

OMBUDSMEN IN INDIA UNDER THE HIV/AIDS (PREVENTION AND CONTROL), ACT 2017 WITH SPECIAL REFERENCE TO THE STATE OF MIZORAM

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ABSTRACT

This study critically discuss the effectiveness of the Ombudsman mechanism provided by the HIV/AIDS (Prevention and Control) Act, 2017 with specific reference to the State of Mizoram. The Act establishes a rights-based approach to combating HIV and AIDS-related discrimination and access to grievance redressal. The study uses data gathered via questionnaires with 301 PLHIV respondents from selected ICTC centres in Aizawl and 42 officials from various government and health institutions to analyse awareness, accessibility, record keeping, complaint resolution and institutional coordination with regard to the Ombudsman system. These findings indicate low awareness of PLHIV, gaps in institutional knowledge, limited interaction with the Ombudsman, inadequate documentation and poor follow up. While the Ombudsman mechanism has a legal importance, the study suggests that its effectiveness would benefit from increased awareness of its value, training of Ombudsmen staff, standardization of reporting, easy access to complaint channels and regular monitoring. The paper recommends that the Ombudsman system be strengthened and effective implementation of HIV/AIDS Act, 2017 in Mizoram must be achieved.

KEYWORDS: HIV/AIDS Act 2017; Ombudsman; PLHIV; Mizoram; grievance redressal; discrimination; healthcare rights.

1. INTRODUCTION

HIV/AIDS is not only a public health problem, but also a major human rights problem, as people with HIV and AIDS experience stigma, discrimination, lack of confidentiality, and a lack of equal access to health, work, and education, among other things. To tackle these concerns, the Indian Parliament passed the Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (Prevention and Control) Act, 2017. The purpose of the Act is to protect the rights, dignity and to prevent discriminatory practices against persons living with HIV and AIDS (PLHIV) both in the public and private sectors.

The HIV/AIDS (Prevention and Control) Act, 2017, has an important provision which calls for the appointment of Ombudsmen. Section 23 of the Act requires each State Government to appoint one or more Ombudsmen to investigate complaints of breaches of the Act. The Ombudsman should be a forum easily accessible to PLHIV, independent from government bodies, and time bound to redress grievances, especially those related to discrimination in access to health, work, education, and public services. Whereas, the Ombudsman may investigate complaints, make recommendations for remedies and conciliate the parties as may be necessary.

The Ombudsman has a quasi-judicial function and he/she has powers similar to those of a civil court to summon persons, to require documents and to examine witnesses. The Ombudsman is a critical institutional tool to guarantee the proper implementation of the Act. The mechanism also represents the overall aim of the legislation, which is to advance the dignity, equality, confidentiality and rights of people infected and affected by HIV/AIDS.

In the State of Mizoram, the HIV/AIDS (Prevention and Control) Rules, 2022 came into force on 1 November 2022 and would be the bases for the functioning of the Ombudsman. As per these Rules, the Ombudsman shall be an officer of not below Joint Secretary in Department of Health and Family Welfare, Government of Mizoram. The Ombudsman's jurisdiction is across the State and he is empowered to take complaints, carry out enquiries, defend the rights of children and those affected by HIV/AIDS, coordinate with relevant authorities and make recommendations for more effective implementation of the Act and Rules.

The Ombudsman in Mizoram also liaison with the Mizoram State AIDS Control Society, District AIDS Prevention and Control Units, health care institutions, non-governmental organizations and social welfare agencies. If complaints are not resolved at the Complaint Officers' level, the Ombudsman can step in and act as necessary. The Ombudsman can also suo-moto consider an issue and it is also mandatory to file quarterly report of the complaints disposed of and pending before the Department of Health and Family Welfare via the Project Director, Mizoram State AIDS Control Society.

The effectiveness of the Ombudsman mechanism under the HIV/AIDS (Prevention and Control) Act, 2017 in State of Mizoram is explored in the present study in the backdrop of the legal and institutional framework. It highlights awareness,

access, complaints handling, institutional co-ordination and the real-life issues of implementation of the Ombudsman system.

2. REVIEW OF LITERATURE

HIV/AIDS remains a significant public health and human rights issue in need of not just medical services, but also of legal, social and institutional safeguards for people living with HIV and AIDS (PLHIV). HIV is at a critical juncture in the world and ending stigma, discrimination and structural inequalities is a critical component of effective prevention, treatment, care and support, UNAIDS (2024) notes. The report also identifies the legal and policy contexts as an important factor in guaranteeing the right to health services and justice for PLHIV without discrimination. This global approach is applicable in the Indian context as the HIV/AIDS (Prevention and Control) Act, 2017 establishes a rights-based approach to safeguard PLHIV against discrimination and facilitates grievance redressal.

