Gender Inputs to the NACP III
Prepared by UNIFEM South Asia Regional Office& Submitted to NACPIII planning Group
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The global challenge to prevent HIV infection among women, men, girls and boys is urgently growing with time. "The rate of new HIV infections continues to climb every year, with an estimated 4.9 million people having been infected in the twelve months, ending December 2004[1]. "Globally, the total number of people living with the virus also continues to grow, reaching 40 million at the end of 2004 and trends indicate that left unchecked, the epidemic will continue to increase[2]."

India itself is seeing an alarming trend of increasing HIV cases over the years.[3] It has 5.134 million people found to be HIV+ in 2004, accounting for 13% of the global HIV/AIDS prevalence[4], 2nd to South Africa[5]. Women account for 37% of HIV infected adult in India[6].

Twenty years of HIV/AIDS response have seen a gamut of initiatives, opening up avenues for innovative interventions at various levels and the coming together of multi-stakeholders for coordinated efforts. Within this period, the connection between gender and HIV/AIDS had been explored and established in no uncertain terms. It is recognized that "(t)oday, the face of the HIV/AIDS epidemic is typically that of the impoverished, undernourished woman from the third world".[7] Thus, "(t)he international community has clearly endorsed that "gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS", both at the Millennium Summit held in 2000, as well as the UN General Assembly Special Session (UNGASS) on HIV/AIDS in June 2001. The Theme of World AIDS Campaign 2004 has been identified as: Women, Girls, HIV and AIDS"[8].

In drawing clear linkages between gender issues and HIV/AIDS, it is noted that "(t)he ability to address gender issues is central to the success of program(me)s and reducing women and men's

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[1] AIDS epidemic update, UNAIDS, Geneva, 2004 in "Intensifying HIV Prevention", UNAIDS Policy Position Paper, UNAIDS, 2004, p3.
[2] AIDS in Africa, Three Scenarios to 2025, UNAIDS, Geneva, 2005 in "Intensifying HIV Prevention", UNAIDS Policy Position Paper, UNAIDS, 2004, p3.
[3] NACO Facts & Figures, 2004 Estimates in www.nacoonline.org

Year (estimates in millions, 1998-2004						
1998	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**
3.5m	3.7m	3.86m	3.97m	4.58m	5.106m	5.134m

[4] NACO/UNAIDS, 2004 in www.kff.org
[5] www.youandaids.org, feature story - Anti retro-viral medication in India costs1300 Indian Rupees per month, UNAIDS/UNDP, August 2005.
[6] WHO/UNAIDS in Population Reference Bureau, 2005 www.prb.org

2003 estimated # of HIV cases (adults & children)	5,100,000
Adults (15-49 years)	5,000,000
Women (15-49)	**1,900,000**
Children	120,000
Estimated number of deaths due to AIDS	---
Estimated Number of AIDS orphans	---

[7] Kelkar and Nathan, 2003 cited in "The Gender Dimensions of HIV/AIDS Challenges in South Asia", UNAIDS SAICT/UNIFEM, New Delhi, August 2004, p9.
[8] Gender and HIV/AIDS in South Asia, An Analytical Paper, UNIFEM, July 2004.

(girls & boys') vulnerability to HIV and its impacts. While this fact is often well-known by program(me) planners and policy-makers, what remains less clear is how to address gender issues when actually designing and implementing HIV/AIDS program(me)s.'"[9] Clarity of grasp of issues and responsiveness of interventions are undoubtedly crucial in effective & efficient HIV/AIDS prevention, care & support.

This paper is meant to reinforce understanding of the link between gender and HIV/AIDS, take stock of the range of initiatives on the ground and provide inputs from a gender perspective to the NACP III.

I. Understanding Gender, Vulnerabilities and HIV/AIDS

A regional scan on "The Gender Dimensions of HIV/AIDS Challenges in South Asia"[10] has underscored, thus:

> *"The experience of the HIV/AIDS epidemic world wide suggests that it is fuelled by the inequitable distribution of material and knowledge resources, exposure and ability to handle risks and risky situation, as well as differential experiences and uneven power relations. Gender is an important aspect of such inequitable distribution and this is demonstrated by trends in vulnerability along gendered lines. The international health and development sector has thus been required to place emphasis on the social, cultural, economic and political realities that underpin vulnerabilities and recognise that the ability of communities to respond is compromised. Undoubtedly, the epidemic has followed paths of least resistance, where people have limited access to resources necessary to protect themselves."*

Essentially, "HIV/AIDS epidemic is fuelled by inequitable distribution of material and knowledge resources, entitlements, risk and power" based on gender and compounded by class, caste, race/ethnicity, age, religion, profession, etc.

contextualizing gender in relation to HIV/AIDS: Departing from the oft-defined "social construction of man-woman, on the basis of which roles, responsibilities and opportunities are assigned", there are contextual realities that need to be understood in appreciating gender in relation to HIV/AIDS in the region, particularly in India.

One, gender, within the context of HIV/AIDS in South Asia, is deemed to address "what it means to be male, female or other gendered category of person[11], and how that impacts the

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[9] How to Integrate Gender into HIV/AIDS Programs, Using Lessons Learned from USAID and Partner Organizations, IGWG/USAID, May 2004, p1.
[10] UNAIDS SAICT/UNIFEM, New Delhi, August 2004, pp 8-9.
[11] "(I)n the context of South Asia, as with many parts of the world, we find that there exist not two, but multiple gendered identities and realities. In the South Asian context, (especially in India), these include *Hijras*[11], *Kothis*[11], *Jogappas, Alis, Khojas, Metis, Zenanis, Aravanis,* just to name a few. Each of these gendered categories has a long and rich history, and each escapes the western categories of 'transgender' and 'transexual', which have come to simply describe a process of 'moving' from 'one gender to the other'. Many of these categories are enmeshed in local practices and mythologies as well as religious scriptures… (I)t needs to be emphasised that rather than being considered 'aberrations' necessitated by a simple dualistic system of gender, these genders exist in South Asian

person's roles, responsibilities, relationships and the distribution of resources, risk and power"[12]. The simple dualistic system of male-female is not necessarily representative of reality as we recognize transgender, transsexual and/or homosexual people in our midst. While HIV transmission in India is understood to be predominantly heterosexual, there is likewise a growing evidence of incidence of HIV/AIDS among MSM[13]. There is also evidence that hijras and those of other gendered identities, face immense amounts of violence based on their sexual identity and are amongst the most vulnerable to HIV/AIDS due to their socio-economic exclusion[14]. They are constantly faced with society's homophobia, resulting in stigma and discrimination as well as denial of rights.

Two, a "framework of intersectionality envisages gender not as a static, 'natural' reality, but rather, as a dynamic and constantly changing idea on the basis of which power relations are maintained". It poses the question, thus: "How does gender, intersecting with other social, cultural, economic and political factors have such power as to determine the direction and scope of the HIV/AIDS epidemic? The framework of intersectionality does not take away from the need to facilitate women's power over their lives, but rather, attempts to provide a more holistic approach that addresses the complexity of mechanisms through which gender relations are maintained"[15].

gender & material resources: One of the most populous countries in the world with over a billion people[16], India's population represents 17% of the global inhabitants[17] and 40% of the world's poor earning USD1/day[18]. Twenty-eight point 6(28.6) percent of its population live below the national poverty line[19].

In the midst of flagrant poverty, India's economy is marked by disparities on the basis of gender. Records show that only 41% women as against 86% men in India are deemed economically active (ages 15+)[20]. It is estimated that women earn USD 1442 annually as against that of USD

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cultures as legitimate, but marginalised categories". UNAIDS, 1998 in Gender and HIV/AIDS in South Asia, An Analytical Paper, UNIFEM, July 2004.

[12] UNAIDS, 1998 in Gender and HIV/AIDS in South Asia, An Analytical Paper, UNIFEM, July 2004.
[13] Refers to "men having sex with men"; "HIV transmission through sex between men is also a major cause for concern in many areas of India. Recent research shows that many men who have sex with men also have sex with women. In 2002, behavioural surveillance in five cities among men who have sex with men found that 27% reported being married, or living with a female sexual partner. In a study conducted in a poor area of Chennai in 2001, 7% of men who have sex with men were HIV-positive. Attention currently focuses on areas with high recorded prevalence, but there is concern about what might be happening in the vast areas of India for which there are little data". www.youandaids.org, India at a glance, UNAIDS/UNDP.
[14] Humsafar Trust, 2004, PUCL-K, 2003, in Gender and HIV/AIDS in South Asia, An Analytical Paper, UNIFEM, July 2004.
[15] Gender and HIV/AIDS in South Asia, An Analytical Paper, UNIFEM, July 2004.
[16] 1,027,000,000 as of 2001, Census of India, 2001.
[17] NACO, 2004; UNAIDS 2004.
[18] HDR in Progress of South Asian Women 2005, Accountability to the World's Women, UNIFEM, New Delhi, 2005.
[19] 1984-1999 per HDR, 2004 in Progress of South Asian Women 2005, Accountability to the World's Women, UNIFEM, New Delhi, 2005.
[20] 1995/2002, Population Reference Bureau, 2005 www.prb.org

3820 that men earn[21]. Major barrier to women's productive engagement is the private-public dichotomy where women are expected to stay out of the public domain in the main. Additionally, entrenched sexual division of labour based on stereotypical notion of gendered roles and responsibilities limits women's option in the informal sector, service industry and low-end jobs. With women in non-farm activities, "an estimated 45% are home-based workers[22]" as caregivers and nurturers (e.g. child-care, domestic service, cook, etc), food processing personnel, garments production sub-contractor, etc.

Property rights, let alone inheritance rights, remains elusive for girls, women and other gendered identities – and these are issues integral in rights to citizenship and political engagement, including decision-making. The prevailing system in the country is male-centric: from registration of birth, obtaining ration card, titling of property, access to credit and finance, etc.

