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Ministry of Health & Family Welfare
Government of India

OPERATIONAL GUIDELINES

ON HIV/STI/TB AND HEPATITIS INTERVENTIONS IN PRISON AND OTHER CLOSED SETTINGS

नए समाज की ओर
Towards a new dawn

Ministry of Social Justice & Empowerment

NACO
National AIDS Control Organisation

National Tuberculosis Elimination Programme

National Viral Hepatitis Control Program

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And Hepatitis intervention in Prisons and
other Closed Settings, please contact:

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स्वास्थ्य और परिवार कल्याण मंत्रालय
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National AIDS Control Organisation
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FOREWORD

The National AIDS Control Organisation (NACO) is the nodal agency responsible for approving, implementing and supervising all HIV/AIDS related activities in the country, including research, under the Ministry of Health and Family Welfare (MoHFW), Government of India. NACO implements the National AIDS Control Programme (NACP) as a comprehensive programme for prevention and control of HIV/AIDS in India. The goal of the fifth phase of the programme - NACP-V (2022–2026) - is to promote universal access to quality STI/RTI services to at-risk and vulnerable populations.

It is with great pleasure that NACO introduces the revised Operational Guidelines for Prison and Other Closed Settings Intervention for HIV, TB, STI, and Viral Hepatitis Services in India. These guidelines are the result of a collaborative effort between the Ministry of Health and Family Welfare, the Ministry of Home Affairs, and other key stakeholders, including civil society organizations and people living in closed settings.

As we all know, people living in closed settings are often at higher risk of acquiring and transmitting infectious diseases, such as HIV, TB, STI, and Hepatitis. This is due to a combination of factors including poor living conditions, limited access to healthcare, stigma and discrimination. High turnover of prison inmates fuels the spread of HIV and other infectious diseases such as TB. Post release, infected prisoners return to their social network and increases the chance of facilitating the spread of HIV and other infections.

The revised guidelines aim to address these challenges by providing a comprehensive framework for delivering quality health services to incarcerated population across the country in close collaboration with Ministry of Women and Child Development, Govt. of India and respective State Governments.

These revised operational guidelines cover a wide range of topics, including infection prevention, testing, diagnosis, treatment, care and community engagement through social reintegration and mainstreaming P&OCS interventions. It promotes the use of Telemedicine approaches and enables healthcare providers to deliver essential services remotely by overcoming barriers such as distance, limited resources and security concerns. Through telemedicine, individuals in incarceration can access timely and quality care including counseling, diagnosis and treatment.

I would like to take this opportunity to thank all those who contributed to the revision of these guidelines including Bureau of Police Research and Development. I am certain that this will help State AIDS Control Societies and line departments towards ensuring the provision of HIV, TB, STI and Viral Hepatitis prevention and treatment services for incarcerated population across the country.

(V. Hekali Zhimomi)

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PREFACE

Globally, it is estimated that 4.6 per cent of people held in prisons are living with HIV. Furthermore, it is estimated that 15.1 per cent of the total incarcerated population have hepatitis C (HCV), 4.8 per cent have chronic Hepatitis B (HBV) and 2.8 per cent have active Tuberculosis (TB). In countries with high incarceration rates of people who inject drugs, the prevalence of HIV in prisons can be 15 to 20 times that of the general population. (*2020 update UNODC*).

Prisoners have been identified as one of the special groups under NACP and NACO addresses all inmates living in prisons and other closed settings in the Country. Data from HIV Sentinel Surveillance Plus (HSS Plus) 2021 shows that HIV prevalence among inmates is 1.93% higher than the prevalence among migrants, truckers and female sex workers. This is evident that a comprehensive intervention with multiple strategies is needed to address people living in prisons and other closed settings. Post-release social reintegration is to be addressed through networking and referral linkages.

I am delighted to introduce the operational guidelines that encompass innovative approaches for HIV, TB, STI, and Viral Hepatitis intervention in Prison and Other Closed Settings. One of the key aspects of these guidelines is the incorporation of Peer-Led Interventions. Peers, may be from under trials, play a crucial role in providing support, education, and counseling. Peer-led interventions have proven to be effective in promoting behavior change, reducing stigma, and improving health outcomes.

Additionally, the guidelines emphasize the use of various options of preventive measures for HIV, TB, STI and Hepatitis. I encourage all stakeholders to adopt and implement these operational guidelines, ensuring the provision of comprehensive and person-centered care in prison and other closed settings.

Together, we can make a significant impact on the health and well-being of individuals, reduce the transmission of infectious diseases and promote a supportive as well as stigma and discrimination free environment for all, especially for those incarceration.

(Nidhi Kesarwani)

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MESSAGE

In recent years, the landscape of corrections and offender care has undergone significant transformation. As we strive for a more compassionate and effective approach to incarceration, it is crucial that we prioritize the well-being and healthcare needs of those within our prison and offender care systems. With the advancements in technology, particularly in the field of telemedicine, we now have an opportunity to revolutionize the way we provide comprehensive services to incarcerated individuals.

As per the Prison Statistics India 2021, a total of 1319 Prisons across the country housed 5, 54,034 prison inmates, well above the authorized capacity of 4, 25,609: this translates to occupancy rate of 130.2%. Of the total 5, 54,034 inmates, 4, 27,165 were under-trials., constituting 77.1% of the total inmate population. These figures are not only indicative of the overcrowding in jails but also high turnover rate in the prison population with majority of prisoners eventually returning to their communities. Reducing transmission of HIV, STI, TB and Viral Hepatitis is, therefore, crucial for reducing the spread of these infections in the general community. Early diagnosis, combined with effective treatment, is the best strategy of prevention of HIV. STI, TB and VH in prisons.

NACO in collaboration with key stakeholders conducted national consultation meetings on May 19-21, 2022, under the chairpersonship of AS&DG, NACO. Based on the experience of implementing intervention in Prisons, it is advised to expand HIV/TB intervention to women in correctional institutes as well as to provide comprehensive package of service. As recommended in the consultation, a National Working Committee on Prisons & Other Closed Settings was constituted and existing operational guideline is revised under their guidance.

Furthermore, the guidelines prioritize Rapid Antiretroviral Therapy (ART) Initiation for individuals diagnosed with HIV. Initiating ART promptly not only improves health outcomes but also reduces the risk of transmission within closed settings.

The operational guidelines on HIV, STI, TB and Viral Hepatitis intervention in prisons and other closed settings, as detailed in this document, build on the legal obligations, commitments, recommendations and standards on HIV/AIDS, prison health, prison conditions and human rights articulated in various national and instruments.

I would like to express my sincere gratitude to all the stakeholders involved in developing these guidelines, including government agencies, healthcare professionals, civil society organizations. By outlining best practices, procedures, and considerations, this comprehensive resource will serve as a roadmap for the successful integration of telemedicine services in Prison and Other Closed settings.

Shobini

(Dr. Shobini Rajan)

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ACKNOWLEDGEMENT

We would like to express our heartfelt appreciation to all the experts, researchers, practitioners, and organizations who have contributed their knowledge and expertise to the development of these revised operational guidelines for HIV/STI/TB and VH intervention. Their valuable insights and commitment to improving the lives of incarcerated individuals have been instrumental in shaping this document.

It is our sincere hope that these guidelines will serve as a roadmap for correctional facilities including Prisons, Other Closed Settings, Juvenile Homes and Drug Rehabilitation Centers and healthcare providers as they navigate the complexities of incorporating integrated package of services in the operations. By embracing these recommendations, we can create a more accessible, efficient, and compassionate healthcare system within our prisons and other closed settings, ultimately contributing to the well-being and successful reintegration of those entrusted to our care.

We sincerely thank Ms. V. Hekali Zhimomi, Additional Secretary & Director General (AS & DG), NACO, for her resolute leadership and guidance in providing the vision and strategic provision of integrated package of services among incarcerated population, both convicts and undertrials. We also extend our heartfelt gratitude to Ms. Nidhi Kesarwani, Director, NACO; Dr. Anoop Kumar Puri, DDG, NACO; Dr. U.B. Das, Sr. CMO(SAG), NACO; Dr. Shobini Rajan, CMO(SAG), NACO for their continuous support and guidance.

I am honored to introduce the Operational Guidelines on Prison and Other Closed Settings, with a special focus on providing a comprehensive package of services, including telemedicine, mental health, Peer led intervention, mainstreaming and social reintegration. These guidelines represent a landmark effort to bridge the gap between technology and justice, promoting the delivery of accessible and high-quality healthcare to inmates and under- trials.

These guidelines aim to assist correctional facilities, healthcare providers, and administrators in implementing and enhancing comprehensive package of services to the incarcerated population within their systems.

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I extend my deepest gratitude to all the individuals, organizations, and experts who have contributed to the development of these revised operational guidelines. Their collective wisdom, expertise, and dedication have paved the way for a more equitable and progressive approach to healthcare within our correctional settings.

It is my sincere hope that these guidelines will serve as a valuable resource for decision-makers, healthcare professionals, and stakeholders involved in the management of prisons and other closed settings.

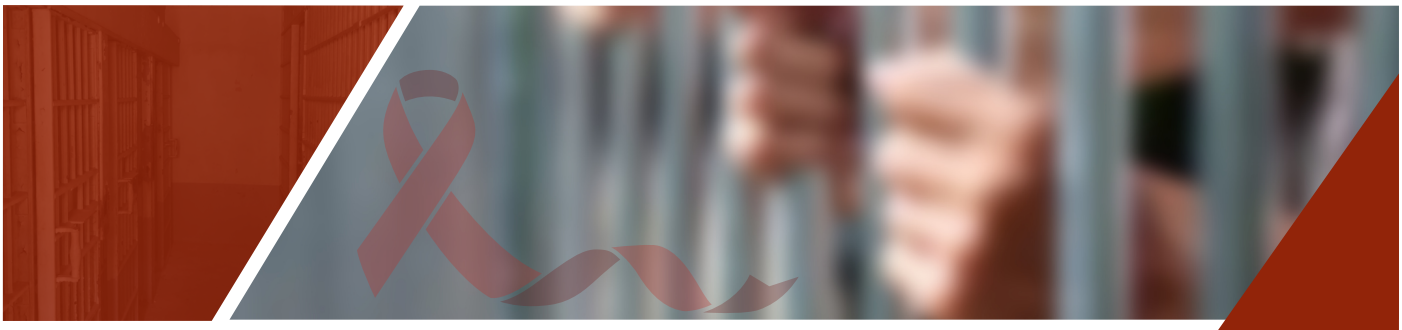
(Dr. Bhawani Singh Kushwaha)

TABLE OF CONTENTS

ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
AIIMS	All India Institute of Medical Sciences
ART	Antiretroviral Therapy
ARV	Antiretroviral
ATT	Anti-TB Treatment
BCC	Behaviour Change Communication
CBNAAT	Cartridge-Based Nucleic Acid Amplification Test
CBO	Community-Based Organisation
CBS	Community-Based Screening
CTD	Central TB Division
DAPCU	District AIDS Control and Prevention Unit
DDAP	Drug De-Addiction Programme
DMC	Designated Microscopy Centre
DOT	Directly Observed Therapy
DTC	District TB Cell
F-ICTC	Facility-Integrated Counselling and Testing Centre
HCTS	HIV Counselling and Testing Services
HIV	Human Immunodeficiency Virus
HRG	High-Risk Group
IBBS	Integrated Biological and Behavioural Surveillance
ICTC	Integrated Counselling and Testing Centre
IEC	Information, Education and Communication
IPT	Isoniazid Preventive Therapy
LAC	Link ART Centre
LEA	Law Enforcement Agency

MoHFW	Ministry of Health and Family Welfare
MoU	Memorandum of Understanding
MSJE	Ministry of Social Justice and Empowerment
MWCD	Ministry of Women and Child Development
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NETSU	North-East Technical Support Unit
NGO	Non-governmental Organisation
NHM	National Health Mission
NTSU	National Technical Support Unit
OST	Opioid Substitution Therapy
PLHIV	People Living with HIV
PPTCT	Prevention of Parent-To-Child Transmission
RNTCP	Revised National Tuberculosis Control Programme
RTI	Reproductive Tract Infection
SACS	State AIDS Control Society
SA-ICTC	Stand-Alone Integrated Counselling and Testing Centre
SOP	Standard Operating Procedure
STC	State TB Cell
STI	Sexually Transmitted Infection
TB	Tuberculosis
TI	Targeted Intervention
TOT	Training of Trainers
TSU	Technical Support Unit
UNDP	United Nations Development Programme
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization



1 INTRODUCTION

People living in prisons and other closed settings 1,2 are particularly vulnerable to increased risk of HIV infection. Low access to preventive and care services, overcrowding and poor prison conditions, neglect and denial, gang violence and lack of protection for younger inmates significantly increases the vulnerability of prison inmates to HIV transmission. Prison conditions can enhance the spread of tuberculosis (TB), due to overcrowding, poor ventilation, weak nutrition and inadequate or inaccessible medical care, among others. Over-representation of key populations contributes to making these settings a high-risk environment for HIV transmission.

Lifestyle of many inmates prior to incarceration includes unprotected sexual intercourse, drug and alcohol abuse, poverty, homelessness, under-education and unemployment, all of which are associated with risk of HIV/AIDS (Rajkumar et al., 2004). Drug users are often over-represented in prison populations, usually incarcerated for drug-related crimes, and may continue to use drugs during their incarceration (United Nations Office on Drugs and Crime; UNODC). Frequent sharing of contaminated drug injection equipment is the predominant mode of HIV transmission among prisoners. HIV is also transmitted in prisons through unsafe sexual behavior, sometimes associated with sexual violence (UNODC). High turnover of prison inmates fuels the spread of HIV and other infections such as TB. After their release, infected prisoners return to their social networks in the general community, facilitating the spread of HIV and TB infection in the non-incarcerated community.

As per Prison Statistics India 2021, a total of 1,319 prisons across the country housed 5,54,034 prison inmates, well above the authorized capacity of 4,25,609; this translates to occupancy rate of 130.2% (see Table 1). The occupancy rate stood even higher for district and central jails, at 155.4% and 123.7%, respectively. Of the total 5,54,034 inmates housed in all types of jails, 4,27,165 were under-trials, constituting 77.1% of the total inmate population. A significant 2,04,637 (47.9%) of these under-trial inmates were of ages 18–30 years, and 1,75,182 (41.0%) under-trials were of ages 30–50 years. These figures are not only indicative of the overcrowding in jails but also high turnover rate in the prison population, with a majority of prisoners eventually returning to their communities. Reducing transmission of HIV and TB in prisons is, therefore, crucial for reducing the spread of these infections in the general community. Early diagnosis, combined with effective treatment, is the best strategy for prevention of TB in prisons. Measures to reduce overcrowding and improve the living conditions of all prisoners should be implemented to reduce TB transmission.

Table 1. Total Number of Jails in India, their Capacity and Occupancy

Sl. No.	Type	Number of Jails	Capacity	Population of Inmates	Occupancy Rate
1	CENTRAL JAIL	148	193536	239311	123.7
2	DISTRICT JAIL	424	163606	254214	155.4
3	SUB-JAIL	564	45436	46736	102.9
4	SPECIAL JAIL	41	7473	6582	88.1
5	OPEN JAIL	88	5953	2178	36.6
6	WOMEN JAIL	32	6767	3808	56.3
7	BORSTAL SCHOOL	19	1775	745	42.0
8	OTHERS	3	1063	460	43.3
TOTAL		**1319**	**425609**	**554034**	**130.2**

Source: Prison Statistics India 2021, National Crime Records Bureau

The Ministry of Women and Child Development (MWCD), Government of India, is supporting Swadhar Greh, a new scheme focused on establishing a home in every district to provide relief and rehabilitation to destitute women and women in distress. This scheme targets women who are deserted and without any social and economic support; women survivors of natural disasters who have been rendered homeless and are without any social and economic support; women prisoners released from jail and without family, social and economic support; and women victims of domestic violence, family tension or discord, who are made to leave their homes without any means of subsistence and have no special protection from exploitation and/or are facing litigation on account of marital disputes. Similarly, trafficked women/girls who are rescued or have escaped from brothels or other places where they face exploitation and women affected by HIV/AIDS, who do not have any social or economic support. Hence, it is strongly recommended that SACS, in coordination with Social Welfare Department and department of Women and Child Development of the respective State government, should identify and cover such closed settings. As per MWCD statistics, there are around 697 Swadhar Greh and Ujjawala scheme, catering to nearly 48,000 women across the country. Besides this, there are an equal number of homes for women run by respective state governments.

The National AIDS Control Organisation (NACO) is the nodal agency responsible for approving, implementing and supervising all HIV/AIDS related activities in the country, including research, under the Ministry of Health and Family Welfare (MoHFW), Government of India. NACO implements the National AIDS Control Programme (NACP) as a comprehensive programme for prevention and control of HIV/ AIDS in India. One of the goals of the fifth phase of the programme — NACP - V (2021–2026) is to promote universal access to quality STI/ RTI services to at-risk and vulnerable populations.

The Central TB Division (CTD), under MoHFW, is responsible for the care of all TB patients in the country through the Revised National TB Control Programme (RNTCP). The Government of India is committed to ending TB by 2025, five years ahead of the global End TB target. The programme aims to provide universal access to TB care to achieve TB-free India with zero deaths and poverty due to TB.

Considering the concentrated nature of the HIV epidemic in the country, NACO has targeted its preventive efforts on sub-groups of populations identified as being at a high risk of acquiring the HIV infection. These high-risk groups (HRGs) are provided a number of preventive services

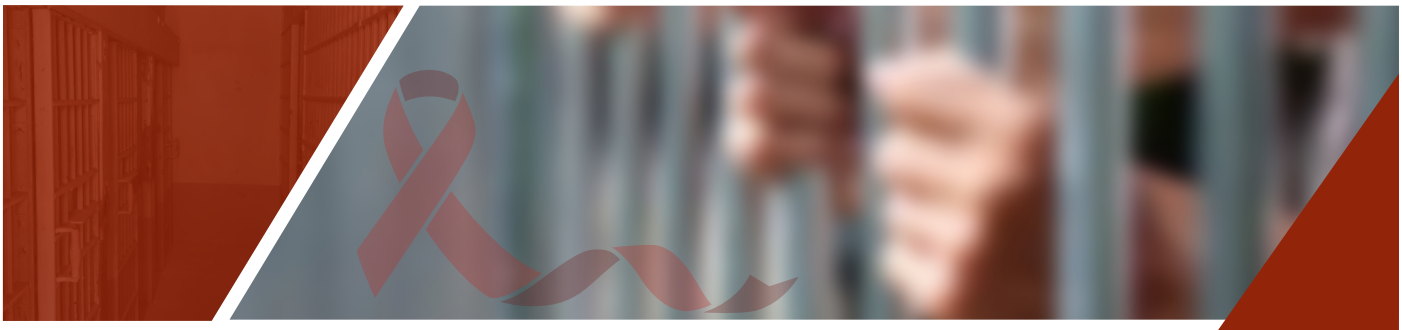
through non-governmental organisation/community-based organisation (NGO/CBO) led targeted interventions (TIs). At present, over 1,500 such interventions are providing HIV prevention, treatment, care and support services to various HRGs and Bridge Populations including female sex workers, men who have sex with men, transgender persons, injecting drug users, Truckers and Migrants.

Data from HIV Sentinel Surveillance (HSS) 2017 shows that HIV is concentrated among HRGs, with HIV prevalence rates of 6.26% among injecting drug users, 3.14% among transgender persons, 2.69% among men who have sex with men, 1.56% among female sex workers, 0.86% among truckers and 0.51% among migrants. Prisoners have been identified as one of the special groups under NACP and NACO addresses all inmates living in prisons and other closed settings in the Country. Data from HIV Sentinel Surveillance (HSS) 2019 shows that HIV prevalence among inmates is 2.1%, higher than the prevalence among migrants, truckers and female sex workers. This is evident that a comprehensive intervention with multiple strategies is needed to address people living in prisons and other closed settings. Post-release social reintegration is to be addressed through networking and referral linkages.

