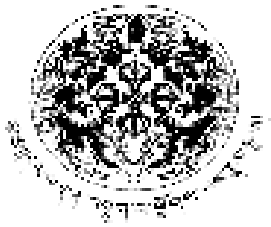
March 2014

BHUTAN Progress Report – 2014

Global AIDS Response Progress Report



National HIV/AIDS and STI Prevention and Control Porgramme (NACP), MOH

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ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
BCC	Behavioural Change Communication
BHU	Basic Health Unit
BNCA	Bhutan Narcotic Control Agency
BSS	Behavioural Surveillance Survey
DOPH	Department of Public Health
DOTS	Directly Observed Treatment Short Course
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GNH	Gross National Happiness
HISC	Health Information Service Centre
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IBBS	Integrated Biological Behavioural Surveillance
JDWNRH	JigmeDorjiWangchuck National Referral Hospital
KAP	Key Affected Population
MDG	Millennium Development Goal
MoH	Ministry of Health
MSM	Men who have Sex with Men
MSTF	Multi Sectoral Task Force
NACP	National STI, HIV and AIDS Prevention &Control Programme
NGO	Non-Government Organization
NHAC	National HIV/AIDS Commission
NSP	National Strategic Plan
ORC	Outreach Clinic
PMTCT	Prevention of Mother-To-Child Transmission
RBA	Royal Bhutan Army
RBG	Royal Body Guard
RBP	Royal Bhutan Police
RENEW	Respect Educate Nurture and Empower Women
RHU	Reproductive Health Unit
SBN	Sexual and Behavioural Network
STI	Sexually Transmitted Infection
TB	Tuberculosis
UN	United Nations

UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary Counselling and Testing
VHW	Village Health Worker
WB	World Bank
WHO	World Health Organization
YDF	Youth Development Fund

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ཐིམ་ཕུ།

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Foreword

Bhutan recognizing the unpropitious impact of HIV on the social and economic development of the country, prevention, treatment and care and support for those living with HIV, has received notable support and attention. Today services related to prevention, treatment and care are integrated with the primary health care delivery system and are provided at health facilities at different level. To further facilitate delivery of services several manual and guidelines were develop with support and guidance from our implementing and donor partners to guide the national programme in its mandate to mitigate the impact of HIV. In light of the recent evidence on the emerging risk and vulnerability for HIV, Ministry of Health in collaboration with its implementing partners have embarked on a new strategy of targeted intervention for the Most at Risk Population (MARPs) in 2012. The New Strategic Plan (2012-2016) embraces both the national review recommendation and international best practices to mitigate the impact of the epidemic.

Although Bhutan fall short of reporting on the high risk group related indicators due to lack of data capturing system for MARPs, the National strategy –II clearly outlines strategies for providing the much-needed services to the MARPs across the country with comprehensive targeted interventions. Thus the Report presented here features not only the country's progress toward the 2011 UN Political Declaration on HIV/AIDS but also reflects the synergistic efforts of diverse stakeholders – the leadership and commitment of national governments, the solidarity of the international community, innovation of the programme implementers, and the passionate engagement of civil society, most notably people living with HIV.

Under the collective and meaningful response to HIV in the country, we are happy to put forward our two "best practices" titled: The core pillar of our response - benevolent leadership and Meaningful partnership.

Lastly with the submission of the report, we would also like to take this opportunity to thank all our developmental partners for their support and commitment.

Tashi Delek!

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CHAPTER 1: STATUS AT A GLANCE

1.1 Methodology: The inclusiveness of the stakeholders

The process and submission of Global AIDS Response Progress Report (GARPR) 2014 was led by the National HIV/AIDs and STI Prevention and Control programme (NACP), under the Department of Public Health, Ministry of Health with technical support from UNAIDS country office in Kathmandu, Nepal. The report presented is based on the consolidated findings of both the GARPR and the NCPI data, which were discussed and validated by all key stakeholders working toward the common goal of mitigating the impact of HIV/AIDS in the country.

The stocktaking of the policy, strategies and legal environment was conducted as part of the desk review (Annex 1: Bibliography). The desk review was then followed by a semi-structured interview with key stakeholders, initiated with an issuance of a formal letter of introduction to the respective agencies by the National STI, HIV and AIDS Prevention &Control Programme (NACP) (Annex 2: Copy of the letter of introduction). The objective of the interview was to; validate the data collected through desk review and to collect information regarding challenges and gaps in the current system and way forward for the HIV response in the county at all level. During the semi-structured interviews, interviewees were requested to provide responses as representatives of their institutions or constituencies and not their own personal views. The list of selected stakeholders for the interview represented various actors of the HIV response in the country; The National program, The Policy and Planning Division (PPD) under the Ministry of Health, Monitoring and Evaluation Unit, Care and Treatment, Testing and Counseling, Pharmacy Department at the National Referral Hospital, HIV focal person in the Armed forces, Healthcare providers treating People living with HIV (PLHIV), Civil Society Organizations (CSO), Faith based Organization (FBO) and network of positive people in the country (Annex 3: List of key stakeholders).

The triangulation of the information collected from the desk review and interviews were then further validated and discussed during a full day workshop with all the relevant key stakeholders including Multilateral organization (UNICEF, WHO, UNDP, UNAIDS) in Paro (Annex 4: List of participant and Agenda). The discussion during the workshop contributed immensely toward understanding the ground reality and lesson learned for future strategy and way forward for the national programme.

1.2 The Status of the Epidemic

As of November 2013, the total HIV reported cases stands at 346 with equal proportion of male and female. Included in the total number are 27 children below 15 years of age representing 7.7% of the total case detected. Till date, there are 272 people living with HIV in the country. Although the total numbers of

HIV cases detected remain small, according to UNAIDS estimates there could be more than 1,100 (<1000-2700)[1] people living with HIV in Bhutan. Since the first detection of HIV in the country, the annual reported cases has substantially increased with approximately 87% of the total HIV cases reported between 2004 and 2013. The analysis of the data shows that similar to many countries in the region, majority (87%) of the PLHIV are within the productive age group of 20-49 years with a significant bearing on the social and economic development of the country.

Mode of transmission is predominantly through heterosexual intercourse (90.5%) followed by mother to child transmission (7.8%) and less than 2% through blood transfusion and injecting drug use. However, it can be noted that due to data limitations (in specific, blind spots regarding HIV prevalence and sizes of key affected populations) it makes it difficult to determine the level of HIV epidemic in the country.

Risk and vulnerability

Although, Bhutan is a low prevalence country there are several factors that likely contribute to higher risk and vulnerability for HIV such as; sixty percent of the country's population are below 25 years of age; growing trade with neighboring regions such as northeastern India, Nepal, and Bangladesh have led to high levels of cross border mobility; several neighboring states in India face "concentrated" HIV epidemics and evidence of high-risk practices in Bhutan. Thus it is critical to acknowledge that with the growing evidence of risk and vulnerability (as mentioned below), the epidemic dynamic is rapidly changing in Bhutan.

