

**Mainstreaming HIV and AIDS for Women's Empowerment**

**NATIONAL AIDS CONTROL ORGANISATION**

**Government of India**

**2008**

Peer reviewed in 2007 and validated in April 2008 at a 2 day meeting of experts on gender and HIV, officials from NACO and SACS, senior government bureaucrats, civil society partners, PLHIV networks, and donor and UN agencies. Full report of this validation meeting is available at [www.nacoonline.org](http://www.nacoonline.org)

## CONTENTS

### Women and HIV and AIDS

The global context	5
The Indian context	10
<i>Situational Analysis: Women and HIV and AIDS</i>	10
<i>The gender dimension</i>	12
<i>Understanding the role of men as a part of HIV response to women</i>	13
<i>The socio- cultural and structural context</i>	14
The prevailing norms and the status of women in India	15
<i>Legal Rights and government schemes and programmes for women</i>	15
Impact of prevailing norms and status of women on HIV prevention and care programmes	17
<i>Sexual behaviour and relations</i>	17
<i>Information/Education- reproductive and health needs</i>	19
<i>Adolescent girls</i>	19
<i>Gender dynamics and related facts</i>	20
<i>Biological differences</i>	21
<i>Psycho- social and economic impact</i>	21
Guiding Principles for mainstreaming HIV and AIDS with a focus on women	24
Purpose	24
Objective	25
Guidelines for Action	25

**Annexure 1-** A checklist which will help planners and implementers to monitor whether and to what extent the gender sensitive approach to HIV prevention and care is being implemented.

**Annexure 2-** A plan for capacity building of relevant stakeholders to assist them to adopt the gender sensitive approach to HIV prevention and care.

**Annexure 3 –** An action plan for Government ministries, civil society and private sector, to adopt a gender sensitive approach to their work in HIV prevention and care.

## Women and HIV and AIDS

### **The global context**

The existence and rapid spread of HIV and AIDS poses a serious challenge to every nation across the globe. HIV and AIDS have the potential to undermine the massive improvements that have been made in global health over the years. Apart from being a serious health problem, the multi layered effects of the epidemic on the socio-economic fabric of whole nations, makes HIV and AIDS a potential development threat worldwide. The seriousness of the situation and the need to take action has been captured aptly in the following statement by Hon'ble Prime Minister of India, Dr. Manmohan Singh:

"HIV/AIDS has become a serious socio-economic and developmental concern. We have no choice but to act, and act with firmness, with urgency and with utmost seriousness. To push this effort forward we constituted the National Council on AIDS and I myself head this Council so that the combined attention of the Government as a whole is given to our campaign against AIDS."  
***" In the absence of a vaccine, the social vaccine of education and awareness is the only preventive tool we have."***

In this regard, in June 2001, at the United Nations General Assembly Special Session on HIV and AIDS (UNGASS), 189 national governments signed the Declaration of Commitment on HIV and AIDS. The document commits signatory governments to improve their responses to their domestic AIDS epidemics and sets targets for AIDS-related financing, policy and programming. Public Health Watch, established by the Open Society Institute in 2004, supports independent monitoring of governmental compliance with the UNGASS Declaration and other regional and international

commitments on HIV and AIDS. Public Health Watch aims to promote informed civil society engagement in public health policy and practice on HIV and AIDS. The Open Society Institute's Public Health Program promotes health policies based on social inclusion, human rights, justice, and scientific evidence.

While the effects of HIV and AIDS are equally detrimental for all persons affected or infected, certain sections of the population, across the world, however, are more vulnerable in terms of both, contracting the infection and the subsequent consequences. Both structural (socio-economic, political) and cultural (traditional norms etc.) factors are responsible for rendering certain sections like, women, commercial sex workers, youth, migrants, orphans, children and dependants of family members who are positive, more vulnerable than others.

Women, whether, married/single, divorced/ widowed, sex workers or seasonal migrants or adolescent girls, are most susceptible to the negative impacts- direct or indirect, i.e. infected or affected, of HIV and AIDS owing to the dynamics between the structural and cultural factors which places them in a weaker and vulnerable position than most others. Further, women are biologically more prone to HIV infection than men in terms of any single act of unprotected sex with an infected partner with the male- to female transmission of the virus being 2 to 4 times higher than the female to male transmission among such sero- discordant couples. The biological structure of women thus also renders them more vulnerable than others to HIV and AIDS. Gender disparities in terms of access to education, resources, income, political power, coupled with incidences of sexual violence, coercion, social dislocation in conflict situations like war etc. or owing to migration for work, serve to increase the risk of HIV infection to women through unprotected sexual intercourse. As a result, women now account for more than half of those living with HIV worldwide and 60 % in sub- Saharan Africa. They constitute one- fourth of those infected with HIV in India and one – third in Peru which is indicative of the manner in which gender disparities serve to pose increasing and disproportionate risks to women even in places which have relatively low national prevalence rates.

Each nation, whether or not a part of UNGASS or another centralized body, is making efforts to respond to the challenges posed by this epidemic. However, gender perspectives are still not being systematically addressed in policies and programs related to STI/HIV AND AIDS.

The U.S. Global AIDS Strategy, it is believed, overlooks the dynamics between gender disparities and HIV infection worldwide as it is based on certain assumptions regarding the spread of HIV which are not in the least supported by evidence based analysis. For instance, the strategy is guided by assumptions like-: marriage serves to protect women against HIV infection, the majority of adolescents in the focus countries are not sexually active and can be fully persuaded to abstain from sexual intercourse until married, women and girls can control abstinence and faithfulness. Evidence shows another picture of reality, for instance, in Cambodia, which has the highest prevalence rates in South East Asia, there is a decrease in the prevalence rates among sex workers while those among married women are on the rise. Further, the strategy's focus on programmes encouraging abstinence until marriage is based on the assumption that women and girls can control the timing and frequency of sexual intercourse. However, evidence indicates that young women and girls are at a greater risk of being subjected to rape and sexual coercion since they are perceived to be free from infection and owing to the prevalent myth that a man can be cured of infection through sex with a virgin.

Thus while efforts are being made to curb the spread of the epidemic, there however remain a number of challenges to be addressed and streamlining the policies to the actual trends on the ground is critical. The concerns of gender equity and equality, and women's empowerment in all respects are essential to the prevention, treatment and care in relation to HIV and AIDS. There is an urgent need to strengthen the response towards HIV among women. As has been pointed out by Bill Gates,

"It should be an urgent priority to accelerate research on promising new HIV prevention methods, and I hope that the discovery and development of an effective microbicide or oral prevention drug could mark a turning point in the epidemic. We need tools that will allow women to protect themselves. This is true whether the woman is a faithful married mother of small children, or a sex worker trying to scrape out a living in a slum. No matter where she lives, who she is, or what she does - a woman should never need her partner's permission to save her own life. The pace of research on new HIV prevention methods has not been fast enough, given the urgent need.

Bill Gates,

Bill & Melinda Gates Foundation

In the context of women and HIV and AIDS, access to the health information, prevention, treatment, and care and protection from stigma and discrimination related to HIV and AIDS are some of the aspects which need critical attention across the globe. There has been an increasing realization at the global front regarding the urgent need to address issues related to women in the wake of the rising HIV epidemic which has found place in the national policies of most nations. The government of Ukraine, for instance, has registered considerable success in reducing mother-to-child transmission, with rates declining from 27.8 percent in 2001 (when no interventions were available) to 8.2 percent in 2004. According to the national UNGASS progress report, by 2004 all pregnant women had access to HIV tests and received ARV drugs and evaporated milk formula for their babies; 86 percent of HIV-positive pregnant women received ARVs for prevention of mother-to-child transmission. Prior to 2004, ARV treatment was available to only 268 patients—137 were treated by the government and the rest (mostly pregnant women) were sponsored by Médecins Sans Frontières.

Further, in Kenya, a program run by [Family Health International](#) (FHI) combines HIV testing and family planning services to address the common needs and concerns of clients. FHI contends that adding family planning to programs to prevent mother-to-child transmission (PMTCT) helps achieve HIV AND AIDS goals and that even moderate decreases in unintended pregnancies to HIV infected women will reduce as many HIV+ births as PMTCT programs.

In South Africa, a program run by the [Reproductive Health Research Unit](#) (RHRU) of the University of Witwatersrand to prevent mother-to-child transmission of HIV has found that providing adequate anti-retroviral regimens to infected women can effectively reduce pediatric HIV and infant and child mortality. The HIV prevalence rate among pregnant women in South Africa is about 29 percent, and the transmission rate about 20 percent, leading to some 63,000 infants being infected in 2006. RHRU contends that PMTCT can be used to fight HIV more broadly. RHRU emphasizes the need to improve PMTCT services to care for HIV-infected women, and to shift the focus from preventing HIV infection in children to caring for HIV infected women. In addition, this approach will lead to improvements in maternal and pediatric health, decreases in pediatric HIV, increased HIV awareness in communities, reductions in the HIV treatment gap.

With the rise of the HIV and AIDS epidemic, in Cambodia, there is recognition of the need to improve services and promote the protection and empowerment of women and girls. The Ministry understands



HIV and AIDS to be a gender-based pandemic, the spread of which among women and girls can be slowed only if concrete changes are brought about in the sexual behavior and attitude of men. Gender and HIV mainstreaming efforts at the national, provincial and local levels, in Cambodia, are hampered by negative attitudes towards discussing sex, sexuality and reproductive rights. In this light, the Ministry of Women's and Veterans' Affairs has placed prevention, care, support and protection of women and the girl child as well as the need to change the behavior of men on the agenda for policy-makers and service-providers through the "Policy on Women, the Girl Child and STI/HIV AND AIDS" (2003).

The causes, consequences and risk factors in the context of women and HIV and AIDS largely remain common to all nations and societies across the world, although the particular structural and cultural differences among societies render significant the need for a context specific approach to address the issue effectively. Thus while the global context of HIV and women enables an understanding of the larger dynamics at work at the universal level, the particular aspects specific to each country and region need to be considered through a situational analysis of the context in question. Although, such models, approaches adopted and policies developed in other contexts may be referred to, to enhance the understanding on the issue, relevant portions of which may be incorporated in the indigenous context. However, a simple aping of the other existing successful models and policies must be clearly avoided since an approach suited to one context may not be a complete 'fit' for another context.

### **The Indian context**

#### ***Situational Analysis: Women and HIV and AIDS***

In India, experts point out that there is no one single epidemic. Instead there are numerous sub epidemics which are localized in nature reflecting the diverse socio-cultural reality of the country. Some significant structural and socio-economic factors serve to exacerbate the existing vulnerabilities to HIV infection:

- High poverty levels, with more than 35 percent of the population living below the poverty line;
- skewed gender relations
- Large scale migration
- Low levels of literacy;
- Unsafe mobility;

- Lack of awareness
- Cultural myths, misconceptions, silence and resulting stigma regarding sex, sexuality and HIV;
- Commercial sex and unprotected sex with multiple concurrent partners;
- Male resistance to condom use;
- High prevalence of sexually transmitted infections; and
- Low status of women, resulting in inability to negotiate safer sex;
- Women's limited control over and access to economic resources;

Since the detection of the first case in Chennai in 1985, the epidemic has spread to all parts of the country from urban to rural areas, infecting the most marginalized especially the poor women, and has moved out to general population from High Risk Groups. Among the high risk groups, the infection rate is as high as 7.23 percent among Injecting Drug Users (IDUs), while it is 7.41 percent and 5.06 percent among Men who have Sex with Men (MSM) and Female Sex Workers (FSWs), respectively.

