

## Abstract

*Gender inequality is driving two distinct yet interlinked epidemics among women in India: HIV and AIDS and domestic violence. As domestic violence is increasingly recognized and HIV infection expands, policy and programs do not reflect the interlinked risks and consequences in married women's lives. This article seeks to establish the nexus between HIV and AIDS and domestic violence and identify potential areas for a state-led response. In a health and human rights approach, it assesses women's vulnerability to each epidemic at the individual, societal, and program levels to analyze direct and underlying factors that determine women's risk. Three areas are identified as opportunities for an integrated response: strengthen HIV and domestic violence strategies and address their overlap; mainstream gender; and improve data and research.*

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*L'Inde fait face à une double épidémie de violence domestique généralisée et d'augmentation des infections VIH chez les femmes mariées monogames. Bien que la reconnaissance de la violence domestique et de l'expansion des infections VIH s'améliore, les politiques et les programmes n'en reflètent pas les risques et conséquences conjugués au détriment des femmes mariées. Cette analyse cherche à établir le lien entre le VIH et le SIDA et la violence domestique, ainsi qu'à identifier les secteurs potentiels pour une réponse de l'État. Se basant sur une approche santé et droits de l'homme, elle évalue la vulnérabilité des femmes vis-à-vis de chaque épidémie aux niveaux individuel, de la société et des programmes, afin de saisir les facteurs qui déterminent les risques pour les femmes. Parmi les secteurs identifiés comme des occasions de réponse intégrée: le renforcement des stratégies relatives au VIH et à la violence domestique, et la gestion de leur chevauchement, l'intégration des considérations liées au genre, et l'amélioration des données et des recherches.*

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*India encara una doble epidemia de violencia doméstica generalizada y la infección, cada vez mayor, de VIH entre mujeres monógamas casadas. La violencia doméstica se reconoce cada vez más y las infecciones con VIH incrementan, pero las políticas y los programas no reflejan los riesgos y consecuencias interrelacionados en las vidas de las mujeres casadas. Este análisis procura establecer el nexo entre VIH/SIDA y la violencia doméstica e identificar áreas potenciales para una respuesta impulsada por el estado. Utilizando un enfoque basado en la salud pública y los derechos humanos, el análisis evalúa la vulnerabilidad de la mujer a cada epidemia al nivel individual, social y de programas, para identificar los factores que determinan el riesgo para la mujer. Las áreas identificadas como oportunidades para una respuesta integrada incluyen: fortalecer las estrategias contra VIH y la violencia doméstica y abordar sus aspectos coincidentes; incorporar una perspectiva de género; y mejorar los datos y la investigación.*

# HIV AND DOMESTIC VIOLENCE: Intersections in the Lives of Married Women in India

*Sapna Desai*

**G**ender inequality is driving two distinct yet inter-linked epidemics among women in India: HIV and AIDS and domestic violence. Gender-based violence is widespread — attesting to the social, economic, and cultural inequalities in women's lives. As HIV infection expands, married women in monogamous relationships, previously deemed to be sheltered from risk, are increasingly emerging as a vulnerable group. These two epidemics operate in a complex interplay, with similar root causes, coinciding risk factors, and intersecting consequences.

Policy and programs do not yet recognize the relationship between domestic violence and HIV and its implications for interventions. Domestic violence has recently been more documented in India, but programs and policy have little focus on health-related concerns. As the HIV epidemic grows in India, the few programs that may reach married women largely do not reflect the reality of domestic violence in women's lives. This article assesses the interlinked vulnerability of married women to domestic violence and HIV and, accordingly, calls for increased recognition through an integrated, rights-based response.<sup>1</sup>

## **Vulnerability**

Existing research quantifies risk of HIV and domestic violence in India in epidemiological terms and, to a lesser extent, assesses the broader factors that render married

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women vulnerable to either, or both. In an effort to call attention to their specific vulnerabilities, married monogamous women are the deliberate focus of this analysis. Marriage is nearly universal (94%) among Indian women by the age of 25-29 and is most often accompanied by a bride's residence in her husband's family home.<sup>2</sup> A focus on monogamous women does not imply that women in India do not engage in extra-marital relations (one recent study in rural Gujarat points to the contrary) but rather emphasizes the predominant situation of married women whose husbands present the primary risk of domestic violence or HIV infection.<sup>3</sup>

Vulnerability implies a lack of empowerment and indicates the extent to which an individual is capable of making informed decisions about his or her own life.<sup>4</sup> Vulnerability manifests itself at the individual, programmatic, and societal levels, thereby linking epidemiological risk to broader and deeper factors that increase the likelihood of exposure to risk-generating situations. Vulnerability at the individual level illustrates an individual's cognitive ability related to risk of HIV infection or domestic violence, while program vulnerability refers to the extent that services address individual needs and circumstances.<sup>5</sup> Societal vulnerability encompasses the socio-cultural and economic factors that create risk-inducing circumstances and influence who is affected by HIV and AIDS and domestic violence. This article compiles data and research to identify married women's vulnerability to HIV and domestic violence separately at each of these levels in order to ultimately highlight their intersections and identify areas for intervention.

## **A Health and Human Rights Framework**

In an effort to link the underlying causes of HIV infection and domestic violence to state obligation to promote and protect women's human rights, this vulnerability analysis is situated within a health and human rights framework.<sup>6</sup> Integration of human rights obligations within the analysis provides a normative context in which to assess and improve the national program response, while drawing

attention to broader factors that affect public health. Although the nongovernmental sector plays a critical role in service delivery and policy advocacy, this article focuses on the state's importance as the central policy-maker and its role in ensuring a nationwide response in accord with human rights obligations.

International human rights treaties do not explicitly address domestic violence or HIV and AIDS; however, relevant rights are enshrined in the International Covenant on Economic, Social and Cultural Rights (ICESCR), the International Covenant on Civil and Political Rights (ICCPR), and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).<sup>7</sup> India has been party to both covenants since 1979 and ratified CEDAW in 1993, with reservations in regard to cultural and customary practices and equality in marriage and family relations, including age at marriage in the latter.<sup>8</sup> India also entered a declaration stating that it would not interfere in the personal affairs of any community without its consent.<sup>9</sup>

### **Limitations**

The internal regional variation, divergent cultural and linguistic traditions, and complex social structures of India force any meta-analysis to make broad assumptions. A lack of comprehensive national data on married women's vulnerability to HIV infection and limited research on domestic violence limit this analysis. Further, while recognizing that the nongovernmental sector plays a critical role in service delivery and policy advocacy, the sheer number of nongovernmental organizations (NGOs) in India prevents an analysis of program efforts within this article. Lastly, the spread of HIV infection is at different stages throughout the country, whereas domestic violence is a nationwide phenomenon.<sup>10</sup> Yet given that the HIV and AIDS epidemic is steadily progressing and that the vulnerability of women is pervasive throughout India, addressing the nexus of domestic violence and HIV will be widely relevant for public health.