- High prevalence of multi partner sex practices with concurrent sexual relationships
- High rates of Sexually Transmitted Infections (STIs) amongst the general population
- Growing commercial sex activities and high STI rates among Female Sex Worker (FSW)
- Evidence of men having sex with men (MSM) and associated high risk behavior
- Growing evidence of drug use, unsafe Injecting practice, low condom use and high incidence of STIs.
- High risk behavior among bridge and mobile populations; truckers, taxi drivers and non-Bhutanese migrants

1.3 Policy and Programmatic Response

Five years prior to the detection of first case of HIV, recognizing the adverse impact of HIV on the National development, Government initiated the establishment of the National STI and HIV/AIDS Prevention and Control Programme (NACP) in 1988. The establishment of NACP was followed by the inception of National AIDS Committee (NAC) in 1993 to oversee and coordinate multi-sectoral efforts to ensure a

[1] http://www.unaids.org/en/regionscountries/countries/bhutan/

harmonized response to HIV in the country. The NAC was later restructured to form the National HIV and AIDS Commission (NHAC) for policy formulation and strategic responses to mitigate the impact of HIV in the country. Following the institutional establishment, planned activities were implemented over the years with a major focus on prevention and improving access to care and treatment services for the PLHIV in the country.

Guided by the strong political will and commitment, the National Strategic Plan for HIV/AIDS and STI (NSP-I, 2008–2013) was launched in 2008, in line with the Government's 10th Five Year Plan (FYP). The NSP-I provided the strategic direction for STI and HIV response in the country. In light of limited empirical data on the epidemic, NSP-I had a major focus on prevention through collaboration and meaningful participation of all key stakeholder to mitigate the impact of the epidemic and to create a supportive environment for people living with and affected by HIV and AIDS. The NSP-I, built on past achievements, existing gaps and focused on scaling-up existing cost effective preventive interventions to ensure accessibility to preventive and VCT services. During the Period of NSP-I various fundamentals guidelines and policies were developed in addition to building the capacity of the health care providers and other HIV services providers in the country. In addition to the guidelines, several studies have been undertaken to inform the National Programme such as:

- Knowledge, Attitude, Practice and Behavior Study on HIV/AIDS/STI (Among Uniform Personnel, In-School & Out-School Youth and Construction Workers in Bhutan. (2012).
- A Rapid Assessment on Sexual Behaviors and Networks in Thimphu conducted by the Center for Global Public Health (CGPH), University of Manitoba, Canada with support from Government of Bhutan between October 2009 and January 2010.
- National Baseline Assessment (NBA, 2009) among drug users
- KABP survey on HIV among Uniformed personnel, in and out of school youth 2009.
- Quality assessment for youth friendly health services (2009).
- Health Facility Survey 2009.
- Behavioral Sentinel Surveillance among the general population in 2008.

Considering the review recommendation of the national programme in 2011 and to address the changing dynamic of the epidemic, National Strategic Plan -II (2012-2016) was launched in 2012 with a goal to ***"reduce new STI and HIV infections and provide continuum of care to people living with and affected by HIV***". Besides crossing cutting prevention and health system strengthening strategic areas, NSP-II had a major focus on the following key affected populations defined under different categories:

- The sexually active and potentially vulnerable general population;
- People at highest risk to STI and HIV exposure such as; sex workers and their clients, people who inject drugs and men who have sex with men;
- Populations at increased risk to STI and HIV exposure such as youth, mobile populations including truckers, taxi drivers and migrant workers, uniformed services personnel;

- People at increased vulnerability, including the intimate partners/spouses of people higher risk group, prisoners and people in monastic institutions

Furthermore acknowledging the UNAIDS vision of 'Getting to Zero" and "Millennium Development Goal", Bhutan has embarked on achieving zero new HIV infections by 2015 with the scale up of HIV screening at the Basic Health facilities to allow all ANC attendees to undergo voluntary testing for HIV.

1.4 Indicator Data Overview

Of the total indicators (n=32) under the ten targets in the 2014 report, Bhutan is in the position to confidently report only few indicators that reflect key features of the HIV epidemic and response in Bhutan. With the targeted intervention being rolled out, many of the indicators related to KAP are unable to report. Furthermore, the unreported indicators are either not relevant to the country context or those for which data is not available at the time of reporting.

#	Indicators Titles			Data Source
		2013	2012	
Target 1. Reduce sexual transmission of HIV by 50 per cent by 2015				
Indicators for the general population				
1.1	Young People: Knowledge about HIV Prevention	Female: 21%	Female: 21%	BMICS – 2010 (NSB and UNICEF) Respondents are only females (15-49 yrs).
1.2	Sex Before the Age of 15	Female = 3.7%	Female = 3.7%	
1.3	Multiple sexual partners	Female 0.3%	Female 0.3%	
1.4	Condom Use at last sex among people with multiple sexual partnership	Female 20.4%	Female 20.4%	
1.5	HIV Testing in the General Population	N/A		
1.6	HIV Prevalence in young population			
Indicators for sex workers				
1.7	Sex Workers: Prevention programmes	Although there are TI to reach KAP under the GFATM – TFM proposal, there are no data available at this time. There is a IBBS in the proposal for KAP under the regional R-9 grant.		
1.8	Sex Workers: Condom Use			
1.9	Sex Workers: HIV Testing			
1.10	Sex Workers: HIV Prevalence			

#	Indicators Titles	2013	2012	Data Source
Indicators for men who have sex with men				
1.11	Men who have sex with men: Prevention programmes	There are TI both under the GFATM-TFM proposal and R-9 regional grant, but currently there are no data available for the indicator. The size estimation report is yet to be endorsed by the government.		
1.12	Men who have sex with men: Condom Use			
1.13	Men who have sex with men: HIV Testing			
1.14	Men who have sex with men: HIV Prevalence			
Target 2. Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015				
2.1	People who inject drugs: Prevention Programmes (Number of Syringes distributed per IDU per year by Needle and Syringe Programmes)	NO NSP and OST under the harm reduction framework and no TI for the IDU.		
2.2	People who inject drugs: Condom Use		53.7%	BSS 2008. The sample is any drug users
2.3	People who inject drugs: Safe Injecting Practices	N/A		
2.4	People who inject drugs: HIV Testing		28.2%	BSS 2008. The sample is any drug users
2.5	People who inject drugs: HIV Prevalence	N/A		
Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths				
3.1	Prevention of Mother-to-Child Transmission	Numerator 0 as of November 2013		
3.2	Early Infant Diagnosis	Awaiting implementation: Commodities procured through UNCEF support.		
3.3	Mother-to-Child transmission rate (modelled)	Non Applicable		
Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015				
4.1	HIV Treatment: Antiretroviral Therapy	149/1100=13.5%	64/1100=5.8%	149 on ART as of Nov 2013 (including 7 children) 1 child on 2nd line regiment.
4.2	HIV Treatment: 12 months	90%+	89%	Based on program data

#	Indicators Titles	2013	2012	Data Source
	retention			maintained by care and treatment unit.
Target 5. Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015				
5.1	Co-Management of Tuberculosis and HIV Treatment	Implementation rolled out under the HIV/TB collaboration. Data will available for next reporting period.		
Target 6. Reach a significant level of annual global expenditure (US$22-24 billion) in low and middle-income countries				
6.1	AIDS Spending - Domestic and international AIDS spending by categories and financing sources	No NASA has been conducted till date, but majority of the HIV program is supported exclusively by GFATM: total grant amount of 3.26 Million USD has been allocated since 2004 and till date disbursement to the CSOs (SR) amount for 0.25 million USD.		
Target 7. Critical enablers and synergies with development sectors				
7.1	National Commitments and Policy Instruments (NCPI)	Completed	Completed	Separate consultation with government and CSO including Un Agencies, Bilateral/Multilateral agencies was conduced
7.2	Prevalence of Recent Intimate Partner Violence (IPV) (Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months)	The indicator is capture in the most recent Health household survey conducted by Ministry of health. The report is not yet out.		
7.3	Orphans and non-orphans school attendance	Lhak-Sam (positive network) has 13 children under their program who are single or/and double orphans of HIV – all attending school.		
7.4	Economic support for eligible households	No data.		
Target 8: Eliminating stigma and Discrimination				
8.1	Discriminatory attitude toward people living with HIV	No formal indicator data capturing system: specific study limited to the formative assessment for MSM/TG/PLHIV under the regional R-9 looking at compound stigma.		