Discrimination based on gender, taken along with economic difficulties, impact opportunities for girls, women and other gendered identities. India's literacy rate is 65.38%, out of which 75.85% represent literacy among males and 54.16% among females[23] - notably, statistics do not even specifically cover other gendered identities. Girls have an average of 3.7 years of schooling in India as against 6.3 years for boys[24]

Aside from education and literacy, health is an area that is likewise tenuous for girls, and women. Infant mortality rate in India is 67/1000[25]; more than half of all children under the age of four are malnourished and 30 percent of newborns are significantly underweight[26]. Lifetime births per woman (TFR) is 3.1, 11% of women ages 15-19 giving birth in a year. Only 43% of births are attended by skilled personnel[27]. There are 540 maternal deaths per 100,000 live births[28], accounting for almost 25% of the world's childbirth-related deaths[29]. Every woman out of 48 has a lifetime chance of dying from maternal causes[30]. Meantime, 60 % of India's women are anaemic[31].

Access to health care presents daunting limitation to girls, women and other gendered identities. In addition to non-health seeking behaviour, limited economic resources, cultural barriers to being examined, inability to decide on one's own without the man agreeing or initiating the process (especially for women), there is the threat associated with medical processes and the results of medical examinations, especially where this relates to HIV infection due to stigma and discrimination.

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[21] for 2002 per HDR 2004 in Progress of South Asian Women 2005, Accountability to the World's Women, UNIFEM, New Delhi, 2005

[22] Women and the Economy, Progress of South Asian Women 2005, Accountability to the World's Women, UNIFEM, New Delhi, 2005

[23] As of 2001, Census of India 2001.

[24] Human Development in South Asia, 2003.

[25] 2001, HDR 2003

[26] www.youandaids.org, India at a glance, UNAIDS/UNDP

[27] Population Reference Bureau, 2005 www.prb.org

[28] 2000, Population Reference Bureau, 2005 www.prb.org; as of 2001, HDR 2003.

[29] www.youandaids.org, India at a glance, UNAIDS/UNDP

[30] Population Reference Bureau, 2005 www.prb.org

[31] www.youandaids.org, India at a glance, UNAIDS/UNDP

Material resources for girls, women and other gendered identities could spell the difference between prevention and infection. It could mean proper schooling and better future opportunities for children, better negotiating power for safe(r) sex for women and other gendered identities, access to adequate health care and information for all.

gender & knowledge resources: Norms of femininity and masculinity[32] inhibit knowledge, generally, and foster greater vulnerability to HIV/AIDS. "Gender norms for femininity may place high value on sexual innocence, passivity, virginity and motherhood… (Women and girls) are often, therefore, remain poorly informed about sex, sexuality, and reproduction and are less able to discuss these issues with their sex partners"[33], let alone negotiate for protection and safe sex. Gender norms for masculinity encourages early initiation in sexual activities & sexual adventures in men including multiple partners, aggression that many times result in gender-based violence and reservation/inability to seek knowledge about sex, HIV/AIDS, etc. Either way, lack of knowledge of either women or men compromises prevention against HIV but impacting girls, women and gendered identities more, given lopsided equation existing in sexual relations.

Procreation is considered a social value in many cultures, India included, and attributed as responsibility for both men and women. Condom use, therefore, is seen as contradictory to procreation thus, the resistance to take to it.[34] Yet, in the context of Reproductive and Child Health (RCH) Programme, "female sterilization is routinely practiced and preferred in the country and with women undergoing sterilization at the average age of 24 years, the rest of the sexually active phase is without any protection because husbands (and wives, too) do not see the need for condoms any more[35]. The need to understand the use of condom in relation to HIV/AIDS tends to be overlooked. Thus, "the HIV-RCH linkage needs to be better understood and treated as strong rationale for integrating the two national programmes"[36].

The impact of violence against women and children, including the physical trauma associated with forced sex, likewise increases vulnerability to infection. Psychologically, it affects a woman's control over her body. More linkages need to be further highlighted between VAW and HIV, including links with migration and trafficking, and information hereon disseminated.

gender & entitlements: Where the legal system is unable to provide basic entitlements for its citizens, especially the majority poor, whether with regard to education, livelihood and

[32] "(T)he normative ideal of a good woman and wife is often seen to be one who is subservient, self-sacrificing and innocent about sex, whereas men are expected to be knowledgeable about sex, seek multiple partners and physically dominate over women (UNICEF, UNAIDS, 2003). ..For women, this implies a limit to knowledge and access to sexual health and capacity to negotiate protection in sexual interactions. Similarly, reproductive and sexual health services do not consider people outside of marriage to have desires and as sexually active. As such the denial of pleasure has implied the denial of safe sex information and sexual health services also to adolescents, men who have sex with men and single women." Gender and HIV/AIDS in South Asia, An Analytical Paper, UNIFEM, July 2004.
[33] Gupta, et al, 2003; Gupta, 2000 cited in How to Integrate Gender into HIV/AIDS Programs, Using Lessons Learned from USAID and Partner Organizations, IGWG/USAID, May 2004, p3.
[34] Gupta, et al, 2003; Gupta, 2000 cited in How to Integrate Gender into HIV/AIDS Programs, Using Lessons Learned from USAID and Partner Organizations, IGWG/USAID, May 2004, p3.
[35] Bharat, S., Social Assessment of the Reproductive and Child Health Programme, Ministry of Health & Family Welfare and Department for International Development (DFID), New Delhi, 2003.
[36] Bharat, S., Social Assessment of the Reproductive and Child Health Programme, Ministry of Health & Family Welfare and Department for International Development (DFID), New Delhi, 2003.

employment, health care, social services, rights to property and inheritance, voice in decision-making, political participation & leadership, among others, chances are, vulnerabilities of communities and the nation can only get compounded. Whether in law and in fact, women are at the receiving end of a bad bargain.

- "… There is now evidence that the largest proportion of new (HIV) infections in India is amongst women whose only 'high-risk behaviour' is being married. (Gangakhedkar et al, 1997).
- Recent behavioral surveillance also provides evidence of the gender inequity in access to information and resources for self-protection in the general population (NACO 2001)"[37].
- Women provide care but do not receive it; the care and support structure for women is weak and tenuous at best with natal family offering the greatest support, if at all[38].

The CEDAW Committee[39] aptly noted "that India has a very large and mainly rural population living in absolute poverty and that the feminization of poverty and growing income disparities prevent the benefits of economic development being transferred to women… (W)idespread poverty, (and) such social practices as the caste system and son preference, as reflected in a high incidence of violence against women, significant gender disparities and an adverse sex ratio, present major obstacles to the implementation of the (Women's) Convention[40]"[41] to which India is a signatory and likewise, to the fight against HIV/AIDS.

gender & power: Given inequalities in the social, economic, cultural, political milieu, women often have very weak bargaining footing as against men. As shown above, whether in material or knowledge resources, women are faced with more challenges than men. When women do not have decision-making power, their control over their lives is severely curtailed and their future compromised. Further, the unequal burden on women in the prevention of HIV/AIDS and in the care economy[42] must be understood and recognized. "That women (mothers, wives, daughters and daughters-in-law) provide care, but do not themselves receive care, is a social and cultural reality and lies at the core of the informal, home based care-giving phenomenon. This reality is highly accentuated in the case of AIDS due to its stigmatizing nature. Women not only experience enormous physical, emotional and social burden of such care giving but also bear heavy costs in the form of alienation from market economy, lost opportunities for schooling, reduced time

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[37] "The Gender Dimensions of HIV/AIDS Challenges in South Asia", UNAIDS SAICT/UNIFEM, New Delhi, August 2004, p9.

[38] Bharat, S., Facing the Challenge: Household and Community Responses to HIV/AIDS in Mumbai, India. WHO and UNAIDS, Geneva, Switzerland, 1996; also, Bharat, S., (Household Study and S&D), HIV/AIDS Related to Discrimination, Stigmatization and Denial in India, UNAIDS, Geneva, 1999.

[39] refers to the Committee on the Elimination of Discrimination Against Women, the treaty-monitoring body created by the Convention on the Elimination of Discrimination Against Women to monitor State compliance with that Convention

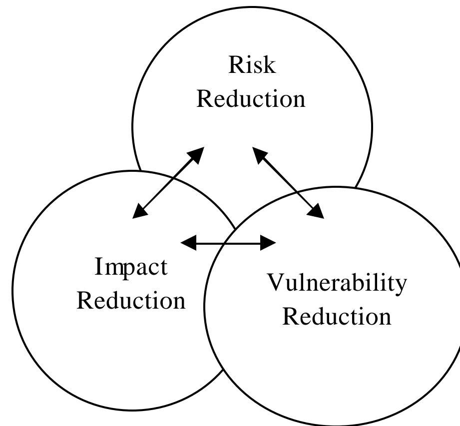
[40] Convention on the Elimination of All Forms of Discrimination Against Women (otherwise referred to as the Women's Convention), adopted in 1979 and entered into force in 1981

[41] Concluding Observations of the Committee on the Elimination of Discrimination Against Women : India, 01/02/2000, A/55/38,paras.30-90. (Concluding Observations/Comments), CEDAW, Twenty-second session, 17 January-4 February 2000.

[42] Care Economy: refers to the pattern of feminised care-giving that is informal, home based and largely unremunerated seen in parts of societies in Asia, Africa and Latin America. Gender and HIV/AIDS in South Asia, An Analytical Paper, UNIFEM, July 2004.

for self growth, nutritional neglect, delayed or shelved marriage plans, etc."[43]

gender & risk: Gender issues, as elaborated in other sections, bring about greater risk of infection to girls, women and other gendered identities. The Global Strategy Framework on HIV/AIDS[44] had acknowledged the "reinforcing strategies of risk, vulnerability and impact reduction" as it suggests a "comprehensive approach to HIV prevention (which) must address not only risk but also deep-seated causes of vulnerability which reduce the ability of individuals and communities to protect themselves and others against infection."[45]



II: *Taking Stock of India's Multi-faceted Response: Civil Society, NACO and the NACP*

From the painful initial stages of denial, India has come a long way since the first ever reported case of HIV in 1986. The response has been both earnest and broad-based with both the government and the non-government sectors coming together to address the issues of HIV/AIDS. This, in spite "(i)ssues of human sexuality (being) extremely sensitive, and (where) attempts to broaden the discourse on human sexuality matters are considered by some as attempts to debase the local cultures and traditions"[46].