A national consultative meeting held on May 19 – 21, 2022, at The Hayat, Gurugram, under the chairmanship of Shri. Alok Saxena, Former Additional Secretary, NACO, paved the way for evolving differentiated strategy for HIV intervention in prisons, both for convicts. Key stakeholders, including the Ministry of Social Justice and Empowerment (MSJE), along with senior-level representation from the State police and Prisons departments of Andhra Pradesh, Nagaland and Madhya Pradesh, representatives from UNODC; United Nations AIDS; World Health Organization, United States Agency for International Development, Global Fund and Centre for Disease Control and Prevention participated in the consultation. Representatives from John Hopkins University, I-Tech, PATH, YRG Care, Alliance India, SAATHII, PLAN India, SHARE India, FHI, PHFI, HLFPPT and SPYM, along with officials from State AIDS Control Societies also participated in the meeting.

Based on the experience of implementing intervention in prisons, Shri. Alok Saxena, AS & DG (NACO), advised NACO to expand HIV/TB intervention to Women living in Swadhar, Ujjawala and other State-run Homes across the country in close collaboration with respective State governments and Ministry of Women and Child Development, Govt. of India.

As recommended in the consultation, a National Working Committee on Prison & Other Closed Settings was constituted and existing operational guideline is revised along with strategy document on differentiated strategies is developed under the guidance of NWG.

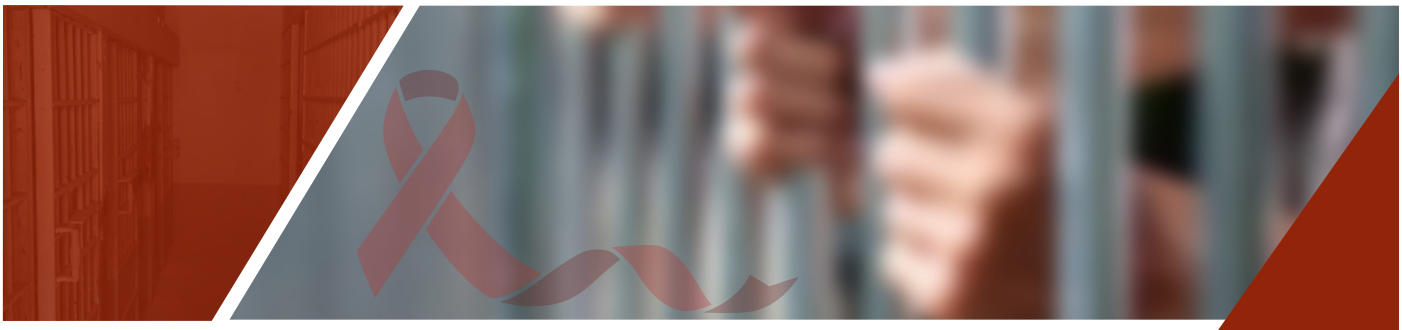


2 Purpose of developing guidelines on HIV, STI, TB and Viral Hepatitis Interventions in Prisons and Other Closed Settings

World Health Organization (WHO) guidelines on HIV infection and AIDS in prisons state that all prisoners have the right to receive health care, including preventive services, equivalent to that available in the community and without discrimination, especially with respect to their legal status or nationality. The HIV/AIDS prevention and control Act, 2017 states that "Every person in the care and custody of the state shall have right to HIV prevention, testing, treatment and counselling services". With regards to TB prevention and care, WHO and The Union have, globally, recommended screening of all inmates to prevent infection transmission, isolation of infected person (known TB patients), right of inmates to access medical services, and integration of TB services in prisons with national TB programs 3,4,5,6.

The proposed interventions are in line with this guidance and aim to ensure HIV, STI, TB, and Viral Hepatitis prevention and treatment services for all inmates living in prisons and other closed settings. It seeks to encourage NGOs and CBOs to provide services to inmates, especially information, education and communication (IEC), after care, and drug dependence treatment as an alternative to incarceration. The operational guidelines on HIV, STI, TB and VH intervention in prisons and other closed settings, as detailed in this document, build on the legal obligations, commitments, recommendations and standards on HIV/AIDS, prison health, prison conditions and human rights articulated in various national and international instruments 7.
The operational guidelines on HIV, STI, TB and VH intervention in prisons and other closed settings covers:

1) Eligible intervention from the United Nations comprehensive package of services comprising 15 key intervention8 that are essential for effective HIV prevention and control in prisons and other closed settings
2) Creating an enabling environment in the context of drug use and HIV
3) Working Committee on HIV/TB intervention in Prisons and Other Closed Settings
4) Modalities of implementation
5) Functions of key stakeholders, including state prisons department and other closed settings
6) Social reintegration
7) Main streaming HIV and TB interventions



3 Eligible Intervention from the comprehensive package of services

State AIDS Control Society (SACS) in every State has a central role in implementing various measures and strategies to address HIV/AIDS. However, many of the intervention identified for implementation require strong referral and linkages. Therefore, fostering and strengthening collaboration, coordination and integration among all stakeholders, including the departments of Prisons, Health and Family Welfare, Social Welfare and Women and Child Development and community-based service providers, are most important to scale up and ensure the quality and effectiveness of HIV/TB prevention and treatment services.

The majority of people living in prisons and other closed settings eventually return to their communities. The diseases contracted in prisons and other closed settings, or made worse by imprisonment/short stay, are, therefore, a major concern from the public health point of view. Initiating or ensuring continuity of care, thus, assumes great importance, and provisions should be made by health systems (department of state prisons/social welfare/women and child development department/SACS) to ensure that benefits of treatment such as Antiretroviral Therapy (ART), TB treatment and Opioid Substitution Therapy (OST) started before or during imprisonment are not discontinued. Further, in general, whenever adequate care cannot be provided in prisons and other closed settings, inmates may be allowed to access health services available in the community.

Table 2. Comprehensive Package of Services and their Implementation Eligibility

Sl. No.	Recommended Package of Services	Eligibility for implementation (based on preparedness)
1	Information, education and communication	Eligible for implementation
2	HIV counselling and testing	Eligible for implementation
3	HIV care, support and treatment	Eligible for implementation
4	Prevention, diagnosis and treatment of TB	Eligible for implementation
5	Prevention of parent-to-child transmission of HIV	Eligible for implementation
6	Condom programs	SACS/NACO to advocate with the prison authorities
7	Prevention and treatment of sexually transmitted infections	Eligible for implementation
8	Prevention of sexual violence	The prison system has institutional arrangement to deal with issues of sexual violence
9	Drug dependence treatment	Eligible for implementation

Sl. No.	Recommended Package of Services	Eligibility for implementation (based on preparedness)
10	Needle and syringe programme	Not eligible
11	Vaccination, diagnosis and treatment of viral hepatitis	Eligible for implementation
12	Post-exposure prophylaxis	Eligible for implementation
13	Prevention of transmission through medical or dental service	Eligible for implementation
14	Prevention of transmission through tattooing, piercing and other forms of skin penetration	Eligible for implementation
15	Protecting staff from occupational hazards	Prison system has institutional arrangement to deal with issues of occupational hazards

United Nations' (UNODC/WHO/UNAIDS/UNDP/ILO) comprehensive package of services comprising 15 key interventions (see Table 2 above) that are essential for effective HIV prevention and control in prisons and other closed settings, had been discussed with prison authorities through a series of national and regional consultations held between 2014 and 2018. The aim of these consultations was to identify the feasibility of providing the package of services to people living in prisons and other closed settings. It was recommended that needle and syringe distribution not be too considered for implementation, as prison settings are completely regulated and do not allow prison inmates to smuggle in and abuse drugs.

Core eligible intervention to be considered for implementation

1) Information, education and communication
2) HIV counselling and testing
3) HIV care, support and treatment
4) Prevention, diagnosis and treatment of tuberculosis
5) Prevention of parent-to-child transmission of HIV
6) Prevention and treatment of sexually transmitted infections
7) Drug dependence treatment, including opioid substitution therapy
8) Referral for diagnosis and treatment of viral hepatitis
9) Raising awareness on HIV transmission through medical or dental service
10) Raising awareness on HIV transmission through tattooing, piercing and other forms of skin penetration
11) Utilizing telemedicine to provide Mental Health & other care and treatment services (as recommended by NWG)

3.1 INFORMATION, EDUCATION AND COMMUNICATION

In the absence of a vaccine to prevent HIV infection, there is a need to educate people living in prisons and other closed settings on the risks of unsafe sexual and injecting drug behavior. It is important to disseminate correct information on HIV/AIDS prevention. Those in charge of information, education and communication (IEC) programs from SACS and NGO partners must therefore plan programs through a wide range of activities, such as advocacy to obtain commitment and support from correctional authorities, working with partners such as NGOs, community leaders, and prison peer volunteers and counsellors in developing appropriate messages for dissemination and mobilizing mid- media and on ground activities to reach out to inmates living in these settings.

Information and education about HIV, sexually transmitted infections (STIs), viral hepatitis and TB are much needed for inmates living in prisons and other closed settings. Since the turnover of inmates is very high, ensuring even basic information and awareness among all inmates will prove beneficial for the community at large.

Communication is the key to generate awareness on prevention as well as motivating access to treatment, care and support. HIV/TB intervention in prisons and other closed settings should primarily focus on: to increase knowledge among inmates (especially most-at-risk population) on safe sexual behavior; to sustain behavior change in at risk inmates; to generate demand for care, support and treatment services; and to strengthen the enabling environment by reinforcing positive attitudes, beliefs and practices to reduce stigma and discrimination.

While NACO is responsible for creating the prototypes of IEC material, it is the responsibility of SACS to refine, replicate and distribute the IEC materials in their respective intervention sites, and ensure that it is properly displayed and disseminated at all prisons and other closed settings.

- Peer-led interventions can be deployed to carry out behavior change communication (BCC) activities among inmates. This will also help in enhancing their life skills, communication skills, and knowledge and skills on safe practices.
- It is important to ensure that all inmates possess basic knowledge and awareness about HIV/AIDS, STIs, hepatitis B and C, TB and consistent condom usage.
- Peer-to-peer networking and reach is crucial to prevent the spread of HIV and TB to new inmates.
- Jailors/wardens should be encouraged to become master trainers and train the prison inmates identified as peer volunteers.
- IEC materials, such as wall paintings, posters, pamphlets, booklets and audio-visuals, can be developed and reproduced in different languages for use across States in the Country. It is highly recommended that inmates to be involved in the development of IEC materials.

3.1.1 PEER-LED INTERVENTION

Training of trainers (TOT) should be organized to create peer leaders and master trainers, involving staff as well as inmates in prisons and other closed settings. Subsequently, site-specific trainings can be conducted to create a cadre of peer volunteers. A peer volunteer is one who has been trained on HIV/AIDS and TB and made accountable for training and delivering the messages to his/her peers. Peer volunteers may not necessarily be convicted individuals. Under-trail prisoners can be identified to carry out peer-led intervention, so that when released, they become champions and spread information on HIV and TB prevention and treatment services.

Implementing NGOs, social welfare officers, prison medical professionals, vocational trainers and rehabilitation officers may act as facilitators for training peer volunteers.

The training programme should provide knowledge on: drug use and HIV; various problems faced by injecting drug users; myths related to drugs, HIV and STIs; modes of HIV transmission; risk behavior and risk perception; signs, symptoms, diagnosis and treatment of TB and its prevention; services available in prisons and other closed settings and in the community; how the services can be accessed; and formation of support groups inside closed settings.

- Inmate education in the correctional facility on prevention from various infections are critical therefore the role of Peer Volunteers becomes vital. The peer volunteer should educate peer inmates in their barracks or wards on misconceptions, methods of prevention and treatment for HIV, TB, STI and Hepatitis, harm reduction and positive living. Education and information should be delivered in the inmate's first preferred language and should be culturally sensitive with respect to ethnicity, sex, and age.
- Positive Inmates who have not been started on therapy should be counselled on their risk factors, encouraged to adhere to the treatment guideline, visit the public health department on regular basis and be provided with information about access to care after release.
- The peer volunteer should have the acceptance among the peer inmates and willingness to volunteer the services
- Peer volunteers may not necessarily be convicted individuals. Under-trail prisoners can be identified to carry out peer-led intervention, so that when released, they become champions and spread information on HIV and TB prevention and treatment services.
- While engaging the Peer Volunteers, representation from the Lesbian, Gay, Bi-sexual, Transgender, PWID, FSW and PLHIV may be included wherever possible
- Depending on the size of the inmate population, the peer group may consist of 25-50 inmates under a peer volunteer.
- Mechanisms can be devised to encourage peer volunteers, for example, by providing certificates conferring special recognition during Independence Day/Republic Day celebrations.
- It is highly advisable that all staff, including assistant jailor, jailor and wardens, resident superintendent, medical doctor, counsellor, office assistant-cum-data entry operator, and guard/watchman, be involved in the formation of the peer network to ensure accountability and sustainability.

3.2 HIV COUNSELLING AND TESTING

The national HIV counselling and testing services (HCTS) guidelines published by NACO in 2016 state that HIV screening/confirmation should be included as an integral component of the health care service package being offered to inmates in prisons across India. As per the guidelines, a plan for HCTS in prisons and other closed settings needs to be developed in all the States to scale up HIV testing among inmates. SACS should facilitate appropriate training on HCTS for the existing health staff in prisons and other closed settings. The HCTS facility should ensure audio-visual privacy and confidentiality. It is suggested that the same national HCTS guidelines be followed, as detailed for a Stand-Alone Integrated Counselling and Testing Centre (SA-ICTC)/Facility-Integrated Counselling and Testing Centre (F-ICTC), including for maintenance of records and reports.

It is recommended that priority can be given to establish facility integrated counselling and testing services within prisons. SACS/ NGO partners involved in providing the services should not

encourage mandatory or compulsory HIV testing. Whey they have easy access to HIV counselling and testing, and particularly when they are offered such testing and it is accompanied by access to treatment, care and support (including Antiretroviral Treatment), many prisoners will take up testing and counselling in prison.

To institutionalize the HIV testing services in prison and OCS, it is important to adopt the approaches and strategies for providing counselling and testing services to inmates as per the infrastructure and resources available at the sites. Following are the possible scenarios based on the available medical staff-

Model 1: Doctor, Pharmacist, and LT are available in prison/OCS
Model 2: Only paramedical staff is available in prison/OCS
Model 3: No HCP available in prison/OCS

According to the above models the state may adopt following approaches which can be considered for providing HCT services to inmates living in prisons and other closed settings:
Approach-I: Stand-Alone Integrated Counselling and Testing Centre (SA-ICTC) established already in prisons can be continued and opportunities may be explored to establish similar services in high load prison sites.

Approach-II: Facility-Integrated Counselling and Testing Centre (F-ICTC) can be established in central and some largest district prisons where sizable numbers of convicted and under trial inmates are available.

Approach-III: SACS/District AIDS Control and Prevention Unit (DAPCU) can arrange regular HIV testing camps by deputing counsellor/s and lab technician/s on specific days to provide HCT services for inmates living in district jails. Similarly, wherever Mobile ICTC facilities are available, SACS/DAPCU can deploy them to provide HCT services for inmates living in district jails. In the sequence, the lab technicians are advised to collect the blood samples of inmates found STR at the same time for undergoing HIV confirmatory tests especially in those prisons and OCS where escorting STR inmates to ICTCs are hampering or getting delayed.

Approach-IV: Paramedical staff of prison medical facility and staff of TI-NGOs (PE /ORW /Counsellor / Nurse) should be trained on Community Based Screening (CBS) and trained staff can be utilized for providing HCT services to inmates living in sub-jails, women jails, open jails, special jails, and other jails.

Approach-V: At any given point in time, each center of Swadhar, Ujjwala and State-run Homes will have a maximum capacity of 30 inmates. Establishing HCT facility within these settings may not be a viable option and hence it is recommended to use TI-NGO's staff trained on CBS to provide HCT services for inmates living in Swadhar, Ujjwala and State-run Homes.

Approach-VI: Staff of Swadhar, Ujjwala and State-run Homes can be trained on Community Based Screening (CBS) so as to make the center a self-sustaining unit for providing HCT services. SACS, DAPCU, TI-NGOs and other partner NGOs will help these centre for availing confirmatory tests and linkages for ART services.

Inmates with high-risk behaviour/s can be linked to SA-ICTCs available in the community if none of the above options are feasible. Service facilities available with the National Health Mission (NHM) and/ or state health services may also be used to ensure continuity of services established inside prison settings. It is recommended that each Jail/Home can be registered or named as F-ICTC for reporting purposes.

3.2.1 Index Testing:

It is an approach of voluntary case-finding focusing on eliciting the spouse/sexual and/or needle sharing partners and biological children of consenting HIV-positive individuals and offering them HIV testing services (HCTS).

The WHO 5 Cs (Consent, Confidentiality, Counselling, Correct test result and Connection to treatment services) are principles that apply to all HCTS including Index Testing services.

There are eight core principles of Index testing services: Client centered and focused, confidential, voluntary and non-coercive, free of cost, non-judgmental, culturally/ linguistically appropriate, accessible and available to all, comprehensive and integrative.

Steps for providing Index Testing

There are 10 steps for implementing Index testing services:

Step 1- Introduce Index testing services to the index client during visit at ART Centre. Inform the index client that his/her information will be kept confidential

Step 2- Offer Index testing as a voluntary service to all newly registered clients or those with high viral load or with unknown HIV status of family members or after a change in relationship status

Step 3- If client accepts index partner testing, then obtain consent to inquire about their partner(s) and biological child(ren)

Step 4- Obtain a list of sexual and needle sharing partners and biological children with unknown HIV status

Step 5- Conduct an intimate partner violence (IPV) assessment for each named partner

Step 6- Determine the preferred method of partner notification or child testing for each named partner/child

Step 7- Contact all named partner and biological children with unknown status using preferred approach

Step 8 - Record outcomes of partner notification and family testing

Step 9- Provide appropriate services for children and partner (s) based on HIV status

Step 10- Follow-up with client to assess for any adverse events associated with Index testing

Approaches for providing Index Testing services

- Client referral/Passive: Index client takes responsibility for encouraging/bringing partners/children to seek HCTC
- Assisted partner Notification/Active: Provider/counsellor assists the index client to notify partner/family about HCTS through three different approaches:
- Provider referral- Health care provider contacts clients partner and offers voluntary HCTS services with client consent and confidentiality
- Dual referral- A trained provider sits with the Index client while they disclose their status. HCTS voluntary services are offered
- Contract Referral- Index client enters into an informal contract with health provider to notify partners. If they do not do this within specified time, provider contacts partners directly.

Targets of Index Testing services (ITS) in Prison

- Family of inmates
- Spouse with unknown status
- All biological children (< 19 years) if the:
- Mother is HIV positive OR
- Father is HIV positive AND reports the child's mother is HIV positive, deceased, or her status is unknown
- Partners: All sexual or injecting drug partners from the past year, irrespective of consistent condom use/ clean needle use.

Method to provide Index Testing in Prison

- All PLHIV inmates to be offered Index testing.
- Repeat Index Testing Services: Partner/contact elicitation and testing is a dynamic event and should be offered continuously by ART Centre from where client is taking ART
- For clients returning to care after treatment interruption
- For clients with an unsuppressed viral load
- After a change in relationship status

Elicitation can be done by a trained counsellor or staff nurse in Prison or by the staff of the ICTC or ART Centre, where client is registered for testing or taking ART. Follow up at field level shall be done by staff at ART Centre or Care and Support Centre (CSC). At the CSC, the peer counsellor or outreach worker can do elicitation.

3.2.2 Social Network Strategy (SNS):

A social network refers to a group of individuals linked by a common set of relationships or behaviors and includes sexual and drug-injecting partners as well as social contacts.

Social network-based HIV testing strategy (SNS) is an extension of HIV partner services: A trained provider asks people with HIV or those who are HIV-negative and at ongoing risk of HIV to encourage and invite individuals in their sexual, drug injecting or social networks to participate in voluntary HTS.

Integrating network testing

- TI Project staff will support Prison/ICTC/ART staff in integrating KP network testing.
- ICTC counsellor will offer testing to positive inmate's network members.
- On acceptance, will provide four coupons.
- Testing of network members who come with coupons will be conducted and navigated to prevention/treatment services based on outcome.