2007 estimates suggest national adult HIV prevalence of approximately 0.34 percent, amounting to 1.8 to 2.9 million people living with HIV in India. One third of the AIDS cases are among the youth in the age group of 15-29 years who are the future of the country. Women and youth are disproportionately affected with women accounting for about 39% of all infections despite the fact that more than 90% of them are in monogamous relationships. Currently, most HIV infections among women who do not engage in sex work, in rural and urban areas, are attributable to their husbands' risky behavior. It is estimated that about 30 million men in India buy sex on a regular basis while the social and cultural limits placed on women's sexuality imply that a majority of women abstain from sex before marriage and post marriage remain monogamous.

The virus has expanded the circle of infected populations to include adolescent girls (married and single); married women of reproductive age; sexually active single women; pregnant women; and women survivors of gender based violence, sexual abuse and rape.

These trends point towards the need to consider the dynamics between the broader cultural and socio-economic conditions and the increased vulnerability of women to HIV. Therefore, it is essential to understand the gendered nature of the epidemic so as to achieve the targets under

NACP III and to translate the principled commitment to gender equality in the national HIV response into reality. As has also been noted by Sh.L.K. Advani, Hon'ble MP and Leader of Opposition in Lok Sabha:

"Our society certainly needs to be more open in discussing HIV AIDS the ways to prevent it control it treat it and overcome the challenge it poses our society needs to empower women with the knowledge about HIV AIDS and right to use the knowledge for their own protection."

### ***The gender dimension***

The HIV response in India is firmly located within the rights framework. There exists an inextricable link between human rights, gender and HIV and AIDS. Available evidence establishes beyond doubt that safer sexual practices for HIV prevention can be adopted by individuals and communities on a sustained basis only when the gender relations between sexual partners and between them and their social environment are equitable and based on mutual respect. Evidence also suggests that individuals' and communities' demand for HIV related prevention and care services is directly impacted by the stigma surrounding HIV, which for the large part stems from the social constructs of masculinity and femininity.

Gender inequality, thus not only impacts the spread of HIV but also its consequences. Men, women and transgender are vulnerable in different ways - leading to differential rates of susceptibility to infection, access to information and available services for prevention and management of illnesses. A successful programme on HIV needs to address gender based differences which stem from the underlying structural (socio-economic, political) setting and the cultural norms and adopt a transformative approach.

Gender and sexuality are cultural constructions rather than being empty categories pre-defined by nature. Thus, it is critical that any response to HIV in the context of women is based on a nuanced understanding of the manner in which the socio- cultural norms and ideologies that determine

gender roles and relations serve to exacerbate the disproportionate spread and impact of the HIV infections and directly affect sexual and reproductive health outcomes.

Further, it must be noted, here, that it is critical to ensure that the subjective influence of the individuals, in terms of the gender attitudes and behaviors of planners, policy makers, implementers and service providers from health, education and other service sectors at different levels, although unavoidable, is curtailed, and prevented from becoming an impediment to a gender sensitive HIV response.

### ***Understanding the role of men as a part of HIV response to women***

A gender sensitive response to HIV with a focus on empowering women, must account for the attitude and behavior of men which are largely conditioned by the same socio- cultural gender norms that accrue more power and control to men in all respects than women, in the traditional patriarchal setting which continues to bind and determine the lives of women even today to a large extent. Thus, men play a key role, intentional or unintentional, in perpetuating the vulnerabilities of women in relation to HIV and AIDS. Further, HIV and AIDS is largely driven by male behavior, in that, men encounter more opportunities, owing to their indulgent and risky behavior, to contract and transmit HIV, they usually determine the circumstances of intercourse (within or outside marriage, and in coercive situations like rape) and men often do not use protective measures during intercourse which places not only them but also their partners at risk. Therefore, any attempt to address the issue of women and HIV in a holistic manner and for effective policy implementation, must also aim at positively influencing the stereotypical attitudes and behaviors exhibited by men to reduce the risk of HIV infection to women apart from men themselves.

Influencing the mind set of people and bringing about a change in their attitudes and behavior is more often than not faced with severe resistance and is by no means a simple task. Likewise, there are a number of challenges involved here too, such as, a lack of knowledge about how to bring about normative changes, improve accountability mechanisms or motivate programme personnel to consider and address gender issues. Scarce allocation of resources to implement and manage a gender sensitive response, lack of efficient M&E system for tracking progress, lack of adaptable

materials, tools and methods, among others, further compound the issue and need to be addressed.

HIV programmes, rather than placing the onus of prevention on women, must address the gender issues related to HIV and AIDS, at the socio- cultural, structural level, and attempt to redefine gender relations while accounting for the significant aspects of the dynamics between women and HIV and AIDS.

### ***The socio- cultural and structural context***

Traditionally, patriarchy, has guided the gender relations, roles and behaviors in the Indian society. In a patriarchal setting, the head of the household would be the eldest male member of the family and all control and power in terms of resources, decisions etc. lay with him. The roles for men and women were clearly defined with men venturing out for work and to earn a livelihood while the women were strictly restricted to the domestic sphere, performing the roles of a housewife/ mother, attending to the daily household chores and needs of the children and other family members. It is only upon becoming a mother herself that a woman would attain some amount of power and status in the household, essentially in relation to the daughter- in law which would increase in the case of the death of her spouse in case he happened to be the head of the household. In this context, a chaste, morally upright and ideal woman was required to exhibit certain characteristics that were attributed to the notion of femininity in accordance with the prevailing gender norms. Thus she was meant to be submissive, unquestioning, and a person with immense capacity to bear any pain or ill treatment meted out to her. She was seen as the nurturer and caregiver.

The men on the other hand, in lieu of being the bread earners of the family, enjoyed power and control both within and outside the household, over economic resources, decisions, and practically owned the lives and the very being of their women. Women were thus at best shadows of their men and were treated as mere objects devoid of any subjectivity. The lack of any kind of rights to the women- economic, legal, social, political or negotiating powers in such a context was hardly ever questioned by the women themselves.

In contemporary India, while women have managed to negotiate for equal rights to a certain extent, and may be seen as breaking out of the chains of patriarchy, it however remains limited to a certain section and class of women, both in the urban and rural context. The middle and lower class women in urban India, whether, educated and economically empowered or not, and majority of women in rural areas continue to experience their lives within the patriarchal framework that determines their choices, opportunities and rights to a large extent.

### **The prevailing norms and the status of women in India**

#### ***Legal Rights and government schemes and programmes for women***

Women have equality of status under the country's Constitution. In the past years many empowering legislations have also been passed; these are devised to protect women from violence, dowry related harassment, rape, etc. However, the Hindu law still does not give women equal rights in ancestral property. For instance, they cannot be coparceners in ancestral property and have limited rights to inherit it. They cannot ask for division of the property. Separated, deserted or divorced women face major hurdles in claiming maintenance for themselves and their children.

The right to make safer and informed decisions is still not seen as the prerogative of women and girls. Social restrictions on women's mobility also contribute to lesser healthcare for women, girls and children. The potent amalgamation of low levels of literacy, economic dependence and exploitation, patriarchy, religious beliefs, political interests and cultural practices continue to shrink the choices women have, making them vulnerable at multiple levels, and reducing their quality of life.

Several Government schemes have been developed and implemented specifically targeting women and girls, whether it is the Indira Awaas Yojana or the Swashakti scheme. The 73<sup>rd</sup> and 74<sup>th</sup> amendments empower women to be part of village and district level governance. Nearly a million women have entered the *panchayats* and local bodies, thanks to one-third reservation. However, the impact of these schemes will only really reach the last mile, to the doorstep of all women, when the power equations between men and women are equalized and all sectors of governance and society ensure that a gender sensitive approach is adopted.

However, numerous key quantifiable indicators point to the fact that prevailing gender norms are biased against women and impact them adversely, especially their health and quality of life and thereby overshadow the gains (if any) from the schemes and programmes. Women continue to be subjected to social neglect and discrimination right from childhood (sometimes even before they are born) and throughout their lives which is exemplified through the following facts:

- There were only 927 females per 1000 males in India (the world average is 990 women per 1000 men), according to the 1991 Census. The sex ratio of the 0-6 age group has declined sharply from 945 in 1991 to 927 in 2001.
  - In India, women eat the last and the least. This practice partly explains why 83 percent of women in India suffer from iron deficiency anemia, as opposed to about 40 percent in sub-Saharan Africa.
  - In rural India almost 60 per cent of girls are married before they are 18. Nearly 60 per cent of married girls bear children before they are 19.
  - In 2005-06, only about 46.6% of births were assisted by skilled health personnel (about 73.5% in urban areas and 37.5% in rural areas). Nine states—Bihar, Jharkhand, Orissa, Madhya Pradesh, Chhattisgarh, Rajasthan, Uttar Pradesh, Uttarakhand, and Assam—constitute nearly half the country's population account for two-thirds of maternal deaths. According to estimates by UN agencies, the occurrence of a maternal death is 41 times more likely in India than of a maternal death in the US, and 10 times more likely than in China.
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- According to the 2001 Census, the total population literacy rate was 65% with 75% of the male population and 54% of the female population literate.
  - At the primary level, 95 girls are enrolled for every 100 boys; this ratio reduces to 88 girls per 100 boys at the upper primary level. In a nation-wide government study, 47% of total SCs enrolled were girls and 46% of total STs enrolled were girls.
  - 90 per cent of married women in Uttar Pradesh and Jammu and Kashmir and about 80 per cent in Bihar, Madhya Pradesh, Rajasthan, Haryana, West Bengal, Andhra Pradesh and Assam need permission to visit even friends and relatives.
  - Out of the total number of persons employed in the non- agricultural sector, the percentage of women engaged in wage employment in the non-agricultural sector was 17.9% in 2004 (ILO Data 2004).

## **Impact of prevailing norms and status of women on HIV prevention and care programmes**

### ***Sexual behaviour and relations***

Predictably, the inequality that characterizes the social and economic spheres of society, as mentioned above, is often mirrored in sexual interactions, creating an unequal balance of power in sexual relations. As a result, majority of women have little or no control over the circumstances in which and with whom sexual intercourse takes place. This inequality in sexual decision-making is perpetuated by norms of femininity and masculinity that curtail women's sexual autonomy and expand men's sexual privilege and adventurism, and cast women in the role of passive recipient rather than active agent. Prevalent notions of masculinity and femininity generally mean that women have little control or negotiating power in their sexual relationships, including within marriage. It also makes it difficult for women to be informed about risk reduction or be proactive in negotiating safer sex, making negotiation of condom use or practice other safer behaviours challenging.

Another important dimension of masculinity is the underlying belief that force or coercion in sex is unavoidable as a good woman can never say yes to sex. In a study of men in India, a majority of men said that force in sex was a marker of their ability to satisfy their wives sexually.