There has been extensive literature discussing the link between HIV/AIDS and stigma. Gouda (2023) notes that stigma and discrimination remains to have an impact on the lives of people living with HIV, particularly vulnerable and migrant individuals. The research points to the fact that stigma associated with HIV is not only personal, but also a reflection of social attitudes, institutional practices and inequalities in access to support. Likewise, Kohli et al. (2024) have reviewed the psychological consequences of stigma on HIV/AIDS and seen that stigma can have a detrimental effect on one's self-esteem, mental wellbeing, and social engagement when they have an HIV infection. These studies indicate that legal protection is not enough without awareness, sensitization and support that is accessible.

Lalhruaimawii, Danturulu, Rai, Chandrashekar and Radhakrishnan (2022) gave a narrative review on the factors influencing stigma of PLHIV in the Indian context. Their work shows that social misconceptions, fear of transmission, moral judgment, gender inequality, lack of awareness and discriminatory behaviour in healthcare and community settings all impact on stigma in India. This is particularly important on the present study since the Ombudsman mechanism established by the HIV/AIDS Act has been designed to deal with discrimination, confidentiality issues and denial of services. PLHIV may not approach the grievance redressal institutions if they are not aware of their rights and fear disclosure of their HIV status.

There are also a few studies that have studied the impact of stigma on treatment uptake and living with HIV. Ekstrand et al. (2018) concluded that stigma may have an impact on ART adherence and quality of life for women living with HIV in India. Overall, the study demonstrates the negative influence of stigma on people's trust in healthcare providers and access to services. This is directly related to the current study as the effectiveness of the Ombudsman system lies in the willingness of PLHIV to report violations in healthcare and administrative systems with the feeling of being safe, informed, and confident in the process.

On this issue, the impact of the HIV/AIDS (Prevention and Control) Act 2017 has been the subject of law research. Verma, Verma, Verma and Richhariya (2018) talk about the medico-legal significance of the Act and its applications in the case laws, as the Act gives a formal legal frame for the protection of confidentiality, prevention of discrimination and securing rights of the PLHIV. The Act is important because it acknowledges that HIV/AIDS-related discrimination may happen in a variety of contexts, such as in healthcare, employment, education, housing and public services. In this regard, the legal right to an Ombudsman is an important institutional process that can be invoked to improve on access to remedies.

This wider connection between public health law, ethics, harm reduction, and social justice has also been noted in more recent publications. The authors of this article (Kumawat, Sunita, Singh and Kaur, 2026) believe that the public health law needs to reconcile the need to prevent disease with respect for rights, dignity and social justice of individuals. Their discussion is more of a general nature than HIV/AIDS, but it is appropriate for this article because the Ombudsman mechanism is an attempt to integrate public health governance and rights-based accountability. In this respect, the Ombudsman is not only an administrative body, but also a legal and ethical protection of vulnerable people.

There is also empirical evidence from India that discrimination against PLHIV is an issue in its own right that is ongoing. Based on the NFHS data of India from high HIV prevalence states, Singh and Shri (2023) highlight socio-demographic factors associated with the discrimination faced by PLHIV. They conclude that differences in discriminatory attitudes exist by social and demographic groups, and continue to play a role in stigma reduction through awareness and education. This strengthens the importance of enhancing institutional awareness building particularly in areas of high HIV prevalence where PLHIV may need available grievance redressal systems.

The World Health Organization (2024) also emphasizes the importance of integrated health and policy approaches, targeting environmental, social and institutional determinants of health. WHO guidance is general but it reinforces the idea that health protection needs to be coordinated through the interaction of legal, administrative and healthcare organisations. Coordination is significant in the context of the HIV/AIDS Act for the effective operation of Complaint Officers, Ombudsmen, State AIDS Control Societies, healthcare institutions and legal service authorities.

In the light of the existing literature, therefore, it can be concluded that the impact of HIV/AIDS-related stigma and discrimination persists at social, psychological, healthcare and institutional levels of the lives of PLHIV. It also highlights the need for legal protection but also implies that this protection needs to be complemented by awareness, access, confidentiality, institutional coordination and effective grievance redressal. However, very little has been done to examine the working and effectiveness of the Ombudsman mechanism at the state level, especially in Mizoram. To bridge this gap, the present study aims to explore the issues of awareness, access, complaints, record keeping, institutional coordination and implementation problems of the Ombudsman under the HIV/AIDS (Prevention and Control) Act, 2017 in Mizoram.