Network testing

- ICTC counsellor will offer testing to inmate.
- On acceptance, will carry out testing and offer index testing if turned out positive.
- Four coupons will be offered to inmates irrespective of HIV testing status.
- Testing of network members who come with coupons will be conducted and navigated to prevention/treatment services based on outcome.

3.2.3 POST EXPOSURE PROPHYLAXIS

"Post exposure prophylaxis" (PEP) refers to comprehensive management given to minimize the risk of infection following potential exposure to blood-borne pathogens (HIV, HBV, HCV). This includes:

a. First aid b. Counseling c. Risk assessment d. Relevant laboratory investigations based on informed consent of the source and exposed person e. Depending on the risk assessment, the provision of short- term Antiretroviral drugs 6. Follow up and support.

"Exposure" which may place a Health Care Provider (HCP) at risk of blood-borne infection is defined as: a. Per cutaneous injury (e.g. needle-stick or cut with a sharp instrument), b. Contact with the mucous membranes of the eye or mouth, b. Contact with non-intact skin (particularly when the exposed skin is chapped, abraded, or afflicted with dermatitis), or d. Contact with intact skin when the duration of contact is prolonged (e.g. several minutes or more) with blood or other potentially infectious body fluids. It is suggested that SACS make post-exposure prophylaxis available in all prisons and other closed settings where intervention is initiated.

3.3 CARE, SUPPORT AND TREATMENT

All HIV-positive inmates have special needs, ART Guidelines for HIV-infected Adults and Adolescents, released by NACO in 2021, strongly recommend establishing effective linkages between ART and harm-reduction programs. It also states that ART should be given as part of a comprehensive package of prevention (including harm reduction), care and support and treatment. Hence, it is suggested that proper linkages to care, support and treatment services should be ensured for those found positive for HIV.

- Doctor/medical staff can be trained on ART initiation, and the prison hospital can be made as Link ART Centre (LAC) for dispensing medication to HIV-positive prisoners.
- SACS/DAPCU can, in association with relevant authorities, arrange for transportation with appropriate security to take HIV-positive inmate(s) to ART center for initiation on treatment and regular monitoring tests.
- In line with MoHFW's 'Test and Treat Policy for HIV', as soon as an inmate is tested and found HIV positive, he/she should be provided with ART irrespective of his/her CD4 count or clinical stage. This will improve the longevity and quality of life of inmates living in prisons and other closed settings and save them from many opportunistic infections, especially TB.
- Authorities administering prisons and other closed settings should be sensitized to provide nutritional supplements to patients under treatment.
- Rapid ART initiation to the diagnosed positive inmates; Rapid ART initiation is defined as "ART initiation within seven days from the day of HIV diagnosis". Following a confirmed HIV diagnosis and clinical assessment, same-day /rapid ART initiation should be offered to all PLHIV adequately prepared and ready for initiation. However, if an active OI is present, ART initiation may be deferred as required.

Care, Support and Treatment (CST) services are provided through a spectrum of service delivery models including ART Centre, Centre of Excellence (CoE), Pediatric Centre of Excellence (PCoE), Facility Integrated ART Centre (FIART), Link ART Centre (LAC), Link ART Plus Center (LAC Plus) and Care & Support Centre (CSC) established by NACO in health facilities across the Country with aim to provide universal access to free and comprehensive CST Services. There are active linkages and referral mechanism for monitoring, mentoring, decentralization and specialized

care. CST Services are also linked to ICTCs, STI clinics, PPTCT services and other clinical departments in the institutions of their location as well as with the RNTCP programme in order to ensure proper and comprehensive care and management.

SACS and NGO partners should carefully select the models required for inmates living in prisons and other closed settings. In order to facilitate the delivery of ART services nearer to the inmates, LAC may be established within central and high load prisons where more than 25 PLHIV inmates are living. LAC should be linked to a Nodal ART center within accessible distance. The LAC helps in enhancing access; reducing cost of travel; time spent at the center and most importantly helps in improving clients adherence to treatment.

Facility Integrated ART Center (FIART) may also be considered for central prisons. The FIART may be established within central prison where more than 100 PLHIV inmates are living. The concept of FIARTC is much similar to ART center except for the patient load and the number of staff serving at the center. The main objective of initiating this concept was to serve prisons which have less accessibility, with fewer infrastructures to access the treatment. This initiative will help to reduce the number of LFU and will also help to increase the drug adherence among those inmates who are on ART.

Relevant information about an HIV-positive inmate's discharge from the prison must be provided to the concerned ICTC, ART center and TI-NGO, so that the HIV-positive individual can be followed up at regular intervals and linked to an ART center close to his/her place of residence. SACS should devise, in collaboration with authorities who are administering prisons and other closed settings, a mechanism to ensure continuity of care at all stages, from arrest to release.

PLHIV in prisons and other closed settings

ART initiation for the newly detected cases as well as ART refill for PLHIV in prisons is challenging due to various operational issues, including limited availability of security personnel and vehicles at the prison to take PLHIV to ART centres. To address this gap in HIV care for PLHIV in prisons, National AIDS Control Programme (NACP) recommends setting up of Link ART centres (LAC) in prisons

Steps to be taken to provide services to these patients are detailed below. These are applicable for undertrials as well, as it is difficult to determine the exact duration of his/her stay in the prison. The objective is to ensure the provision of ART to the undertrials as well as convicts regardless of the term they serve in the prison

Not on ART

a. MO of the prison hospital/ designated MO for the prison should be trained for ART initiation using rapid ART algorithm and concurrent sample collection for baseline investigations
b. In case, the above is not possible SACS may work with prison authorities for intervention to ensure ART initiation in PLHIV in prisons
c. A facility for tele-consultation can be established in prison for ART initiation with expert opinion.

Already on ART

a. Efforts should be made to have LAC at prisons and other closed settings, wherever feasible. Prison staff should be trained on SOPs for LAC. The patient shall be managed at the prison

clinic/LAC as per the operational guidelines for Link ART centres.

b. If the patient is registered in any ART centre other than the nodal ART centre of the prison LAC, the patient will be transferred from his/her parent ART centre to the nodal ART centre and, in turn, transferred out to the prison LAC.

c. In case setting up of LAC is not feasible, ART refill group comprising all positive persons may be formed and an authorized staff (such as prison staff/ICTC staff/CSC staff) may collect ARV drugs for PLHIV and provide them to patients at prison. Refer to SOP for community ART refill groups (CARG) as in ART operational guidelines
d. Prison inmates should be prioritized for MMD, if fulfilling the criteria.
e. Decentralized sample collection mechanism needs to be established in prison for viral load monitoring
f. A facility for tele-consultation can be established in prison for expert opinion as per need.

6-monthly follow-up: If there is no MO available at the prison, every patient will be sent to the nodal ART centre once in 6 months for clinical and laboratory monitoring and before 6 months in case of any other medical need.

Post-release linkage plan

ART centre should work with prison staff on post release plan for all PLHIV in prison-date of release, probable destination after release from prison with contact details. Accordingly, PLHIV at the prison should be guided to reach nearest the ART centre after release from prison.

Upon completion of the patient's term in prison, the nodal ART centre should be intimated, and the patient should be transferred out to an ART centre preferred by the patient. The prison staff has the responsibility to ensure that the patient is successfully transferred out and reached the ART centre where s/he was referred to.

3.4 PREVENTION, DIAGNOSIS & TREATMENT OF TUBERCULOSIS

National TB Elimination Program (NTEP has been recognized as the largest and the fastest expanding TB control programme in the world. NTEP is presently being implemented throughout the Country. Under the programme, diagnosis and treatment facilities are provided free of cost to all TB patients including in select prisons and other closed settings. Free treatment services are available for TB at all Government hospitals, Community Health Centers (CHC), Primary Health Centers (PHCs). DOT centers have been established near to residence of patients to the extent possible. All public health facilities, subs centers, Community Volunteers, ASHA, Women Self Groups etc. also function as DOT Providers/DOT Centers.

The objectives of strengthening TB services in prisons and other closed settings are: to reduce the incidence of and mortality due to TB; to prevent further emergence of drug resistance and effectively manage drug-resistant TB cases; and to improve outcomes among HIV-infected TB patients.

In collaboration with the NTEP, active case finding for TB should be undertaken and other effective TB control measures should be introduced. Authorities in prisons and other closed settings should be sensitized on the following:

- Inmates living with HIV should be screened for TB through 4s verbal screening.

linkages with Integrated Counselling & Testing Centre (ICTC), Prevention of Parent to Child Transmission (PPTCT) centre, Anti-retroviral Therapy (ART) centre, Blood Banks, Adolescent Reproductive and Sexual Health (ARSH) clinics, FP/FW clinics, other specialty clinics and general laboratory, Targeted Intervention projects, and Care and Support Centre including PLHIV networks. This ensures enhanced coverage and better utilization of DSRC (STI/RTI) services. Further, DSRC also have referral linkages with State STI Training and Reference Laboratories (SSTRL) and Regional STI Training, Research and Reference Laboratories (RSTRRL) for managing cases of suspected treatment failure and persistent infections.

Sexually transmitted infections (STIs), especially those that cause genital ulcers, increase the risk of transmission and acquisition of HIV. Early diagnosis and treatment of such infections should, therefore, be part of HIV prevention programs in prisons and other closed settings. Training should be provided to medical personnel in these settings. After the training, it is equally important to provide testing kits (rapid test) for case detection inside prisons.

- Inmates with TB should be advised to have an HIV test.
- Inmates living with HIV without symptoms of active TB (no current cough, fever, weight loss or night sweats) should be offered isoniazid preventive therapy (IPT).9
- Inmates should be provided rooms that are well ventilated and have good natural light.
- Inmates with TB should be segregated until they are no longer infectious, and should be educated and counselled on coughing etiquette and respiratory hygiene.
- Facility for diagnosis and treatment of TB should be made available to effectively manage HIV-TB co-infection and ensure continuity of treatment, as that is essential to prevent the development of resistance; this must be ensured throughout the period of imprisonment.
- Contact investigation should be carried out for all inmates residing with a person diagnosed with TB.
- Ensure nutrition as per guidance on nutrition for TB; this should be done for both TB patients and close contacts of person with TB.
- Inmates can be trained as DOTS provider and incentive scheme exist in NTEP may be extended to prisons and other closed settings

3.5 PREVENTION OF PARENT-TO-CHILD TRANSMISSION OF HIV

In the absence of any intervention, a substantial proportion of children born to women living with HIV, acquire HIV infection from their mothers either during pregnancy, labor/delivery or during breastfeeding. Without any intervention, the risk of transmission of HIV from infected pregnant women to her children is estimated to be around 20-45%. In order to enhance the coverage of PPTCT, a joint directive from the National AIDS Control Programme and the National Rural Health Mission regarding convergence of the two programme components was issued in July 2010, explicitly stating that universal HIV screening should be included as an integral component of routine ANC check-up. The objective was to ensure that pregnant women who are diagnosed with HIV would be linked to HIV services for their own health as well as to ensure prevention of HIV transmission to newborn babies under the PPTCT programme.

Inmates living in prisons and other closed settings can be provided services for prevention of parent-to- child transmission (PPTCT) of HIV through ICTCs facilities established within prisons and other closed settings or by linking them to stand-alone ICTCs available in the community.

- Measures should be taken to ensure that women living with HIV, pregnant women and breastfeeding mothers access the full range of interventions for prevention of mother-to-child

HIV transmission. These interventions include family planning and antiretroviral therapy in line with the National Guidelines for Prevention of Parent-to-Child Transmission of HIV.

- In accordance with these guidelines, there should be follow up on children born to mothers living with HIV.

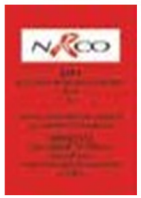
3.6 PREVENTION AND TREATMENT OF SEXUALLY TRANSMITTED INFECTIONS

The STI/RTI management services are a key programme strategy for prevention of HIV. The syndromic case management of STI/RTI is adopted as a universal strategy, is applicable at all levels of the health care system (Primary, Secondary and Tertiary care) and ensures access to a package of standardized STI/RTI management services both for the general population with an emphasis on pregnant and non- pregnant women, children and adolescents and high-risk behavior groups. The Designated STI/RTI Clinic (DSRC) comprises both STI and Gynaecology clinic have cross referral

The aim of STI/RTI syndromic case management is to identify the syndrome correctly and manage them accordingly. While clinical diagnosis is based on identifying the specific causative agent, syndromic diagnosis leads to immediate treatment for all of the most important possible causative agents. This is important because mixed infections occur frequently in STI/RTI. Besides, syndromic management of STI/RTI can effectively treat cases in settings such as prisons and other closed settings which have limited or no laboratory facilities. This means syndromic treatment can quickly render the patient non- infectious.

- Training can be provided to medical professionals available within prisons and other closed settings on syndromic approach to ensure the minimum STI/reproductive tract infection (RTI) services for inmates.
- SACS should ensure availability of pre-packed (color-coded) STI/RTI kits for effective syndromic management of STIs/RTIs.
- SACS should also facilitate the availability of other essential, general and additional drugs through the State health system.
- Linkages should be established with existing STI/RTI service providers in the community.

STI/RTI SYNDROMIC CASE MANAGEMENT

Urethral Discharge	Cervical Discharge	Painful Scrotal Swelling	Vaginal Discharge	Genital Ulcer-Non Herpetic		Genital Ulcer - Herpetic	Lower Abdominal Pain (LAP)	Inguinal Bubo (IB)
▪ Urethral Discharge (Pus or muco-purulent) ▪ Pain or burning while passing urine ▪ Increased frequency of urination ▪ Systemic symptoms like malaise, fever	▪ Nature and type of discharge (quantity, color and odor) ▪ Burning while passing urine, increased frequency ▪ Genital complaints by sexual partners ▪ Low backache *(Take menstrual history to rule out pregnancy)*	▪ Swelling and pain in the scrotal region ▪ Pain or burning while passing urine ▪ Systemic symptoms like malaise, fever ▪ History of urethral discharge	▪ Nature and type of discharge (quantity, color and odor) ▪ Burning while passing urine, increased frequency ▪ Genital complaints by sexual partners ▪ Low backache *(Take menstrual history to rule out pregnancy)*	▪ Genital ulcer, single or multiple, painful or painless ▪ Burning sensation in the genital area ▪ Enlarged lymph nodes		▪ Genital ulcer or vesicles, single or multiple, painful, recurrent ▪ Burning sensation in the genital area	▪ Lower Abdominal Pain ▪ Fever ▪ Vaginal Discharge ▪ Menstrual irregularities like heavy, irregular vaginal bleeding ▪ Dysmenorrhoea, dysparenunia, dysuria, tenesmus ▪ Lower backache ▪ Cervical motion tenderness	▪ Swelling in inguinal region which may be painful ▪ Preceding history of genital ulcer or discharge ▪ Systemic symptoms like malaise, fever etc
Tab. Azithromycin 1 gm OD Stat + Tab. Cefixime 400 mg OD Stat	Tab. Azithromycin 1 gm OD Stat + Tab. Cefixime 400 mg OD Stat	Tab. Azithromycin 1 gm OD Stat + Tab. Cefixime 400 mg OD Stat	Tab. Secnidazole 2 g OD Stat + Cap. Fluconazole 150 mg OD Stat	Inj. Benzathine penicillin (2.4 MU) - 1 vial Tab. Azithromycin (1 gm) - Single dose	**If allergic to Inj. Penicillin:** Doxycycline 100 MG (Bid for 15 days) Azithromycin 1GM (Single dose)	Tab. Acyclovir 400 mg TDS for 7 days	Tab. Cefixime 400 mg OD stat + Tab. Metronidazole 400 mg BD X 14 days + Doxycycline 100 mg BD X 14 days	Tab. Azithromycin 1 gm OD Stat + Tab. Doxycycline 100 mg BD for 21 days
KIT 1/Grey	KIT 1/Grey	KIT 1/Grey	KIT 2/Green	KIT 3/White	KIT 4/Blue	KIT 5/Red	Kit 6/Yellow	Kit 7/Black
								
Treat all recent partners	Treat partners when symptomatic	Treat all recent partners	Treat partners when symptomatic	Treat all sexual partners for past 3 months		No partner treatment	Treat male partners with Kit 1	Treat all sexual partners for past 3 weeks

IMPORTANT CONSIDERATIONS FOR MANAGEMENT OF ALL STI/RTI

- Educate and counsel client and sexual partner/s regarding STI/RTI, safer sex practices and importance of taking complete treatment
- Treat partner/s
- Advise sexual abstinence or condom use during the course of treatment
- Provide condoms, educate about correct and consistent use
- Refer all patients to ICTC
- Follow up after 7 days for all STI, 3rd, 7th, and 14th day for LAP and 7th, 14th, and 21st day for IB
- If symptoms persist, assess whether it is due to re-infection and advise prompt referral
- Consider immunization against Hepatitis B

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3.7 DRUG DEPENDENCE TREATMENT (INCLUDING OPIOID SUBSTITUTION THERAPY)

There are strong links between opioid use and dependence, and criminal behavior. Studies from around the world reveal that many prisoners have a history of problematic drug use and that drug use, including injecting drug use, occurs in prisons in a large scale (WHO,2007). Prisoners are also one of the four key populations which have a higher prevalence of HIV infection than the general population (Hellard & Aitken, 2004; UNAIDS, 2006). These drug dependent prisoners may then go on to share drug injecting equipment and have unprotected sex, both inside prison and back in the community (Estebanez et al., 2002; UNAIDS, 2006), thus posing a grave threat to public health. On release, opioid dependent prisoners are at high risk of relapse and overdose (UNAIDS/WHO/UNODC, 2004) and rates of reoffending amongst this group of prisoners are extremely high (Hough, 2002). To address these problems, pure criminal justice interventions, without associated opioid dependence treatment, have been found to be inadequate and have very limited impact on drug-using behavior and re-offending among individuals with drug dependence. (UNAIDS/WHO/UNODC, 2004). Hence, providing both drug dependence treatment and harm reduction programs in prisons is therefore essential (Stöver et al. 2007). Consequently, an increasing number of prison systems are offering substitution therapy (OST) with methadone and buprenorphine to opioid dependent prison inmates, worldwide.

OST as a HIV prevention strategy among IDUs was formally integrated in National AIDS Control Programme (NACP) in 2007, during its third phase. Before formal integration, OST for HIV prevention among IDUs was being implemented in India by some NGOs. The NGO OST centre were also accredited through an independent accreditation agency, following which they started receiving support through NACO. In this NGO-based model of OST, the OST centre located within the Drop-in-Centre (DIC) of an IDU TI are managed by the staff implementing the IDU TI. A part-time doctor, a full-time nurse, a counsellor/ANM, programme manager and outreach workers are part of the team delivering OST services.

To further expand the OST programme, since 2010, Government hospitals have also been roped in for providing OST services through a collaborative public health model. In this model, the OST center is located within the government hospital and is manned by a full-time staff comprising of a doctor, a nurse, a counsellor and a data manager. The staff of the OST center works under the direct supervision of a designated 'nodal officer', who is a full-time employee of the hospital. The OST center is linked with an IDU TI located in the vicinity of the hospital for initial referral of IDU clients to the center, as well as field-based follow-up and advocacy. NACO is currently implementing OST through more than 210 centre.

Various terminologies have been used to describe the clinical practice of maintaining opioid dependent drug users on opioid medicines over a long period of time. These include–oral substitution treatment, opioid substitution treatment, oral substitution–buprenorphine, medication assisted treatment, buprenorphine maintenance treatment, methadone maintenance treatment, etc. All these terminologies describe the same practice. Under the National AIDS Control Programme, the term 'Opioid Substitution Therapy' (OST) is currently in use.

OST is a process in which opioid dependent injecting drug users are provided with long-acting opioid agonist medications for a long period of time under medical supervision along with psycho- social interventions.

Short term treatment of opioid dependence lasting for a couple of weeks called 'detoxification' which involves management of acute withdrawals alone, is associated with very high rates of relapse. Long term treatment is hence necessary for opioid dependence. OST is one such long-term treatment option.

