Country Progress Report on the HIV Response in Bhutan-2015

National AIDS Control Programme,
Department of Public Health
Ministry of Health

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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
EDP	External Development Partner
eVT	Elimination of Vertical Transmission
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GNH	Gross National Happiness
GV	Gender Violence
HISC	Health Information Service Centre
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IBBS	Integrated Biological Behavioural Surveillance
JDWNRH	Jigme Dorji Wangchuck National Referral Hospital
KAP	Key Affected Population
MDG	Millennium Development Goal
MoH	Ministry of Health
MSA	Multi-country South Asia
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

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

Foreword

We are pleased to put forward Bhutan's Country Progress Report on AIDS Response, 2014. This report highlights the progress made towards the "2011 UN Political Declaration on HIV/AIDS". Although we are not able to report on several of the indicators, this year's report captures more data than any of the previous progress report.

Bhutan has a low prevalence of HIV and analysis of the reported cases so far doesn't reveal concentration of HIV in any of the key populations groups. Interventions for specific key populations for MSM/TGs and Injecting drug use in Bhutan are now being initiated but remains limited due to several obstacles such as the non-existence of networks of key population and the fear that the society will not accept them keeps them hidden from the reach of interventions. In order to ensure that excluded and marginalized individuals and groups are reached and have access to relevant health, social, and legal services the national response to HIV/AIDS is now focusing on working with key populations in priority and encouraging the formation of CBOs to scale-up community-led interventions to identify, understand, and meet the needs of individuals and groups of these populations.

HIV testing and counseling (HTC) form the gateway to care, treatment and support for persons in need. To ensure that people can exercise their right to know their HIV status, and that people with HIV can benefit from access to early treatment, HIV testing and counseling services have been scaled up in the country. Now HTC is available in all the 20 district of the country through 31 hospitals and 157 Basic Health Units.

The Royal Government of Bhutan is fully committed to support the national response to HIV/AIDS and continues to provide treatment and all associated medical cost such as necessary laboratory test, medical consultation to the people living with HIV/AIDS free of cost.

I would also like to take the opportunity to thank all our partners whose support and participation have been crucial in the progress that we have made to contain the threat of HIV/AIDS.

(Dr.Pandup Tshering)
Director

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

I. STATUS AT A GLANCE

a. Inclusiveness of the stakeholders in the report writing process

The Global AIDS Response Progress Report (GARPR) 2015 was led by the National HIV/AIDS and STI Prevention and Control Programme (NACP) with technical support from the UNAIDS Country Office in Kathmandu, Nepal. The progress report presented here is based on the consolidated findings from the recently completed country exercise of preparing the Global Fund concept note; the national review, wider consultations and inputs from all the relevant stakeholders; from EDPs; People Living with HIV, and Civil Society Organizations in Bhutan.

b. Status of the epidemic

The Kingdom of Bhutan is a small land-locked country located between China in the north, and India in south, with an estimated population of 733,643 of which 52% are male and 48% are female. The majority of the population continues to live in rural areas (65.5%), with the vast majority engaged in agriculture and livestock farming. Nearly 61% of the population is in the economically active age group of 15-64 years, and about 5 per cent is above 64 years old. According to the Population and Housing Census of Bhutan (National Statistics Bureau 2005), life expectancy at birth stood at 66.2 years (65.65 years for males and 66.85 years for females). Demographically, Bhutan is characterized by a high fertility rate and a declining mortality rate, leading to very rapid population growth.

The first case of HIV was detected in 1993, and the number of cases increased from the year 2000 onwards, with more than 80% of the total cases reported within the last 10 years. This noticeable increase is attributed to the scale up of HIV testing and counseling services in the country. The majority of the cases are found within the younger populations, with over 53% of cases detected in the population group below the age of 30.