Starting from a high-power committee in 1986 under the Ministry of Health and Family Welfare, a National AIDS Control Programme was launched in 1987 and a National HIV Programme has evolved since. The National AIDS Control Organization (NACO) was established in 1993, to carry out India's National AIDS Programme through policy formulations and HIV/AIDS control programmes. State AIDS Societies were formed with mechanisms for state level programme management. NACO had undertaken the National AIDS Control Project (NACP) Phase I (ending 1999) and is presently completing Phase II (recently extended to 2006). NACO is now preparing for Phase III of the NACP.

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[43] Gender and HIV/AIDS in South Asia, An Analytical Paper, UNIFEM, July 2004.
[44] UNAIDS, Geneva, 2001.
[45] "Intensifying HIV Prevention", UNAIDS Policy Position Paper, UNAIDS, 2004, p11.
[46] www.youandaids.org, India at a glance, UNAIDS/UNDP

In retrospect, it is important to highlight key activities facilitated through NACO since the initial phases of interventions[47]:

- broad-based research projects
- surveillance activities
- focused interventions on coverage amongst high risk groups like sex workers, truck drivers and injecting drug users
- increasing efforts to make the programming multi-sectoral
- strong decentralized programme mechanisms, the responsibility of implementation vested with the states.
- establishing a network of 12 Technical Resource Groups (TRGs), each covering different thematic areas of the epidemic, mandated to provide technical support to states.
- Legislation and policies[48] facilitated:
  - Goa Public Health Act Amendment of 1985 (Section 53.I.vii) allowed the public health authorities and police discretion to isolate people with HIV/AIDS; repealed in 1996.
  - Railway Board Administrative Notification of 1989 designating HIV/AIDS as "infectious disease" which can allow denial of passage; rescinded in 1996.
  - Draft legislation in 1989 Session of National Parliament, which was evaluated as extremely prejudicial to rights of PLWH/As withdrawn after intervention of WHO and national authorities.
  - The 1992 Administrative Notification from Minister of Health & Family Welfare (GOI) to all State Governments directing them to ensure non-discriminatory access to treatment and care for PLWH/As in all Central and State Government health care institutions.
  - The Government has, by Administrative Order, required the screening for HIV of all units of blood to be used for transfusion purposes.
  - May 1997, Mumbai High Court Judgment held that employers cannot base employment decisions on HIV status of employee.
  - A legislative framework on HIV is on the anvil.

The NACP II built on earlier work and laid emphasis on strengthening initial gains per its stated objectives, thus:
1)" To *shift the focus from raising awareness to changing behaviour* through interventions, particularly for groups at high risk of contracting and spreading HIV;
2) "To support decentralization of service delivery to the States and Municipalities and a new facilitating role for National AIDS Control Organization. Program delivery would be flexible, evidence-based, and participatory and to rely on local programme implementation plans;
3) "To *protect human rights* by encouraging voluntary counseling and testing and discouraging mandatory testing;
4) "To support *structured and evidence-based annual reviews and ongoing operational research*; and
5) "To encourage management reforms, such as better-managed State level AIDS Control Societies and improved drug and equipment procurement practices. These reforms are proposed

[47] www.youandaids.org, India at a glance, UNAIDS/UNDP
[48] www.youandaids.org, India at a glance, UNAIDS/UNDP

with a view to bringing about a sense of 'ownership' of the programme among the States, Municipal Corporations NGOs and other implementing agencies'[49].

NACO, in its Phase II, focused on three(3) main components, namely: surveillance, prevention and care. Lessons[50] have been learned therefrom and strategies for
NACP III can be drawn, hence:

- higher coverage of high risk groups through TIs
- aggressive condom promotion including social marketing
- greater focus on vulnerable states with poor health indicators
- need for capacity-building of NACO and SACs and continuity in staffing
- strengthening M&E mechanisms at all levels
- (avoid) duplication and scattered response by stakeholders
- Greater attention on MSMs and IDUs
- Integrating prevention and care and support
- Need for greater focus on youth
- Developing effective partnerships with the private sector for STD control
- Tackling stigma and discrimination more effectively
- Making HIV everyone's business

As part of further stock-taking, select projects are hereunder being revisited to facilitate more insights into ways of approaching issues of gender and HIV/AIDS especially in light of NACP III.

A. Surveillance

Evidence-based studies and mapping exercises continue to shed light into the evolved nuances of the HIV/AIDS epidemic in the country and assist intervention planning.

A.1) A joint Government and UN effort through the CHARCA (Coordinated HIV/AIDS response through Capacity-Building and Awareness) project has been underway to address the larger vulnerabilities of women. CHARCA is a project generally aimed at reducing the vulnerability of young women, (13-24 years) from HIV infection. It is a district level project, operational in the states of Bihar (Kishanganj), Rajasthan (Udaipur), Karnataka (Bellary), Uttar Pradesh (Kanpur), Andhra Pradesh (Guntur), and Mizoram (Aizawl).

The program specifically aims to -

- increase women's awareness and knowledge regarding sexually transmitted infections and HIV/AIDS through a reproductive and sexual rights perspective
- build women's skills and capacity to exercise their rights and access appropriate and high quality services
- create an enabling environment by supporting participation in community based networks and working with men to increase their understanding of women's health and rights issues
- promote responsible sexual behaviour.

[49] NACO, www.nacoonline.org; also, "Response to HIV/AIDS in India 2003", UNAIDS (italics supplied).
[50] NACP III Preparatory Phase, NACO (Paper), July 2005

The CHARCA baseline survey[51] was conducted to examine current knowledge and awareness levels of women and men on knowledge, attitude, behaviour and practices related to STIs/HIV, map and list current support structures (formal as well as informal) for young women, and understand attitudes of the target population in relation to collective action at community level to reduce young women's vulnerability to HIV/AIDS. The baseline survey also collected data to inform project interventions on building local leadership and support networks to take up the issues of young women at community level, identifying referral systems for reproductive and sexual health needs of adolescents, identifying potential issues for further research during the project implementation, and strengthening local capacity in baseline studies.

A.2) "Awareness and knowledge of prevention are crucial to checking the spread of HIV. In 2001, a behaviour surveillance survey (BSS) conducted by NACO indicated increased levels of awareness but the same study found that very few people correctly understood how to prevent transmission. And, awareness was especially low among women. The survey found that while 70% of men were aware about the protective value of a condom, only 48% women knew about this"[52].

A.3) Women's health is to be addressed through a more holistic approach underlining their basic rights for health education. Links need to be made with RCH.

DESH started Reproductive and Child Health project in 1996, and has programs in ten cities spread in six States. It works through 50 NGOs in six cities in five States covering 100000 Families; 104 Workplaces; 260 Schools - (Year 2000 - 2003).

Several studies have been undertaken by DESH in a bid to establish link between RCH and HIV prevention.

- Surveys highlighted an increase in Knowledge among women about Condom use from Base line Survey (BLS) 12 % to end line survey (ELS) 52%, about STI Infection from BLS 7% to ELS 45%, about HIV Transmission from BLS 17% to ELS 55%, and Knowledge about Family Planning from BLS 18% to ELS 54%. It has also brought out the difference in increase of empowerment and knowledge about sex determination. On the other hand it showed that Ignorance has decreased, through reduction in 'Don't Know Responses' among women from the target population in all six cities, about STI Infection from BLS 65% to ELS 6%, about HIV Transmission from BLS 32% to 3% and Family Planning Methods from BLS 17% to ELS 2%.

  Similarly, the average for all target areas in six cities measured through base line and end line surveys shows manifold increase in Knowledge (K) among Girls as follows:The surveys highlighted an increase in Knowledge among girls about HIV Transmission from BLS 19% to 57%, while Ignorance has decreased through reduction in 'Don't Know Responses', about HIV Transmission from BLS 35% to ELS 5%.[53]

- DESH likewise facilitated studies to appreciate change in levels of empowerment. The findings reveal that there is a change in the levels of empowerment among group and non-group members in comparison with the baseline survey, in the following aspects:
  -Going out to attend functions in relatives' house
  -Going out with friends who are women
  -Handling drinking water problem in the area
  -Becoming a member of local Sangams
  -Taking up job one likes

[51] S K Singh, H Lhungdim, A Chattopadhyay, November 2004, Women's Vulnerability to STI/HIV in India. International Institute for Population Sciences, Deonar, Mumbai
[52] "Knowledge, Attitudes and Practices of Young Adults (15-24 years),Disaggregated Data from the National Behavioural Surveillance Survey (2001)", NACO/UNICEF
[53] DESH document, 2005

-Adopting permanent contraception despite husband's insistence against the same
-Reaction to poor treatment in the hospitals
-Husband's alcoholic problem

A.4) A study[54] on gender and masculinity opened up new vistas for engagement on gender issues and HIV/AIDS. Although the study catered to the need to understand femininity and masculinity and the roles that women and men can play to build a supportive environment/community, it underscored the significance of men's participation towards the achievement of gender equality. To correct the inequality on the basis of gender, it is important to promote women's agency, on one hand, and build on men's responsibility, on the other hand.

A.5) The South Asia Political Advocacy Project/India Database on HIV/AIDS (Behavioural Dimensions)[55] was undertaken, aimed at: a) development of HIV epidemic modeling and projection tools: estimation and projection package, b) development of secondary national and regional HIV/AIDS database, and c) development of national and regional advocacy strategies for political advocacy. This study threw some questions and insights for follow-up, e.g. women's vulnerabilities are not assessed in clear terms; the need to understand why vulnerability in high prevalence state is the same in low prevalence state; etc.

A.6) Many other evidence-based studies have been undertaken on stigma and discrimination, care economy, and impact on households, too. Findings hereon have to be made accessible through the development of information, education & communication materials in formats and languages which are accessible and widely disseminated.

B. Prevention

B.1) *Evolved framework*: India's National HIV/AIDS Programme has evolved tremendously in terms of framework and depth of engagement. From a purely health approach to HIV/AIDS, interventions have considered the entirety of the socio-economic, cultural & political milieu in its engagement with the issues, employing rights-based approach in the recent years. The linkages between HIV/AIDS and manifold vulnerabilities are getting more clearly drawn, locating women at the center of the discourse & interventions.