## **HIV and AIDS**

### ***The International Human Rights Framework***

A range of human rights address factors that relate to women's vulnerability to HIV infection — specifically ability to negotiate safer sex, access to health services, and social status. In particular, Article 12 of the ICESCR guarantees the individual the right to health — a key obligation in regard to women's access to services.<sup>11</sup> In General Comment 14, the Committee on Economic, Social and Cultural Rights interprets this right to health to include being free from discrimination on grounds related to HIV and AIDS and also notes the need for prevention and education programs related to sexual health.<sup>12</sup> Further, Article 19 of the ICCPR guarantees the right to information — an especially pertinent factor related to sexual decision-making and health.<sup>13</sup> Although not legally binding, the Declaration of Commitment of the UN General Assembly Special Session on HIV/AIDS in June 2001 is the first government pledge to ensure that human rights are integrated into the response to HIV and AIDS.<sup>14</sup> The United Nations High Commissioner for Human Rights (UNHCR) and Joint United Nations Program on HIV/AIDS (UNAIDS) International Guidelines on HIV/AIDS and Human Rights establish that states are obligated to ensure equal access to information on HIV-related policies and programs and health services.<sup>15</sup>

CEDAW provides specific human rights guidelines on women's vulnerability in marriage and to HIV infection. In Article 16, the treaty establishes that women are entitled to equal rights in marriage and in regard to reproductive decisions.<sup>16</sup> Further, the CEDAW Committee in General Recommendation 15 highlights women's vulnerability to HIV and calls for programs to address the factors related to women's reproductive role and subordinate social status that render them especially vulnerable to HIV infection.<sup>17</sup>

### ***The Indian Environment***

In India, UNAIDS and the National AIDS Control Organization (NACO) estimate that 5.1 million people were living with HIV and AIDS in India by the end of 2003, of

which approximately one-third are women.<sup>18,19</sup> While adult prevalence is less than 1%, India has the world's second largest population of persons living with HIV and AIDS.<sup>20</sup> The vast diversity in societal and demographic patterns of India's regions renders it difficult to illustrate an overall picture of the epidemic. Rather, the spread of HIV can be seen as an amalgamation of regional micro-epidemics — each with distinct vulnerabilities, scale of impact, and modes of transmission. Ninety-six percent of all reported HIV-infected individuals live in only 10 states, with Maharashtra, Tamil Nadu, and Manipur accounting for more than 75% of all those infected.<sup>21</sup> Unprotected sexual activity accounts for close to 85% of HIV transmission, and over 35% of cases occur in the age group 15 to 24 years.<sup>22</sup> After India's first HIV infection was reported in 1986, high-risk groups were identified as sex workers, intravenous drug users, and those attending sexually transmitted disease clinics.<sup>23</sup> The most vulnerable groups then shifted to include "bridge" populations, such as truck drivers and migrant populations. In the present scenario, the epidemic is shifting toward women and young people — and married women's risk of being infected by their partners is increasing.<sup>24</sup> For example, research has shown that 82% of HIV-infected women in Maharashtra who were not sex workers were married and monogamous.<sup>25</sup> In a retrospective study of married, HIV-positive women in South India, 81% were married housewives — 89% of whom reported heterosexual sex as their only risk factor and nearly 90% of whom reported a history of monogamy.<sup>26</sup> Apart from ante-natal clinics, there is limited data on the prevalence of HIV in married women. Yet as research on HIV prevalence will be incorporated into general population surveys, such as the National Family and Health Survey (NFHS), India will have more data to verify a growing base of anecdotal evidence on the risk and prevalence in married women.

### ***Women's Vulnerability***

Lack of knowledge, combined with their inability to negotiate condom use, places women whose husbands have multiple partners at risk of HIV infection. Literacy, years of

formal education, and exposure to mass media affect women's knowledge of HIV.<sup>27</sup> Yet 40% of Indian women have no exposure to mass media and half of women above age 6 are illiterate, with the figure up to 72% in rural areas.<sup>28</sup> Overall, 74% of girls between 6 and 14 years old attend school, with girls in poor, rural families generally among those who do not attend.<sup>29</sup> The national Behavioral Surveillance Survey (BSS) of the general population (conducted in 2001) found that overall 50% of women are aware of how to prevent HIV infection, compared to 62% of men. Significant regional differences exist: less than 15% of women in several states, including Bihar, Assam, and West Bengal, were aware that having an uninfected faithful partner and consistent condom use can prevent HIV infection, compared to over 60% of women reporting knowledge of these two methods in Kerala and Delhi.<sup>30</sup>

Although data are limited, studies have indicated that sexual coercion in marriage is widespread in India.<sup>31</sup> International research indicates that women in coercive sexual situations have little ability to negotiate safer sex and are highly vulnerable to sexually transmitted infections (STIs).<sup>32</sup> A qualitative study on sexual relations and negotiation among married couples in Mumbai found that women commonly have sexual relations against their will and that many husbands believe that sex is their right in a marriage.<sup>33</sup> In this study, women respondents whose husbands had other partners generally did not use condoms when having sex with their husbands. In a study conducted in Uttar Pradesh, a large Northern state, two-thirds of all respondents reported that their husbands had at one time or another coerced them into having sex — one-third by means of physical abuse.<sup>34</sup> Notably, Indian law does not consider marital rape an offense.<sup>35</sup>

Women in the first study reported that they lacked the courage or power to suggest condom use to their husbands, believing that the risks of upsetting the status quo in their marriages outweighed the benefits.<sup>36</sup> In situations where married women perceive they are at risk, negotiating condom use requires overcoming women's traditionally more submissive role in sexual relations, as well as a cultural

emphasis on fertility. On average, women in India marry at 19.7 years of age, and a significant proportion become pregnant during their first year of marriage.<sup>37</sup> Also, younger women are biologically more susceptible to HIV infection.<sup>38</sup>

## **Domestic Violence**

### ***The International Human Rights Framework***

Globally, the human rights system provides a normative context to assess a government's obligations regarding domestic violence. Violence against women is one of the most pervasive yet least recognized human rights violations because it is most commonly perpetrated in intimate-partner relationships.<sup>39</sup> The UN Declaration on the Elimination of Violence against Women, the first set of international norms in this area, defines violence against women as "any act of gender-based violence that results in or is likely to result in, physical, sexual, or psychological harm or suffering to women."<sup>40</sup> The UN Special Rapporteur on Violence against Women has recognized that both the ICCPR and ICESCR — legally binding documents in international law — in their nondiscrimination clauses, together with the right to security of person, prohibit violence against women.<sup>41</sup> Further, the Beijing Platform for Action reaffirmed the human rights obligations of states to eliminate violence against women and detailed necessary actions by governments.<sup>42</sup> Women's rights articulated in CEDAW include protection against harmful traditional attitudes, customs, and practices; violence and health; rural women; and family violence. In General Recommendation 19, the Committee articulates that the prohibition of gender-based discrimination in CEDAW includes violence against women, and it calls for States parties to include measures instituted to eliminate violence in their regular reporting on CEDAW.<sup>43</sup>

### ***The Indian Environment***

In India, despite regional differences in women's status, the prevalence of domestic violence is widespread throughout the country.<sup>44</sup> The NFHS in 2000 of more than 90,000 women reported that at least 1 in 5 women, and 1 in



3 poor women, has experienced physical violence since age 15.<sup>45</sup> The International Clinical Epidemiologists Network (INCLEN), which conducted a more in-depth, multi-site household study that included psychological violence, reported that 40% to 43% of the women (N=9,938) experienced at least 1 incident of physical or psychological violence.<sup>46</sup> The study included only women who had at least one child, and may have therefore underreported prevalence. Rural women reported the highest prevalence of violence, followed by women living in urban slums.

