सत्यमेव जयते

HIV AND TB INTERVENTION IN PRISONS & OTHER CLOSED SETTINGS

OPERATIONAL GUIDELINES

नए सवेरे की ओर
Towards a new dawn

NACO
National AIDS Control Organisation
India's Voice against AIDS
Ministry of Health & Family Welfare, Government of India
www.naco.gov.in

DOTS
Pura course, Pakka ilaaj

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Date & Year of Publication:

Hon'ble Minister of State (Health & Family Welfare), Govt. of India, Smt. Anupriya Patel, released the Operational Guidelines on HIV/TB Intervention in Prisons and other Closed Settings on 1st December 2018 at Dr Ambedkar International Centre For Socio-Economic Transformation, New Delhi.

For additional information about HIV/TB intervention in Prisons and other Closed Settings, please contact:

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भारत सरकार
Minister of Health & Family Welfare
Government of India

स्वच्छ भारत
एक कदम स्वच्छता की ओर

Message

I am pleased to note that National AIDS Control Organization (NACO) is releasing Operational Guidelines on HIV and TB intervention in prisons and other closed settings.

2. India is committed to 'Ending the AIDS' epidemic as a public health threat by 2030 in line with Sustainable Development Goals (SDG). The Government of India has reaffirmed this commitment at the United Nations General Assembly in June 2016 during the High Level Meeting (HLM) on AIDS, as well as at other platforms, such as BRICS. 'Effective Last Mile Connectivity' is on top of the list in the present Government. I am certain that providing comprehensive HIV/TB prevention and treatment services for people living in prisons and other closed settings would eventually help in achieving 90-90-90 targets, by 2020.

3. There has been a 64% decline in the estimated number of annual new HIV infections in the Country from 2000 to 2010. The number of people living with HIV, who are receiving antiretroviral therapy free of cost through the government programme, has increased substantially. Consequently, AIDS-related deaths have declined. In recent past, the response has been further augmented through game changer policies of 'Test and Treat', 'HIV/AIDS Prevention and Control Act' and 'Viral Load Testing'. These services should be made available for most at risk population living in prisons and other closed settings as well.

4. I am sure that these Operational Guidelines would be extremely useful for all stakeholders engaged under NACP in providing HIV/TB prevention and treatment services for people living in prisons and other closed settings.

5. I take this opportunity to commend all organisations involved, especially the team of National AIDS Control Organization, Ministry of Home Affairs, Ministry of Social Justice and Empowerment, Ministry of Women & Child Development, Narcotics Control Bureau, Customs, Bureau of Police Research and Development, Indian Council of Medical Research, Directors General and Inspectors General of Prisons and authorities from Department of Social Welfare and Department of Women and Child Development.

(Jagat Prakash Nadda)

New Delhi,
Nov. 29, 2018

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अश्विनी कुमार चौबे
Ashwini Kumar Choubey

सत्यमेव जयते
सर्वेसन्तु निरामया

स्वच्छ भारत
एक कदम स्वच्छता की ओर

स्वास्थ्य एवं परिवार कल्याण राज्य मंत्री
भारत सरकार
MINISTER OF STATE FOR
HEALTH & FAMILY WELFARE
GOVERNMENT OF INDIA

MESSAGE

Globally, prisons are characterized by relatively high prevalence of HIV, hepatitis C virus and tuberculosis. The generally accepted principle that prisons and prisoners remain part of the broader community means that the health threat of HIV/AIDS within prisons, and the health threat outside of prisons, are inextricably linked and therefore demand coordinated action. The operational guidelines developed by NACO provides a comprehensive action plan to implement a response to HIV/TB in prisons and other closed settings based on accepted international standards and guidelines from the United Nations, the World Health Organization, and other international declarations, and that reflect principles of effective development programmes.

The vast majority of people committed to prison eventually return to the wider society. Therefore any diseases contracted in prison, or any medical conditions made worse by poor conditions of confinement, become issues of public health for the wider community when people are released. Section 31 of the HIV/AIDS (prevention and control) Act, 2017 states that "Every person in the care and custody of the state shall have right to HIV prevention, testing, treatment and counselling services".

Govt. of India is fully committed in providing comprehensive intervention with multiple strategies to address people living in prisons and other closed settings including post-release social reintegration services. Although women and girls represent 4% of the prison population in India; similar intervention has been extended to women living in prisons and other closed settings such as Swadhar, Ujjawala and State-run Homes in the country. I am happy to note that efforts taken by NACO to reduce the transmission of HIV/TB in prisons and other closed settings, and to care for those living with HIV/AIDS, are holistic and integrated with broader community.

I commend the efforts of all stakeholders involved in implementing HIV/TB intervention in prisons and other closed settings. I am confident that these operational guidelines shall be of immense support to all concerned for further enhancing the access to HIV/TB prevention and treatment services for people living in prisons and other closed settings.

(Ashwini Kumar Choubey)

New Delhi
December, 2018

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NATIONAL HEALTH MISSION
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अनुप्रिया पटेल
Anupriya Patel

सत्यमेव जयते

स्वच्छ भारत
एक कदम स्वच्छता की ओर

स्वास्थ्य एवं परिवार कल्याण राज्य मंत्री
भारत सरकार
MINISTER OF STATE FOR
HEALTH & FAMILY WELFARE
GOVERNMENT OF INDIA

Message

The focus of the global effort to end the HIV/AIDS epidemic, now 37 years on, the reduction of the annual number of new infections is the central challenge in epidemic control. National AIDS Control organization has been carrying out various HIV prevention and treatment services which include community based HIV screening, treat all, prevention of mother-to-child transmission, pre-exposure prophylaxis and targeted behavioral and structural interventions, especially for key populations. Taking this scientific evidence to provide comprehensive package of HIV/TB services to people living in prisons and other closed settings is commendable.

As detailed in these guidelines, Women Prisoners present specific challenges for correctional authorities despite, or perhaps because of the fact that they constitute a very small proportion of the prison population. The profile and background of women in prisons and other closed settings, and the reasons for which they are living in these settings, are different from those of men in the same situation. Women's psychological, social and health care needs will also be different. Existing prison facilities, programmes and services for women inmates have all been developed initially for men, who have historically accounted for the largest proportion of the prison population. Therefore, HIV/TB programmes and services must be tailored to meet the particular needs of women offenders.

India is committed to ensure people in prisons and other closed settings are entitled, without discrimination, to HIV/TB health care, including preventive measures, of a standard equivalent to that available in the outside community. This is important, both for prisoners and for the community outside prisons, as the vast majority of people who enter prisons will eventually return to the community. I am equally glad to note that NACO in collaboration with the Ministry of Women and Child Development and Ministry of Social Justice and Empowerment, is providing HIV/TB prevention and treatment services and drug de-addiction facilities to Women living in Prisons, Swadhar, Ujjawala & State-run Homes in the country.

Building relationships and creating partnerships with key stakeholders in the public health, justice, and community are important to making progress to address the health disparities of these people living in prisons and other closed settings. I am sure that the concerted efforts being taken by NACO will result in achieving Global commitment of "Ending AIDS" by 2030.

(Anupriya Patel)

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सत्यमेव जयते

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Government of India
Department of Health and Family Welfare
Ministry of Health & Family Welfare
Dated : 12th September, 2018

MESSAGE

India's AIDS response has shown remarkable success in reducing new infections & deaths, improving access to prevention services for key population and treatment services for people living with HIV (PLHIV). The National AIDS Control Programme has evolved through three phases of implementation and is currently in its fourth phase, and is globally acclaimed as one of the most successful programmes.

The Importance of implementing HIV interventions, including drug treatment pogrammes, in prisons was recognized early in the epidemic. India had introduced HIV programmes in prisons in the second phase (NACP II, 1999-2006). However, the intervention was small in scale, restricted to a few prisons due to lack of strategic information. NACO has recently revived the National Strategic plan and introduced comprehensive programmes (including information and education, particularly through peers; measures to reduce sexual transmission; drug dependence treatment, in particular opioid substitution therapy; voluntary counseling and HIV testing; and HIV care, treatment and support, including provision of antiretroviral treatment), and scaling them up rapidly across the country in a phased manner.

The health of inmates in prisons and other closed settings including Swadhar, Ujjawala and State-run Homes and their access to services is a wide and complex issue. Very often people arrive in prisons and other closed settings with many health problems such as drug addiction, infectious diseases, mental or psychiatric disorders, malnutrition, dental problems, and skin diseases. Most women living in these settings are from socially marginalized groups and some might have engaged in sex work and/or drug use. Many have also been victims of gender-based violence or have a history of high-risk sexual behavior. All these factors make women especially vulnerable in prisons and other closed settings.

The unique strengths that contributed to success of NACP in India such as prevention focused policies, evidence-driven strategies, community-centric approaches, designs for scale, dynamic multi-stakeholder response, openness for innovation and country stewardship are being deployed to make this unique programme for accelerating reversal of the epidemic.

I am sure that these operational guidelines will help towards ensuring the provision of quality HIV/TB services for people living in prisons and other closed settings across the country.