There is now a widespread acceptance of the fact that the disempowerment of women – because of which they have no control over decisions about their bodies or sexual health – is largely responsible for the pace at which the infection is spreading among women. Typically, HIV programmes have emphasized condom use, abstinence or faithfulness as key prevention strategies. However, in a gender inequitable setting, none of the three strategies are within the control of the woman, therefore making her increasingly more vulnerable to HIV infection and less able to exercise safer choices. The above issues coupled with women's poor access to justice leave her increasingly vulnerable to infection and vulnerable to high levels of multiple distress factors after infection. The complex interplay of social and economic gender differences and inequalities, combined with the unequal balance of power in sexual relations heightens the risk among men and the vulnerability of women to HIV. These inequalities are marked by gender-based violence.

As elsewhere in the world, a culture of silence surrounds sex, and the implicit assumption is that "good" women should be ignorant about sex and passive in sexual interactions. This makes it difficult for women to be informed about risk reduction or be proactive in negotiating safer sex. Practices such as purdah—the seclusion of women from public observation among several



population groups in India—also restrict the mobility of women and their ability to access resources, including information and counseling, testing and treatment services. Gender roles, for men and women, within marital relationships are at most times rigid laid out as per the patriarchal norms that guide the different sets of attitudinal and behavioral ethics and practices for men and women within marriage, the family and the community.

Integral to these moral codes is the tolerance of multiple partners and sexual experience for men, while protecting the virginity of women. Sex and sexuality are also not discussed very openly, rendering negotiation of condom use or other protective behaviours, a challenge. These inequalities are marked by gender-based violence.

Norms that reinforce the belief that variety in sexual partners is essential to men's nature are at odds with prevention messages that call for fidelity in partnerships or a reduction in the number of sexual partners. Another important dimension of masculinity is the underlying belief that force or coercion in sex is unavoidable as a good woman can never say yes to sex. In a study of men in India, a majority of men said that force in sex was a marker of their ability to satisfy their wives sexually. Prevalent notions of masculinity and femininity largely imply that women have little control or negotiating power in their sexual relationships, including within marriage.

Violence against women and HIV AND AIDS continue to be inextricably linked: rapes, incest, assault by family members or friends, violence in the course of trafficking or at workplace expose them to the risk of HIV infection. Quite often, women are aware that their partners are not monogamous, but might choose to stay on in these relationships or not express their concerns due to fear of violence mainly due to fear of violence, and financial dependence on men. This is exacerbated by the fact that many women are unemployed and few have skills that would make them employable.

Other existing practices such as early marriage, sexual and other forms of gender based violence, lack of economic opportunities; control and ownership of economic assets are the major socio-economic reasons of vulnerability of women to HIV infection.

***Information/Education- reproductive and health needs***

Women have poor access to information and education, which is critical in the context of HIV since behaviour change is the key to controlling the epidemic. There is evidence that suggests beyond doubt that women's access to health services in general is significantly impacted by the social and economic conditions within which she negotiates her health needs. Often a woman's health needs outside her reproductive roles are ignored; a woman's own health seeking behaviour places her own health as a last priority. Her access to health services including information and counselling, testing and treatment is hindered by limited mobility, socially restrictive practices such as *pardah*, and strong and often harmful gender stereotypes related to men and women's roles prevalent among service providers resulting in increased stigma and discrimination.

### ***Adolescent girls***

Young girls are vulnerable to HIV infection and its multi layered effects which may impact the psyche of the girls in a serious manner apart from other consequences. A number of factors place the adolescent girls at a heightened risk to the infection:

- Limited and differential access to opportunities such as education, access to information and services, knowledge of reproductive health and sexual issues.
- Limitations with regard to their rights and protection from exploitation.
- Low socioeconomic status coupled with lack of or low level of education render adolescent girls particularly vulnerable to the effects of gender inequality and increase their risk factors for child/ early marriage.
- At their age and they are less likely to be informed about HIV and the required protective measures to be adopted, or to assess their risk. They have negligible or no power to insist on condom use or to refuse unwanted sex within marriage. The patriarchal norms requiring a wife to serve the sexual needs of her husband as and when he wills and the age difference between the girls and the husband (who in most cases in such a context is much older than the girls) makes the situation much worse for young girls and serves to heighten the risk to HIV infection through their husbands.
- Further, the common myth that having sex with virgin girls will protect a man or cure him from sexually transmitted diseases and HIV also increases demand for sex with younger girls and places them at a higher risk to HIV.
- Young girls and particularly virgins are at a greater risk of being trafficked for commercial sex which renders them completely vulnerable to the risk of HIV infection.

- Adolescent girls are also vulnerable to sexual abuse and rape within the family – by fathers, brothers and within marriage as well as outside the family, thus subjecting them to high risk of contracting the infection.

***Gender dynamics and related facts***

Women are in part made vulnerable to HIV due to social norms and values that: (1) undervalue their contributions to society, as home makers and in their child bearing and rearing roles; (2) persist in casting them in the role of upholders of family honor; (3) limit their identity options to wife, mother, daughter and respectable housewife; and (4) fail to recognize their sexuality, or cast their sexual desires and expression in a judgmental framework of ‘good’ and ‘bad’ as being immoral, deviant and decadent.

According to NACO, BSS 2006 estimates, relatively higher proportion of male respondents (71%) had heard of both HIV and AIDS as compared to female respondents (55%). The pattern was alike for both rural and urban areas. Further, 45.2 – 50.8% of rural women demonstrated awareness about HIV and AIDS as compared to 69.4 – 76.6% of urban women. Out of the total number of non- literate persons surveyed, 45.8% were aware about HIV and AIDS (NACO,BSS 2006) and among women with no education, only 30% had ever heard of AIDS (NFHS-3). Awareness is lower among poorer people. On an income scale, 9% of the women in the bottom fifth of the population said that they were aware that using condoms can prevent HIV AND AIDS whereas 70% of the top fifth displayed this awareness (NFHS-3). Out of the total number of persons surveyed, 76.4% of men knew that consistent condom use can prevent transmission of HIV in comparison to only 53% of women.

According to the BSS 2006 data, awareness about STIs is consistently low among men and women, with 38% of men and 37% of women being aware. These figures and the trends they indicate, have significant implications for HIV prevention programmes and processes.

The gender dynamics described above are a critical part of the social context that frames the vulnerability of both women and men to HIV and influences the ways in which it impacts men and women differently as well their coping mechanisms.

***Biological differences***

Biologically, women are more susceptible than men to infection from HIV in any given heterosexual encounter due to greater area of mucous membrane exposed during sex in women than in men; greater quantity of fluids transferred from men to women; higher viral content of male sexual fluids; and micro-tears that than can occur in vaginal (or rectal) tissue from sexual penetration.

***Psycho- social and economic impact***

Global and local evidence shows that women also bear significant brunt of the psychological, social and economic burden because of HIV related to:

*Care of the sick* – Women account for more than 70 per cent of caregivers when it comes to providing care to PLHIV. It is a matter of concern that nearly 20 per cent of caregivers themselves are HIV positive. They also need social safety net and means for sustainable livelihood. In situations where both parents are positive, the burden of care falls on the girl child. This in turn constricts social and economic opportunities for the girl child, further contributing to the cycle of poverty, inter-generational gender inequality, and vulnerability to HIV infection due to disempowerment. Lack of time and resources, sickness and exhaustion, malnutrition and food deprivation may lead to the neglect of children. There are significant gender differences in the percentages of untreated opportunistic infections (that further lead to HIV and AIDS). Not only the percentage of women's illnesses, which go untreated is higher than that of men, but in case of women, financial constraints turn out to be an important reason for not seeking treatment.

*Loss of livelihoods* – As care of the sick takes women's time, or she becomes sick herself, she may be forced to abandon work in formal or informal sectors, with consequent reduction in family income and food security. Due to HIV related health and care burden, the value of women's productive, reproductive and household care related labour is further diminished.

*Economic support to the family* – Unemployment is often the push factor that makes both men and women undertake unsafe practices, making them vulnerable to HIV infection. With loss of income as a result of illness or death of the earning member, women have to very often support the family and children in whatever way they can. This may include doing low paid unskilled work or being pushed into sex work as the options for meeting the economic demands of the family. Nearly 60

per cent of the HIV-positive widows are nearly less than 30 years of age and staying with their natal families after being thrown out from their marital homes following the death of their husbands.

*Stigmatization and Discrimination* – Stigma also affects women more intensely than men, preventing them from accessing treatment, information and prevention services. The construct of ‘social evils’, produces greater stigma among women because HIV is closely associated with behaviours considered immoral, such as sex work. This compounds the stigma experienced by women with HIV. It is often the woman who is blamed for her husband and/or child falling sick. In some cases, women experience dual stigmatization – as a widow and especially a widow of positive man. Discriminatory access, ownership and control of property rights, residence and care facilities are some issues which confront the single and widowed women. 90 % of women who were widows as a result of their husbands dying of AIDS has stopped living in her marital homes.

*Increased risk of violence* - The experience of violence, or the fear that it might take place, disempowers women in their homes, workplaces and communities leading to an increased vulnerability to coercion, HIV related insecurity and unsafe living conditions. Pervasive gender based violence also limits women and young girls’ ability to participate in and benefit from initiatives for HIV prevention and AIDS mitigation.

In the above context, women’s empowerment along with behaviour change among and meaningful involvement of men is among the important ways for her to make safer choices especially when there is a near absence of female controlled methods of prevention.

Evidence indicates that

- Out of the total number of persons tested at ICTCs in the country in 2007, 47% women were tested and 53% men (CMIS, NACO 2007).
- Women in the age group of 15- 24 are significantly more vulnerable than men
- Men in the age group of 30 and above are significantly more vulnerable than women
- Percentage of women (37.7 %) receiving ART treatment is lower than men (62%) (ART, CMIS, NACO- July 2008)
- "...in HIV households, due to limited resources, the girls are more likely to be withdrawn from schools than boys as they are expected to take care of their younger siblings and household chores. "
- 8.9% men and 2.6 % women out of the total number of persons surveyed during the 2006 BSS (NACO) admitted to sexual experimentation with non- regular partners. Out of the 2.6 % women, 2.2% are rural women and 3.6 % women from urban areas.

It is clear that approaches to HIV and AIDS prevention will be effective only if they include interventions that recognize specific problems of and solutions for **women and men**. Engaging men more extensively in HIV prevention has a tremendous potential to reduce women's risk of HIV. While ways of interacting with intimate partners change over time, context and relationship, there is strong reason to believe that reaching boys is a way to change how they interact with women as grown-ups.

### **Guiding Principles for mainstreaming HIV and AIDS with a focus on women**

In the context of gender equality, the NACP III plan document reflects an understanding of the following principles;

- Equitable access at all levels in the national HIV response
- Empowerment of women and girls to take decisions for prevention of HIV transmission
- Non-judgmental and rights based HIV response with a commitment to social inclusion, and gender parity

- Create an enabling environment to address the legal and socio- economic barriers which are likely to adversely impact the outcomes of national HIV response.
- Enable and support women, girls and young people to make informed decisions regarding all aspects of their lives including sexuality and reproductive
- Promote Behaviour change to enable men and women to be safe from HIV and men to be responsible and equal partners in prevention of HIV
- Reduce the prevalent stigma and discrimination especially in the health care settings

### **Purpose**

The above guidelines for HIV programmes which are oriented towards HIV related needs and issues of women, represents the commitment of National AIDS Control Organization (NACO) to address issues of gender inequality in the context of HIV and AIDS. The guidelines will inform the formulation of all policies and programmatic interventions of NACO.