Research Objective

The main objective of this study is to examine the efficacy of the Ombudsman mechanism under the HIV/AIDS (Prevention and Control) Act, 2017 in the State of Mizoram, with particular reference to awareness, accessibility, complaint handling, record-keeping, institutional coordination, and implementation challenges.

Hypothesis

The HIV/AIDS (Prevention and Control) Act, 2017 has been implemented in Mizoram; however, the effectiveness of the Ombudsman mechanism depends on the level of awareness among PLHIV, accessibility of the grievance redressal system, institutional coordination, and proper monitoring of complaints.

3. METHODOLOGY

The present study used questionnaires to evaluate the effectiveness of the Ombudsman mechanism provided by the HIV/AIDS (Prevention and Control) Act, 2017 in Mizoram. Respondents were selected through non probability sampling technique. The study was carried out in selected Integrated Counselling and Testing Centres (ICTCs) within the Aizawl city area, which include Civil Hospital, Kulikawn hospital, Zoram Medical College and Synod hospital, Durtlang. Structured questionnaires were used to gather primary data from PLHIV. A total of 301 responses were collected from PLHIV out of 10,158 registered cases as of December 2025. The targeted sample size was obtained using Cochran's formula. However, in some of the targeted sample size could not be realized because of non-availability of PLHIV respondents on the days of data collection. As shown in Table 1, data were collected from 301 PLHIV respondents across four selected ICTCs in Aizawl, with the highest number of responses collected from Synod Hospital, Durtlang.

Table 1: Distribution of PLHIV Respondents across ICTCs

S.No	ICTC	Number of data collected from PLHIV	Number of targeted samples as per Cochren's formula
1	Civil Hospital	181	226
2	Kulikawn Hospital	83	108
3	Zoram Medical College	8	8
4	Durtlang Hospital	29	29

Apart from the PLHIV respondents, data were also gathered from the officials and staff of the relevant government and health departments/organs such as Secretariat, Health and Family Welfare Department, Directorate of Hospital and Medical Education, Department of Health and Family Welfare, and Mizoram State AIDS Control Society. The respondents in the study were forty two (42) official respondents. The distribution of official respondents from government and health institutions is shown in Table 2.

Table 2: Distribution of Official Respondents from Government and Health Institutions

S. No.	Name of Office	Number of Samples
1	Secretariat, Health and Family Welfare Department	10
2	Directorate of Hospital and Medical Education	9
3	Health and Family Welfare Department	12
4	Mizoram State AIDS Control Society	11

Data collected was analysed descriptively. The answers were analyzed to gauge awareness of the Ombudsman mechanism, accessibility to grievance redressal, record-keeping, complaint resolution, institutional coordination and issues faced in implementing the HIV/AIDS (Prevention and Control) Act, 2017 in Mizoram.

4. Data Analysis and Interpretation

The data gathered from the official and the PLHIV respondents were analysed to understand the role of Ombudsman in the HIV/AIDS (Prevention and Control) Act, 2017 in Mizoram. The analysis emphasizes on awareness, accessibility, documentation, complaint handling, monitoring, institutional coordination and the experience of PLHIV.

4.1 Awareness and Accessibility among Officials

The answers show that there is moderate but uneven awareness of the Ombudsman mechanism among officials of institutions. Twenty-four (24) out of the forty-two (42) official respondents were aware of the appointment of an Ombudsman under the HIV/AIDS (Prevention and Control) Act, 2017, while eighteen (18) official respondents were not aware of the appointment. The awareness was greater among the MSACS respondents and less among the DHME respondents. The table also reveals that the situation regarding accessibility is still not clear as the same number of respondents said the Ombudsman was "approachable" and "not approachable".

Table 3: Awareness and Accessibility of the Ombudsman among Officials

Indicator	Yes	No	Not Sure/NA	Total
Awareness of appointed Ombudsman	24	18	-	42
Helpline/communication channel publicized	20	14	8	42
Ombudsman easily approachable	17	17	4	42
Present Ombudsman system sufficient	13	4	22	42
Preference for medical/SACS background	24	9	4	42

The results indicate that the Ombudsman is institutionally present, but not all visible and accessible. The preference for an Ombudsman who has a medical or SACS background also shows that respondents believe that domain expertise will be important when dealing with complaints relating to HIV/AIDS.

