DRAFT
(Version 19 March)

POLICY GUIDELINES

MAINSTREAMING GENDER
IN
HIV PROGRAMMES

NATIONAL AIDS CONTROL ORGANISATION
Government of India
2008

Background

The HIV response in India is firmly located within the rights framework. There exists an inextricable link between human rights, gender and HIV/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 morality applied differently to those who display dominant and accepted behaviours of masculinity and those who display dominant and accepted behaviours of femininity.

Gender inequality is thus not only associated with the spread of HIV but also with its consequences. Men and women 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 the gender based differences which have their basis in socio – economic, cultural norms. It is critical that the response is based on a nuanced understanding of how and why the gender roles and relations fuel the uneven spread and impact of the HIV infections.

Purpose

The Policy guidelines to *Mainstream Gender in HIV programmes* represent NACO's commitment 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 gender inequality by the National AIDS Control Organisation; State AIDS Control Societies (SACS); District AIDS Prevention and Control Units (DAPCUs) and Implementing Partners.

The guidelines have been developed and framed in consultation with implementing staff in the government, civil society including people living with HIV and the UN system.

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

Gender and HIV

2006 estimates suggest national adult HIV prevalence of approximately 0.36 percent, amounting to 2 to 3.1 million people living with HIV in India. More men are HIV positive than women. Nationally, the prevalence rate for adult females is 0.29 percent, while for males it is 0.43 percent. This means that for every 100 people living with HIV and AIDS (PLHAs), 61 are men and 39 women. Prevalence is also high in the 15-49 age group (88.7 percent of all infections), indicating that most people living with HIV are in the prime of their working lives and have the responsibility of supporting families. In large numbers of cases, women in monogamous relationships are becoming infected because their husbands have had multiple sexual partners and unprotected sex. 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 sexual abuse and rape.

Nonetheless, some population groups are at higher risk of infection than others. These key population groups include sex workers, injecting drug users, truck drivers, migrant workers and men who have sex with men. These groups inevitably show higher numbers. Among Injecting Drug Users (IDUs), it is as high as 8.71 percent, while it is 5.69 percent and 5.38 percent among Men who have Sex with Men (MSM) and Female Sex Workers (FSWs), respectively.

The latest HIV prevalence estimates also indicate that the infections are moving from the urban areas to the rural areas infecting the most marginalized especially the poor women. These trends indicate that broader cultural and socio-economic conditions heighten vulnerability to HIV. Therefore, it is essential to understand the gendered nature of the epidemic to improve targeting and responsiveness.

Why women are vulnerable

The prevailing gender inequalities render women more vulnerable to the infection. These inequalities not only facilitate the spread of HIV but they also get reinforced in those infected and affected. Gender norms impact

the way in which infected men and women are perceived,[1] thus influencing the ways in which they cope with HIV.

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

There is a 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 emphasised condom use, abstinence or faithfulness as key prevention strategies. However, in a gender iniquitous setting, none of the three are within the control of the woman, therefore making her increasingly more vulnerable to HIV infection and less able to exercise safer choices.

Early marriage, violence and sexual abuse against women are the major socio-economic reasons of their vulnerability to HIV infection. Prevalent notions of masculinity and femininity generally mean that women have little control or negotiating power in their sexual relationships, including within marriage. Violence against women and HIV/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 HIV infection. Quite often women are aware that their partners are not monogamous, but might chose to stay on in these relationships or express their concern mainly due to fear of violence, and financial dependence on men. This is exacerbated by the fact that many of the women are unemployed, and few have skills that would make them employable.

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. The National Family Health Survey, 3 shows that only 57 % of women have heard of AIDS as against 80 % of men.

There is evidence that suggests beyond doubt that women's access to health services in general is significantly impacted by the social and

---

[1] Men who become infected may be seen as homosexual, bisexual or as having had sex with prostitutes. Women with HIV/AIDS are viewed as having been 'promiscuous' or as having been sex workers.

economic conditions within which she negotiates her health needs. Often a woman's health needs outside her reproductive roles are ignored. Her access to health services is hindered by limited access to information, physical distance and often insensitive service providers.

Gender norms influence the ways in which individuals cope with HIV and the society treats them. (See Box 1)

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

1. *Care of the sick* – Women account for more than 70 per cent of caregivers when it comes to providing care to PLWHAs. It is a matter of concern that nearly 20 per cent of caregivers themselves are HIV positive and need relaxation and extra nutritional care themselves. In situation where both parents are positive, the burden of care falls on the girl child. This in turn constricts social and economic opportunities, further contributing to the cycle of poverty, lack of empowerment, and vulnerability to infection.
2. *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. Lack of time and resources, sickness and exhaustion may lead to the neglect of children.
3. *Economic support to the family* – 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 flesh trade as the options for meeting the economic demands of the family.
4. *Alienation or stigmatization* – It is often the woman who is blamed for her husband and/or child falling sick, as well as being railed for her infection, leading to rejection and expulsion by the family and the community. In some cases, women experience dual stigmatization – as a widow and especially a widow of positive man. Discriminatory access to property rights, residence and care facilities are some issues with which confront the single and widowed women.
5. *Increased risk of violence* - The experience of violence, or 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 men is one of the only ways for her to make safer choices especially when there is a near absence of female controlled methods of prevention.

Box 1 - Women are vulnerable in various ways...

a) "….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. "

b) 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".

Evidence indicates that

Number of persons undergoing testing is lower for women (40%) than for men (60%)

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 (32 %) receiving ART treatment is lower than men (62%)

c) "…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. "

Gender Impact of HIV/AIDS in India', UNDP-NACO-NCAER 2005

Why men are vulnerable to HIV infection

Through socialisation, both men and women are subject to ideas about what is considered "normal behaviour" for women and men respectively; what are 'typical' feminine and masculine characteristics; and how women and men should behave in particular situations. As a result of this socialization process, men may be excused for not using condoms or for 'normal masculine behaviour' such as coercing women into intercourse (UNFPA, 2000a).

Another challenge is the societal expectation that men are "supposed" to be knowledgeable about sex and there is social acceptance of aggressive behaviour for men. This can make them uncomfortable about admitting that they do not know, limiting their access to information and push them for more risk taking and violent practices and behaviours. (UNAIDS, 2001a).

All over the world, men tend to have more sexual partners than women, including more extramarital partners. Male migration and mobility, common in many developing countries where men are forced by economic factors to leave their village and obtain work elsewhere, reinforce this tendency for men to have sexual relationships outside their marriage Predominantly male occupations, such as truck-driving, seafaring and the military, also entail family disruption and create a high demand for commercial sex. When men return home to their households, they re-establish sexual relationships and increase the possibility that HIV/AIDS will be transmitted to rural women (UNIFEM, 2001). Men may believe that their control of women's lives is an essential element of masculinity. They may become angry or frustrated when they appear to be losing control (UNFPA, 2000a).