Bhutan bears a low burden of HIV; the estimated adult HIV prevalence was 0.1% (range 0.1%-0.4%) in 2013, or less than 1,000 people living with HIV. (UNAIDS, HIV in Asia and the Pacific, 2013). However, due to data limitations, particularly related to the HIV prevalence and size of the traditionally vulnerable populations, it remains difficult to fully understand and explain the dynamics of the overall HIV epidemic in the country.

c. Policy and programmatic response;

The national response to HIV is guided by the "Bhutan National Strategic Plan for the Prevention and Control of STI, HIV and AIDS, 2012-2016 and National Vision 2020 document (*"Bhutan 2020: Vision for Peace, Prosperity and Happiness"*) based on principles of universal access, human rights, and engaging the key sectors to combat the epidemic. Under the vision of the Kings and the Five-Year Plans, Bhutan is pursing the Gross National Happiness (GNH) development philosophy, which also upholds strong principles of equality and rights for all human beings.

d. Indicator data in an overview table:

Some of the indicator data have not been collected, particularly on bio-behavioural indicators for key populations, due to the lack of IBBS-type surveys. These unreported indicators are either not relevant in the country context, or the data was not available at the time of reporting.

#	Indicators Titles	2014	2013	Data Source
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: 23.2%	Female: 21%	National Health Survey 2012
1.2	Sex Before the Age of 15	No new data	Female= 3.7%	BMICS – 2010 (NSB and UNICEF) Respondents are only females (15-49 yrs).
1.3	Multiple sexual partners	No new data	Female 0.3%	
1.4	Condom Use at last sex among people with multiple sexual partnership	No new data	Female 20.4%	
1.5	HIV Testing in the General Population	N/A	N/A	
1.6	HIV Prevalence in young population	N/A	N/A	
Indicators for sex workers				
1.7	Sex Workers: Prevention programmes	There is no IBBS or BSS survey conducted among sex workers in Bhutan.		
1.8	Sex Workers: Condom Use			
1.9	Sex Workers: HIV Testing			
1.10	Sex Workers: HIV Prevalence			
Indicators for men who have sex with men				
1.11	Men who have sex with men: Prevention programmes	There is no IBBS or BSS survey conducted among MSM in Bhutan.		
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			
1.15	Number of health facilities that provide HIV testing and counselling services	188		
1.16	HIV Testing and counselling in women and men	Adults: 25,335 P.women: 7,861 Children: 342		
1.17	Diagnosis of HIV cases	50	51	
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)	There is no needle syringe (NSP) and opioid substitution therapy (OST) programme. However in 2015 country is planning to pilot NSP and OST programme through Global Fund funding.		
2.2	People who inject drugs: Condom Use	No new data	53.70%	BSS 2008 includes any drug users as respondents of the survey.
2.3	People who inject drugs: Safe Injecting Practices	N/A		
2.4	People who inject drugs: HIV Testing	No new data	28.20%	BSS 2008 includes any drug users as respondents of the survey.
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				

#	Indicators Titles	2014	2013	Data Source
3.1	Prevention of Mother-to-Child Transmission	7 (preg. Women)		Routine programme data 2014. In the reporting period 7 HIV positive pregnant women receive the MTCT services.
3.1a	Prevention of mother-to-child transmission during breastfeeding	N/A		
3.2	Early Infant Diagnosis	N/A		
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	16.7% (167/1,000)	13.5% (149/1,100)	Routine programme data 2014. PLHIV database 2014
4.2a	HIV Treatment: 12 months retention	87.2% (34/39)	90%+	Routine programme data 2014. PLHIV database 2014
4.3a	Health facilities that offer antiretroviral therapy	5	5	
4.4	ART stock outs	20%		Logistics report. 1 out of 5 ART sites has experienced the stock out.
4.5	Percentage of HIV positive persons with first CD4 cell count < 200 cells/µL	23.5%		Routine programme data. PLHIV database 2014.
4.6	Enrolled in HIV Care	307		Routine programme data. PLHIV database 2014. Data as of 30th November 2014
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	5 PLHIV receiving ART+ TB treatment	N/A	Routine programme data. PLHIV database 2014.
5.2	Percentage of adults and children living with HIV newly enrolled in care who are detected having active TB disease	N/A		
5.3	Percentage of adults and children newly enrolled in HIV care starting isoniazid preventive therapy (IPT)	N/A		
5.4	Percentage of adults and children enrolled in HIV care who had their TB status assessed and recorded during their last visit	81.8%		Routine Programme data. PLHIV database 2014.
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	N/A	N/A	No data.