The purpose of these policy guidelines is to facilitate increased and improved action on the intersecting issues of HIV and AIDS and women by the National AIDS Control Organisation; State AIDS Control Societies (SACS); District AIDS Prevention and Control Units (DAPCUs) and all development partners.

The guidelines have been developed and framed in consultation with policy and programme personnel from the government, civil society including people living with HIV, women's organizations and the UN system.

The policy may be periodically reviewed by a Committee comprising representatives from the government, development partners and civil society.

### **Objective**

The objective of this framework is to develop and implement mechanisms to halt and reverse the spread of HIV among women and girls. In particular, the policy aims to provide a framework which serves to enhance equitable access of services to women living with HIV, as well as to curb the spread of HIV infection among women and girls, such that all aspects of governance are oriented to the needs of women infected and affected by HIV and AIDS and / or vulnerable to the infection.

**A gender sensitive approach** recognizes that women and men differ in terms of both sex and gender. Such an approach, therefore, has the potential to define appropriate interventions for women and men according to their specific needs, thereby making interventions more effective and enhancing health outcomes.

### **Guidelines for Action**

#### ***All HIV prevention and care interventions, with a focus on women, will be based on:***

- Application of the understanding of the different concerns, experiences, capacities and needs of women/girls and men/boys in both rural and urban settings.
- Acknowledgement of diversity in sexual practices and behaviors prevalent in communities. Service providers will respect the rights of women and girls belonging to all stratas of society, especially those who are marginalized, like sex workers and so on. Ensuring their dignity and empowerment will be a key strategy to enable safer practices among such groups in a sustained manner. There is a need to transgress the gender divide between men and women, to move towards a continuum of femininity and masculinity.
- Ensuring men's role as equal partners and not that of adversaries in change.
- Reduction of HIV related violence, denial, stigma and discrimination against women, along gender dimensions.
- Application of culture specific and equality based development approaches that are tailored to the specific populations groups in which it is used.
- Formulation of short and long-term strategies from the community to the national level.

#### ***All HIV prevention and care interventions, especially for women, will ensure:***

- More emphasis on providing an enabling environment for women and girls and men and boys to adopt safer practices, access equal and substantive opportunities for livelihoods and basic services and participate in public life.
- Provision of special attention to women, girls and individuals from key populations to ensure easy and equal access to quality care, treatment and information for them.
- Non judgmental advocacy and IEC communication to consciously refrain from reinforcing gender stereotypes, in order to develop an enabling environment.



- Implementation agencies at all levels to have adequate and appropriate skills (human, technical and financial)
- Developing policies for effective integration in service delivery e.g. integrated delivery of reproductive health service along with HIV services wherever possible, in order to increase access.

***Strategies to ensure successful implementation of above interventions:***

- Training and capacity building- which will include mandatory training on gender & sexuality and its links with HIV with the specific objective of facilitating internal attitudinal as well as behavioral change among participants. Training programmes will include discussions on social, cultural norms (for e.g.: with regard to masculinity/ femininity, power relation between men and women), sexual & reproductive health/rights and harmful traditional practices that increase the vulnerability and impact of HIV and AIDS on women.
- Enhanced and increased support to the social mobilization programmes and processes which have been successful at the grass roots level in formulating functional collectives, especially of women and socially excluded and poor sections of the society.

***All HIV prevention and care intervention, especially for women, will be strengthened by:***

- Skills enhancement in gender analysis and planning; the capacity to collect and interpret sex-disaggregated data; availability of adequate, sustained and quantitative human, technical and financial resources.
- Supporting programmatic and legal interventions to address all forms of discrimination against women/girls, such as gender based violence including sexual violence, trafficking of women and girls, child labour, forced marriage, sexual and economic exploitation, sexual harassment at the workplace(both formal and informal sector, including domestic workers) that increase their vulnerability and exacerbate the impact of HIV and AIDS.
- Assisting policy makers, and government functionaries to respond in a gender sensitive manner to human rights abuses, discrimination and gender based violence within the context of sexual health and HIV

- Promoting socio- cultural and economic rights of women and girls, enhancing their access to safety nets, ensuring their right to education, nutrition, health , livelihood, land and other resources in the family rights and socio-legal protection
- Ensuring that all partnerships and alliances are based on a common understanding of rights framework and an unequivocal commitment and adoption of this gender policy.
- Developing an M&E framework to ensure accountability for all sectors of government, implementing partners and programme managers for the implementation of this framework in letter and spirit.

The complete and sustained implementation of the above policy guidelines will ensure gender sensitive governance of the National AIDS Programme, leading to enhanced systems, structures and programmes to address the HIV vulnerabilities of both men and women adequately and effectively. The effective and timely implementation of these policy guidelines will ensure empowerment and increased agency of women and girls based on equality, respect and informed decision making which will serve to reduce the gender based heightened vulnerability of women and girls to HIV and mitigate the impact of the infection.

#### **Attached annexures for guidance on implementation**

Annexure 1- A checklist which will help planners, and implementers to monitor whether and to what extent the gender sensitive approach to HIV prevention and care is being implemented.

Annexure 2- A plan for capacity building of relevant stakeholders to assist them to adopt the gender sensitive approach to HIV prevention and care

Annexure 3 – An action plan for Government ministries, civil society and private sector, to adopt a gender sensitive approach to their work in HIV prevention and care

### **Annexure 1**

#### **Suggested Checklist**

A checklist has been designed to mainstream gender equity considerations in HIV programmes. This checklist will serve as a tool to assist in monitoring and reporting upon

gender mainstreaming activities. This checklist is complementary to the *Gender and HIV Policy of NACO*

### **Gender training and briefing sessions**

- Have the needs of NACO/SACS/DAPCUs/IPs personnel for training or information on gender mainstreaming been identified?
- Have these needs been analysed so as to identify the most effective means of meeting them (training, briefing, weekly consultation, one-on-one discussion, etc.)?
- Has training or capacity building been provided to meet these needs?
- Have relevant documentation and training materials been identified and provided?
- Is gender equality information systematically prepared and presented at meetings, in order to ensure productive discussion of gender issues and learning by participants?
- Are training methodologies monitored for gender sensitivity, especially in order to neutralize impact of discriminatory attitudes among trainers?
- Have appropriate monitoring mechanisms to measure the impact of training on improved performance been established?

### **Priority Setting**

- Has relevant gender information, especially socio-economic information been identified and collated in such a way as to be included in country programming planning discussions?
- Is background data/situation analyses disaggregated by age, sex and ethnic origin?
- How far have gender specialists and representatives of women, men & transgender at all levels been consulted throughout the process?
- Has attention been paid to the inclusion of gender equality concerns in macro-economic and public administration programming in particular, including the linkages between micro, meso and macro levels of analysis and policy-making?

### **Project and programme formulation**

- Have gender issues relevant to each project/programme, including gender impact and anticipated outcomes, been systematically identified, and updated as appropriate through periodic interactions with concerned communities?

- How far have individuals, women's groups, NGOs, PLHIV with knowledge and experience of gender mainstreaming participated in project identification, formulation and appraisal?
- Have infected & affected women, especially female beneficiaries, been consulted equally with men and transgender during the project/programme formulation process?
- Has the proportion of financial resources allocated to the attainment to empower young girls, women and sexuality minorities been clearly indicated? How has the allocation been used to achieve the desired gender outcomes. i.e. Undertake expenditure analysis ?
- Has all background information been disaggregated by age, sex, and ethnic origin?

### **Project and programme implementation**

- Has gender balance in project trainings been ensured?
- How far has gender balance among participants in all consultations been attained?
- Do Programme and Project Evaluation Reports reflect gender issues, and is all information disaggregated by gender, sex & ethnic origin?
- Do final project reports systematically identify gender gaps and gender-related project successes?
- Do NACO/SACS/DAPCUs/IPs personnel monitor project disbursements to ensure that inputs are used in such a way as to ensure equality of outcome for women, transgender and men project/programme beneficiaries?
- Have new structures, mechanisms, and processes been put in place within NACO in order to guide, plan monitor and evaluate the process of mainstreaming gender into all areas of NACO's work?
- Has there been refocusing of direction and a shift in emphasis in light of gender and HIV & AIDS framework?

### **Gender sensitive project/programme evaluation**

- Do evaluation mission terms of reference require relevant gender expertise and experience?
- Are evaluation mission members briefed on relevant gender issues and provided with documentation?

- How far are the conventional knowledge about gender & sexuality challenged by narratives of diverse groups?
- Do relevant personnel review the draft evaluation report to ensure that gender-related omissions and successes in the project/programme are reflected?
- Do relevant personnel understand and apply process indicators of success?

**Special events (workshops, seminars, press conferences, launchings, receptions, etc.)**

- Have gender equality priorities been reflected in the selection of topics and agendas for special events?
- Are there consistent mechanisms in place to ensure that women, transgender and men participate equally in special events as speakers, chairpersons, decision-makers etc. and are equally consulted during preparations and follow-up?
- Are all participants made aware of the gender dimensions of the special event, through background documentation, presentations, agenda-setting and through the discussions at the meeting?
- Is the press routinely informed of the gender dimensions of NACO/SACS/DAPCUs/IPs special events?
- Has the press been fully briefed on NACO/SACS/DAPCUs/IPs gender equality priorities and gender-related activities?

**Annexure 2**

**CAPACITY DEVELOPMENT PLAN**

**MAINSTREAMING GENDER AND HIV  
IN MINISTRIES**

**(2008 – 2010)**

**NATIONAL AIDS CONTROL ORGANISATION  
Government of India  
2008**

## **Capacity Development Plan**

This document introduces the framework of operational guidelines for addressing gender in specific components of the National Project Implementation Plan for HIV prevention, treatment care and support. Owing to widely divergent situations obtaining across the country, an effective programme needs to be decentralised and based on local situation and locally felt needs. This operational guideline has made an attempt to identify key issues that need to be addressed in order to establish a gender-sensitive response to the HIV/AIDS epidemic in the country and also suggests key elements in order to catalyse the prevention and control programme. Translating these operational guidelines into reality will need to be preceded by intensive sensitisation and training of all categories of staff at the national, state and district levels to enable a deeper understanding of gender issues in their programme context and to enable a gender-sensitive response.

This plan encompasses the following:

- Strategic Training Plans to integrate gender concerns of HIV in the ministries / departments of health, women and child development and youth affairs and Sports
- Guidelines for Gender-specific situation analysis for implementation of programme package for targeted interventions and the general population.
- Guidelines for Programmes for the Care and support Needs of women infected or affected by HIV
- Gender blenders in the communication and advocacy package
- Gender checklist for monitoring and evaluation of each programme component in its qualitative and quantitative parameters.

It is imperative that the capacity development takes a sequential view for mainstreaming gender in the NACP-III. It begins with proposing an orientation plan for all key functionaries at the state and district levels, followed by a state-level gender analysis of the state Programme Implementation Plan. The framework of the capacity development plan is to support them further in a focused manner in order to mainstream gender-centric programming in all thematic areas – both in training and capacity building of providers and in the NGO-supported programme for community level intervention. The matrix that follows is an effort in this direction. Although it is recognised that for actual implementation certain tools will need to be developed for facilitating rollout of the capacity development plan, strengthening of state-level functionaries will be necessary for gender mainstreaming, without which the capacity development plan shall remain a partial exercise.