Men are less likely than women to seek health care or pay attention to their sexual health. Further, men who have sex with men have been disproportionately affected by the HIV epidemic. Contributing factors are multiple sex partners, unprotected anal sex and the hidden nature of sexual relations between men in many communities. Risk-taking behaviour may be exacerbated by denial and discrimination, making it difficult to reach them with HIV prevention interventions. (Box 2)

Box 2 - Men, gender and sexuality

A cross sectional survey of 2910 rural Indian men aged 18-40 years from five rural districts in five different states in north India revealed that nearly 10% of single and 3% of married men had had unprotected anal sex with a man in the past year. Homosexually active men are not a separate sexual category, and report extensive mixing with female partners. They have more female partners than other men and they practiced anal intercourse in 11% of their heterosexual contacts.[2] (Ravi Verma , 2004)

Bisexual behaviour among men is usually attributed to the following factors:

- Moral and social policing of females making them more difficult to be sexually accessed by men;
- Ready availability of males involved in male-to-male sex in certain environments;
- Socially compulsory marriage, but often delayed till mid-twenties and older;
- Poverty leading to the provision of sex as transactional commodity

[2] Verma, Ravi, and Martine Collumbien: Homosexual activity among rural Indian men. Research Letters, AIDS 2004, 18: 1845-1847

When gender roles determine that men should provide for their families, those who are unable to do so may respond by becoming dependent on alcohol or inflicting violence on those weaker than themselves, often their partners (UNAIDS, 2001a). Risk and vulnerability are heightened by the link between socialising and alcohol use and by higher frequency among men of drug abuse, including by injection (Nath, 2001b).

Risk and Vulnerability to HIV		
	Men	**Women**
Behaviour	Multiple sex partners	High risk behaviour of regular sexual partner
Social Norms	Sexual domination	Virginity and marriage; Value of motherhood
	Social inhibitions in seeking correct information and Knowledge; peer/social pressure for sexual performance	Silence and invisibility over female sexuality
	Violence	Culture of violence
Economic	Power – command over resources, pressure of the bread winner role for the family	Insecurity – exchange sex for money/favours
…leads to increased risk and vulnerability for BOTH men and women		

It is clear from above that approaches to HIV and AIDS prev ention will be effective only if they include interventions that recognize specific problems of and solutions for **women and men.**

2. Guiding Principles

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

- Gender equity and GIPA are intrinsic to India's response to HIV at all levels
- Empowerment will be the key strategy to enable women be safe and protected from HIV, as their subordinate position in the society accentuates their vulnerability
- Behaviour change will be the key strategy adopted to enable men be safe from HIV and be responsible and equal partners in prevention of HIV
- The response will not be based on moral judgments of right vs. wrong behaviours. It will be based on an agreed understanding of HIV related safer vs. unsafe behaviours

- Women, men and young people will be enabled and supported to make informed choices regarding all aspects of their lives including sexuality and reproductive behaviours to make HIV response sustainable
- HIV prevention and care related services will be provided on the understanding that prevailing gender relations in communities determine the demand for and utilisation of such services

3. Policy Guidelines

All HIV prevention and care interventions will be based on:

1. **Thorough understanding** of the different concerns, experiences, capacities and needs of women/girls and men/boys.
2. **Acknowledgement of diversity** in sexual practices and behaviours prevalent in communities. Service providers will respect the rights of sexual minorities[3] and behaviors outside the mainstream. Their dignity and empowerment will be a key strategy to assist sustained practice of safer practices among such groups.
3. **Recognition of men's role as equal partners** and not that of adversaries in change will be the **basis** of this policy
4. **Assessment** of gender dimensions of HIV related stigma, discrimination and denial **and awareness** will be created to challenge and reduce them.

All HIV prevention and care interventions will ensure:

5. **Enabling environment** for women and girls and men and boys to adopting safer practices, accessing equal and substantive opportunities for livelihoods, participation in public life, safety and accessing basic services.
6. Personnel at service delivery points pay special attention to women, girls and individuals from sexual minorities to make sure they have **easy and equal access** to quality care, treat ment and information.

[3] Sexual minorities include MSM (men having sex with men) and transgenders.

7. **Training and capacity building processes** for HIV prevention control and care will include mandatory training on gender issues and its links with HIV with the specific objective of facilitating internal attitudinal change among participants. Training programmes include discussion on social, cultural norms (for e.g.: with regard to masculinity/ femininity, power relation between men and women) and harmful traditional practices that increase the vulnerability and impact of HIV/AIDS on men and women
8. Advocacy and IEC messages **will not perpetuate gender stereotypes** and pronounce moral judgments on sexual minorities, sex workers and PLHIV, with respect to their sexual practices and way of life.

All HIV prevention and care interventions will be strengthened by:

9. **Supporting programmatic and legal interventions** to address all forms of discrimination against women/girls and men/boys such as (trafficking of women and girls, child labour, forced marriage, sexual and economic exploitation) that increase their vulnerability and exacerbate the impact of HIV/AIDS
10. **Assisting government stakeholders and duty bearers to effectively** respond in a gender sensitive manner to human rights abuses, discrimination and gender based violence within the context of sexual health and HIV
11. **Promoting economic rights** of women and girls, ensuring property ownership and inheritance rights and equal participation of men and women in income generating activities in the context of HIV/AIDS
12. Ensuring that all **partnerships and alliances** will be based on a common understanding of rights framework and an **unequivocal commitment to the understanding of gender equity**
13. **Institutionalizing accountability** for all implementing partners and programme managers for the implementation of this gender policy in letter and spirit.

It is envisaged that by incorporating gender into HIV, NACP III can not only effectively address feminization of the HIV epidemic but also contribute to change in an array of gender issues around equity, empowerment and promotion of human rights.

4. Implementation Guidelines

Role of NACO

Key role of NACO will be to ensure that the gender policy is implemented across the programme components of NACP III. Specifically, NACO will:

- Invest in organization wide capacity development on gender issues in HIV
- Develop accountability measures to ensure effective implementation of this policy
- Provide technical support to SACS to implement gender and HIV policy
- Will help different ministries map available resources (persons, tools, institutions) for mainstreaming and help in building additional resources through training institutions, inside and outside the ministry.
- Work with the faculty of the training institutions under the ministry to add gender and HIV/AIDS related information to their training curriculum. One or more training institutions identified by the ministry will be supported to become the nodal resource centre for the sector, e.g. NIPCCD or State Institutes of Rural development (SIRDs).
- Ensure that the advocacy and Information, Education and Communication materials do not reinforce gender stereotypes.
- Document and disseminate good practices, and create a forum for ministries to share information and learn from each other on gender issues

Role of SACS

1. Directors of SACS will ensure that all efforts are made to have hundred percent gender sensitized staff.
    a. Staff will be hired on the basis of their understanding of gender; and
    b. Existing staff will be provided the opportunity to upgrade their levels of understanding
2. Provide technical support to DAPCUs and other implementing partners to implement gender and HIV policy
3. Regularly communicate concerns pertaining to stigma and discrimination against men and women living with HIV/AIDS to the ministries and to the private sector so as to help them reflect the issues in their plans.
4. Share good practice in this context and encourage learning across the organization.

Role of DAPCUs

1. Maintain proactive interface with District Collectors/CEO for the implementation of the action plan on mainstreaming gender and HIV

2. Provide technical support for the implementation of the gender and HIV policy.

District Collector/CEO will play an important role at district level in the HIV related interventions. They will ensure inter-departmental coordination, provide direction to the mainstreaming of HIV by identifying strengths and specific problems in their respective district s.

