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

Azadi Ka Amrit Mahotsav

Handbook on Prevention and Management of Stigma and Discrimination Associated with HIV & AIDS

सत्यमेव जयते

आलोक सक्सेना
अपर सचिव एवं महानिदेशक

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AIDS Helpline 1097
जानें समझें, जुग-जुग जीयें!

राष्ट्रीय एड्स नियंत्रण संगठन
स्वास्थ्य और परिवार कल्याण मंत्रालय
भारत सरकार

National AIDS Control Organisation
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FOREWORD

The impact of the HIV epidemic is further fueled due to the prevalence of stigma and discrimination associated with it. HIV-related stigma and discrimination negatively affects people living with HIV in different setting, including the healthcare setting, workplace setting, educational setting and community setting.

One of the quantifiable goals defined under the National AIDS & STD Control Programme (NACP) Phase V is to eliminate HIV- related stigma and discrimination by ensuring that less than 10% PLHIV and key populations experience stigma and discrimination.

In ensuring an effective response to HIV, the National AIDS Control Organisation (NACO) has put together a Handbook which will act as a guide in countering and redressing discriminatory actions faced by people infected with and affected by HIV.

The Handbook will help you to identify what constitutes as an act of discrimination and the ways in which it may manifest. The mitigation strategies presented in the Handbook for the four key settings must be adopted as well. Specifically, for the workplace setting, we have prepared the HIV and AIDS Policy for Establishments which stipulates non-discrimination, confidentiality related to HIV status and HIV-related data and setting up of a grievance redressal mechanism as the guiding principles for establishments.

It is my hope that the readers will be inspired by the approaches highlighted in the Handbook and will bring us one step closer to achieving the public health goals and to overcome the HIV epidemic.

(ALOK SAXENA)

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अपनी एचआईवी अवस्था जानें, निकटतम सरकारी अस्पताल में मुफ्त सलाह व जाँच पाएँ

Know you HIV status, go to the nearest Government Hospital for free Voluntary Counselling and Testing

सत्यमेव जयते
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PREFACE

Stigma and discrimination touch every aspect of our lives - including the family, community, workplace, education and health care settings. We all know that HIV is not merely a health issue. The epidemic is driven by a number of socio-economic factors. Therefore, health interventions alone are not sufficient to address causes and consequences of the epidemic. It requires a multi-faceted and multi-sectoral response in particular to reduce HIV related stigma and discrimination.

The Government of India has enacted the HIV and AIDS (Prevention & Control) Act, 2017 to eliminate HIV-related stigma and discrimination, maintain confidentiality and to establish a grievance redressal mechanism. The Act prohibit specific acts of discrimination by the State or any other person that arise on account of stigma associated with HIV and provides protection against HIV-related stigma & discrimination in various settings including employment, healthcare services, educational services, public facilities, property rights, holding public office and insurance. Besides, the Act also deals with various other related issues such as informed consent, measures by government to provide ART and risk reduction measures, ensuring safe working environment, etc.

NACO has been at the forefront in sensitizing the Ombudsman, Complaints Officer, healthcare professional and the community on issues related to stigma & discrimination and the various provisions under the 'HIV and AIDS (Prevention & Control) Act 2017' and the 'HIV & AIDS Policy for Establishments'.

This handbook presents the specific guideline for prevention and management of stigma and discrimination, in alignment with the Act and its clauses in various settings. It aims to address HIV-related stigma & discrimination faced by HIV infected and affected persons and families.

I congratulate the IEC & Mainstreaming Division at NACO and the support of UNDP for preparing the handbook.

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ACKNOWLEDGEMENT

This handbook provides specific directions for prevention and management of HIV-related stigma and discrimination, in alignment with the provisions of the HIV and AIDS (Prevention & Control) Act, 2017. It is a comprehensive document that covers the four key settings and provides initiatives that must be undertaken to remedy the discriminatory attitudes, practices and institutions etc.

We place on record our sincere gratitude to Shri Alok Saxena, AS & DG, NACO and Ms. Nidhi Kesarwani, Director, NACO for their continuous advice and overall support in the development of this Handbook.

We sincerely thank Dr. Ravi Verma, Regional Director, ICRW and Chairman of the 'Technical Resource Group (TRG) on Stigma Reduction' at NACO and TRG members namely Dr. Samiran Panda (Former Addl. DG, ICMR), Dr. Seema Sahay (Scientist 'G', NARI), Ms. Alka Narang (Former Adviser, UNDP), Dr. Shalini Bharat (Director, TISS), Dr. Venkatesan Chakrapani (Chairperson, C-SHaRP), Ms. Anandi Yuvraj (Consultant), Dr. Beena E Thomas (Former Scientist, NIRT), Mr. Ashok Row Kavi (LGBTQ Rights Activist) for reviewing the Handbook and sharing their inputs as subject experts.

We place on record our gratitude to UNDP and Dr. Chiranjeev Bhattacharjya, NPM, Health & Governance Unit, UNDP for the support in development of the Handbook.

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The contributions of Dr. Shikha Dhawan (Director Programs, SHARE INDIA), Ms. Samridhi Uniyal (Lead Policy, Law and Stigma, SHARE INDIA) and Mr. Karan Prasad (Program Officer-Digital & Innovation, SHARE INDIA) have been valuable in shaping the document.

(Dr. Anoop Kumar Puri)

MESSAGE

HIV-related stigma and discrimination significantly impact the health, lives, and well-being of people living with HIV (PLHIV), and Key Populations like Female Sex Workers (FSW), Men having Sex with Men (MSM), Transgender/Hijra (TG/H) and People who Inject Drugs (PWID).

The world has set itself an ambitious target to end AIDS as a public health threat by 2030. Global solidarity, community resilience, and access to life-saving HIV services have supported millions until now. But with less than a decade to achieve the goal, eliminating all forms of HIV-related stigma and discrimination is critical.

Globally, the Joint UN Programme on HIV/AIDS (UNAIDS) has rolled out a bold new approach to use an inequalities lens to close the gaps preventing progress toward ending AIDS. The End Inequalities. End AIDS. Global AIDS Strategy 2021–2026 aims to reduce inequalities that drive the AIDS epidemic and prioritise people who are not yet accessing life-saving HIV services.

In India, the National AIDS Control Programme (NACP) implemented by the National AIDS Control Organization (NACO) under the Ministry of Health and Family Welfare (MoHFW), the Government of India, has been taking proactive measures to address HIV-related stigma and discrimination. The introduction and implementation of the HIV and AIDS (Prevention and Control) Act 2017 has been a landmark step in this direction. The National AIDS and STD Control Programme Phase V (2021-26) has set a target of ensuring less than 10% of people living with HIV and Key Populations experience stigma and discrimination.

I am happy to present the 'Handbook on Prevention and Management of Stigma and Discrimination associated with HIV and AIDS.' The Handbook provides specific guidance on preventing and managing discrimination and stigma in alignment with the Act. My congratulations to NACO on the development of the Handbook. I am confident it will support policymakers, government departments, and civil society organisations to strengthen programmes and address the vulnerabilities of PLHIV and Key Populations.

As one of the co-sponsors of UNAIDS, UNDP is honoured to support MoHFW and NACO on various aspects of HIV mainstreaming and human rights, including the implementation of the HIV and AIDS (Prevention and Control) Act 2017. We are committed to working with the Government of India to support people living in vulnerable communities to build a better future for themselves and leave no one behind.

Shoko Noda
Resident Representative
UNDP India

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ACRONYMS

AEP	Adolescence Education Programme
AIDS	Acquired Immune Deficiency Syndrome
ANM	Auxiliary Nurse Midwifery
ART	Anti-Retroviral Therapy
AWW	Anganwadi Worker
CABA	Children affected by AIDS
CBO	Community Based Organisation
CHV	Community Health Volunteer
CLHIV	Children Living with HIV
CSC	Care & Support Centre
CSO	Civil Society Organisation
DLSA	District Legal Services Authority
FBO	Faith Based Organisation
DAPCU	District AIDS Prevention & Control Unit
FICTC	Facility Integrated Counselling and Testing Centre
FSW	Female Sex Worker
FOGSI	Federation of Obstetric and Gynaecological Societies of India
GRM	Grievance Redressal Mechanism
HIV	Human Immunodeficiency Virus
HRG	High Risk Group
HSS	HIV Sentinel Surveillance
HST	HIV Self Testing
IAP	Indian Academy of Pediatrics
IBBS	Integrated Biological & Behavioural Surveillance
ICDS	Integrated Child Development Scheme
ICPS	Integrated Child Protection Scheme
ICRW	International Centre for Research on Women
ICTC	Integrated Counselling and Testing Centre

IDA	Indian Dental Association
IDU	Injecting Drug User
IEC	Information, Education and Communication
ILO	International Labour Organization
IMA	Indian Medical Association
INC	Indian Nursing Council
MSM	Men who have Sex with Men
NACO	National AIDS Control Organisation
NACP	National AIDS and STD Control Programme
NCAER	National Council of Applied Economic Research
NFHS	National Family Health Survey
NGO	Non-Governmental Organisation
OI	Opportunistic Infection
PLHIV	People Living with HIV
PLV	Para-legal Volunteer
PRI	Panchayati Raj Institutions
RTI	Reproductive Tract Infection
SDGs	Sustainable Development Goals
SOGIESC	Sexual orientation, gender identities and sexual expressions
STI	Sexually Transmitted Infections
TG	Transgender
ULB	Urban Local Bodies
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme

01

INTRODUCTION

India is committed to 'Ending the AIDS' epidemic as a public health threat by 2030 in line with Sustainable Development Goals (SDG). This ambitious target cannot be achieved without meeting the needs of people living with and affected by HIV, and the determinants of health and vulnerability, being addressed. The people living with HIV often experience stigma and discrimination. HIV-related discrimination is grounded in stigma that attaches to people living with HIV and their families; and often in already stigmatised populations, such as female sex workers, men who have sex with men, transgender people, people who use drugs etc The concerns of these fragile communities must therefore be at the forefront of sustainable development efforts.

The human rights framework in India is governed by the Constitution of India and the Protection of Human Rights Act, 1993. The Constitution of India through its Articles 14, 15 and 16 guarantees the right to equality and provides against discrimination and equality of opportunity in matters of employment. The Article 21 provides for protection of life and personal liberty. HIV-related stigma and discrimination are violations of human rights and undermine public health efforts to tackle HIV and AIDS. The journey is encountered by many challenges and HIV-related stigma is considered one of the foremost barriers to effective responses to the HIV and AIDS epidemic.

A research by International Centre for Research on Women (ICRW), a non-profit organisation outlines the possible consequences of HIV-related stigma as: loss of income and livelihood, loss of marriage and childbearing options, poor care within the health sector, withdrawal of caregiving in the home, loss of hope and feelings of worthlessness, loss of reputation. The human rights approach would prove to be a long-term investment for HIV epidemic treatment and prevention. There is a need to bring an understanding between the rights of the individual, who is at risk of exposure and condemnation because of stigma, and the rights of the rest of the society for the effective development of large scale effective public health programme.

Fear of these consequences keep people away from seeking HIV information, adopting preventive behaviour, getting tested, disclosing their sero-status and accessing treatment. As a result, stigma and discrimination compromise AIDS responses and drive the spread of HIV.

Therefore, it is imperative that the various settings addressed in the Handbook – health, work, community, education, and media – will respect and recognize the special needs and sensitivities of the people from the high risk groups.

This Handbook recognizes the international framework actively promoted by UNAIDS and ILO known as SOGIESC (sexual orientation, gender identities and sexual expressions). While high risk group population namely female sex workers, men who have sex with men, transgender people, people who use drugs are at the dreadful end of experiencing stigma and discrimination in general, the level of their miseries is elevated further if they get infected with HIV.

1.1 AN OVERVIEW OF NATIONAL AIDS CONTROL PROGRAMME AND INTERVENTIONS TO ADDRESS HIV-RELATED STIGMA AND DISCRIMINATION

In 1992, the Government of India launched its comprehensive programme for prevention and control of HIV and AIDS in India. The first National AIDS Control Programme (NACP I -1992-1999) was implemented with an objective of slowing down the spread of HIV infections so as to reduce morbidity, mortality and impact of AIDS in the country.

In November 1999, the second phase of National AIDS Control Project (NACP II - 1999-2006) was launched with two key objectives of NACP II: (i) to reduce the spread of HIV infection in India; and (ii) to increase India's capacity to respond to HIV and AIDS on a long-term basis.