(Preeti Sudan)

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सत्यमेव जयते

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Preface

India's response for containing HIV from the time the first HIV case was identified in 1986 and the achievements of National AIDS Control Program during initial phases, the focus was to address the needs of high risk population who were visible, and the present strategy of National AIDS Control Programme is to ensure the last mile connectivity which include people living in prisons and other closed settings. The National AIDS Control Organisation is currently focusing on implementing HIV/TB prevention and treatment services in prisons in a phased manner. Major steps have been taken to expand similar services to women living in other closed settings such as Swadhar, Ujjawala and State-run Homes in the country.

The outcomes of the intervention reiterate the significance of rapid expansion of programme activities in prisons and other closed settings across the country. The involvement of inmates living in prisons and other closed settings and personnel working in these institutions in carrying out HIV intervention is, therefore, most critical. Diversities of culture, customs, lifestyle and laws in different States of the country reiterate the need to have State-specific, and site-specific intervention strategies.

World Health Organization (WHO) guidelines on HIV infection and AIDS in prisons state that all prisoners have the right to receive health care, including preventive services, equivalent to that available in the community and without discrimination, especially with respect to their legal status or nationality. The HIV/AIDS prevention and control Act, 2017 states that "Every person in the care and custody of the state shall have right to HIV prevention, testing, treatment and counselling services". The operational guidelines on HIV/TB intervention in prisons and other closed settings, as detailed in this document, build on the legal obligations, commitments, recommendations and standards on HIV/AIDS, prison health, prison conditions and human rights articulated in various national and international instruments.

These operational guidelines on HIV/TB intervention in prisons and other closed settings has been developed with valuable inputs from key stakeholders including Ministry of Home Affairs, Ministry of Social Justice and Empowerment, Ministry of Women & Child Development, Narcotics Control Bureau, Customs, Bureau of Police Research and Development, Indian Council of Medical Research, Director General and Inspector General of Prisons and authorities from Department of Social Welfare and Department of Women and Child Development. I am certain that these operational guidelines will help State AIDS Control Societies and line departments towards ensuring the provision of HIV/TB prevention and treatment services for people living in prisons and other closed settings across the country.

(Sanjeeva Kumar)

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दिनांक/Dated 27.09.2018

Message

The Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 ensures every person who is in the care or custody of the State shall have the right to HIV prevention, counselling, testing and treatment services. In these settings, people who are already more likely to be exposed to HIV, including people who use drugs, sex workers, and gay men and other men who have sex with men should be prioritized for the intervention.

Access to HIV/TB prevention and treatment services in prisons and other closed settings at times might be limited due to various factors. Therefore, the primary objective of the intervention should focus on establishing service facilities inside these settings to ensure long-term commitment and sustainability.

High frequency of dual infection of tuberculosis and HIV has been reported among prison inmates and provision of treatment not only will decrease the risk of mortality and the likelihood of developing active tuberculosis, it will also reduce the risk of further transmission of HIV to people living in larger community. Treatment programmes should, therefore, be available to eligible inmates after arrival, along with follow-up support to ensure continuity of care, especially during interfacility transfers and release. HIV infections among prisoners can be averted by the provision of noncoercive harm reduction programmes. NACO through respective SACS and in coordination with State Prisons department should scale up opioid substitution therapy across central prisons in the country.

Although women prisoners constitute relatively a smaller group, measures are to be taken to ensure that women living with HIV, pregnant women and breastfeeding mothers to access the full range of interventions for prevention of mother-to-child HIV transmission. Similar interventions should be expanded for women living in other closed settings in the country.

We take note of the new Prison manual released by Ministry of Home Affairs in 2016 which strongly recommends that bringing medical services within the domain of the State Medical Services / Health Department instead of the Prison Department. The Directorate General of Health Services is a repository of technical knowledge concerning Public Health, Medical Education and Health Care. The Directorate co-ordinates with the Health Directorates of all States/UTs for implementation of various National Health Programmes through its Regional Offices of Health and Family Welfare. All measures would be taken and the Dte.GHS will extend all possible support to make these efforts of providing HIV/TB prevention and treatment services for people living in prisons and other closed settings a great success.

(S. Venkatesh)

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Dated: 18th July, 2018

MESSAGE

I am happy to learn that NACO has commenced implementing HIV/TB intervention for Women who are living in closed settings such as Swadhar, Ujjawala and other State-run Homes. As there is lack of adequate data available with regard to HIV/TB prevalence among Women living in these Homes, it is important that the intervention proposed by NACO also include activities with an aim to generate strategic information so that evidence-based intervention may be planned and implemented in future.

Ministry of Women and Child Development provides assistance under UJJAWALA Scheme to women/girls who were trafficked or runaway from brothels or other places where they face exploitation and women affected by HIV/AIDS who do not have any social or economic support provided in areas where it is in operation. Therefore, comprehensive HIV/TB intervention extended by NACO would not only benefit inmates to avail HIV/TB services, but would also immensely benefit them to have access to other health services such as prevention and treatment of sexually transmitted infections, opioid substitution therapy and referral for diagnosis and treatment of viral hepatitis.

Developing guideline on HIV/TB intervention in Prisons and other Closed Settings is a crucial step towards ensuring women living in Swadhar, Ujjawala and other State-run Homes to have the same standards of health care that are available in the community, without discrimination on the grounds of their legal status. Ministry of Women and Child Development, Government of India is committed to extend all possible support and coordination to NACO to make this endeavor a great success.

Nandita Mishra

(Nandita Mishra)

सुरेन्द्र सिंह, आई.ए.एस.
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MESSAGE

The Ministry of Social Justice and Empowerment provides community-based services for the identification, treatment and rehabilitation of addicts through voluntary organizations. For the purpose of drug demand reduction, the Ministry of Social Justice & Empowerment has been implementing the Scheme of Prevention of Alcoholism and Substance (Drug) Abuse since 1985-86. Under this scheme, financial assistance up to 90% of the approved expenditure is given to the voluntary organizations and other eligible agencies for setting up/running Integrated Rehabilitation Centre for Addicts (IRCAs).

The Scheme provides financial support to NGOs mainly for the following activities: Awareness and Preventive Education; Drug Awareness and Counselling Centres (CC); Integrated Rehabilitation Centres for Addicts (IRCAs); Workplace Prevention Programme (WPP); De-addiction Camps (ACDC);NGO forum for Drug Abuse Prevention; Innovative Interventions to strengthen community based rehabilitation; Technical Exchange and Manpower development programme; Surveys, Studies, and Evaluation and Research.

The spread of HIV in prisons has significant public health implications as almost all prisoners return to their community thereby facilitating the spread of HIV infection to the general population. HIV prevention and treatment services initiated for prison inmates under the National AIDS Control programme is an important strategy which would eventually result in halting and reversing the HIV epidemic in the country. MSJE encourages State Governments to submit proposal for initiating drug de-addiction facility inside prison settings. MSJE is happy to collaborate with National AIDS Control Organisation on this important endeavor.

14.08.18
(Surendra Singh)

आलोक सक्सेना
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Alok Saxena
Joint Secretary

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National AIDS Control Organisation
Ministry of Health & Family Welfare
Government of India

Foreword

The revised United Nations Standard Minimum Rules for the treatment of Prisoners recommends providing HIV services, including prevention and Antiretroviral Treatment for prisoners (The Nelson Mandela Rule, (25-2; 2015). Programme data has shown that prevalence of HIV, sexually transmitted infections and tuberculosis in prison populations is 2 to 10 times high. The prevalence of hepatitis C among prison inmates is much higher (21%) than in the general adult population. Therefore, the National strategic plan (NSP) 2017-24, included HIV intervention in prisons and other closed settings.

NACO in collaboration with key stakeholders conducted series of national and regional-level consultation meetings to develop operational guidelines. The valuable inputs received from these meetings were instrumental in identifying key eligible interventions from the comprehensive package that are essential for effective HIV/TB prevention and control in prisons and other closed settings.

These operational guidelines on HIV/TB in prisons and other closed settings aims to provide information and guidance primarily to individuals and institutions with responsibilities for inmates living in prisons, Swadhar, Ujjawala and State-run Homes and to people who work in these settings. Its focus is on HIV/TB, however it recognizes that other diseases in particular hepatitis and STI are linked to HIV.

The total prison population in the country at any given point in time is approximately somewhere between 4 lakhs to 4.2 lakhs. However, more than 12,00,000 undertrials released every year. HIV/TB in prisons and other closed settings is both a public health and a human rights issue that needs to be addressed for an effective response to the epidemic. I am sure strengthening HIV/TB intervention in prisons and other closed settings would eventually result in halting and reversing the HIV/TB epidemic in the country.

(ALOK SAXENA)

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Message

Launch of prisons HIV intervention by the Hon'ble Union Minister of Health & Family Welfare on 6th February, 2016 had been the major step not only for HIV prevention but also towards early identification of TB cases and management. This is a bold step towards tackling the dual problem of TB & HIV and is prestigious initiative being undertaken by Government of India in collaboration with states & districts

People living in prisons and other closed settings are not only vulnerable to increased risk of HIV infection but prison conditions can also enhance the risk of spread of tuberculosis (TB). Reducing transmission of HIV and TB in prisons is, therefore, crucial for reducing the spread of these infections in the general community. Early diagnosis, combined with effective treatment, is the best strategy for prevention of TB in prisons. Measures to reduce overcrowding and improve the living conditions of all prisoners should also be implemented to reduce TB transmission.