Suggested Checklist

A checklist has been designed to mainstream gender equality 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*

A. Priority Setting

1. 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?
2. Is background data/situation analyses disaggregated by age, sex and ethnic origin?
3. How far have gender specialists and representatives of women at all levels been consulted throughout the process?
4. Has attention been paid to the inclusion 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?

B. Project and programme formulation

1. Have gender issues relevant to each project/programme, including gender impact and anticipated outcomes, been systematically identified, and updated as appropriate?
2. How far have personnel belonging to NACO/SACS/DPACUs/IPs informed themselves substantively of the gender dimensions of the HIV challenge to be solved?
3. How far have individuals and women's NGOs with knowledge and experience of gender mainstreaming participated in project identification, formulation and appraisal?
4. Have women been consulted equally with men during the formulation process, especially female beneficiaries?
5. Has the proportion of financial resources allocated to the attainment to empower young girls, women and sexual minorities been clearly indicated?

6. Have gender-related linkages with other projects and programmes been identified and incorporated in documentation?
7. Has all background information been disaggregated by age, sex, and ethnic origin?

C. Project and programme implementation

1. Has gender balance in project training been ensured?
2. How far has gender balance among participants in all consultations been attained?
3. Do Programme and Project Evaluation Reports reflect gender issues, and is all information disaggregated by sex?
4. Do final project reports systematically identify gender gaps and gender-related project successes?
5. Do NACO/SACS/DPACUs/IPs personnel monitor project disbursements to ensure that inputs are used in such a way as to ensure equality of outcome for both women and men project/programme beneficiaries?

D. Gender sensitive project/programme evaluation

1. Do evaluation mission terms of reference require relevant gender expertise and experience?
2. Are evaluation mission members briefed on relevant gender issues and provided with documentation?
3. Do relevant personnel review the draft evaluation report to ensure that gender-related omissions and successes in the project/programme are reflected?
4. Do relevant personnel understand and apply process indicators of success?

E. Policy advice and dialogue

1. Do NACO/SACS/DPACUs/IPs document GOI core messages on gender equality issues and analysing local gender-related priorities available to contribute to policy dialogue?
2. Has all information used in policy dialogue been disaggregated by age, sex and ethnic origin?

F. Resource mobilisation activities

1. Is summary information on the gender dimensions of NACO/SACS/DPACUs/IPs activities, systematically prepared and distributed as appropriate?
2. Are governments and donors informed on NACO/SACS/DPACUs/IPs core messages on gender equality?

3. Do all project/programme briefs and summaries reflect the relevant gender equality dimensions?
4. Do NACO/SACS/DPACUs/IPs personnel actively interact with donors, including gender equality dimensions appropriately in all discussions?

G. Gender training and briefing sessions

1. Have the needs of NACO/SACS/DPACUs/IPs personnel for training or information on gender mainstreaming been identified?
2. 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.)?
3. Has training or capacity building been provided to meet these needs?
4. Have relevant documentation and training materials been identified and provided?
5. Is gender equality information systematically prepared and presented at meetings, in order to ensure productive discussion of gender issues and learning by participants?
6. Have appropriate monitoring mechanisms to measure the impact of training on improved performance been established?

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

1. Have gender equality priorities been reflected in the selection of topics and agendas for special events?
2. Are there consistent mechanisms in place to ensure that women and men participate equally in special events as speakers, chairpersons, decision-makers etc. and are equally consulted during preparations and follow-up?
3. 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?
4. Is the press routinely informed of the gender dimensions of NACO/SACS/DPACUs/IPs special events?

I. Representation of NACO/SACS/DPACUs/IPs gender equality activities in the public arena, especially in the local media.

1. Have contacts with members of the local press corps who are sympathetic to gender equality been systematically built up?
2. Has the press been fully briefed on NACO/SACS/DPACUs/IPs gender equality priorities and gender-related activities?

3. Has a briefing note or brochure on the NACO/SACS/DPACUs/IPs gender mainstreaming priorities and activities been prepared and distributed to the press?

DRAFT FOR REVIEW

ACTION PLAN

MAINSTREAMING GENDER AND HIV IN MINISTRIES (2008 – 2010)

NATIONAL AIDS CONTROL ORGANISATION

Government of India
2008

What does mainstreaming mean for HIV

Mainstreaming must address two domains – the **internal and external**. The internal AIDS response deals mainly with the development of workplace policies and programmes for personnel in a sector or a ministry. The external AIDS response focuses on aligning HIV and AIDS to the core mandate, targets, policies and strategies of the ministry.
Some salient features of a mainstreaming approach includes –

- **A)** Understand the impact of HIV on development and consequent results, including spread and mitigation of the spread of HIV;
- **B)** Mainstreaming into the work plan of major government/ private (for profit and not -for-profit) organisations and modify their core practices to respond to the challenges of HIV/AIDS; and
- **C)** Use the comparative advantage of different stakeholders to put in place strategies and programmes to address HIV; and
- **D)** Partner organisations demonstrate ownership of the HIV/AIDS prevention and control strategies by allocating internal resources to the programme.
- **E)** Recognise the complementarity amongst stakeholders and their mandates, as a pre-requisite for preventing duplication

Why mainstreaming strategy for HIV should look at gender …

It is vital that in developing and applying the mainstreaming HIV strategy , the concept of gender is included at every stage. An understanding of the gender issues and dimensions of HIV/ AIDS must be central to the analysis of causes and contributory factors as well as to the planning and execution of responses, whether these are aimed at preventing transmission or mitigating the impacts of the disease. (For more details, see Policy Guidelines). Gender mainstreaming is the most efficient and equitable way to use existing resources for combating HIV/AIDS by focusing on the real needs of the whole population. Gender mainstreaming involves:

- Assessing the implications for women and men of any policy, programme or intervention
- Making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and

evaluation of policies and programmes so that women and men benefit equally

- The ultimate goal is to achieve gender equality

Gender mainstreaming was conceived of in 1985 in the Third World Conference on Women in Nairobi. The idea was formally featured in 1995 on the Fourth World Conference on Women in Beijing. The Economic and Social Council formally defined the concept 1997 January.Gender mainstreaming does not automatically remove the need for women-specific programmes or for projects targeting women. These will often remain necessary to redress particular instances of past discrimination or long-term, systemic discrimination. Budgeting for pro- women programmes can increase the effectiveness of implementation of the programmes.