The framework for the proposed capacity development plan for mainstreaming gender in the National AIDS Control Programme phase-III (NACP-III) is as under:

	<b>N A C P - I I I C o m p o n e n t P r e v e n t i o n / C a r e / S u p p o r t / T r e a t m e n t</b>	<b>Proposed Plan (what and for whom)</b>	<b>Action to address gender issues (process / methodology)</b>	<b>Required and or available resources and tools</b>
1	Prevention / care / treatment	1. State-level capacity building of SACS and Directorate of line department officials  Gender mainstreaming under the NACP-III and the NRHM/RCH-II action plan	<ul style="list-style-type: none"> <li>One-day reorientation of officials.</li> </ul> (It is proposed that such reorientation be done during their coordination meeting. Since, only a one-day meeting might not be sufficient, follow up meetings of two to four hours of orientation needs to be positioned as part of ongoing programmes every year.)	Orientation Package on Gender and HIV/AIDS to be prepared  Expected outcome: Better understanding of mainstreaming gender and issues and barriers in utilisation of services by different group of people
<b>Gender mainstreaming in the training of frontline workers of the Ministries of Health and Family Welfare, Women and Child Development, and Youth Affairs and Sports, etc.</b>				
2	Prevention / care / treatment	1. Joint planning for convergence related interventions involving the District AIDS Prevention and Control Unit / District Resource Persons, the Ministries of Health and Family Welfare and Women and Child Development and the	Planning meeting/ core group meeting while implementing Programme Implementation Plan under NACP-III and the NRHM/RCH II with the involvement of key stakeholders, especially	Block/ district health action plan with gender lens after the orientation has been carried forward.  Outcome:- better state / district level



ICDS for voluntary counselling and testing centres, prevention of parent to child transmission of HIV centres, partner notification, and counselling for SRH needs of positive people.

- Gender blender in key training programmes of frontline workers
- Training of ANMs and skill-based attendants on RTI/STI, adolescent friendly sexual and reproductive health
- Immediate training of ASHAs, trained birth attendants on integrated management of neonatal and childhood illness
- Training of anganwadi workers
- Vitamin A supplementation, Kishori Shakti Yojana, ICDS
- Training of Nehru Yuva Kendra Sangathan volunteers and their district coordinators

2. Physical services:

As envisaged by the line Ministries, SACS/ District AIDS Prevention and Control Unit to coordinate expansion of services like availability of services at the

positive women and people living with HIV/AIDS.

Emphasis on accessibility and availability of services to all including women, men, marginalised people, adolescents and unmarried young persons. Training of trainers for master trainers to sensitise them on needs of different people, especially the weaker / marginalised section, HIV-positive women and people living with HIV/AIDS in general.

In coordination with the respective line Ministries

planning

Since all training tools have already been prepared, a self learning manual (a ready-reckoner on gender and HIV) is to be prepared for master trainers. This, along with a two-three page handout may be used for training of frontline workers.

Gender sensitive micro-planning exercise for locating health care services strategically, along with the prevention programme sites (to be done at the time of implementing district Programme Implementation Plans and block /district health action plans: this district Programme Implementation Plan should be developed from a gender perspective, in consultation with the SACS.

NACO training manuals for voluntary counselling and training, prevention of parent to child transmission of HIV, etc. should be suitably reinforced for use by RCH workers.

Training programmes using participatory methods, role plays and case analysis. Gender games to be included in the skill building manual in the existing training programmes for

		<p>primary health centre level, integration of prevention of parent to child transmission of HIV in safe motherhood initiatives – MCH programmes to include breastfeeding etc, cervical cancer screening, counselling and RTI/STI services at the PHC/CHC.</p> <p>4. Involvement of men in sexual and reproductive health</p>		frontline workers.
			Capacity building for life skills sexual and reproductive health needs, risk assessment for HIV/STI, communication skills for dealing with sexual and reproductive health issues of men, and internalising life skills.	
<b>Targeted interventions among high-risk groups and the general population</b>				
3	Prevention	1. Capacity building for gender analysis and incorporation of the findings into interventions for target groups and the general population	State-level expert consultation: half-day consultation meetings for every targeted intervention / general population programme	Analysis tool is attached as an Annexure 1

Needs of women living with and affected by HIV				
4	Care / Support	<p>1. Formation of HIV-positive women's networks at the district level</p> <p>2. Equal representation of HIV-positive women in the national / regional, larger HIV-positive networks</p> <p>3. Developing criteria for accrediting HIV-positive networks</p> <p>4. Positive women in decision-making role</p> <p>5. Mainstreaming HIV related services in community based organisations and involvement of infected and affected women in existing community based organisations</p> <p>6. Support to affected and positive</p>	<p>Facilitation of HIV-positive women's networks by SACS and the District AIDS Prevention and Control Unit</p> <p>Organise leadership and skill building workshops for positive women; capacity building for developing proposals, managing and implementing programmes that are sensitive to people living with HIV/AIDS</p> <p>Extend financial and technical support for formation of HIV-positive women's networks</p> <p>Invite HIV-positive women to advocacy workshops</p> <p>Accreditation guidelines for positive networks</p> <p>Representation of HIV-positive women in the NACO and other decision-making bodies</p> <p>District AIDS Prevention and Control Unit support to community based</p>	<p>Gender-sensitive recruitment policy in the NACO, the SACS and the District AIDS Prevention and Control Unit, with scope for including qualified positive women in key bodies at the state and district levels</p> <p>Operational guidelines for the SACS and the District AIDS Prevention and Control Unit, with gender checklist</p> <p>Gender-sensitive capacity building of civil society representatives and sensitising them on specific livelihood needs of positive women</p> <p>Training curriculum under Mahila Samakhya to be revised with gender content, as necessary.</p> <p>Gender-sensitive guidelines and training for Panchayat members</p> <p>Guidelines for the National Steering Committee under public-private partnership with gender perspective</p> <p>Inter-sectoral coordination meeting with HIV-positive women's representatives</p>

		women	<p>organisations for sensitising Panchayats and Mahila Mandals on HIV-positive women's issues</p> <p>Roll out of credit facilities from banks for community based organisations that have mainstreamed infected and affected women and are working for savings and credit</p> <p>Sensitisation of representatives in inter-sectoral coordination on socio-economic needs of positive women</p> <p>Facilitation and advocacy of health insurance cover for people living with HIV/AIDS, especially HIV-positive women</p> <p>Promotion of micro-finance schemes</p>	Specific guidelines for extending support for HIV-positive women
<b>IEC, Advocacy and Communication ( See Annexure 2)</b>				
5	Prevention	1. Address gender equality, human rights and vulnerability in all tools designed for IEC advocacy and communication	Discussion through orientation training and capacity building of functionaries in the NACO, SACS and the District AIDS Prevention and Control Unit in	Advocacy kit, IEC toolkit, audiovisual aids, and folk art in the form of puppetry and street theatre with tailored scripts should be developed, keeping the gender perspective in mind as well as

Treatment	<p>2. Understand vulnerability to HIV as a step towards prevention of spread of the epidemic</p> <p>3. Address links of HIV prevention and control with gender-based violence, socialisation processes and messages for a more egalitarian family, enhanced partnerships with men and the communities</p> <p>Non-discriminatory attitude needs to be adopted against all segments and target groups, people living with HIV/AIDS, high-risk groups, bridge populations and the general population</p>	<p>order to facilitate usage of tools suggested alongside</p> <p>Analysis of IEC material etc. from the gender / rights perspective</p> <p>Critical evaluation of media messages and TV spots (by the NACO, SACS and the District AIDS Prevention and Control Unit), e.g., on HIV prevention through common gender-based guideline</p> <p>Sensitisation of media managers, media houses, health care providers and IEC programmers in the NACO, SACS and the District AIDS Prevention and Control Unit</p> <p>Lay emphasis on inter-spousal communication through dialogue and discussion to reduce stigma and discrimination</p> <p>Weave in the element of responsible male participation in the IEC, Advocacy and Communication strategy for enhanced accessibility of treatment services</p>	<p>involvement of men (needs some form of standardisation)</p> <p>Customised and gender-sensitive advocacy and IEC toolkit for community outreach workers and health care service providers</p>
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Care and support	women's networks in all A and B category districts and ensuring their representation in the state Programme Implementation Plan to help fight stigma and discrimination	Integration plan through representation in the Action Plans of the state, the district and other bodies	Operational guidelines, along with attached checklist, for accreditation of such networks
Monitoring and evaluation	4. Integration plan through inclusion of suggested indicators into the reporting format at the SACS and the DPACUs	Gender sensitisation training of the existing MIS staff at the SACS and the District AIDS Prevention and Control Unit levels to help understand gender and why gender mainstreaming is important from the point of view of data collection	Reformulating existing formats from the gender perspective to collect information on the list of monitoring indicators suggested in the NACP-III. This format needs to be developed, if not developed.

**Annexure 1 - Gender Checklist- for programmes of targetted intervention and for general population**

Analysis	<p>Which gender iniquities exist in the area of intervention of the project?</p> <p>Do men, women and transgender persons among the target group have different problems and demands/needs?</p> <p>Do gender-related obstacles exist insofar as participation is concerned? If so, which are these?</p>
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Objectives	Which objective relating to gender equality is included in the project objectives?
Realisation	<p>Is the same opportunity for access and participation/control guaranteed to all persons regardless of genders?</p> <p>How is it being ensured that all persons regardless of gender benefit from the project in the same manner and to the same extent?</p> <p>How is reproduction of gender inequities being avoided by the project?</p> <p>How does the project contribute to a reduction in gender inequities?</p>
Evaluation	<p>Are all data and results being compiled in a gender-segregated way?</p> <p>How will achievement of objectives relating to gender equality be evaluated?</p>

Adapted from the website [http://www.wecf.de/cms/download/20042005/Gender\\_Tools\\_final\\_version.pdf](http://www.wecf.de/cms/download/20042005/Gender_Tools_final_version.pdf) accessed on March 28, 2007

**Annexure 2 - Gender mainstreaming in advocacy and communication in NACP-III**

Target audience	Segment	Objective	Message	Gender blender	Outcome
Priority 1					



High-risk groups	Commercial sex workers, intravenous drug users, men having sex with men	Behaviour Change from casual, multiple partner, unprotected sex Reassurance through enabling environment	Use condoms Opt for STD Treatment and ICT services Supportive Environment	As a triple protection mode. SRH rights, of women, tools to address inter-spousal communication and Adolescent girls (girl child in certain cases)	Awareness among women about HIV/AIDS to propel behaviour change. Behaviour Change to use Condoms Increased STD check-ups Increased off-take of integrated counselling and testing services Environment – empathetic and non-abusive non discriminatory and non stigmatised against women
Bridge populations	Clients of commercial sex workers, truckers, migrants	Behaviour change from casual, multiple partner, unprotected sex, being faithful to partner / wife	Use condoms, opt for STD treatment and integrated counselling and testing services	Draw perspective of responsible partner to wife / commercial sex worker, highlight risks and vulnerabilities to trafficking, sexual abuse and commercial sex work	Same as above
<b>Priority 2</b>					