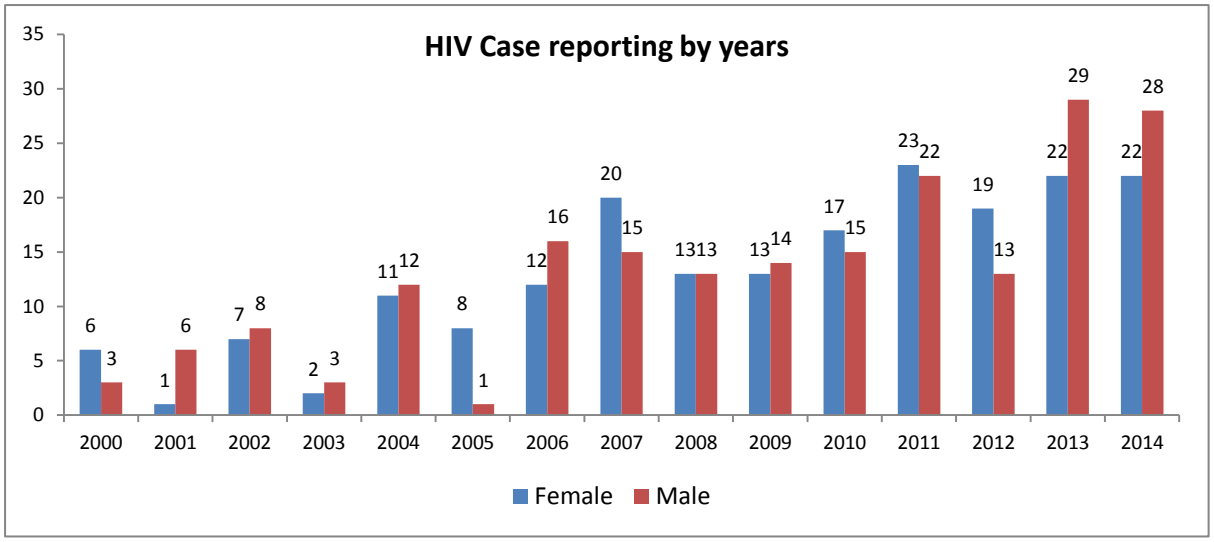
#	Indicators Titles	2014	2013	Data Source
Target 7. Critical enablers and synergies with development sectors				
7.1	Prevalence of Recent Intimate Partner Violence	2%	N/A	National Health Survey 2012.
Target 8: Eliminating stigma and Discrimination				
8.1	Discriminatory attitude toward people living with HIV	N/A	N/A	No data.
Target 10: Strengthening HIV integration				
10.1	Orphans school attendance	N/A	N/A	No data.
10.2	External economic support to the poorest households	N/A	N/A	No data.

N/A= Not Avail

II. OVERVIEW OF THE AIDS EPIDEMIC

Bhutan is one of the few countries in South Asia that continues to experience a low adult (15-49 years) HIV prevalence, which is estimated to be under 0.1 per cent (<0.1-0.4%). According to UNAIDS' estimations, there are less than 1,000 people living with HIV, and the total number identified as HIV positive in the country stands at 403, since the first case was detected in 1993. (Programme report, December 2014). In Bhutan there has been no significant difference over the last two decades, among the proportion of males and females detected with HIV (204 males and 199 females), unlike in many other countries where females are disproportionally higher affected by HIV.