CHAPTER 2: OVERVIEW OF THE AIDS EPIDEMIC

2.1 Contextual Background

Bhutan is a land-locked country with total area of 38,394 Square Km and located between China in the North and India in the south on the southern slopes of the Eastern Himalayas. The north to south mountain band divides the country into three distinct regions with three major ethnic groups: Ngalops, Sharchops, and Lhotshampas living in Western, Eastern and Southern parts of the country respectively. Administratively, Bhutan is divided into 20 districts (dzongkhags) and 205 Gewogs (blocks). The country is largely an agrarian economy with 79 percent of its population engaged in agriculture and livestock farming. According to RNR statistics 2000, only about 7.8 percent of the land is arable. Furthermore due to steep terrains farm mechanization is limited and traditional farming practices are followed. In recent years more dynamic sectors such as electricity production, construction and tourism contribute to Bhutan's healthy economic growth of more than 6 precent per year. Modern economic development is largely limited to the public sector as Bhutan's private sector is relatively underdeveloped. However, with a rapidly growing educated workforce, private sector development is becoming a compelling necessity.

2.1.1 Demography

Majority of the population continue to live in rural areas (65.5%) while the current 36 per cent that live in urban areas is expected to increase with rapid rural – urban migration. Demographically, Bhutan is characterized by high but gradually declining fertility rate and a declining mortality rate. According to the Dzongkhags Population Projection 2006-2015, the population is projected to increase by 19 percent in 2015 reaching about 757,042 from the base population of 634,982[2] in 2005. The overall male to female ratio is estimated at 111 male per100 females. Of the total population almost 41 per cent are under 19 years of age (292,705:147,916 males and 144,789 females).[3] About one third of the population is below 15 years of age and approximately about 60 percent in the economically active age group of 15-64 years, while a little less than 5 precent is older than 64 years. The population pyramid demonstrates a large population in the younger age group although with a population growth rate of 1.8 %, this is likely to decrease over the years. Life expectancy at birth currently stands at 66.2 years (65.65 years for males and 66.85 years for females).[4]

[2] National Statistics Bureau (2005). Dzongkhags Population Projection 2006-2015, 2008 RGOB, Thimphu
[3]National Statistical Bureau. Population projections Bhutan 2005-2030; July 2007
[4]National Statistical Bureau. Bhutan at a glance; 2007

2.1.2 Socio-Economic Status

The overall development of the country has been guided by the philosophy of Gross National Happiness (GNH), which aims to balance the spiritual and material advancement through four major pillars: sustainable and equitable economic growth and development; preservation and sustainable use of the environment; preservation and promotion of cultural heritage; and good governance. The Human Development Index (HDI) for Bhutan is valued at 0.522 and ranked 141 out of 187 countries. Bhutan was recently upgraded to middle income country status due to its increasing GNI per capita of $5,293 but it is important to note that 23.2 per cent of the population continue to live on less than USD 1.25 a day[5]. The net primary school enrolment ratio, which is now 95 per cent, demonstrates the impressive scale up of education services across the country.[6] The secondary school enrolment ratio is however 52% with greater gender disparity and the youth literacy rate is 84 per cent for 15-24 year olds. Bhutan has achieved some of the Millennium Development Goals (MDGs) indicators and is on track to meet all the eight-millennium development goals.[7]

2.1.3 Health Outcomes

The health care services are delivered through the three-tiered system and managed by trained health care providers at all levels. At the highest level is the Jigme Dorji Wangchuck National Referral Hospital (JDWNRH) in Thimphu, along with regional referral hospitals at Gelephu in the South and Mongar in the Eastern Region. The district hospitals located in the district headquarters represent the middle level and BHUs linked to these hospitals represent the lowest level. Mobile clinics are regularly carried out in rural areas. In addition, more than 1,000 Village Health Workers (VHWs) participate actively in outreach activities. The STI and HIV services are integrated with the delivery of basic health services that is delivered through a network of 29 hospitals, 176 Basic Health Units (BHU) and 514 Outreach Clinics (ORC).

Bhutan's high investment in health has contributed to promising trend in health indicator outcomes. Immunization rates are excellent, with 100 per cent of children aged 1 year immunized against TB and 99 per cent of children under12 months immunized against measles.[8] Child and maternal mortality rates have declined over the years and in 2010 the infant mortality rate (IMR) was 47 per 1000 live births, the under-five mortality rate (U5MR) is 69 per 1000 live births and the maternal mortality ratio is 145.7 per 100,000 live births.[9] Nutritional status among children has similarly shown a steady decline, although

[5]UNDP. Human Development Report 2011; explanatory note on 2011 HDR composite indices; Bhutan 2011

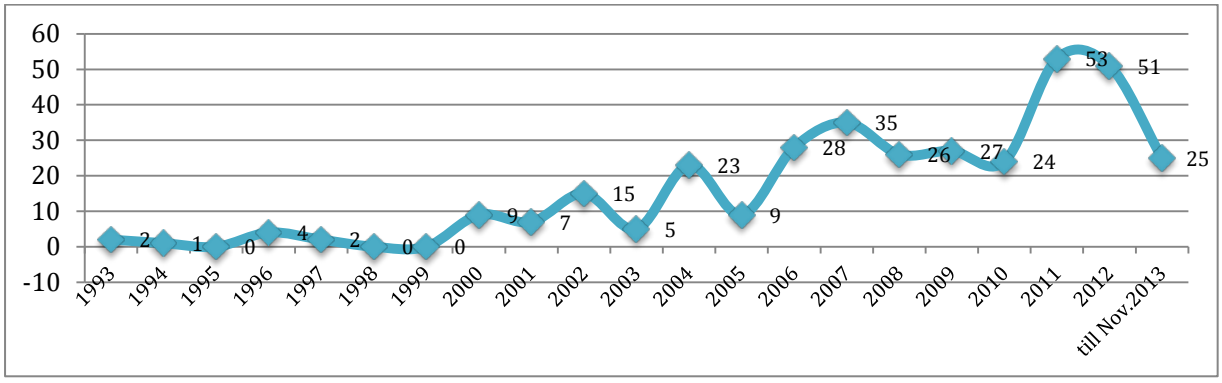
[7]UNDP. Bhutan Human Development Report 2011
[8] Ministry of Health. National Immunization Survey; 2010
[9] UNICEF/UNDP/NSB. Bhutan Multi Indicator Survey; 2010

stunting continues to remain an issue, with 33.5 per cent of children found to be short for their age. 58.4 per cent of the population now use improved sanitation facilities.

2.2 Epidemiological Profile

According to UNAIDS, Bhutan is one of the few counties in South Asia that continue to experience a low adult (15-49years) HIV prevalence of below 0.2per cent (0.1-0.6%)[10]. Although, the UNAIDS estimate approximately about 1,100 (<1000-2700) HIV infection cases, the program data as of November 2013 shows a total case detection of 346 with equal proportion of male and female. Of the total 346, there are 27 children below the age of 15 years representing 7.8% of the total case. Till date there has been 74 deaths (including one child) amongst the total reported cases. Since the first detection of HIV in the country in 1993 the annual reported cases have substantially increased significantly starting from 2004 with a major funding support from the World Bank and the Global Fund. Of the total reported cases approximately 87% of the total HIV cases were reported between 2004 and 2013.