Action Plans for Ministries

Based on the deliberations of the National Council on AIDS, NACO has prepared a recommended list of activities for most of the ministries represented on the NCA. This document builds on the above action plan and suggests entry points to specifically reduce the vulnerabilities of women. The activities for the focus ministries are detailed below. **The following indicators could track the progress of this action plan:**

- All levels of staff (ministry, institution & work site) are aware of gender aspects of HIV/AIDS
- Number of directives issued by State councils on gender and HIV
- Number of identified schemes of ministries amended to include gender and HIV related concerns and activities
- Number of ministries reporting on gender and HIV in their respective sectors
- Number of training programmes which have substantive sessions and course material dealing with Gender and HIV/AIDS

MINISTRY SPECIFIC ENTRY POINTS		
S.No	**Ministry**	**Schemes**
1	**Rural Development**	1. Swarna Jayanti Gram Swarojgar Yojana
		2. NREGA
		3. Indira Awas Yojana
2	**Panchyati Raj Institutions**	4. Panchayat Mahila Shakti Abhiyan
		5. Panchayat Yuva Shakti Abhiyan
		6. Backward Region Grant Fund
3	**Tourism**	7. Tourist information and publicity
		8. Tourist infrastructure
		9. Training
4	**Human Resource Development**	10. Mahila Samkhya Programme
		11. Kendriya Vidaylaya Sangthan
		12. National Council for Teachers Education

5	**Women and Child Development**	13. Rashtriya Mahila Kosh
		14. NIPCCD
		15. Rajiv Gandhi National Creche Scheme for Children
		16. Integrated Child Development Scheme
		17. Swayamsidha
6	**Social Justice and Empowerment**	18. Machinery for Implementation of Protection if Civil Rights Act 1955 and Prevention of Atrocities Act 1989
		19. Deendayal Disabled Rehabilitation Scheme
		20. Education Work for Prohibition and Drug Abuse Prevention
7	**Housing & Urban Poverty Alleviation**	21. Swarna Jayanti Sahari Rojgar Yojana
8	**Urban Development**	22. JNNURM
9	**Youth Affairs**	23. National Service Scheme
		24. Nehru Yuva Kendra Sangathan
		25. Financial Assistance for Promotion of Youth Activities and Training

MINISTRY OF RURAL DEVELOPMENT

1) Swarna Jayanti Gram Swarojgar Yojana - The objective of the Swarnjayanti Gram Swarozgar Yojana (SGSY) is to bring the assisted poor families (Swarozgaries) above the Poverty Line by ensuring appreciable sustained level of income over a period of time. This objective is to be achieved by inter alia organising the rural poor into Self Help Groups (SHGs) through the process of social mobilization, their training and capacity building and provision of income generating assets.

Entry Points

Avail option of "Special Projects" component under the scheme

PD, DRDA will design special projects for PLHIV as a part of 15% special project component of the scheme and submit to Commissioner, RD. NACO, SACS may provide consultation in designing the project.

Design incentives for positive people

Schemes/ bank loans to be made friendlier for people living with HIV in terms of incentives in a way of wavering /relaxing some rules regarding the life span, paying back capacity. NABARD could be consulted on this. An option of mixed SHG groups where equal membership by positive people could lead to easier payment terms and other incentives.

Include HIV in the training component

Under the schemes, the funds are provided for training and capacity building including basic orientation, skill development, entrepreneurship development. As part of the training, providing information on HIV should be made mandatory. Working with Red Ribbon Clubs could also be encouraged. The existing training modules should incorporate HIV specific chapter, especially the modules for training of trainers who facilitate formation of SHGs.

2) National Rural Employment Guarantee Act - The National Rural Employment Guarantee Act, 2005 (NREGA) guarantees 100 days of employment in a financial year to any rural household whose adult members are willing to do unskilled manual work. This work guarantee can also serve other objectives: generating productive assets, protecting the environment, empowering rural women, reducing rural urban migration and fostering social equity, among others.

Entry Points

NREGA related advocacy should also include targeting positive women and men

Ensure availability of condoms at the construction work-sites

3) Indira Awas Yojana - The objective of Indira Awaas Yojana is primarily to help construction of dwelling units by members of Scheduled Castes/ Schedule Tribes, freed bonded labourers and also non- SC/ST rural poor below the poverty line by providing them with grant-in-aid. Funds to the tune of 3% is earmarked for the benefit of disabled persons below poverty line. This reservation of 3% under IAY for disabled persons below the poverty line would be horizontal reservation i.e., disabled persons belonging to sections like SCs, STs and Others would fall in their respective categories.

Entry Points

Provision for rehabilitating positive people dispossessed from their houses due to their HIV status could be given priority.

2. MINISTRY OF PANCHYATI RAJ INSTITUTIONS

A) Panchayat Mahila Shakti Abhiyan

Each State Government will constitute a Core Committee comprising activists, feminists, social workers, NGO workers, EWRs and those interested in issues of participatory governance. The Committee will discuss the issues relating to the EWRs and draft a Women's Charter listing both their commitments, their issues and their demands. The State specific charter will lay down the road map for taking forward the Panchayat Mahila Shakti Abhiyan in the State.This committee will cease to exist after an year to enable the Association to function independently.A State level Sammelan will be organized in each State followed by district . All the elected women representatives will assemble together for 2-3 days to debate, discuss and deliberate on the issues that affects them as Panchayati Raj representatives. Division/District level Sammelan will follow the State Level Sammelan in each State wherein approximately 250 EWRs including the Zilla Pramukhs, Panchayat Samiti Pradhans and at least 5-10 women.A major outcome of the Sammelan is to form an association of the EWRs with elected office bearers to raise a collective voice against major issues and provide the main knowledge support to the EWRs during times of uncertainty and knowledge gaps. An elected Executive Body of the EWR Association will be formed during the sammelan, or just subsequent to it, which may register itself, and decide on the detailed activities which it may undertake in order to fulfill its mandate comprising activists, feminists, social workers, NGO workers, EWRs and those interested in issues of participatory governance. State Support Centers will be established in each State/UT to keep updated information related to the participation of EWRs in Panchayati Raj Institutions for the entire State and serve as knowledge support institutions.

Entry Points

- **Include networks of PLHAs, NGOS working on issues of HIV as members in the Core Committee and subsequently in the EWR association**
- **Organise sensitization camps on HIV during Sammelan to enable them to raise concerns pertaining to positive women and men at the appropriate fora**
- **Information on HIV should be made available at the State support centres**
- **Inclusion of HIV in the training modules for the training of newly elected PR representatives.**

DRAFT FOR REVIEW

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:

	NACP-III Component Prevention / Care / Support / Treatment	**Proposed Plan (what and for whom)**	**Action to address gender issues (process / methodology)**	**Required and or available resources and tools**
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	✓ One-day reorientation of officials. (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
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.				
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	Planning meeting/ core group meeting while implementing Programme Implementation Plan under NACP-III and the NRHM/RCH II with the involvement of key	Block/ district health action plan with gender lens after the orientation has been carried forward. Outcome:- better state / district

		Development and the 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 primary health centre level,	stakeholders, especially 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	level 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