Figure 1: Trend in HIV case detection by sex, 2000-2014



Source: National AIDS Control Programme (NACP), 2014

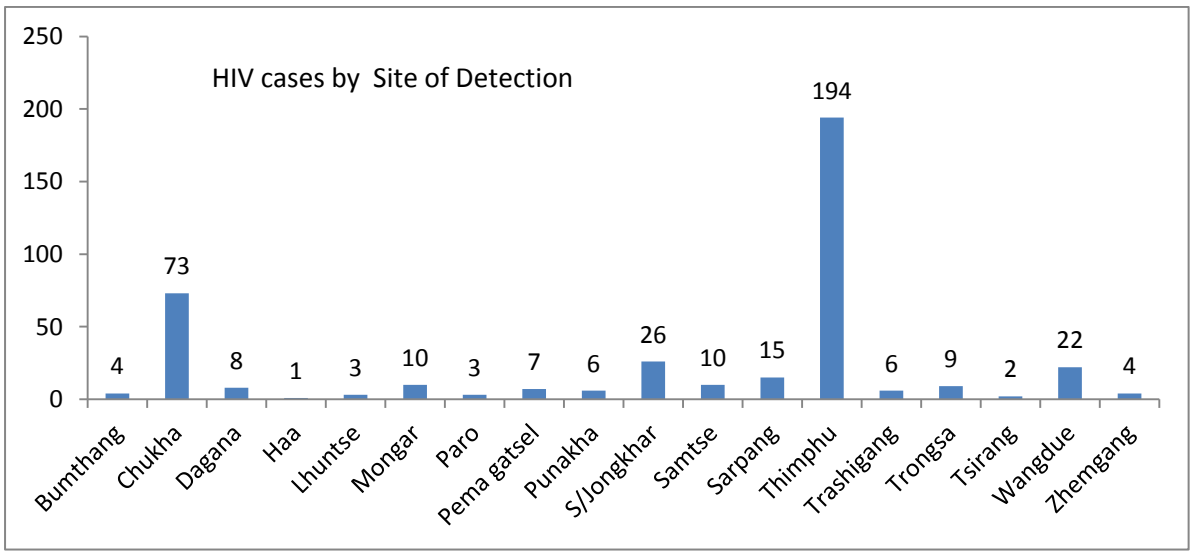
From 2006 to 2010, an average of 30 cases were detected. However, since 2011, around 45 cases have been reported annually. More than 50% of the cases were reported in the last five years, due to the increased efforts and scaling up of the HIV testing services and mass awareness programmes by the Ministry of Health and its partners.

a. Geographical status of HIV

Geographically, HIV cases have been detected in 18 out of the 20 districts. As shown in figure 2, more than half of the cases reported are found in Thimphu and Chukkha. Within the Chukkha district, the bordering towns of Phuntsholing and Thimphu are the two most urbanized and populated towns in the country. Additionally, the towns in the districts close to the country's borders have also reported a higher numbers of cases. For instance, Bhutan has porous borders with India and most of the towns located there are major sites for business activities, with high population mobility and higher risk behaviours (Gelephu under Sarpang in the Central and Samdrujongkhar in the East). Due to the diffused nature of HIV and STI in Bhutan, interventions must also focus on other districts.

The geographical mapping of the high risk districts includes the three bordering towns in the south, Thimphu (capital city) in the west, and in Wangduephodrang and Trongsa, due to the ongoing mega hydro power project (Punatsangchu I & II, Mandechu Hydro Power Project).

Fig 2: Geographical distribution of reported number of HIV cases (by district), 1993-2014 (n=403)

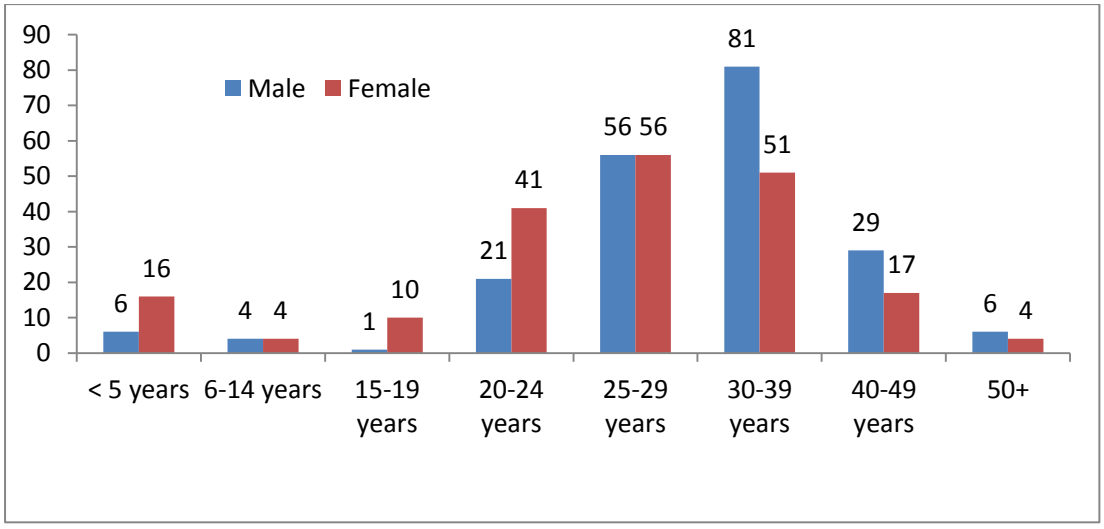


Source: National AIDS Control Programme(NACP), 2014

b. Age and Sex pattern of reported cases

Figure 3 shows the age pattern of the reported cases and that the majority of people living with HIV are in their reproductive and economically active age. Out of the total 403, there are 30 children below the age of 15 years, representing 7.4% of the total cases. While the aggregated number of the total reported cases shows that the HIV distribution in both sexes is almost equal, the age at detection for female is younger compared to the males.