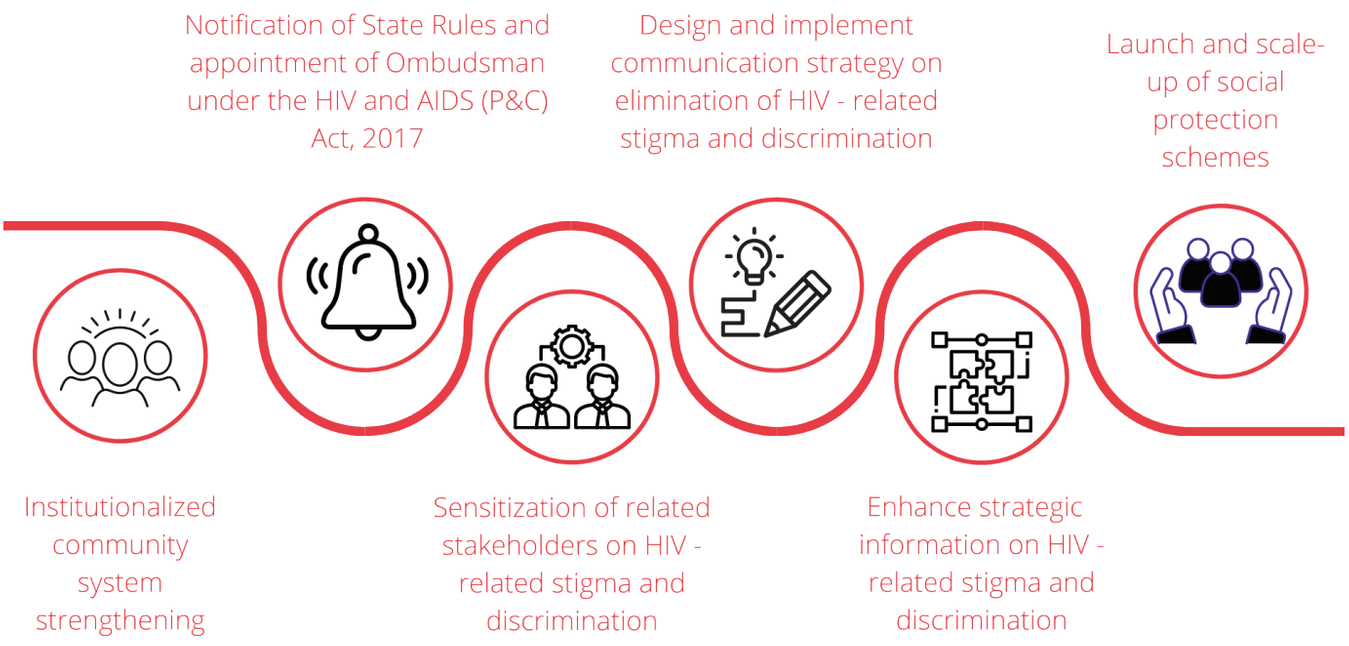
The third phase of the national programme (NACP III - 2007-2012) was launched in July 2007 with the goal of halting and reversing the epidemic by the end of project period by scaling up prevention efforts among the High-Risk Groups (HRGs) and General Population and integrating them with care, support and treatment services. In addition to above, District AIDS Prevention and Control Unit (DAPCUs) were also established in high priority districts to undertake cross-cutting management and coordinate with all the HIV facilities in the district and report on stigma and discrimination issues in their respective districts.

The NACP- Phase IV (2012-17) was launched with the goal to accelerate reversal and integrate response. Other objectives were to reduce new infections by 50% (2007 Baseline of NACP III) and to provide comprehensive care and support to all persons living with HIV and AIDS and treatment services for all those who require it.

The NACP-Phase IV was extended from 2017-2021 to achieve the goal of "Ending AIDS by 2030". The initiatives during the phase included enactment of the HIV and AIDS (Prevention and Control) Act, 2017, Mission Sampark and launch of 'Test and Treat' policy.

The NACP Phase V (2021-2026) was launched with the aim to reduce annual new infections and AIDS-related mortalities by 80%, eliminate vertical transmission of HIV and syphilis, promote universal access to Quality STI/RTI services and eliminate HIV/AIDS-related stigma and discrimination. One of the specific objectives of the NACP Phase-V is that less than 10% of people living with HIV and key populations experience stigma and discrimination.

The strategies to eliminate HIV-related stigma & discrimination are as follows:



1.2 THE HUMAN IMMUNODEFICIENCY VIRUS AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (PREVENTION AND CONTROL) ACT, 2017

The Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 came into force from 10th September 2018. This Act is a progressive legislation safeguarding human rights, legal rights and reinforcing constitutional rights for PLHIV. The law addresses discrimination against people infected and affected with HIV and AIDS, including within employment, healthcare, education, accessing public places or using any other service or facility.

It envisages an enabling environment at workplace, education setting, healthcare setting, community setting. for the protected person. The Act also prohibits discrimination and provides for various rights like right to hold elections, right to reside, purchase property and right to movement. There are punitive provisions for people who spread hatred against the protected person.

Protected person as defined under section 2 (s) of the HIV and AIDS (P&C) Act, 2017

Protected person means a person who is—

HIV-Positive; or

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

ordinarily lived, resided or cohabited with a person who was HIV- positive.

Discrimination as defined under section 2 (d) of the HIV and AIDS (P&C) Act, 2017

Means any act or omission which directly or indirectly, expressly or by effect, immediately or over a period
of time, —

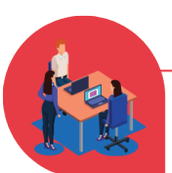
imposes any burden, obligation, liability, disability or disadvantage on any person or category of persons, based on one or more HIV-related grounds; or

denies or withholds any benefit, opportunity or advantage from any person or category of persons, based on one or more HIV-related grounds, and the expression "discriminate" to be construed accordingly.

The Act prohibits discrimination under following circumstances:

Discrimination at public places (sub-section (e) of section 3)

The protected person cannot be discriminated at public places like shops, public restaurants, hotels and places of public entertainment, use of wells, tanks, bathing ghats, roads, burial grounds or funeral ceremonies and places of public resort

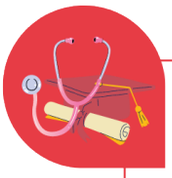


Discrimination at workplace (sub-section (b) of section 3)

The protected person cannot be discriminated in terms of denial of, or termination from, employment or occupation

Pre-requisite for obtaining employment (sub-section (l) of section 3)

Prohibition of HIV testing as a pre-requisite for obtaining employment



Discrimination at healthcare and education settings (sub-section (c)&(d) of section 3)

The protected person cannot be discriminated in terms of denial, discontinuation or unfair treatment in educational settings

Discrimination at holding public and private offices (sub-section (h) of section 3)

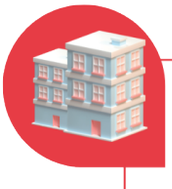
Prohibition of denial, discontinuation or unfair treatment in the opportunity to stand for or hold public or private offices

Under Custody (Section 31)

Prohibition of denial of access to or unfair treatment in Government or private establishment in whose care or custody a person may be

Right to Movement (sub-section (f) of section 3)

Assures right to movement which is a fundamental right entrusted under Article 19 of part- III of the constitution. There is prohibition of denial, discontinuation or unfair treatment



Right to residence (Section 29)

Every protected person has been entitled right to reside in the shared household. Shared household includes a household where a person lives or at any stage has lived in a domestic relationship either singly or along with another person, could be owned or tenanted

Segregation (sub-section (k) of section 3)

Prohibition of segregation of people affected and infected with HIV is prohibited

1.3 CO-RELATED PROVISIONS UNDER THE HIV AND AIDS (P&C) ACT, 2017 INCLUDE

With the HIV and AIDS (P&C) Act, 2017 prohibiting acts of discrimination against protected persons, it also safeguards their basic human rights of consent, privacy and confidentiality in order to create an enabling environment for testing and treatment.

Disclosure of status (Section 8&9):

Any HIV positive person cannot be forced to disclose her/his/others status or any other HIV related information except by an order of the court that the disclosure of such information is necessary in the interest of justice.

Informed Consent (Section 5&6):

The Act mandates informed consent (see box below) as a pre-requisite for HIV test. Informed consent also includes pre and post-test counselling.

Confidentiality of data related to HIV (Section 11):

The Act outlines the obligation of establishments in protection of data related to HIV and AIDS.

Informed consent as defined under section 2 (n) of the HIV and AIDS (P&C) Act, 2017

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 maybe.

Protection of Healthcare Providers

Universal Precautions for establishments susceptible to exposure of HIV (Section 19):

The Act provides that 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 provide for 'Universal Precautions' and capacity building for its use. It also provides for provisioning of 'Post Exposure Prophylaxis' to all persons working in such establishment.

Protection of vulnerable population

Protection for children (Section 16 and 32):

The Act provides for protection of property of children affected by HIV. It makes a provision for parents or guardians of such children to approach the Child Welfare Committee for the safe keeping and deposit of documents related to the property rights of such child. The Act also recognizes guardianship of a person below the age of eighteen but not below twelve years who has sufficient maturity of understanding to act as guardian of other sibling below the age of eighteen years.

Protection of people in custody of State (Section 31):

Every person who is in the care or custody of the State has been provided the right to HIV prevention, counselling, testing and treatment services. It covers those who are convicted of a crime and serving a sentence, awaiting trial and even those detained under preventive detention laws.

Strategies for risk reduction (Section 22):

The Act has provision for adoption of risk reduction strategies and also protects them from civil or criminal liability. Strategies may include, use of safer sex tools including condoms, drug substitution and drug maintenance, comprehensive injection safety requirements etc.

Under Section 12 of the HIV and AIDS (Prevention and Control) Act, 2017, the Central Government has also notified the HIV and AIDS Policy for Establishments, 2022 which mandates to generate awareness on HIV and AIDS in establishments, prevent transmission of HIV infection amongst workers, protect rights of those infected with and affected by HIV and AIDS, ensure safe, non-stigmatised and non-discriminatory working environment and maintaining the confidentiality of HIV-related data for protected persons.

1.4
PURPOSE OF THIS HANDBOOK

This handbook is meant for Government departments, the Private sector, Non-Governmental Organizations (NGOs), Civil Society Organizations (CSOs), Advocacy groups, and the Community Based Organizations (CBOs) to provide an understanding of prevention and management of stigma and discrimination associated with HIV and AIDS. The document attempts to provide stigma and discrimination mitigation strategies in different settings such as in the workplace, health care, educational and community settings and the role of media and FBOs in addressing HIV-related stigma and discrimination. It also provides the key provisions of the HIV and AIDS (Prevention and Control) Act, 2017 and the grievance redressal mechanism.

1. Focus on elimination of stigma and discrimination against people affected by HIV

2. Reduce stigma and discrimination among health service providers, educational institutions, family, community and society through attitude changing education that enhances care and support for people living with HIV and AIDS

3. Create a workplace environment that encourages prevention, treatment and care, promotes voluntary counselling and testing and is supportive to all workers irrespective of their HIV and AIDS status

4. Engage the media and media personnel and all forms of communication in raising awareness and promoting action to challenge HIV and AIDS related stigma and discrimination

5. Provisioning a robust Grievance Redressal Mechanism to be established at every facility level and TIs for speedy redressal of grievances and timely reporting at the State and National Level

1.5
FOR WHOM IS THIS HANDBOOK INTENDED?

The handbook provides information to the users (an employer, employee/workers and the people infected and affected by HIV/AIDS) on the rights and various strategies for prevention and management of stigma and discrimination associated with HIV and AIDS.

1.6
STRUCTURE OF THE HANDBOOK

To begin with the specific chapters, the first chapter presents the various interventions for HIV prevention, care and treatment under the National AIDS and STD Control Programme and its efforts in addressing the issues of stigma and discrimination. It also discusses the different provisions of the HIV and AIDS (P&C) Act, 2017.

The second chapter presents a brief introduction to HIV-related stigma and discrimination and provides an over-arching analysis of structural issues of stigma. It further introduces the four key settings where HIV-related stigma and discrimination may manifest.

The third chapter mentions in details the efforts of mitigating the stigma and discrimination at these various settings.

The fourth chapter provides details about the grievance redressal mechanism authorities- State Ombudsman and Complaints Officer under the HIV and AIDS (Prevention and Control) Act, 2017.

The last chapter presents the monitoring and evaluation framework for implementing the handbook. It details out the monitoring tools, reporting structures and various data collection measures of HIV-related stigma and discrimination.

02

HIV-RELATED STIGMA AND DISCRIMINATION- WHAT IS IT?

2.1 DEFINING STIGMA AND DISCRIMINATION

Stigma refers to negative beliefs, feelings and attitudes[5] towards people living with, or seen to be linked to HIV. Stigma also promote social exclusion. Stigma is a socially debilitating label that makes the stigmatized person or group feel secluded from mainstream society. (Goffman, 2009)

Stigma often lies at the root of discriminatory actions denying the right to healthcare, work, education, and freedom of movement, among others. It is expressed in stigmatising language and behaviour, such as shunning and avoiding everyday contact, verbal harassment as well as physical violence.

Stigma may also be internalised by stigmatised individuals in the form of feelings of shame, self-blame and worthlessness. On a personal level, stigma may mean loneliness, abandonment, ostracism, violence, starvation and death. Internalized stigma or self-stigma occurs when a person living with HIV agrees with the negative attitudes associated with HIV and accepts them as applicable to themselves.

Other stigma experiences are perceived stigma, which refers to perceptions about how stigmatized groups are treated in a given context, and 'Anticipated stigma', which refers to expectations of bias being perpetrated by others if their health condition becomes known (Evidence for eliminating HIV-related stigma and discrimination. (UNAIDS, 2020).