The Revised National TB Control Programme (RNTCP) under the Ministry of Health & Family Welfare has also focussed on the vulnerable population with the objective of reaching the unreached with special focus on slum dwellers, prison inmates, construction site workers, HRG for HIV, weaving & glass industrial workers, cotton mill workers, unorganised labourers etc.

I wish all the best for this important initiative undertaken by the Government of India and hope that this operational guideline on HIV and TB interventions in prisons and other closed settings would provide information and guidance to individuals and institutions with the focus on quality care for both TB & HIV.

9/8/18

(Vikas Sheel)

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Acknowledgement

Prison is a State subject as per List II of Seventh Schedule to the Constitution and hence the primary responsibility of prison administration lies with the respective State Governments. The new Prison manual, released in 2016 by Hon'ble Home Minister, recommends bringing medical services within the domain of the State Medical Services/ Health Department instead of the prison department. The manual also states that it is the responsibility of the States to devise and develop mechanisms for rehabilitation of released inmates. Towards this end, NACO from time to time has been advising the State Governments to give more focused attention to implement comprehensive HIV/TB intervention in Prisons and other closed settings.

Under the dynamic stewardship of Shri Sanjeeva Kumar, AS & DG (NACO& RNTCP), HIV/TB interventions in prisons have been catalyzed and extended to women living in other closed settings including Swadhar, Ujjawala and State-run Homes. Shri Alok Saxena, JS, NACO actively guided the team and provided impetus in developing the operational guidelines.

We gratefully acknowledge Dr S Venkatesh (the then Addl. DG, NACO and now DGHS, Officer In-Charge, MoHFW, Govt. of India), Shri Vikas Sheel, Joint Secretary, Central TB Division, Dr Neeraj Dhingra (the then DDG, NACO and now Additional Director, National Vector Borne Disease Control Programme), Dr Naresh Goel (DDG, NACO), Dr R S Gupta (DDG, NACO), Dr Anoop Puri (DDG, NACO) and Dr K S Sachdeva (the then DDG, NACO and now DDG-TB, CTD) for their leadership and guidance in developing these operational guidelines.

We thank Shri Ajay Kashyap, Director General of Tihar Prisons and other Director General of Prisons, Inspector General of Prisons of respective States, authorities from Department of Social Welfare, Department of Women and Child Development, Project Directors of State AIDS Control Societies and their teamsfor their inputs in identifying eligible intervention from the comprehensive package of services recommended by UNODC, ILO, UNDP, WHO and UNAIDS. We thank the senior officers from the following Ministries and Departments for their active participation and contribution in finalizing the Operational Guidelines: Ministry of Home Affairs, Ministry of Social Justice and Empowerment, Ministry of Women & Child Development, Department of Revenue, Narcotics Control Bureau, Customs, Bureau of Police Research and Development, and Indian Council of Medical Research.

We are grateful to Dr Timothy H. Holtz, Division of Global HIV and Tuberculosis, CDC/India, Dr Melissa Nyendak, Branch Chief, Prevention, CDC/India, Dr Henk Bekedam, WHO Representative, Dr Bilali Camara, UNAIDS Country Director; Shri Sergey Kapinos, Representative for South Asia, UNODC; Dr Sampath Kumar, Public Health Specialist, CDC; Dr Bitra George, Country Director, FHI360; Dr Pradeep Kumar,Programme Officer (Surveillance), NACO; Dr. Atul Ambekar, National Drug Dependence Treatment Centre and Department of Psychiatry, AIIMS; Dr Rebecca Sinate, Additional Director, EHA; and Dr Sai Subhasree Raghavan, President, SAATHII for providing technical insights in finalising the operational strategies.

We commend Dr Bhawani Singh and Mr. S.Abraham Lincoln, from NACO for their significant contributions in developing the Operational Guidelines on HIV and TB intervention for people living in prisons and other closed settings.

I am certain that line departments of respective States including Prisons, Women and Child Development, Social Welfare, Social Defence, State AIDS Control Societies and other key stakeholders would make use of these Guidelines to enhance the access and quality of HIV/TB prevention and treatment services for people living in prisons and other closed settings.

Shobini

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ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
AIIMS	All India Institute of Medical Sciences
ART	Antiretroviral therapy
ARV	Antiretroviral
ATT	Anti-TB treatment
BCC	Behaviour change communication
CBNAAT	Cartridge-based nucleic acid amplification test
CBO	Community-based organisation
CBS	Community-based screening
CTD	Central TB Division
DAPCU	District AIDS Control and Prevention Unit
DDAP	Drug De-Addiction Programme
DMC	Designated Microscopy Centre
DOT	Directly observed therapy
DTC	District TB Cell
F-ICTC	Facility-Integrated Counselling and Testing Centre
HCTS	HIV counselling and testing services
HIV	Human immunodeficiency virus
HRG	High-risk group
IBBS	Integrated Biological and Behavioural Surveillance
ICTC	Integrated Counselling and Testing Centre
IEC	Information, education and communication
IPT	Isoniazid preventive therapy
LAC	Link ART Centre
LEA	Law enforcement agency

MoHFW	Ministry of Health and Family Welfare
MoU	Memorandum of understanding
MSJE	Ministry of Social Justice and Empowerment
MWCD	Ministry of Women and Child Development
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NETSU	North-East Technical Support Unit
NGO	Nongovernmental organisation
NHM	National Health Mission
NTSU	National Technical Support Unit
OST	Opioid substitution therapy
PLHIV	People living with HIV
PPTCT	Prevention of parent-to-child transmission
RNTCP	Revised National Tuberculosis Control Programme
RTI	Reproductive tract infection
SACS	State AIDS Control Society
SA-ICTC	Stand-Alone Integrated Counselling and Testing Centre
SOP	Standard operating procedure
STC	State TB Cell
STI	Sexually transmitted infection
TB	Tuberculosis
TI	Targeted intervention
TOT	Training of trainers
TSU	Technical support unit
UNDP	United Nations Development Programme
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

1 INTRODUCTION

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

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

> Reducing transmission of HIV and TB in prisons is crucial for reducing the spread of these infections in the general community.

As per Prison Statistics India 2015, a total of 1,401 prisons across the country housed 4,19,623 prison inmates, well above the authorized capacity of 3,66,781; this translates to occupancy rate of 114.4% (see Table 1). The occupancy rate stood even higher for district and central jails, at 131.1% and 116.4%, respectively. Of the total 4,19,623 inmates housed in all types of jails, 2,82,076 were under-trials, constituting 67.2% of the total inmate population. A significant 1,35,634 (48.1%) of these under-trial inmates were of ages 18–30 years, and 1,15,181 (40.8%) under-trials were of ages 30–50 years. These figures are not only indicative of the overcrowding in jails but also high turnover rate in the prison population, with a majority of prisoners eventually returning to their communities. Reducing transmission of HIV and TB in prisons is, therefore, crucial for reducing the spread of these infections in the general community. Early diagnosis, combined with effective treatment, is the best strategy for prevention of TB in prisons. Measures to reduce overcrowding and improve the living conditions of all prisoners should be implemented to reduce TB transmission.

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

S. No.	Type of Jails	Number of Jails	Capacity	Total Inmates	Occupancy Rate (%)
1	Central Jails	134	1,59,158	1,85,182	116.4
2	District Jails	379	1,37,972	1,80,893	131.1
3	Sub Jails	741	46,368	39,989	86.2
4	Women's Jails	18	4,748	2,985	62.9
5	Open Jails	63	5,370	3,789	70.6
6	Borstal School	20	1,830	1,003	54.8
7	Special Jails	43	10,915	5,769	52.9
8	Other Jails	3	420	13	3.1
Total		1,401	3,66,781	4,19,623	114.4

Source: Prison Statistics India 2015, National Crime Records Bureau

The Ministry of Women and Child Development (MWCD), Government of India, is supporting Swadhar Greh, a new scheme focused on establishing a home in every district to provide relief and rehabilitation to destitute women and women in distress. This scheme targets women who are deserted and without any social and economic support; women survivors of natural disasters who have been rendered homeless and are without any social and economic support; women prisoners released from jail and without family, social and economic support; and women victims of domestic violence, family tension or discord, who are made to leave their homes without any means of subsistence and have no special protection from exploitation and/or are facing litigation on account of marital disputes. Similarly, trafficked women/girls who are rescued or have escaped from brothels or other places where they face exploitation and women affected by HIV/AIDS, who do not have any social or economic support. Hence, it is strongly recommended that SACS, in coordination with Social Welfare Department and department of Women and Child Development of the respective State government, should identify and cover such closed settings. As per MWCD statistics, there are more than 500 Swadhar Greh and 140 Ujjwala scheme, catering to nearly 21,000 women across the country. Besides this, there are an equal number of homes for women run by respective state governments.

> SACS in coordination with Social Welfare Department and or department of Women and Child Development of the respective state government should cover closed settings.