Figure 3: HIV case by age-group and sex

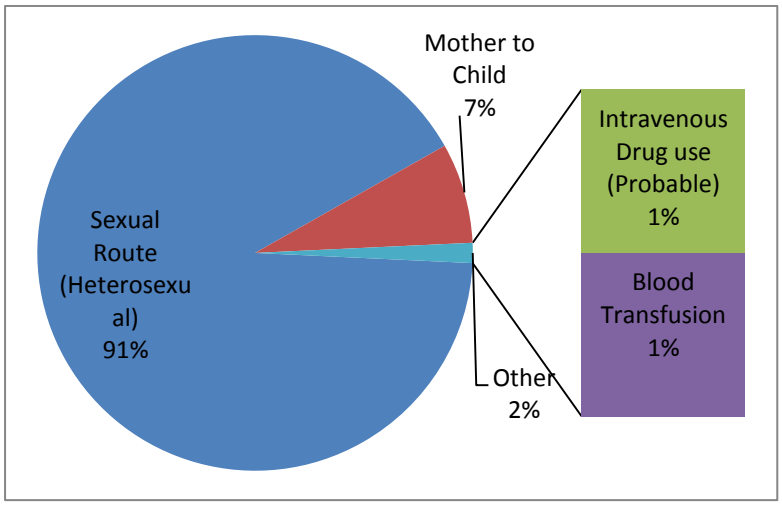


Source: National AIDS Control Programme(NACP), 2014

c. Sources of Infections

As shown in figure 4, further analysis of the reported cases shows that more than 90% of the infections are reportedly spread from heterosexual transmission. Apart from heterosexual transmission, almost 7% of transmissions are vertically transmitted and about 2% are reported to be transmitted through intravenous drugs and blood transfusion. The vertically transmitted cases have been significantly reduced in the recent years with the implementation of the PMTCT programme nationwide and only two cases of vertical transmission have been reported in 2014.

Figure 4: Sources of Infections among all the reported cases



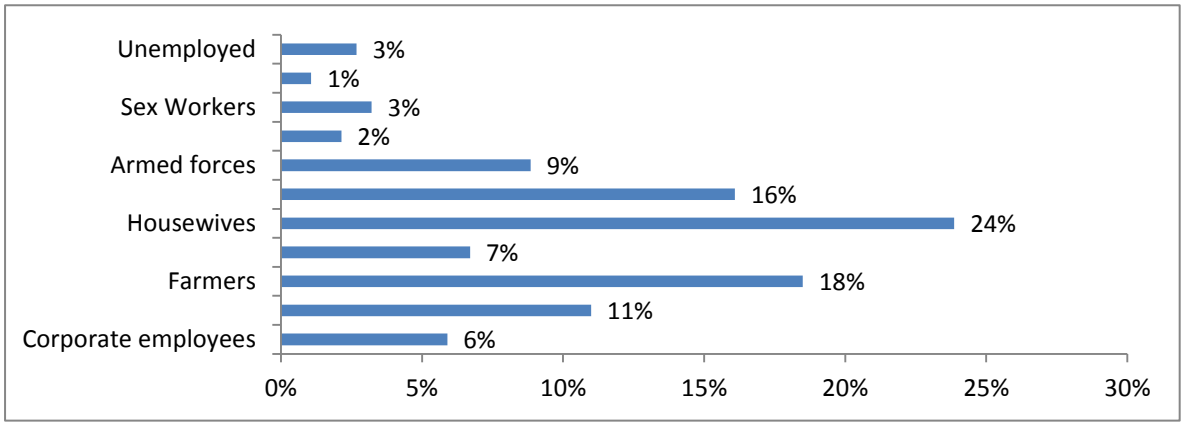
Source: National AIDS Control Programme (NACP), 2014