Figure 1: Total number of reported HIV cases



Similar to many countries in the region the reported cases are predominantly (87%) are among the productive age group of 20-49 years with a significant bearing on the social and economic development of the country. Of the total, one-fifth are between the ages of 15–24 years. While there are equal proportion of male and female, relatively there are younger, below 24 years female infected compared to male in the same age category.

Figure 2: Age distribution of total reported cases in the country

[10] http://www.unaids.org/en/regionscountries/countries/bhutan/

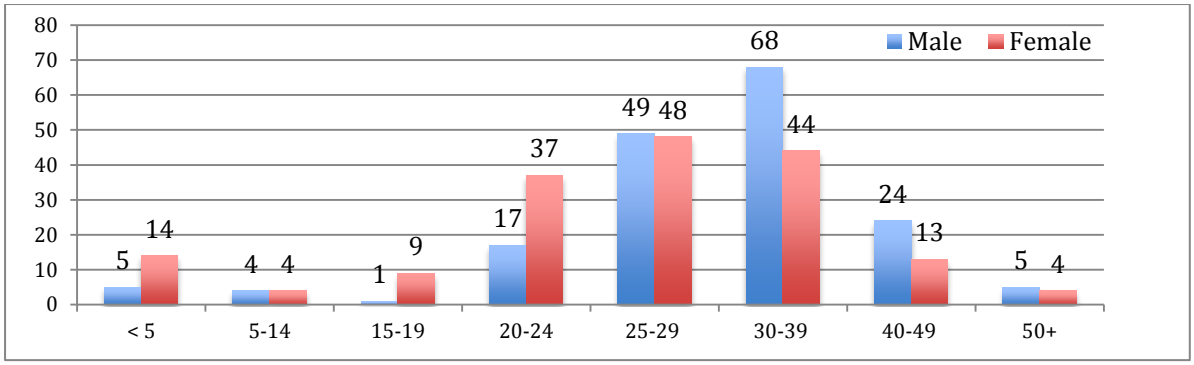
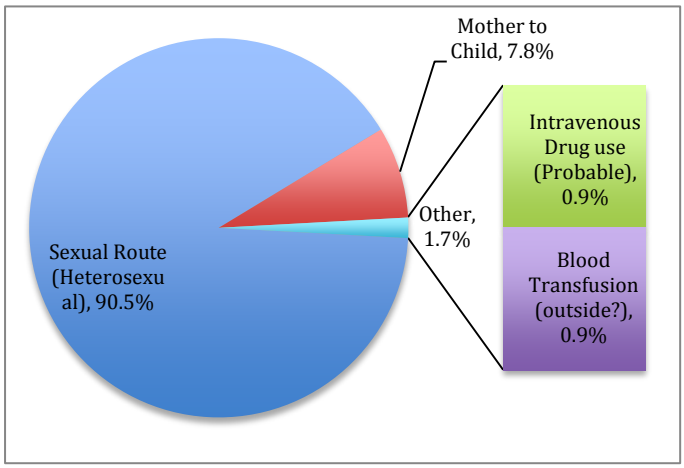


Figure 3: Mode of transmission of the Cohort Data

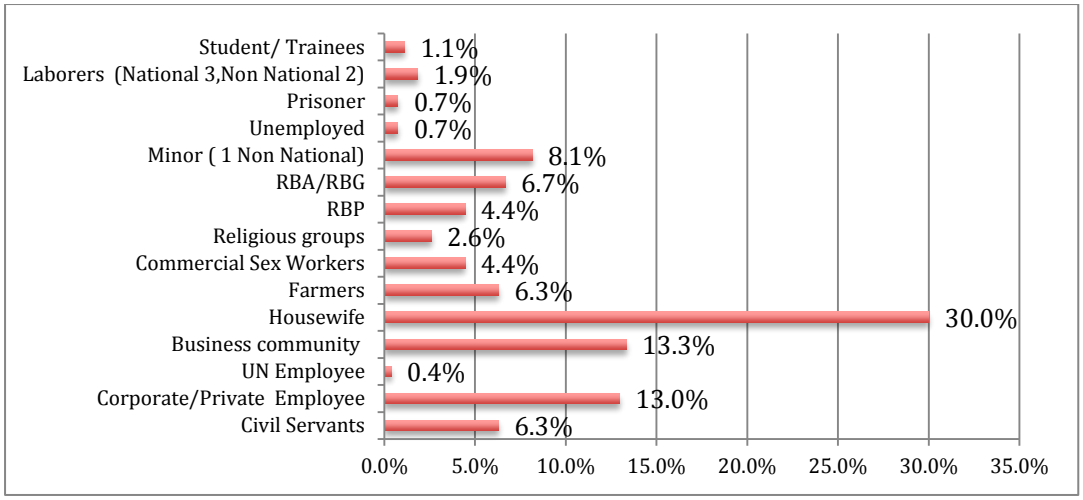


The analysis of the current cohort data show that HIV predominantly transmitted through heterosexual intercourse (90.5%) followed by mother to child transmission (7.8%) and less than 2% through blood transfusion and injecting drug use.

With the decentralization and integration of the HIV services within the primary health delivery services, facility for voluntary counseling and testing (VCT) is available in all district hospitals and in four of the stand-alone Health Information Service Centers (HISC) located in major urban centers to improve access to services. Although the rapid test are available in all the hospital and four HISC, confirmatory tests is only available at the National Referral Hospitals in Thimphu. Analysis of the care and treatment data shows that almost half of the HIV cases (49%) are detected through the VCT service delivery points followed by medical screening / check up and blood donation screening and ANC care at 20%, 11% 9% respectively.

In terms of social background, the analysis of the cohort data shows that the total reported cases represent all major occupational background in the country from all 20 districts. Significantly majority reported as being housewives (31%) followed by uniform personal together (RBG/RBA/RBP) at 14.1% and private and business community accounting for one forth of all cases detected.

Figure 4: Reported occupational background of the total reported cases



Till date, there are 149 PLHIV including 7 children on ART based on the previous WHO guideline of CD4 count of less then 350. The analysis of the ART patients data maintain with the Case and Treatment Unit at JDWNRH show that of the total PLHIV on ART who died (n= 14) 23.5% were 29 years old or younger. Among those in the age group 30–39 years, 16.7% had died and among those in the age group 40 years or older, 30% had died. More women were on ART (56.3%) as compared to men. However, 22.2% of the women died as compared to 18.5% of the men and the gender difference was not statistically significant.