Of all women reporting violence, 63% reported at least 3 instances of physical abuse, while 68% indicated experiencing psychological violence. Nearly 15% of the total sample reported 1 or more incidents of forced sex during the past year. Further, 50% of women who experienced violence also indicated abuse during pregnancy.<sup>47</sup> An additional study on women's autonomy found that 37% to 40% of women reported physical violence or intimidation, with narrow disparities in regard to religion or age, and slightly higher prevalence in a Northern state.<sup>48</sup>

### *Women's Vulnerability*

A woman's economic position in the home is related to violence. Unemployment of both husband and wife is strongly associated with physical and psychological violence, and there is a positive correlation between a husband's regular employment and a lack of both physical and psychological violence. Women in homes with fewer appliances, a proxy indicator for lower socio-economic status, are also more likely to experience abuse — or be more likely to report it.<sup>49</sup> Notably, violence occurs more frequently when women are more educated than their husbands or have better jobs than their husbands.<sup>50</sup> While these data do not indicate a simple relationship between employment and violence, it is clear that violence is closely linked to economic power relations.

Women's health, another indicator of status within the home and society, is associated with domestic violence. The INCLEN study reported that women with poor physical or mental health were more likely to report both physical and

psychological violence.<sup>51</sup> Although almost half of women required health care due to violence, very few seek services. Most cited shame, home-based care, and lack of economic capacity as reasons for not seeking external medical care. One in five also cited lack of freedom, imposed by their husbands, as an obstacle to receiving health care.<sup>52</sup> In addition to causing physical and psychological harm, domestic violence increases women's long-term vulnerability to other health problems such as chronic pain, depression, and drug and alcohol abuse.<sup>53</sup>

Studies cite harassment related to dowry as a cause for violence: 12% of women experienced violence due to her marital home finding her dowry unsatisfactory.<sup>54</sup> A husband's use of alcohol is positively correlated with a woman's risk of violence.<sup>55</sup> Although spousal alcohol use is not necessarily an indicator of women's vulnerability, the situation leading to violence demonstrates a lack of women's capacity to protect herself from alcohol-induced violence. Research has also indicated that women with violent childhoods were twice as likely to report abuse in marriage.<sup>56</sup> Conversely, women with higher levels of social support within the home and community were significantly less likely to report physical or psychological violence.

Between 50-75% of women interviewed for various studies believe that violence against a woman is justified if she neglects household responsibility or acts disrespectfully.<sup>57</sup> Women also cited that their husbands' suspicions of infidelity were a leading cause of violence; according to the NFHS, one-third of women felt that infidelity justifies abuse.<sup>58</sup> Few women permanently leave abusive relationships. More than half explained that they stayed in a relationship because they considered violence to be normal, whereas others cited socio-cultural norms, economic stability, or family honor as reasons not to leave.

## **The Societal Context**

Although domestic violence and HIV and AIDS have distinct individual and programmatic vulnerability structures, the underlying societal factors are overwhelmingly similar. The status of women in marriage and the marital

home reduces a woman's negotiating power, possibly increasing her vulnerability to both violence and HIV. In particular, the dowry system perpetuates the idea that women are an economic liability and largely contributes to a culture that permits violence against women and prefers sons to daughters. Further indication of women's subordinate status is that, according to the NFHS, the majority of married women are excluded from household decisions even in mundane matters: nearly 90% of women in Uttar Pradesh, for example, reported needing permission to leave the home to visit friends.<sup>59</sup> In the state of Kerala, where women reportedly exercise the greatest degree of freedom and where literacy rates for women are nearly 100%, more than 50% of women report that they need permission to leave the home.<sup>60</sup>

Gendered power dynamics also underlie sexual relations. A range of studies finds that women have difficulty discussing sexual relations with their husbands, including contraception.<sup>61</sup> With respect to HIV prevention, societal pressure on motherhood and fertility impedes use of barrier contraceptives for women of reproductive age.<sup>62</sup> Accusations of infidelity are closely correlated with incidents of domestic violence.<sup>63</sup> The imbalance of power within the home curtails a woman's ability to negotiate the terms of sex and thereby increases her vulnerability to HIV. Public discussions about sexual relations are also considered taboo, hampering women from receiving information related to risk factors and being proactive in negotiating safe sex. Although media campaigns are slowly breaking taboos, societal norms still largely dictate the extent to which programs can directly address sexual behavior.<sup>64</sup>

Women's economic vulnerability, arising from unequal wages and limited control of household resources, creates a dependence on men and reduces negotiating power in the household. Thirty-seven percent of women are employed, excluding household responsibilities, of which two-thirds are in the agricultural labor force.<sup>65</sup> Of the agricultural labor force, 91% of women work in the informal economy, compared to 70% of men. Additionally, women's wages are generally lower than those of men.<sup>66</sup> In two surveys of women in Mumbai and Uttar Pradesh, the ma-

majority of women believed that the economic consequences of leaving a risky relationship are far worse than the health risks of remaining.<sup>67</sup> Furthermore, women have been discriminated against in property and inheritance rights: until recent changes in August 2005, a woman was entitled to half that of her brothers, or dependent upon a father's will.<sup>68</sup> There is no standard governing distribution of matrimonial property in most states, and women are dependent on their husbands for typically small sums of maintenance money. Divorce, though increasing in urban areas, remains a little-used option in violent or risky marriages.<sup>69</sup>

Analysis of research in Uttar Pradesh shows that greater proportions of rural men, men of lower socio-economic status, and men of lower castes were more likely to be perpetrators of abuse.<sup>70</sup> An alternate theory, however, contends that research trends and bias, as well as reporting differentials between socio-economic classes, tend to focus on the relationship between violence and economic status — whereas in actuality women of all classes experience violence.<sup>71</sup> Lower economic status does, however, correlate with lower HIV and AIDS awareness.<sup>72</sup> While neither domestic violence nor HIV is only in lower-income households, overall poverty is associated with increased risk of both. Both epidemics prey on the vulnerable at the individual, family, and societal levels.