The first case of vertical transmission of HIV was reported only in 2002 and until now the total reported cases of paediatric HIV had remained constant after the aggregation of old cases. The vertical transmission of HIV appears to be declining in Bhutan; although precise data is lacking due to the absence of facilities for early infant diagnosis (EID). Between the years 2012-2014, a total of 7 mothers to child transmissions of HIV (MTCT) were reported.

d. HIV by occupational group

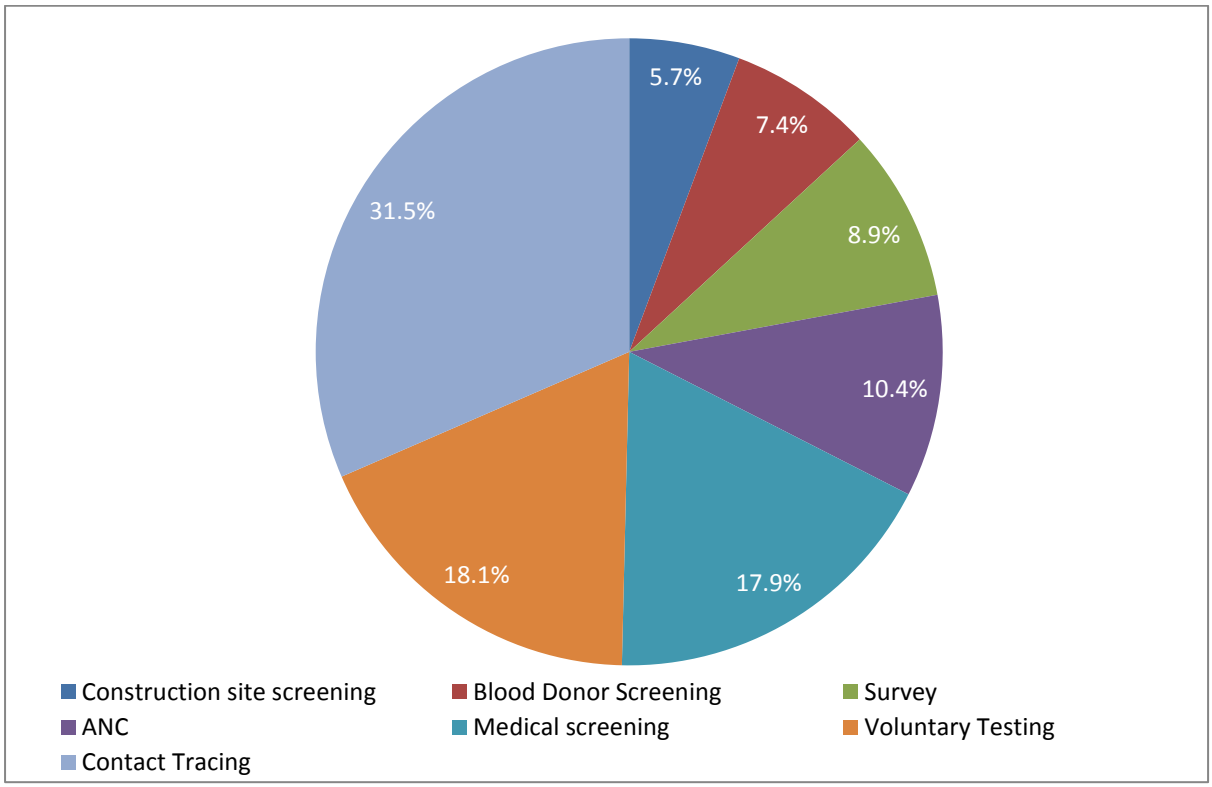
The disaggregated reported cases by occupational groups suggest that one fourth of the reported cases are from low risk females who are likely to be infected by their male partner. The other occupational groups infected included religious bodies, farmers, armed forces, private/business owners, drivers and corporate employees (Figure 5). As illustrated in figure 6, the majority of these were detected through contact tracing after their spouses/partners were found to be HIV positive. There has also been a recent increase in newly reported cases among drivers, private/business owners and farmers.

Figure 5: HIV cases reported by occupation group



Source: National AIDS Control Programme (NACP), 2014

Figure 6: Distribution of Case Detection at various intervention levels, 1993-2014 (n=403)



As shown in figure 6 about the mode of detection for the 403 reported cases, almost 31.5% of the total reported cases were diagnosed through contact tracing followed by 18.1% through VCT, 17.9% from medical screening and almost 10.4% were diagnosed in pregnant women during their routine antenatal visits. This indicates that the HIV testing coverage in ANC is promising, yet needs to improve so that no child is born to HIV positive women given Bhutan has high ANC coverage. The National Health Survey 2012 suggested 97.9% of women received at least one ante-natal care visit during their most recent pregnancy, and 73.7% of all births in the two years preceding the survey occurred in health facilities.