CHAPTER 3: NATIONAL RESPONSE TO THE AIDS EPIDEMIC

3.1 Leadership and Political commitment

Recognizing the social and economic impact of HIV on the individual, family and community the response to HIV in Bhutan started long before the first HIV case detection in the country. The government initiated the National STI and HIV/AIDS Prevention and Control Programme (NACP) in 1988, five year before the detection of first case in the country. Five year into the establishment of NACP, in 1993, a National AIDS Committee (NAC) was formed to oversee and coordinate multi-sectoral efforts in order to ensure a harmonized response to HIV. The NAC was later restructured to form the National HIV and AIDS Commission for policy formulation and strategic responses to mitigate the impact of HIV. To promote meaningful and effective coordination, head of the key stakeholder organizations working toward mitigating the impact of HIV in the country are represented including two memberships seat for KAP (Annex 5: List of NAC members)

Unique to Bhutan's response to HIV is the high-level commitment and leadership rendered by the Royal family, Religious Institution and the Government for a robust HIV prevention programme. Apart from coordinated government efforts, the high level concern and commitment is reflected in the top-level initiative from the Royal family. On May 24, 2004, Fourth King, His Majesty Jigme Singye Wangchuck, issued a Royal Decree to participate in HIV prevention and to respect the rights of PLHIV. It is important to note that in the country the Royal Decree carries the highest moral authority and are widely respected and honored by the people. The same year, the Royal Edict broadened the roles of the organizational and individual-level participation for HIV prevention and addressing stigma and discrimination toward PLHIV. With the growing number of infections among the younger generation, in 2005, the Fifth King, His Majesty Jigme Khesar Namgyel Wangchuck, proclaimed to the nation, "HIV is no exception. The youth will use their strength of character to reject undesirable activities; their compassion to aid those afflicted and their will to prevent its spread".[11] Beside the benevolent leadership of the two kings, Her Majesty, the Queen Mother Ashi Sangay Choden Wangchuck tirelessly works with the local communities for HIV prevention and promotion of reproductive health and rights. Today, after more than a decade of advocacy, Her Majesty remains as the icon of HIV prevention in Bhutan.

3.2 Enabling Environment

[11] Royal Decree His Majesty Jigme Gesar Namgyel Wangchuck, NACP/IEC, Ministry of Health, Thimphu

Following the institutional establishment of NACP and NAC, planned activities have been implemented over the years through a Short-Term Plan (STP) with a focus on prevention, capacity building, establishment of testing facilities and case detection. The STP progressed to a three-year Medium Term Plan (MTP-I, 1990–1993) with a focus on condom promotion, strengthening of infrastructure, capacity building of health workers, strengthening programme monitoring and evaluation, and preparing groundwork for HIV care and management. Aligning to the Five-Year Plan, MTP-II, was developed in 1995 to include a multi-disciplinary framework to involve various government ministries and the private sector to prevent the spread of HIV and AIDS in the country, with financial assistance from World Health Organization (WHO) and Danida. [12]

The increasing trend of HIV in the country later prompted the government to increase efforts to confront the spread of the disease through mainstreaming sexually transmitted disease (STI) and HIV prevention, at the all level through education and engagement of Persons living with HIV. With the Royal Decrees as the guiding principle in the fight against HIV in Bhutan, the National Strategic Plan for HIV/AIDS and STI (NSP -I 2008–2013) was developed. The NSP -I guided the STI and HIV response in the country and supplemented the Government's 10th Five Year Plan (FYP) under the Health and Education Sector goals. In light of limited empirical data on the epidemic in the country, the first NSP -I had a major focus on the advocacy on prevention through collaboration and meaningful participation from all key stakeholder to mitigate the impact of the epidemic and to create a supportive environment for people living with and affected by HIV and AIDS in the country. The NSP -I was builds on past achievements of the STPs/MTPs and assessment of the existing gaps to ensure increase accessibility to preventive and VCT services. The main strategic areas outlined in the Bhutan National Strategic Plan -I 2008–2012 are:

- Promoting safe sex behaviours;
- Promoting condom use, including social marketing of condoms;
- Ensuring clear accurate information on HIV and AIDS and STIs, and increasing Information, Education and Communication (IEC) including on HIV/TB co-infection;
- Strengthening access to STI services and regularly updating STI prevention and control policies;
- Enhancing surveillance and access to Voluntary Counselling and Testing (VCT);
- Preventing interventions among the general population, with additional focus on vulnerable population groups;
- Continuing treatment, care and support of infected and affected population with a special focus on infected/affected children;
- Decentralizing antiretroviral (ARV) treatment to Dzongkhags;
- Enhancing coordination and collaboration between stakeholders;
- Generating local evidence/information on HIV vulnerabilities in Bhutan;
- Building capacities, integration of STI and HIV and AIDS interventions within health sector;

[12] 'National Strategic Plan for Prevention and Control of STIs and HIV/AIDS (2008)'. Department of Public Health, MoH, Thimphu, Bhutan.

- Community mobilization and empowerment, leadership and mainstreaming, coordination and networking.

During the Period of NSP-I various fundamentals guidelines and policies were developed in addition to building the capacity of the health care providers and other HIV services providers in the country:

Time frame 2008 – 2012:

- National Guideline for Prevention of Mother to Child Transmission of HIV. (2011). NACP, Ministry of Health
- Guideline for Management of Pediatric HIV/AIDS. (2011). NACP, Ministry of health
- National Guidelines for Care, Support, and Management of HIV/AIDS in Adults and Adolescents. (2011). NACP, Ministry of Health.
- National Health Policy (2011). Ministry of Health.
- National Guidelines on TB-HIV Collaboration (2013). Department of Public Health, Ministry of Health.
- TB-HIV Co-infection Management Training Manual for the Health Care Providers (2012). NACP and NTCP, Ministry of Health.
- Review of the National Response to STIs and HIV/AIDS in Bhutan. (2011). NACP, DoPH, Ministry of Health.

In addition to the guidelines, several studies have been undertaken to inform the National Programme such as:

- A Rapid Assessment on Sexual Behaviors and Networks in Thimphu conducted by the Center for Global Public Health (CGPH), University of Manitoba, Canada with support from Government of Bhutan between October 2009 and January 2010.
- National Baseline Assessment (NBA, 2009) among drug users
- KABP survey on HIV among Uniformed personnel, in and out of school youth 2009.
- Quality assessment for youth friendly health services (2009).
- Health Facility Survey 2009.
- Behavioral Sentinel Surveillance among the general population in 2008.

Considering the review recommendation of the national programme in 2011 and to address the changing dynamic of the epidemic, National Strategic Plan -II (2012-2016) was launched in 2012 with a goal to ***"reduce new STI and HIV infections and provide continuum of care to people living with and affected by HIV***". Besides crossing cutting prevention and health system strengthening strategic areas, NSP-II had a major focus on the following key affected populations defined under different categories:

- The sexually active and potentially vulnerable general population;

- People at highest risk to STI and HIV exposure such as; sex workers and their clients, people who inject drugs and men who have sex with men;
- Populations at increased risk to STI and HIV exposure such as youth, mobile populations including truckers, taxi drivers and migrant workers, uniformed services personnel;
- People at increased vulnerability, including the intimate partners/spouses of people higher risk group, prisoners and people in monastic institutions.

Prevention treatment and care

With all the foundational institutional structures and policy in place, various prevention activities such as mass awareness both through media and group sensitization workshops are carried out by the implementing agencies. Lhak-Sam, the positive network organization has been identified as a key implementing partner in advocacy and sensation workshops, till date Ministry of Health in collaboration with Lhak-Sam has conducted mass awareness campaign in schools and institutions across the country.

Realizing the need to provide care, support and treatment, in 2012, MOH formally established the Care, Support and Treatment Unit (CSTU) at the National Referral hospital (JDWNRH) with the following objectives to:

- Assure equitable access to diagnosis, medical care, treatment and supportive services for PLHIV
- Reduce morbidity and mortality from HIV/AIDS related complications
- Promote prevention opportunities
- To improve quality of life of infected and affected individuals with HIV/AIDS
- Improve HIV related data recording and reporting in the country.

Although the care and support elements are not well integrated in the existing delivery system, it is complemented through programmes implemented by Lhak-Sam's care and support unit. Lhak-Sam under the care and support programme provides educational support to orphans and living support to the most economically disadvantaged individuals affected and effected by HIV in the country.