'Courtesy stigma', also referred to as 'stigma by association', involves public disapproval evoked as a consequence of associating with a stigmatised individual or group for e.g., stigma experienced by family members, healthcare and other service providers (Rachel Phillips, et.al.,)

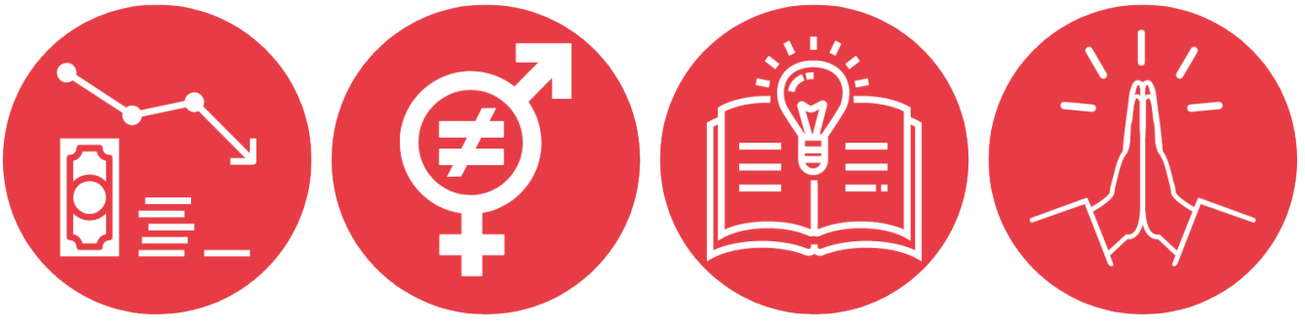
Discrimination refers to the unfair and unjust treatment of someone based on their real or perceived HIV status. It is blaming and showing negative emotions onto a certain group/ population, attributing them or their morals to be the cause of their illness (Gilmore & Somerville, 1994).

It adversely affects family and friends, and those who care for people with HIV. Discrimination is often fuelled by myths of casual transmission of HIV and pre-existing biases against certain groups, certain sexual behaviours, drug use, and fear of illness and death.

'Covert discrimination' is defined as discriminatory behavior that can be justified by the context as neutral or even moral behavior (Lennartz C, Proost K, Brebels L. 2019)

2.2 WHAT ARE THE CAUSES FOR HIV-RELATED STIGMA AND DISCRIMINATION?

The National AIDS Control Programme over the years have made efforts in understanding and responding to HIV related stigma and discrimination. Various studies have indicated that the structural causes of stigma and discrimination are as follows:



01
ECONOMIC INEQUALITY

HIV-related stigma negatively impacts the health and well-being of people living with HIV, with deleterious effects on their care, treatment and quality of life. Lack of employment, shelter, food security and the burden of HIV treatment and at times forced migration for living increases vulnerability and drastically reduces self-esteem resulting in increased self-stigma

02
GENDER INEQUALITY

Stigma is at its peak among the MSM and TG population. Women account for a growing proportion of people living with HIV and experience higher levels of poverty and encounter greater barriers to accessing services because of multiple work and child-care burdens, restricted mobility, and economic dependence upon men. The traditional patriarchal societies put women at higher risk of HIV infection. The social hierarchy and the differential power relations that exist, blame women for bringing the infection in the family, especially seen when the woman has been tested for HIV before the husband, as happens in several antenatal clinics. Women have greatest risk because of husband's behaviour ranging from 1 per cent in general population of antenatal cases to 14 per cent in monogamous women attending STD clinics. Gender norms combined with taboos about sexuality have a huge impact on the ability of adolescent girls and young women to protect their health and prevent HIV, seek health services and make their own informed decisions about their sexual and reproductive health and lives.

03
LACK OF KNOWLEDGE

The greatest fear is that of transmission which arises out of myths and misconception and it is worsened in societies where health literacy is poor. Only one in three young people globally can demonstrate accurate knowledge about HIV prevention and transmission. Knowledge about HIV prevention among young people has remained stagnant over the past 20 years. The National Family Health Survey (NFHS-5) indicates that 21.6% women and 30.7% men have comprehensive knowledge of HIV and AIDS.

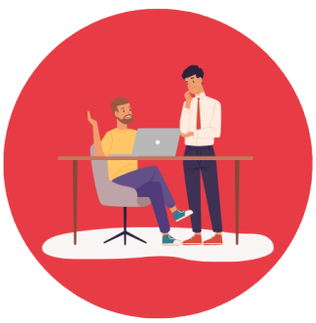
04
SOCIAL AND CULTURAL NORMS

The socio-cultural norms prevailing in the society considers sex as a taboo. As the predominant route of HIV transmission in India is through the sexual route, society has a tendency to appraise the person negatively with HIV. The social stratification in the form of gender, caste and class further accentuate stigma against the infected communities. Certain religious beliefs that condemn homosexuality and substance abuse contribute to or strengthen sources of HIV stigma.

2.3 WHAT IS HIV-RELATED STIGMA AND DISCRIMINATION AT INSTITUTIONAL SETTINGS?

HIV-related stigma and discrimination manifests itself in many ways. PLHIV in India, often face stigma and discrimination in a variety of situations. Both individual and institutional factors contribute to HIV-related stigma. Therefore, self-stigma, or internalised stigma, is also deemed as an equally damaging form of stigma that affects the mental wellbeing of people living with HIV or other key populations.

Healthcare Settings



Workplace Settings

Educational Settings

Household Settings

The battle against reduction of HIV-related stigma and discrimination remains weak when it is viewed, understood and addressed only through one particular form. It should include multi-dimensional approach with bio-psycho and social aspects making a path for resilience and empathy in the communities, thus addressing stigma. It is imperative that in order to end stigma and discrimination, it demands a comprehensive effort to mitigate it.

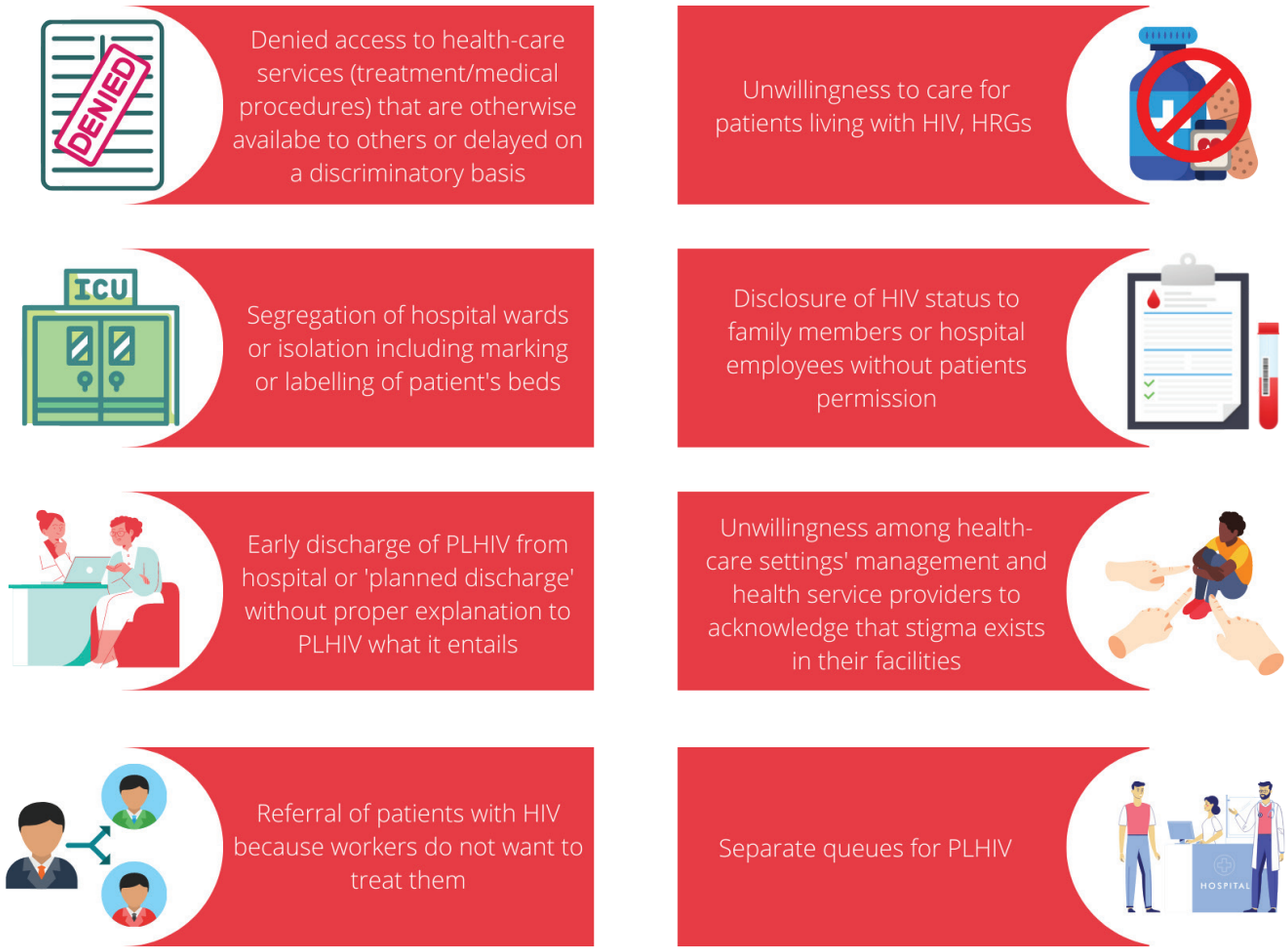
Stigma and discrimination touch every aspect of our lives - including the family, community, workplace, education and health care settings. Where efforts are being undertaken to build capacities of the personnel in these various settings to address stigma and discrimination issues, care should be taken to use the UNAIDS Terminology Guidelines which could serve as a good tool for stigma free language in these trainings. Language shapes beliefs and may influence behaviours hence use of appropriate language has the power to strengthen the appropriate response to the HIV epidemic. There have been numerous studies conducted to understand the effects and impact of HIV-related stigma in various institutional settings. Additionally, it is known that manifestations of stigma take many forms, including isolation, ridicule, physical and verbal abuse, and denial of services and employment. Experiences of stigma can differ by sex, reflecting broader gender inequalities, etc.

Some of the various settings where HIV-related stigma negatively impacts the persons regardless of their HIV status, sexual orientation, gender identity, or other key population characteristics are:

Healthcare Setting

Stigma and discrimination experienced within the health sector represents one of the most inimical forms of institutional stigma. HIV-related stigma hampers the people's access to, or quality of, healthcare. Discrimination in health-care settings is one of the major obstacles to ending the AIDS epidemic as a public health threat by 2030. This seriously undermines the ability to reach people with HIV testing, treatment and prevention services. The lack of training and educational programmes to inform health workers of the needs, health issues and strategies and interventions for HRGs and PLHIV contributes to marginalization. It leaves providers ill-equipped to address health needs and perpetuates stigmatizing and discriminating practices, even to the point of refusing services.

HIV-related stigma and acts of discrimination against people living with HIV include the following:



Workplace Setting

The workplace setting is a very important environment where issues of stigma and discrimination are detrimental to the majority of those infected as they are in their prime productive period. People living with HIV have higher unemployment rates and face lack of access to work which increases the vulnerability of people living with HIV and affected communities. Confidentiality of HIV status, including loss of confidentiality as a result of mandatory testing, remains a central workplace issue.

HIV-related stigma and acts of discrimination against people living with HIV include the following:

Conducting pre-employment HIV testing

Denial of recruitment, promotion and staff development opportunities

Unwillingness to provide reasonable accommodation to HIV positive persons by employer

Disclosure of HIV status to employees and staff without seeking consent PLHIV

Wrongful termination of protected persons

Difference in employment compensation and other terms and conditions of employment

Stigma against Workers in formal and informal settings

Workplace settings comprise all settings in which workers work, including formal (traditional wage employment) and informal (e.g., street vending, sex work, house cleaning) economies. The formal economy includes employment in both the private and public sectors. People living with HIV are three times as likely to be unemployed as people in the general population.

Evidence for eliminating HIV-related stigma and discrimination, UNAIDS 2020

Educational settings

Stigma and discrimination in education settings can have a profound impact on school retention, self-image and self-stigma, and can exacerbate vulnerability to HIV. Gender non-conforming and non-binary young people are particularly vulnerable to violence and bullying at school. Children and young people living with HIV may drop out of school or be excluded altogether. The stigmatized person becomes laden with intense disabling feelings of anguish, shame, dejection, self-doubt, guilt, self-blame and inferiority. They may perform poorly and leave school with little gained. Teachers living with HIV are also subject to stigma and discrimination in education settings.

HIV-related stigma and acts of discrimination against people living with HIV include the following:

Denial of admission or expulsion on the basis of HIV status of a student

·Name-calling and labelling or physical abuse of HIV positive students

Denial of promotion or staff development activities

Isolation in seating arrangements

Rejection/exclusion during learning activities, denying resources etc

Exclusion from physical/sports activities

Children and Teachers excluded from formal educational settings

It is important that educational institutions address the specific needs of populations "being left behind"—including but not limited to people living with HIV, key populations, indigenous populations, people in prisons and other incarcerated people, migrants, and women and girls, particularly adolescent girls and young women—alongside protecting their rights to confidentiality, freedom from stigma and discrimination, and equal treatment.

It is recommended to use contact strategies in educational settings (e.g., inviting people living with HIV to present at schools or teacher training sessions) to raise awareness about stigma and its harmful effects and to reduce negative attitudes towards populations "being left behind" from educational settings. (UNAIDS, 2020)

Household setting: Communities and Families

PLHIV often face a double burden, stigmatising attitudes and behaviours from family and community members too. Within their own families and communities, people living with and affected by HIV, face internalized stigma and isolation as a result of judgment and rejection. It is often observed that in household and community settings, HIV-related stigma and discrimination can also manifest through subtle gestures, such as refusing to share food or utensils with people living with HIV, as well as more overt actions, such as rejecting or shunning a person living with HIV. Stigma or anticipation of stigma may cause affected people to conceal their condition from family and community and hence they may withdraw themselves from taking part in any social activities.