General population	Youth Women	Awareness generation about personal risks and safe behaviour	<p>Youth – abstinence / be faithful delay sexual debut, use condoms</p> <p>Women – be aware of the need for husbands to use condoms, about STD/ integrated counselling and testing and prevention of parent to child transmission of HIV</p>	<p>Awareness facilitating behaviour change. Positive health seeking behaviour (rights based) with particular reference to SRH.</p> <p>Negotiate for condom use – triple protection phenomenon.</p>	Same as above
	People living with HIV/AIDS	Networking and utilisation of services	Non-stigmatisation and social acceptance friendly environment to live and work	<p>Safe supportive work place environment positive women and those affected. (Widows, destitute) and other gendered identities.</p> <p>Non discrimination and stigmatisation for women, young girls and other gendered identities (HIV/AIDS infected and affected)</p>	<p>Better-enabled environment for networking, care and support for women girls and other gendered identities.</p> <p>Motivating more HIV-infected and affected people; (women, adolescent girls and other gendered identities) to opt for integrated counselling and testing, ART</p> <p>Better work place environment for all the above segments of pop.</p>

	Children (street children, runaways, child labour)	Awareness of HIV/AIDs and danger of sexual abuse Acceptance of NGOs working for their health/STD check-ups, etc	Friendly environment Safe houses Freedom from harassment	Draw attention to the girl child (right to protection, CRC), risk/vulnerabilities to sexual abuse (commercial sex workers, paedophiles, pornography, etc.) Address age at marriage and early sexual debut.	More protection from sexual abuse and hence, STD/HIV infection and rights violation. More awareness about need to seek check-ups if abused Awareness about condoms
	Tribal populations (different ethnic groups and in different areas)	Awareness of safe sex and the need to use condoms. Behaviour change.	Use condoms. Opt for STD treatment and integrated counselling and testing services.	Highlight women's right to SRH. Risks of casual, multi-partner relationships. Introduce and promote condom use and accessibility.	Awareness about HIV/AIDS and behaviour change. Awareness of STD/ integrated counselling and testing.
<b>Priority 3</b>					
Service providers and healthcare workers	Hospital staff NRHM / RCH / RNTCP / STD / VCT	Sensitise / improve attitude to People living with HIV/AIDS offer better quality service	Training and capacity building	To be sensitive towards the needs and rights of women adolescent and other gendered identities. Gender friendly service delivery.	Better quality care and service delivery which creates better off-take amongst women, young girls and other gendered identities. Better synergy between different programmes. Higher motivation levels among staff. Upgraded knowledge and efficiency levels.
Blood banks	All staff	Sensitise to blood safety issues and the need to	Training and Capacity Building	Gender friendly approach. Respect their specific needs and identity, and	Same as above

		improve quality, promote voluntary blood donation		facilitate responsible positive health seeking behaviour.	
<b>Priority 4</b>					
Mainstreaming and multi-sectoral Partners	Government, Ministries, Departments . Other government services, corporate sector, PSU	Include HIV/AIDS into their communication efforts, programmes, human resource policies, community welfare programmes	Sensitisation through top level Government / NACO meetings, workshops, etc.	Gender-sensitive human resource personnel and field staff. Orientation exercise on women's issues, adolescent girls and other gendered identities Advocacy communication kit addressing the above mentioned	Wider scope to tackle gender specific issues Awareness generation about HIV/AIDS, promote behaviour change, in favour of women and other gendered identities. Create policies which support programmes and initiatives around HIV/AIDS
Social mobilisation and advocacy Community involvement – leaders and influencers	All sections of society organisations, clubs and media	Create an environment to discuss HIV/AIDS and safe sex	Sensitisation Through Media, Local Influencers, Youth	Understand women's vulnerability Garner collective efforts with male partnership in responsible behaviour Facilitate behaviour change. (beyond awareness)	'Normalisation' of the topic of sexuality and behaviour Change and the word "condom" More public involvement in spreading awareness about HIV/AIDS No stigma for people living with HIV/AIDS.

### ANNEXURE 3 - Gender Mainstreamed Indicators for Monitoring and Evaluation

The list of the M and E indicators below is from the NACP III PIP document)

<b>SN</b>	<b>List of indicators by components</b>	<b>Add-on indicators by including the Gender Component, which correspond to the Gender Checklist</b>	<b>Bodies / Departments responsible for making the component operational</b>	<b>Level of analysis N = national S = state D = district</b>	<b>Source for information</b>	<b>Frequency of indicator generation</b>	<b>Current status of indicator: generated (Y) or not generated (N)</b>
1.	Prevention and enabling environment						
1.1	Preventive interventions for high-risk groups (targeted interventions)						
4.	Percentage of injecting drug users (segregated into male, female and other gender) reporting access and use of condoms at last sex		Report on condom utilisation and SACS	N/S	Behaviour surveillance survey of high-risk groups	Once in three years	Y
8.	Male sex workers, female sex workers and men who have sex with men having STI symptoms and seeking services for self / partner(s) from qualified and gender-sensitised medical providers, expressed as a percentage of the general population of men / women		Women and Child Development Department, SACS and reports of service providers	N/S	Behaviour surveillance survey of high-risk groups and general population of men	Once in three years	N
15	Number of HIV-positive people (segregated into male, female		Women and Child	S	Computerised Management	Quarterly	N

	and other gender) among the high-risk group in targeted interventions and in the general population, who receive ARV treatment and nutritional supplement support		Development Department, SACS, targeted intervention NGO reports and reports of service providers		Information System, ART centre		
17	Number of SACS, DACS and NGOs that have members drawn from among high-risk groups and people living with HIV/AIDS (segregated into male, female and other gender) on their decision-making bodies to ensure participation and representation		State AIDS Control Societies, District AIDS Prevention and Control Units	S/D	Sentinel surveillance	Annual	N
1.2	Interventions for vulnerable populations (women, children, adolescents, migrants, trafficked persons and workers)						
	b) Youth						
21	Percentage of youth (segregated into male, female and other gender) who have accurate knowledge of HIV/AIDS (who recall three modes of transmission, two modes of prevention, understand gender related human rights and gender-based vulnerability, and who can reject			N/S	Behaviour surveillance survey of youth	Once in two years	N

	major HIV related misconceptions)						
	d) Migrants						
29	Percentage of male migrants, their wives / female sexual partners and wives of potential migrants, who have accurate knowledge of HIV/AIDS (who recall three modes of transmission, two modes of prevention, and who can reject major misconceptions about HIV transmission)		Ministry of Women and Child Development / anganwadi workers and District AIDS Prevention and Control Units / Targeted intervention NGO reports	N/S/D	Behaviour surveillance survey of migrants	Once in two years	N
1.3	Package of services						
	b) Voluntary Counselling and Testing Centres / integrated counselling and testing						
44.	Percentage of male sex workers, female sex workers, men who have sex with men and injecting drug users (segregated into male, female and other gender), who have undergone HIV testing in the last 12 months, know their results and are getting their partners tested (rights-based approach)		District Hospital / Voluntary Counselling and Testing Centre data	N/S	Behaviour surveillance survey of high-risk groups	Once in three years	N
	c) Prevention of parent to child transmission of HIV						

54.	Percentage of women in prevention of parent to child transmission of HIV/ANC who are HIV positive, are aware of their status and have male involvement (rights-based approach)		Data from anganwadi workers / Ministry of Women and Child Development  and prevention of parent to child transmission of HIV services	N/S	Computerised Management Information System	Monthly	Y
1.4	Condoms						
61	Percentage of persons by all genders reporting consistent use of condoms with regular and non regular partners in the last 12 months	Add on: percentage of young boys and girls having increasing access to male and female condoms and reporting consistent use.  Add on: Percentage increase in more young men and	NGO reports on social marketing of condoms, and Youth Clubs / Nehru Yuva Kendra Sangathan  Ministry of Women and Child Development and State AIDS Control Society	N/S	Behaviour surveillance survey of the general population	Once in three years	Y



		women being aware of their reproductive and sexual health and rights.  Add on: increase in more young women to be able to negotiate safety in sexual behaviour with regular and non-regular partners.	through qualitative measures such as focused group discussions, in-depth interviews				
66.	Percentage of persons (males and females) reporting availability of condoms within 15-minute walking distance			S	Behaviour surveillance survey	Once in three years	Y
6 1. 6	Communication and social mobilisation						
74.	Urban and rural specific and marginalised population to whom the IEC message that 'each one of us are vulnerable' is being reached, expressed as a percentage of the general population (segregated by male, female and other gender)		District AIDS Prevention and Control Unit reporting	N/S	Behaviour surveillance survey of the general population	Once in three years	Y

76.	Percentage of students (girls and boys) covered under the Adolescence Education Programme, including life skills (coping and negotiation skills). (target: raise from 30% in 2005 to 100% by 2011)		Ministry of Youth Affairs and Sports	N/S	Computerised Monitoring Information System	Quarterly	Y
77.	Percentage of out of school youth (both boys and girls) reached by HIV awareness programme, including the SRH component (target: raise from 10% in 2005 to 100 by 2011)		Ministry of Youth Affairs and Sports (Scouts and Guides wing)	N/S	Behaviour surveillance survey among out of school youth	Once in two years	N
79.	Percentage increase in media coverage on HIV/AIDS issues (sexuality / legal issues), increased vulnerability of women to HIV and positive messaging on gender, sexuality, HIV and masculinity issues targeting men and the other gender		Nehru Yuva Kendra Sangathan	S	Press and TV audits	Annually	N
2.	Care, support and treatment						
80.	Total number of HIV+ people (male, female and other gender, including the marginalised population) having access to HIV care and support		District Hospital report / Ministry of Women and Child Development / State AIDS Control Society	N/S/D	AHSS and modelling	Annual	Y
2.3	Establishing paediatric ART						

	services						
94.	Number of children (segregated into male, female and other gender) requiring ART		ART centre	N/S/D	Sentinel surveillance	Quarterly	N
2.4	Integration of prevention with care, support and treatment						
98.	Number of people living with HIV/AIDS enrolled by gender in a district network (target: raise from 10% in 2005 to 100% by 2011)	Add on: number of positive women's network in all A and B category districts	Ministry of Women and Child Development and State AIDS Control Society	S/D	Computerised Monitoring Information System	Quarterly	N
2.7	Greater involvement of people living with AIDS						
103	Number of decision-making bodies at the national, state and district levels and NGOs working in the field of HIV that have people living with HIV/AIDS (male, female and other gender) representatives.		NACO, State AIDS Control Society and NGO reports	N/S	Sentinel surveillance	Twice in three years	N
2.8	Stigma and discrimination						
3.1	Capacity strengthening						
111.	Number and proportion of staff imparted induction and refresher training on gender, rights, HIV counselling, male involvement, stigma and discrimination, etc.– in respect of blood banks, laboratories, facilitators for workplace interventions, counsellors, doctors, technicians	Add on: trainings shall be recommended as separate set of indicators.	Ministry of Women and Child Development and State AIDS Control Society	N/S/D	Computerised Monitoring Information System	Monthly	N

	and nurses in Voluntary Counselling and Testing Centres, centres for prevention of parent to child transmission of HIV and PHCs/CHCs, Strategic Information Management System staff and ART staff						
3.2	Mainstreaming						
113.	Number of states having a coordinating committee with female representation	Add on: number of states having a Monitoring and Evaluation Committee responsible for gender mainstreaming	State AIDS Control Society and District AIDS Control and Prevention Unit	N/S	Sentinel surveillance	Annual	N
4.0	Strategic Information Management System						
116.	Number of State AIDS Control Societies generating a report every quarter that includes (i) gender sensitive monitoring indicators and checklist, and (ii) findings on the ongoing/concurrent evaluation with gender perspective		Monitoring and Evaluation Section in the State AIDS Control Society and in NACO	N	Computerised Monitoring Information System	Quarterly	N
122.	Proportion of districts with gender sensitised monitoring and evaluation staff in position		State AIDS Control Society	S/D	Computerised Monitoring Information System	Annual	N



**Annexure 3**

**ACTION PLAN**  
**MAINSTREAMING WOMEN AND HIV**  
**IN MINISTRIES, CIVIL SOCIETY and PRIVATE SECTOR**

**NATIONAL AIDS CONTROL ORGANISATION**  
**Government of India**  
**2008**

## **Background**

A key underlying principle of HIV prevention and care programme is the empowerment of women, based on the understanding that when women have more autonomy, they may be better able to make decisions on issues that concern their lives. The empowerment of women hinges on a number of factors including awareness, information & knowledge, skills, economic viability & independence, control over resources, mobility and decision-making power.