B.2) *Laws and Human Rights:* The guarantees of CEDAW[56] to which India is a signatory, especially in the absence of a law on HIV/AIDS to date, and commitment under BPFA[57] and MDG[58] provided more impetus in ensuring the will, the action and the resources from the government towards a gendered approach to HIV/AIDS.

B.3) *Awareness-Raising towards Behaviour Change:* Awareness-raising needs to be continuous for behavioural change to materialize. Although NACP II, as mentioned earlier, meant "to *shift the focus from raising awareness to changing behaviour* through interventions, particularly for

[54] "From Violence to Supportive Practice: Family, Gender and Masculinities in India", Chopra, R (ed), UNIFEM, New Delhi, 2002.
[55] TISS/UNAIDS, 2001-2003.
[56] Considered women's "international bill of rights" mandating non-discrimination;
[57] Platforms of action on health, on VAW, on human rights of women, among others;
[58] Goal 6. combat HIV and AIDS, malaria and other diseases.

groups at high risk of contracting and spreading HIV", misinformation due to absence or lack of information hinder work on HIV/AIDS. Evidence-based data need to inform awareness-raising interventions to make them purposive and effective. The use of multi-media (posters, flyers, videos, publications) to reach out to various sectors can be very effective.

B.4) *Multi-Sectoral Partnerships*:

- Multi-stakeholders collaborations between local and international organizations, women's groups & other sectoral groups, private and public organizations and other partnerships are pushing the agenda of HIV prevention forward. Multi-agency responses have also been initiated whether from agencies working on children, women, population, health, etc.
- Coordinated international efforts by the different UN agencies under the aegis of the UN Theme Group (UNIFEM, UNDP, UNFPA, UNICEF, UNODC, ILO, WHO) have given high visibility to the issues of gender and HIV/AIDS. UN agencies have worked on mainstreaming HIV into their ongoing programmes through facilitation, technical and financial support.
- Responses from the women's movements have addressed the structural issues of women's disempowerment and vulnerabilities through campaigns, advocacy for law reforms, addressing violence against women, strengthening links with the elected women representatives and economic empowerment. They have also worked on rescue, rehabilitation and reintegration of women survivors of violence, especially of trafficked women. They have developed media spots, campaigns across borders and networking.

B.5) *Gender Mainstreaming:* Several efforts at mainstreaming have been done with several Ministries, both at the center and the states. Gender interventions have been afoot with the ministries of Road, Transport and Highways, of Education, of Social Justice and Empowerment, of Railways, of the Department of Women and Child Development. Under the leadership of NACO, round-tables across ministries (and other stakeholders) have been held and gender sensitive materials developed.

As part of its mainstreaming work, UNIFEM entered into partnership with the Ministry of Railways to facilitate a project called "Equalizing Gender Relationship in the context of HIV/AIDS Epidemic"[59]. This project is being implemented by the Railway Women's Empowerment and AIDS Prevention Society (REAPS) in Vijayawada, Andhra Pradesh. The intervention was built around the established railway infrastructure of institutions – railway schools, health units, hospitals, trade unions, mahila samitis, that serve as entry points for a gender sensitive, multi-sectoral response for HIV/AIDS prevention, treatment & care.

Since the project began in 1992, it has:

- sensitized railways officials so they can help create enabling environment for the successful implementation of the project;
- selected, trained and sent into the field 48 peer counselors in all the 8 project districts with a special focus on gender sensitization;
- tested, identified and counseled thousands of individuals and HIV/AIDS persons within the railway community of Vijayawada division;
- initiated a revolving fund for women and families living with and affected by HIV/AIDS.

B.6) *Women-focused interventions, especially engaging WLHA:* Focusing on women's participation & leadership highlighted the need for a broad developmental framework. Breaking

[59] Making Change, Making History – Gender and HIV/AIDS, Progress Report, phase 1, REAPS/UNIFEM

the silence around the issues of gender and HIV/AIDS has been a big achievement in itself in the fight against HIV/AIDS and has led to an understanding of issues from the perspective of positive women thus, strengthening programmes on prevention of HIV, care and support. Moreover, positive women directly talking about issues has helped conquer the stigma and discrimination associated with HIV/AIDS and about WLHA. It also facilitated organizations of women who are similarly situated and likewise facilitated collective initiatives. The empowerment of positive women emanating from a unified fight against HIV/AIDS has been an inspiring experience.

The story of the Positive Women Network (PWN+)[1], India is a story of empowerment and of reclaiming legal and moral entitlements. It talks of a journey from silence to leadership.

> ***"Our vision is that women living with HIV/AIDS and their children should have absolute right to live a life of dignity, in an environment free of any stigma and discrimination and that we succeed in mainstreaming our concerns to enable women to access their fundamental constitutional rights, especially the rights to equality, health, education, livelihood, to form association, enhance participation and be protected from violations and neglect"(Vision Document, PWN+).***

Started in 1998, PWN+ consisted of 18 founder members, predominantly from Tamil Nadu. The group received technical guidance from UNIFEM through regional workshops in the North (New Delhi), North East (Guwahati) and the South (Chennai). A unified vision document came out of the process, enabling the network members to arrive at strategic goals, spell out core objectives and agree upon practical strategies and activities. In 2004, PWN+ boasts of 5000 WLHA as members, many leaders and frontline workers from Karnataka, Kerala, Andhra Pradesh, Maharashtra, Gujarat, Manipur, West Bengal, Assam and Orissa.

Over the years, PWN+ has endeavoured to -

- *build active national network of WLHA,*
- *facilitate societal acceptance and social integration of WLHA,*
- *improve delivery & transmission of information on HIV prevention, care & support to WLHA and vulnerable to HIV,*
- *improve access to services for WLHA by providing counseling, treatment, general health care and drug rehabilitation,*
- *reduce & eliminate stigma & discrimination and protect the human rights of WLHA in all settings – household, community, hospital, workplace and educational institutions, and*
- *Provide affirmative action for WLHA in the area of livelihood, employment, vocational training & credit.*

B.7) *Leadership of women; involvement of men and the community*: "In number, there is strength" – thus, harnessing number to build collectives like self-help groups (SHGs) or community-based organizations (CBOs) has proven to be effective, time and again. The critical mass that collectives provide act as countervailing force needed to overturn a situation, otherwise discriminatory. Gender-based programming requires the participation of both men and women to succeed. Women's participation AND leadership, however, are crucial in order to make a difference.

THE BAGALKOT experience: Involving the community - advocating at all levels[60]

[60] CFAR document, 2005.

ICHAP, in 2002 in collaboration with KSAPS (Karnataka State AIDS Prevention Society) and NACO (National AIDS Control Organization) decided to undertake a demonstration project with a focused target-group (e,g, devadasi community) that would provide a rural model. And the goal of the project "was not to change tradition, because tradition does not change in a year or two, it is a long process and it is not for us to decided whether a tradition is good or bad. But to mitigate HIV/AIDS by promoting their health and if possible to enable and empower them so that in time they will change their traditional practices which is to a large extent responsible for the high incidence of HIV/AIDS in the region."

Parallel interventions were facilitated comprising capacity-building, organizing, mobilizations, etc. The power of the collective was underlined and the group realized early on that for the project to succeed it was imperative to involve not just the sex workers but the entire community because "different people play different roles and influence the sex workers lives in different ways." So community programs are held regularly to sensitize the community as a whole about the project and to advocate against the dedication of young girls. The collective has in particular been advocating among the older women and mothers in the community who have a role in influencing condom use and treatment seeking behavior among the sex workers. And also among the men "since they make the rules in the community even on such issues as to whether a woman should wear a sari or salwar kameez, or how should she should entertain or solicit a client. At the same time they also step in and help out when the police harass the girls or arrest them.

B.8) *Community-based structures:* The Panchayati Raj is a potent site for social change, and for prevention of HIV/AIDS. Formalized in the villages across the country, the reach and network is massive if utilized appropriately. Projects to tap into the processes of Panchayati Raj have been initiated in Tamil Nadu[61]. The Hunger Project also initiated discussion on the issues of gender and HIV/AIDS with Panchayati Raj in parts of Rajasthan in 2003.

B.9) *Media Advocacy:* The important role of media in the prevention of HIV, care and support has been accordingly recognized. The Prime Minister, no less, called a Media Summit on January 2005 "to discuss the role of media in addressing the challenge of combating HIV/AIDS" [62].

The media, however, needs more than good intentions. "For an HIV positive person, the support from the media is very critical as it can break the barrier between the common people and people affected by HIV/AIDS. The media must realize that although fear ridden stories and reports will be read, these will not have a constructive effect. In many ways, such stories contribute and add to the stigma and discrimination that face positive people are facing."[63]

The media is notably doubly-challenged having to understand HIV/AIDS on one hand and having to reckon with gender issues on the other. Stereotyping of women in the media is commonplace to date and has always been a site of struggle for women. In this light, UNIFEM supported efforts for media advocacy through a series of training-workshops and consultations to develop "Media Tool for Gender-Sensitive Reporting on HIV/AIDS."[64] Other projects using the media have also been forthcoming, e.g. the BBC World Service Trust has a co-production

[61] The Role of Panchayats in Addressing HIV/AIDS, Case of Tamil Nadu, UNIFEM/ISS, 2003.
[62] NACO News, NACO, New Delhi, vol. 2, Feb 2005.
[63] Media Tool for Gender-Sensitive Reporting on HIV/AIDS, CFAR/UNIFEM, June 2003
[64] workshops and consultations were facilitated by Center for Advocacy and Research (CFAR) in collaboration with PWN+, with support from UNIFEM to produce "Media Tool for Gender-Sensitive Reporting on HIV/AIDS", June 2003

partnership with NACO and Doordarshan, the government-supported broadcaster, on HIV/AIDS programming[65]. Special programmes on World AIDS Day which focused on Women, Girls and HIV/AIDS was also launched by NACO in 2003-2004. Heroes Project with Prasar Bharati, Kaiser Family Foundation, Avahan Initiatives of the Bill & Melinda Gates Foundation works closely with NACO, too.