### **Pathways of Intersection**

The reality of many women's lives is that vulnerability to domestic violence and HIV co-exist. Domestic violence directly and indirectly exacerbates vulnerability to HIV; HIV status increases vulnerability to violence; and common factors for each function in a dynamic interplay. Although empirical research on this link is scant, a growing body of international literature provides a sound basis for identifying the major intersections between HIV and domestic violence in India.<sup>73</sup>

### ***Domestic Violence: A Risk Factor for HIV***

Women in violent relationships are likely to experience a combination of emotional, physical, and sexual forms of violence. Sexual coercion or violence in marriage most

likely occurs without condom use, and thus increases women's vulnerability to STIs and HIV. In general, women's inability to negotiate condom use due to fear of violence, lack of risk perception, or socio-cultural norms increases risk of infection by husbands with multiple partners. Intercourse that is rough may also cause lacerations or wounds that facilitate disease transmission, thereby also increasing a woman's biological vulnerability.<sup>74</sup> Moreover, the broad factors that render women vulnerable to violence — social, economic, and cultural inequalities — also limit access to HIV prevention services, including condoms, voluntary counseling and testing (VCT), and STI treatment. Thus, women who experience violence, or who are fearful of it, are likely to be more vulnerable to HIV transmission from partners who engage in high-risk behavior.

### ***HIV: A Risk Factor for Domestic Violence***

There is a growing body of evidence indicating that disclosure of HIV-positive status increases vulnerability to domestic violence. Limited research from the United States and Africa points to a linkage between HIV status and domestic violence; further study is needed to incorporate women's previous history of violence.<sup>75</sup> In India, qualitative interviews in Mumbai reveal that married women who test positive for HIV are subject to violence or abandonment.<sup>76</sup> Research and testimonials from the Positive Women's Network in India also indicate that HIV infection often leads to emotional abuse and stigma within the home and community.<sup>77</sup> In interviews, women have reported that being accused of infidelity or forced from the home are common reactions to testing positive.<sup>78</sup> On the other hand, qualitative research and international studies also reveal that many women who are known to be HIV-positive may receive support from their families.<sup>79</sup>

### ***HIV and Domestic Violence Operate Together***

Initial evidence, although limited, points to a dynamic interplay between HIV and violence. For example, men in Uttar Pradesh who reported engaging in extramarital affairs were 6.2 times more likely to report abusing their wives or

being violent.<sup>80</sup> Furthermore, men with STIs were 2.4 times more likely to abuse their wives than those who were disease free.<sup>81</sup> While causal patterns cannot be discerned, the relationship between domestic violence and risk of HIV transmission is clear. The societal context of women's lives and similar risk factors for HIV and domestic violence provide a clear basis for an intersection between the epidemics. Needless to say, more research is needed in India to understand specific mechanisms and potential intervention areas.

## **Assessing the Response**

### ***HIV and AIDS***

NACO is the official body responsible for establishing HIV and AIDS policy, and 38 State AIDS Control Societies implement programs. Prevention and control strategies are primarily targeted interventions for vulnerable groups including commercial sex workers, migrant laborers, injecting drug users, truck drivers, and men who have sex with men.<sup>82</sup> The National AIDS Control Policy II (NACP II) from 1999-2004 recognized HIV and AIDS as not "merely a public health challenge" but also as a political and social development issue.<sup>83</sup> Draft legislation has been introduced in Parliament in an effort to protect people living with HIV and AIDS and other marginalized groups from discrimination.<sup>84</sup> The national policy response also cites that a paradigm shift is imperative to address the risks of a widespread epidemic and accordingly calls for a multi-sectoral, expanded response.<sup>85</sup>

To reach the general population, NACO has scaled up its general outreach and awareness programs. The government-sponsored Family Health Awareness Campaign, an effort to increase knowledge about STIs, reproductive health, and disease transmission, reached women in urban slums and rural areas with fieldworker home visits to treat STIs.<sup>86</sup> Awareness-raising activities have also been extended to youth through school-based information campaigns and teacher training for sexual health education. The number of VCT centers has increased nationwide and has been recognized as a key component in combating the generalized epidemic, particularly for women.<sup>87</sup> NACO has instituted pre-

vention of mother-to-child transmission (PMTCT) programs in several states, supplemented by anti-retroviral (ARV) provision for HIV-positive mothers where available.<sup>88</sup> Further, the UN system, in partnership with NACO and state governments, has initiated the pilot project Coordinated HIV/AIDS Response Through Capacity-Building and Awareness (CHARCA) to reduce the vulnerability of young women to STIs and HIV/AIDS in six districts through information provision and improved access to quality services.<sup>89</sup>

Despite these initial steps, India's increasingly generalized HIV epidemic will require a much more scaled-up and intense effort to reach women and prevent transmission in marriage. Although current policy in India does promote awareness campaigns, poor women in both rural and urban areas have limited exposure to mass media, and illiteracy also inhibits their access to information. Further, given that only 65% of women receive even 1 ante-natal checkup and that one-third of births occur in health facilities, programs based in the formal health system will have limited reach.<sup>90</sup> Similarly, the reach of clinic-based programs to treat STIs is limited by low utilization of reproductive health services — two-thirds of women who report reproductive health problems do not seek care.<sup>91</sup> Finally, the success of VCT in reaching women depends on their utilization and trust of health services and assumes they are empowered to seek and access VCT services.

Condom promotion, one of the most effective ways to prevent HIV infection, requires a major shift in perception for married women in India. Promoted for decades as a family planning tool, condom use in the context of preventing STIs and HIV within marriage will require open discussion of sexual behavior and sexuality — issues that have long been taboo in Indian society. As the Ministry of Health initiates an effort to integrate aspects of HIV and reproductive health programming, condom promotion as dual protection will likely gain more focus.<sup>92</sup> The female condom may also widen options, but general barriers to condom use for married women may also hinder utilization in marriage.<sup>93</sup>

Widespread discrimination and stigma regarding HIV have also prevented women from using HIV education and

services. NACO has launched a mass media campaign to counter stigma, with a recent effort directed toward women.<sup>94</sup> In fact, activists have criticized some media advertisements for portraying women as vectors of transmission — a strategy that ultimately reinforces gender power dynamics.<sup>95</sup> Over the past decade, at least two high-prevalence states have proposed bills that would require mandatory reporting or partner notification.<sup>96</sup> Further, in 1998, in a ruling stating that a person should be prevented from “spoiling the health and consequently, the life of an innocent woman,” the Supreme Court revoked the right of HIV-positive persons to marry.<sup>97</sup> After considerable activism and in response to an appeal in 2002, the Supreme Court restored the right of HIV-positive persons to marry.<sup>98</sup>

### ***Domestic Violence***

In 1983, the Indian Penal Code criminalized domestic violence under Section 498A, by recognizing matrimonial cruelty as a criminal offense.<sup>99</sup> By integrating physical, mental, and economic violence, the act recognizes the vulnerability of women within the marital home and attempts to provide them with legal leverage. Also, by allowing perpetrators of domestic violence to be arrested without a warrant, the act has deterrent value with immediate legal repercussions. Section 498A also demonstrates the state’s willingness to address domestic violence as a public, criminal concern and thereby recognizes the vulnerability of women inside the private sphere of the home.<sup>100</sup> In practice, however, legal implementation and interpretation have remained weak.<sup>101</sup>