		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. 4. Involvement of men in sexual and reproductive health	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.	programmes for frontline workers.
Targeted interventions among high-risk groups and the general population				
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	1. Formation of HIV-positive women's networks at the district level 2. Equal representation of HIV-	Facilitation of HIV-positive women's networks by SACS and the District AIDS Prevention and Control Unit	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

		positive women in the national / regional, larger HIV-positive networks 3. Developing criteria for accrediting HIV-positive networks 4. Positive women in decision-making role 5. Mainstreaming HIV related services in community based organisations and involvement of infected and affected women in existing community based organisations 6. Support to affected and positive women	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 Extend financial and technical support for formation of HIV-positive women's networks Invite HIV-positive women to advocacy workshops Accreditation guidelines for positive networks Representation of HIV-positive women in the NACO and other decision-making bodies District AIDS Prevention and Control Unit support to community based organisations for sensitising Panchayats and Mahila Mandals on HIV-positive women's issues Roll out of credit facilities from banks for community based organisations that have mainstreamed	Operational guidelines for the SACS and the District AIDS Prevention and Control Unit, with gender checklist Gender-sensitive capacity building of civil society representatives and sensitising them on specific livelihood needs of positive women Training curriculum under Mahila Samakhya to be revised with gender content, as necessary. Gender-sensitive guidelines and training for Panchayat members Guidelines for the National Steering Committee under public-private partnership with gender perspective Inter-sectoral coordination meeting with HIV-positive women's representatives Specific guidelines for extending support for HIV-positive women

			infected and affected women and are working for savings and credit Sensitisation of representatives in inter-sectoral coordination on socio-economic needs of positive women Facilitation and advocacy of health insurance cover for people living with HIV/AIDS, especially HIV-positive women Promotion of micro-finance schemes	
IEC, Advocacy and Communication (See Annexure 2)				
5	Prevention	1. Address gender equality, human rights and vulnerability in all tools designed for IEC advocacy and communication 2. Understand vulnerability to HIV as a step towards prevention of spread of the epidemic 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	Discussion through orientation training and capacity building of functionaries in the NACO, SACS and the District AIDS Prevention and Control Unit in order to facilitate usage of tools suggested alongside Analysis of IEC material etc. from the gender / rights perspective Critical evaluation of media messages and TV spots (by the NACO, SACS and the	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 involvement of men (needs some form of standardisation) Customised and gender-sensitive advocacy and IEC toolkit for community outreach workers and health care service providers

	Treatment	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	District AIDS Prevention and Control Unit), e.g., on HIV prevention through common gender-based guideline Sensitisation of media managers, media houses, health care providers and IEC programmers in the NACO, SACS and the District AIDS Prevention and Control Unit Lay emphasis on inter-spousal communication through dialogue and discussion to reduce stigma and discrimination Weave in the element of responsible male participation in the IEC, Advocacy and Communication strategy for enhanced accessibility of treatment services	

Monitoring and Evaluation

- The indicators are to be derived from the gender components of the programme objectives.

- Gender related indicators in this context are both process and output indicators. These indicators are additional / complementary to – and not a replacement of – indicators used for monitoring and evaluating the NACP-III.

- Three-pronged monitoring: review of the programme design implementation, periodic assessment and end-of-programme evaluation of outcomes and impacts

- Reporting on indicators (Annexure 3) should be collected, without any alteration.

6	Prevention Treatment Care and support Monitoring and evaluation	1. Equal access of information and utilisation of client-friendly services (condoms, STI clinics, voluntary counselling and testing centres, prevention of parent to child transmission of HIV centres, ART, SRH etc.) regardless of gender, and especially for high-risk groups, at the service delivery level 2. Access of people living with HIV/AIDS (segregated by sex) care, support – including nutritional supplementation – and treatment of opportunistic infections and ART 3. Formation of HIV-positive 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 4. Integration plan through inclusion of suggested indicators into the reporting format at the SACS and the DPACUs	Related indicators to be integrated into existing programmes run by line Ministries such as those of women and child development, health and family welfare, human resource development and social justice and empowerment as well as Nehru Yuva Kendra Sangathan, etc. Plan with available data for integration with service providers under the prevention of parent to child transmission of HIV programme, the RNTCP and the NRHM Integration plan through representation in the Action Plans of the state, the district and other bodies Gender sensitisation training of the existing MIS staff at the SACS and the District AIDS Prevention and	Computerised Monitoring Information System and reporting formats to be rephrased from the gender perspective Develop and share with people living with HIV/AIDS through their networks gender-specific operational guidelines on accessing care, support and treatment for opportunistic infections and ART Operational guidelines, along with attached checklist, for accreditation of such networks 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,

			Control Unit levels to help understand gender and why gender mainstreaming is important form the point of view of data collection	if not developed.

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

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

Adapted from the website 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	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	Same as above

Target audience	Segment	Objective	Message	Gender blender	Outcome
		partner / wife		commercial sex work	
			Priority 2		
General population	Youth Women	Awareness generation about personal risks and safe behaviour	Youth – abstinence / be faithful delay sexual debut, use condoms 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	Awareness facilitating behaviour change. Positive health seeking behaviour (rights based) with particular reference to SRH. Negotiate for condom use – triple protection phenomenon.	Same as above

Target audience	Segment	Objective	Message	Gender blender	Outcome
	People living with HIV/AIDS	Networking and utilisation of services	Non-stigmatisation and social acceptance friendly environment to live and work	Safe supportive work place environment positive women and those affected. (Widows, destitute) and other gendered identities. Non discrimination and stigmatisation for women, young girls and other gendered identities (HIV/AIDS infected and affected)	Better-enabled environment for networking, care and support for women girls and other gendered identities. Motivating more HIV-infected and affected people; (women, adolescent girls and other gendered identities) to opt for integrated counselling and testing, ART Better work place environment for all the above segments of pop.
	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

Target audience	Segment	Objective	Message	Gender blender	Outcome
	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.
Priority 3					
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 improve quality, promote voluntary blood donation	Training and Capacity Building	Gender friendly approach. Respect their specific needs and identity, and facilitate responsible positive health seeking behaviour.	Same as above
Priority 4					

Target audience	Segment	Objective	Message	Gender blender	Outcome
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)

SN	List of indicators by components	Add-on indicators by including the Gender Component, which correspond to the Gender Checklist	Bodies / Departments responsible for making the component operational	Level of analysis N = national S = state D = district	Source for information	Frequency of indicator generation	Current status of indicator: generated (Y) or not generated (N)
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-		Women and Child Development Department, SACS and	N/S	Behaviour surveillance survey of high-risk groups and general population of	Once in three years	N

	sensitised medical providers, expressed as a percentage of the general population of men / women		reports of service providers		men		
15	Number of HIV-positive people (segregated into male, female and other gender) among the high-risk group in targeted interventions and in the general population, who receive ARV treatment and nutritional supplement support		Women and Child Developme nt Department , SACS, targeted intervention NGO reports and reports of service providers	S	Computerised Management Information System, ART centre	Quarterly	N
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 major HIV related misconceptions)			N/S	Behaviour surveillance survey of youth	Once in two years	N
	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 Developme nt / 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,		District Hospital /	N/S	Behaviour surveillance	Once in three years	N

	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)		Voluntary Counselling and Testing Centre data		survey of high-risk groups		
	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 Developme nt 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	NGO reports on social marketing of condoms, and Youth Clubs / Nehru Yuva	N/S	Behaviour surveillance survey of the general population	Once in three years	Y

		male and female condoms and reporting consistent use. Add on: Percentage increase in more young men and 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.	Kendra Sangathan Ministry of Women and Child Developme nt and State AIDS Control Society through qualitative measures such as focused group discussions, in-depth interviews				
66.	Percentage of persons (males and females) reporting			S	Behaviour surveillance	Once in three years	Y

	availability of condoms within 15-minute walking distance				survey		
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		Nehru Yuva Kendra Sangathan	S	Press and TV audits	Annually	N

	issues targeting men and the other gender						
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 Developme nt / 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 Developme nt 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		NACO, State AIDS Control	N/S	Sentinel surveillance	Twice in three years	N

	working in the field of HIV that have people living with HIV/AIDS (male, female and other gender) representatives.		Society and NGO reports				
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 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	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
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	State AIDS Control Society and District AIDS Control and Prevention Unit	N/S	Sentinel surveillance	Annual	N

		for gender mainstreamin g					
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

B) Panchayat Yuva Shakti Abhiyan

It is the largest grass root level non-political organization in the world catering to the As a leading youth organization NYKS functions as the Government's implementing body for the major quantum of mobilization and development activities in the sphere of non-student rural youth. Over the years, Nehru Yuva Kendra Sangathan witnessed expansion of its district offices (Kendras) to over 500 districts as well as formation of village based organizations namely Youth Clubs and Mahila Mandals across the country. State Support Centers will be established in each St ate/UT to keep updated information related to the participation of EYRs in Panchayati Raj Institutions for the entire State and serve as knowledge support institutions.