The National AIDS Control Organisation (NACO) is the nodal agency responsible for approving, implementing and supervising all HIV/AIDS related activities in the country, including research, under the Ministry of Health and Family Welfare (MoHFW), Government of India. NACO implements the National AIDS Control Programme (NACP) as a comprehensive programme for prevention and control of HIV/AIDS in India. The goal of the fourth phase of the programme—NACP-IV (2012–2017)—is to accelerate reversal and ensure integration of the programmatic response to the HIV/AIDS epidemic.

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

Considering the concentrated nature of the HIV epidemic in the country, NACO has targeted its preventive efforts on sub-groups of populations identified as being at a high risk of acquiring the HIV infection. These high-risk groups (HRGs) are provided a number of preventive services through nongovernmental organisation/community-based organisation (NGO/CBO) led targeted interventions (TIs). At present, over 1,500 such interventions are providing HIV prevention, treatment, care and support services to various HRGs and Bridge Populations including female sex workers, men who have sex with men, transgender persons, injecting drug users, Truckers and Migrants.

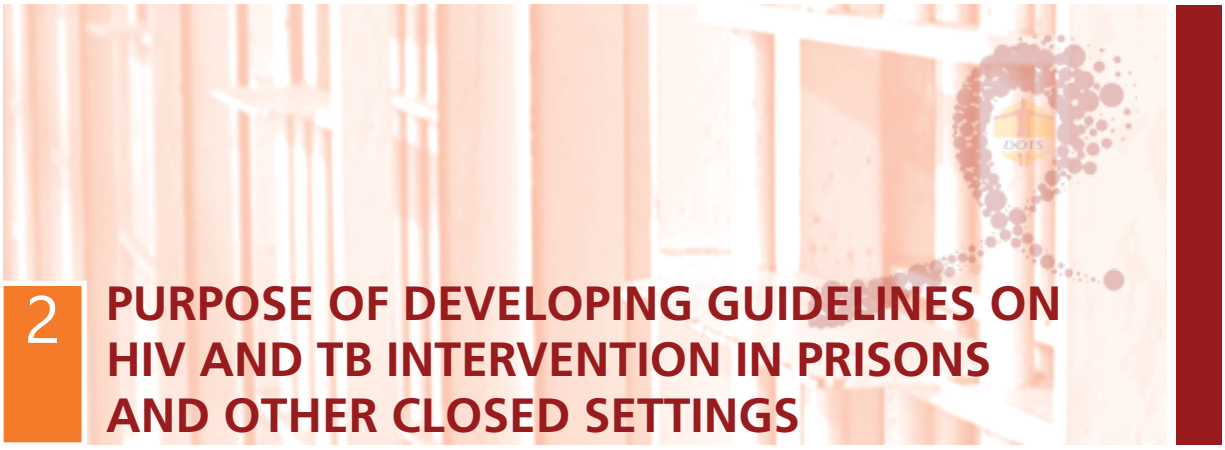
Data from national Integrated Biological and Behavioural Surveillance (IBBS) 2014–2015 shows that HIV is concentrated among HRGs, with HIV prevalence rates of 9.9% among injecting drug users, 7.5% among transgender persons, 4.3% among men who have sex with men and 2.2% among female sex workers. Prisoners have been identified as one of the special groups under NACP and NACO aims to address all high-risk populations living in prisons and other closed settings in the Country. A comprehensive intervention with multiple strategies has been proposed to address people living in prisons and other closed settings. Post-release social reintegration is to be addressed through networking and referral linkages.

A national consultative meeting with law enforcement agencies (LEAs), held on October 29, 2014, at Nirman Bhawan, New Delhi, and a regional sensitisation workshop with LEAs, held on November 13–14, 2014, at The Ashok Hotel, New Delhi, under the chairmanship of Shri. Lov Verma, Former Union Secretary, MoHFW, paved the way for evolving a strategy for HIV intervention in prisons. Key ministries and departments, including the Ministry of Home Affairs, Ministry of Social Justice and Empowerment (MSJE), Narcotics Control Bureau, Office of Delhi Police Commissioner, Bureau of Police Research and Development, participated in the meeting, along with senior-level representation from the State police and Prisons departments of Himachal Pradesh, Uttarakhand, Punjab, Chhattisgarh, Karnataka, Tamil Nadu, Andhra Pradesh, Delhi, Mumbai, Arunachal Pradesh, Assam, Sikkim, Tripura, Mizoram, Manipur, Meghalaya, and Nagaland. Representatives from UNODC; United Nations Development Programme; National Drug Dependence Treatment Centre, All India Institute of Medical Sciences; and Centers for Disease Control and Prevention also participated in the consultation.

> Prisoners have been identified as one of the special groups under NACP.

Key eligible HIV interventions from the comprehensive package of services, recommended by UN agencies to support countries in planning and implementing an effective response to HIV/TB in prison settings, were identified during the aforesaid consultative meeting. Based on suggestions from subject knowledge experts, a concept note on 'HIV Prevention and Control in Prison Settings in India' was finalized and approved by Union Secretary, MoHFW. As recommended in the concept note, a National Working Committee on Prison HIV and Law Enforcement was constituted and a series of regional sensitisation workshops with LEAs were held.

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



2 PURPOSE OF DEVELOPING GUIDELINES ON HIV AND TB INTERVENTION IN PRISONS AND OTHER CLOSED SETTINGS

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

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

The operational guidelines on HIV and TB intervention in prisons and other closed settings will cover:

1) Eligible intervention from the United Nations comprehensive package of services comprising 15 key intervention[8] that are essential for effective HIV prevention and control in prisons and other closed settings
2) Creating an enabling environment in the context of drug use and HIV
3) Working Committee on HIV/TB intervention in Prisons and other Closed Settings
4) Modalities of implementation
5) Functions of key stakeholders, including state prisons department and other closed settings
6) Social reintegration
7) Mainstreaming HIV and TB interventions

> Every person in the care and custody of the State shall have right to HIV prevention, testing, treatment and counselling services.

3 ELIGIBLE INTERVENTION FROM THE COMPREHENSIVE PACKAGE OF SERVICES

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

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

The majority of people living in prisons and other closed settings eventually return to their communities. The diseases contracted in prisons and other closed settings, or made worse by imprisonment/short stay, are, thus, a major concern from the public health point of view.

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

Table 2. Comprehensive Package of Services and their Implementation Eligibility

S. No.	Recommended Package of Services	Eligibility for implementation (based on preparedness)
1	Information, education and communication	Eligible for implementation
2	HIV counselling and testing	Eligible for implementation
3	HIV care, support and treatment	Eligible for implementation
4	Prevention, diagnosis and treatment of TB	Eligible for implementation
5	Prevention of parent-to-child transmission of HIV	Eligible for implementation
6	Condom programmes	SACS/NACO to advocate with the prison authorities
7	Prevention and treatment of sexually transmitted infections	Eligible for implementation
8	Prevention of sexual violence	The prison system has institutional arrangement to deal with issues of sexual violence
9	Drug dependence treatment	Eligible for implementation
10	Needle and syringe programme	Not eligible
11	Vaccination, diagnosis and treatment of viral hepatitis	Eligible for implementation
12	Post-exposure prophylaxis	Eligible for implementation
13	Prevention of transmission through medical or dental service	Eligible for implementation
14	Prevention of transmission through tattooing, piercing and other forms of skin penetration	Eligible for implementation
15	Protecting staff from occupational hazards	Prison system has institutional arrangement to deal with issues of occupational hazards

Core eligible intervention to be considered for implementation

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

3.1 INFORMATION, EDUCATION AND COMMUNICATION

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

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

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

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

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

3.1.1 PEER-LED INTERVENTION

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

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

- Depending on the size of the inmate population, the peer group may consist of 5–25 inmates under a peer volunteer.

> Peer volunteers may not necessarily be convicted individuals. Undertrail prisoners can be identified to carry out peer-led intervention, so that when released, they become champions and spread information on HIV and TB prevention and treatment services.

- Mechanisms can be devised to encourage peer volunteers, for example, by providing certificates conferring special recognition during Independence Day/Republic Day celebrations.
- It is highly advisable that all staff, including assistant jailor, jailor and wardens, resident superintendent, medical doctor, counsellor, office assistant-cum-data entry operator, and guard/watchman, be involved in the formation of the peer network to ensure accountability and sustainability.

3.2 HIV COUNSELLING AND TESTING

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

It is recommended that priority can be given to establish voluntary counselling and testing services within prisons. SACS/NGO partners involved in providing the services should not encourage mandatory or compulsory HIV testing. When they have easy access to HIV counselling and testing, and particularly when they are offered such testing and it is accompanied by access to treatment, care and support (including antiretroviral treatment), many prisoners will take up testing and counselling in prison.

Following are some of the approaches can be considered for providing HCT services to inmates living in prisons and other closed settings:

Approach-I: Stand-Alone Integrated Counselling and Testing Centres (SA-ICTC) established already in prisons can be continued and opportunities may be explored to establish similar services in largest prison sites.

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

Approach-III: SACS/District AIDS Control and Prevention Unit (DAPCU) can arrange regular HIV testing camps by deputing counsellor/s and lab technician/s on specific days to provide HCT services for inmates living in district jails. Similarly, wherever Mobile ICTC facilities are available, SACS/DAPCU can deploy them to provide HCT services for inmates living in district jails.