The motivation for, and commitment to, responding to HIV and AIDS is underscored by core values that guide both what and how an organization works. At the centre of all development work is the commitment to:

- valuing human life;
- respecting the dignity of all persons;
- respecting diversity and promoting the equality of all people without distinction of any kind such as sex, race, colour, age, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV AND AIDS), sexual orientation or civil, political, social or other status;
- preventing and eliminating human suffering;
- supporting community values that encourage respect for others and a willingness to work together to find solutions, in the spirit of compassion and mutual support; and
- addressing social and economic inequities and fostering social justice.

These values are common to the work of governments, civil society and private sector, in responding to HIV AND AIDS. Many of these same values also find expression in the Universal Declaration of Human Rights.

**The action plan for ministries, civil society organizations and private sector aims at increasing both access and equity for women and girls.**

## **ACTION PLANS FOR MINISTRIES**

The National Council on AIDS, chaired by the Prime Minister of India, mandates 31 ministries to integrate HIV into their ongoing development activities. The key focus of this integration needs to be issues related to HIV prevention and care for women, who are key beneficiaries of many government programmes and schemes.

This action plan recommends key steps to be taken by different ministries and identifies entry points across select schemes of the key ministries to empower women by promoting economic security, information and awareness and decision making.

Working towards empowerment of women is a cross cutting theme for all development activities under the 11<sup>th</sup> 5 year plan. However, this assumes greater importance in the context of HIV, and urges Ministry level decision makers to take prompt actions: women are becoming increasingly vulnerable to HIV for a variety of reasons, and this is especially affecting younger women and girls.

The UN Millennium Declaration, and the goals it sets, highlight the interconnectedness between development goals and the need to address the causes of vulnerability to HIV AND AIDS and its impacts, by alleviating poverty through sustainable development, the promotion of gender equality and access to education.

### **Recommendations**

- In addition to ongoing gender analysis of development programmes of Government of India, programmes also need to be analyzed in from the HIV perspective. As we know, if HIV continues to spread, it will reduce the gains from other development activities.
- Trainings must include Gender issues, women's empowerment issues and where possible linkages between sexuality and HIV. All the trainings must accommodate concerns of sexual minorities and address attitudinal change. Messages should be relevant to men and women, boys and girls. Men should be part of the programmes as partners for change; they should be sensitized to take responsibilities in the prevention of HIV.
- If required, business development, enterprise management and vocational skills should be provided to persons living with HIV and AIDS (PLHIV) after conducting aptitude/qualification tests.

### **The following indicators could track the progress of this action plan:**

- All levels of staff ( Ministry, institution & work site) are aware of gender in general and vulnerabilities of women and girls to HIV AND AIDS in particular
- Number of identified schemes of ministries amended to include women and HIV related concerns and activities and subsequently monitored for achievement of results
- Number of ministries reporting on women and HIV in their respective sectors
- Number of training programmes which have substantive sessions and course material dealing with women and HIV AND AIDS

### **Following are the suggested areas of intervention for different ministries:**



<b>R u r a l Development</b>	<p>Through Self Help Groups (SHGs), could reach positive members to equip them with relevant information, provisions of income generating assets and better access to services to reduce their vulnerability to the infection</p> <p>Mainstream HIV component in all the trainings</p> <p>As regards employment opportunities, advocacy efforts could be oriented towards positive women and men, with a special focus on the female headed households</p> <p>Ensure reduction of stigma and discrimination against positive women and men as well as devise special work options for PLHIV to suit their needs</p> <p>The ministry could also contribute towards empowering women in terms of HIV and AIDS by ensuring provisions for rehabilitating positive persons, especially HIV positive widows dispossessed from their homes due to their HIV status.</p>
<b>P a n c h y a t i R a j Institutions</b>	<p>Could collaborate with networks of PLHAs, and NGOS working on issues of HIV to strengthen efforts towards empowering women in relation to HIV. Also, by organizing sensitization camps on HIV during Sannelan (state as well as district levels), the PRIs could help to raise concerns pertaining to positive women and men at the appropriate fora</p> <p>Further, the ministry could undertake to disseminate gender sensitive information on HIV at the State support centres as well as through incorporation of HIV component in the training modules and among staff member through sensitization workshops.</p> <p>The ministry could undertake to create peer educators through a training of selected youth regarding access to condoms and the skills to correctly use them, user-friendly STI services, voluntary counseling and testing (VCT), and other resources for reproductive and sexual health. To provide referrals to these services, outreach, peer education, media, hotlines, and information, education, and communication (IEC) materials could be used.</p>
<b>Tourism</b>	<p>The ministry could focus its efforts towards promoting socially responsible tourism and developing guidelines for the same, with a focus on HIV prevention, in the context of the dynamics between gender and HIV. In this regard, it could intensify existing campaigns to expand the reach of messages on safe tourism with respect to HIV</p>

Through advocacy efforts with hotels, tour operators and hotel associations, the ministry could undertake to make condoms available for clients.

Through a collaboration with NGOs working with high risk populations in tourist destinations, the ministry could advocate for safe practices.

The ministry could contribute towards empowering HIV positive persons, especially women by devising mechanisms to set up market for products prepared by positive people

The ministry could ensure sensitization on HIV related issues, with a focus on women by mainstreaming HIV in all tourism related training programmes with emphasis on migration, trafficking and drug abuse.

**H u m a n  
R e s o u r c e  
D e v e l o p m e n t**

The ministry could contribute towards empowerment of women by ensuring benefits of existing schemes and programmes to HIV-positive/affected women and their dependents, especially children. Also, to empower women, the ministry could encourage formation of collectives of HIV-Positive/affected women and spread awareness regarding HIV and AIDS issues among them.

A significant contribution of the ministry towards empowerment of women would be to ensure reduction of stigma and discrimination against HIV positive/ affected women

Through an integration of HIV and AIDS awareness programmes in all training programmes for the staff, Mahila Samakhya, students and teachers (as mentors and counselors even outside school premises), the ministry could address vulnerabilities of rural women and girls, especially those who are infected and affected and serve to reduce stigma and discrimination

The ministry could undertake to ensure availability of counseling services and access to treatment to all children living with HIV.

**W o m e n   a n d  
C h i l d  
D e v e l o p m e n t**

The ministry could serve to empower HIV-positive /affected women by giving them preference for receiving credit as well as by providing flexible payment modalities and lower interest

Empowerment of positive women could also be ensured through a facilitation of greater involvement of positive women at local level planning processes, as well as by ensuring access to livelihood programmes for HIV positive women through mixed SHG groups and also those formed exclusively by women infected and affected by HIV

Reach out to women living with HIV and AIDS and who have been deserted by their family or women who have lost their husbands due to HIV and AIDS without any social /economic support

Measure and value the additional burden of care shouldered by women and girls as a result of HIV and AIDS, and develop and implement policies to ensure appropriate recognition, material, financial and psychological support and treatment for caregivers.

Ensure that women, men, girls and boys involved in caring for People Living with HIV and AIDS receive appropriate training regarding the care of such persons, and ensure their emotional, psychological and physical well being and safety.

Legal services could be made a part of the process of rehabilitation to ensure empowerment of PLHIVs, especially women

HIV and AIDS awareness programmes to be integrated in all training programmes of the ministry. Also, positive/affected women could be empowered by imparting vocational training to them, including training on conducting HIV and AIDS awareness programmes.

Develop policies and programmes that support the needs of orphans, and children who are positive or whose parents are positive and incapacitated to work, including education, nutrition, health care, psychosocial support, housing, legal support, and skills development . Modify ICDS guidelines to integrate nutritional support to women and children on ARTs.

Training programmes for crèche personnel to include information about the needs of children infected and affected with HIV

Promote gender awareness and sex education for girls and boys in schools and encourage the delay of sexual activeness;

The ministry could commit itself to reducing the vulnerability of existing sex workers to HIV infection as well as to empower women and girls with adequate information and knowledge and vocational employment opportunities to protect them from being engulfed into sex work

Ensure counseling of HIV positive parents, who wish to have children, regarding the options available to them.

Ensure adequate and accessible Prevention of Mother To Child Transmission programmes and services and encourage the participation of fathers in such programmes

Ensure reduction of stigma and discrimination and extend supplementary Nutrition Program through Anganwadi workers to PLHIV.

Establish Red Ribbon clubs among adolescent girls and provide them access to holistic development - life skills, distance education,

nutrition and information on HIV and AIDS prevention  
Integrate HIV into all departmental training programmes in order to mainstream HIV issues towards empowerment of PLHIVs, especially women  
Provide gender sensitive and youth friendly sexual and reproductive health services free of charge, especially to positive women and girls.

**Social Justice  
and  
Empowerment**

The ministry could commit itself to reducing stigma and discrimination against positive persons, especially women by expanding the definition of atrocities to include stigma and discrimination.

Ensure that People Living with HIV and AIDS, especially women, are economically empowered to afford the basic requirements.

Ensure that women who become widows as a result of HIV and AIDS have the right to succession and inheritance to their property.

Ensure access to treatment for People living with HIV and AIDS, especially women and girls, in vulnerable situations, including those in rehabilitation facilities, internal displacement camps, refugee camps, the elderly and those with disabilities.

Sensitization of judges on HIV could be undertaken to ensure gender sensitive redressal of HIV cases

The ministry could serve to empower PLHIVs especially women by ensuring awareness of legal rights among them as well as free legal services by encouraging the lawyers providing free legal aid to PLHIV, especially women, through monetary incentives

Ensure access to counseling services, if needed to HIV-positive disabled persons, especially women

Set up helplines in collaboration with NGOs to provide information and counseling to persons affected/infected with HIV and who may have inhibitions in visiting counseling centers due to fear of stigma.

Such helplines should also cater to rape victims who become infected during the act, sex workers, other women who are vulnerable to HIV. Legal services should be offered in such cases, if possible.

Through a sensitization of NGOs, who apply for funds to the ministry, on HIV and AIDS – symptoms, treatment, prevention, nutrition and the importance of reducing stigma, the ministry could facilitate the empowerment of PLHIVs who could be engaged in different capacities in the NGOs, even as volunteers.

