Gulalia, a lecturer at the Delhi School of Social Work, helped in contacts with several Hijra groups.

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