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

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

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

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

3.2.1 POST EXPOSURE PROPHYLAXIS

"Post exposure prophylaxis" (PEP) refers to comprehensive management given to minimize the risk of infection following potential exposure to blood-borne pathogens (HIV, HBV, HCV). This includes: a. First aid b. Counseling c. Risk assessment d. Relevant laboratory investigations based on informed consent of the source and exposed person e. Depending on the risk assessment, the provision of short term antiretroviral drugs 6. Follow up and support.

"Exposure" which may place an Health Care Provider (HCP) at risk of blood-borne infection is defined as: a. Per cutaneous injury (e.g. needle-stick or cut with a sharp instrument), b. Contact with the mucous membranes of the eye or mouth, b. Contact with non-intact skin (particularly when the exposed skin is chapped, abraded, or afflicted with dermatitis), or d. Contact with intact skin when the duration of contact is prolonged (e.g. several minutes or more) with blood or other potentially infectious body fluids.

It is suggested that SACS make post-exposure prophylaxis available in all prisons and other closed settings where intervention is initiated.

3.3 CARE, SUPPORT AND TREATMENT

All HIV-positive inmates have special needs, ART Guidelines for HIV-infected Adults and Adolescents, released by NACO in May 2018, strongly recommend establishing effective linkages between ART and harm-reduction programmes. It also states that ART should be given as part of a comprehensive package of prevention (including harm reduction), care and support and treatment. Hence, it is suggested that proper linkages to care, support and treatment services should be ensured for those found positive for HIV.

- Doctor/medical staff can be trained on ART initiation, and the prison hospital can be made as Link ART Centre (LAC) for dispensing medication to HIV-positive prisoners.
- SACS/DAPCU can, in association with relevant authorities, arrange for transportation with appropriate security to take HIV-positive inmate(s) to ART centre for initiation on treatment and regular monitoring tests.
- In line with MoHFW's 'Test and Treat Policy for HIV', as soon as an inmate is tested and found HIV positive, he/she should be provided with ART irrespective of his CD4 count or clinical stage. This will improve the longevity and quality of life of inmates living in prisons and other closed settings and save them from many opportunistic infections, especially TB.
- Authorities administering prisons and other closed settings should be sensitised to provide nutritional supplements to patients under treatment.

Care, Support and Treatment (CST) services are provided through a spectrum of service delivery models including ART Centers, Centers of Excellence (CoE), Pediatric Centers of Excellence (PCoE), Facility Integrated ART Centers (FIART), Link ART Centers (LAC), Link ART Plus Center (LAC Plus) and Care & Support Centers (CSC) established by NACO in health facilities across the Country with aim to provide universal access to free and comprehensive CST Services. There are active linkages and referral mechanism for monitoring, mentoring, decentralization and specialized care. CST Services are also linked to ICTCs, STI clinics, PPTCT services and other clinical departments in the institutions of their location as well as with the RNTCP programme in order to ensure proper and comprehensive care and management.

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

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

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

3.4 PREVENTION, DIAGNOSIS & TREATMENT OF TUBERCULOSIS

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

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

In collaboration with the Revised National Tuberculosis Control Programme (RNTCP), active case finding for TB should be undertaken and other effective TB control measures should be introduced. Authorities in prisons and other closed settings should be sensitized on the following:

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

3.5 PREVENTION OF PARENT-TO-CHILD TRANSMISSION OF HIV

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

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

- Measures should be taken to ensure that women living with HIV, pregnant women and breastfeeding mothers access the full range of interventions for prevention of mother-to-child HIV transmission. These intervention include family planning and antiretroviral therapy in line with the National Guidelines for Prevention of Parent-to-Child Transmission of HIV.
- In accordance with these guidelines, there should be follow up on children born to mothers living with HIV.

3.6 PREVENTION AND TREATMENT OF SEXUALLY TRANSMITTED INFECTIONS

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

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

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

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

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

STI/RTI SYNDROMIC CASE MANAGEMENT

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

IMPORTANT CONSIDERATIONS FOR MANAGEMENT OF ALL STI/RTI

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

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3.7 DRUG DEPENDENCE TREATMENT (INCLUDING OPIOID SUBSTITUTION THERAPY)

> Intervention for drug dependent people in the criminal justice system should address treatment as an alternative to incarceration, and also provide drug dependence treatment while in prison and after release.

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

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

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

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

OST is a process in which opioid-dependent injecting drug users are provided with long acting opioid agonist medications for a long period of time under medical supervision along with psycho-social interventions. Short term treatment of opioid dependence lasting for a couple of weeks called 'detoxification' which involves management of acute withdrawals alone, is associated with very high rates of relapse. Long term treatment is hence necessary for opioid dependence. OST is one such long-term treatment option.

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

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

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

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

The Tihar prisons have been providing OST service to prison inmates since 2008, with technical support from National Drug Dependence Treatment Centre, All India Institute of Medical Sciences (AIIMS). SACS can refer to NACO's national guidelines and the standard operating procedure (SOP) on OST and the scientific study conducted by the AIIMS in collaboration with Tihar prisons to learn about the effectiveness of OST with buprenorphine as a long-term treatment for opioid dependence in prison settings.

3.8 REFERRAL FOR SCREENING AND TREATMENT OF HEPATITIS

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

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

3.9 RAISING AWARENESS ON HIV TRANSMISSION THROUGH MEDICAL OR DENTAL SERVICES

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

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

3.10 RAISING AWARENESS ON HIV TRANSMISSION THROUGH SKIN PENETRATION

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

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

4 REFERRAL AND LINKAGES FOR HEALTH AND OTHER SERVICES

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

- Prisons and other closed settings should maintain referral directory of service providers
- Linkages with key health services such as DOTS, OI management, HCT, ART, OST, HCV, HBV, PPTCT, PLHIV networks for home based care and support
- Reproductive health services for drug-using women and women who have male injecting partners
- Linkages with the MSJE/MoHFW supported centres and other private detoxification and rehabilitation centres.
- Linkages and referrals for social welfare schemes and entitlements
- Establishment of other referral linkages based on inmates-identified needs and available services in the community
- Psychiatric services within government settings and NGOs

Prisons and other closed settings should maintain referral directory of service providers.

5 CREATING AN ENABLING ENVIRONMENT IN THE CONTEXT OF DRUG USE AND HIV

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

- In order to operationalize the provisions existing in the amended Narcotic Drugs and Psychotropic Substances Act, commonly known as the NDPS Act, sensitisation workshops can be organised at the state/district/prison (site specific) level to strengthen partnerships between LEAs and the NGOs implementing HIV prevention and treatment services.

> People who are dependent on drugs should be referred for appropriate drug de-addiction and rehabilitation services as per NDPS Act Sec 64(a).

- Advocacy meetings can be organised for judges and district magistrates to refer (with informed consent and willingness) people who are dependent on drugs for appropriate drug de-addiction and rehabilitation services as per NDPS Act Sec 64(a).
- SACS can create institutional mechanisms for coordinating with LEAs on a regular basis at the state/district level.
- SACS can organise regular exposure visits for jail superintends and constables working at the beat level through NGOs/CBOs,

6 WORKING COMMITTEE ON HIV/TB INTERVENTION IN PRISONS AND OTHER CLOSED SETTINGS

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

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

> Operational guidelines on HIV and TB interventions in prisons recommend formation of working committees at the state level.

Functions of the Working Committee:

- Develop a state implementation plan on HIV/AIDS and TB prevention and care in prisons and other closed settings
- Develop an advocacy plan to strengthen the partnership between LEAs and civil society organisations
- Provide strategic direction to effectively implement HIV/AIDS and TB prevention and care initiatives
- Identify 'champions' to lead advocacy efforts at the state as well as district level
- Prepare an action plan and propose seminars/workshops in the context of HIV/TB intervention in prisons and other closed settings

7 MODALITIES FOR IMPLEMENTATION OF HIV AND TB INTERVENTION

SACS and STC should coordinate with key stakeholders, including department of state prisons, women and child development and social welfare, to conceptualize and implement various components of services HIV and TB interventions (refer to section 3 – 'Eligible Interventions from the Comprehensive Package') in prisons (central jails[10] and other select jails) and other closed settings (Swadhar, Ujjwala and state-run homes) in a phased manner under overall guidance from NACO and CTD. District jails, sub jails and special jails should be covered based on need, especially in the following States: Arunachal Pradesh, Meghalaya, Andaman and Nicobar Islands, Dadra and Nagar Haveli, Daman and Diu and Lakshadweep.

Table 3. Phase-wise Coverage of States and Union Territories

Phases	States/UTs Covered
Phase I	Arunachal Pradesh, Assam, Manipur, Mizoram, Meghalaya, Tripura, Sikkim, Nagaland, Delhi, Punjab and Chandigarh
Phase II	Bihar, Uttarakhand, Uttar Pradesh and Rajasthan
Phase III	Madhya Pradesh, Chhattisgarh, Odisha, Jharkhand and West Bengal
Phase IV	Jammu & Kashmir, Himachal Pradesh, Haryana, Gujarat, Goa and Maharashtra
Phase V	Karnataka, Tamil Nadu, Kerala, Andhra Pradesh and Telangana
Phase VI	Andaman and Nicobar Islands, Dadra and Nagar Haveli, Daman and Diu, Lakshadweep and Puducherry

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

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

The list of core indicators was developed through a consultative process as part of the National HIV/TB strategic framework. In order to measure the progress of the intervention, the performance should be monitored based on the following indicators. It is suggested that SACS and STC may choose to add more indicators so as to maintain comprehensive data at the facility level. TI Division at SACS should compile and share the progress in the 17 indicators monthly reporting format as found in Annex-10.