In March 2002, the Indian Parliament introduced a civil mechanism, The Protection of Women from Domestic Violence Bill, in response to extensive lobbying by women’s activist groups.<sup>102</sup> Not yet ratified into law, the bill is intended to serve as a preventive mechanism and a civil tool for effective immediate responses to domestic violence.<sup>103</sup> Although the bill represents an important step in providing civil remedies, it does not guarantee a woman’s right to reside in the matrimonial home and is dependent on judicial interpretation.<sup>104,105</sup> A focus of long debate for women’s



groups, the bill has been criticized by activists as contrary to its initial intention to provide women with viable, empowering options.<sup>106</sup>

While international and nongovernmental organizations are increasingly recognizing violence as a public health issue, the Ministry of Health and Family Welfare has initiated programs but has not yet spearheaded a multi-sectoral response. Supported by the United Nations Population Fund, an information kit on violence against women has been developed for health care providers.<sup>107</sup> Research reiterates that neither the state nor the voluntary sector has been able to fulfill the immediate need for effective health services.<sup>108</sup> Fewer than 2% of respondents in an INCLEN study sought services from institutions for domestic violence-related health concerns.<sup>109</sup> Presently, there are few state-run shelter homes, and those that do exist are often equipped to provide only short-term help, with restrictive policies on resident mobility. State-sponsored shelters also rarely provide for material support, childcare facilities, or income generation activities.<sup>110</sup> The nongovernmental sector plays a key role in providing services for domestic violence survivors, but lack of state policy support may have an impact on the reach and quality of services, and, to some extent, funding. Public awareness campaigns on domestic violence and legal rights are increasing, but they are constrained due to political pressure and lack of support.<sup>111</sup>

### **Opportunities for Integration**

The current responses to HIV and domestic violence in India treat each epidemic singularly, with little recognition of their nexus. What is needed is a combination of short- and long-term integrated strategies that address both immediate risk and the underlying societal context. The purpose of an integrated approach is not to completely merge domestic violence with HIV prevention efforts, leaving no room for distinct strategies. Rather, an integrated response highlights the concentric overlap between singular interventions and the importance of addressing the underlying societal context of women's vulnerability. The human rights framework provides the normative context to hold

the state accountable, and the wide scope of enshrined women's rights supports the need to address societal roots of vulnerability.

### ***Strengthen Individual Approaches***

Policies and programs in each area would be mutually strengthened through addressing the overlap between HIV and domestic violence. A key action by the government may be to develop linkages between policy-makers in HIV and domestic violence prevention and to establish a plan for developing training and education modules at the national, state, and district levels for each issue that integrates the other. Within HIV efforts, domestic violence awareness can be mainstreamed into prevention efforts such as information campaigns and peer education curricula. As NACO prepares for NACP III, it will be critical that programs to address women also address domestic violence. Similarly, domestic violence policy and programs can ensure that counselors and health care providers are trained to screen women for HIV and provide counseling and testing referral services for those at risk. Further, government-led integration of HIV and reproductive health services presents an opportunity to integrate domestic violence in both programs.

Within the existing HIV and AIDS program, wider and systematic integration of initiatives to address gender, such as life-skills training on sexual negotiation through peer-based community programs and local women's groups, can improve outreach to married women. Also, through exploring innovative approaches to promoting safer sex within marriage, such as male responsibility and female-controlled methods, prevention campaigns present an opportunity to address the obstacles that women face in negotiating condom use. With intensified initiatives such as the Family Health Awareness Campaigns to reach rural women, HIV prevention efforts are a forum to raise sexuality and sexual negotiation in direct, forthright communication.

The intersection between domestic violence and HIV has specific implications for VCT services and partner-notification policies. Specifically, programs must re-evaluate the utilization and access of married women to VCT centers in

light of the widespread prevalence of domestic violence. Fear of violence may be an impediment to utilization of VCT; further monitoring and research is critical. Also, existing VCT centers can improve accessibility by ensuring the availability of female counselors and providing couple counseling on request. VCT services also provide an opportunity to screen and counsel women for domestic violence and identify women at risk of HIV due to a history of violence. Training for VCT counselors should include domestic violence awareness, service referral, and recognition of the potential harm of disclosure of HIV status for women.

In the domestic violence response, a multi-sectoral national action plan that integrates health, legal, and social responses will be critical to addressing domestic violence. Collaborations between state and nongovernmental services have proven successful and should be replicated.<sup>112</sup> A key facet of such a response should be community-level interventions such as shelters, counseling cells, referral services, legal aid, and one-stop crisis centers that give women access to legal, social, and health services in a discreet location. Given the socio-economic and cultural obstacles to seeking legal redress or divorce, centers that ensure women's safety and provide access to vocational training, income generation, and support systems will likely be most effective. A clear definition of domestic violence within the law will improve implementation of legal codes, combined with continued training and sensitization of police officers. Also, the response of health services to domestic violence would be considerably strengthened through provider training and outreach efforts, with special effort to integrate psychosocial services. Building on the government initiative, all providers and health clinics should have response and referral protocols.

### ***Mainstream Gender in Programs and Policies***

Mainstreaming gender in programs and policies calls for addressing the power relations between men and women as well as the societal context that increases vulnerability to both domestic violence and HIV. Gender mainstreaming occurs at different levels and is critical to addressing underlying issues.<sup>113</sup> Addressing root causes of women's vulnera-

bility requires a long-term, integrated, and multi-sectoral effort across sectors that include education, health, finance, and law. For example, in the legal code, reform of personal law to ensure equal inheritance, property rights, and criminalization of marital rape would greatly improve women's status and accordant ability to negotiate. Existing initiatives to work with men and women through life-skills training on relationships, sex, and gender roles within schools and community are also an opportunity to equalize gender dynamics.<sup>114</sup> In entertainment and media, portrayal of positive gender roles in mainstream Bollywood cinema and television has wide potential for impact. In light of women's economic inequality, improving women's access to formal employment and credit, as well as social security and health benefits in formal and informal employment schemes, will have far-reaching benefits. Lastly, but not least, efforts must include men: to ensure meaningful male participation, successful models must be documented and replicated. Though this range of initiatives to mainstream gender is necessarily long term and challenging, it is key to reducing the vulnerability of women to HIV and domestic violence.

### ***Improve Data and Research***

Evidence is key to mobilizing action. Research and data collection efforts have not yet empirically captured this intersection: only one study has compiled information on both abuse and prevalence of sexually transmitted infection.<sup>115</sup> Also, given the growing anecdotal evidence of HIV infection in married women, quantitative and qualitative nationwide research studies on the vulnerability of married women to HIV are crucial to substantiate increased focus. More nationwide studies on domestic violence, including the health impact, are critical to ensure a comprehensive response. Intervention-specific research that integrates men's attitudes toward violence, sexual relations, and negotiation will inform state programs and policy to maximize effectiveness. Further, a monitoring system that documents violence and utilization of health, legal, and social services will provide continuous information for evidence-based programming.