CHAPTER 4: BEST PRACTICES

4.1 The Core Pillar of our response –Benevolent leadership

Unlike many countries in the world, where political support and leadership still remain ambiguous, Bhutan has demonstrated a strong political commitment to preventing and controlling the spread of HIV in the country. The response to HIV in Bhutan is guided by the principle of Gross National Happiness (GNH), enshrine in it is the principal of equality and human rights for a meaningful human development approach. In light of this fundamental framework of GNH, the country's achievement toward the response to HIV has been possible primarily because of the high level commitment, leadership and coordinated multi-sectorial response in combating the HIV epidemic in the country. In addition to the government 's efforts, it is the explicit top-level initiative from the royal family that stands as a testament to Bhutan's commitment to an effective HIV response.

On May 24, 2004, the Fourth King, His Majesty Jigme Singye Wangchuck, issued a royal decree to encourage HIV prevention and to respect the rights of PLHIV. During that same year, through royal edict, broadened the scope of organizational and individual-level participation in HIV prevention to address stigma and discrimination. The following year, in 2005, with the growing rate of infection among the younger generation, the Fifth King, His Majesty the Jigme Khesar Namgyel Wangchuck, proclaimed to the nation, "HIV is no exception. The youth will use their strength of character to reject undesirable activities; their compassion to aid those afflicted and their will to prevent its spread", giving the much needed support to the organization exclusively working with the Youth in the country. The two decrees today serves as a core pillar of the country's HIV responses and provides the much needed political support. Furthermore the work of Her Majesty, the Queen Mother Ashi Sangay Choden Wangchuck continues to be a source of great inspiration for the grass-root communities to work towards HIV prevention, substance abuse and reproductive health issues. Her Majesty has selflessly engaged in many high level dialogues and in strengthening, supporting and guiding the only positive network CSO – Lhaksam, in the country. Today, the Royal Decrees and the continuous support from Her Majesty the Queen Mother, not just provides great inspiration, leadership and moral authority, but serves as a visionary institutional rectitude and the capacity to mobilize resources and collective strength toward the HIV response in the country.

Decree issued by His Majesty Jigme Singye Wangchuck (4th King of Bhutan)

Decree issued by His Majesty the Jigme Khesar Namgyel Wangchuck (5th King of Bhutan)

4.2 Meaningful partnership

"In 2009 we got an opportunity to attend a meeting of the PLHIV. The meeting was organized by the Ministry of Health. We got a chance to meet others like us. It was such an overwhelming moment for us to see that we were not the only HIV positive people but there were many others and they were living normal lives. We felt inspired and alive again," Jigme (quote from the "Be Positive").

HIV treatment and counseling are available exclusively under the Bhutanese universal health care system. In addition to the free treatment, the care and support for those living with HIV has received considerable attention in Bhutan. The Ninth Five Year Plan provided a multi-sectoral strategy to prevent and control HIV and also identified this as one of the country's most important programme in promoting healthy outcomes. Recognizing the need for a social support system for PLHIV in the country, Ministry of Health initiated a self-help group in 2009 at the HISC to facilitate psychosocial support amongst the PLHIV. A year later with the support and commitment from the Ministry of Health the network got registered as the first and the only CSO working primarily for people affected and effected by HIV in the country.

Unique to Bhutan is the backbone support rendered by the National Government to a CSO (Lhaksam) that was not socially accepted to carry the organization's mandates. Today staffed by a dedicated team of mostly positive members, Lhaksam has been able to bring some of the important issues and challenges right at the core of public discourse and policy making in the country. In a traditionalist society, few founding members of the Lhaksam openly declared their HIV positive status and discussed the issues at great length on national television, radio and print media. This event has a huge impact to dispel some of the conventional myths associated with HIV and AIDS and gave the confidence to thousands across the

country to come out and test their status. Lhaksam, today is the only NGO to provide care and support directly to the affected population in addition to emotional and basic financial support to live a meaning and productive life. With the collective and collaborating working relation with the National Programme as a foundation, Lhaksam today is a key collaborating organization working and complementing the efforts of Ministry of Health in delivery the much needed services to PLHIV and their family.

CHAPTER 5: MAJOR CHALLENGES AND REMEDIAL ACTIONS

5.1 Programmatic Management and implementation

Challenges in the implementation of the NSP-II (2012-2016) interventions:

- HIV services are mostly facility based. The system has limited outreach or linkages to vulnerable population groups or population groups with high risk. Even the MSTFs [13], which were established to support the HIV program at district, are often not effective and lack community participation and resource mobilization.
- Stigma, discrimination, and legal barriers pose a wider response problem for implementing interventions among high-risk group.
- Vulnerable groups are extremely hidden population with no formal networks or means to reach services.
- High turnover of peer educators due to high mobility.
- Limited opportunity to engage community members both during the inception and implementation of the program.
- Capacity, financial and Human resource limitation within the CSOs to actively participant in delivery of services

Challenges in delivery Care and treatment

- Standard protocols for care and support need to be developed to provide adequate care and support services to PLHIV.
- The health system has limited capacities to address specific treatment and care needs of high risk group populations. The National Baseline Assessment among DU, 2009 found that drug users are not accessing voluntary testing facilities and STI/HIV services. The World Bank, Aide Memoire, 2010 points out that the program needs to urgently reach hot spots and increase its focus on HRG.
- The health system not geared to deliver the (WHO recommended) 'comprehensive package' of services essential for prevention of HIV among drug users and other HRGs.
- Linkages for referral needs to be established for delivery coordinated care and treatment services.
- Capacity and human resource constraints of the care and treatment unit at the JDWNRH that is functioning as an apex body for providing and coordinating care and treatment services.

[13] Multi-sectoral Task Forces (MSTF) for HIV prevention was established at district level (chaired by the district governors) to raise awareness among the general population

Challenges in the community system

- There are only very limited number of community organizations in the country and from there very few with an experience and capacity in delivery HIV prevention services to HRG.
- There is a lack of peer groups. The DU support group and the PLHIV support group have weak capacities and poor linkages within and outside the community.
- Limited collective voice from the CSOs to influence policy and program implementation and inceptions.
- Limited experience with peer educators and outreach workers.
- Lack of self help groups or CBOs addressing the needs of MARPS and vulnerable populations.

5.2 Health System Challenges

- The quality of health services needs improvement. A 2009 [14] Health Facility Survey recommends that the VCT/STI services need to be generally improved. The same survey also found that 60% of facilities (BHU I and above) did not have adequate STI/HIV leaflets and recommends that these should be made available in all health facilities.
- The HIV program has a separate M&E system which is not integrated with the HMIS thus posing challenges in reporting at the national level.
- Linkages between HIV and TB program need to be establish for better collaboration in order to provide better counseling services to TB patients and increase routine HIV testing among TB patients.
- Linkages and referrals within the HIV programs and linkages to other program are weak. Standard referral slips needed to be implemented in order to facilitate patient referral to other facilities.
- There is a lack of trained psychologist and psychiatrists in the country. There are no counseling training institutions and there is a lack of counselors with specialized counseling skills for HRG such as risk reduction counseling, psychological support, de addiction counseling.