1) Number of inmates tested for HIV
2) Number of inmates found HIV positive
3) Number of positive inmates linked to ART
4) Number of inmates diagnosed with STI
5) Number of inmates treated for STI
6) Number of inmates screened for TB
7) Number of inmates diagnosed with TB
8) Number of inmates started on treatment for TB
9) Number of inmates screened for hepatitis C
10) Number of inmates diagnosed with hepatitis C
11) Number of inmates started on hepatitis C treatment
12) Number of inmates started on OST
13) Number of released inmates linked to a TI program
14) Number of released inmates linked to OST
15) Number of released inmates linked to ART
16) Number of released inmates linked to social security schemes
17) Number of deaths reported (of HIV-positive inmates)

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

SACS and STC should coordinate with key stakeholders, including department of state prisons, women and child development and social welfare, to conceptualize and implement various components of HIV and TB interventions.

8 RESPONSIBILITIES OF TARGETED INTERVENTION NGOs (TI-NGOs)

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

1) Implementation of eligible interventions from the comprehensive package of services
   - i. Information, education and communication
   - ii. HIV counselling and testing
   - iii. HIV care, support and treatment
   - iv. Prevention, diagnosis and treatment of TB
   - v. Prevention of parent-to-child transmission of HIV
   - vi. Prevention and treatment of sexually transmitted infections
   - vii. Drug dependence treatment, including OST
   - viii. Referral for diagnosis and treatment of viral hepatitis
   - ix. Raising awareness on HIV transmission through medical or dental services
   - x. Raising awareness on HIV transmission through tattooing, piercing and other forms of skin penetration
2) Behaviour change communication
   - i. Support SACS in developing IEC/BCC materials, such as posters, pamphlets, booklets, audio-visual materials and wall paintings
   - ii. Carry out focused BCC activities to provide information and education on HIV/AIDS to inmates and staff working in prisons and other closed settings
   - iii. Ensure and enable peer volunteers to regularly conduct one-to-one and one-to-group education sessions using IEC materials
   - iv. Organise recreational activities, such as games, sports competitions and other appropriate cultural activities with the purpose of creating awareness on HIV/AIDS
3) Human resources
   - i. Ensure recruitment of recommended resources, including formation of peer leaders and peer volunteers

4) Advocacy

   i. Conduct site-specific orientation-cum-sensitisation meetings for staff on the eligible interventions identified for implementation

   ii. Carry out regular advocacy and sensitisation meetings with key stakeholders in prisons and other closed settings

   5) Capacity building and generation of strategic information

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

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

   iii. Carry out periodic situational and needs assessment surveys

6) Health and other key services

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

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

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

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

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

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

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

9 FUNCTIONS OF NATIONAL AIDS CONTROL ORGANISATION (NACO)

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

NACO will provide overall guidance to plan, implement, monitor and evaluate the programme. NACO will ensure coordination with relevant Ministries and Departments, develop Operational Guidelines and Manuals to effectively implement the programme.

10 FUNCTIONS OF CENTRAL TB DIVISION (CTD)

1) Ensure signing of MoU between CTD, NACO and the Ministry of Home Affairs (MHA), MWCD and other line ministries and departments
2) Provide technical inputs on:
   i. SOPs, guidelines and operational manuals to effectively implement the TB programme
   ii. Training manuals for training of officials, doctors, lab technicians and treatment supporters
   iii. Social reintegration module for rehabilitating and reintegrating released prisoners and other inmates into the community
   iv. Training manuals to sensitise police personnel, including those who work in prisons, through police training academies and state training and resource centres
3) Participate in national and regional sensitisation workshops for law enforcement officials organized by NACO to strengthen TB intervention in prisons and other closed settings
4) Partner with NACO in advocating with police training academies to incorporate a component on TB in their training curriculum
5) Participate in national Working Committee on HIV/TB intervention in prisons and other closed settings

CTD will provide overall guidance to implement comprehensive TB services in Prisons and other closed settings. CTD will replicate the best practices demonstrated in community settings to prevent the spread of tuberculosis among inmates living in prisons, Swadhar, Ujjawala and other State-run Homes.

11 FUNCTIONS OF STATE AIDS CONTROL SOCIETY (SACS)

1) Arrange infrastructure at the State's prison sites and other closed settings for the following purposes:
   i. Integrated Counselling and Testing Centre
   ii. Opioid substitution therapy
   iii. Diagnosis and treatment services for STI/RTI
   iv. Store room
2) Ensure supply of the following commodities to intervention sites:
   i. HIV testing kits
   ii. Antiretroviral (ARV) medicines
   iii. STI/RTI treatment kits
   iv. Medicines for drug treatment (Tab. buprenorphine/methadone)
3) Seek necessary permissions for inmates diagnosed with HIV to avail treatment, care and support services, including ARV drugs in the community
4) Seek necessary permissions for NGOs/CBOs contracted by NACO/SACS to carry out HIV/TB intervention
5) Seek necessary permissions for SACS officials to visit intervention sites, interact with staff and inmates to understand progress and extend necessary guidance to the HIV team working in prisons and other closed settings; schedule regular visits (weekly/monthly) to monitor and provide the required assistance to programme staff
6) Ensure training/capacity building of all staff through respective technical support units (TSUs)
7) Develop IEC materials in consultation with key stakeholders for implementing peer-led BCC activities
8) Organise periodic state-level sensitisation workshops/trainings for LEAs, including prison officials
9) Provide weekly/monthly reporting formats to the staff employed in prisons and other closed settings

10) Ensure regular collection of data and share the technical report with NACO and the prison department on a regular basis

11) Share the service providers' list, including ICTC, ART, TB, STI, drug dependence treatment, with the nodal officer to ensure referral and linkages

12) Coordinate with the respective nodal officers and participate in state-level police/prison/departmental review meetings

13) Advocate to bring medical services, including HIV prevention and treatment, within the domain of state medical services/health department instead of prison department

SACS will remain as a nodal agency at State-level to plan, implement, monitor and evaluate the programme jointly with State Prisons department, Women and Child Development department and Social Welfare department. SACS should incorporate the ongoing/proposed HIV/TB work plan in the Annual Action Plan (AAP) so as to ensure the supply of HIV testing kits, ARV medicines, STI/RTI treatment kits, and buprenorphine/methadone for OST services.

12 FUNCTIONS OF STATE/DISTRICT TB CELL

1) Arrange infrastructure at the state's prison sites and other closed settings for the following purposes:
   i. Designated Microscopy Centre (DMC), wherever eligible
   ii. TB treatment centres
2) Ensure supply of the following commodities to intervention sites:
   i. Reagents and consumables for DMC
   ii. Anti-TB treatment (ATT) drugs
3) Establish linkages to DMC/CBNAAT site for TB case-finding activities
4) Coordinate with SACS to:
   i. Obtain necessary permissions from prison authorities for District TB Cell (DTC) officials to visit intervention sites, interact with staff and inmates to understand progress and extend necessary guidance to the TB team working in prisons and other closed settings
   ii. Develop IEC materials in consultation with key stakeholders

STC should incorporate the ongoing/proposed TB work plan in their respective State Implementation Plans (SIP) so as to ensure the supply of reagents and consumables for DMC and Anti-TB treatment drugs.

13 FUNCTIONS OF TECHNICAL SUPPORT UNIT (TSU)

1) Facilitate the formation of a state-level working committee and organise periodic meetings at regular intervals (refer to Section 6)
2) Help in planning, implementation and monitoring the intervention
3) Facilitate formation of peer-led interventions and arrangement of training programmes to create a cadre of peer leaders/peer volunteers among inmates and officials
4) Facilitate development of prison-specific IEC materials
5) Submit report on the individual performance of each intervention site along with a consolidated report on the programme's progress on a monthly basis to SACS and NACO
6) Facilitate situational and needs assessment studies to foster evidence-informed programming
7) Facilitate site-specific capacity building programmes for officials, including medical professionals attached with prisons and other closed settings
8) Nominate a nodal person for each prison site to facilitate implementation of planned activities
9) Liaise with DAPCU and make joint field visits at least once a month in addition to regular monitoring visits
10) Organise quarterly review meeting involving focal persons from NACO, the prison department, SACS and NGOs working with the programme

Team Leader (TSU) should consider Prisons, Swadhar, Ujjawala and other State-run Homes as TI sites and allocate these intervention sites to Programme Officers to help in planning, implementation and monitoring the intervention.