B.10) *Legal Advocacy and Reform:* Part of advocacy efforts was legal literacy processes to facilitate rights-awareness of positive women. This is especially relevant for WLHA to help them address discrimination and other violations from a rights-based approach and ensure their full Constitutional entitlements. While demand for a specific law to address HIV/AIDS has been made, draft legislation has been submitted to NACO. Among the several consultations facilitated through Lawyers Collective a national consultation with women's organizations throughout the country was held in 2004 and recommendations with a strong gender perspective has been submitted.

C.Care

C.1) NACO reports increasing number of VCTC and PPTCT over the years, as well as access by WLHA.[66] There have been initiatives by NGOs and multi-lateral groups to train field counselors, including male counselors to reach out to more people. Yet, reports of inadequate information especially for pregnant women at PPTCT, and 'unhelpful', if discriminatory, behaviour by service providers persists[67].

C.2) India has pioneered low-cost treatment bringing down the price of antiretroviral treatment from $ 200 - $ 300 a month a decade ago to approximately $29.85 (1,300 rupees) a month[68]. This has brought immense hope to PLHA in India and in other places, including those in the sub-Saharan Africa.

Yet, the economic woes of those affected especially WLHA cannot be ignored even with the advent of much cheaper ARVs. In fact, women clamour for support for travel and lodging during treatment[69]. NACO, meantime, has identified women and children as key targets in its programming.

"In 2003, the Indian Government announced its intention to provide free ART at government hospitals to people living with HIV/AIDS in the six high prevalence states and in the city of Delhi, beginning in April 2004. The WHO is procuring ARVs for the treatment roll-out. Eight government hospitals were selected for the initial launch (expected to increase to 25 in 2005).* As of December 2004, an estimated 28,000 people were receiving ARV therapy, including 2,841 people receiving treatment through the public sector. This represents 4% of the estimated 770,000 adults in need of ART in India.**

[65] www.bbc.co.uk/worldservice/trust/pressreleases/story/2004/01/040119_doordarshanprojectextended.shtml cited in www.kff.org
[66] www.nacoonline.org
[67] Articulated at the UNIFEM Meeting on Inputs into NACP III, participant from PWN+, UNIFEM Office, New Delhi, 03/08/05.
[68] www.youandaids.org, feature story - Anti retro-viral medication in India costs1300 Indian Rupees per month, UNAIDS/UNDP, August 2005.
[69] Articulated at the UNIFEM Meeting on Inputs into NACP III, participant from PWN+, UNIFEM Office, New Delhi, 03/08/05.

*NACO, Annual Report, 2002-2004; **WHO, 3x5 Progress Report, December 2004, January 2005, cited in www.kff.org

C.3) Positive women have scanned a number of national programmes and schemes and submitted their concerns to various ministries/departments - Rural Development, Education, Urban Development, Youth Affairs, Railways, Social Justice and Empowerment, Department of Women and Child, NACO, as well as with the President of the Parliamentary Forum on HIV/AIDS on gender issues. They have formulated vision document on the basis of their demands.

C.4) Basic provisions such as water, sanitation and other bare essentials are not available in places, hindering treatment and care. Government should facilitate delivery of these services if communities have to deal with health-related concerns, including HIV/AIDS[70].

III. Gender and HIV/AIDS in the context of NACP III: Programme Design and Gender Mainstreaming Checklist

NACP III opens up fresh &/or heightened opportunities for collaborative interventions on both strategic and practical planes. A number of gaps have been identified from earlier responses as above-discussed but the mainstreamed strategies employed to date point to greater opportunities to integrate HIV/AIDS in development programming. The evolved interventions within the almost two (2) decades of work on HIV/AIDS in India stresses the need for strategic possibilities in the coming years.

The enormous challenge posed by the rapidly increasing incidence of HIV/AIDS calls for intensified, concerted and comprehensive efforts to stem the trend. While conceding that "AIDS remains a complex and incurable disease devastating individuals, communities and nations", there is much that can be done to intensify HIV prevention[71], a decidedly strategic measure that could probably reverse the pandemic, if pursued effectively.

Drawing from the range & continuum of experiences of the many groups working on the ground, with particular mention of groups working with women and WLHA, NACP III can only be strengthened and scaled-up henceforth. "Scaling-up" indubitably means the following, among others:

- pursuing with more intensity & depth the strategies which have proven responsive especially from a gender perspective, e.g. multi-sectoral partnerships, participation of WLHA, gender mainstreaming, etc;
- ensuring an army of people as trained resource to sustain processes involved;
- expanding the engagement of WLHA/PLHA, in furtherance of the GIPA approach through leadership and management;
- expanding the target group/reach of interventions, to attain the required critical mass to push the campaign forward on HIV prevention, care and support ;
- extending sectoral linkages to achieve rights-based developmental responses; and

[70] Articulated at the UNIFEM Meeting on Inputs into NACP III, participant from PWN+, UNIFEM Office, New Delhi, 03/08/05.
[71] "Intensifying HIV Prevention", UNAIDS Policy Position Paper, UNAIDS, 2004.

- impacting services to heighten mechanisms for HIV prevention, care and support especially for WLHA.

Significantly, the framework for effective NACP III should consider strengthening the following[72]*:*

(i) The broad *framework of human rights-women's rights* in the context of CEDAW and the Indian Constitution which take into account HIV/AIDS in relation to vulnerabilities that intersect gender, sexual orientation/preference, class, caste, religion, race/ethnicity, age, etc, ensuring that women's special and diverse concerns and gender issues are factored into the understanding of the epidemic, in terms of methods, priorities and focus;

(ii) The need to situate HIV/AIDS programme within the *context of larger developmental issues and empowerment processes* especially where they relate to women, holistically addressing the contexts of violence against women and gender based violence[73];

(iii) The need for *sustained facilitating mechanisms of interventions on the ground* (planning, implementation, monitoring and evaluation) that could stand the test of time and respond to both gender strategic & practical requirements;

(iv) The need to *harness numbers on the ground*, especially that of WLHA, recognising women as agents in HIV/AIDS policy and in women's rights advocacy; further, the need to work with men and the community members, too, to engage in both preventive, care and support interventions and together create supportive environment;

(v) The need to *strengthen multi-sectoral, multi-stakeholders partnerships* on gender and HIV/AIDS at every level of interventions;

(vi) The crucial need to back gendered-approach to NACP III with the *highest degree of political will* at every level of interventions.

(vii) The need to ensure *adequate resources* for sustained gender and HIV/AIDS programming.

Premises considered, hereunder is the proposed Programme Design from a gender perspective for the NACP III and the Gender Mainstreaming Checklist for reference of all Working Groups.

Programme Design

In the first meeting of the Working Group on Gender, Youth, Adolescent and Children held on July 28-29, 2005 in New Delhi, a decision was taken to constitute the following subgroups within the Working Group:

- Subgroup on Gender
- Subgroup on Young People
- Subgroup on Children

[72] summary of discussions from UNIFEM Meeting on Inputs into NACP III, UNIFEM Office, New Delhi, 03/08/05.

[73] For the purposes of this paper, 'domestic violence' and violence in intimate relationships are treated as different, though over-lapping phenomena. For example, domestic violence includes violence by family members other than the intimate partner and intimate violence includes relationships that are not 'domestic' in the traditional sense of the term

Separate subgroup consultations were facilitated with organizations working on the issues. The Subgroup on Gender held a consultation meeting on August 3, 2005 at the UNIFEM office in New Delhi, to specifically generate inputs into NACP III. This meeting was attended by twenty-five representatives of organizations from across the country working on women, health, community-based interventions, RCH, HIV/AIDS, care economy, as well as representatives of UN agencies, e.g. UNFPA, UNDP, UNICEF, UNIFEM.

In the second meeting of the Working Group on Gender, Youth, Adolescent and Children on August 23-24, 2005 in New Delhi, the Subgroup on Gender agreed to work on the following premises, thus:

1. Gender as an analytical framework: It is recognized that the HIV/AIDS epidemic is fuelled by the issues of inequity & inequality between men, women, girls, other gendered identities & boys, compounded by caste/ethnicity, class, age, profession, etc. In this context, girls, women & other gendered identities face more risks & vulnerabilities. They are likewise at the receiving end of lopsided policies and laws.
2. Based on the analysis of the linkages between gender & HIV/AIDS, the approach is two-pronged, thus:
   - specific interventions for girls, for women & for other gendered identities[74]; and
   - gender mainstreaming;
3. It is particularly acknowledged that girls, women and other gendered identities in the unorganized sector face tremendous risks & vulnerabilities and their needs have to be specially catered to and their agency promoted, therefore, a separate strategy is included for this purpose under objective 1;
4. To guide the process of programme designing, the Subgroup on Gender identified the over-all considerations in responding to gender issues in relation to HIV/AIDS:
   - Reduction of risks and vulnerabilities of girls, women and other gendered identities through the promotion of their agency.
   - Promotion of increased responsibility of men for prevention, care & support.

[74] It is acknowledged that, while girls/women/other gendered identities are all disadvantaged by their vulnerabilities to HIV/AIDS on the basis of gender, strategies for girls, for women and for other gendered identities have to be specifically devised according to each of the respective group's special needs & issues.

Vision **:**

NACP III envisions to mitigate the vulnerabilities of girls, women & other gendered identities in relation to HIV/AIDS by enhancing their agency and leadership in the prevention of HIV, care and support continuum.

Strategic Results Framework

Objective 1: In support of the national goal to reduce infection, the programme aims to reduce growth of infection among women, girls and other gendered identities.		
Outputs	**Indicators**	**Activities**
1.1. Access to accurate and comprehensible information related to HIV/AIDS prevention to various groups of women, e.g. widowed women, single women, etc, ensured.	❑ Increased availability of materials in user-friendly formats (language specific, medium specific) ❑ Increased number of people, esp girls, women & other gendered identities, informed across geographical areas	1.1.1. collect & collate adequate information about the subject; 1.1.2. undertake gender scan of all information; 1.1.3. develop IEC materials in user-friendly format (e.g. about HIV, opportunistic illnesses, treatment, costs, sources of support, networks, where to get treatment, importance of clean water, options in the context of cheap but good nutrition, etc); 1.1.4. disseminate information to wide-ranging audience.