HIV-related stigma and acts of discrimination against people living with HIV include the following:

Disclosure of HIV status to family members

Forced to move out from the shared household or any accommodation

Minimizing contact with PLHIV within the household by family members

Abandonment, mental and physical violence

Social isolation, ridicule, gossip by neighbors, family friends etc. about HIV status

Physical and social isolation of the family by neighbors or community members

03

MITIGATING STIGMA AND DISCRIMINATION AT VARIOUS SETTINGS

3.1
MITIGATING HIV-RELATED STIGMA AND DISCRIMINATION AT HEALTH-CARE SETTINGS

Stigma towards people living with or at risk of HIV drives acts of discrimination in healthcare settings. A stigma-free health facility is one in which PLHIV, and other key populations are treated with respect and compassion and are provided with high-quality care. Improving access to health-care services by reducing HIV-related stigma and discrimination is both possible and essential to achieving the targets of eliminating stigma and discrimination by 2024.

A variety of interventions to address the issue of stigma and discrimination at healthcare settings include - sensitization of all healthcare workers on the HIV and AIDS (Prevention and Control) Act, 2017, providing equal access to quality health services for all, ensuring respect, confidentiality of PLHIV and HRGs, building capacities of healthcare workers, putting in place grievance redressal mechanisms and continuous monitoring and evaluation of all these activities.

The following table provides details of proposed steps and key activities for reduction in HIV-related stigma and discrimination at various healthcare settings.

TABLE 1: STEPS FOR REDUCTION IN HIV-RELATED STIGMA AND DISCRIMINATION AT HEALTHCARE SETTINGS

PROPOSED STEPS	KEY ACTIVITIES
Sensitisation of all healthcare workers on India's HIV and AIDS (Prevention and Control) Act, 2017 to foster a supportive environment within the healthcare system.	Ensure all key personnel of healthcare facility are trained on salient points of the India's HIV and AIDS (Prevention and Control) Act, 2017
	Assist healthcare facility to implement the HIV and AIDS Policy for Establishments, 2022 which specifies respectful and equal care and treatment for all patients, regardless of HIV status, sexual orientation, gender identity, or other key population characteristics within a stigma free environment.
	Designate Complaints Officer (for healthcare settings having more than 20 people). Train the Complaints Officer on her/his service conditions and aide in speedy disposal of cases.
	Ensure facility has procedures that promote a stigma-free facility, and these are actively communicated to all staff members and, as appropriate, posted in all departments and patient waiting areas.

Equal access to quality health services for all	Staff or a committee are assigned to monitor adherence to HIV stigma-related policies and procedures on equal access to all patients, quality of care to PLHIV and HRGs and patient's confidentiality and privacy is maintained.
	Ensure HIV test results are provided without delay or necessary referrals for services available within the facility.
	PLHIV patients are integrated with other patients unless there is a medical basis for isolation.
Healthcare providers respect confidentiality and demonstrate good communication skills	All HIV tests are voluntary and accompanied by informed consent.
	Information about HIV status is communicated only to the patient and treating healthcare workers, and otherwise is kept strictly confidential. It is not disclosed to a patient's family except with the explicit informed consent of the patient and fulfilment of four pre-requisites as mentioned under the HIV and AIDS (Prevention and Control) Act, 2017.
	Beds, wards, staff, and files are not labelled in ways that would convey HIV status to other patients or staff.

TABLE 1: STEPS FOR REDUCTION IN HIV-RELATED STIGMA AND DISCRIMINATION AT HEALTHCARE SETTINGS

PROPOSED STEPS	KEY ACTIVITIES
Training health workers to overcome personal and institutional discriminatory attitudes and actions to provide stigma free services	Contact strategies, such as testimonials of PLHIV and activities that encourage interaction between health care workers, PLHIV and HRGs. This will help the healthcare staff to see the effects of stigma and discrimination on PLHIV, families, children and communities and its impact on the lives of those stigmatised and discriminated.
	All staff are trained in patients' rights and the right of PLHIV and patients regardless of their HIV status, sexual orientation, gender identity, or other key population characteristics to equal care.
	Continuous capacity building initiatives for healthcare providers to ensure they have sufficient capacities and competencies to provide services free from stigma and discrimination.
	Training of healthcare workers on the use of Universal Precautions and Post Exposure Prophylaxis who may be occupationally exposed to HIV or AIDS.
	Training healthcare workers in private sector involving professional bodies like IMA, FOGSI, IAP, INC, IDA, etc. on stigma free language based on the UNAIDS Terminology guidelines.

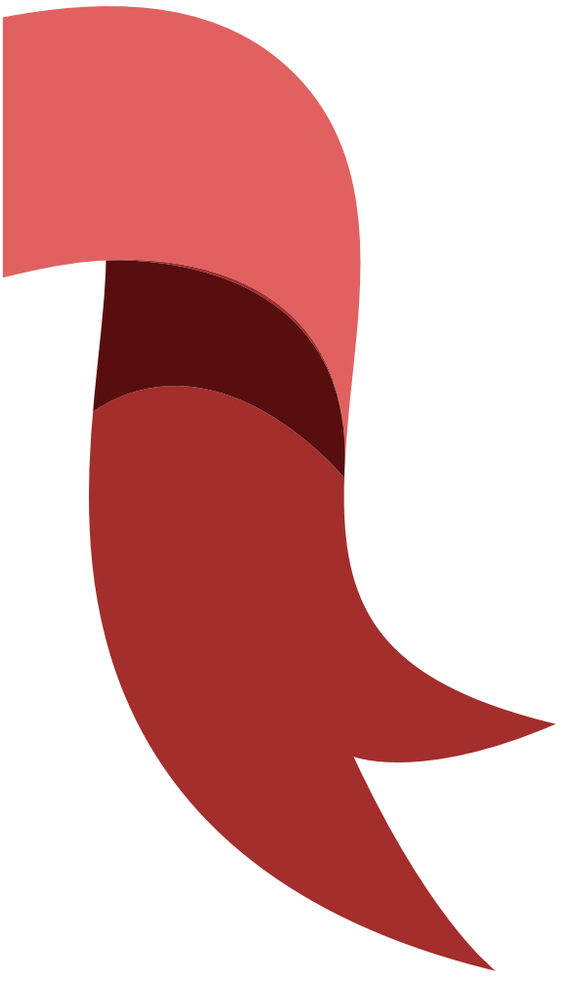
Grievance redressal mechanism is in place in all healthcare settings	An accessible patient grievance redressal cell/ Complaints Officer which registers and addresses patient complaints, is in place and open daily.
	The existence of the above grievance redressal mechanism is posted in each ward and all patient waiting areas.
	The facility monitors periodically and provides effective resolution of client complaints.
	Facility has clear guidance and timelines for responding to patient complaints related to stigma and discrimination.
	Facility to report to SACS the number and nature of complaints received, the action taken, and orders passed in relation to such complaints.
	Facility may develop an IT based system for the reporting of the complaints and accordingly State may have a centralized IT system with log in facilities for all concerned officials to view, take appropriate actions and finally for reporting.

TABLE 1: STEPS FOR REDUCTION IN HIV-RELATED STIGMA AND DISCRIMINATION AT HEALTHCARE SETTINGS	
PROPOSED STEPS	**KEY ACTIVITIES**
Monitoring and evaluation of stigma and discrimination reduction efforts in healthcare settings	Develop monitoring tools to measure PLHIV and HRGs who experienced stigma at healthcare settings.
	The monitoring tools to measure healthcare staff on their knowledge, attitudes and practices towards PLHIV and HRGs.
	The tool should help address healthcare staff expressing fear of contracting HIV from non-invasive contact with people living with HIV and AIDS, healthcare staff refusing contact with a person living with HIV.

Communication campaigns including social media and mid-media campaigns to reduce stigma and discrimination	Communication strategies that employ sympathetic narratives, or stories that humanize the experiences and struggles of PLHIV and HRGs can influence public support to help them seek better healthcare.
	Innovative messages and prototypes focused on non-discriminatory practices towards institutions or individual healthcare providers who are involved in treating PLHIV or HRGs.
	Mass-media campaigns relating to HIV-related stigma its knowledge, attitudes and behaviours to be broadcast (radio, television, etc) targeting varied audiences.
	Develop mid-media campaigns including hoardings, posters, pamphlets, dramas, social media, websites etc. aimed to disseminate messages about HIV / AIDS could potentially reduce HIV-related stigma
	Develop communication campaign aiming to build content. about – togetherness, empathy and care. The campaigns should actively move away from using terms such as 'them & us' but should have 'infected and affected' together. This helps preventing polarisation.

3.2
MITIGATING HIV-RELATED STIGMA AND DISCRIMINATION AT WORKPLACE SETTINGS

In order to mitigate the issue of stigma and discrimination at workplaces, it is imperative to understand that HIV and AIDS should be recognized and treated as a workplace issue. These organizations should be included in the national response in addressing the HIV related stigma with full participation of employers and workers. There should be no discrimination against or stigmatization of workers, in particular jobseekers and job applicants, on the grounds of real or perceived HIV status, gender or sexual orientation whether or not they belong to a vulnerable group and perceived to be at greater risk of or more vulnerable to HIV infection.



Some of the measures to mitigate HIV-related stigma and discrimination in workplace settings should include:

Sensitization of key personnel of workplaces settings on the HIV and AIDS (Prevention and Control) Act, 2017. The workplace settings to have a Complaints Officer (in case of hundred or more people while in case of healthcare setting for 20 or more people). Workplace settings to report to SACS the number and nature of complaints received, the action taken, and orders passed in relation to such complaints.

Establish a central apex body and monitor system to capture stigma, discrimination and rights violations experienced by people living with HIV and key populations in workplace settings for support and redress.

Implementation of the HIV and AIDS Policy for Establishments, 2022 and also Ministry of Labour and Employment's National Policy on HIV and AIDS and world of work.

Development of workplace health and safety policy to ensure a safer work environment which includes occupational health services for the entire workforce so that access to HIV prevention, treatment, care and support can be attained by the organization.

Integrated training programme inclusive of workers' rights and stigma reduction, into existing training programmes to be developed.

TABLE NO.2: STEPS FOR REDUCTION IN HIV-RELATED STIGMA AND DISCRIMINATION AT WORKPLACE SETTINGS	
PROPOSED STEPS	**KEY ACTIVITIES**
Sensitization of key personnel of workplaces settings on the HIV and AIDS (Prevention and Control) Act, 2017 (every establishment with hundred or more staff are mandated to ensure safe working environment)	Develop monitoring tools to measure PLHIV and HRGs who experienced stigma at healthcare settings.
	Ensure that staff at workplace settings have the knowledge and tools to effectively reduce HIV stigma and discrimination.
	Incorporate stigma principles into the organisation's HIV workplace policies and inclusive gender practices as a starting point for integration.
Develop workplace health and safety policy to ensure a safer work environment.	Ensure occupational health services for the entire workforce so that access to HIV prevention, treatment, care and support can be attained by the organization.
	Ensure regular, free, voluntary, and confidential HIV counselling and testing, including addressing sexual orientation, gender identities and sexual expressions and reproductive health issues in the families of health workers in a non-stigmatizing, gender-sensitive, confidential, and convenient.
	The facility to undertake appropriate steps to create an enabling environment to discourage stigma and discrimination towards persons regardless of their HIV status, sexual orientation, gender identity, or other key population and those infected and affected by HIV and AIDS in workplace settings.

TABLE NO.2: STEPS FOR REDUCTION IN HIV-RELATED STIGMA AND DISCRIMINATION AT WORKPLACE SETTINGS	
PROPOSED STEPS	**KEY ACTIVITIES**
Develop training programmes for all key decision makers on workers' rights and stigma reduction, integrating these into existing training programmes and including PLHIV and HRG representatives.	Sensitize members of board, management, HR and trade unions/ associations to develop policy regarding grievance redressal mechanism against HIV-related stigma and discrimination and a designated Complaints Officer to be responsible grievance redressal mechanism to be in place.
	Organise stigma and discrimination-reduction workshops for all key decision makers of the workplace settings and ensure that workshops include people living with HIV.
	Share information on HIV stigma and discrimination with staff and emphasise the public health benefits of reducing HIV stigma and discrimination.
	Training curriculum to promote the involvement and empowerment of all workers regardless of their HIV status, sexual orientation, gender identity, or other key population and whether or not they belong to a vulnerable group.

TABLE NO.2: STEPS FOR REDUCTION IN HIV-RELATED STIGMA AND DISCRIMINATION AT WORKPLACE SETTINGS	
PROPOSED STEPS	**KEY ACTIVITIES**
Grievance redressal mechanism is in place in workplace settings	Strengthen and mainstream activities with industry and business confederations on greater involvement of HRGs and PLHIV and various approaches to address issues of stigma and discrimination.
	Set up an internal committee on HIV and AIDS, drawing officers from different departments to work PLHIV and HRG in planning, developing and implementation of the non-discriminatory workplace policies that ensure continued employment and benefits to PLHIV.
	The existence of the grievance redressal cell is posted at all strategic locations in the organization.
	The organization designates officials to continuously monitor and provide effective resolution of complaints to address the issues of stigma and reduction.
	Facility has clear guidance and timelines for responding to complaints as received by the grievance cell.
	Facility may develop an IT based system for the reporting of the complaints and accordingly State may have a centralized IT system with log in facilities for all concerned officials to view, take appropriate actions and finally for reporting.