14 FUNCTIONS OF DISTRICT AIDS PREVENTION AND CONTROL UNIT (DAPCU)

1) Arrange, in association with SACS, regular HIV testing camps in prisons and other closed settings by deputing a counsellor and a lab technician on specific days at a given prison
2) Arrange, in association with SACS and other relevant authorities, for transportation with appropriate security to take HIV-positive inmates to ART centre for initiation of treatment and regular monitoring tests
3) Ensure sharing of the service providers' list, including ICTC, ART, TB, STI, drug dependence treatment, with the nodal officer for referral of released prisoners and other inmates for necessary HIV prevention, treatment, care and support services
4) Act, in coordination with the district department, as a nodal officer to help released prisoners, including those who use drugs, in availing various government welfare schemes, such as loans and pension
5) Visit prisons and other closed settings and interact with inmates to understand the progress of HIV/TB intervention
6) Liaise with the office of the district collector, prisons department and authorities of other closed settings to address issues related to stigma and discrimination of inmates and released prisoners

DAPCU should ensure sharing of the service providers' list, including ICTC, ART, TB, STI, drug dependence treatment, with the nodal officers for referral of released prisoners and other inmates for necessary HIV/TB prevention, treatment, care and support services.

15 ROLE OF STATE PRISONS DEPARTMENT AND OTHER CLOSED SETTINGS

1) Provide infrastructure at respective intervention sites for the following purposes:
   i. Integrated Counselling and Testing Centre
   ii. Opioid substitution therapy
   iii. Diagnosis and treatment services for STI/RTI
   iv. DOT centre/Designated Microscopy Centre for TB
   v. Store room
2) Appoint nodal officers at each intervention site to liaise with SACS, STC/DTC and NGOs
3) Provide necessary permissions to inmates diagnosed with HIV and TB to avail various treatment, care and support services, including ARV and ATT drugs
4) Provide permissions to NGOs/CBOs contracted by NACO/SACS to carry out HIV and TB interventions
5) Provide necessary permissions to SACS and STC/DTC officials to visit prisons and other closed settings, where interventions have been initiated, to interact with staff and inmates to understand progress and to extend necessary guidance to the HIV and TB team working at intervention sites
6) Provide facilities, including venue and refreshments, when organising site-specific advocacy meetings and training programmes for staff, peer leaders and peer volunteers
7) Invite SACS, STC/DTC and/or DAPCU officials to participate in review meetings
8) Ensure separate cell are provided for transgender persons

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

16 GENDER RESPONSIVENESS, AND ADDRESSING STIGMA & DISCRIMINATION

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

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

Some programmatic issues which need attention are:

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

17 SOCIAL REINTEGRATION

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

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

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

- Pre-release planning programmes and transition facilities are often crucial for the offenders' successful re-entry into community and desistance from crime.
- Linkages with health services in the community, including HIV or TB clinics and drug dependence services, need to be established prior to release. The treatment initiated in prisons and other closed settings for PLHIV and TB patients is often interrupted once the inmate is released, and this can lead to treatment failure, with its own negative consequences. Therefore, inmates living with

HIV must have access to treatment programmes in the community when they are released so that support, counselling and treatment can continue.

- Complete recovery from drug dependence takes time and requires effective treatment, followed by effective management of the problem over time. Post-release continuum of care is particularly important for drug-dependent offenders receiving treatment. Access to appropriate drug dependence treatment, including OST, in the community is essential for ensuring successful social reintegration of drug-abusing offenders.
- It is important to help released inmates become part of support groups; counsel their family members to provide necessary support at the time of release; provide networking and referral details of various HIV prevention and treatment services available in the community; provide details about Narcotics Anonymous/faith-based institutions and other support groups existing in the community; and identify existing social/governmental structures to provide them the necessary support.
- As per New Prison Manual 2016, it is envisaged that special committees, known as Discharged Prisoners' After-Care and Rehabilitation Committees, will be set up at the district or state level to plan and devise appropriate mechanisms for rehabilitation and after-care assistance to prisoners.
- It has been observed that there is a critical need to have the services of a qualified psycho-social counsellor within prison settings, for initiating post-release continuum of care. Therefore, SACS should advocate for such resources under MoHFW's Mental Health Programme or through budgetary allocation by the prison department for providing this service.
- Formation of a social support network through respective TI-NGOs for released prisoners (injecting drug users) may also be explored.

Linkages with health services in the community, including HIV or TB clinics and drug dependence services, need to be established prior to release. The treatment initiated in prisons and other closed settings for PLHIV and TB patients is often interrupted once the inmate is released, and this can lead to treatment failure, with its own negative consequences. Therefore, SACS in coordination with relevant departments and STC should institutionalize a mechanism to ensure post-release linkages.

18 MAINSTREAMING HIV and TB INTERVENTIONS

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

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

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

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

> In order to ensure sustainability, the HIV and TB interventions provided to inmates by SACS and STC/DTC should be mainstreamed into State Medical Services / Health Department / Prison Department rather than under NACP/RNTCP.

19. ANNEXURES

ANNEXURE 1: INMATE REGISTRATION FORM

Inmate Intake/Registration Form

(Note: This form is confidential and should be kept under lock and key with the District Coordinator/ Advocacy Officer.)

1	a) Name of the prison/home b) Prison code	_____ _____ _____
2	Date of registration	DD / MM / YYYY ____ ____ _____
	a) State code b) District code	_____ _____ _____
3	Inmate a) Serial No. b) Case No.	_____ _____
4	Name of the inmate	_____ _____
5	Father's/Husband's/Mother's name	_____ _____

6	Age in completed years	_____
7	Sex	Male ----------1 Female ---------- 2
8	Contact address	_____ _____
9	Aadhaar card no.	
10	Phone no. of family member	
11	Identification marks	
12	Prisoner type	Convicted ……..1 Under-trial ……..2
13	Period of imprisonment/stay	Years _____ Months _____
14	Date and time of admission in the prison	Date: DD / MM / YYYY ------- / -------- / ---------- Time: HRS _____
15	Reason for imprisonment/stay	Using drugs ……1 Selling drugs ……..2 Theft ……..……3 Family dispute ……4 Antisocial activity ……5 Other (Specify) ……6 _____

16	Number of times stayed in prison/home	
17	Marital status	Never married .....1 Currently married.....2 Divorced/Separated.....3 Widow/Widower.....4
18	Occupation	Never employed ..... 1 Currently unemployed ..... 2 Full-time employed ..... 3 Part-time employed ..... 4 Student ..... 5 Housewife ..... 6 Others (Specify) ..... 7 _____
19	Education	Illiterate ..... 1 Primary (1-5) ..... 2 Middle (6-8) ..... 3 Secondary (9-10) ..... 4 Hr. Secondary (11-12) ..... 5 Graduate ..... 6 Technical/Professional ..... 7 _____

Substance Use and Sexual Behaviour Pattern			
20	Which of the following substances you are addicted to? a) Tobacco (smoking/chewing) ..... b) Alcohol ..... c) Cocaine ..... d) Drugs ..... e) Opioids ..... f) Any other (Specify)	Yes ....1 No .....2 Yes ....1 No .....2 Yes ....1 No .....2 Yes ....1 No .....2 Yes ....1 No .....2 Yes ....1 No 2	
21	Have you ever injected drugs?	Yes ....1 No .....2 If 'No' GO TO Q24	
22	How long have been injecting drugs?	Years _____ Months _____	
23	Have you shared (borrowed/lended) needle/syringe with others?	Yes ....1 No 2	
24	Have you ever received OST?	Yes ....1 No 2	
25	Were you on OST at the time of arrest? /Admission ?	Yes ....1 No 2	
26	Do you have the following type of sexual partners? a) Spouse/Girl or Boy friend ..... b) Paid partners ..... c) Paying partners ..... d) Casual partners ..... e) Same sex partner	Yes ....1 No .....2 Yes ....1 No .....2 Yes ....1 No .....2 Yes ....1 No .....2 Yes ....1 No 2	
27	Do you use condom regularly while having sex with a) Spouse/Girl or Boy friend ..... b) Paid partners ..... c) Paying partners ..... d) Casual partners ..... e) Same sex partner	Yes ....1 No .....2 NA .....3 Yes ....1 No .....2 NA .....3 Yes ....1 No .....2 NA .....3 Yes ....1 No .....2 NA .....3 Yes ....1 No .....2 NA 3	
28	Have you ever been forced to have sex by other inmates inside the jail?	Yes ....1 No 2	

29. Please collect the following information from the Jail Authority (Doctor):

A) Hepatitis C status	Positive.....1	Negative.....2
B) TB status	Positive.....1	Negative.....2
C) HIV status	Positive.....1	Negative.....2
D) STI status	Positive.....1	Negative.....2

Counselling Register (Inside the Prison)										
S. No.	Date	Type of Counselling			Name of Inmate Counselled (If it is group counselling, write "Group" only)	UID Number(s) (For group counselling, mention number of participant & barrack no.)	Duration of Counselling	Topic Discussed** (Code)	Follow Up Date for the Next Visit	Remarks
		Individual	Family	Group						
1.										
2.										
3.										
4.										
5.										