In recent years, evaluation of prison substitution therapy has provided clear evidence of their benefits. Evidence suggests that OST is feasible in a wide range of prison settings. The benefits of opioid agonist maintenance in prisons include less injecting drug use while in prison, increase in uptake of treatment on leaving prison, and reduction of rates of return to prison. (WHO,2009). The risk of transmission of HIV and other blood-borne viruses among prisoners is also likely to be decreased. OST has shown to have a positive effect on institutional behavior by reducing drug-seeking behavior and improving prison safety. While prison administrations have often initially raised concerns about security, violent behavior and diversion of methadone, these problems have not emerged or have been addressed successfully where OST programs have been implemented (WHO, 2007). OST can also increase attendance of general health care services, which would be desirable especially with respect to the often diverse physical and psychological health problems common amongst chronic drug users (EMCDDA, 2003).

Drug-free treatment approaches continue to dominate interventions in prisons in most countries (Zurhold, Stöver, Haasen, 2004). Despite being widely accepted as an effective intervention or opioid dependence elsewhere, OST remains controversial in many prison systems. Prison administrators have often not been receptive to providing OST, due to moral opposition to this type of treatment and concerns about whether the provision of such therapy will lead to diversion of medication, violence, and/or security breaches (Magura et al., 1993).

Hence, there still prevails a huge gap between prisoners requiring opioid substitution therapy and those receiving it (Stöver, Casselman & Hennebel, 2006). This gap denotes not only a shortcoming of treatment options and harm reduction chances for the individual prisoner patient but also a threat to public health. There have also been instances and reports from the existing OST centre that some clients, who were otherwise regularly taking medicine, dropped out due to imprisonment. NACO through respective SACS aims to address these gaps by establishing Opioid Substitution Therapy (OST) centre in prison settings in India.

- SACS can establish OST centre/satellite OST facility in prison settings to ensure the service for both convicts and under trials.
- OST services should strictly be initiated only after securing consent from inmates.
- SACS should devise a mechanism through implementing TI-NGOs and the Link Worker Scheme to ensure post-release linkages.
- Prison authorities should be sensitized to initiate drug de-addiction treatment centre in collaboration with the Ministry of Social Justice and Empowerment (MSJE) and the MoHFW's Drug De-Addiction Programme (DDAP).
- SACS should organize induction / refresher training on OST for staff available with prison medical facility.
- SACS should ensure supply of OST medicine through the existing supply chain management.

The Tihar prisons have been providing OST service to prison inmates since 2008, with technical support from National Drug Dependence Treatment Centre, All India Institute of Medical Sciences (AIIMS). SACS can refer to NACO's national guidelines and the standard operating

procedure (SOP) on OST and the scientific study conducted by the AIIMS in collaboration with Tihar prisons to learn about the effectiveness of OST with buprenorphine as a long-term treatment for opioid dependence in prison settings.

3.8 REFERRAL FOR SCREENING AND TREATMENT OF HEPATITIS

Evidences shows that HIV burden among injecting drug users living in prison settings is expanding. Blood-borne infections, such as HIV, hepatitis B and hepatitis C, are spreading primarily through risk behaviours related to sharing of contaminated needles and syringes as well as through high-risk sexual behaviours, such as unprotected sex, unsafe sex under the influence of drugs/alcohol and sex in exchange of drugs.

- NACO's blood safety programme facilitates mobility by supporting the provisioning of vehicles to regional blood centre (RBTCs)/district-level blood banks. This is seen as vital for dissemination of IEC and BCC materials and for promoting a movement for voluntary blood donation. To minimize the risk of transmitting infections, the blood being utilized for transfusion must mandatorily be screened and tested for hepatitis B and C, syphilis, malaria and HIV. Testing of blood for hepatitis C virus (HCV) antibodies was made mandatory with effect from June 1, 2001. SACS can train medical/paramedical staff in prisons and supply testing kits to prisons where HIV/TB intervention are initiated.
- Prison inmates can be referred for screening hepatitis B and C.
- If the test confirms reactivity to hepatitis B or C, the prison inmate can be referred to the state health system, with the help of TI-NGO, for appropriate treatment.

3.9 RAISING AWARENESS ON HIV TRANSMISSION THROUGH MEDICAL OR DENTAL SERVICES

Evidence strongly suggests that HIV and hepatitis can easily spread through contaminated medical or dental equipment. It is important to ensure that standards are followed and caution be taken during medical and dental procedures to minimize the risk of blood borne infections.

- Medical professionals must be sensitized to strictly follow the infection control and safe-injection protocols recommend by WHO.
- It is important to advocate with medical professionals to adequately equip their facilities to practice these preventive measures.

3.10 RAISING AWARENESS ON HIV TRANSMISSION THROUGH SKIN PENETRATION

Tattooing and body piercing are often prohibited inside prisons and other closed settings. Tattooing, body piercing and sharing of shaving blades is associated with the risk of acquiring HIV, hepatitis B and C and tetanus. Authorities should be sensitized to implement initiatives to reduce sharing and reuse of equipment used for tattooing, piercing and other forms of skin penetration.

- Implementing agencies/SACS/authorities in prisons and other closed settings should, through peer-led initiatives, promote awareness among inmates on the need to avoid sharing and reuse of equipment used for shaving, tattooing, piercing and other forms of skin penetration.

3.11 UTILIZING TELE MEDICINE TO PROVIDE HIV CARE AND TREATMENT SERVICES

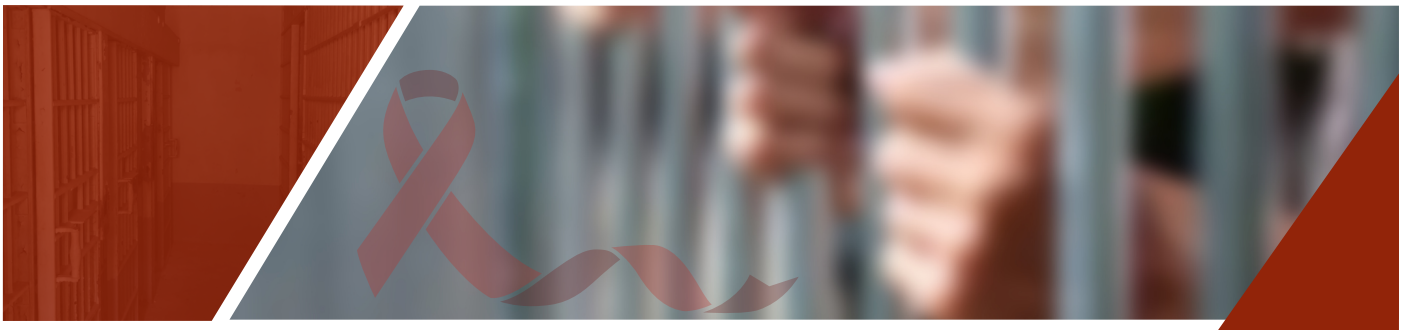
The medical services requirements cannot be effectively met within the facility because the cost for onsite medical specialists is high, medical specialists are unavailable when needed, and the small number of requests for specialists does not warrant a contract for outside services.

Transporting the inmate to an outside facility requires security officials from the Police department and a vehicle. The prisons and OCSs are already having a high burden of health cases to be referred outside on a routine basis; therefore, receiving escorts for transporting inmates becomes challenging for diagnosed HIV-positive inmates, and also, the cost of transportation is very high for prisons, and OCS as many of the facilities are far from medical services. This leads to delays in initiating ART services for HIV-positive inmates, and meanwhile, most of the under trial inmates get released.

Tele medicine also leads to improved safety for security personnel by avoiding the outside transport of high-risk inmates, improved safety to the community and medical staff because inmates remain in the institution, improved quality of medical care, shorter waiting lists, and an improved response time to inmates' medical needs.

Tele medicine may be added as a most effective intervention under the following conditions:

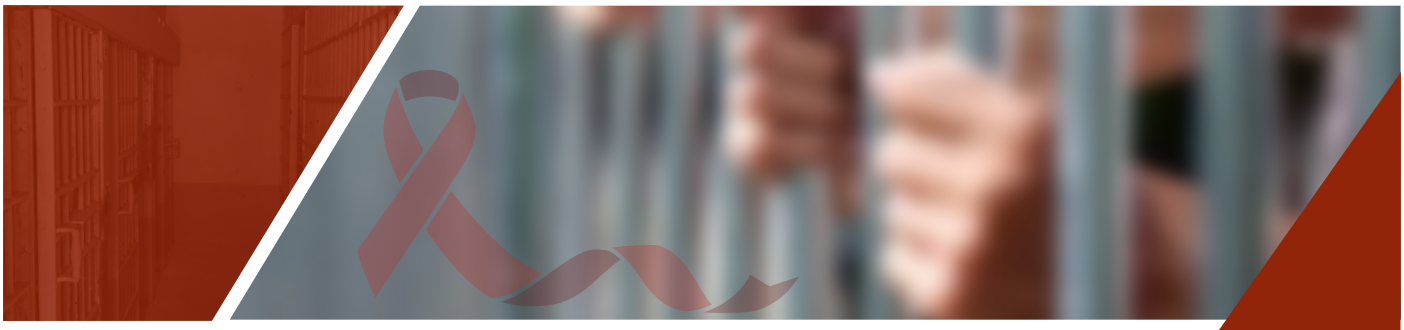
- Baseline clinical assessment and ART initiation of diagnosed positive inmates
- Routine monitoring of on-ART inmates
- ART Adverse Effect management
- Comorbidities management



4 Referral and Linkages for Health and Other Services

The inmates and his or her sexual partner (s) may require many things: primary health care, shelter, drug abuse treatment, food, HIV counselling, employment opportunities, Hepatitis B and Hepatitis C and antiretroviral treatment, and recreational opportunities. Many agencies offer these services, and coordination between the various agencies ensures that inmates and their sexual partner(s) are able to access them. Therefore, it is important to link the various agencies offering help and provide coordinated services to inmates during their stay and/or after their release from prisons and other closed settings.

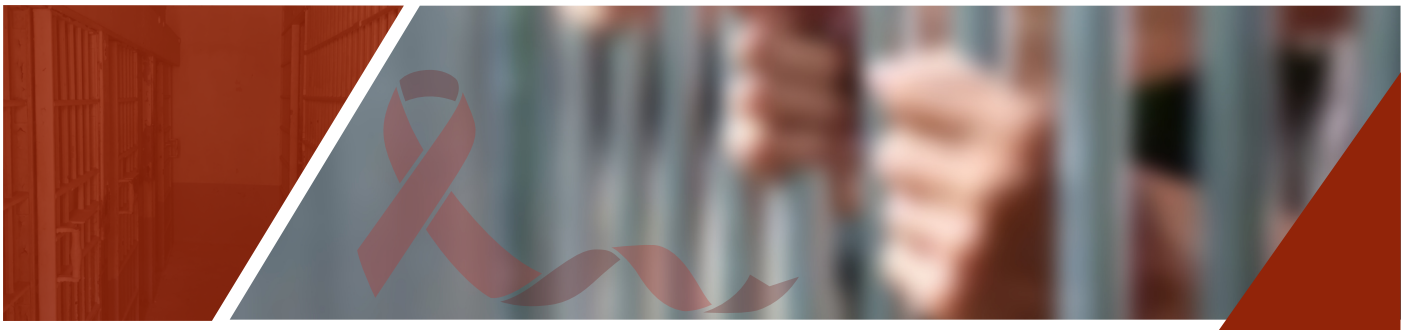
- Prisons and other closed settings should maintain referral directory of service providers
  a. SACS will coordinate with the concerned departments and develop a resource directory comprising information of the service providers including ART, ICTC and OST centre, STI clinics, mental health, TI projects, social security schemes and other necessary services available across the state
  b. SACS will ensure the availability of resource directory in all prisons and OCS across state and further it's distribution to the eligible inmates at the time of their release.
- Linkages with key health services such as DOTS, OI management, HCT, ART, OST, HCV, HBV, PPTCT, PLHIV networks for home-based care and support
- Reproductive health services for drug-using women and women who have male injecting partners
- Linkages with the MSJE/MoHFW supported centre and other private detoxification and rehabilitation centre.
- Linkages and referrals for social welfare schemes and entitlements
  a. SACS should establish an institutional mechanism for increasing access to Social Welfare Schemes among incarcerated or released HIV positive inmates and their family members
  b. State and district level working committee will ensure coordination among ART, ICTC, CSC, PLHIV networks and other NGOs for educating HIV positive inmates and their family members and support in submitting scheme applications
  c. SACS to coordinate with various government departments and facilitate for inclusion of HIV positive inmates and their family members in their schemes and provisions
- Establishment of other referral linkages based on inmates-identified needs and available services in the community
- Psychiatric services within government settings and NGOs



5 Creating an Enabling Environment in the context of drug use and HIV

The Narcotic Drugs and Psychotropic Substances (Amendment) Act, 2014, allows for "management" of drug dependence, thereby legitimizing OST, maintenance and other harm reduction services in the Country. However, people who inject drugs often do not carry syringes and other drug paraphernalia due to fear of police harassment or arrest. Services such as OST and needle syringe programme have been made available to people who are injecting drugs in a more restricted environment. Stigma and discrimination continue to restrict injecting drug users from accessing these essential harm reduction services. Law enforcement agencies (LEAs) including prisons department can play a pragmatic role in protecting individual and public health, especially of diverse and vulnerable communities. LEAs must understand how to engage more effectively with service providers, including both government and civil society organizations, to ensure that access to services is never compromised. Government and civil society organizations working with people who use drugs and other key affected populations should also know how to better engage with each other to maximize service delivery.

- In order to operationalize the provisions existing in the amended Narcotic Drugs and Psychotropic Substances Act, commonly known as the NDPS Act, sensitization workshops can be organized at the state/district/prison (site specific) level to strengthen partnerships between LEAs and the NGOs implementing HIV prevention and treatment services.
- Advocacy meetings can be organized for judges and district magistrates to refer (with informed consent and willingness) people who are dependent on drugs for appropriate drug de-addiction and rehabilitation services as per NDPS Act Sec 64(a).
- SACS should organize training for prison and OCS health care providers on national guidelines for testing, and treatment of HIV, TB, STI, and VH, emphasizing harm reduction, withdrawal management, overdose management, and management of comorbidities among PWIDs inmates.
- The state and district-level working committee should ensure the adequate availability of drugs for the treatment of opioid addiction among PWID inmates. The committees may also engage health professionals or NGOs to provide mental health counseling and treatment services for the inmates who are in need of it.
- The Satellite OST centre can be provisioned by SACS in prisons having high numbers of PWID inmates to reduce the spread of HIV, hepatitis C, and other blood-borne diseases, and also decreases the deaths from a drug overdose
- It has been observed that there is a critical need to have the services of a qualified psycho-social counselor within prison settings for initiating a post-release continuum of care. Therefore, SACS should advocate for such resources under MoHFW's Mental Health Programme or through budgetary allocation by the prison department for providing these services.
- SACS can create institutional mechanisms for coordinating with prison & OCS officials, and LEAs on a regular basis at the state/district level.
- SACS can organize regular exposure visits for jail superintends and constables working at the beat level through NGOs/CBOs



6 National Working Committee on Prison & Other Closed Settings Intervention

Operational Guidelines on interventions in prisons and other closed settings recommend strengthening of steering committees at the state and formation of steering committees at district level to ensure effective implementation of P&OCS interventions in these settings across the Country. The objective of forming a working committee is to contribute to HIV/AIDS and TB prevention and care activities in prisons and other closed settings. The working committee would form a core group for promoting HIV and TB intervention and help respective SACS, State prisons department, Women and Child development department and State TB Cell in effective implementation of program activities.

State Working Committee:

The Project Director, SACS, could serve as the Chairman of the proposed Working Committee and convene and coordinate the meeting. Members of the working committee should include key stakeholders, such as, departments mandated with drug supply and demand reduction, state prison department, STC, relevant development partners, nodal drug treatment center, police training academy, NGOs and community experts. The constitution of the working committee should be reviewed periodically to ensure active and contributing members are part of it. Presence of key stakeholders must be ensured to protect overall interests. The working committee can meet once in three months; the expenses related to travel, stay, conveyance and logistics may be borne by the respective SACS and STC, as applicable.

Functions of the State Oversight Committee:

- Develop a state implementation plan on HIV/AIDS and TB prevention and care in prisons and other closed settings
- Develop an advocacy plan to strengthen the partnership between LEAs and civil society organizations
- Provide strategic direction to effectively implement HIV/AIDS and TB prevention and care initiatives
- Identify 'champions' to lead advocacy efforts at the state as well as district level
- Prepare an action plan and propose seminars/workshops in the context of HIV/TB intervention in prisons and other closed settings
- Ensure designation of a complaint officer at the state level in Prison, WCD, SJE departments in accordance to the section 21 of the HIV & AIDS Act 2017

District Oversight Committee:

The Chief Medical and Health Officer (CMHO) could serve as the chairperson of the proposed working committee and convene the meeting. Members of the working committee should include official from prison, OCS, TB unit, ICTC, ART, CSC, district Viral Hepatitis unit, Nodal drug center centre, police, relevant NGOs & CBOs, and released inmates who served as health volunteer during incarceration.

Functions of District working committee

- Oversee progress of prison and OCS intervention in the district and provide strategic direction to concerned units and agencies to ensure the quality of program
- Develop district project implementation plan for Prisons and OCS
- Develop advocacy plan to strengthen the partnership between law enforcement agencies and civil society organizations and identify champions to lead advocacy efforts
- Review and delegate responsibilities among the key stakeholders for ensuring provision of post-release services to the HIV positive inmates and their family members
- Ensure designation of a complaint officer in all prison or OCS, with 100 or more staff, in accordance to the section 21 of the HIV & AIDS Act 2017

The state should implement and support legal support services for inmates that will educate people affected by HIV about their rights, provide free legal services to enforce those rights, develop expertise on HIV-related legal issues and utilize means of protection in addition to the courts, such as offices of Ministries of Justice, health complaint units and human rights commissions.

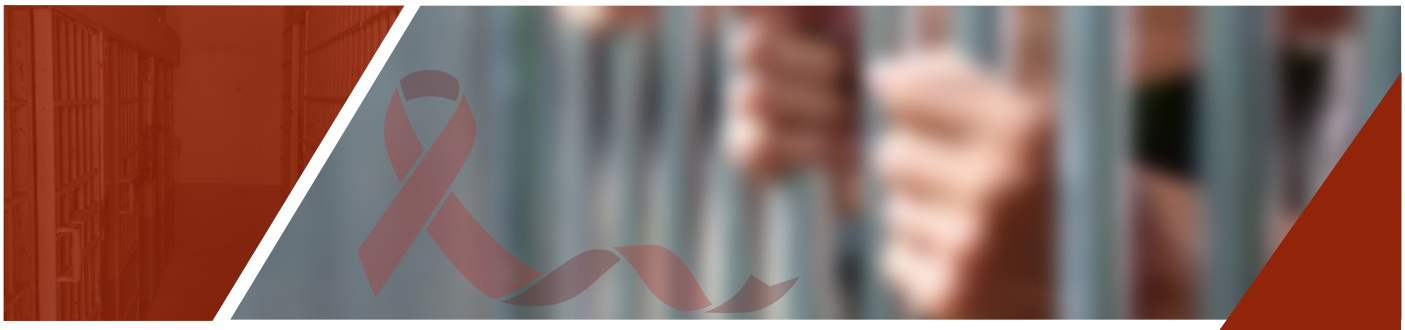
States should consider the following features in establishing such services:

- State support for legal aid systems specializing in HIV casework, possibly involving community legal aid centres and/or legal service services;
- State support or inducements (e.g. tax reduction) to private sector law firms to provide free services to people living with HIV in areas such as anti-discrimination and disability, health-care rights (informed consent and confidentiality), property (wills, inheritance) and employment law;
- State support for programmes to educate, raise awareness and build self-esteem among people living with HIV concerning their rights and/or to empower them to draft and disseminate their own charters/declarations of legal and human rights;
- State support for the production and dissemination of HIV legal rights brochures, resource personnel directories, handbooks, practice manuals, student texts, model curricula for law courses and continuing legal education and newsletters to encourage information exchange and networking should also be provided. Such publications could report on case law, legislative reforms, national enforcement and monitoring systems for human rights abuses;
- State support for HIV legal services and protection through a variety of offices, such as Ministries of Justice, other legal support offices, health complaint units, and human rights commissions.