TABLE NO.2: STEPS FOR REDUCTION IN HIV-RELATED STIGMA AND DISCRIMINATION AT WORKPLACE SETTINGS	
PROPOSED STEPS	**KEY ACTIVITIES**
Monitoring and evaluation of stigma and discrimination reduction efforts in workplace settings	Develop tools for monitoring and evaluation of stigma and discrimination reduction efforts in workplace settings.
	The monitoring indicators to include actions undertaken by the organization to prevent and prohibit violence and harassment of PLHIV and their family members associated with the organization.
	The monitoring indicators to include protection of sexual and reproductive health and sexual and reproductive rights of persons of all sexual orientations.
	Monitor the effective confidentiality of personal data, including medical data of all members of the organization.

3.3 MITIGATING HIV-RELATED STIGMA AND DISCRIMINATION AT EDUCATIONAL SETTINGS

Educational institutions should provide access to HIV and AIDS education programmes especially relating to stigma and discrimination and its ill-effects on both boys and girls. Education also gives HIV infected and affected children a better understanding to equip themselves with life skills to cope with the challenges brought about by both the HIV infection and also the ill-effects of stigma and discrimination. Educational institutions can play a vital role in limiting the HIV related stigma and also the spread and effects of the HIV infection. There should be no discrimination against students with respect to the normal health benefits accessed and enjoyed by other students in these educational settings.

Some of the child centred approaches / strategies that address HIV-related stigma and discrimination at educational settings are:

Capacity building of students and teachers regarding HIV and AIDS to be regularised. The training should also include comprehensive SOGIESC (sexual orientation, gender identities and sexual expressions) as per the international framework of UNAIDS with accurate knowledge about HIV transmission and emphasis on the importance of equal rights for people living with HIV.

Implementation the AEPs in right spirit and also form and strengthen the Red Ribbon Clubs (RRC) to play a crucial role in educational institutions and create awareness on stigma and discriminatory practices with children (CABA).

Impart Psychosocial Counselling Support including life skill education with psycho-social counselling techniques including the physical, emotional, social, mental and spiritual needs of an individual, all of which are considered to be essential elements for students coping with HIV related stigma and discrimination. These counselling sessions must impart healthy living information (on nutrition, positive living, and sexual behaviour).

Ensure that no employee, student, or parent on behalf of the student, is compelled to disclose HIV status to authorities at the education institution or service and all health records of students and employees of educational institution to be kept confidential. A special consideration can be made in terms of sickness. Considering the individual's case, the school may provide necessary support but in no way should limit their participation in any activity or extend differential treatment which warrants unwanted attention.

Establishment of grievance redressal mechanism as per the HIV and AIDS (Prevention and Control) Act, 2017. The institutions should train the Complaints Officer on her/his service conditions and aide in speedy disposal of cases. All investigations should be child friendly and should involve the guardian/parent.

Regular reporting to SACS, the number and nature of complaints received, the action taken, and orders passed in relation to such complaints

Opportunities at staff meetings, Parent-Teacher Association meetings, institutional assemblies or other meetings as appropriate to discuss steps taken to mitigate HIV related stigma.

TABLE NO.3: STEPS FOR REDUCTION IN STIGMA AND DISCRIMINATION AT EDUCATION SETTINGS	
PROPOSED STEPS	**KEY ACTIVITIES**
Building the capacities of large number of students and teachers regarding HIV and AIDS especially with HIV-related stigma and discrimination information	Quality comprehensive sexuality education in lines with UNAIDS framework on SOGIESC (sexual orientation, gender identities and sexual expressions) provides young people with accurate knowledge about sexuality education, HIV transmission and emphasizes the importance of equal rights for sexual minorities and people living with HIV.
	Impart quality comprehensive sexuality education to young people and teachers with accurate knowledge about HIV transmission and emphasize the importance of equal rights for sexual minorities and people living with HIV.
	Develop training curriculum to include the culture of silence on HIV and AIDS stigma and sexual orientation, gender identities and sexual expressions among children, teachers and their families and ways to address the same.
	Enable families to develop coping strategies on the SOGIESC and HIV related stigma and discrimination among children including legal issues and strategies to continue the children's education.
	Form and strengthen the Red Ribbon Clubs can play a crucial role in educational institutions to create awareness on stigma and discriminatory practices with children (either CLHIV or CABA).
	Develop teacher-oriented training curriculum to impart quality education and coping mechanisms to children facing questions pertaining to sexual minorities and HIV infection and its related stigma.

TABLE NO.2: STEPS FOR REDUCTION IN STIGMA AND DISCRIMINATION AT EDUCATION SETTINGS	
PROPOSED STEPS	**KEY ACTIVITIES**
Develop and impart Psychosocial Counselling Support including life skill education	Psycho-social counselling techniques including the physical, emotional, social, mental and spiritual needs of an individual, all of which are considered to be essential elements for students coping with HIV related stigma and discrimination.
	Education institutions should set up programmes of care and support to CLHIVs that guarantee access to treatment.
	Impart healthy living information (on nutrition, positive living, and sexual behaviour), including life skills education where relevant, and consider teacher and student assistance programmes in educational settings.
Develop HIV related policy and programme focusing on gender equality and HIV related stigma	Assist educational institution to develop the gender equality policy highlighting the facts that women and girls are often more adversely affected by the epidemic and more vulnerable due to unequal gender relations.
	Ensure sexual harassment and HIV-related stigma cases in the educational setting should be duly reported and addressed as per the gender sensitive HIV related policy of the institution.
	Testing for HIV should not be carried out at the education institution either for students who wish to enrol or teachers for employment and no person to be discriminated based on their HIV related illnesses.
	No employee, student, or parent on behalf of the student, is compelled to disclose HIV status to authorities at the education institution or service and all health records of students and employees of educational institution to be kept confidential.

TABLE NO.3: STEPS FOR REDUCTION IN STIGMA AND DISCRIMINATION AT EDUCATION SETTINGS	
PROPOSED STEPS	**KEY ACTIVITIES**
Establish grievance redressal mechanism in educational institutions as per the HIV and AIDS (Prevention and Control) Act, 2017	Ensure grievance redressal committee as per the Act is composed at all educational institutions with representatives from the management, teachers, other employees, parents, HIV and AIDS specialist (NGO or Doctor etc.)
	The grievance redressal policy is to be kept on display in the institution and made available to all employees, parents and students for reading.
	The education institution should appoint and provide training for an HIV and AIDS representative on managing and addressing the grievances as received. Any investigation initiated should be child friendly and should involve the guardian/parent.
	The management should provide opportunities at staff meetings, Parent-Teacher Association meetings, institutional assemblies or other meetings as appropriate to discuss steps taken to mitigate HIV related stigma.
	Ensure implementation of "zero stigma and discrimination policy" against children infected and affected by HIV in the schools.

TABLE NO.3: STEPS FOR REDUCTION IN STIGMA AND DISCRIMINATION AT EDUCATION SETTINGS	
PROPOSED STEPS	**KEY ACTIVITIES**
Develop appropriate communication messages to address the issue of HIV related stigma and discrimination in educational settings	All forms of communication - for example, posters, circulars to employees, staff meetings, notices of governing bodies, student body meetings and institution - should be used to disseminate its HIV and anti-stigma efforts.
	Mass-media campaigns to be broadcast (radio, television, etc) focusing on child specific issues relating to HIV-related stigma.
	Develop mid-media campaigns including hoardings, posters, pamphlets, dramas, social media, websites etc aimed to disseminate messages ill-effects of HIV-related stigma on children especially girl child.
Monitoring and evaluation of stigma and discrimination reduction efforts in educational settings	Monitor the number of children and young people living with HIV if there are any reports of drop out of school or be excluded altogether because of stigma and discrimination.
	Study the effects of HIV related stigma on CLHIV and other staff of educational institution.
	The monitoring indicators to include gender-based violence and other forms of violence as it has profound impact on school retention and can exacerbate vulnerability to HIV.
	Develop tools for monitoring and evaluation of stigma and discrimination reduction efforts in educational settings like schools, colleges and universities.
	Facility may develop an IT based system for the reporting of the complaints and accordingly State may have a centralized IT system with log in facilities for all concerned officials to view, take appropriate actions and finally for reporting.

3.4 MITIGATING HIV-RELATED STIGMA AND DISCRIMINATION AT HOUSEHOLD SETTING: COMMUNITIES AND FAMILIES

HIV-related stigma and discrimination has profound effects on the family system. It acts as a powerful barrier to access healthcare as it inhibits HIV testing and disclosure of HIV status. In addition, it poses a serious problem to PLHIV and their immediate family members as judgement and constant scrutiny from relatives, community members and other social institutions can be one of the worst personal struggles that they have to deal with.

The HIV status often puts the spouses, children and family of the infected person exposed to stigmatisation often compromising the family support particularly required at these initial stages for the PLHIV to cope with. The family members are forced to limit their social interactions with relatives, friends and community members to look after the HIV patient at home. PLHIV conceal their HIV status often risking their health conditions and also accessing treatment services. Children become the unwarranted targets of neglect as adult caregivers are forced to give much time and attention to the PLHIV. Families also face financial difficulties adversely affecting their economic situations often incurring debts owing the expenses of treatment, travel and food.

Some of the community centred approaches that address HIV-related stigma and discrimination at community / family settings are:

Increase awareness among families and communities on prevention, treatment and care, support for PLHIV through participatory training of family members of PLHIV, community leaders, influential persons, ASHA/AWW, faith-based leaders, etc. on HIV related information especially focusing on ill-effects of stigma and discrimination. Sensitize members on key areas to discuss gender inequality, violence against PLHIV especially children and women and Rights of the PLHIV.

Appropriate steps to sensitize PLHIV on HIV-related stigma and discrimination and ways to address them by strengthening and building capacity of PLHIV / stigmatised individuals and groups, e.g., through "know your rights" campaigns, skills-building, legal services, network building, counselling, training, income generation, etc.

The community should be mobilized for PLHIV support groups for social, legal and human rights, economic support and action for campaigning and advocacy against stigma and discrimination.

'Advocates for change' campaign among community organizations like SHGs, ICDS/ICPS and women PRIs/ ULBs etc. This should include training of ICDS/ICPS/ SHGs programme and women PRI/ULB/RWAs members to disseminate information about HIV prevention and reduce stigma and discrimination for women and children living with HIV. Greater involvement of community leaders is vital to the acceptance, success and sustainability of the activities that meet the needs of people living with HIV and their families. Extension of social protection to people infected and affected by HIV and AIDS and their family members through existing schemes.

Sensitizing and engaging the media in efforts to mitigate HIV related stigma and discrimination towards PLHIV and HRGs at family and community level. Media platform to be used to propagate correct and accurate information about modes of HIV transmission, prevention, treatment and care and challenging stigma and discrimination. Sensitizing and engaging the media and mass communications to address issues of HIV related stigma and reduction (e.g., compassionate messages from influential persons, political leaders, engaging celebrities for "edutainment"). Use of social media, folk media and mass media of Internet, TV and Radio to broadcast messages on Rights of PLHIV and educating people against stigma and discrimination.

TABLE NO.4: STEPS FOR REDUCTION IN STIGMA AND DISCRIMINATION AT FAMILY / COMMUNITY SETTINGS

PROPOSED STEPS	KEY ACTIVITIES
Increase awareness among families and communities on prevention, treatment and care, support for PLHIV	Participatory training of family members of PLHIV, community leaders, influential persons, ASHA/AWW, faith-based leaders, etc. on HIV related information especially focusing on ill-effects of stigma and discrimination.
	Trainings to include PLHIV and Organizations associated with HIV for interactions with key stakeholders at family/ community to dispel myths and fears about HIV infection.
	Sensitize members on key areas to discuss gender inequality, violence against PLHIV especially children and women and rights of the PLHIV.
Sensitize PLHIV on HIV-related stigma and discrimination and ways to address them	Strengthening and building capacity of HRG, PLHIV/ stigmatised individuals and groups, e.g., through "know your rights" campaigns, skills-building, legal services, network building, counselling, training, income generation, etc.
	Collectivization and social mobilization strategies for PLHIV and HRG support groups for social, legal and human rights, economic support and action for campaigning and advocacy against stigma and discrimination.

TABLE NO.4: STEPS FOR REDUCTION IN STIGMA AND DISCRIMINATION AT FAMILY / COMMUNITY SETTINGS	
PROPOSED STEPS	**KEY ACTIVITIES**
'Advocates for change' campaign among community organizations like SHGs, ICDS / ICPS and women PRIs etc.	Include SOGIESC and HIV and AIDS in the training of ICDS/ICPS/SHGs programme and women PRI members to disseminate information about HIV prevention and reduce stigma and discrimination for HRG, women and CLHIV.
	Involving community leaders is vital to the acceptance, success and sustainability of the activities that meet the needs of HRG, PLHIV and their families.
	Extend social protection to people infected and affected by HIV and AIDS and their family members through existing schemes.
Sensitizing and engaging the media in efforts to mitigate HIV related stigma and discrimination towards PLHIV and HRGs at family and community level	Media platform to be used to propagate correct and accurate information about modes of HIV transmission, prevention, treatment and care and challenging stigma and discrimination.
	Use of social media, folk media and mass media of Internet, TV and Radio to broadcast messages on rights of PLHIV and educating people against stigma and discrimination.
	Sensitizing and engaging the media and mass communications to address issues of SOGIESC, HIV related stigma and reduction (e.g., compassionate messages from influential persons, political leaders, engaging celebrities for "edutainment").