Entry Points

- **Sensitization of the members** of Youth Clubs and youthful elected representatives of the PRIs through orientation programmes on issues pertaining to HIV & AIDS, sex determination and health related issues
- Select youth could be trained as **peer educators** on the issue of HIV /AIDS. Young people need access to user-friendly STI services, voluntary counseling and testing (VCT), and other resources for reproductive health. They also need access to condoms and the skills to correctly use them. Outreach, peer education, media, hotlines, and information, education, and communication (IEC) materials can provide referrals to these services.
- Engage with **community and political leaders** to reach out to youth as they are strongly influenced by the people and institutions that surround them.
- **Link HIV programs to various areas of NYKS** such as education and training, awareness generation, skill development and self employment, enterprise creation, thrift and cooperation. Young people are not particularly interested in health issues like HIV/AIDS. Young people invest their time and interest in such areas as religion, schools, job training, agriculture, sports and the media. Interventions must take advantage of these sectors and seek to integrate HIV messages into their activities.

C) Backward Region Grants Fund

The Backward Regions Grant Fund (BRGF) is aimed at catalyzing development in 250 selected backward districts by: (a) providing infrastructure (b) promoting good governance and agrarian reforms and

(c) converging, through supplementary infrastructure and capacity building, the substantial existing development inflows into these districts as part of a well conceived, participatory district plan.

The funds are provided on a 100% grant basis and allocated as Additional Central Assistance to State Plans. The quantum of BRGF funds given to each Panchayat will be on the basis of a transparent formula decided at the local level. Within a district, the formula can be aimed at targeting specific pockets of backwardness. Such an exercise would provide clarity and transparency regarding the totality of funds available in these districts and would also avoid duplication and the consequent leakage of funds. To ensure steadiness and predictability in funding to Panchayats, once decided, deviations from the formula will be discouraged. BRGF funds will be used by the Panchayats for gap filling and to converge and add value to other programmes, which provide much larger resources to the same districts.

Key conditionalities include: The transfer of funds to the Districts would be conditional only upon the finalization of the district development plans through Panchayats and DPCs, which would be approved at the State level. For effective decentralized planning at the grassroots level, States will be encouraged to adopt such innovations as (a) village data bases will be created on natural endowments as also a family register (b) securing outside expert assistance in plan preparation (c) eliciting Gram Sabha participation along with steps to democratize the functioning of the Gram Sabha and increasing accountability of Panchayats through transparent procedures and effective implementation of the right to information (d) ensuring effective devolution of funds.

Entry Points

- **Districts with high prevalence of HIV/AIDS should emphasise setting up health infrastructure for treatment of HIV/AIDS: this infrastructure should include testing facilities, ARV clinics, drop in centres, including awareness generation programmes**
- **Modalities should be developed to ensure participation by the positive people in district planning**

3. MINISTRY OF TOURISM

A) Tourist Information and Publicity

Promotion and Marketing are undertaken through a network of Government of

India Tourist Offices located in India and abroad. Besides the regular promotional activities, production of publicity material, media and public relations, hospitality and special campaigns including Marketing Development Assistance Scheme have been
introduced from 2000-01. Under the Scheme stake holders and Star Trading Houses in the Tourism Sector are also eligible for drawing assistance for market development. This was approved for tourism enterprises after tourism was given an "Export House"
status. Besides, centralized electronic and internet campaign have also been taken up by this Ministry.

Entry Points

- **Special campaign can be developed on socially responsible tourism with a focus on HIV prevention**
- **Existing campaigns should carry messages on safe tourism**

B) Tourist Infrastructure

This provision relates to the expenditure on creation of Infrastructural facilities on construction of Budget hotels, Tourist complexes, Wayside amenities, Tourist Reception Centres, Refurbishment of monuments, Special Tourism Projects, Adventure and sports facilities, Sound and Light Shows, Illuminations of monuments, providing for improvement in solid waste management and sewerage management. improvement of surroundings, Signages, Procurement of equipments directly related to tourism and Rural tourism projects etc. This provision also relates to the large revenue generating projects, generating revenue through levy of fees or user charges
like Tourist Trains, Cruise vessels, Cruise terminals, Convention Centre, Golf Courses, etc. and creation of land bank for hotels to provide the hotel accommodation in the country by purchasing land and build hotels through Public Private Partnerships on
BOOT basis. This includes equity support of Rs.73.00 crores to India Tourism Development Corporation (ITDC).

Entry Points

- **Guidelines for socially responsible tourism could be developed to address issues cross cutting issues of gender and HIV**
- **Advocate with hotels, tour operators and hotel associations to modify their operating practices to integrate HIV prevention**
- **Engage with NGOs working with high risk populations in tourist destinations to reduce vulnerabilities**
- **Existing health facilities within premises or on call can be sensitized to HIV/AIDS**

C) Training
Trained manpower is an essential feature for the development of tourism in the country. At present there are 24 Institutes of Hotel Management (IHMs) and 7 Food Craft Institutes (FCIs), which are following courses of National Council for Hotel Management & Catering Technology (NCHMCT). In addition, Indian Institute of Tourism and Travel Management (IITTM) and the National Institute of Water Sports (NIWS) there under, are other bodies involved in manpower development in
tourism. Besides this, regular courses of various duration are conducted for fresh as well as existing service providers including Guides, Govt. employees etc., posted at places of tourist interest, airports etc. A new 'Priyadarshini' project has also been launched aimed at imparting training skills to women and also in tour guiding with the objective to empower women in tourism & travel industry.

Entry Points

- **HIV sensitization should be made mandatory in all tourism related training programmes with emphasis on migration, trafficking and drug abuse**
- **Women trained under the Priyadarshini project should be made aware about HIV and women rights**
- **Tourism policy should be amended to highlight issues of HIV and gender**
- **Tourism industry should evolve workplace policy of HIV prevention and care**
- **NGOs associated with the Ministry can also be trained for HIV mainstreaming.**
- **Availability of condom vending machines**
- **Inclusion of HIV component in CBSP scheme**

4. MINISTRY OF HUMAN RESOURCE DEVELOPMENT

A) Mahila Samkhya Programme

Started with the objective of initiating Programmes for the education & the empowerment of women in rural areas, especially for women from socially & economically marginalized groups to address and deal with the problems they face in society.
Interventions: Literacy, education and vocational education program trough *Sangha* or village collective as the nodal point on village level where women meet and begin the process of reflection; Sahayogini as the key link and motivator or guide for ten villages.