As per the provisions of The HIV & AIDS (Prevention & Control) Act, 2017 each establishment (establishment means a body corporate or co-operative society or any organization or institution on or two or more persons jointly carrying out a systematic activity for a period of twelve months or more at one or more places for consideration otherwise, for the production, supply or distribution of goods and services) and complaint officers designated in the establishments need to abide by the following procedures :

- The Establishments as per the definition of the HIV & AIDS (P&C) Act, 2017 should display the Model HIV & AIDS Policy on the establishment's website for wider dissemination.
- The Complaints Officers designated in the establishment as per HIV & AIDS (Prevention &Control) Act, 2017 should submit a report to NACO via email at complaints.hivact@gmail.com . If any complaint is received, then only the establishment may report on half yearly basis else no reporting is required.
- The Complaint Officers as per provisions of The HIV & AIDS (Prevention & Control) Act, 2017 designated by Establishments should maintain records online following NACO's Data Management Guidelines.

(Ref. : Office Memorandum, A- 11014/01/2021 -NACO (Admin), Government of India dated 13th July 2021)



7 Modalities for implementation of P&OCS Intervention

SACS should coordinate with key stakeholders, including department of state prisons, women and child development and social welfare, to conceptualize and implement various components of services HIV and TB interventions (refer to section 3 – 'Eligible Interventions from the Comprehensive Package') in prisons (central jails10 and other select jails) and other closed settings (Swadhar, Ujjwala and state-run homes) in a phased manner under overall guidance from NACO, CTD and NVHCP. District jails, sub jails and special jails should be covered based on need, especially in the following States: Arunachal Pradesh, Meghalaya, Andaman and Nicobar Islands, Dadra and Nagar Haveli, Daman and Diu and Lakshadweep.

The activities proposed in section 3 can be implemented through GFATM partners and existing TI-NGOs; selection of NGOs can be done based on proximity to prison sites and consistency in demonstrating good performance. NGOs engaged for the implementation should carry out eligible interventions from the comprehensive package of services under the overall supervision of SACS, STC and SVHCP.

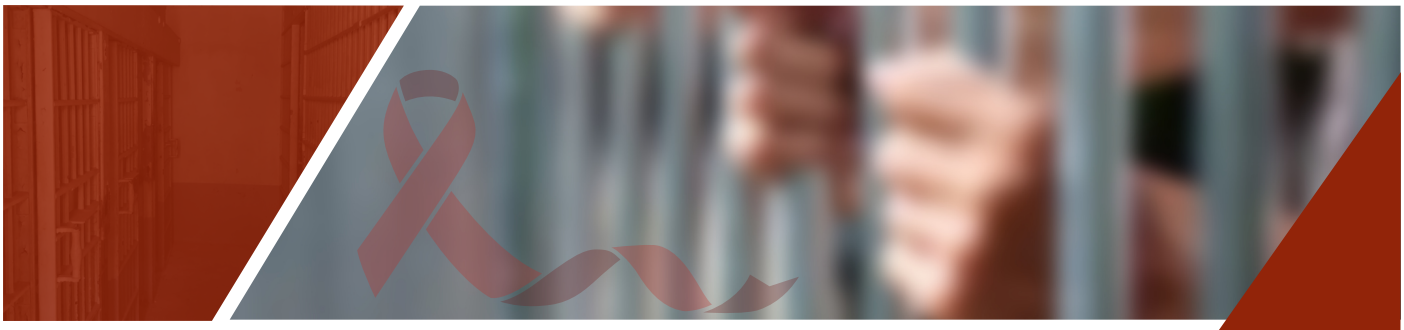
SACS may also explore the possibility of hiring staff directly through development partners supporting the national programme for implementing HIV/TB intervention in prisons and other closed settings. The staff members employed for carrying out the intervention should be stationed at SACS to operationalize the intervention and should report to the Joint Director/ Deputy Director/ Additional Director-TI.

The list of core indicators was developed through a consultative process as part of the National HIV/TB strategic framework. In order to measure the progress of the intervention, the performance should be monitored based on the following indicators. It is suggested that SACS and STC may choose to add more indicators so as to maintain comprehensive data at the facility level. TI Division at SACS should compile and share the progress in the 14 indicators monthly reporting format as prescribed.

1) Number of inmates in the prison/ other closed settings
2) Number of inmates covered through IPC
3) Number of inmates tested for HIV
4) Number of inmates found HIV positive
5) Number of HIV positive inmates offered Index testing
6) Number of contacts elicited from the PLHIV
7) Number of contacts of Index case tested
8) Number of contacts found positive
9) Number of positive inmates and their contacts linked to ART
10) Number of inmates diagnosed with STI

11) Number of inmates treated for STI
12) Number of inmates screened for TB
13) Number of inmates diagnosed with TB
14) Number of inmates started on treatment for TB
15) Number of inmates screened for hepatitis C
16) Number of inmates diagnosed with hepatitis C
17) Number of inmates started on hepatitis C treatment
18) Number of inmates started on OST

Besides these indicators, it is also important to document the number of pregnant women screened for HIV and provided with EMTCT services.



8 Responsibilities of GFATM Partner NGOs/ Targeted Intervention NGOs

Following is some of the broad range of duties and responsibilities of NGOs in the implementation of HIV/ TB intervention in prisons and other closed settings.

1) Implementation of eligible interventions from the comprehensive package of services

i. Information, education and communication
ii. HIV counselling and testing, index testing
iii. HIV care, support and treatment
iv. Prevention, diagnosis and treatment of TB
v. Prevention of parent-to-child transmission of HIV
vi. Prevention and treatment of sexually transmitted infections
vii. Drug dependence treatment, including OST
viii. Referral for diagnosis and treatment of viral hepatitis
ix. Raising awareness on HIV transmission through medical or dental services
x. Raising awareness on HIV transmission through tattooing, piercing and other forms of skin penetration

2) Behavior change communication

I. Support SACS in developing IEC/BCC materials, such as posters, pamphlets, booklets, audio-visual materials and wall paintings
ii. Carry out focused BCC activities to provide information and education on HIV/AIDS to inmates and staff working in prisons and other closed settings
iii. Ensure and enable peer volunteers to regularly conduct one-to-one and one-to-group education sessions using IEC materials
iv. Organize recreational activities, such as games, sports competitions and other appropriate cultural activities with the purpose of creating awareness on HIV/AIDS

3) Human resources

I. Ensure recruitment of recommended resources, including formation of peer leaders and peer volunteers

4) Advocacy

I. Conduct site-specific orientation-cum-sensitization meetings for staff on the eligible interventions identified for implementation
ii. Carry out regular advocacy and sensitization meetings with key stakeholders in prisons and

other closed settings

5) Capacity building and generation of strategic information

I. Visit the intervention site regularly (at least five days in a week) for identification of and contact with new cases as well as follow-up with identified cases through one-to-one communication

ii. Carry out capacity building exercises for staff and inmates to ensure retention of the resource pool inside prison settings

iii. Carry out periodic situational and needs assessment surveys

6) Health and other key services

I. Organize monthly health camps, using mobile ICTC if available or organising through outreach mode in line with NACO's existing guidelines

ii. Establish linkages with existing services in the community for HIV counselling and testing if F-ICTC or mobile ICTC is not available for this purpose

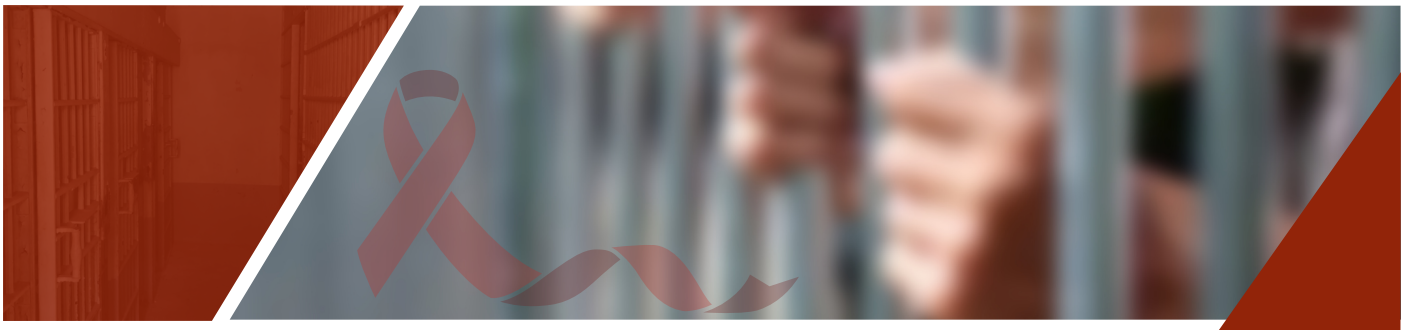
iii. Make injecting drug users aware of the various HIV prevention and treatment services, and link them to appropriate services available in the community; provide referral and linkages to necessary reproductive health services for female injecting drug users

iv. Support inmates in availing vocational training/income generation/livelihood schemes and in accessing free social and legal services

7) Conduct periodic stakeholder meetings and take initiatives to commemorate World AIDS Day and other important events in collaboration with the prison department and SACS

8) Be willing to undertake other activities as may be requested by SACS for strengthening the current response to reduce drug-related HIV in prisons and other closed settings

9) Provide post-release services to released HIV-positive inmates and their family members and also support in increasing access to social protection schemes among them.



9 Functions of National AIDS Control Organization (NACO)

1) Ensure the signing of memorandum of understanding (MoU) between NACO, CTD and the Ministry of Home Affairs (MHA), MWCD and other line ministries and departments
2) Develop SOPs, guidelines and operational manuals to effectively implement the programme
3) Develop training manuals for training of officials, doctors, counsellors, peer-educators and lab-technicians
4) Develop social reintegration module for rehabilitating and reintegrating released prisoners and other inmates into the community
5) Develop training manuals to sensitize police personnel, including those who work in prisons through police training academies and state training and resource centers
6) Organize national and regional sensitization workshops for law enforcement officials, including senior prison officials, to strengthen HIV and TB interventions in prison settings
7) Advocate with police training academies to incorporate a component on HIV/AIDS in their training curriculum
8) Devise mechanisms to monitor and scientifically evaluate interventions to strengthen evidence- informed programming
9) Establish a national working committee on HIV/TB intervention in Prisons and other closed Settings, comprising key stakeholders that include relevant ministries, state prison department, relevant development partners, nodal drug treatment centers, police training academy, NGOs and community experts

National Coordination Committee

The primary need for a joint undertaking should be the Health and Social Justice/ Home affairs Ministries, with substantial input from the National AIDS Control Organization and the National TB Elimination Programme. Leadership and direction should come from the responsible national party; for example, the National Minister of Social Justice/Home Affairs or the National Ministry of Health. It is important to explain to decision-makers (most importantly the Ministry or Ministries responsible for places of detention, the Ministry of Health and the National AIDS Control Organization) why a situation and needs assessment along with program intervention should be undertaken; how it should be initiated; and how its findings should guide future action. Involving other stakeholders is critical to the success of the situation and needs assessments. These stakeholders include representatives from the prison authorities.

Potential Members of a National Coordination Committee could include representatives from:

- Ministries of Health, Social Justice & Empowerment, Home affairs
- Mental Health Department
- Prison Authorities
- National HIV and TB Control Programmes;
- National Drug Control Authorities;
- National Central Statistics Office;
- Relevant civil society organizations, for example, NGOs dealing with high-risk populations such as injecting drug users, sex workers, unauthorised immigrants, faith-based organizations implementing HIV/AIDS programs in prisons, and persons living with HIV);
- Prison management;
- Judiciary;
- National Bar Association; NALSA
- National Human Rights Commission /organizations;
- Technical assistance partners, e.g. GFATM, SAATHII, PLAN India, Principal investigator as an adviser.

The role of the National Steering Committee is to guide and monitor the design and implementation of a situation and needs assessment for HIV which will guide policy and programming on HIV prevention, treatment, care and support, in consideration of related conditions such as TB, viral hepatitis, and STIs. The involvement of a National Steering Committee will facilitate the implementation of programme interventions because of the strong interest among the key institutions and partners. To the extent possible, the consensus among members of the Steering Committee should be obtained. The primary tasks of the National Steering Committee are to:

- Select an independent Principal Investigator OR Identify the most capable national institutions for designing and conducting the assessment process (if the assessment team has not yet been nominated);
- Facilitate the work of the Principal Investigator with advice and guidance, source funding, and provide access to prisons;
- Identify and engage an appropriate ethics committee;
- Prioritise recommendations derived from the needs assessment and disseminate the recommendations strategically, to provide maximum support for the implementation of the recommendations;
- Provide overall policy direction of the assessment and ensure advocacy;
- Discuss the draft of the assessment protocol and the methodological agreement, before submitting it to the Ethics Committee for approval;
- Agree on a budget, allocate assessment funding and ensure fiscal accountability;
- Select the prisons to be covered by the assessment to ensure representativeness of the country's prison population;
- Determine data collection needs; and
- Plan and coordinate national and regional activities.

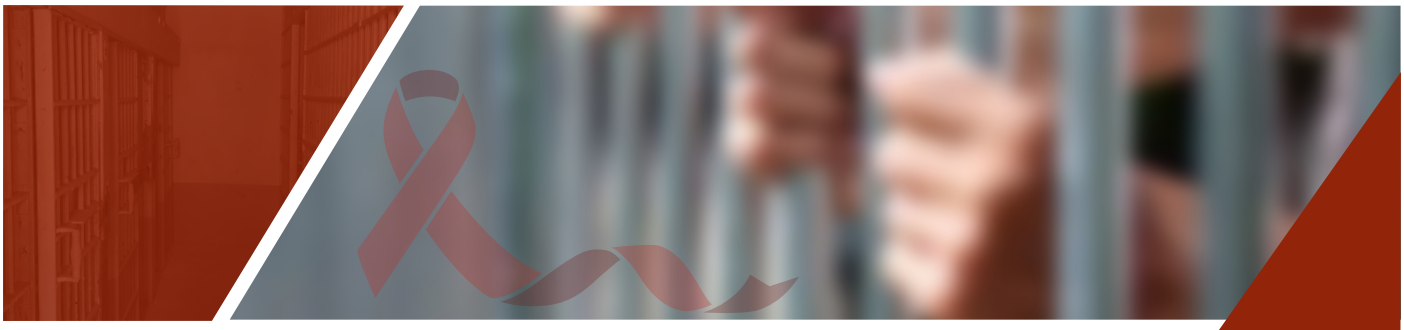
Periodic meetings with key departments

NACO will facilitate conducting program review meetings with CTD, NVHCP, and other line departments for performance reviews and quality control assessments, including independent monitoring of prison conditions and prison health services, which should be encouraged as an integral component of efforts to prevent the transmission of HIV, hepatitis, and TB in prisons and to provide care for inmates living with HIV/AIDS.

National Working Group

A National Working Group (NWG) on Prison & Other Closed Setting Intervention under the National AIDS Control program will be formed to provide technical inputs in the planning & implementation of customized service packages for prison & other closed setting interventions components of the National AIDS Control organization. This Technical Resource group will be located at NACO Office, Delhi. The Terms of Reference for this TRG will be as follows :

- To exchange experience, evidence-informed practices/models on Prison and other closed setting interventions, which are taking place across all prisons and other closed settings
- To provide technical inputs for enhancing the quality of implementation of P&OCS Intervention services under the National AIDS Control Program
- To review the existing guideline in terms of implementation mechanism for providing customised health care services to P&OCS inmates based on technical updates, evidence-based best practices and emerging needs of the programme
- To provide technical guidance in the formulation of guidelines, protocols/tools for M & E framework including the assessment process for P&OCS Intervention outcomes
- To share and review the programmatic update/challenges experienced in the field of implementing Prison & Other Closed Setting intervention
- Any other emerging issues related to P&OCS Intervention.



10 Functions of Central TB Division (CTD)

1) Ensure signing of MoU between CTD, NACO and the Ministry of Home Affairs (MHA), MWCD and other line ministries and departments

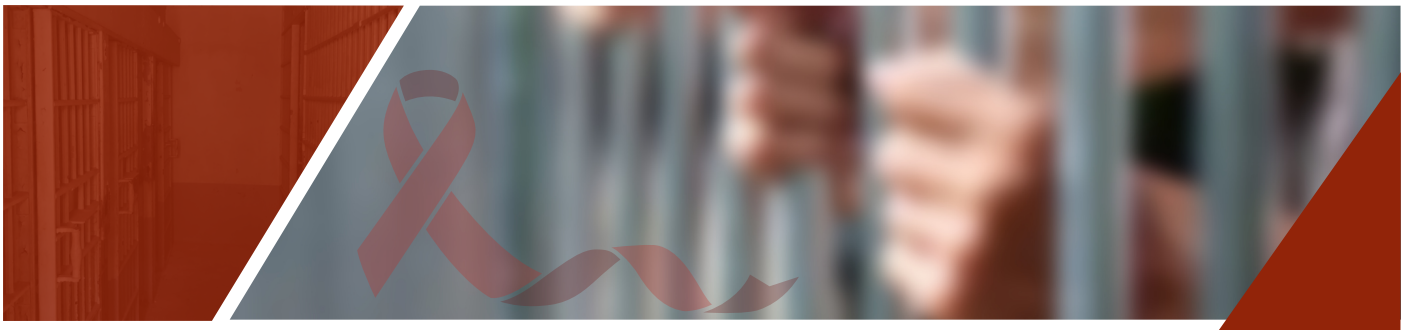
2) Provide technical inputs on:

i. SOPs, guidelines and operational manuals to effectively implement the TB programme
ii. Training manuals for training of officials, doctors, lab technicians and treatment supporters
iii. Social reintegration module for rehabilitating and reintegrating released prisoners and other inmates into the community
iv. Training manuals to sensitize police personnel, including those who work in prisons, through police training academies and state training and resource centers

3) Participate in national and regional sensitization workshops for law enforcement officials organized by NACO to strengthen TB intervention in prisons and other closed settings

4) Partner with NACO in advocating with police training academies to incorporate a component on TB in their training curriculum

5) Participate in national Working Committee on HIV/TB intervention in prisons and other closed settings



11 Functions of National Viral Hepatitis Control Program (NVHCP)

1) Ensure signing of MoU between NVHCP, NACO and the Ministry of Home Affairs (MHA), MWCD and other line ministries and departments

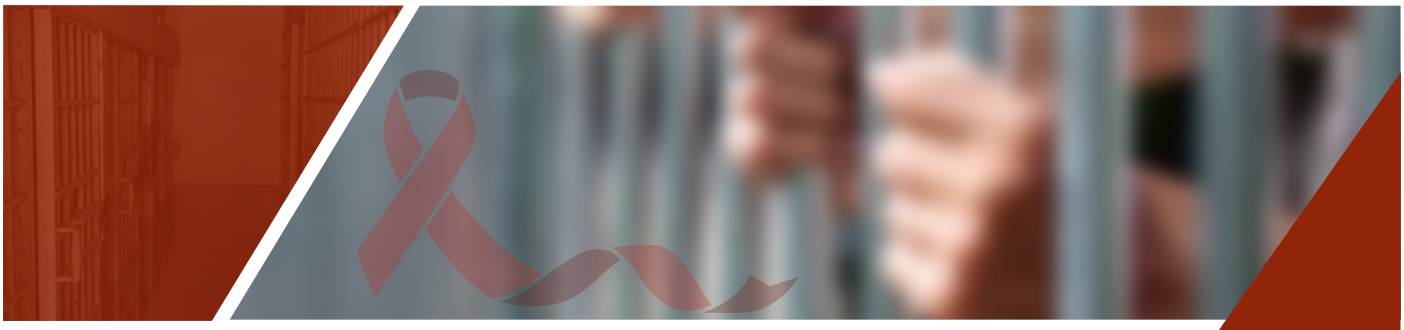
2) Provide technical inputs on:

i. SOPs, guidelines and operational manuals to effectively implement the NVHC programme
ii. Training manuals for training of officials, doctors, lab technicians and treatment supporters
iii. Social reintegration module for rehabilitating and reintegrating released prisoners and other inmates into the community
iv. Training manuals to sensitize police personnel, including those who work in prisons, through police training academies and state training and resource centers