## Conclusion

The deep-rooted nature of both HIV and domestic violence in India calls for an expanded response to each epidemic, an integrated response at the nexus, and confrontation of their underlying determinants. India's historically strong women's movement and nongovernmental sectors have pushed forward reform in domestic violence legislation, have called attention to injustice in women's health, and continue to advocate for the disempowered. Yet, increasing rates of HIV infection in married women, coupled with the fact that up to half of all married women in India are subject to domestic violence, portend a significant crisis. The role of the state is therefore crucial to a widespread, comprehensive response.

Although this complex interplay has explosive potential, it also provides impetus to transform India's public health response. There are expansive opportunities for a state-led, rights-based response to addressing HIV and AIDS, domestic violence, and their links. Effective policies and programs must span a wide range of sectors, from the legal to school-based education, to address the roots of vulnerability. Focusing on women's vulnerability allows for recognition of the underlying determinants of risk and thereby integrates a broader perspective for intervention. Through policy and programs, the state can and should ensure an environment in which women are free from violence and empowered to mitigate their vulnerability to HIV infection. To begin, it must recognize this intersection.

## References

1. In this article, the term domestic violence is utilized, as opposed to intimate partner violence, to recognize the extended family setting in which most women live.
2. IIPS and ORC Macro, *National Family and Health Survey (NFHS-2) India, 2000* (Mumbai: IIPS, 2000), p. 4 (Summary Report).
3. There has been little focus on understanding women's extramarital sexual activity in India. A. Lakhani et al., "Married Women in Extramarital Relationships in a Rural Area of Gujarat" in R. Verma et al. (eds), *Sexuality in the Time of AIDS* (New Delhi: Sage Publications, 2004), pp. 217-243 is one recent, yet rare study. The study found frequent multi-partner relationships with low condom use. Yet research thus far on married women reporting HIV-positive status has reported that the large majority are monogamous, with marriage the primary risk factor. (See notes 24-26). This area clearly warrants much further study and will have significant implications for understanding women's vulnerability to HIV.
4. J. Mann and D. Tarantola, *AIDS in the World II* (Oxford: Oxford University Press, 1996), pp. 441-476.
5. *Ibid.*
6. Human rights obligations of a government are defined on three levels: to respect, protect, and fulfill. The duty to respect ensures that states do not directly violate rights; and obligation to protect requires states to adopt legislation and other measures to ensure that individuals can enjoy rights as well as provide proper mechanisms for redress for violations by state or non-state actors. The duty to fulfill human rights obliges states to create the enabling conditions for the enjoyment of rights. Implying both immediate action and progressive realization, this level of obligation entails confronting social, economic, and political factors that contribute to violations and the lack of enjoyment of human rights as defined by international treaties.
7. The Convention on the Rights of the Child (CRC) is not utilized in this analysis as its primary focus is the rights on children and young people. While the age of some married women in India would qualify them as children, the CRC does not provide the normative context to analyze a government's obligations regarding violence within marriage or HIV.
8. See Initial Report of India to the Committee on the Elimination of Discrimination against Women (CEDAW), UN Doc. CEDAW/C/IND/1, and Discussion in the Committee, UN Doc. CEDAW/C/SR.452, 453, and 462 (2000).

9. Ibid.

10. (Regarding domestic violence, see note 44). The National AIDS Control Organization has classified states according to prevalence. Six high prevalent states (Maharashtra, Tamil Nadu, Karnataka, Andhra Pradesh, Manipur, and Nagaland) report over 1% prevalence of HIV in ante-natal clinics, while 14 highly vulnerable states report HIV prevalence above 5% in groups who practice high-risk behavior but have not crossed 1% in ante-natal clinics. See [www.nacoonline.org](http://www.nacoonline.org) for classification and future changes.

11. International Covenant on Economic, Social and Cultural Rights, General Assembly Res. 2200 (XXI), UN GAOR, 21st Sess., Supp. No. 16, at 49, UN Doc. A/6316 (1966).

12. Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4 (2000), paras. 11, 12(b), 16, 18, and 21.

13. International Covenant on Civil and Political rights, General Assembly Res. 2200 (XXI), UN GAOR, 21st Sess., Supp. No. 16, at 52, UN Doc. A/6316 (1966).

14. UNAIDS, *UNGASS and Human Rights*. Available at [http://www.unaids.org/en/in+focus/hiv\\_aids\\_human\\_rights/ungass\\_human\\_rights.asp](http://www.unaids.org/en/in+focus/hiv_aids_human_rights/ungass_human_rights.asp).

15. Office of the United Nations High Commissioner for Human Rights (OHCHR) and the Joint United Nations Program on HIV/AIDS (UNAIDS), *HIV/AIDS and Human Rights International Guidelines* (New York and Geneva: United Nations, 1998).

16. Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), UN General Assembly Res. 34/180 (1979), Article 16.

17. Committee on the Elimination of All Forms of Discrimination against Women, General Recommendation No. 15, Avoidance of Discrimination against Women in National Strategies for the Prevention and Control of Acquired Immunodeficiency Syndrome (AIDS), UN Doc. A/45/38 (1990).

18. National AIDS Control Organization, "Note on HIV Estimates" (2003), p. 3. Available at <http://www.nacoonline.org>.

19. HIV infection in women who do not practice sex work is primarily captured through STD and ante-natal clinics that are part of the national surveillance system. Given that utilization of ante-natal clinics is low throughout India, there is likely an underreporting of women infected with HIV.

20. UNDP, "India at a Glance," *You and AIDS Portal for Asia Pacific*. Available at <http://www.youandaids.org/Asia%20Pacific%20at%20a%20Glance/India/index.asp>.