1.2. Adequate awareness & capacity on HIV prevention, care & support ensured among girls/women/ other gendered identities in the unorganized sector through collectives like self-help groups, Panchayati Raj, Mahila Mandal, home-based workers, farm-based groups & other collectives.	❑ Availability of information on policies and experiences of the unorganized sector in the context of HIV/AIDS prevention, care & support ❑ Increased effort to reach out to the unorganized sector esp girls, women & other gendered identities, ❑ Increased networking among community-based collectives ❑ Increased coordination among government ministries dealing with the unorganized sectors	1.2.1. review care economy and document community based models on social & economic empowerment of girls, women & other gendered identities in the unorganized sector; 1.2.2. prepare user-friendly materials for mass-scale awareness-raising among girls, women & other gendered identities in the unorganized sector; 1.2.3. undertake mass-scale awareness-raising campaigns targeting women in the unorganized sector through different community-based collectives; 1.2.4. strengthen linkages among women in various collectives and develop networking across various groups within the unorganized sector; 1.2.5. strengthen inter-ministerial coordination to institute mechanisms to reach out to various collectives of women in the unorganized sector; 1.2.6. undertake pilot projects for developing gender-sensitive community based care economy & support systems; 1.2.7. provide continuing vocational training to girls, women & other gendered identities; 1.2.8. mainstream & develop partnerships to evolve mechanisms for social and economic empowerment of girls, women & other gendered identities.

1.3. Targeted interventions strengthened by including : -girls/women/other gendered identities in sex work, -clients of sex workers, -MSM & their partners/ spouses -IDUs & their partners/ spouses -widowed women of positive men, -survivors of trafficking, -survivors of violence, -migrant & mobile population and their partners/spouses, etc .	❑ More detailed recording system as basis for policy and programme planning ❑ Increased participation of target groups in advocacy & programmes ❑ Greater coordination among groups working on issues of VAW, trafficking, sex work, early marriage, conflict situation, migration, HIV/AIDS	1.3.1. develop sex-disaggregated database with details of relevant information (women-headed household, single women, widowed women, etc) 1.3.2. share database with all stakeholders; 1.3.3. undertake studies for more nuanced understanding of vulnerabilities & needs of groups for target interventions & disseminate findings thereof; 1.3.4. develop partnership with groups working with other gendered identities & together identify effective strategies for interventions; 1.3.5. institute referral services to facilitate economic empowerment of girls, women and other gendered identities.
1.4. Gender dimension of HIV/AIDS duly incorporated in the proposed national law on HIV/AIDS.	❑ Proposed national law on HIV/AIDS with gender perspective. ❑ Increased collaboration among various groups supporting engendering process of the proposal;	1.4.1. develop IEC materials on the proposed law on HIV/AIDS; 1.4.2. conduct wide-ranging consultation among girls, women & other gendered identities living with HIV/AIDS, women's groups, health groups, law groups & other support groups on the basis of the proposed law on HIV/AIDS; 1.4.3. form technical support group to input into the proposed law and help formulate mechanisms for enforcement.; 1.4.4. support continuing legal advocacy & ensure implementation of GIPA guidelines with a strong gender focus; 1.4.5. undertake legal literacy among girls, women & other gendered identities living with HIV/AIDS through workshops, training, campaigns.

1.5. Positive norms and standards instilled at the workplace and implementation thereof ensured to safeguard people, especially girls, women & other gendered identities, from HIV infection and to care for those infected.	❑ Increased partnership with ILO, women's groups, private-public sector, corporates on workplace norms & standards regarding HIV prevention, care & support ❑ Availability of model policy for workplace norms & standards on HIV prevention, care & support; ❑ Constitution of technical support group to help workplaces institute model policy; ❑ Policies that protect tenure, respect confidentiality & provide for care & necessary facilities for girls, women & other gendered identities in place at the workplace. ❑ Increased number of programmes undertaken at the workplace to raise awareness among staff, encourage testing, etc; ❑ Increased number of condom dispensaries installed at workplaces; ❑ Increased number of health clinics catering to special needs of girls, women & other gendered identities.	1.5.1. conduct wide-ranging consultation, in partnership with ILO, women's groups, private-public sector, corporates, etc, to develop a gender-sensitive model policy on workplace norms and standards; 1.5.2. develop IEC on the model policy; 1.5.3. disseminate awareness-raising materials at workplaces, in partnership with employers,; 1.5.3. provide technical support to help workplaces institute model policy; 1.5.5. set-up health clinics at the workplace to cater to health needs of girls, women & other gendered identities; 1.5.6. encourage installations of dispensaries for condom & female-controlled contraceptives in strategic public locations, including the workplace. 1.5.7. initiate dialogue to develop health/life insurance model for girls, women & other gendered identities.

1.6. Responsibility of men and the community in bringing about enabling environment in the fight against HIV/AIDS and the realization of gender equality promoted & ensured.	❑ Increased number of initiatives taken by men's groups &/or community to help with HIV prevention, care, support ❑ Visible change in gender relations at the household & community levels, e.g. shared parenting, shared household responsibilities, reduced or zero incidence of violence, gender balance in community-based organizations & decision-making bodies, etc ❑ Increased number of male counselors/ facilitators in HIV prevention, care & support ❑ Increased participation of men & community in training, dialogue, advocacy, etc ❑ Increased condom use by men	1.6.1. promote alliance-building between groups working with women, with girls, with other gendered identities & those working with men; 1.6.2. document stories of men as partners and disseminate documentation; 1.6.3. develop IEC materials on men's responsibilities in the HIV prevention, care & support; 1.6.4. advocate through campaigns for men's responsibility in the HIV prevention, care & support; 1.6.5. enlarge pool of male counselors & trainers along side women to conduct training on gender-sensitivity; 1.6.6. support continued advocacy & campaign addressing VAW and safety in sexual relations; 1.6.7. encourage condom use by men across sections of society

1.7. Stigma and discrimination in media and in policies/law reduced.	❑ Increased number of voluntary testing among the public, especially girls, women & gendered identities. ❑ More media spots, articles & reports which are gender-sensitive; ❑ National Law on HIV/AIDS with gender perspective and use of CEDAW & other legal tools for HIV prevention, care & support ❑ More tools and materials for gender-sensitive journalism ❑ Constitution of media relations group to look into media & gender-HIV/AIDS ❑ Increased partnership between media and NACO, women's groups, networks of WLHA, etc	Specific to media: 1.7.1. develop IEC materials to continuously inform & sensitize media; 1.7..2. develop gender-sensitive guidelines for media to follow in reporting on HIV/AIDS; 1.7.3. commission regular articles to be written to further awareness-raising & prevention; 1.7.4. provide for fellowship to media professionals to deepen understanding on gender & HIV/AIDS; 1.7.5. constitute media relations group to look into media & gender-HIV/AIDS Specific to policies/law 1.7.6. build partnerships with women's groups working on law reforms; 1.7.7. build linkages between CEDAW, BPFA, the equality principle in the Indian Constitution, the proposed law on HIV/AIDS to further legal advocacy & reform. generally- 1.7.8. create an enabling environment for testing where utmost confidentiality & privacy is respected; 1.7.9. train VCTC staff on scale to provide gender-sensitive & responsive services.
1.8. National RCH & NRHM converged with HIV programmes to improve access to services.	❑ Increased linkages between RCH, NRHM with HIV ❑ Developing pool of trainers on integrated packages of RCH, NHRM & HIV.	1.8.1. develop integrated packages on RCH-NRHM-HIV and women's human rights; 1.8.2. develop pool of trainers on the integrated packages; 1.8.2. continue advocacy on convergence of RCH-NRHM-HIV.

1.9. Women, girls and other gendered identities empowered to protect and care for themselves and able to negotiate safer sex.	❑ Increased articulation by girls, women & gendered categories about gender equality & HIV prevention; ❑ Greater assertiveness by women, girls & other gendered identities for control over their body and increased ability to negotiate for safer sex ❑ Revised gender-sensitive laws on property, inheritance, financing ❑ Increased gender sensitivity among government agencies and in the delivery of services across ministries	1.9.1. invest into & undertake further research on female condoms, female-controlled contraceptions & development of microbicides; 1.9.2. develop IEC on women-centred & controlled condoms, contraceptives; 1.9.3. disseminate information on women-centred & controlled condoms, contraceptives; 1.9.4. conduct training on negotiation skills for girls, women & other gendered identities; 1.9.5. ensure access to female condoms and female-controlled contraceptives; 1.9.6. identify schemes of government agencies on livelihood and disseminate information on the same.
1.10. Participation and leadership of girls & women living with HIV/AIDS enhanced in policy, advocacy and programme interventions.	❑ Increased participation & leadership of girls, women & other gendered identities living with HIV/AIDS in policy, advocacy and programme interventions. ❑ Greater voice by girls, women & other gendered identities living with HIV/AIDS in decision-making processes. ❑ Heightened articulation of girls & women living with HIV/AIDS to counter stigma & discrimination as well as to emphasize rights of positive women	1.10.1. develop leadership & management of girls & women living with HIV/AIDS through continuing capacity-building; 1.10.2. ensure participation of girls & women living with HIV/AIDS in policy decisions and government initiatives; 1.10.3. document best practices on leadership of girls & women living with HIV/AIDS & highlight lessons for prevention, care & support. 1.10.4. publish and disseminate best practices on leadership of girls & women living with HIV/AIDS
Objective 2: In support of the national goal on care, support and treatment, the programme aims to increase the proportion of women, girls & other gendered identities living with HIV/AIDS receiving care, support and treatment.		
Outputs	**indicators**	**activities**