3) Participate in national and regional sensitization workshops for law enforcement officials organized by NACO to strengthen NVHCP intervention in prisons and other closed settings

4) Partner with NACO in advocating with police training academies to incorporate a component on NVHCP in their training curriculum

5) Participate in National Working Committee on HIV/TB intervention in prisons and other closed settings



12 Functions of Ministry of Women & Child Development (MWCD)

1) Ensure signing of MoU between NACO and the Ministry of Home Affairs (MHA), MWCD and other line ministries and departments

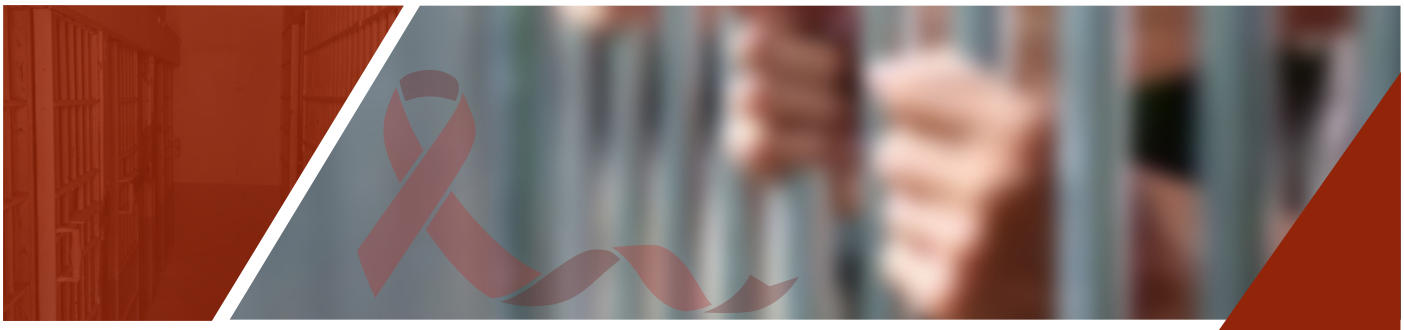
2) Provide technical inputs on:

i. SOPs, guidelines and operational manuals to effectively implement the other closed settings
ii. Training manuals for training of officials, doctors, lab technicians and treatment supporters
iii. Social reintegration module for rehabilitating and reintegrating released inmates into the community
iv. Training manuals to sensitize home's personnel, including those who work in other closed settings, through training academies and state training and resource centers

3) Participate in national and regional sensitization workshops for law enforcement officials organized by NACO to strengthen HIV/TB intervention in other closed settings

4) Partner with NACO in advocating with police training academies to incorporate a component on HIV/TB in their training curriculum

5) Participate in National Working Committee on HIV/TB intervention in other closed settings



13 Functions of Ministry of Social Justice & Empowerment (MSJE)

1) Ensure signing of MoU between NACO and the Ministry of Home Affairs (MHA), MSJE and other line ministries and departments

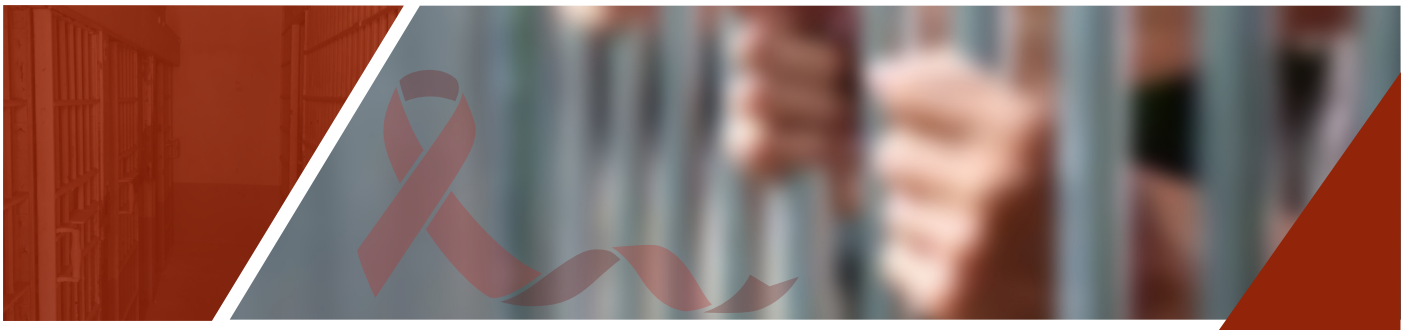
2) Provide technical inputs on:

i. SOPs, guidelines and operational manuals to effectively implement the other closed settings
ii. Training manuals for training of officials, doctors, lab technicians and treatment supporters
iii. Social reintegration module for rehabilitating and reintegrating released inmates into the community
iv. Training manuals to sensitize home's personnel, including those who work in other closed settings, through training academies and state training and resource centers

3) Participate in national and regional sensitization workshops for law enforcement officials organized by NACO to strengthen HIV/TB intervention in other closed settings

4) Partner with NACO in advocating with police training academies to incorporate a component on HIV/TB in their training curriculum

5) Participate in National Working Committee on HIV/TB intervention in other closed settings



14 Functions of State AIDS Control Society (SACS)

1) Arrange infrastructure at the State's prison sites and other closed settings for the following purposes:

i. Integrated Counselling and Testing Centre
ii. Opioid substitution therapy
iii. Diagnosis and treatment services for STI/RTI
iv. Store room

2) Ensure supply of the following commodities to intervention sites:

i. HIV testing kits
ii. Antiretroviral (ARV) medicines
iii. STI/RTI treatment kits
iv. Medicines for drug treatment (Tab. buprenorphine/methadone)

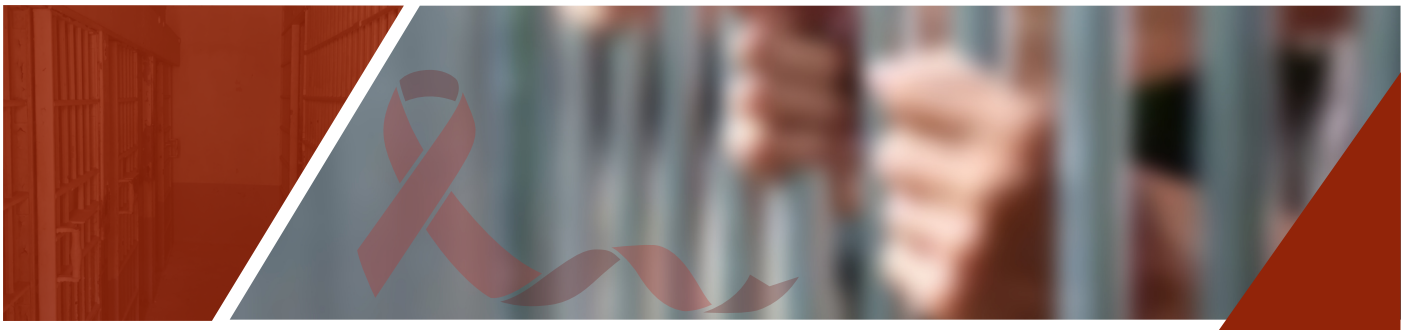
3) Seek necessary permissions for inmates diagnosed with HIV to avail treatment, care and support services, including ARV drugs in the community
4) Seek necessary permissions for NGOs/CBOs contracted by NACO/SACS to carry out HIV/TB intervention
5) Seek necessary permissions for SACS officials to visit intervention sites, interact with staff and inmates to understand progress and extend necessary guidance to the HIV team working in prisons and other closed settings; schedule regular visits (weekly/monthly) to monitor and provide the required assistance to programme staff
6) Ensure training/capacity building of all staff through respective technical support units (TSUs)
7) Develop IEC materials in consultation with key stakeholders for implementing peer-led BCC activities
8) Organize periodic state-level sensitization workshops/trainings for LEAs, including prison officials
9) Provide weekly/monthly reporting formats to the staff employed in prisons and other closed settings
10) Ensure regular collection of data and share the technical report with NACO and the prison department on a regular basis
11) Share the service providers' list, including ICTC, ART, TB, STI, drug dependence treatment, with the nodal officer to ensure referral and linkages
12) Coordinate with the respective nodal officers and participate in state-level police/prison/departmental review meetings
13) Advocate to bring medical services, including HIV prevention and treatment, within the

domain of state medical services/health department instead of prison department

14) Ensure signing of MoU with prison and WCD/ SJE department

15) State AIDS Control societies will define the role of ICTCs:

- Considering the high positivity of HIV among inmates SACS establish Stand Alone ICTCs in Central Jails
- Depute counsellors & Laboratory Technicians of nearby stand-alone ICTCs for counselling, offering Index testing and screening of prisoners on a mission mode in coordination with P&OCS intervention project staffs
- Take care of LFU tracking and linkages with ART centres for P&OCS positive inmates by ICTC staffs
- Strengthen the family counselling of inmates
- Mobile ICTC Vans, Health Camps, involving TI–NGO/CBO located in proximity to prisons/Other closed settings to carry out Community Based Screening of P&OCS inmates
- Strictly adhere to national guidelines on Quality Management Systems by ICTC staff so that testing kits be stored in a clean, secure place and maintain the cold chain.
- Final reporting of prison & OCS intervention at SACS level as part of ICTC reporting (besides reporting by Prison Peer Mobilizer under P&OCS Intervention). This will help to take necessary action to strengthen the testing and counselling facilities for P&OCS Inmates.
- Arrange HIV-focused health infrastructure (as per need) namely Integrated Counselling and Testing Centre, Opioid substitution therapy, Diagnosis and treatment services for STI/RTI, Store room within P&OCS premise
- Ensure the supply of commodities to intervention sites (HIV testing kits, Antiretroviral [ARV] medicines, STI/RTI treatment kits. medicines for drug treatment [Tab. buprenorphine/methadone])
- Seek necessary approvals for visits of SACS/ SETU/ ICTCs/ HCPs to intervention sites, interact with staff and inmates to understand progress and extend necessary guidance to the HIV team working in prisons and other closed settings; schedule regular visits (weekly/monthly) to monitor and provide the required assistance to programme staff
- Seek necessary approvals for organizing health camps in Prison & OCS sites, care and treatment support of HIV-positive inmates and inmates diagnosed with STIs, TB, HCV etc.
- Seek necessary approvals for data collection, share progress updates and ensure timely SOCH entry (by SA ICTCs in prisons)



15 Functions of State/ District TB Cell

1) Arrange infrastructure at the state's prison sites and other closed settings for the following purposes:

i. Designated Microscopy Centre (DMC), wherever eligible
ii. TB treatment centres

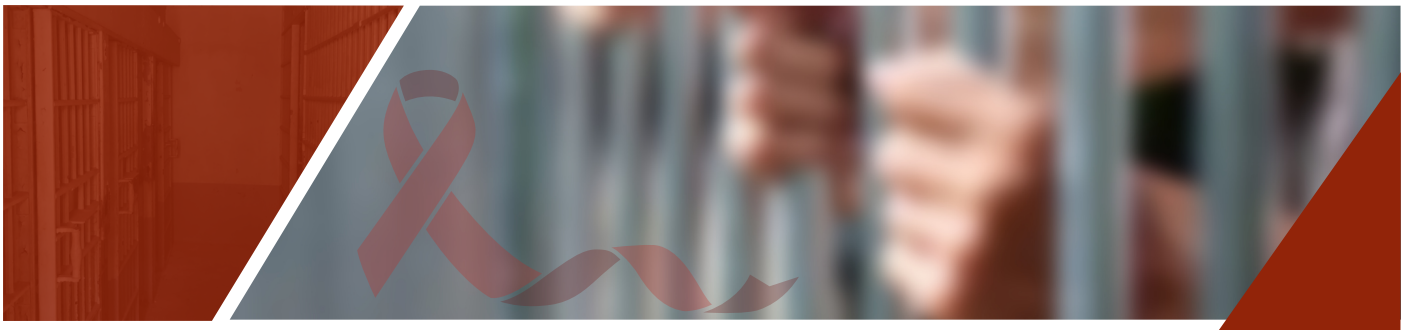
2) Ensure supply of the following commodities to intervention sites:

i. Reagents and consumables for DMC
ii. Anti-TB treatment (ATT) drugs

3) Establish linkages to DMC/CBNAAT site for TB case-finding activities

4) Coordinate with SACS to:

I. Obtain necessary permissions from prison authorities for District TB Cell (DTC) officials to visit intervention sites, interact with staff and inmates to understand progress and extend necessary guidance to the TB team working in prisons and other closed settings
ii. Develop IEC materials in consultation with key stakeholders



16 Functions of Strategic Expertise Technical Unit (SETU)

1) Facilitate the strengthening of a state-level steering committee and facilitate in organizing periodic meetings at regular intervals (refer to Section 6)

2) Help in planning, implementation and monitoring the intervention

3) Facilitate formation of peer-led interventions and arrangement of training programs to create a cadre of peer mobilizers/peer volunteers among inmates and officials

4) Facilitate development of prison-specific IEC materials

5) Submit report on the individual performance of each intervention site along with a consolidated report on the program's progress on a monthly basis to SACS and NACO

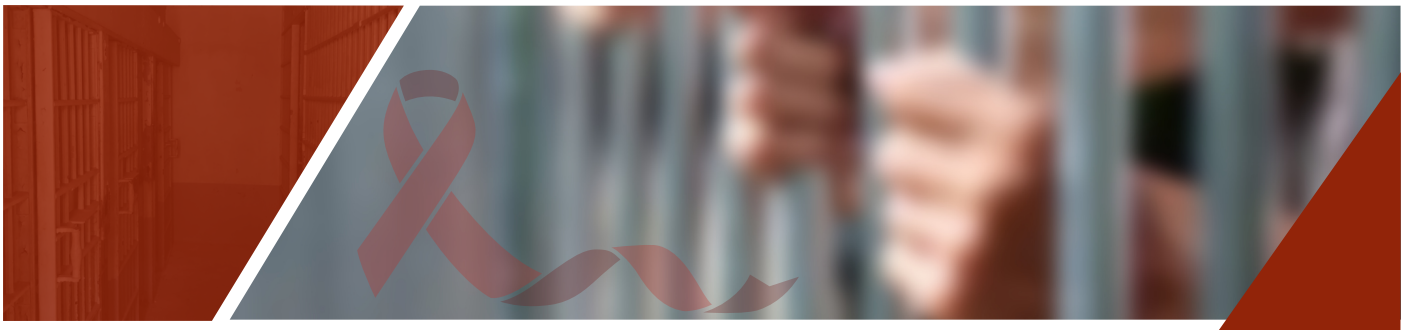
6) Facilitate situational and needs assessment studies to foster evidence-informed programming

7) Facilitate site-specific capacity building programs for officials, including medical professionals attached with prisons and other closed settings

8) Nominate a nodal person for each prison site to facilitate implementation of planned activities

9) Liaise with DISHA/DAPCU and make joint field visits at least once a month in addition to regular monitoring visits

10) Organize quarterly review meeting involving focal persons from NACO, the prison department, SACS and NGOs working with the programme



17 Functions of District Integrated Strategy for HIV/ AIDS (DISHA)/ District AIDS Prevention and Control Unit (DAPCU)

1) Arrange, in association with SACS, regular HIV testing camps in prisons and other closed settings by deputing a counsellor and a lab technician on specific days at a given prison

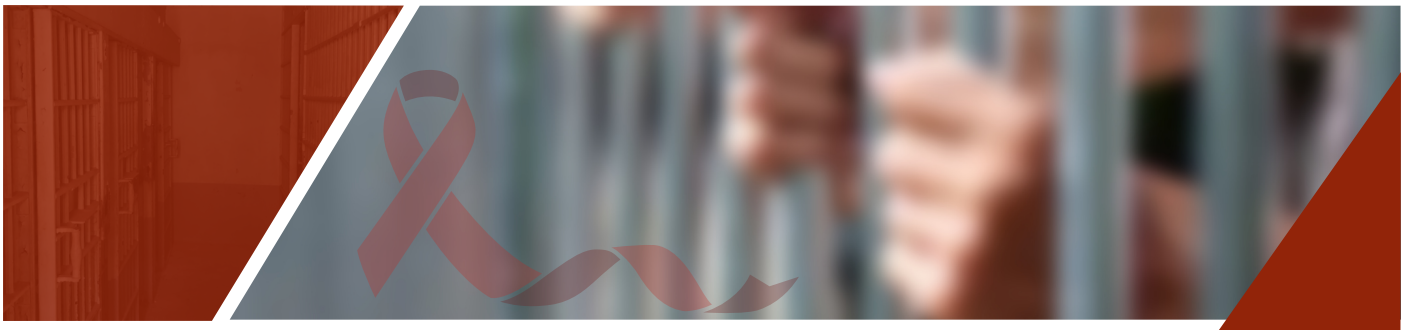
2) Arrange, in association with SACS and other relevant authorities, for transportation with appropriate security to take HIV-positive inmates to ART centre for initiation of treatment and regular monitoring tests

3) Ensure sharing of the service providers' list, including ICTC, ART, TB, STI, drug dependence treatment, VH with the nodal officer for referral of released prisoners and other inmates for necessary HIV prevention, treatment, care and support services

4) Act, in coordination with the district department, as a nodal officer to help released prisoners, including those who use drugs, in availing various government welfare schemes, such as loans and pension

5) Visit prisons and other closed settings and interact with inmates to understand the progress of HIV/TB intervention

6) Liaise with the office of the district collector, prisons department and authorities of other closed settings to address issues related to stigma and discrimination of inmates and released prisoners



18 Roles of State Prison Department and Other Closed Settings

1) Provide infrastructure at respective intervention sites for the following purposes:
i. Integrated Counselling and Testing Centre
ii. Opioid substitution therapy
iii. Diagnosis and treatment services for STI/RTI
iv. DOT centre/ Designated Microscopy Centre for TB
v. Store room

2) Appoint nodal officers at each intervention site to liaise with SACS, STC/DTC and NGOs

3) Provide necessary permissions to inmates diagnosed with HIV and TB to avail various treatment, care and support services, including ARV and ATT drugs

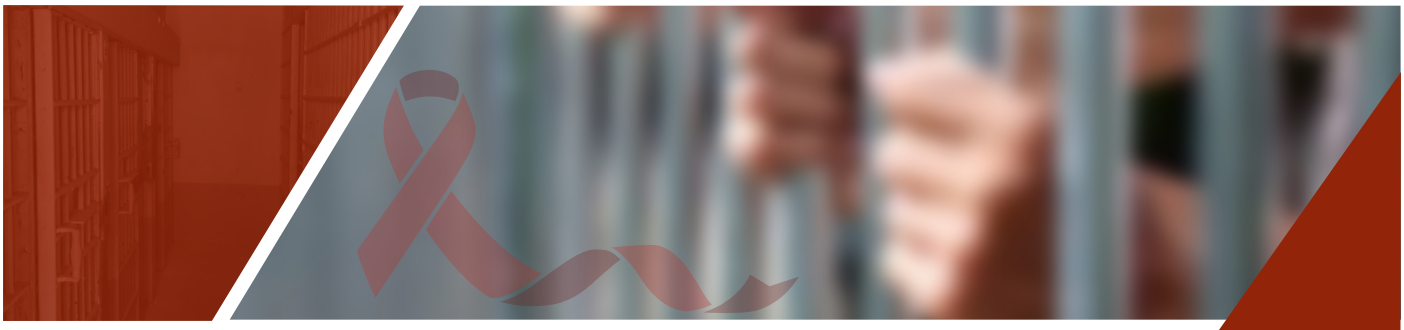
4) Provide permissions to NGOs/CBOs contracted by NACO/SACS to carry out HIV and TB interventions

5) Provide necessary permissions to SACS and STC/DTC officials to visit prisons and other closed settings, where interventions have been initiated, to interact with staff and inmates to understand progress and to extend necessary guidance to the HIV and TB team working at intervention sites

6) Provide facilities, including venue and refreshments, when organizing site-specific advocacy meetings and training programs for staff, peer leaders and peer volunteers

7) Invite SACS, STC/DTC and/or DAPCU officials to participate in review meetings

8) Ensure separate cell are provided for transgender persons



19 Gender Responsiveness and addressing Stigma & Discrimination

HIV/TB response for people living in prisons and other closed settings needs to be formulated on the basis of an understanding of their specific vulnerabilities. Some inmates are particularly vulnerable to HIV, TB and other negative health outcomes in prisons; these inmates include: people who inject drugs, young adults, people with disabilities, PLHIV, transgender persons and other sexual minorities, indigenous people, racial and ethnic minorities, and people without legal documents or lacking legal status. Most of these inmates are from socially marginalized groups and are more likely to have been engaged in sex work and/or drug use. Many inmates might have been victims of gender-based violence or have a history of high-risk sexual behavior.