21. UNAIDS and WHO, *India: Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections* (Geneva: UNAIDS and WHO Working Group on Global HIV/AIDS and STI Surveillance, 2002).
22. National AIDS Control Organization, *Annual Report* (New Delhi: NACO, 2004), p 14.
23. UNDP (see note 20).
24. See R. Gangakhedkar and M. Bentley et al. "Spread of HIV Infection in Married Monogamous Women in India," *Journal of the American Medical Association* 278 (1997): pp. 2090-2092, which examined spread of HIV infection in married monogamous women in India over three years and concluded that infection in HIV is increasing in women who do not practice sex work, previously thought to be at low risk in India.
25. J. Rodrigues et al., "Risk Factors for HIV Infection in People Attending Clinics for Sexually Transmitted Diseases in India," *British Medical Journal* 311/7000 (1995): pp. 283-286, found a high prevalence of HIV (14%) in women who were not sex workers who attended a sexually transmitted disease clinic.
26. S. Newmann et al., "Marriage, Monogamy and HIV: A Profile of HIV-Infected Women in South India," *International Journal of STD & AIDS* 11/4 (2000): p. 250.
27. N. Chatterjee, "AIDS-Related Information Exposure in the Mass Media and Discussion Within Social Networks Among Married Women in Bombay, India," *AIDS Care* 11/4 (1999): p. 443.
28. IIPS and ORC Macro 2000 (see note 2), p. 3.
29. IIPS and ORC Macro 2000 (see note 2), p. 4.
30. National AIDS Control Organization, *Behavioural Surveillance Survey in the General Population* (New Delhi: NACO, 2001), pp. 31 and 34.
31. M. E. Khan et al., "Sexual Violence Within Marriage" (paper prepared for Annual Meeting of the American Public Health Association, November 1997) (New Delhi: Population Council, 1997), pp. 10 and 12.
32. L. Heise, *Sexual Coercion and Reproductive Health: A Focus on Research* (New York: Population Council, 1995).
33. A. George, "Differential Perspectives of Men and Women in Mumbai, India on Sexual Relations and Negotiations Within Marriage," *Reproductive Health Matters* 6/12 (1998): p. 91.
34. Khan et al., (see note 31), p. 10.
35. There is no legally defined age of consent for sexual intercourse, although Indian Penal Code Section 375 defines sex with a female less than 16 years as rape (Indian Penal Code, 1860, 2003).
36. George (see note 33), p. 93.



37. IIPS and ORC Macro (see note 2). Also see K. Menon-Sen and S. Kumar, *Women in India: How Free, How Equal?* (New Delhi: United Nations, 2001).
38. C. Garcia-Moreno and C. Watts, "Violence against Women: Its Importance for HIV/AIDS," *AIDS 2000*, 14 (suppl 3): S253-S265. Also Heise (see note 32).
39. C. Watts and C. Zimmerman, "Violence Against Women: Global Scope and Magnitude," *The Lancet* 359 (2002): p. 1233.
40. UN Declaration on the Elimination of All Forms of Violence against Women, General Assembly Res. 48/104, 48 UN GAOR Supp. No.49, at 217, UN. Doc. A/48/49 (1993). Although this declaration is not legally binding, it merges a range of recognized human rights standards into a comprehensive statement.
41. R. Coomaraswamy, Preliminary Report Submitted by the Special Rapporteur on Violence Against Women, its Causes and Consequences, UN Doc. E/CN.4/1995/42 (1994), para 81.
42. Beijing Declaration and Platform for Action, Fourth World Conference on Women, UN Doc. A/CONF.177/20 (1995), paras. 124-126.
43. CEDAW, General Recommendation No. 19, Violence against Women, UN Doc. A/47/38 (1992).
44. There are interstate and intrastate variations, but overall domestic violence is widely prevalent throughout the country. International Center for Research on Women (ICRW), *Domestic Violence in India 3: A Summary Report of a Multi-Site Household Survey* (Washington, DC: ICRW and the Center for Development and Population Activities, 2000).
45. IIPS and ORC Macro (see note 2), p. 5.
46. International Clinical Epidemiologists Network (INCLEN), *Domestic Violence in India: A Summary Report of a Multi-Site Household Survey* (Washington, DC: International Center for Research on Women, 2000), p. 9.
47. *Ibid.*, p. 10.
48. S. Jejeebhoy, "Wife-beating in Rural India: A Husband's Right?" *Economic and Political Weekly* 33/15 (1998): pp. 855-862. Section IV, as available at [www.hsph.harvard.edu/Organizations/healthnet/SAsia/forums/dv/articles/beating.html](http://www.hsph.harvard.edu/Organizations/healthnet/SAsia/forums/dv/articles/beating.html).
49. INCLEN (see note 46), p. 18.
50. *Ibid.*
51. INCLEN (see note 46), p. 19
52. *Ibid.*
53. For a further discussion on the public health impact of violence against women, see L. Heise, "Violence Against Women: A Neglected Public Health Issue in Less Developed Countries," *Social Science and Medicine* 39/ 9 (1994): pp. 1165-1179.

54. INCLLEN (see note 46), p. 16.
55. INCLLEN (see note 46), p. 19.
56. INCLLEN (see note 46), p. 19-20. S. Martin et al., "Domestic Violence Across Generations: Findings from Northern India," *International Journal of Epidemiology* 31 (2002): pp. 560-572, also found that, compared to men raised in non-violent homes, men from violent homes were significantly more like to be abusive to their own wives. The study found that one-third of wife abuse in one generation was attributable to parent-to-parent violence in the previous generation.
57. Jejeebhoy (see note 48), p. 6, and IIPS and ORC Macro (see note 2), p. 5.
58. IIPS and ORC Macro (see note 2), p. 6, and INCLLEN (see note 46) p. 15-16.
59. IIPS and ORC Macro (see note 2), p. 5.
60. Ibid.
61. Studies cited throughout the article concur on women's inability to take part in sexual decision-making, particularly George (see note 32) and Rao Gupta (see note 62). For further analysis of contemporary attitudes and behavior, see R. Verma et al. (eds), *Sexuality in the Time of AIDS* (New Delhi: Sage, 2004), a compilation of community-based research and interventions over the past decade.
62. G. Rao Gupta, *Gender, Sexuality and HIV/AIDS: The What, the Why, and the How* (Plenary Address XIIIth International AIDS Conference, Durban, South Africa, 2000). Available at <http://www.icrw.org>.
63. INCLLEN (see note 46), p. 15.
64. Several articles outline the difficulty in addressing sexuality in society and within media messages. See Lawyers Collective, Media Abstract. Available at <http://www.lawyerscollective.org/lc-hiv-aids/Abstracts/Media.htm>; B. Simon, "AIDS Out of Control in India" *60 Minutes* (April 11, 2004). Available at <http://www.saaids.org/media/aidsOutOfControl.html>.
65. IIPS and ORC Macro (see note 2), p. 4-5.
66. J. Unni and U. Rani, *Women in Informal Employment in India* (Paper presented at the International Association for Feminist Economics 2000 Conference, Ahmedabad, India: Gujarat Institute of Development Research, 2000).
67. S. Jaswal and A. George, *Understanding Sexuality: An Ethnographic Study of Poor Women in Bombay* (Washington, DC: International Center for Research on Women, 1995) and Khan et al. (see note 31).
68. M. Dhaliwal, "Creation of an Enabling and Gender-Just Legal Environment As a Prevention Strategy for HIV/AIDS among Women in India," *Canadian HIV/AIDS Policy and Law* 4 (2/3)

(1999). Available at <http://www.aidslaw.ca/Maincontent/other-docs/Newsletter/spring99/geneva98-3.htm>. Also, in August 2005, the Rajya Sabha passed an amendment to the Hindu Succession Act of 1956, which would guarantee women equal rights to inheritance as their brothers. *The Hindu* (August 16, 2005). Available at <http://www.hindunet.com/onps/showarticle.php?pb=21&ag=1&a=19515>.

69. Ibid.

70. S. Martin et al., "Sexual Behaviors and Reproductive Health Outcomes: Associations with Wife Abuse in India," *Journal of the American Medical Association* 282/20 (1999): pp. 1967-1972.