TABLE NO.4: STEPS FOR REDUCTION IN STIGMA AND DISCRIMINATION AT FAMILY / COMMUNITY SETTINGS	
PROPOSED STEPS	**KEY ACTIVITIES**
Monitoring and evaluation of stigma and discrimination reduction efforts in community settings	Develop 'Stigma Index of SOGIESC and PLHIV' through wide consultations with various key stakeholders working with persons regardless of HIV status, sexual orientation, gender identity, or other key population characteristics in terms of the harmful impact that stigma and discrimination are having on the HIV response and the need to address the same.
	The community-led monitoring to monitor the PLHIV and HRGs experiencing HIV related stigma and rights violations.
	Include relevant questions on stigma and discrimination in various regular monitoring tools and also the evaluation studies conducted by NACO.
	Develop an IT based system for the reporting of the complaints.

3.5 ROLE OF FAITH-BASED ORGANIZATIONS IN ADDRESSING HIV-RELATED STIGMA AND DISCRIMINATION

Individual's health and person's religiosity are intricately connected throughout history. An estimated 84% of the world's population is religiously affiliated. The strong influence of religion on individual's health is recognized in various cultures across the country. The influence behind faith-based organizations (FBO) is not difficult to discern.

In many developing countries, FBOs not only provide spiritual guidance to their followers; they are often the primary providers for a variety of local health and social services. In fact, faith-based groups have provided care, education, and health and social support long before present development agendas were advanced. Situated within communities and building on relationships of trust, these organizations have the ability to influence the attitudes and behaviours of their fellow community members.

It is also important to note that spirituality and religion are important to many persons regardless of their HIV status, sexual orientation, gender identity, or other key population characteristics. It helps people to cope with stressors, especially those emerging from stigma and discrimination. While many faith-based organizations tend to advocate abstinence and sometimes find themselves in unpleasant situations to promote condoms, continuous advocacy, capacity building have helped them the spiritual interventions utilizing the power of prayer and meditation and addressing struggle of HRG and PLHIV with stigma and discrimination.

Today, many faith-based community interventions have focused on stigma and have helped improve the individual outcomes through access to spiritual and social support for HRG and PLHIV to implement an effective and sustainable programme of care and treatment. The religious organizations have strengths, credibility and are grounded in communities. This places them the opportunity to make a real difference in combating HIV related stigma. To respond to this challenge, the faith-based organizations must be transformed in the face of the HIV related stigma and discrimination crisis, in order that they may become a force for transformation — bringing healing, hope, and accompaniment to all affected by HIV and AIDS.

3.5.1 MITIGATING HIV-RELATED STIGMA AND DISCRIMINATION THROUGH FAITH-BASED ORGANISATIONS

HIV and AIDS and the stigma that fuels its spread is one of the most serious challenges. It requires courage, commitment and leadership at all levels, especially among religious leaders who can use the trust and authority they have in their communities to change the course of the pandemic. For the religious leaders who are adept at speaking about HIV and AIDS it is sometimes fraught with sensitivities. Some people find the subject difficult to talk about at all, hence, it is imperative that the NGOs/CBOs play proactive role to make the religious leaders aware of the most appropriate language and importantly to avoid insults, hurt, disempowerment or stigmatization.

Reducing HIV-related stigma and discrimination at religious settings will act in two ways: provide spiritual solace to the persons regardless of their HIV status, sexual orientation, gender identity, or other key population characteristics and provide capacity and confidence to the religious leadership to influence the large community in extending care and support to them and their family members.

A variety of interventions to address the issue of stigma and discrimination through faith-based organisations include - sensitization of all religious heads on the HIV and AIDS (Prevention and Control) Act, 2017, ensuring they provide equal access for all, ensuring respect, confidentiality of PLHIV and family members, helping the religious institutions develop innovative strategies to use their influence and infrastructure for care and support and continuous monitoring and evaluation of all these activities.

The following table provides details of proposed steps and key activities for reduction in stigma and discrimination through faith-based organisations.

TABLE NO.5: STEPS FOR REDUCTION IN STIGMA AND DISCRIMINATION THROUGH FAITH-BASED ORGANISATIONS

PROPOSED STEPS	KEY ACTIVITIES
Sensitisation of all faith-based leaders on India's HIV and AIDS (Prevention and Control) Act, 2017 to foster a supportive environment within the religious system.	Ensure all key leaders and staff of faith-based facility are trained on salient points of the India's HIV and AIDS (Prevention and Control) Act, 2017.
	Faith-based institutions to promote the HIV and AIDS Policy for Establishment, 2022 which specifies respectful and equal care and treatment, regardless of HIV status, sexual orientation, gender identity, or other key population characteristics within a stigma free environment.
Faith-based organisation to include stigma related issues in their religious discourses and encourage compassion and hope among PLHIV	The FBO leaders can include topics such as prevention, counselling, leadership, care and support and help normalize the topics surrounding sexual orientation and HIV and AIDS.
	Through such initiatives which are delicately crafted should help break silence around the topic and help end ignorance of the masses. They can offer compassion, hope and reconciliation.
	The FBOs can also organize special events for supporting the HRG, PLHIV and their family members, offer their good offices to encourage community (especially women and children who are key influencers) to mitigate fears of contracting by involving them in their religious institutions.

TABLE NO.5: STEPS FOR REDUCTION IN STIGMA AND DISCRIMINATION THROUGH FAITH-BASED ORGANISATIONS	
PROPOSED STEPS	**KEY ACTIVITIES**
Communication campaigns including social media and mid-media campaigns to reduce stigma and discrimination	Communication strategies that employ religious, sympathetic narratives, or stories that humanize the experiences and struggles of persons regardless of HIV status, sexual orientation, gender identity, or HRGs can influence public support to help them.
	Innovative messages and prototypes focused on non-discriminatory practices towards institutions or individual who are involved in treating PLHIV or HRGs.
	Speaking at Mass-media campaigns relating to HIV-related stigma its knowledge, attitudes and behaviours to be broadcast (radio, television, etc) targeting varied audiences.

3.6 ROLE OF MEDIA IN ADDRESSING HIV-RELATED STIGMA AND DISCRIMINATION

The role of the media and entertainment industry in tackling HIV related stigma is crucial. Public health messages can reach large or hard-to-access audiences through these popular media formats. They are key drivers of HIV reduction, yet the media and entertainment are far from reaching its full potential. There are numerous models of media intervention: TV and radio drama; sponsored TV or radio talk shows; journalism training; the creation of journalist networks; public service announcements (PSAs); feeding storylines into existing dramas; multi-platform approaches; reactive campaigns, and comedy.

Training of journalists has had a notable impact. Enabling journalists to hear the personal testimony of persons regardless of their HIV status, sexual orientation, gender identity, or other key population characteristics gives them a powerful insight into the human story. TV news reporting has emerged to be an important driver of public opinion; they influence decision makers and set the agenda for other media coverage. Television and radio drama can be used to be effective at engaging audiences and making them more sympathetic towards PLHIV and HRGs and the issue of stigma faced by them. TV soaps and drama attempts to engage the audience with a storyline, which works on a deeper, more emotional level than factual content.

CHALLENGES OF ENGAGING MEDIA:

The challenges with regular media are observed that while there is apparent lack of appetite for HIV related content in the media, there is evidence that the media is a cost-effective way of tackling HIV. UNAIDS in 2011 released an investment framework for reducing HIV which mentioned that mass media in concentrated epidemics helps in 'normalising treatment acceptance, encouraging adherence and notifying treatment advances.' In generalised epidemics mass media 'enables promotion of safer behaviour by challenging the norms, values and culture that fuel risky behaviour.'

HIV and its related stigma are no longer the crisis and hence there is fatigue with the subject. Also, there is a perception in many societies that HIV is something that other people catch. This provides a very challenging environment in which to engage people with the issue of HIV related stigma because they feel they have heard it all before. Therefore, it is imperative that innovative methods such as personal testimony of people living with HIV provides a powerful insight into the human story.

Language is an issue which is considered important because it can easily reinforce HIV related stigma and cultural norms. Training needs ought to include sensitisation of stakeholders in media to the type of language they use. Too much sensational coverage of people living with HIV especially in various media platforms can be detrimental.

3.6.1
MITIGATING STIGMA THROUGH MEDIA:

The media have a pivotal role to play in the fight against sexual orientation, gender identity and HIV epidemic. It is often said that education is the best weapon against HIV. It is observed that many local and international media organizations are rising to the challenge by promoting discourse on sexual orientation and gender identity. They also play crucial role in creating awareness on sexual orientation, gender identity and HIV and AIDS by educating listeners and viewers about the needs and interests of HRGs and PLHIV. Media sources such as television do play a critical role in disseminating and improving the AIDS-related knowledge. A study conducted in 2015 indicated that radio and newspapers in India have lower impact in educating individuals on AIDS prevention and transmission modes because of possibly low literacy rates in India. In 2019, there were an estimated 762 million TV viewers recorded per week. The numbers only indicate the powerful media and the wide reach which can be used to disseminate HIV associated stigma and its adverse effects on PLHIV and HRGs. Thus, development of media sources such as television in rural areas and change in the conservative attitude of political leaders could possibly result in easy access to accurate AIDS information among all Indians through television, radio, and newspapers.

It is imperative that media houses recognize stigma as one of the key impediments to the community members in seeking HIV testing and care services. Therefore, they have an important role in positively responding to the needs of stigmatized populations. The HIV programme should facilitate to use the media to show that HIV and AIDS has a human face by greater involvement of the PLHIV and HRGs.

The following table provides details of proposed steps and key activities for reduction in stigma and discrimination with media settings.

TABLE NO.6: STEPS FOR REDUCTION IN STIGMA AND DISCRIMINATION THROUGH MEDIA	
PROPOSED STEPS	**KEY ACTIVITIES**
Sensitisation of all media house leaders / owners on India's HIV and AIDS (Prevention and Control) Act, 2017 to foster a supportive environment within the media settings.	Ensure all key leaders and staff of media facility are trained on salient points of the India's HIV and AIDS (Prevention and Control) Act, 2017.
	Media facilities to implement the HIV and AIDS Policy for Establishments, 2022 which specifies respectful and equal care and treatment for all PLHIV and HRGs regardless of HIV status, sexual orientation, gender identity, or other key population. Create shorter formats for social media to disseminate widely amongst their contacts.
	Designate Complaints Officer and provide training on her/ his service conditions and aide in speedy disposal of cases.
	Ensure facility has procedures that promote a stigma-free facility, and these are actively communicated to all staff members in the media houses.
Media personnel to respect confidentiality and demonstrate good communication skills	Language is considered important as it can easily reinforce stigma and cultural norms related to sexual minorities and HIV. All media personnel to ensure that confidentiality of PLHIV and HRGs is respected.
	Engaging public in discourse around sexual orientation, HIV and its related stigma issues should aim at making audiences more sympathetic towards HRGs, sexual minorities and people living with HIV.

TABLE NO.6: STEPS FOR REDUCTION IN STIGMA AND DISCRIMINATION THROUGH MEDIA	
PROPOSED STEPS	**KEY ACTIVITIES**
Training media workers to positively report how PLHIV and HRGs fought the issues of stigma and discrimination	Capacity building of media personnel to identify and report positive cases highlighting the challenges of PLHIV and HRGs battling stigma and discrimination.
	Continuous capacity building initiatives for media leadership and senior journalists / opinion makers to ensure they have sufficient capacities and competencies to report on HIV-related stigma and discrimination cases.
	Powerful testimonies and activities that encourage interaction between community and PLHIV and HRGs. The same to be made for social media platforms too.
Grievance redressal mechanism is in place in all media settings	An accessible grievance redressal cell/Complaints Officer which registers and addresses complaints of PLHIV and HRG on stigma and discrimination faced by negative reports in media.
	The existence of the above grievance redressal mechanism to be widely circulated among all divisions / departments of media houses and through social media channels.
	The media facility monitors periodically and provides effective resolution of client complaints. Grievances on social media platform to be tracked and resolution provided.
	Media facilities of newspaper, TV, Radio and others have clear guidance and timelines for responding to complaints related to stigma and discrimination.
	All complaints to be reported to SACS the number and nature of complaints received, the action taken, and orders passed in relation to such complaints.
	Develop an IT based system for the reporting of the complaints.

TABLE NO.6: STEPS FOR REDUCTION IN STIGMA AND DISCRIMINATION THROUGH MEDIA	
PROPOSED STEPS	**KEY ACTIVITIES**
Communication campaigns including social media and mid-media campaigns to reduce stigma and discrimination	Communication strategies that employ sympathetic narratives, or stories that humanize the experiences and struggles of PLHIV and HRGs can influence public support to help them seek better healthcare
	Social media toolkit to be developed containing graphics, sample hashtags, sample social media posts, and other resources used to help promote the social media channels.
	Mass-media campaigns relating to HIV-related stigma its knowledge, attitudes and behaviours to be broadcast (radio, television, etc) targeting varied audiences.
	Develop mid-media campaigns including hoardings, posters, pamphlets, dramas, social media, websites etc aimed to disseminate messages about HIV / AIDS could potentially reduce HIV-related stigma.