[14] Health Facility Survey, 2009

CHAPTER 6: SUPPORT FROM DEVELOPMENT PARTNERS

6.1 The UN Partners

The UN agencies in Bhutan are supporting national priorities in line with United Nations Development Framework (UNDAF). The World Health Organization (WHO) under the preview of their mandates provides technical guidance and support to NACP for disseminating information on global initiatives, in strategic planning for health sector response and for building capacities to enable their adaptation into strategic and operational plans. WHO also supports capacity building for adaptation of WHO recommended tools for agreed interventions at the country level. The UNICEF extends technical support to NACP in the area of PMTCT and VCT. The agency trained health care providers on PMTCT and VCT functioning at all level and are key partner for implementing the CABA framework, which in Bhutan is under the Child Care and protection framework. The UNFPA in collaboration with the Reproductive Health programme has been instrumental in improving access to reproductive health services to women in the country. In addition to the procurement of reproductive health products, they have over the years support NGOs (RENEW and Lhak-Sam) in building institutional capacity. UNAIDS, through its country office in Nepal, provide technical support to NACP in the area of strategic information, resource mobilization and coordination of HIV activities through other UN partners. Besides, UNAIDS also works with civil society partuicularly with PLHIV network to build its capacity.

6.2 The Global Fund and Other

In 2004, Bhutan received its first financial aid for HIV from the World Bank for total amount of 5.7 Million USD over the five-year period. The WB support was provided for the four major component of the HIV response under the NSP-I:

- HIV and STI prevention
- Treatment and Care for People Living with HIV including treatment of STI
- Institutional Development through capacity building
- Strategic information—promoting research-based studies and surveys

Overlapping a year with the WB support, in 2008 Bhutan was approved for Round 6 Global Fund for HIV, TB and Malaria grant (GFATM) which was later consolidated with the Transitional Funding Mechanism (TFM) in 2013 for the total amount of 3.26 million USD. Till date 2.9 million has been disbursed. Contrary to the Round 6 grant, the TFM grant had a major investment on targeted interventions for MARPS and to reach the most vulnerable sections of population including youth through coordinated multi-sectoral response.

CHAPTER 7: MONITORING AND EVALUATION ENVIRONMENT

7.1 The Current Environment

In order to guide the planning and implementation of HIV services and activities at the national and sub national levels, the Government of Bhutan is committed to implementing the UNAIDS's principle of "Three One's":

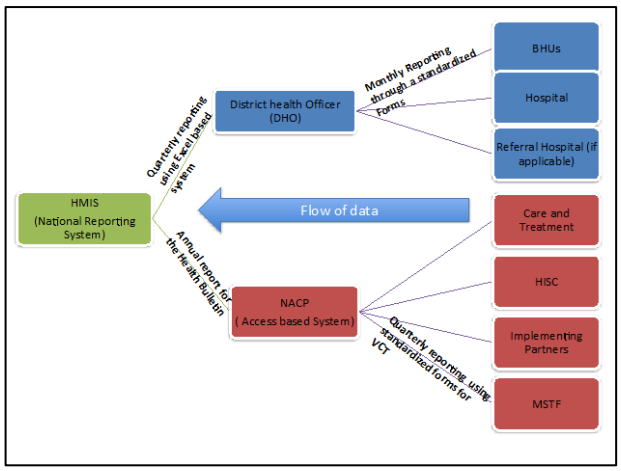
- One agreed HIV action framework that provides the basis for coordinating the work of all partners.
- One national AIDS coordinating authority, with a broad based multi-sector mandate.
- One agreed HIV country-level monitoring and evaluation system

The Ministry of Health (MoH) is the lead agency responsible for guiding the implementation of the National Strategy, coordinating with other ministries and agencies and directing HIV prevention and treatment services at all levels of the health sector. The NACP is the coordinating body that is mainly responsible for monitoring and evaluation of the national response and to liaison with NHAC and other implementing agencies. The NHAC is the highest national body that ensures the proper implementation of National Strategic Plan in the country.

7.1.1 M&E System

Monitoring and evaluation of the national response in Bhutan is carried out based on the Monitoring & Evaluation Plan framework, which was developed along with the National Operational Plan (NOP) for the period 2012-2016. The framework consists of core set of indicators that are mostly at the Impact/Outcome level for most of the strategies outlined in the NSP. In order to periodically monitor the program at the national level, process and output level indicators are monitored on a monthly/quarterly basis to assess the progress in the national response through a vertical reporting system managed by NACP.

Currently the National reporting system, Health Management Information System (HMIS) do not collect data on any of the HIV indicators. However there are three indicators related to STI symptoms that are directly collected through the HMIS reporting forms; A51 (Genital Ulcer/Bubo; A54 (Urethral/Vaginal Ulcer); and A56 (other sexually transmitted diseases). For annual publication of the Health Bulletin, the HIV related data are collected from the national programme.



The vertical reporting system is parallel to the national HMIS and it maintained exclusively by the National programme. The primary data re collected from various service delivery points: Care and treatment unit at JDWNRH, HISC, MSTF and from other implementing partners. The complied report is send to the national programme every quarter. The M&E focal person at the national program then enters the data into software based database. Routine monitoring of the interventions are carried out by respective service delivery entities in collaboration with the district health officer and HISC focal person. The reporting mechanism for the vertical system is presented below:

7.1.2 Recording and Reporting Responsibilities

Forms /Reports	**Responsibilities for Data**		
	Recording at Facility Level	**Reporting at Facility Level**	**Compilation and transmission to NACP**
VCT Report (Quarterly)	All health care providers (doctors, health assistant, nurses) proposing/prescribing HIV test	District medical officer in hospital Health assistant in BHU Focal person in HISC	District health officer
New HIV positive cases report (Quarterly)	All health care providers (doctors, health assistant, nurses) proposing/prescribing HIV test	District medical officer in hospital Health assistant in BHU Focal person in HISC	District health officer
STI report (Quarterly)	Health care providers in out – patient and in-patient services taking charge of STI patients Reproductive health staff: syphilis screening in pregnant women	District medical officer in hospital Health assistant in BHU Focal person in HISC	District health officer
PMTCT report	Reproductive health staff	District medical officer	District health officer

(Quarterly)		in hospital Health assistant in BHU	
MSTF activity report (Quarterly)	Fieldworkers in each organization part of the MSTF	Focal MSTF person in each organization	MSTF secretariat coordinator
HIV care and HAART, PMTCT report (Annual)	Health care providers taking charge of PLWHA	Health care providers taking charge of PLWHA with the direct support of NACP (seeing the limited number of patients)	
Targeted intervention report (Quarterly)	All M&E officers in targeted intervention program level	M&E officers in targeted intervention program	District health officer

7.2 Challenges

The Challenges outlined under the 12 component of the functional M&E system are complied based on the MESST assessment conducted on March 11, 2014 with all key stakeholders.

Components	Challenges / Gap
Organizational Structure	• Operationalization of M&E unit within the MOH as per the organogram and to fill the required position
Human Capacity	• To build the capacity of M&E staff • Capacity building plan to be prepared and implemented; • To capacitate district level staff other service delivery focal person to develop report based on rudimentary data analysis
National M&E Plan	• Integration of the vertical reporting system into the national HMIS system to enable national monitoring of HIV indicators
Advocacy, Communication and Culture	• Improvement/enhancing information dissemination mechanism and data sharing culture within and outside the organization.
Routine Monitoring	• Enhance human resource capacity for carrying out M& E mandates • Develop plan for routine monitoring and quality assurance • Integration of HIV indicators with other routine national level survey
Surveys & Surveillance	• Setting up HIV surveillance system. • Mapping and Size estimation of Key affected population. • Evaluation and assessment of the ongoing interventions

	particularly HIV testing, treatment and key population activities.
Data Use	• Ensure that the data providers receive information products - update inventory/update on program. • In adequate platform for routine report dissemination both at national and subnational level.