Over the years, as HIV has progressed and its impact on lives of people evolved, many specific issues, concerns and nuances that require particular attention with regard to MSM/TG/Hijra have also come to light through programs and intervention design and delivery. To reduce stigma and discrimination associated with the infected and affected persons and ensure that they have an access to prevention and quality treatment, care, and other supports like legal services, NACP – III took affirmative actions, which were aimed at Creating an Enabling Environment, Addressing Stigma and Discrimination, Addressing Human Rights, Legal and Ethical Issues, Addressing the Gender Equality, Addressing the needs of the Vulnerable and Specific Groups. SACS and STC should therefore, work through DAPCU/ DTC and implementing partner NGOs, to pay attention to their protection and address their needs for HIV and TB prevention and treatment services within prisons and other closed settings.

HIV-related stigma and discrimination significantly impact the health, lives and well-being of people living with or at risk of HIV, especially key populations Stigma and discrimination impede the HIV response at every step, limiting access to:

- Prevention services
- Broader sexual and reproductive health services
- Testing, treatment and adherence

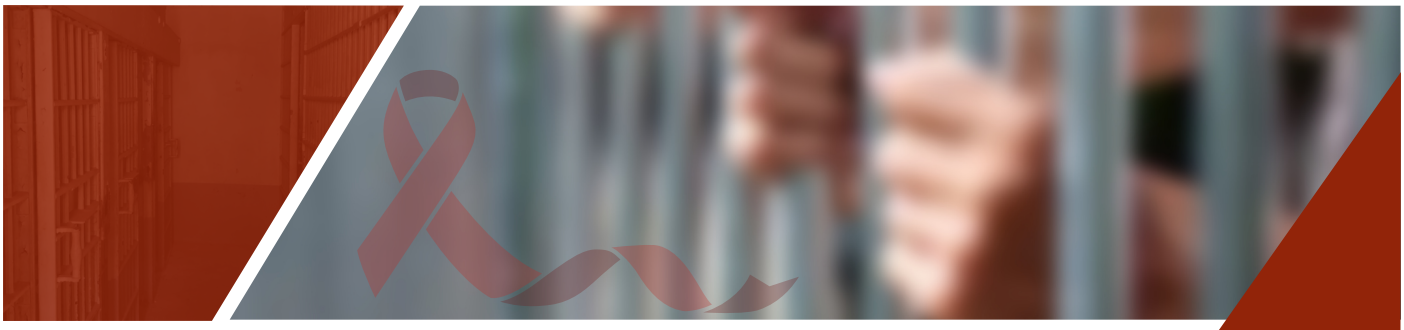
Stigma and discrimination increase the risk of HIV acquisition and progression to AIDS, violence, and marginalization while reducing access to education, employment and justice.

Prison & other Closed Settings inmates face double stigma because of their criminal identity as a prisoner along with their sexual and gender identities as key population groups. In prison & other

closed settings, FSW inmates are prejudiced because of their profession as sex workers, MSM/TGs and other LGBTQ faces sexual and physical exploitation because of their gender identities, in some cases, these key population groups also face denial of services by health care providers based on the types of crimes they performed. In some cases, HIV and TB-positive inmates are also segregated in different barracks and are treated with discriminatory behaviour. Transgenders are confined in barracks based on their biological sex, which also leads to difficulties.

Therefore, efforts should be made to create a supportive atmosphere for LGBTQ populations inside prisons and other closed settings by providing psychological and legal support, educating the jail population, and distributing communication materials. Some programmatic issues which need attention are:

- Trans-gender and MSM population face multiple layers of stigma and powerlessness.
- There are gender related differences in accessing services and psycho-social support.
- Women living in closed settings experience stigma in multiple and highly debilitating ways.
- Women affected by HIV lack economic and legal support.
- Youth including young women living in prisons and other closed settings are highly vulnerable to HIV transmission.
- Transgender persons living in prisons and other closed settings need a separate cell.



20 Social Reintegration

After their release from prisons and other closed settings, inmates enter an environment that does not have any control over them. They might get exposed to the same high-risk places, situations and persons, resulting in a very high likelihood of relapsing into crime. Although a few inmates do develop relapse-prevention skills during their imprisonment, a majority may not know how to deal with such situations. The limited research conducted in this area shows that released offenders show ineffective or destructive ways of coping with everyday problems. Effective reintegration of released prisoners into the community, thus, assumes significant importance.

'Social reintegration' refers to the process of socially and psychologically integrating into one's social environment. However, in the context of drug use and HIV, the term refers more specifically to various forms of interventions and programs targeting individuals to prevent them from HIV transmission, which may also eventually prevent criminal behavior or reduce the likelihood of reoffending. Successful reintegration of offenders means that fewer of them will appear again before criminal courts, come back to prisons and contribute to prison overcrowding, and generally increase the costs of the criminal justice system. Many of the services initiated in prisons and other closed settings have to be continued with appropriate referral and linkages, which may require active involvement of NGOs/ CBOs implementing TIs in their respective areas. Social reintegration interventions should, therefore, partner with social agencies, NGOs/CBOs, educational institutions, communities and offenders' families, to enable successful social reintegration of individuals.

Generally, there are two main categories of social reintegration programs: (a) programs and interventions, including ART, OST, diagnosis and treatment for TB and STI, being offered in the institutional setting itself, in advance of the offenders' release, to prepare them for their release and re- entry into society and (b) community-based programs to facilitate social reintegration of offenders after their release from custody. Institutional and community-based reintegration programs can address dynamic risk factors by focusing on motivation, education, skill development, employment, accommodation, interpersonal relationships, drugs and alcohol treatment, mental health care and cognitive-behavioral interventions. Some initiatives may eventually focus mainly on offenders with substance abuse problems (UNODC, 2012).

- Pre-release planning programs and transition facilities are often crucial for the offenders' successful re-entry into community and desistance from crime.

- Linkages with health services in the community, including HIV or TB clinics and drug dependence services, need to be established prior to release. The treatment initiated in prisons and other closed settings for PLHIV and TB patients is often interrupted once the inmate is released, and this can lead to treatment failure, with its own negative consequences. Therefore, inmates living with HIV must have access to treatment programs in the community when they are released so that support, counselling and treatment can continue.

- Complete recovery from drug dependence takes time and requires effective treatment, followed by effective management of the problem over time. Post-release continuum of care is particularly important for drug-dependent offenders receiving treatment. Access to appropriate drug dependence treatment, including OST, in the community is essential for ensuring successful social reintegration of drug-abusing offenders.

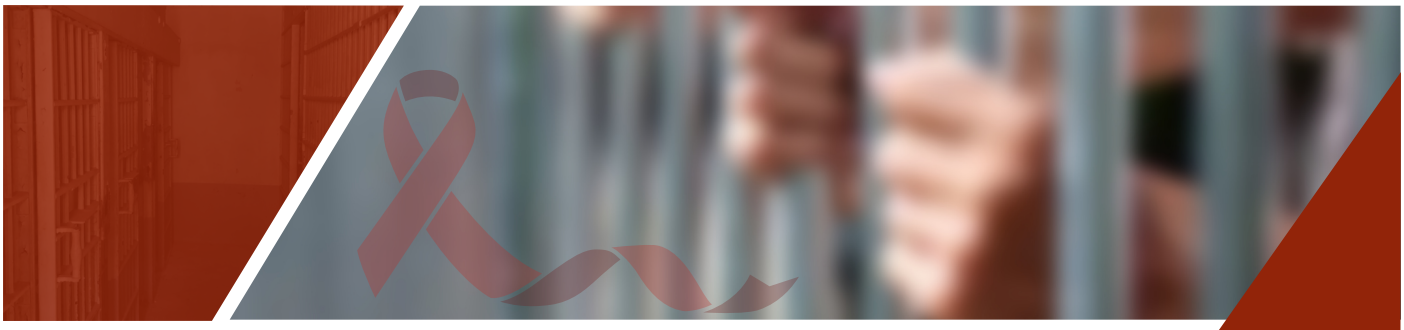
- It is important to help released inmates become part of support groups; counsel their family members to provide necessary support at the time of release; provide networking and referral details of various HIV prevention and treatment services available in the community; provide details about Narcotics Anonymous/faith-based institutions and other support groups existing in the community; and identify existing social/governmental structures to provide them the necessary support.

- As per New Prison Manual 2016, it is envisaged that special committees, known as Discharged Prisoners' After-Care and Rehabilitation Committees, will be set up at the district or state level to plan and devise appropriate mechanisms for rehabilitation and after-care assistance to prisoners.

- It has been observed that there is a critical need to have the services of a qualified psycho-social counsellor within prison settings, for initiating post-release continuum of care. Therefore, SACS should advocate for such resources under MoHFW's Mental Health Programme or through budgetary allocation by the prison department for providing this service.

- Formation of a social support network through respective TI-NGOs for released prisoners (injecting drug users) may also be explored.

- Plan and implement Aadhar provisions for all under trial as well as convicted inmates in Prison & Other Closed Settings



21 Mainstreaming HIV and TB Intervention

HIV/AIDS is not a mere health issue as its occurrence is influenced by a number of socio-economic elements. Health interventions alone, therefore, cannot lead to prevention. HIV prevention requires concerted collaborative efforts from all departments, institutions or organizations in public life through their work and programme. Addressing the various socio-economic factors, the response to HIV needs to be multi-faceted and multi-sectorial.

Involvement of various stakeholders including State Prisons department and Women and Child Development department are crucial to: spread awareness on HIV and AIDS; enhance the access to HIV /TB prevention and treatment services; strengthen linkages with available services (ICTC, STI Clinic, OST, ART Clinic etc.); reduce stigma and discrimination against PLHIV; and also, to reach out to maximum number of inmates living in prisons and other closed settings.

Rule 24 of the United Nations Standard Minimum Rules for the Treatment of Prisoners (1955), also known as Nelson Mandela Rules (2015), clearly states that provision of health care for prisoners is a responsibility of the State. Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health care services free of charge without discrimination on the ground of their legal status. Health care services should be organized in close relationship with the general public health administration and in a way that ensures continuity of treatment and care, including for HIV, TB, other infectious diseases and drug dependence. The HIV/ AIDS prevention and control Act, 2017 states that "Every person in the care and custody of the State shall have right to HIV prevention, testing, treatment and counselling services".

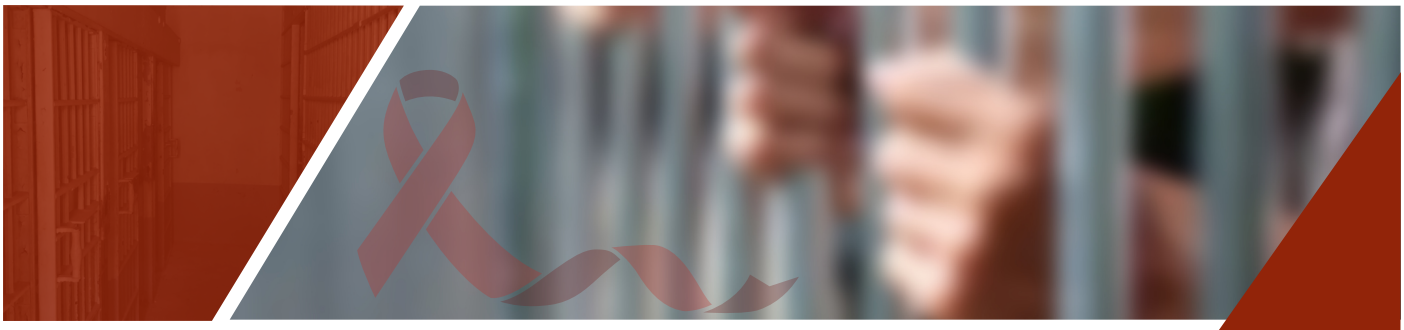
The New Prison Manual, approved in 2016 by the Minister for Home, Government of India, strongly recommends that prison medical administration should be part of state health services/medical department instead of prison administration. Hence, in order to ensure sustainability, the HIV and TB interventions provided to inmates by SACS and STC/DTC should be mainstreamed into State Medical Services / Health Department / Prison Department rather than under NACP/RNTCP.

Mainstream Matrix

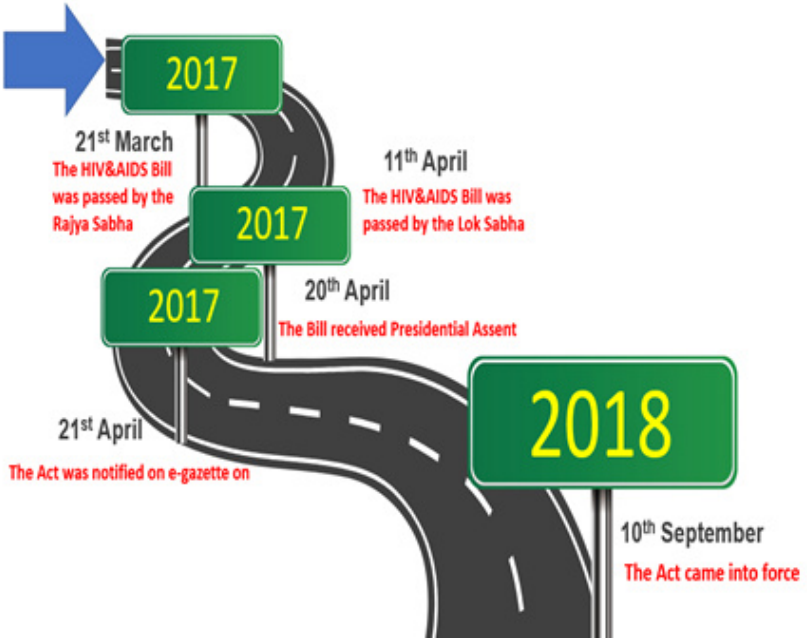
Stakeholders	Responsibility
State Prisons Department	• Enhance the access to HIV /TB prevention and treatment services for inmates • Provide adequate information and awareness on HIV/AIDS, TB, Viral Hepatitis & STI to their own staff • Strengthen linkages with available services (ICTC, STI Clinic, OST, ART Clinic etc.)

Stakeholders	Responsibility
State Prisons Department	• Reduce stigma and discrimination against PLHIV and TB-positive inmates • Formation of work place policy and nominating nodal person to deal with HIV related issues • Including project components in their training modules • Increase heath infrastructure and additional budget for health services • Sensitive towards high-risk groups and their housing
Women and Child Development Department	• Provide adequate information, education and awareness on HIV/ AIDS, TB, Viral Hepatitis & STI to staffs in Swadhar Grah, Ujjawala Homes, Nari Niketans. • Enhance the access to HIV /TB prevention and treatment services for inmates • strengthen linkages with available services (ICTC, STI Clinic, OST, ART Clinic etc.) • Reduce stigma and discrimination against PLHIV and TB-positive inmates • Reach out to maximum number of inmates living in Swadhar Grah, Ujjawala Homes, Nari Niketans through HIV and AIDS/STI/Hepatitis & TB materials development & distribution • Skill building and employment for girls and women in the high-risk and vulnerable groups as well as those infected with HIV/AIDS through facilitating support to training and employment programme (STEP) for HIV infected women, high-risk groups such as FSWs, female drug users, victims of violence and transgender people and for HIV affected women (wives and widows of HIV positive persons). • Design special programs for social protection of women infected and affected by HIV/AIDS support and safe shelter for such women covering their nutrition, shelter, skill building and employment. • Including project components in their training modules
Department of Social Justice and Empowerment	• Inclusion of FSWs, MSM, transgender, IDUs and inmates living with HIV/AIDS as priority groups for social defense programs • Enhancing linkages and effective coordination between Injecting Drug Users with Targeted Intervention (IDUs-TI) supported by NACO and Integrated rehabilitation Centre for Addicts (IRCAs) supported by DSJE. • Developing welfare schemes aiming at social inclusion and empowerment of hijras-transgender inmates who face extreme social alienation, enhancing their vulnerability to

Stakeholders	Responsibility
Department of Social Justice and Empowerment	HIV, TB & other related health problems • Addressing the risk of HIV, TB, Hepatitis & STI transmission among all substance users through preventive risk reduction messaging on HIV/STI/Hepatitis/TB and linkages with ICTC/ART/ NTEP/NVHCP and other services. • Working towards empowerment of discriminated and vulnerable prison & Other closed setting inmate groups like FSWs and hijras, transgender people by nurturing a supportive and congenial environment which promotes human development by safeguarding the human rights of all, providing social protection and rendering psychosocial care.
Ministry of Law & Justice	• Promoting legal awareness amongst the Networks of People Living with HIV, CBOs of marginalized communities and civil societies towards reducing the incidence of violation of rights and discrimination with PLHIV and HRG inmates and their family members • Strengthen the mechanism of legal aid by NALSA, SALSA and DLSA, Bar Council and para-legal workers to target groups, including PLHIV and affected groups, FSWs, IDUs, MSMs, transgender persons, hijras, etc.
Ministry of Home Affairs	• Integration of HIV/AIDS/TB/Hepatitis awareness in police training • Regularly and periodically organize awareness programs for police personnel and their families on HIV/TB/Hepatitis/ STI. Pamphlets, leaflets and booklets on HIV/TB/Hepatitis/ STI to be published and disseminated • Treatment and other services (ICTC, ART, DMC, DSRC etc.) to be established in Hospitals • Prison welfare officers/services in prisons support risk reduction activities, including providing information on the prevention of STI/HIV/Hepatitis/TB. • HIV/AIDS/TB/Hepatitis/ STI to be included in the induction trainings and refresher training of all cadres of staff in the prisons' services. • All medical staff including doctors, staff nurses/para-medical staff and pharmacists are trained on counselling, testing as well as on providing care, support and treatment to inmates as per national treatment protocols and guidelines published by NACO/CTD/NCHCP. • All health services in prisons provide counselling and testing services of HIV/TB/Hepatitis/ STI as per national protocols and guidelines and provide referral linkages, wherever necessary. • Provide timely escort services to the inmates for availing HIV, TB, STI and VH testing and treatment services that are available outside prisons



22 The Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017



The Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome Bill, 2014 was passed by the Parliament and it received Presidential assent on 20th April, 2017.

The HIV and AIDS (Prevention and Control) Act, 2017 was notified on e-gazette on 21st April, 2017. Passing of the Act has brought many policy decisions in relation to HIV and AIDS under the legal ambit. It has been hailed as landmark legislation, first of its kind in the health sector in specific to HIV/AIDS. This has been an outcome of relentless efforts, commitment and hard work of civil society members, legal experts, community members, NACO officials etc. for more than a decade. The Act came into force from 10th September, 2018.

Important Provisions of the HIV and AIDS (P&C) Act, 2017

Address stigma & discrimination

Section 3: Prohibition of discrimination

For the purpose of this section, the definitions of 'protected person' and 'discrimination' need to be referred to. As per section 2 (d) of the Act, discrimination is defined as any act or omission which directly or indirectly, expressly or by effect, immediately or over a period of time, —

I. imposes any burden, obligation, liability, disability or disadvantage on any person or category of persons, based on one or more HIV-related grounds; or

ii. denies or withholds any benefit, opportunity or advantage from any person or category of persons, based on one or more HIV-related grounds

As per section 2 (s) of the Act, protected person means a person who is—

(I) HIV-Positive; or

(ii) ordinarily living, residing or cohabiting with a person who is HIV-positive person; or

(iii) ordinarily lived, resided or cohabited with a person who was HIV- positive; Section 3 of the Act provides that no person shall discriminate against the protected person on any ground including any of the following:

(a) the denial of, or termination from, or unfair treatment in, employment or occupation

(I) unless, in the case of termination, the person who is otherwise qualified, is furnished with a copy of the written assessment of a qualified and independent healthcare provider competent to do so that such protected person poses a significant risk of transmission of HIV to other person in the workplace, or is unfit to perform the duties of the job; and

(ii) a copy of a written statement by the employer stating the nature and extent of administrative or financial hardship for not providing him reasonable accommodation;

(iii) section 2(t) defines reasonable accommodation as minor adjustments to a job or work that enables an HIV-positive person who is otherwise qualified to enjoy equal benefits or to perform the essential functions of the job or work, as the case may be.