3.6.2 ROLE OF SOCIAL MEDIA IN ADDRESSING STIGMA AND DISCRIMINATION

The social media platforms including mobile technologies and social networking sites which are being used increasingly as part of human immunodeficiency virus (HIV) prevention and treatment efforts by various organizations. Social media provides users with the opportunity to generate, share, and receive information which may transcend geographic borders and provide an opportunity for anonymity. Although stigma and cultural context may prevent PLHIV and at-risk populations from accessing in-person HIV prevention and treatment initiatives, social media can offer a neutral platform for engagement. The increased social support provided by social media has been shown to improve treatment adherence and access to HIV testing and prevention services and assist with coping with HIV-related stigma. Social media use among key populations affected by the HIV epidemic, including men who have sex with men (MSM) demonstrate that these groups use social media to form social ties, access health information and emotional support, and build a sense of community with peers.

As social media has expanded globally, the social media platforms have been adopted to deliver HIV interventions, especially for key populations by various agencies. These platforms can enable convenient access, at any time and place, to information and services on stigmatized diseases such as HIV. In addition, social media if effectively used, can help to form online communities to seek social support, which is known to improve treatment adherence and uptake of HIV services.

The most common disadvantages to using social media to communicate about HIV prevention and treatment that studies reported were related to technology barriers, costs, and lack of physical interaction and its limitations in the amount of support health professionals can offer online.

04

GRIEVANCE REDRESSAL MECHANISM

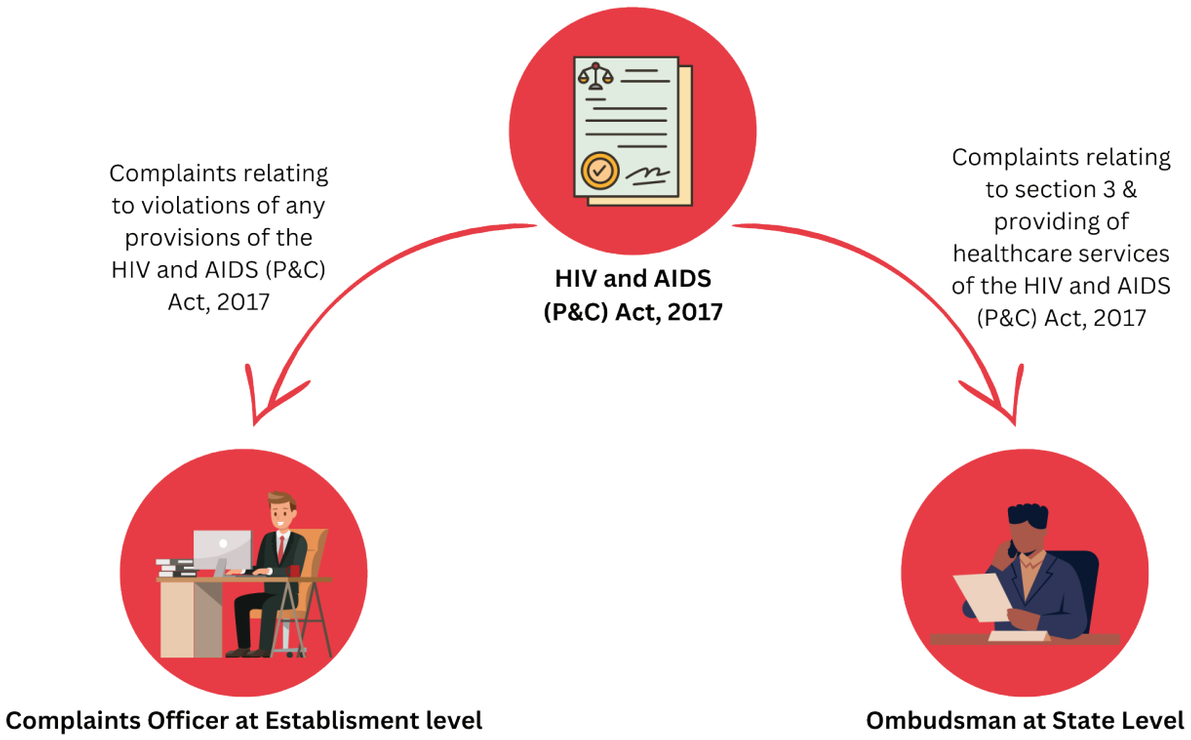
4.1 WHO CAN REGISTER THE COMPLAINT?

The Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 is a landmark legislation to provide a conducive environment to people infected with and affected by HIV and AIDS. The Act aims to address stigma and discrimination so that people infected with and affected by HIV and AIDS are not discriminated in healthcare setting, workplace setting, educational setting and community setting. Their right to insurance, movement, holding public and private office, residence etc. should be maintained as per the prevailing laws and policies. The Act also reinstates constitutional, statutory and human rights of people infected with and affected by HIV and AIDS. It also provides for a robust grievance redressal mechanism in form of Complaints Officer at establishments and Ombudsman at state level.

Any person may approach and register the complaint in case of a violation under the HIV and AIDS (Prevention & Control) Act, 2017.

4.2 TO WHOM CAN THE COMPLAINT BE REGISTERED?

Any person may approach and register the complaint in case of a violation under the HIV and AIDS (Prevention & Control) Act, 2017.



4.2.1
STATE OMBUDSMAN

State Governments have to appoint or designate Ombudsman and specify their service conditions, jurisdiction, manner of inquiry, manner of maintaining records and filing complaints in State specific rules.

Any complaints relating to violations of the provisions of this Act, in relation to acts of discrimination mentioned under section 3 and providing of healthcare services by any person can be registered with the State Ombudsman.

4.2.2
COMPLAINTS OFFICER

Establishments consisting of one hundred or more persons (whether an employee or officer or member or director or trustee or manager as the case may be) shall designate Complaints Officer. Similarly healthcare establishments with twenty or more persons shall designate Complaints Officer.

Any complaints relating to violations of the provisions of the HIV and AIDS (P&C) Act, 2017 in the establishments shall be registered with the designated Complaints Officer in the establishment.

4.3 MANNER OF REGISTERING THE COMPLAINT

4.3.1 MANNER OF REGISTERING THE COMPLAINT TO STATE OMBUDSMAN:

(1) Any person may make a complaint to the State 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 State 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 State Ombudsman in writing in accordance with the form set out in Annexure 1 as specified in respective state rules. Provided that where a complaint cannot be made in writing the State Ombudsman shall render all reasonable assistance to the complainant to reduce the complaint in writing.

(3) In cases of medical emergency, the State 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 State Ombudsman may receive complaints made in person, via post, telephonically, or through electronic form through the State Ombudsman's website.

4.3.2 MANNER OF REGISTERING THE COMPLAINT TO THE COMPLAINTS OFFICER

01

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.

02

Every complaint shall be made to the Complaints Officer in writing in the Form set out in Annexure 2:

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.

03

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 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.

4.4 DECISION MAKING POWER OF STATE OMBUDSMAN AND COMPLAINTS OFFICER

4.4.1 DECISION MAKING POWER OF STATE OMBUDSMAN

The State 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.

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

Procedure of complaint (Section 25): The Act provides that complaints may be made to the State Ombudsman in such manner as may be prescribed by the respective State Government.

Authorities to assist State Ombudsman (Section 27): The Act provides that all authorities including the civil authorities functioning in the area for which the State Ombudsman has been appointed under section 23 shall assist in execution of orders passed by the State Ombudsman.

4.4.2
DECISION MAKING POWER OF COMPLAINTS OFFICER

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.

(iii) Upon subsequent violation of the Act by the same person, the Complaints Officer may recommend that the establishment take disciplinary action in accordance with the law.

(iv) 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 State Ombudsman or to any other appropriate legal recourse in case the complainant is dissatisfied with the action taken.

(v) 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.

4.5 REPORTING OF STATE OMBUDSMAN AND COMPLAINTS OFFICER

4.5.1 REPORTING OF STATE OMBUDSMAN (SECTION 28)

The State 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 State Ombudsman and a copy thereof be forwarded to the Central Government.

4.5.1 REPORTING OF COMPLAINTS OFFICER

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.

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.

4.6 MAINTAINING OF RECORDS BY STATE OMBUDSMAN AND COMPLAINTS OFFICER

4.6.1 MAINTAINING OF RECORDS BY STATE OMBUDSMAN:

The State Ombudsman shall –

- 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;
- On receipt of the complaint, acknowledge it including by sending the unique complaint number by SMS or e-mail to the complainant where available;
- Record the time of the complaint and the action taken on the complaint in the register; and
- Maintain the register of complaints in a manner that ensures confidentiality of data

The State Ombudsman shall comply with data protection measures in accordance with section 11 of the HIV and AIDS (P&C) Act, 2017.

4.6.2 MAINTAINING OF RECORDS BY COMPLAINTS OFFICER

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.
- The register shall record the time of the complaint and the action taken on the complaint.
- Every complaint shall be numbered sequentially in the register.
- The Complaints Officer shall act in an objective and independent manner while deciding complaints made under the Act.
- 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.

4.7: TIMELINE FOR STATE OMBUDSMAN AND COMPLAINTS OFFICER

4.7.1 STATE OMBUDSMAN

The State Ombudsman shall pass the order within a period of thirty days of the receipt of the complaint, after giving an opportunity of being heard to the parties.

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.

4.7.2 COMPLAINTS OFFICER

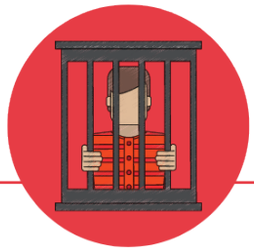
The Complaints Officer shall decide a complaint promptly and in any case within seven working days. Provided that in case of emergency or in the case of healthcare establishment where the complaint relates to discrimination in the provision of, or access to health care services or provision of universal precautions, the Complaints Officer shall decide the complaint on the same day on which he receives the complaint.

As a part of the grievance redressal mechanism set up under the HIV and AIDS (P&C) Act, 2017, the State Ombudsman and Complaints Officer have to ensure a speedy redressal of complaints in a time bound manner.

State Ombudsman shall resolve the complaint within a period of thirty days and the Complaints Officer shall resolve the complaint within seven days.

In case of a medical emergency, both the State Ombudsman and Complaints Officer have to resolve the complaint within twenty-four hours.

4.8 PENALTIES



For contravention of Section 4

Propagation of hatred or physical violence:

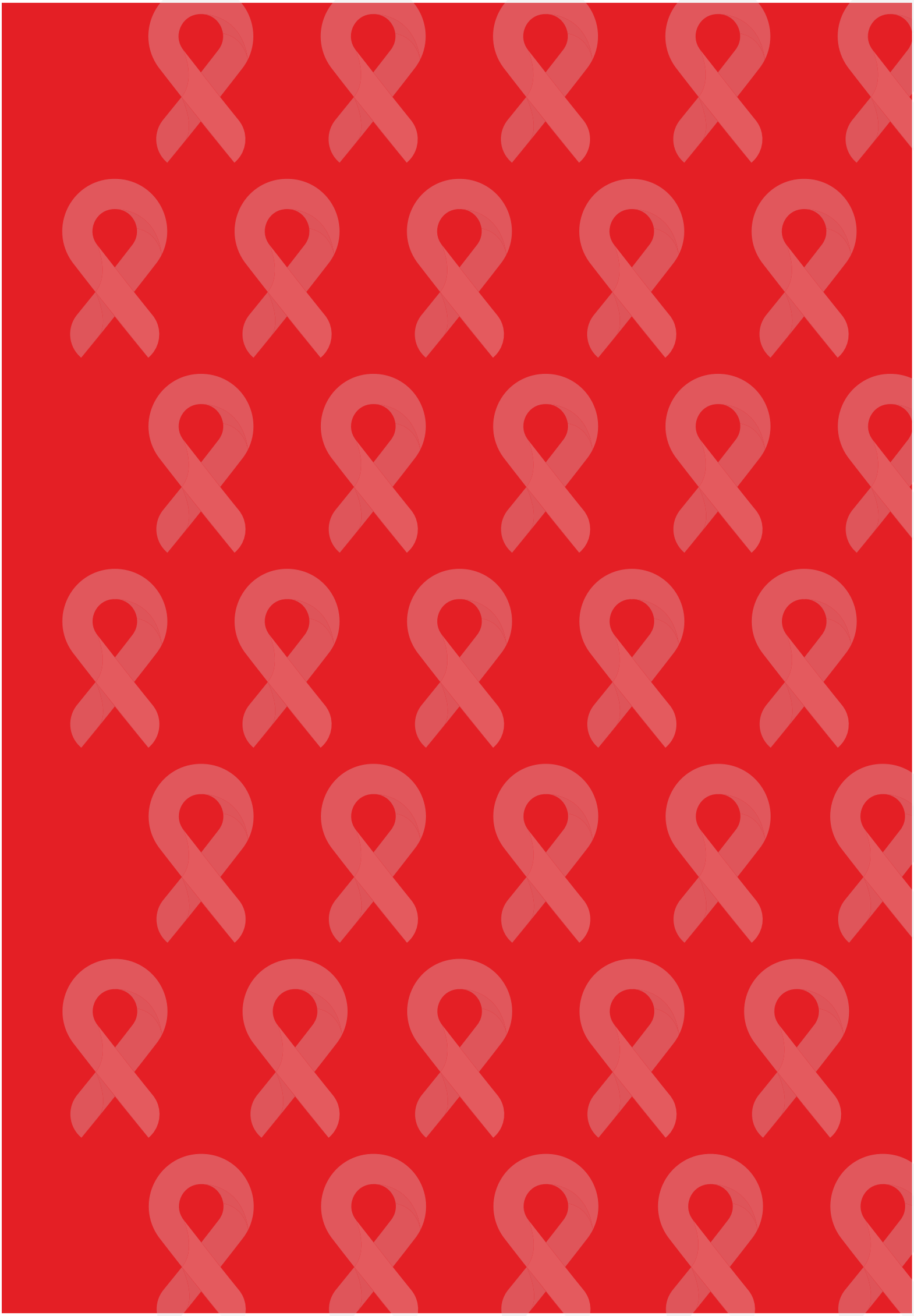
- Imprisonment (3 months - 2 years)
- Fine upto Rs. 1,00,000/-