4.2 Record-Keeping and Case Disposal

Tracking grievance redressal effectiveness is crucial and requires documentation. Table 4 is based on responses from forty-two (42) official respondents drawn from the Secretariat, Health and Family Welfare Department; Directorate of Hospital and Medical Education; Health and Family Welfare Department; and Mizoram State AIDS Control Society. It indicates that only fifteen (15) official respondents reported that records or reports of Ombudsman-related cases were maintained, while seventeen (17) official respondents reported that such records were not maintained, and ten (10) official respondents were not sure.

Table 4: Record-Keeping and Case Disposal Based on Official Respondents

Indicator	Number
Respondents reporting that records are maintained	15
Respondents reporting that records are not maintained	17
Respondents not sure about records	10
Total cases recorded	9
Total cases resolved	8

All of the data indicate that a large number of cases recorded were resolved but the number of reported cases is very limited. That can be a sign of reporting problems, data not being known, fear of being disclosed or poor sharing of data between offices. Lack of consistency in documentation also makes it difficult to accurately measure the Ombudsman's effectiveness.

4.3 Monitoring, Follow-Up, and Institutional Coordination

Table 5 is based on responses from forty-two (42) official respondents drawn from the Secretariat, Health and Family Welfare Department; Directorate of Hospital and Medical Education; Health and Family Welfare Department; and Mizoram State AIDS Control Society. It indicates that only four (4) official respondents reported the existence of a regular mechanism for performance evaluation, while only eight (8) official respondents reported that follow-up was conducted after grievance resolution.

Table 5: Monitoring, Follow-Up, and Coordination

Indicator	Yes/Reported	No	Not Sure/NA	Total
Regular evaluation mechanism exists	4	3	26	42
Follow-up after grievance resolution	8	3	31	42
Coordination through meetings	9	-	-	42
Report sharing	1	-	-	42
Joint training	0	-	-	42

The results show a low level of transparency in evaluating performance and poor follow up after the resolution. Coordination seems to be conducted primarily via meetings, and limited report sharing and joint training occur. This indicates a need for a more formalized coordination mechanism between the Ombudsman, the MSACS, healthcare institutions, complaint officers and other agencies.

4.4 Complaint Channels and Nature of Complaints

The data also indicate that direct complaints by PLHIV is extremely low. Table 6 illustrates that 3 respondents indicated that complaints were made by patients directly. Other complaint channels mentioned were phone calls and other unspecified methods.

Table 6: Complaint Channels Used to Address Stigma or Discrimination in Healthcare Settings, as Reported by Officials

S. No.	Name of Office	Number of Samples	Complaint by Patient	Complaint by Staff	Complaint by Other Person on Behalf of PLHIV	Phone Call	Others
1	Secretariat, Health and Family Welfare Department	10	NA	—	—	NA	NA
2	Directorate of Hospital and Medical Education	9	NA	—	—	NA	NA

3	Health and Family Welfare Department	12	1	—	—	4	6
4	Mizoram State AIDS Control Society	11	2	—	—	2	1
Total		42	3	—	—	6	7

Note: Table: 6 is based on data collected from official respondents. “NA” indicates that no complaint data were reported by the concerned office. Dash marks indicate that no specific response was recorded under that category in the original manuscript.

The low number of direct complaints from patients may be due to fear of stigma, fear of disclosure, lack of awareness, or lack of confidence in the grievance redressal system. The status disclosure complaint type was the most frequently cited type of complaint, which is notable as confidentiality is a key protection under the HIV/AIDS Act 2017.

4.5 Awareness and Experience of PLHIV Respondents

The cross-tabulation of responses obtained from 301 PLHIV respondents reveals a significant gap between awareness of the Ombudsman mechanism and its actual use by the intended beneficiaries. Among the 301 PLHIV respondents, only forty-eight (48) respondents were aware of the existence of the Ombudsman. Of these, only twenty-one (21) respondents knew about the role of the Ombudsman in protecting their rights, and only one (1) respondent had interacted with or approached the Ombudsman for help. The awareness and experience of PLHIV respondents regarding the Ombudsman mechanism are presented in Table 7.