71. INCLIN (see note 46), p. 18.

72. A. Basu, "The Household Impact of Adult Morbidity and Mortality: Some Implications of the Potential Epidemic of AIDS in India," in D. Bloom and P. Goodwin (eds), *The Economics of HIV/AIDS: The Case of South and Southeast Asia* (New Delhi: Oxford University Press, 1997).

73. S. Maman, "The Intersections of HIV and Violence: Directions for Future Research and Interventions," *Social Science and Medicine* 50 (2000): pp. 459-478. Evidence for intersections originates from observed commonalities in quantitative research on each epidemic individually.

74. C. Garcia-Moreno and C. Watts (see note 38) and UNAIDS and UNICEF, "Gender-Based Violence, Sexual Abuse and Exploitation in South Asia Increases Risks and Vulnerability to HIV/AIDS," at *Accelerating the Momentum in the Fight Against HIV/AIDS* (South Asia High-Level Conference, February 3-4, 2003, Nepal; New Delhi: UNICEF, 2003).

75. S. Maman et al., "HIV-Positive Women Report More Lifetime Partner Violence: Findings from a Voluntary Counseling and Testing Clinic in Dar es Salaam, Tanzania," *American Journal of Public Health* 92/8 (2002): p. 1334.

76. Point of View, *XX/XY Voices of Women and Men Living with HIV* (Mumbai: 2001).

77. Positive Women's Network (PWN<sup>+</sup>) *Positive Living* (New Delhi: UNIFEM, 2004).

78. M. Nath, *She Can Cope* (New Delhi: National AIDS Control Organization and UNAIDS, 1997).

79. Maman et al. (see note 73).

80. Martin et al. (see note 70), p. 1969.

81. Ibid.

82. NACO *Annual Report* (see note 22), p. 22.

83. NACO, *National AIDS Control Policy II*, Paragraph 2.4. (1999-2004). Available at <http://www.naconline.org/policy.htm>.

84. The Lawyers Collective has been commissioned by a member of Parliament to draft an anti-discrimination legislation. The process has involved several consultations to ensure input from a range of local stakeholders.
85. NACO (see note 83), paras. 7.1-7.5.
86. *NACO Annual Report* (see note 22), p. 65.
87. *NACO Annual Report* (see note 22), pp. 48-50,
88. The government has introduced free ARV therapy in six high-prevalence states, but with limited roll out to date.
89. See <http://www.youandaids.org/Charca>. The project promotes district-level planning to address the needs of young women.
90. IIPS and ORC Macro (see note 2), p. 13.
91. IIPS and ORC Macro (see note 2), p. 14.
92. The Ministry of Health and Family Welfare and NACO are in the initial stages of planning for integration and certain aspects of reproductive health and HIV/AIDS programs. Preliminary papers, as well as international experience points to condom promotion as a central point of convergence between HIV/AIDS and reproductive health strategies.
93. See a recent preliminary study *Female Condom: The Indian Experience* (New Delhi: Hindustan Latex Family Planning Promotion Trust and The Female Health Foundation, 2004) on factors that may influence acceptability and use of the female condom in India.
94. *NACO Information, Education and Communication Strategy*. Available at [http://www.naconline.org/prog\\_iec.htm](http://www.naconline.org/prog_iec.htm). NACO's IEC campaign includes prime time television spots of a famous actress to address women in raising the issue of HIV infection in the home.
95. People's Health Organization, "PHO Demand Ban to Balbir Pasha" (AIDS-India listserve email, January 4, 2003). Available at <http://groups.yahoo.com/group/AIDS-INDIA> and UNICEF and UNAIDS (see note 74).
96. Lawyers Collective, *Positive Dialogue* (Newsletter 2, July 1999). Available at [http://www.lawyerscollective.org/lc-hiv-aids/positive\\_dialogue/newsletters\\_2.htm](http://www.lawyerscollective.org/lc-hiv-aids/positive_dialogue/newsletters_2.htm).
97. Supreme Court of India, 8 SCC 296 (1998).
98. Lawyers Collective, "Supreme Court of India Restores HIV<sup>+</sup> Person's Right to Marry" (AIDS-India listserve email, December 10, 2002). Available at <http://groups.yahoo.com/group/AIDS-INDIA>. While the court recognized women's vulnerability to HIV infection from a partner, the rights of people living with HIV/AIDS rightfully were restored in this action.

99. India Together, "Laws Against Domestic Violence and Abuse." *Manushi* 137 (November 2003). Available at <http://www.indiatogether.org/manushi/issue137/laws.htm>.
100. N. Mitra, "Best Practices among Responses to Domestic Violence in Maharashtra and Madhya Pradesh" in *Domestic Violence in India I: A Summary Report of Three Studies* (Washington, DC: International Center for Research on Women and the Center for Development and Population Activities, 1999): pp. 21-22 and S. Prasad, "Medico-Legal Response to Violence Against Women in India," *Violence against Women* 5/5 (1999): p. 480.
101. Mitra (see note 100), p. 21; L. Panicker, "Cruelty Within Walls: Legal Redress for Domestic Violence," *Legal News and Views* 13/7 (1999): pp. 16-17; and Prasad (see note 100).
102. Parliament of India, The Protection from Domestic Violence Bill (2002). S1/Bill2002/LS/5238LS. Available at <http://rajyasabha.nic.in/bills-ls-rs/13-2001-1.pdf>.
103. K. Sharma, "Women's Groups Oppose Domestic Violence Bill," *The Hindu* (March 8, 2002). Available at <http://www.hinduonnet.com/thehindu/2002/03/08/stories>.
104. I. Jaisingh and M. Ghose, "Indira's Ire," *Times of India* (July 4, 2003). Available at <http://www.countercurrents.org/gen-ghose040703.htm>.
105. Further, bias on the part of judges cannot be overlooked. One survey, for example, found that 49% of judges surveyed reported violence being justifiable in certain cases. Available at <http://www.the-week.com/22feb03/events1.htm>.
106. Jaisingh and Ghose (see note 104) and Sharma (see note 103).
107. A recent initiative, the press release is available at <http://www.unfpa.org.in/detailnews.asp?newsid=51>.
108. Mitra (see note 100), p. 24.
109. INCLLEN (see note 46), p. 17.
110. Mitra (see note 100), p. 23.
111. V. Poonacha and D. Pandey "Responses to Domestic Violence in Karnataka and Gujarat," in *Domestic Violence in India I: A Summary Report of Three Studies* (Washington, DC: International Center for Research on Women and the Centre for Development and Population Activities, 1999), p. 29; and Mitra (see note 100), p. 25.
112. Mitra (see note 100), p. 24.
113. In one model, gender can be integrated at different levels in programs. Articulated by Geeta Rao Gupta as a continuum, approaches can range from doing no harm; gender-sensitive; transformative; and empowering through their programs and outreach. See Rao Gupta, (see note 62).
114. Rao Gupta (see note 62).
115. Martin et al. (see note 70).