Failure to comply with orders of the Ombudsman

- Fine upto Rs. 10,000/-
- In case failure continues - upto Rs. 5000/- each day

Penalty for breach of confidentiality in legal proceedings

- Fine which may extend to Rs. 1,00,000/-



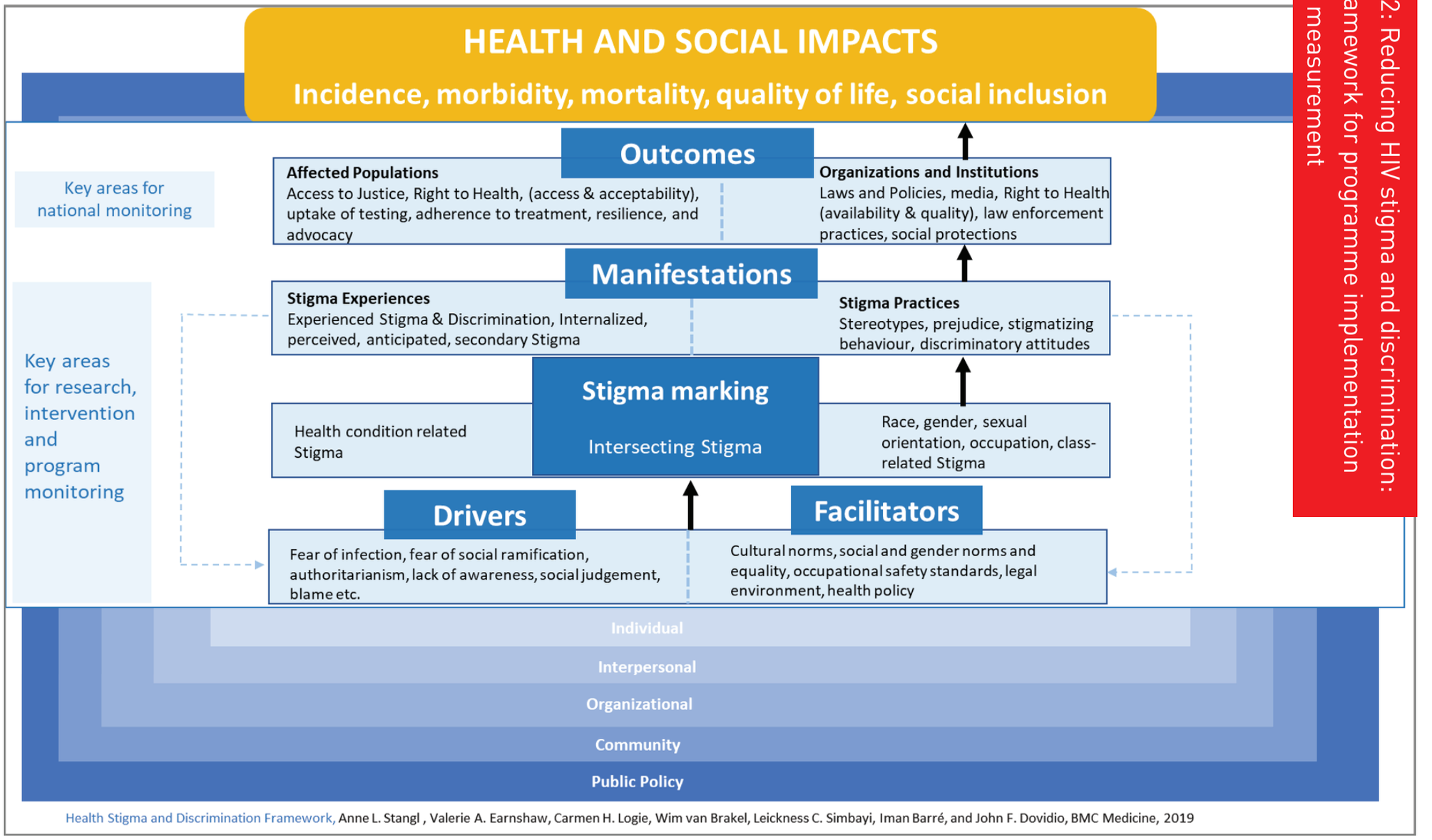
05

MONITORING

5.1 MONITORING AND EVALUATION OF HIV-RELATED STIGMA AND DISCRIMINATION

One of the challenges of integrating stigma reduction activities into programmes has been finding effective ways to monitor and measure the impact of interventions. Stigma discourages people from getting tested for HIV, sharing their HIV positive status with colleagues, family, community and sometimes even with healthcare providers too, while seeking care and treatment. Therefore, measuring stigma is critical to not only understand its scale and dimensions, but also to design effective programme and evaluate progress.

The technical brief of STRIVE on 'Measuring HIV Stigma and Discrimination' (2012) reports that HIV incidence, HIV prevalence and other epidemiological measures do not reflect the structural and social determinants that facilitate the spread of HIV or the substantial stigma and discrimination faced by people living with HIV and key populations.



Health Stigma and Discrimination Framework, Anne L. Stangl , Valerie A. Earnshaw, Carmen H. Logie, Wim van Brakel, Leickness C. Simbayi, Iman Barré, and John F. Dovidio, BMC Medicine, 2019

Fig 2: Reducing HIV stigma and discrimination: A framework for programme implementation and measurement

The new framework as shown above illustrates how stigma functions, how it can be measured and where to intervene. It breaks stigma into several constituent parts. At the bottom are factors that drive or facilitate HIV stigma. Drivers, such as social judgment and fear of infection through casual contact, are seen as inherently negative, while facilitators could have either positive or negative influences – for example, laws that criminalize HIV can fuel stigma and discrimination whereas those that protect the rights of people living with HIV may reduce discrimination. Drivers and facilitators lead to a number of manifestations of HIV stigma that in turn influence the outcomes and impacts of stigma in a given context.

This framework is based on the assumption that any individual can anticipate, experience and/or perpetuate HIV-related stigma and discrimination, regardless of his or her own HIV status. While the framework is specific to HIV stigma, it recognizes that HIV stigma often co-occurs with other, intersecting stigmas, such as those related to sexual orientation, gender, drug use and poverty.

5.2 RATIONALE FOR HIV-RELATED STIGMA AND DISCRIMINATION STRATEGY

Many studies have indicated that if stigma and discrimination are not addressed appropriately, it will result in more people acquiring HIV. Widespread stigma and discrimination towards people living with HIV and HRGs adversely affect their willingness to take an HIV test and even access treatment in a close proximity and therefore increase financial burden resulted.

If people do not know their sero-status, the chances of those who are HIV positive being re-infected and infecting others increases. Therefore, addressing the epidemic through this Stigma and Discrimination Reduction Strategy is an appropriate approach to 'getting to zero stigma' and attainment of end of HIV and AIDS as a public threat 2030 as envisaged by NACO.

The purpose of the HIV and AIDS Stigma Reduction Strategy is to align the efforts of various stakeholders in addressing HIV-related stigma and discrimination in their various health and non-health settings to bring about synergy. The strategy aims at guiding all HIV and AIDS stakeholders NGOs, civil society network, community-based organizations (CBOs), and the formal and informal private sectors) in addressing stigma and discrimination.

VARIOUS DATA COLLECTION METHODS FOR M&E OF HIV-RELATED STIGMA AND DISCRIMINATION:

Several data sources and methods can be employed for monitoring and evaluation of HIV-related stigma and discrimination in the various settings of healthcare, educational, workplace and community and family settings.

This document suggests the following steps to include and enhance reporting mechanism issues pertaining to stigma and discrimination as faced by various members:

1. NACO's various departments should develop necessary tools for effective monitoring and reporting of stigma and discrimination cases. Each facility in the districts having direct or indirect interface with PLHIV and HRGs - TIs, ICTCs, ART, OST, Prison settings and CSCs - should report number of reported, successfully redressed and pending cases on a monthly basis to SACS. It is suggested that at the national level, NACO can appoint a nodal officer who shall coordinate and compile all these HIV-related stigma reports bi-annually for further necessary actions and dissemination.

2. The NACP III guidelines placed much emphasis on grievance redressal mechanism to take up any specific grievances of community members at the targeted interventions for discussion and resolution. It is suggested that NACO may revive the grievance redressal mechanism and ensure steps to enable HIV infected and affected population to register their complaints with Complaints Officer or State Ombudsman to seek legal assistance. Discussions with representatives from SACS, TSU and DAPCU officials along with representatives of community members (CBOs, CSOs, advocacy groups and other key stakeholders) may be held to develop mechanism to capture the reported incidences of HIV-related stigma and discrimination. Additionally, capacity building modules may be developed for training of Ombudsman, Complaints Officers, other SACS/TSU and DAPCU officials on major provisions of the HIV and AIDS (Prevention and Control) Act, 2017 and HIV and AIDS Policy for Establishments, 2022.

3. NACO to ensure that Grievance Redressal Mechanisms (GRM) are appropriately set up in these settings. The staff at these institutions to be trained to address the complaints in a speedy manner, create enabling environment for all PLHIV and HRGs to use the services without any stigma and discrimination and importantly ensure confidentiality of all PLHIV and HRGs data and reports etc. Organizations with more than hundred people to designate Complaints Officer, while any healthcare settings with more than 20 people to have a designated Complaints Officer to look into the matters of stigma and discrimination.

4. HIV-related stigma and discrimination as experienced from various settings of healthcare, education, workplace, etc. can be shared with counsellors on 1097 anonymously. NACO's national toll-free AIDS Helpline '1097' is an innovative facility which not only provides answers to all types of queries related to HIV

and AIDS to People Living with HIV and AIDS (PLHIV), High Risk Groups (HRG), migrants, truckers or general population but also helps in registering complaints on issues of stigma and discrimination. The online counsellors will be able to provide counselling to the anonymous caller. Additionally, they will alert the respective state and institutions which have resorted to such acts of discrimination and take necessary actions to address the same. It is suggested that mass communication campaigns may be organized to promote 1097 and its services to facilitate citizens seeking immediate help for any complaints regarding HIV-related stigma and discrimination.

5. Stigma related complaints can also be registered on the website https://pgportal.gov.in/Home/LodgeGrievance. These complaints can be lodged by any member of the society irrespective of the type or place of stigma.

6. NACO's Sentinel Surveillance system is a cornerstone of the current HIV and AIDS surveillance system in India. Sentinel Surveillance can include suitable methods and protocols for collecting information about disease prevalence and HIV-related stigma and discrimination towards PLHIV and HRGs. Stigma and discrimination in health care settings are key barriers for further improvements of HIV diagnosis and surveillance and hence merits suitable mechanism to be included in the sentinel surveys.

7. National IBBS for the FSW, MSM and IDU population had collected an array of indicators like risk behaviours, HIV -related knowledge and practices, experiences of violence, stigma and discrimination, programme exposure as well as HIV prevalence. These indicators collated during the IBBS study will provide an insight into the current status of HIV epidemic across various districts, states and regions of India and will be used for efficient review, modification and implementation of HIV and AIDS-related services.

8. Quality assessments of institutions providing HIV-related services such as ICTCs and ART centres can facilitate site observations, retrospective review of records, and exit interviews with clients to determine incidences of HIV-related stigma. The tools designed in consultations with key stakeholders need to include all forms of stigma experienced by PLHIV and HRG members at health care facilities, workplace settings, educational institutions and among the community and family too. Care should be taken to include relevant questions to understand if there is self-stigma and perceived stigma too.

9. Special studies on HIV-related stigma and discrimination can be planned at least annually once by NACO to collect specific programme related data on a onetime or infrequent basis. The methods used may include field observations, qualitative methods, facility surveys, and other methodologies according to the data requirements.

ANNEXURE 1

Form for making Complaint to Ombudsman under [Rule 7]

1. Date of Incident ____
2. Place of Incident ____
3. Description of incident _____
4. Person/ Institution responsible for the incident _____

Signature/ Thumb Impression of Complainant*

Name :

Date

Mobile No./email/Fax/Address:

For Official Use only:

Unique Complaint Number: ____

**Where the complaint is received telephonically and reduced to writing by the Ombudsman, the Ombudsman shall sign the Form*

ANNEXURE 2

Form for making Complaint to Complaints Officer under rule 10

1. Date of Incident ____

2. Place of Incident ____

3. Description of incident _____

4. Person or institution responsible for the incident _____

Signature or Thumb Impression of Complainant*

Name: Date:

Mobile No. or email or Fax or Address:

For Official Use only:

Complaint Number: ____

**Where the complaint is received orally or telephonically and reduced to writing by the Complaints Officer, the Complaints Officer shall sign and date the Form.*

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