Table 7: Awareness and Experience of PLHIV Respondents Regarding the Ombudsman Mechanism

S. No.	Question	Yes	No
1	Are you aware that there is an Ombudsman to help people with HIV-related problems?	48	251
2	Do you know what the Ombudsman’s role is in protecting your rights?	21	280
3	Have you ever interacted with the Ombudsman or approached them for help?	1	300
4	How easy is it for you to reach the Ombudsman if you need to?	187	114
5	Were you informed about your right to contact the Ombudsman when there is violation of the provision of the HIV/AIDS Prevention and Control Act, 2017?	46	255
6	Did any staff explain how you can make a complaint or raise a concern?	64	237
7	Do you feel you have enough information about the grievance process?	37	264
8	Have you faced any difficulties in understanding or accessing the Ombudsman’s services?	NA	NA
9	Do you feel your privacy and confidentiality were maintained when you contacted the Ombudsman?	NA	NA
10	Do you feel your complaints or concerns are addressed quickly by the Ombudsman?	NA	NA

Note: Questions 8, 9 and 10 are retained as per the original questionnaire; however, no response data were provided for these items in the original manuscript. For Question 1, the original data account for 299 responses out of 301.

The PLHIV data show that awareness is very low and there was no direct use of the Ombudsman mechanism. The low level of awareness and interaction indicates that while it would be easy to contact the Ombudsman if there were need it, it may be that the Ombudsman does not need to be contacted in practice. The overwhelming majority of respondents were not advised of their right to raise a complaint with the Ombudsman and few had an adequate level of knowledge about how to raise a complaint.

No information was available on the problems accessing services from the Ombudsman, ensuring privacy/confidentiality or speed of complaint resolution. This restricts the ability to fully evaluate the effectiveness of the Ombudsman as seen from the point of view of PLHIV.

In general, the study reveals that the Ombudsman mechanism is present in Mizoram but it is not very effective due to poor awareness among PLHIV, lack of proper documentation, inadequate publicity, inadequate monitoring, poor follow up and insufficient patient education.

5. DISCUSSION

The study reveals that the Ombudsman mechanism provided under HIV/AIDS (Prevention and Control) Act, 2017 has been officially piloted in Mizoram, however, practical implementation of the Ombudsman is hindered by limited awareness, accessibility, documentation, follow up and institutional coordination. The Act establishes an important rights-based framework, but it is evident that legal existence does not give meaning to the use of the rights of PLHIV. There is a discrepancy between statutory protection and ground level awareness, as demonstrated by the low awareness of PLHIV and uneven awareness of officials.

It was one of the most remarkable findings that very few PLHIV respondents knew about the Ombudsman and the role it plays regarding the protection of their rights. The use of grievance redressal mechanism is directly impacted by this weak awareness. It is crucial for communities to be at the forefront of and actively involved in the HIV response, according to UNAIDS (2023). This includes ensuring that PLHIV networks, community organizations, ICTCs, ART centres, healthcare workers are engaged in disseminating information on the Ombudsman, how to file a complaint, confidentiality protection, and legal remedies available in Mizoram.

Official awareness is not uniform, either, but is limited to some of the studies, as this study has indicated. Responses indicated fairly high awareness among MSACS respondents, with other offices indicating low awareness. The finding is

significant as the Ombudsman mechanism involves the involvement of several institutions: Healthcare Departments, MSACS, complaint officers, legal service authorities and community-based organizations. In the study on participation in a health-related scheme by Akinyemi, Owopetu and Agbejule (2021), it was revealed that perception and awareness have a significant impact on institutional participation. While their work is not HIV/AIDS specific, it reinforces the general concept that if public health mechanisms are to be effective, it is important that stakeholders know what they are, and believe in their value.

The other issue is that there is very little direct engagement between PLHIV and the Ombudsman. This could be because of fear of stigma, fear of disclosure, lack of confidence, limited awareness of complaints processes, or lack of understanding about confidentiality. UNAIDS (2024) emphasises that a rights-based approach, which prioritises equality, dignity, non-discrimination and access to justice, is the foundation of ending AIDS. The present study confirms this, and data indicate that the Ombudsman mechanism should be strengthened both legally and socially to make the PLHIV feel safe in reporting violations.

It is also found that there is not consistent record keeping and poor follow-up. While most cases recorded were apparently settled, the number of complaints recorded is relatively low. This does not necessarily mean that violations are uncommon, it might just mean that they are not reported, or that the reporting process is not well documented, or that there is not a high level of trust for the grievance process. Reflecting on India's AIDS response, Rao (2020) underscores the need for 'continuity of institutional effort, involvement of communities and ongoing vigilance'. More specifically, with regard to Mizoram, it is important that complaints are documented and reviewed quarterly and then followed up to ensure that they are addressed.