(b) the denial or discontinuation of, or unfair treatment in, healthcare services

(c) the denial or discontinuation of, or unfair treatment in, educational establishments and services

(d) the denial or discontinuation of, or unfair treatment with regard to, access to, or provision or enjoyment or use of any goods, accommodation, service, facility, benefit, privilege or opportunity dedicated to the use of the general public or customarily available to the public, whether or not for a fee, including shops, public restaurants, hotels and places of public entertainment or the use of wells, tanks, bathing ghats, roads, burial grounds or funeral ceremonies and places of public resort

(e) the denial, or, discontinuation of, or unfair treatment with regard to, the right of movement

(f) the denial or discontinuation of, or, unfair treatment with regard to, the right to reside, purchase, rent, or otherwise occupy, any property

(g) the denial or discontinuation of, or, unfair treatment in, the opportunity to stand for, or, hold public or private office

(h) the denial of access to, removal from, or unfair treatment in, Government or private establishment in whose care or custody a person may be

(I) the denial of, or unfair treatment in, the provision of insurance unless supported by actuarial studies

(j) the isolation or segregation of a protected person

(k) HIV testing as a pre-requisite for obtaining employment, or accessing healthcare services or education or, for the continuation of the same or, for accessing or using any other service or facility

Section 4: Prohibition of certain acts

The section prohibits certain acts that may incite hatred against, promote discrimination or physical violence against any protected persons or group of protected persons in general or specifically.

The section covers many forms of expression, including words, either spoken or written, publish, propagate, advocate or communicate by signs or by visible representation or disseminate, broadcast or display any information, advertisement or notice.

Movie Links:

https://www.youtube.com/watch?v=gWYbw0Bj0rs&list=PL7USUpCMQeK-zhYHm_7EPdSIQH0OY_i-W&index=1

https://www.youtube.com/watch?v=GWBTnCCv5Vw&list=PL7USUpCMQeK-zhYHm_7EPdSIQH0OY_i-W&index=2

https://www.youtube.com/watch?v=eoBo8kX9S0g&list=PL7USUpCMQeK-zhYHm_7EPdSIQH0OY_i-W&index=8

Create an enabling environment for enhancing access to services

Section 5: Informed consent for undertaking HIV test or treatment

As per section 2 (n) of the Act, informed consent means consent given by any individual or his representative specific to a proposed intervention without any coercion, undue influence, fraud, mistake or misrepresentation and such consent obtained after informing such individual or his representative, as the case may be, such information, as specified in the guidelines, relating to risks and benefits of, and alternatives to, the proposed intervention in such language and in such manner as understood by that individual or his representative, as the case may be.

The section mandates obtaining informed consent of such person or his representative for-

(a) undertaking or performing an HIV test

(b) for performing any medical treatment, medical interventions or research.

The informed consent for HIV test includes pre-test and post-test counselling of the person being tested or such person's representative.

Section 6: Informed consent not required for conducting HIV tests in certain cases

The section provides certain instances where seeking informed consent for conducting an HIV test is not required-

a) where a court determines, by an order that the carrying out of the HIV test of any person either as part of a medical examination or otherwise, is necessary for the determination of issues in the matter before it;

(b) for procuring, processing, distribution or use of a human body or any part thereof including tissues, blood, semen or other body fluids for use in medical research or therapy:

Provided that where the test results are requested by a donor prior to donation, the donor shall be referred to counselling and testing centre and such donor shall not be entitled to the results of the test unless he has received post-test counselling from such centre;

(c) for epidemiological or surveillance purposes where the HIV test is anonymous and is not for the purpose of determining the HIV status of a person: Provided that persons who are subjects of such epidemiological or surveillance studies shall be informed of the purposes of such studies; and
(d) for screening purposes in any licensed blood bank.

Section 8: Disclosure of HIV status

(a) The section states that no person can be compelled to disclose their HIV status except by the order of the court that the disclosure of such information is necessary in the interest of justice for the determination of the issues in the matter before it;

(b) It further provides that no person shall disclose or be compelled to disclose the HIV status or any other private information of other person imparted in confidence or in a fiduciary relationship, except with the informed consent of that person or a representative of such other person. Provided that, in case of a relationship of a fiduciary nature, informed consent shall be recorded in writing.
The section also discusses certain exceptions to seeking informed consent for disclosure of HIV-related information:
(a) by a healthcare provider to another healthcare provider who is involved in the care, treatment or counselling of such person, when such disclosure is necessary to provide care or treatment to that person;
(b) by an order of a court that the disclosure of such information is necessary in the interest of justice for the determination of issues and in the matter before it;
(c) suits or legal proceedings between persons, where the disclosure of such information is necessary in filing suits or legal proceedings or for instructing their counsel;
(d) disclosure of HIV-positive status to partner of HIV-positive person
(e) if it relates to statistical or other information of a person that could not reasonably be expected to lead to the identification of that person; and
(f) to the officers of the Central Government or the State Government or State AIDS Control Society of the concerned State Government, as the case may be, for the purposes of monitoring, evaluation or supervision.

Section 11- Confidentiality of data

Every establishment keeping the records of HIV-related information of protected persons shall adopt data protection measures in accordance with the guidelines to ensure that such information is protected from disclosure.
Data protection measures shall include procedures for protecting information from disclosure, procedures for accessing information, provision for security systems to protect the information stored in any form and mechanisms to ensure accountability and liability of persons in the establishment.

Section 22-Strategies for reduction of risk

Any strategy or mechanism or technique adopted or implemented for reducing the risk of HIV transmission, or any act pursuant thereto, as carried out by persons, establishments or organisations in the manner as

may be specified in the guidelines issued by the Central Government shall not be restricted or prohibited in any manner, and shall not amount to a criminal offence or attract civil liability. Strategies for reducing risk of HIV transmission means promoting actions or practices that minimise a person's risk of exposure to HIV or mitigate the adverse impacts related to HIV or AIDS including—

(I) the provisions of information, education and counselling services relating to prevention of HIV and safe practices;
(ii) the provisions and use of safer sex tools, including condoms;
(iii) drug substitution and drug maintenance; and
(iv) provision of comprehensive injection safety requirements.

Movie Links:

https://www.youtube.com/watch?v=S2Z5uA-dnFc&list=PL7USUpCMQeK-zhYHm_7EPdSIQH0OY_i-W&index=7

https://www.youtube.com/watch?v=-VpFL1qa2NY&list=PL7USUpCMQeK-zhYHm_7EPdSIQH0OY_i-W&index=11

Provide free diagnostic facilities and ART to PLHIVs

Section 14- Anti-retroviral Therapy and Opportunistic Infection Management by Central Government and State Government

The Central Government and the State Government shall provide, as far as possible, diagnostic facilities relating to HIV or AIDS, Anti-retroviral Therapy and Opportunistic Infection Management to people living with HIV or AIDS.

Section 15- Welfare measures by Central Government and State Government

The Central Government and the State Government shall take measures to facilitate better access to welfare schemes to persons infected or affected by HIV or AIDS.

Promote safe workplace in healthcare setting to prevent occupational exposure

Section 19- Obligation of establishments to provide safe working environment

Every establishment, engaged in the healthcare services and every such other establishment where there is a significant risk of occupational exposure to HIV, shall, for the purpose of ensuring safe working environment, —

(I) provide, in accordance with the guidelines, —
(a) Universal Precautions to all persons working in such establishment who may be occupationally exposed to HIV; and
(b) training for the use of such Universal Precautions;
(c) Post Exposure Prophylaxis to all persons working in such establishment who may be occupationally
exposed to HIV or AIDS; and
(ii) inform and educate all persons working in the establishment of the availability of Universal Precautions and Post Exposure Prophylaxis

This is applicable on healthcare establishments consisting of twenty or more persons.

Strengthen the system of grievance redressal

The two authorities responsible for addressing grievances relating to violations of the provisions of the Act are the Ombudsman at state level and Complaints Officer at establishment level.

Ombudsman

Section 23- Appointment of Ombudsman

(a) Every State Government shall appoint one more Ombudsman possessing such qualification and experience as may be prescribed or designate any of its officer not below such rank, as may be prescribed, by that Government.

(b) The terms and conditions of the service and jurisdiction of an Ombudsman appointed shall be prescribed by the State Government.

Section 24- Powers of Ombudsman

(a) The Ombudsman shall, upon a complaint made by any person, inquire into the violations of the provisions of this Act, in relation to acts of discrimination mentioned in section 3 and providing of healthcare services by any person, in such manner as may be prescribed by the State Government.

(b) The Ombudsman may require any person to furnish information on such points or matters, as he considers necessary, for inquiring into the matter and any person so required shall be deemed to be legally bound to furnish such information and failure to do so shall be punishable under sections 176 and 177 of the Indian Penal Code.

(c) The Ombudsman shall maintain records in such manner as may be prescribed by the State Government.

Section 25-Procedure of complaint

The complaints may be made to the Ombudsman in such manner as may be prescribed by the State Government.

Section 26-Orders of Ombudsman

The Ombudsman shall, within a period of thirty days of the receipt of the complaint, and after giving an opportunity of being heard to the parties, pass such order, as he deems fit, giving reasons therefor: Provided that in cases of medical emergency of HIV positive persons, the Ombudsman shall pass such order as soon as possible, preferably within twenty-four hours of the receipt of the complaint.

Section 27- Authorities to assist Ombudsman

All authorities including the civil authorities functioning in the area for which the Ombudsman has been appointed under section 23 shall assist in execution of orders passed by the Ombudsman.

Section 28- Report to State Government

The Ombudsman shall, after every six months, report to the State Government, the number and nature of complaints received, the action taken and orders passed in relation to such complaints and such report shall be published on the website of the Ombudsman and a copy thereof be forwarded to the Central Government.

Manner of maintaining records by Ombudsman

(1) The Ombudsman shall -

(a) immediately on receipt of a complaint, record it by assigning a sequential unique complaint number in a register maintained solely for that purpose in physical or computerized form;

(b) On receipt of the complaint, acknowledge it including by sending the unique complaint number by SMS or e-mail to the complainant where available;

(c) Record the time of the complaint and the action taken on the complaint in the register; and

(d) Maintain the register of complaints in a manner that ensures confidentiality of data

(2) The Ombudsman shall comply with data protection measures in accordance with section 11 of the Act.

Manner of making complaints to Ombudsman

(1) Any person may make a complaint to the Ombudsman within whose jurisdiction the alleged violation took place, within (as time mentioned in State specific rules) from the date that the person making the complaint became aware of the alleged violation of the Act.

Provided that the Ombudsman may, for reasons to be recorded in writing, extend the time limit to make the complaint by a further period of (as mentioned in State specific rules), if he is satisfied that circumstances prevented the complainant from making the complaint within the stipulated period.

(2) All complaints shall be made to the Ombudsman in writing in accordance with the form as specified in respective state rules.

Provided that where a complaint cannot be made in writing the Ombudsman shall render all reasonable assistance to the complainant to reduce the complaint in writing.

(3) In cases of medical emergency, the Ombudsman or his assistant may visit the complainant at the location of the alleged violation or any other convenient place to enable written documentation of the complaint.

(4) The Ombudsman may receive complaints made in person, via post, telephonically, or through electronic form through the Ombudsman's website.

Complaints Officer

Section 20- General responsibility of establishments

(a) All establishments consisting of one hundred or more persons, whether as an employee or officer or member or director or trustee or manager, as the case may be:

And in the case of healthcare establishments, consisting of twenty or more persons shall designate Complaints Officer.

These are part of model State rules as required under section 49 of the Act and the Ombudsman should refer to respective state specific rules for detailed information.

(b) Every person, who is in charge of an establishment for the conduct of the activities of such establishment, shall ensure compliance of the provisions of this Act.

Section 21- Grievance redressal mechanism

Every establishment shall designate such person, as it deems fit, as the Complaints Officer who shall dispose of complaints of violations of the provisions of this Act in the establishment, in such manner and within such time as may be prescribed.

Manner of filing complaints with Complaints Officer

1. Any person may make a complaint to the Complaints Officer, within three months from the date that the person making the complaint became aware of the alleged violation of the Act in the establishment:
   Provided that the Complaints Officer may, for reasons to be recorded in writing, extend the time limit to make the complaint by a further period of three months, if he is satisfied that circumstances prevented the complainant from making the complaint within the stipulated period.
2. Every complaint shall be made to the Complaints Officer in writing in the Form set out in the Appendix A i to these rules: Provided that where a complaint cannot be made in writing the Complaints Officer shall render all reasonable assistance to the complainant to reduce the complaint in writing.
3. The Complaints Officer may receive complaints made in person, via post, telephonically, or in electronic form: Provided that the establishment shall within thirty days of HIV/AIDS Module for Complaints Officer Page 35 appointing the Complaints Officer, establish a method for receipt of complaints in electronic form either through dedicated website, webpage or by providing an official email address for the submission of complaints to the Complaints Officer.
4. The Complaints Officer shall, on receipt of a complaint, provide an acknowledgment to the complainant and record the Complaint in a register to be kept solely for that purpose.
5. The register shall record the time of the complaint and the action taken on the complaint.
6. Every complaint shall be numbered sequentially in the register.
7. The Complaints Officer shall act in an objective and independent manner while deciding complaints made under the Act.
8. The Complaints Officer shall decide a complaint promptly and in any case within seven working days: Provided that in cases of emergency or in the case of healthcare establishments where the complaint relates to discrimination in the provision of, or access to health care services or provision of universal precautions, the Complaints Officer shall decide the complaint on the same day on which he receives the complaint.

Decision-Making of Complaints Officer

(a) The Complaints Officer, if satisfied that a violation of the Act has taken place as alleged in the complaint, shall –

i. firstly, direct the establishment to take measures to rectify the violation;

ii. secondly, counsel the person who has committed the violation and require such person to undergo training in relation to HIV and AIDS, provisions of the Act, rules and guidelines, particularly

in relation stigma and discrimination, for a period amounting to one week, and a fixed period of social service, which shall include working with a non-governmental organisation working on HIV and Acquired Immunodeficiency Virus, a protected person's network, or the appropriate authority under the State Government that shall be monitored, and may also require that the person supervising the violator undergo such training.

(b) Upon subsequent violation of the Act by the same person, the Complaints Officer may recommend that the establishment take disciplinary action in accordance with HIV/AIDS Module for Complaints Officer Page 36 the law.

(c) The Complaints Officer shall inform the complainant of the action taken in relation to the complaint and of the complainant's right to approach the Ombudsman or to any other appropriate legal recourse in case the complainant is dissatisfied with the action taken.

(d) On deciding a complaint, the Complaints Officer shall provide brief reasons in writing for the decision to the establishment and the concerned parties to the complaint within a period of ten days from the date of decision.

Reporting by Complaints Officer

(a) The Complaints Officer shall ensure that the complaints, their nature and number and the action taken are reported to the appropriate authority under the Central Government every six months subject to the provisions section 11 of the Act.

(b) The Complaints Officer shall ensure that the complaints, the nature of the complaints, the number of the complaints and the action taken are published on an annual basis or the establishment publishes annual report or on the website of the establishment or in such annual report, subject to section 11 of the Act.

Confidentiality and use of pseudonyms

1. The Complaints Officer shall, if requested by a protected person who is part of any complaint, ensure the protection of the identity of the protected person in the following manner, namely: -

a) the Complaints Officer shall file one copy of the document bearing the full name, identity and identifying details of such protected person which shall be kept in a sealed cover and in safe custody with the Complaints Officer;

b) the Complaints Officer shall provide pseudonyms to protected person involved in complaints before him;

c) the identity of protected person involved in complaints before the Complaints Officer and their identifying details shall be displayed in pseudonym in all documentation and records generated by the Complaints Officer and the establishment in relation to the complaints including in the register of complaints under sub-rule 4 of rule 10; HIV/AIDS Module for Complaints Officer Page 37

d) the identity and identifying details of the protected person involved in a complaint before the Complaints Officer shall not be revealed by any person or their representatives including assistants and staff.

2. No person shall print or publish any matter in relation to a complaint before a Complaint Officer

unless the identity of the protected persons in the complaint is protected.

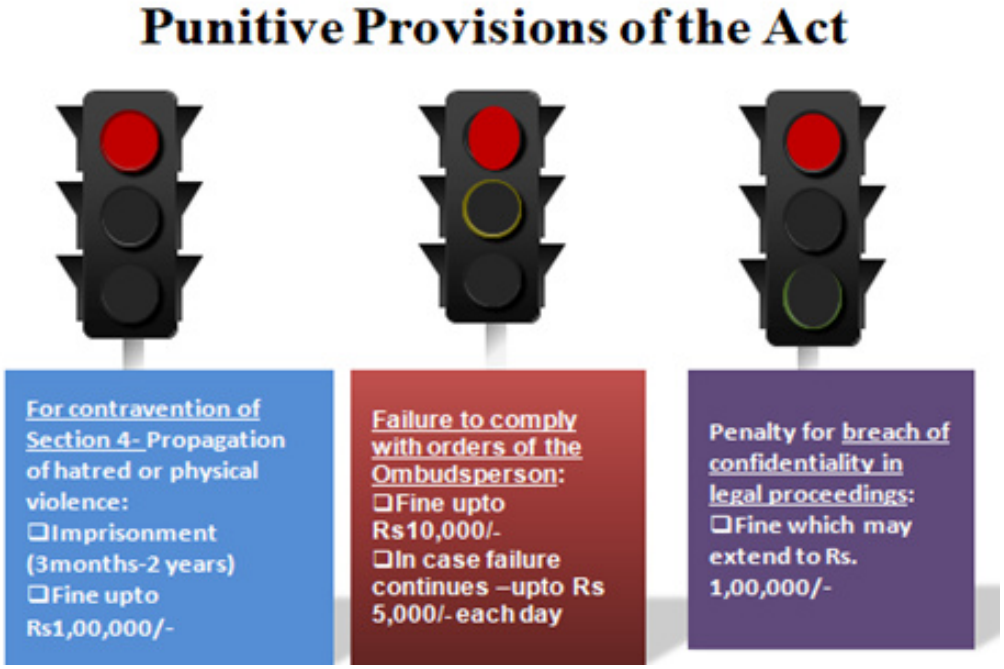
3. The Complaints Officer shall comply with data protection measures in accordance with the provisions of section 11 of the Act.

Movie Links:

https://www.youtube.com/watch?v=l40caytKICQ&list=PL7USUpCMQeK-zhYHm_7EPdSIQH0OY_i-W&index=20

https://www.youtube.com/watch?v=UpH1chjQt0s&list=PL7USUpCMQeK-zhYHm_7EPdSIQH0OY_i-W&index=21

Punitive provisions of the Act



Section 37- Penalty for contravention

Notwithstanding any action that may be taken under any other law for the time being in force, whoever contravenes the provisions of section 4 shall be punished with imprisonment for a term which shall not be less than three months but which may extend to two years and with fine which may extend to one lakh rupees, or with both.

Section 38- Penalty for failure to comply with the orders of Ombudsman

Whoever fails to comply with any order given by an Ombudsman within such time as may be specified in such order, under section 26, shall be liable to pay a fine which may extend to ten thousand rupees and in case the failure continues, with an additional fine which may extend to five thousand rupees for every day during which such failure continues.

Section 39-Penalty for breach of confidentiality in legal proceedings

Notwithstanding any action that may be taken under any law for the time being in force, whoever discloses information regarding the HIV status of a protected person which is obtained by him in the course of, or in relation to, any proceedings before any court, shall be punishable with fine which may extend to one lakh rupees unless such disclosure is pursuant to any order or direction of a court.

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Ministry of Social Justice & Empowerment

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National AIDS Control Organisation
India's response to HIV & Sexually Transmitted Infections
Ministry of Health & Family Welfare, Government of India
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