It is being implemented in 83 districts of 9 states & is being further extended to Madhya .Pradesh & Chattisgarh. The 10th Plan budgetry outlay for the scheme was Rs.98,48 crores, the outlay for the 1st year of the 11th Plan is Rs. 34 crores.

Entry Points

- **Ensure that HIV-positive/affected women and their dependents, especially children benefit from these programmes**
- **Women's groups can be made aware of the issues related to HIV/AIDS.**
- **HIV-Positive/affected women should be encouraged to form collectives, further they should not be discriminated against in groups.**
- **The Scheme should be extended to districts with a high prevalence of HIV/AIDS**
- **HIV/AIDS awareness programmes to be integrated in all training programmes for the personnel**
- **Train Mahila Samakhyas to address vulnerabilities of rural women especially infected and affected ones**

B) National Council for Teacher Education

The act provides for achieving planned & coordinated development of Teacher education & regulation & proper maintenance of norms & standards in Teacher education in the country. The budget for 2007-08 is Rs. 9 crores.

Entry Points

- **Teachers automatically reach out both parents & children, hence the curriculum should be carefully designed for the 2 different age groups vis a vis HIV/AIDS**
- **The National Institute of Open Schooling already has an excellent curriculum on HIV/AIDS prevention, treatment & awareness raising**

C) Kendriya Vidaylaya Sangthan

Wholly financed by the Government to establish control, & managed KV's, the main objective of which is to meet the educational needs of children of transferable Central Government employees. The budget for 2007-08 is Rs. 963.30 crores.

Entry Points

- **Students in the higher classes must be given an orientation on HIV/AIDS**
- **HIV/AIDS awareness programmes to be integrated in all training programmes for personnel**
- **Identify HIV-positive/affected children & ensure that they & their families are counselled & given access to treatment**
- **Train nodal teachers to function as mentors and lay counsellors.**
- **Train children to be ambassadors to reduce stigma and discrimination in the community**

5. MINISTRY OF WOMEN & CHILD DEVELOPMENT

A) Rashtriya Mahila Kosh

Is a national level micro-credit institution engaged in extending non-subsidized credit facilities in a quasi-formal manner through NGO's & other agencies to poor women of the country to help them take up income generating activities for improvement of their socio-economic status. The demand for assistance is increasing.
The budget for 2007-08 is Rs. 12 crores.

Entry Points

- **Credit should be linked to their participation in HIV/AIDS awareness programmes**
- **HIV-positive /affected women should be given preference for receiving credit**
- **Credit for positive /affected women should be made flexible with less interest**

B) Swadhar

The aim of the scheme is to provide support for women in difficult circumstances –

Entry Points

- **Include women with HIV/AIDS deserted by their family or women who have lost their husband due to HIV/AIDS without any social /economic support**

C) National Institute of Public Cooperation & Child Development

The aim is to develop & promote voluntary action for social development, comprehensive view of child development & promotion of programmes in pursuance of the National Policy for children. The institute has emerged as a leading training agency for ICDS functionaries, voluntary sector functionaries & self-help-group based women's empowerment programmes like Swashakti & Swayamsidha.

The budget for 2007-08 is Rs. 12.85 crores.

Entry Points

- **HIV/AIDS awareness programmes to be integrated in all training programmes**
- **Positive/affected women should be targeted for vocational training, including those relating to HIV related services such as counseling**
- **Positive/affected women should be trained to run HIV/AIDS awareness programmes**

D) Rajiv Gandhi National Crèche Scheme for the Children of Working Mothers

Aims to provide day-care services to children of the age group 0- 6 years belonging to economically weaker sections of society. The crèches provide health care, supplementary nutrition, medical check-ups & immunization, etc to the children whose parents are away at work-sites or are incapacitated due to sickness & unable to look after them. It is implemented through the Central Social Welfare Board & 2 other national level voluntary organizations throughout the country.

As on 31.12.2006 more than 27,000 crèches are functioning.

The budget for 2007-08 is Rs. 90 crores, plus 10 crores for North-Eastern States.

Entry Points

- **HIV/AIDS awareness programmes to be integrated in all training programmes for crèche personnel**
- **Identify HIV positive children & ensure that they receive better nutrition & necessary medical attention**
- **Identify HIV positive parents who are unable to work & ensure that their children benefit from this scheme**

E) Integrated Child Development Scheme

The Scheme aims to improve the nutritional and health status of vulnerable groups including pre-school children, pregnant women and nursing mothers through providing a package of services including supplementary nutrition, pre-school education, immunization, health check-up, referral services and nutrition & health education. In addition, the Scheme envisages effective convergence of inter-sectoral services in the anganwadi centres.

Entry Points (identified by NACO)

- **Modify ICDS guidelines to integrate nutritional support to women and children on ARVs**
- **Train Anganwadi workers to detect and report HIV related discrimination in villages and also use them to reduce the incidence of stigma**
- **Establish Red Ribbon clubs among adolescent girls and provide them access to holistic development - life skills, distance education, nutrition and messages on HIV/AIDS prevention**
- **Integrate HIV into all departmental training programmes**
- We should work with the Directorate of Social Welfare and the Programme Directors should initiate activities under this scheme.
- Tie the program with the ASHAs.

F) Swayamsidha

Swayamsidha is the flagship programmes of Ministry of Women and Child Development for holistic empowerment of women through SHGs – improving access to micro credit and involvement of women in local level planning

Entry Points

- **Support access to livelihood programmes – media campaign to overcome stigma (work related), transportation or linkages, see for enterprises in highly prevalence blocks**

6. MINISTRY OF SOCIAL JUSTICE AND EMPOWERMENT

A) Machinery for Implementation of PCR Act 1055, Prevention of Atrocities Act 1989

Assistance is provided by the Central Government to the State Governments. The assistance is mainly provided for strengthening of the administrative, enforcement & judicial machinery, awareness generation, inter-caste marriage & relief & rehabilitation of the affected person, etc. The budget for 2007-08 is Rs. 39 crores.

Entry Points

- **All Government employees should participate in HIV/AIDS awareness programmes**
- **Ensure that HIV positive women benefit from these programmes**
- **Marriage bureau for positive people could be encouraged**
- **Definition of atrocities could be expanded to include issues of stigms especially against positive women**
- **Sensitisation of judges on HIV can be undertaken**

B) Deendayal Disabled Rehabilitation Scheme:

Under the scheme, grants are sanctioned to voluntary Organisations to encourage voluntary action, create a conducive environment for the disabled & to ensure equal opportunity & social justice to the disabled & their families.

The budget for 2007-08 is Rs. 62 crores.

Entry Points

- **Identify HIV-positive disabled children & ensure that they & their families are counselled & given access to treatment**
- **All volunteers should participate in HIV/AIDS awareness programmes.**
- **Positive people should be enrolled as volunteers**
- **NGOs who apply for funds under this scheme, must participate in training on HIV/AIDs – symptoms, treatment, prevention and nutrition and the importance of reducing stigma**

C) Education Work for Prohibition & Drug Abuse prevention

Under this scheme, voluntary organisations are given assistance to the extent of 90% of the total approved expenditure, (95% for North-Eastern States, Sikkim & J&K). These organisations are financially assisted for setting up/maintaining Counselling & Awareness Centres & treatment-cum-Rehabilitation Centres & for organising de-addiction camps, awareness programmes & manpower development.