2.1. Access by girls, women & other gendered identities living with HIV/AIDS to health, social, legal services, etc ensured.	❑ Streamlined system for increased access to health, social, legal & other services by girls, women & other gendered identities living with HIV/AIDS; ❑ Increased number of trained service providers who are gender-sensitive; ❑ Increased assertion of rights by girls, women & other gendered identities living with HIV/AIDS ❑ Increased 'checkpoints' to ensure non-discrimination against girls, women & other gendered identities living with HIV/AIDS	2.1.1. strengthen inter-ministerial coordination, with girls, women & other gendered identities living with HIV/AIDS & women's groups, health groups, groups working with other gendered identities, etc to arrive at consensus to work out mechanisms for provision of respective services by various government agencies/departments; 2.1.2. identify schemes of departments, collate information and disseminate the same to girls, women & other gendered identities; 2.1.3. provide access to various services and girls, women & other gendered identities living with HIV/AIDS; 2.1.4. facilitate legal literacy and rights awareness among girls, women & other gendered identities living with HIV/AIDS to help them reclaim their entitlements and fight gender bias; 2.1.5.provide thorough gender-sensitivity training across government ministries & departments for more responsive services; 2.1.6.identify focal points ('checkpoints') in every agency/office to make sure systems are non-discriminatory.
2.2. Affirmative action for girls, women & other gendered identities living with HIV/AIDS proposed in the area of livelihood, employment, property & inheritance, vocational training and credit inputs.	❑ Revised laws/ policies on livelihood, employment, credit and loans, property, inheritance, etc to meet gendered needs, with affirmative action for girls, women & other gendered identities living with HIV/AIDS, where required ❑ Increased schemes and government initiatives to respond to specific needs of girls, women & other gendered identities living with HIV/AIDS ❑ Increased partnerships for social and economic empowerment of girls, women & other gendered identities.	2.2.1. review and document community based models on social & economic empowerment of girls, women & other gendered identities; 2.2.2. review existing policies, laws regarding affirmative action for girls, women & other gendered identities; 2.2.3. disseminate information on policies & successful initiatives; 2.2.4. develop Pilot for developing community based support system; 2.2.5. propose areas for affirmative action & lobby for policies & mechanisms thereon; 2.2.6. expand & include vocational training to girls, women & other gendered identities living with HIV/AIDS for vocations of their choice; 2.2.7. mainstream & develop partnerships to evolve mechanisms for social and economic empowerment of women.

2.3. Services of VCTC as one-stop site for women, girls & other gendered identities providing referral system to various interventions strengthened.	❑ Increased number of trained service providers who are gender-sensitive ❑ Increased VCTC access by the public, especially girls, women & other gendered identities ❑ Increased collaboration among agencies for service delivery ❑ Increased private-public partnership	2.3.1. build capacity, awareness of VCTC staff on gender issues and in the management of sexual abuse, emergency contraception, access to pep , etc through gender sensitive training on issues of gender based violence, PPTCT, male responsibility in HIV prevention, care & support; 2.3.2. strengthen linkages with referral system by identifying services & agencies like legal, shelter/homes, rehabilitation for girls, women & other gendered identities living with HIV/AIDS and women in distress, setting in place the mechanism & network of operation; 2.3.3. link care & support services for those found positive; 2.3.4. scale up of the VCTC to the sub district level through convergence with RCH and NRHM. 2.3.5. undertake training and placement of positive women in VCTC.
2.4. PPTCT services expanded through strengthened linkages with RCH & NRHM in sub-district level & duly enabled staff.	❑ Increased number of trained service providers who are gender-sensitive ❑ Increased PPTCT access by girls, women & other gendered identities for information & other services ❑ Better ART management	2.4.1. undertake awareness-raising on PPTCT; 2.4.2. educate service providers and girls, women & other gendered identities on ART management; 2.4.3. ensure gender sensitive BCC on ART management for service providers and girls, women & other gendered identities. 2.4.4. scale up PPTCT to the sub district level through convergence with RCH and NRHM; 2.4.5.undertake training and placement of positive women in PPTCT.
2.5. Availability of ART with proper monitoring system in place for all infected and affected girls, women & other gendered identities ensured.	❑ Increased access to & better management of ART by girls, women & other gendered identities ❑ Proper monitoring system in place.	2.5.1. increase access to ART & monitoring system; 2.5.2. educate girls, women & other gendered identities on ART; 2.5.3. provide gender-sensitive management of ART.
Objective 3: In support of the national goal, the programme aims to ensure gender perspective at every step of national planning, monitoring and evaluation system.		
Outputs	**indicators**	**activities**

3.1. Gender-disaggregated database strengthened, with further entries on relevant information about women's status, e.g. widowed women, single women, woman-headed household, etc.	❑ More detailed database especially on girls, women & other gendered identities. ❑ More accurate & responsive planning based on comprehensive database.	3.1.1. review existing data & scan existing materials/documents in the country to identify gaps in gender data. 3.1.2. undertake more rigorous & well-designed research & surveys from a gender perspective to fill in gaps in data; 3.1.3. develop comprehensive database with all relevant details; 3.1.4. disseminate information on the database among various stakeholders.
3.2. Gender-audit of policies, plans, materials & budget related to HIV/AIDS prevention, care & support undertaken.	❑ Engendered policies, plans, materials & budget	3.2.1. build capacities for gendered social audit; 3.2.2. design gender specific indicators for M&E and Mis; 3.2.3. undertake social audit and disseminate findings thereof; 3.2.4. initiate dialogue and come up with proposals for change, where relevant.
3.3. Capacity-building of service providers, policy-makers, other government & non-government, faith-based organizations, etc. ensured.	❑ Increased gender perspective among policy-makers and planners ❑ More gender responsive policies and programmes on HIV/AIDS prevention, care & support ❑ Increased number of groups with capacity on gender-sensitive interventions for HIV prevention, care & support.	3.3.1. conduct training & build skills on project planning, implementation, monitoring & evaluation from a gender perspective for all government ministries; 3.3.2. specially sensitize policy-makers and programme planners on gender issues & the need for gender analysis to address gender & HIV/AIDS.
3.4. Gender-perspective in evidence-based research and other surveillance mechanisms on HIV/AIDS incorporated by ensuring the centrality of gender issues in the framework and the participation of gender experts and girls, women & gendered identities living with HIV/AIDS in the process.	❑ Increased number of gender-based studies, generally, and also documentation of gendered experiences of girls, women & gendered identities living with HIV/AIDS ❑ Greater involvement of girls, women & gendered identities living with HIV/AIDS in surveillance ❑ Constitution of inter-disciplinary research team with gender expert	3.4.1. initiate composition of inter-disciplinary research team to guide surveillance processes; 3.4.2. develop gender perspective in research design and analysis; 3.4.3. facilitate GIPA, esp that of girls, women & other gendered identities living with HIV/AIDS; 3.4.4. undertake mass-scale dissemination of gender-based studies;

3.5. Guidelines in ensuring that gender issues are dealt with by various ministries in the entire programme cycle provided.	❑ Institutionalized gender analysis across agencies & organizations ❑ Set of indicators to guide the process available	3.5.1. undertake gender analysis at all times; 3.5.2. provide space for involvement of stakeholders from across the spectrum, especially that of girls, women & gendered identities living with HIV/AIDS, in planning & indicator-setting 3.5.3. design gender specific indicators for M&E and MIs
3.6. NACO's role as programme catalyst strengthened with a Gender Technical Resource Group supported by the expertise of positive women.	❑ Increased capacity to address gender & HIV/AIDS ❑ Increased voice/substantive engagement of girls, women & gendered identities living with HIV/AIDS	3.6.1. constitute Gender Technical Resource Group within NACO; 3.6.2. ensure engagement of girls, women & gendered identities living with HIV/AIDS through a representation in the Gender Technical Resource Group; 3.6.3. provide active linkage between NACO's Gender Technical Resource Group & civil society groups, especially women's groups.
3.7. HIV/AIDS prevention, care and support strengthened through a gender-budget based on the analysis of the entire spectrum of women's vulnerabilities and risks in relation to HIV/AIDS.	❑ Increased budget for HIV prevention, care & support especially for girls, women & other gendered identities ❑ Increased participation of girls, women & other gendered identities in gender-budgeting process.	3.7.1. review budget for HIV/AIDS programme through a participatory approach with the engagement of all stakeholders including girls, women & other gendered identities; 3.7.2. ensure linkage between gender analysis & gender budgeting, e.g. identify areas needing more interventions & ensure funding therefore; 3.7.3. provide gender-responsive budget for NACP III

Gender Mainstreaming Checklist

Over-all considerations in responding to gender issues in relation to HIV/AIDS:
1)Reduction of risks and vulnerabilities of girls, women and other gendered identities through the promotion of their agency.
2)Promotion of increased responsibility of men for prevention, care & support.

In the context of the over-all consideration above-mentioned, please assess your Working Group's report on the checklist provided below per the recommendations of the Subgroup on Gender (of the Working Group on Gender, Youth, Adolescent & Children).

The checklist covers the vision, objectives, strategies and monitoring & evaluation. Except for strategies, where specific guide questions relevant to each of the thematic areas are provided, the questions are common for all Working Groups. A glossary of key concepts used in this checklist is available at the end of the document for easy & clear reference.

Vision: Does it reflect concerns for girls' & women's risks, vulnerabilities and well-being and focus on efforts to advance substantive equality for girls & women?

Objectives: Review and list objectives which address, directly or indirectly, key gender concerns in the context of HIV/AIDS.

Strategies: Generally, do strategies address special needs of women & men under various components of NACP III in regard to surveillance, prevention, care, support, etc?

Specific question for each of the Working Group:

1. Working Group on Programme Management

- Development of Gender Sensitive Tools and Frameworks
- Gender Balance
    - Representation of men & women
    - Decision making: proportion of women & men in decision-making positions

2.Working Group on Financial Management

- Equitable allocation
- Tracking expenditure on the basis of gender

3. Working Group on Mainstreaming and Partnerships

- Gender balance in all the programmes that are factored in
- Gender sensitization of partners in HIV/AIDS context
- Alliances with women's organisations
- All partners and stakeholders across the board must be able to address stigma and discrimination

4. Working Group on Gender, Youth, Adolescents and Children

- Issues of inequity & inequality between men, women, girls, other gendered identities & boys compounded by caste/ethnicity, class, age, profession, etc fuel HIV/AIDS epidemic;
- On the basis of gender analysis, the approach is two-pronged, e.g.
    1) specific for girls, for women & for other gendered categories[75]; and
    2) gender mainstreaming;

5. Working Group on Condom Programming

- Positioning of condom with gender sensitivity; couple-counseling on condom use
- Negotiating safety: strategies for empowering women
- Female condom

[75] It is acknowledged that, while girls/women/other gendered identities are all disadvantaged by their vulnerabilities to HIV/AIDS on the basis of gender, strategies for girls, for women and for other gendered identities have to be specifically devised according to each of the respective group's special needs & issues.