Coordinated institutional responses also do not seem to be in place. The data indicate that coordination happens primarily in the form of meetings, but there is little report sharing, joint training and systematic collaboration. Successful operation of the Ombudsman's mechanism will depend upon ongoing collaboration among the Ombudsman, MSACS, healthcare institutions, complaint handlers, and legal services organisations. If this is not coordinated, grievance redressal can be disjointed and ad hoc. Bhatia, Sethi, Sharma, Singh and Lakshmi (2026) have discussed behavioural risk clustering among college students and emphasize the need to identify vulnerable groups and public health intervention targeting specific behaviours. In this context, special awareness, legal literacy and confidential assistance is needed to address the needs of PLHIV.

The type of complaint that appeared in the study is the status disclosure. This is particularly important because the HIV/AIDS Act provides that confidentiality is a key protection. The risk of disclosure might prevent PLHIV from approaching institutions or lodging a complaint. For this reason, healthcare and administrative workers need to be educated in a responsible and legal manner to manage HIV-related information.

Overall, from the discussion it is concluded that the Ombudsman mechanism functions significantly in legal aspects, but remains underutilized in the operation and implementation in Mizoram. The issue isn't necessarily the lack of law, it's the disconnect between legal availability and actual availability. Efforts towards strengthening awareness, simplifying the process on complaint, maintaining confidentiality, improving documentation, conducting follow-up and institutional coordination are critical to make Ombudsman system effective for PLHIV in Mizoram. Such measures would also reinforce public trust, prompt reporting at opportune time and help make the rights-based commitment in the HIV/AIDS Act realized in the day-to-day functioning of healthcare and administrative processes in the state for all impacted people in Mizoram.

6. Key Findings

1. Awareness of the Ombudsman is uneven among officials and very low among PLHIV.
2. Direct interaction between PLHIV and the Ombudsman is almost absent.
3. Record-keeping, publicity, and follow-up are inconsistent across offices.
4. Monitoring and evaluation mechanisms are unclear.
5. Complaint reporting is mostly indirect; direct patient reporting is very low.
6. Status disclosure appears as an important complaint type.
7. No suo motu case was reported till date.
8. Data on confidentiality and speed of complaint resolution were unavailable.

7. Suggestions and Recommendations

1. Conduct targeted awareness campaigns for PLHIV, healthcare providers, and officials.
2. Provide mandatory staff training on PLHIV rights, confidentiality, and complaint procedures.
3. Simplify and publicize the complaint process in ICTCs, ART centres, hospitals, and community networks.
4. Develop uniform guidelines for record-keeping and reporting Ombudsman cases.
5. Establish regular monitoring, follow-up, and evaluation mechanisms.
6. Strengthen coordination between the Ombudsman, MSACS, healthcare institutions, and legal service authorities.
7. Encourage complaints through multiple channels, including patient, staff, representative, phone, written, and online modes.
8. Conduct anti-stigma sensitization, especially on confidentiality and status disclosure.

8. CONCLUSION

While the HIV/AIDS (Prevention and Control) Act, 2017 affords a rights-based framework that is progressive, its implementation of the Ombudsman mechanism is still beset with practical and institutional difficulties. The Act aims to make grievance redressal system accessible but in many States, it is hampered by delays in the appointment of officers, lack of awareness, ambiguous roles, meager resources, and inadequate institutional support. It is possible that even in the presence of Ombudsmen, PLHIV, healthcare workers and affected communities may not be aware of their existence, powers and complaint procedures, which can lead to underutilization of the Ombudsman mechanism. The study

demonstrates that the Ombudsman plays an important role in resolving cases of discrimination, breach of confidentiality, denial of services and other cases of violation of rights in terms of the Act. Stigma around HIV/AIDS does, however, deter many people from reporting grievances because they are afraid that they will be discriminated against again or they will be identified as having HIV. Lack of resources, non-standardized training, insufficient follow-up and non-binding recommendations further reduce the effectiveness of the Ombudsman system in practice. There is therefore a need to build capacity of the Ombudsman mechanism to enable its meaningful application to ensure implementation of the HIV/AIDS Act, 2017. Appointment, staffing, guidelines, standard training, and improved infrastructure are required. Awareness campaigns must be carried out for PLHIV, health care workers, officials and public. Complaint process needs to be easy, confidential and readily available. Ongoing monitoring, stakeholder feedback and involvement of civil society can further enhance trust, accountability and protection of PLHIV rights.

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