The budget for 2007-08 is Rs. 29.60 crores.

Entry Points

- **All volunteers should participate in HIV/AIDS awareness programmes.**
- **HIV-positive women should be enrolled as volunteers**
- **Identify IDUs & ensure that they & their families are counselled & given access to treatment**
- **Constitute Red Ribbon clubs**

7. MINISTRY OF HOUSING AND URBAN POVERTY ALLEVIATION

A) Swarna Jayanti Sahari Rojgar Yojana

The objective of the scheme is to provide gainful employment to the urban unemployed or underemployed through encouraging the setting up of self-employment ventures or provision of wage employment. Urban poor living below the urban poverty line

Women (not less than30%), Persons belonging to Scheduled Castes/Tribes, Disabled persons (3%), and Minority communities.

Entry Points

- The training should include HIV & AIDS and women rights as an agenda and IEC material should also include gender sensitive information on HIV & AIDS
- In skill training, HIV & AIDS relate services could be included such as counselling
- Non-discrimination and prioritization and at the level of issue of credit, loans and subsidy for positive people.
- The group schemes could consider having a homogenous group e.g. HIV positive widows
- PMRY Scheme can be availed by HIV positive persons.
- ITI training can be given for individuals who are positive, for economic sustenance.
- Care homes for people living with HIV can be considered.
- Have People living with HIV friendly policies at the level of issue of credit loans and subsidy for people living with HIV – RBI can give guidelines for lower rate of interest for HIV positive people.
- Under urban self employment programme we can provide marketing platforms for people living with HIV.

8. MINISTRY OF URBAN DEVELOPMENT

1) Jawaharlal Nehru National Urban Renewal Mission (JNNURM)

The aim is to encourage reforms and fast track planned development of identified
cities. Focus is to be on efficiency in urban infrastructure and service delivery mechanisms, community participation, and accountability of ULBs/ Parastatal agencies towards citizens. Provision of basic services to the urban poor including security of tenure at affordable prices, improved housing, water supply and sanitation, and ensuring delivery of other existing universal services of the government for education, health and social security.

Entry Points

- Increasing access to HIV/STD information, voluntary counselling and testing and health services for migrants. Further, reduce cultural and language barriers as these worsen their lack of access to such services
- Provide condom vending machines in public toilets
- Ensure provision of sanitation facilities for women
- Increasing safety in public spaces that includes appropriate street infrastructure (lighting, good state of pavements, absence of dark corners or dark parks or parking lots, etc.), for the women in case of sexual harassment or violence
- Making mandatory the inclusion of networks of positive people in the city planning process
- According priority to positive people in securing tenure in urban areas who have been dispossessed from the HHs According priority to people living with HIV to secure tenure in urban areas who have been dispossessed from the HHs. The group debated but was not clear about what securing tenure would entail.
- Municipality staff should be provided with training on gender sensitization.
- Bus stand and PCOs can be utilized for providing information.
- Have special youth friendly centers providing information for adolescent boys and girls.

9. Ministry of Youth Affairs

1) The National Service Scheme (NSS) - The scheme focuses on the development of the personality of students through community service. This scheme is, at present, implemented in Universities, Colleges and +2 institutions. The aim is to inculcate the spirit of voluntary work among the

students and teachers through sustained community interaction. The NSS has emerged as the India's largest student-youth movement in linkage with the community. The NSS volunteers are required to complete 120 hours of national service per academic year. They are also required to complete one special camp for sustainable national development for 10 days continuously and 8 hours per day.

Entry Points

- **HIV/AIDS awareness programmes to be integrated in all training programmes for the teachers & functionaries working in these schemes.**
- **All volunteers must be given an orientation course on HIV/AIDS.**

2) The Nehru Yuva Kendra Sangathan (NYKS)

The scheme caters to the need of non-student rural youth through youth clubs. The areas covered by NYKS relate to education, training, promotion of national integration, awareness generation, skill and entrepreneurial development, thrift and co-operation, and adventure and sports. The aim is to form Youth Clubs and involve the youth in nation-building activities. The NYKS runs its own programmes which include: Youth Club Development Programmes; Vocational Training Programmes; Awareness Campaigns; Work Camp; etc. It also runs programmes of the Ministry which include: Rural Information Technology; Youth Development Centres; Rural Sports Clubs, etc

Entry Points

- **HIV/AIDS awareness programmes to be integrated in all training programmes for the teachers & functionaries working in these schemes.**
- **Teachers/leaders who proactively include positive people in their training sessions should be given incentives like extra pay.**
- **Identify HIV-positive/affected youth & ensure that they participate in these activities & that they & their families receive counselling & given access to treatment.**
- **All participants in every training course or voluntary activity must be given an orientation course on HIV/AIDS.**
- **Mixed groups should be encouraged in order to integrate HIV-positive/affected youth.**

3) Financial Assistance for Promotion of Youth Activities & Training

Under this scheme financial aid is given for imparting Vocational Training and Entrepreneurial Skills to the youth, based on local needs and talents. Assistance is also given to NGOs for holding Youth leadership training programmes and exhibitions involving arts, crafts, folk dances, paintings and various social themes concerning the role of youth. A similar scheme of financial assistance to NGOs for the benefit of Youth belonging to backward/tribal areas and tribes is also being implemented by the Ministry.
10% of the budget allocation earmarked for North Eastern States may be utilized under the Tribal Sub Plan (TSP). In addition, proposals emanating from and involving tribal youth from the community development blocks listed as tribal blocks by the Planning Commission from time to time will be given preference.

The Scheme has the following sub-components:

Vocational Training - Available for 24 trades, the training duration is from 2 to 6 months.

Entry Points

- **HIV/AIDS awareness programmes to be integrated in all training programmes for the teachers & functionaries working in these schemes.**
- **Teachers who proactively include HIV/AIDS infected/affected persons in their training sessions should be given incentives like extra pay.**
- **Identify positive/affected youth & ensure that they participate in these activities.**
- **Positive/affected participants should be given easier terms of payment and other incentives.**
- **All trainees must be given an orientation course on HIV/AIDS.**
- **Size of groups being trained should be kept flexible and mixed groups should be encouraged.**

Entrepreneurship Development - Includes Theatre, folk dances, folk songs

Entry Points

- **Theatre/folk dances etc which focus on HIV/AIDS awareness could be given an incentive in terms of easy release of funds.**
- **HIV/AIDS awareness programmes to be integrated in all training programmes for the teachers & functionaries working in these schemes.**
- **Identify positive/affected youth &ensure that they participate in these activities.**

- **Positive/affected participants should be given easier terms of payment and other incentives.**
- **All participants must be given an orientation course on HIV/AIDS.**

Exhibitions - On arts, crafts, paintings and various social themes concerning the role of youth.

Entry Points

- **Exhibitions which focus on HIV/AIDS awareness could be given an incentive in terms of easy release of funds.**
- **Identify HIV-positive/affected youth & ensure that they participate in these activities**