- Factor in violence against women

6. Working Group on Service Delivery

- Gender-sensitive especially to women and girl; child-friendly
- Facility of informed choices
- Involvement of positive networks- women, other gender identities
- Health Education
- Well-developed referral network mechanisms to be integrated

7. Working Group on STI/RTI Treatment and convergence with RCH

- Women-friendly services including management of sexual abuse
- Partner-management
- Referral network mechanisms to be integrated

8. Working Group on Targeted Intervention

- Specific focus on spouses and partners of IDU, MSM, Truckers, migrant workers & mobile population; also widowed women of HIV+ men.
- Specific focus on migrant women workers;
- Specific focus on MSM, other gendered identities in sex work, male migrants & mobile population;
- Addressing issues of male responsibility

9. Working Group on Communication, Advocacy and community mobilization

- Framing gender- and rights-sensitive issues
- Messages: Gender-sensitive, addressing men/women/girls/boys/other gendered identities
- Intersectionality of issues to be woven in the HIV/AIDS campaigns – e.g., early marriage, violence, abuse, trafficking
- Address stigma and discrimination practices aimed at women through advocacy and community mobilisation

10. Working Group on GIPA, Human Rights, Legal and Ethical issues

- Consider women's human rights
- Enhanced gender participation in GIPA
- Expand positive women's network
- Legal literacy of positive women
- Engendering GIPA policies and programmes
- Link with Mainstreaming and Partnerships

11. Working Group on care, support and treatment

- Integrate the principles of gender equality and non-discrimination
- Enhanced access for women to care, support and treatment
- Need for livelihoods, employment and/or income-generating projects (IGP)
- Mechanisms to support affected and positive women
- Factor in the impact of care economy on women

12. Working Group on R& D and Knowledge Management

- Focused research on emerging issues of women within the country
- Research on women-centred prevention measures
- Involvement of positive women in research and development of gender-sensitive research methodologies

13. Working Group on M and E

- Disaggregated data and baseline on gender, age, marital status
- Special indicators to track impact of women and girl within the household and community
- Special reference to UNGASS and MDG
- Indicators to track stigma and discrimination
- Evaluation of interventions for specific indicators of impact, e.g. how does VTCT impact lives of women in relation to partner? In relation to family? In relation to workplace?

14. Working Group on Surveillance

- Mechanisms for tracking women and other gendered identities outside the identified groups in "target interventions"

M&E: Refer to available sex-disaggregated data;
Allocation of specific resources for women-centred interventions;
Provide at least five(5) major gender-sensitive indicators that are proposed, e.g.

1. Prevention, e.g.
   - More women able to negotiate for safer sex;
   - Increasing access to female condoms;
   - More men using condoms.
2. Treatment, e.g.
   - Equal access to treatment for women & men;
   - Accurate & adequate information provided at the PPTCT sites;
   - Better ART management by service providers and positive women & men.
3. Care, e.g.
   - Increasing awareness about HIV prevention, care & support among women;
   - More men sharing responsibility for care of infected & affected member/s of the family, community;
   - Increasing opportunity for livelihood and economic engagements for women.

Key Concepts Used in the Checklist:

Agency: primarily refers to capacity to participate in decision-making processes especially as they relate to oneself (and/or one's community), the ability to make informed & independent choices and be responsible for decisions made and their consequences.

Care Economy: refers to the pattern of feminised care-giving that is informal, home based and largely unremunerated seen in parts of societies in Asia, Africa and Latin America. That women (mothers, wives, daughters and daughters-in-law) provide care, but do not themselves receive care, is a social and cultural reality and lies at the core of the informal, home based care-giving phenomenon. This reality is highly accentuated in the case of AIDS due to its stigmatizing nature. Women not only experience enormous physical, emotional and social burden of such care giving but also bear heavy costs in the form of alienation from market economy, lost opportunities for schooling, reduced time for self growth, nutritional neglect, delayed or shelved marriage plans, etc[76].

Gender: "(W)hat it means to be male, female or other gendered (identity/)category of person and how that impacts the person's roles, responsibilities, relationships and the distribution of resources, risk, suffering, pleasure & power"[77]

Gender Balance: refers to equal representation of boys, girls, men, women, other gendered identities in terms of numbers; otherwise known as gender parity.

Gendered Identities (or categories): "(I)n the context of South Asia, as with many parts of the world, we find that there exist not two, but multiple gendered identities and realities. In the South Asian context, (especially in India), these include *Hijras*[78], *Kothis*[79], *Jogappas, Alis, Khojas, Metis, Zenanis, Aravanis,* just to name a few. Each of these gendered categories has a long and rich history, and each escapes the western categories of 'transgender' and 'transexual', which have come to simply describe a process of 'moving' from 'one gender to the other'. Many of these categories are enmeshed in local practices and mythologies as well as religious

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[76] Strategic direction for UNIFEM to further its agenda on Gender and AIDS, UNIFEM, 2004.

[77] UNAIDS, 1998 in Gender and HIV/AIDS in South Asia, An Analytical Paper, UNIFEM, July 2004.

[78] The Hijra community, which exists in large parts of South Asia has been variously understood as 'the third sex', 'neither man nor woman', 'eunuchs' and, in western terms 'transgender' and 'transsexual'. While none of these definitions capture the cultural specificity of the community, responses to the HIV/AIDS epidemic have, unfortunately, subsumed this community within the category of MSM or men who have sex with men. See Nanda 1990, Talwar 1999, Goldman 1993 and Busby 1997. Gender and HIV/AIDS in South Asia, An Analytical Paper, UNIFEM, July 2004.

[79] The term *kothi* is a generic term of self reference in the *Hijra* community (which has been understood as the 'transgender' community of India.). The usage of the term varies significantly across India, with different categories constituted in terms of gender performance, class and whether one has undergone castration. These different categories play a significant role in the framing of hierarchies within *hijra* communities. In Bangalore, for instance, there is distinction made between an '*Aqwa* kothi', who largely wears men's clothing, a '*Janini Kothi'* who is not castrated but usually wear's women's clothing and a '*Nirvana kothi*' who has been castrated or had a sex reassignment surgery. Through HIV intervention the term *kothi* has been re-constituted as a 'sexuality identity' of 'effeminate males who are penetrated in a same sex encounter between males'. See generally NFI 2000. Gender and HIV/AIDS in South Asia, An Analytical Paper, UNIFEM, July 2004.

scriptures… (I)t needs to be emphasised that rather than being considered 'aberrations' necessitated by a simple dualistic system of gender, these genders exist in South Asian cultures as legitimate, but marginalised categories"[80].

Gender Mainstreaming: the process by which the acknowledged gendered roles, responsibilities, relationships, opportunities, risks, vulnerabilities of women, men, other gendered identities, girls, boys are rectified through the elimination of biases against women, girls, other gendered identities and the introduction of policies and mechanisms in the larger context of the social, political, economic, cultural system. In the main, gender mainstreaming is meant to promote substantive equality.

Gender-sensitive: refers to intentions, ideas, actions, attitudes & behaviour that provide equal considerations, respect, space & articulation to boys, girls, men, women, other gendered identities, ensuring that no one is excluded from policies & programme interventions or discriminated against in any way.

Human Rights: broadly refer to the inherent and inalienable rights of every human being simply by virtue of being human. Central to the concept of human rights is human dignity inherent in every individual which must be respected and promoted regardless of sex, religion, race/ethnicity, caste, class, culture, nationality, sexuality, etc. Human rights have been deemed to encompass civil, political, social, cultural & economic rights and entitlements for *all.*

Intersectionality: refers to the cross-cutting nature of issues of gender, class, caste/ethnicity/race, religion, age, etc and how they relate to each & compound the other.

MSM: Refers to "men having sex with men" but recent research shows that many men who have sex with men also have sex with women[81].

Non-discrimination: means to treat everyone – girls/boys/women/men/other gendered identities without "...any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field."[82]

Substantive Equality: means 1)equality of opportunity; and, 2)equality of results. The first refers to entitlements and access to the resources of a country which have to be secured by a framework of laws & policies supported by institutions and mechanisms for their operation; the latter refers to equal enjoyment of rights borne out of the opportunities available[83].

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[80] Gender and HIV/AIDS in South Asia, An Analytical Paper, UNIFEM, July 2004.
[81] www.youandaids.org, India at a glance, UNAIDS/UNDP.
[82] Art 1, Part 1, The Convention on the Elimination of All Forms of Discrimination Against Women.
[83] Dairiam, S, Key Concepts & Principles of the CEDAW Convention, Report of the South Asia Regional Consultation on CEDAW, Sri Lanka, 2002, UNIFEM South Asia Regional Office, New Delhi, 2004.

Violence against women (VAW):"any act of gender-based violence that results in or is likely to result in physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life."[84] Further, Recommendation No. 19[85] reinforces CEDAW or Women's Convention by categorically defining "gender-based violence (a)s a form of discrimination that seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men".

Women-centred: refers to an approach that places women at the center of analysis, Planning & intervention after due consideration of their status in relation to gender issues.

Women's human rights: Reinforcing the centrality of women's rights in the whole spectrum of human rights through the Women's Convention, the 1993 World Conference on Human Rights in Vienna accordingly put women at the centre stage with the resounding recognition of "women's rights are human rights". The Vienna conference "helped broaden the core human rights concepts of "violation" and "violator", directing the movement away from exclusive focus on state actions to examine the culpability of state inaction in the face of known abuses by private sector."[86] The consensus document arising out of the Vienna Conference reiterated the universality and indivisibility of human rights as it recognized violence against women and rape in times of war as human rights violations.

[84]Resolution A/RES/48/104, dtd 23.2.94, UN Declaration on the Elimination of All Forms of Violence against Women.
[85] Eleventh Session of CEDAW, 1992
[86] "Right Side Up:Reflections on the Last Twenty-Five Years of Human Rights Movement" (2004, p.2)

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