**** Topic discussed: Code**

(01): Risk assessment (02): Risk reduction counselling (03): STI, safe-sex counselling and condom demonstration (04): Education on HIV/AIDS, TB and HIV testing (05): Counselling on drug-related harm (06): Counselling on drug treatment, including OST (07): Marital counselling (08): Family counselling (09): Education on ART (10): Positive living (11): Counselling on reintegration (12): Any other (specify)

ANNEXURE 3: REFERRAL REGISTER

Referral Register

S. No.	Date	Name of Inmate	UID Number	Testing Date	Referred to								Follow Up Date for the Next Visit	Remarks
					ICTC	ART	OST	STI	TB	Hep C	Other			
1.														
2.														
3.														
4.														
5.														
6.														

Master Register for Inmates

Prison Code: | **District Name:**

REGISTRATION INFORMATION			PERSONAL INFORMATION							SOCIO-DEMOGRAPHIC PROFILE						
S. No.	Date of Registration	UID No.	Name of Inmates	Age	Sex	Address with and PIN Code	Aadhaar Card No (Optional)	Prisoner Type	If Convict (Period of Imprison-ment)	Reasons for Imprison-ment	Marital Status	Educa-tional Status	Earlier Employ-ment Status	Monthly Income	Type of High Risk Behaviour	No. of Years in Sex Work
								Convict		Selling drugs	Married	Illiterate	Employed		IDU	
								Under trial								

DRUG USE AND INJECTING PROFILE					HISTORY of SEX WORK (MSM Activities)				Released			LINKAGE SERVICES				
Injecting Drug Use (last 3 months) (Yes/No)	Category Injecting Drug	Average Injecting Episodes Per Month	Non-injecting Drugs	Period of Involve-ment in Sexual Activities (in years)	Sex in Exchange of Money/ Drugs (Y/N)	STI Symp-toms / Treatment in the Last 12 Months (Y/N)	Knowl-edge of Condom Use (Y/N)	Physically Abused Inside the Jail (Y/N)	When is He Going to be Released		Transfer to TI Name	HIV Status	If HIV Positive, whether Linked to ART	Last CD4 Count	Whether Currently on ART	Linked with OST
Yes	Pentazocine								Month	Year						

ANNEXURE 5: STI RECORD

STI Record

S. No.	Date	Name of Inmates (Patient)	Father's/ Husband's/ Mother's Name	Age	Sex	Present Complaint	Since When	Since When	STI/RTI Syndromic Diagnosis	Treatment	Counselling	Next Visit Date
					TG	M/UN					Yes/No	

ANNEXURE 6: ART MASTER LINE LIST

Master Line List of Patients Enrolled in ART Centre												
S. No.	Date of Registration in HIV Care at ART Centre	Pre ART No.	Name of Patient	Aadhaar Card No.	Complete Address	Block and District	Contact No.	Age	Sex	Baseline CD4 Count	Latest CD4 Count	Date of Latest CD4 count
					TG							

Status in Pre-ART Care		ART Registration No. (If initiated on ART)	Date of Start of ART	Status in ART Care	Due Date of Visit at ART	Remarks for LFU Tracking	Risk Group/ Route of Trans-mission	Special Case	Transfer Out To
Choose one from the drop-down menu: Alive in pre-ART; Initiated on ART; Eligible but not initiated on ART; Died; LFU; Opted out; Transfer out	Date of ART Eligibility			Choose one from the drop-down menu: Alive on ART; Died; LFU; Stopped; MIS; Transfer Out; Unknown					

ANNEXURE 7: ADVOCACY MEETING REGISTER

ADVOCACY MEETING REGISTER												
S. No.	**Date**	**Location**	**Subject Meeting / Event**	**Objec-tives of Meeting/ Event**	***Type of Participants**					**No. of Partici-pants**	**Advocacy Meeting Register**	**Follow up Action**
					Prison Officials	Police	Local NGOs/TIs	Referral Centrals Officials	Others			
Brief Note About the Advocacy:												

ANNEXURE 8: CAPACITY BUILDING REGISTER

Capacity Building/Training Register

S. No.	Date	Venue of Training	Name of Participants and Designation	Type of Training (Induction/Refresher /Training on new skills	Training Agency (NACO/SACS/ STC)	Remarks

Brief Note About the Training:

ANNEXURE 9: COMMUNITY MOBILISATION REGISTER

Community Mobilisation Register											
S. No.	Date	Location	Subject of Community Event	Objectives of Community Event	*Type of Community Event					No. of MARP Attended	Outcome
					Awareness / sensitization Program	Music Competition	Talent Hunt	Slogan writing	Others		
Brief Note About the Community Event:											

ANNEXURE 10: MONTHLY REPORTING FORMAT

Monthly Reporting Format																			
				Number of Inmates Tested for HIV	Number of Inmates Found HIV Positive	Number of Inmates Linked to ART	Number of Inmates Attended STI Clinic	Number of Inmates Diagnosed and Treated for STI	Number of Inmates Screened for TB	Number of Inmates Diagnosed with TB	Number of Inmates Started for TB (DOTS)	Number of Inmates Screened for Hep-C	Number of Inmates Diagnosed with Hep-C	Number of Inmates Started Hep-C Treatment	Number of Inmates Started OST	Number of Released Inmates Linked to TI Program	Number of Released Inmates Linked to OST	Number of Released Inmates linked to ART	Number of PLHIV Inmates death reported	Number of inmates linked to social security schemes
District Name	Type of Jail / Homes	Total no. of Inmates	Type of Inmates	Apr-18	Apr-18	Apr-18	Apr-18	Apr-18	Apr-18	Apr-18	Apr-18	Apr-18	Apr-18	Apr-18	Apr-18	Apr-18	Apr-18	Apr-18	Apr-18	Apr-18

Monthly Reporting Format

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21. FOOTNOTES

1 'Prisons and other closed settings' refers to places of detention that hold people who are awaiting trial, who have been convicted or who are subject to other conditions of security. These settings may differ in some jurisdictions, and can include jails, prisons, police detention, juvenile detention, remand/pre-trial detention, forced labour camps and penitentiaries. There is a need to be inclusive in the language used to describe prisoners and other incarcerated people. Universal access to HIV prevention, treatment, care and support should ideally extend to these settings.

2 A correctional institution is used to detain persons who are in the lawful custody of the government (either accused persons awaiting trial or convicted persons serving a sentence). Correctional institutions can be categorised as: (A) Institutional treatment - 1) Prisons, 2) Observation homes, 3) Special homes, 4) Children's homes, 5) After-care organisations, 6) Protective homes for women, 7) Short stay homes, 8) Beggar homes; (B) Non-institutional treatment - 1) Probation and 2) Parole; and (C) Hybrid treatment - 1) Community service and 2) Work release.

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8 Information, education and communication; HIV testing and counselling; treatment, care and support; prevention, diagnosis and treatment of tuberculosis; prevention of mother-to-child transmission of HIV; condom programmes; prevention and treatment of sexually transmitted infections; prevention of sexual violence; drug dependence treatment; needle and syringe programme; vaccination, diagnosis and treatment of viral hepatitis; post-exposure prophylaxis; prevention of transmission through medical or dental service; prevention of transmission through tattooing, piercing and other forms of skin penetration; protecting staff from occupational hazards

9 It has been known for many years that IPT for people living with HIV (PLHIV) prevents TB. WHO recommends that PLHIV who are unlikely to have active TB should receive at least 6 months of IPT as part of a comprehensive package of HIV care. The effects of IPT augment the effects of ART on reducing the incidence of TB. WHO strongly recommends that in resource constrained settings, tuberculin skin test (TST) should not be a requirement for initiating IPT and that PLHIV should be started on IPT following negative symptom-based screening. In addition, PLHIV who are household or close contacts of people with TB and who after an appropriate clinical evaluation are found not to have active TB should be treated for presumed latent TB infection (LTBI) with IPT. IPT has also been found to be safe in children and in pregnant women. (WHO guidelines 2011: Intensified tuberculosis case-finding and isoniazid preventive therapy for people living with HIV in resource-constrained settings)

10 The criteria for a jail being categorised as a central jail differ from state to state. However, a common feature observed in all states/UTs is that the prisoners sentenced to imprisonment for a longer period (more than 2 years) are confined in central jails, which have larger capacity than other jails. These jails also have rehabilitation facilities. (Prison Statistics India 2012)

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Globally, prisons are characterized by relatively high prevalence of HIV, hepatitis C virus and tuberculosis and India is not an exception to it. Almost all prisoners will return to their communities, many within a few months to a year. Health in prisons and other closed settings is thus closely connected to the health of the wider society, especially as it relates to communicable diseases. Section 31 of the HIV/AIDS (prevention and control) Act, 2017 states that "Every person in the care and custody of the state shall have right to HIV prevention, testing, treatment and counselling services".

National AIDS Control Organization under the Ministry of Health and Family Welfare, Govt. of India is fully committed in providing comprehensive intervention with multiple strategies to address people living in prisons and other closed settings including post-release social reintegration services. Although Women and girls represent 4% of the prison population in India; similar intervention has been extended to women living in prisons as majority of them are from socially marginalized groups and are more likely to have been engaged in sex work and/or drug use. Besides covering women in prisons, NACO is also expanding the services to women living in other closed settings such as Swadhar, Ujjawala and State-run Homes in the Country.

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DOTS
Pura course, Pakka ilaaj