7.3 Way Forward

- Dedicated M&E unit within the NHAC Secretariat for M&E of the national response with linkages to national M&E unit.
- Integration of HIV indicators with the national HMIS system
- Development of treatment compliance monitoring system including referral and monitoring forms
- Development of monitoring and data collection forms for the MARPS intervention that is currently being implemented under the TFM proposal.
- Capacity building of M&E unit at implementing levels (districts and program level) to record, compile, report and analyze data effectively, including analysis of gender and age specific issues.
- Effective coordination across the public health system to improve and establish more effective data collection mechanisms including HIV surveillance system.
- Allocation of adequate resources both financial and Human to be able to fulfill the M&E mandates
- Institutionalize systematic data quality assurance mechanism within the current data collection system.

ANNEXTURES

ANNEX 1: Bibliography

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ANNEX 2: Letter of Introduction from NACP

ROYAL GOVERNMENT OF BHUTAN
DEPARTMENT OF PUBLIC HEALTH
MINISTRY OF HEALTH
THIMPHU BHUTAN
P.O BOX: 726

GARPR/MESST/

MoH/DoPH/ NACP/GFATM/2014/2445

25th February, 2014

To

The .....

.....

Sub: Global AIDS Response Progress Report of Bhutan.

The National HIV/AIDS & STIs Program (NACP) under the Department Public Health, Ministry of Health with support from UNAIDS, Nepal has recruited Ms Dechen Wangmo, Public Health Consultant for drafting the GARPR (Global AIDS Response Progress Reporting) report for Bhutan and for conducting a MESST(Monitoring and Evaluation System Strengthening Tool) assessment. In this regard, we have scheduled a meeting in Paro with the relevant stakeholders on 10th-11thof March, 2014 for validation of data and report to be submitted to UNAIDS. Therefore, in preparation to the validation meeting she will be interviewing and collecting national level data for GARPR indicators and identifying systemic gaps for strengthening the national M&E system for monitoring progress towards the mitigation of HIV impact. In this regards, we would like to request the concerned stakeholders to kindly extend your cooperation to her for the interview and data collection.

Yours Sincerely,

(Tashi Dendup)
Offg. Chief Program Officer

Copy:

1. Office copy, NACP

PABX: + 975-2-322602, 322351, 328091, 328092, 328093 Minister: 323973 Fax: 323113 Secretary 326627
Fax: 324649 HRD: Tel/Fax- 323953 Extension 142

Annex 3: List of key stakeholder for the Semi structured Interview

List of Participants for the semi structured Interview (GARPR-2014)		
SL No	**Agency**	**Names**
1	UNICIEF	Dr. Chandra Mongal
2	UNDP	Annamari Salonen
3	UNFPA	Madam Karma Tshering
4	MOLHR	Dechen Wangmo Dorji
5	GNHC	Sherab Gyeltshen
6	RBP	Major Chogyel
7	RENEW	Karma
8	Dratshang	Ugyen Tshering
9	YDF	Kinley Tenzin
10	Lhaksam	Wangda Dorji
11	HISC, Thimphu	Ngawag Choida
12	CST, JDWNRH	Jurmi Drukpa
13	Pharmacy, JDWNRH	Ugyen Dorji
14	PPD, MoH	Jayendra Sharma
15	HIMS,MoH	Dopo
16	PMT, PPD, MoH	Namgay Wangchuk
17	NACP, MoH	Sonam Wangdi

Annex 4: Participant List and agenda of the validation Workshop

National Consultative Meeting on GARPR - 2014 **Date: 10th march, 2014:** **PARO: BHUTAN**		
Constituency	**Name of Organization**	**Name**
Multi lateral Organization	WHO	Namgay Tshering
	UNICEF	Dr. Chandra Mongal
	UNDP	Annamari Salonen
	UNFPA	Karma Tshering
	UNAIDS	Badal Komal
	UNAIDS	Mahboob Rahman
	Global Fund	Pamela Owiso Liyala
Government implementing Partner	MOLHR	Dechen Wangmo Dorji
	GNHC	Sherab Gyeltshen
Armed forces	RBA – Hospital	Dr. Leki Wangdi
	RBP	Major Chogyel
NGO, CSO and FBO	RENEW	Lhaden Wangmo
	Dratshang	Ugyen Tshering
	YDF	Kinley Tenzin
	Lhaksam	Wangda Dorji
	Community Member	Dechen Seldon
Ministry of Health	HISC, Thimphu	Ngawag Choida
	CST, JDWNRH	Jurmi Drukpa
	Pharmacy, JDWNRH	Ugyen Dorji
	PPD, MoH	Jigme Thinley
	HIMS, MoH	Dopo
	PMT, PPD, MoH	Namgay Wangchuk
	DHO, Haa	Gyem Dorji
	NTCP, MoH	Tashi Dendup
	NACP, MoH	Sonam Wangdi
	NACP, MoH	Phurpa Tenzin
	NACP, MoH	PhubZangmo

Agenda:

Global AIDS Response Progress Reporting (GARPR) -2014

Venue: Olathang Hotal, Paro

Date: 10th March 2014

Objective:

- ***Overview of the GARPR***
- ***Validation of the data through meaningful participation of key stakeholder in the country.***
- ***Draft dissemination of the country report***

Time	***Topic***	***Responsibility***
09:00 AM	***Registration***	***Participants***
09:30 AM	Overview and Objective of the workshop	NACP
09:40 AM	Introduction to Global AIDS Response Progress Reporting: Reporting Process and core indicators	UNAIDS – Country team
10:00AM	Introduction of National Commitment and Policy Instrument (NCPI): Process of data collection	UNAIDS – Country team
10:20 AM	Discussion	
10:30 AM	Methodology for GARPR – 2014 Bhutan	UNAIDS – Consultant
10:40 AM	Validation of the data - what is available	UNAIDS – Consultant
12:50 PM	Discussion	Participants
01:00-02:00 PM	***Lunch***	
02:00 PM	Group work for data validation	
02:50 PM	***Tea***	
03:10 PM	Group Presentation and Discussion	
3:40 PM	Group work on NCPI	
4:10	Group presentation and Discussion	
5pm	Closing Remarks	

TASHI DELEK!

ANNEX 5: National Commitments and Policy Instrument (NCPI)

Annex 6: NAC Members -2014

List of the National HIV/AIDS Commission Members			
SI.No	**Name of the Official**	**Designation**	**Organization**
1	Lyonpo Tandin Wangchuk	Hon'ble Minister	Ministry of Health (Government)
2	Dasho Ugen Tsechup Dorji	Vice Chairman	Singye Group of Company (Private)
3	Dasho Pema Wangda	Secretary	MoLHR (Government)
4	Dasho Nima Wangdi	Secretary	MoH (Government)
5	Dasho Karma Penjor	Secretary	Dratshang Lhentsho (FBO)
6	Dasho Brig Kipchu Namgyel	Chief of Police	RBP (Police)
7	Dr. leki Dorji	CMO, Lungtenphu Hospital	RBA (Army)
8	Mr.Tsheten Dorji	Thrompon	Phuntsholing (Local Government)
9	Mr.Chencho Dorji	Director	DYCs MoE (Government)
10	Aum Chimi Wangmo	Director	RENEW (NGO)
11	Mr.Dorji Penjor	DYT Chairman	Chukha (Local Government)
12	Mr. Wangda Dorji	Executive Director	Lhaksam (CSO)
13	Mr. Ugyen Dorji	Accountant	Lhaksam (CSO)