The ministry could empower networks of HIV-positive men and women by accepting them as NGOs and by enrolling positive persons, especially women as volunteers

**Housing &** HIV and AIDS related services to be included as a part of skill

<b>U r b a n</b>	training, such as counseling
<b>P o v e r t y</b>	The ministry could serve to empower PLHIVs, especially women and girls, by giving priority to them in terms of provision of employment opportunities including credit, loans and subsidies and also
<b>Alleviation</b>	<p>Ensure non-discrimination of positive/affected persons</p> <p>To empower positive persons, priority could be given to them during the selection process for vocational training</p> <p>The ministry could serve to empower positive persons, especially women, by provide marketing platforms for products prepared by them</p>
<b>U r b a n</b>	Ensure increased access to HIV/STD information, voluntary counseling and testing and health services for migrants
<b>Development</b>	<p>Ensure increased installation of condom vending machines in public places</p> <p>Ensure provision of sanitation facilities for women</p> <p>Ensure increased safety in public spaces, including appropriate street infrastructure (lighting, good state of pavements, absence of dark corners or dark parks or parking lots, etc.), for the women to prevent sexual harassment or violence</p> <p>Accord priority to positive people who have been dispossessed from the homes in securing tenure in urban areas</p> <p>Set up special youth friendly centers providing information on HIV and AIDS for adolescent boys and girls to empower them against the risks of HIV infection</p>
<b>Y o u t h</b>	HIV and AIDS awareness programmes to be integrated in all training programmes for the teachers & functionaries to enable them to contribute towards spreading awareness regarding HIV issues
<b>Affairs</b>	<p>Provide gender sensitive and youth friendly sexual and reproductive health services free of charge</p> <p>Ensure counseling &amp; access to treatment and reduction of vulnerabilities for HIV-positive/affected youth and their families</p> <p>Ensure prevention of trafficking of young girls</p>
<b>Information</b>	Ensure responsible programmes and media reporting in order to eliminate reporting which perpetuates the spread of HIV and the stigmatization of People Living with HIV and AIDS
<b>a n d</b>	Intensify messages on the prevention of HIV infection and AIDS that promote long term relationships and reduce multiple and concurrent relationships
<b>Broadcasting</b>	<p>Ensure gender sensitive programmes and media reporting that present women and girls in a respectable light as subjective individuals and not as a mere commodity. The programmes should also serve to reduce stigma and discrimination related to HIV and AIDS and refrain from presenting judgemental and rigid views,</p>

based on traditional patriarchal norms, on issues of sexuality, HIV and AIDS

### **Action Points for NACO**

- NACO, as the national mechanism looking specifically into HIV and AIDS programme, must provide the leadership in terms of commitment to gender equality and must ensure gender sensitivity among its ranks and gender perspective in the planning, design & implementation of its interventions. NACO needs a structure and the preparedness to implement gender mainstreaming and monitor it in other ministries.
- NACO to identify at least 2 outlets in Delhi for marketing of products produced by positive women. NACO to take extra steps to get them the market outlets and also help them to develop quality products. NACO to give them technical assistance to improve the quality of the product but as a counterpart, there should be a community set-up for production and for getting the credit from the bank.
- To introduce a generic 'smart card' that will entitle the bearer to travel concession on buses/trains as applicable. The privacy of PLHIV will be protected if the card does not identify them as such. There is no need to specify whether the bearer is HIV+/senior citizen/cancer survivor, etc. Further, the card could help track women lost to PMTCT follow up.
- NACO to adopt appropriate measures to ensure the preparation and dissemination of gender sensitive accurate information on the sexual and reproductive health needs of People Living with HIV and AIDS.
- There is need to look into the gender sensitivity or the lack of it in the health care system and the need to either facilitate the same or upscale interventions in this regard. For instance, by promoting the strengthening of linkages between sexual and reproductive health and HIV and AIDS in the programmes.
- Measure and value the additional burden of care shouldered by women and girls as a result of HIV and AIDS, and develop and implement policies to ensure appropriate recognition, material, financial and psychological support and treatment for caregivers.
- PLHIV require vocational training and the fees for such training should be waived. Such training should be planned differently for urban and rural PLHIV.
- Print and electronic media should also carry positive prevention messages.

(NACO to take action with Planning Commission)

- To provide higher allocations for PLHIV under existing welfare schemes. There must be available state specific and district specific manuals detailing the schemes that PLHIV may access and mechanisms to improve access to them.

(NACO to take action with Ministry of Finance)

- Interest rates on Fixed Deposits should be made higher for PLHIV just like what senior citizens get
- To evolve HIV sensitive insurance policies. It was suggested that NACO pay a part of the premium.
- IT exemption for those NGOs recognized by SACS/NACO to be considered.

(NACO to take action with MWCD)

- To extend the widow's pension scheme to a larger pool of beneficiaries by reworking the age eligibility criteria as some State have done. Pensions have also been raised in some states from INR 350/month to INR1,000. Support can be requested for transport and nutritional support for the PLHIV. for children with HIV, their access to services should be according to priority
- Resources must be allocated for cases of violence against women. Make stakeholders aware of how the provisions under the Domestic violence Act could be used to help PLHIV especially women. The National Commission for Women should take up HIV related issues.

### **ACTION PLAN FOR CIVIL SOCIETY:**

Given the wide diversity of programming work undertaken by NGOs, different good practice principles will be applicable to different organisations. The action plan for civil society organization is in **2 parts**: one for those organizations who already work on HIV, another for those organizations who are mainstreaming HIV into ongoing development activities.

#### **For civil society organizations working on HIV**

##### **Guiding principles**

- Protect and promote women's human rights in your work.
- Apply public health principles within your work.
- Address the causes of vulnerability to HIV infection and the impacts of HIV and AIDS.

- Ensure that programmes are informed by evidence in order to respond to the needs of those most vulnerable to HIV and AIDS and its consequences.
- Advocate for the meaningful involvement of PLHA and affected communities in all aspects of the HIV and AIDS response, especially women living with HIV

### **Organisational principles**

- Work to scale up appropriate gender sensitive and women focused programmes while ensuring their quality and sustainability.
- Provide and/or advocate for comprehensive HIV prevention programmes to meet the variety of needs of individuals, especially women's and communities.
- Ensure that HIV prevention programmes enable individuals, especially women, to develop the skills to protect themselves and/or others from HIV infection.
- Ensure that in the HIV prevention programmes, individuals have access to and information about the use of commodities to prevent HIV infection.
- Provide and/or advocate for comprehensive harm reduction programmes for people, especially women, who inject drugs.
- Provide and/or advocate for comprehensive treatment, care and support programmes; ensure they are gender sensitive and meet the specific needs of women.
- Enable PLHA , especially women and affected communities to understand their rights and respond to discrimination and its consequences.
- Enable communities, especially women, to understand and address HIV and AIDS-related stigma.
- Foster partnerships with human rights institutions, legal services and unions to promote and protect the human rights of PLHA and affected communities.
- Foster active and meaningful involvement of PLHA and affected communities in all work.
- Build and sustain partnerships to support coordinated and comprehensive responses to HIV and AIDS, which have a strong and measurable gender component.



- Institute transparent governance systems and be accountable to your communities/constituencies, especially to women.
- Value, support and effectively manage human resources to deliver high quality gender sensitive services and products.
- Develop and maintain the organisational capacity necessary to support gender sensitive and effective responses to HIV and AIDS.
- Manage financial resources in an efficient, transparent and accountable manner, ensuring the resources meant to benefit women do actually reach them
- Plan, monitor and evaluate programmes for effectiveness of its gender component and in response to community need.
- Ensure that all programmes are non-discriminatory, accessible and equitable.
- Advocate for an enabling environment that protects and promotes the rights of PLHA and affected communities.
- Undertake and/or advocate for adequate and appropriate research to ensure responses to HIV and AIDS are informed by evidence.

**For civil society organizations mainstreaming HIV into their ongoing developmental work**

- Review development programmes to assess their relevance to reducing vulnerability to HIV infection and addressing the consequences of HIV and AIDS.
- Develop partnerships to maximise the access of PLHA and affected communities to an integrated range of programmes to meet their needs.
- Design or adapt development programmes to reduce vulnerability to HIV infection and meet the needs of PLHA and affected communities.
- Ensure that existing programmes reduce vulnerability to HIV infection and address the needs of PLHA and affected communities.
- If possible, undertake programmes for orphans and vulnerable children affected by HIV and AIDS (OVC) and ensure that they are child-centred, family- and community-focused and rights-based.
- Advocate for an enabling environment that addresses the underlying causes of vulnerability to HIV and AIDS.

- Promote gender awareness and sex education for girls and boys in schools and encourage the delay of sexual activeness;
- Take such steps as are necessary to address harmful cultural, religious and traditional practices that drive the HIV and AIDS epidemic, especially those that exacerbate high infection rates among women and girls.

## **ACTION PLAN FOR MAINSTREAMING GENDER IN PRIVATE SECTOR**

### **1. Promote gender responsiveness in the private sector response to HIV and AIDS**

#### **a. At the workplace:**

- Support prevention programs with a gender-sensitive approach, including gender sensitivity in all training programs.
- Promote men's responsibilities regarding HIV and AIDS prevention including safer sex, and zero-tolerance for gender based violence and sexual exploitation.
- Increase access to HIV and AIDS information and services for women employees including addressing stigma and discrimination at the workplace , especially for those in the unorganized or informal sectors and those on contractual rolls
- Develop, implement and sustain policies prohibiting discrimination against HIV+ employees including women in the formal and contractual rolls at the workplace.
- Promote education, including vocational training, of children for employees both in the formal and contractual rolls at the workplace.

#### **b. In private sector supported delivery of HIV and AIDS care and treatment services**

- Ensure adequate and increased access and coverage of services for women, particularly adolescent girls and women at risk for HIV infection.
- Ensure all services offered are easy to access, culturally appropriate and women-friendly.

- Improve knowledge and statistics on women's participation in design, implementation and monitoring of HIV and AIDS prevention, care and treatment programming.
- Promote outreach and linkages with HIV-related health services as well as RH services such as pregnancy prevention.

**2. Strengthen the position of women – including widows and women living with HIV AND AIDS- in various economic spheres and markets**

- Support business opportunities for women, particularly those most at risk populations, widows and women living with HIV and AIDS.
- Promote female-owned business in supply chains and in public-private dialogue.
- Provide technical assistance and training to community and industry networks on enhancing participation of women, especially those at-risk, widows and infected women in the workforce.
- Develop financial literacy programs tailored to age, gender, marital status and context.
- Strengthen provision of support services such as crèches and day care centers as well as redressal systems that promote an enabling environment for women at work.
- Facilitate access of appropriate government programs for women's empowerment. Build capacities of the community to monitor implementation of the programs.

**3. Build institutional capacity for greater involvement and participation of women, particularly from at-risk populations and infected women in business development, and in the private sector in general**

- Promote the establishment of gender focal points in Ministries, business associations and chambers of commerce relevant to private sector development.
- Network/collaborate with government and civil society initiatives that work on education, economic empowerment and legal rights of women.

- Identify issues for CSR engagement that empower local women communities, particularly at-risk women and adolescent girls, widows and those living with HIV and AIDS.
- Build leadership within the private sector for promoting good gender practices and an enabling business environment for female entrepreneurship.
- Support the development of national monitoring frameworks that include gender segregated data and gender-sensitive indicators.