The data indicates that young women in Bhutan are at higher risk of HIV, with a ratio of male to female for those under the age of 24, of 1:2.4 (29 males, 69 females). Accordingly, they are also at higher risk of contracting a sexually transmitted infection (STI) according to the data, the ratio of male to female STI varies from 1:1.6-2 in those aged 5-14 years; between 2012 and 2014, 0 (STI case reporting data 2012-2014, National AIDS and STI Control Programme).

III. NATIONAL RESPONSE TO HIV

A. Policy and structural response

a. Strategic Plan

The National HIV/AIDS Commission is a multi-sectoral body functioning at the highest level, chaired by the Minister of Health. It coordinates HIV related activities and provides technical support to implementing partners at all levels. It is comprised of representatives from MOH, as well as line ministries from central and district levels, NGOs, faith-based organizations and the private sector.

At the *dzongkhag* (district) level, multisectoral task forces facilitate the coordination of activities. The decentralization of prevention and control initiatives to the district level has enabled the multi-sectoral approach to address STI and HIV prevention in their local cultural, traditional and socioeconomic context. All twenty districts have Multi-Sector Task Forces (MSTF) established since 2001, with an overall goal to prevent new transmission of STI and HIV by focusing on effective prevention strategies, providing support and care to people living with HIV and their families.

Many CSOs and NGOs, such as RENEW, Y-PEER network,YDF, other line ministries and Lhak-Sam (the network of positive people) are engaged in implementation of STI and HIV programmes.

b. Programme focus

In 2011, the NACP updated the National Strategic Plan for the period from 2012 to 2016 (NSP2). In line with the recommendations from the Review, this plan gives top priority to reaching those at highest risk of STI ad HIV exposure, while continuing to provide prevention education and services to the rest of the population, in an enabling environment for coordination and partnership among those involved in the response to HIV in Bhutan. The five priority strategies proposed by the NSP2 include the following areas:

1) Prevention
    i. Crosscutting STI and HIV prevention for all populations
    ii. STI and HIV prevention for populations most at risk
    iii. STI and HIV prevention for people at increased risk including youth
    iv. STI and HIV prevention for people at increased vulnerability including elimination of vertical HIV transmission
2) Treatment and care for people living with/affected by HIV
3) Institutional strengthening
4) Strategic information, monitoring and evaluation, research
5) Partnerships, coordination and institutional arrangements

B. Prevention, Treatment, Care and Support

a. Prevention and reducing sexual transmission of HIV

HIV prevention has been a priority in Bhutan considering the low burden of the epidemic. The following key interventions have been undertaken to further prevent the transmission of HIV:

- Promoting safer sex;
- Promoting condom use and making condoms accessible;
- Ensuring clear accurate information on HIV and STI, and increasing Information, Education and Communication (IEC) including on HIV/TB co-infection;
- Improving access to STI services;
- Enhancing access to HIV testing;
- Preventing HIV among the general population, with additional focus on vulnerable population groups (such as mobile populations, uniform services, transport workers etc);
- Building capacities, integration of STI and HIV interventions within health sector;
- Community mobilization and empowerment, leadership and mainstreaming, coordination and networking.

b. Treatment, care and support

Bhutan has made progress in making HIV treatment accessible to all those who need it. First line ARV drugs have been included in the National Essential Drugs List. This is an important step towards ensuring the sustainability of ART in Bhutan. A slow transition towards domestic funding of ART is planned from 2016 onwards. One potential source of financing for ARVs is the Bhutan Health Trust Fund[1]. A major challenge to improve treatment coverage in Bhutan will be putting more people in HIV testing including innovative ways of community based testing approaches.

In 2014, 25,677 people were tested for HIV through different service outlets. A scaled up and strategic approach to HTC would minimize the gap between the estimated and detected number. Such a strategy needs to be prioritized geographically and on specific populations, while maintaining the principles of universal access and equity, which are strongly enshrined in Bhutan's health system.

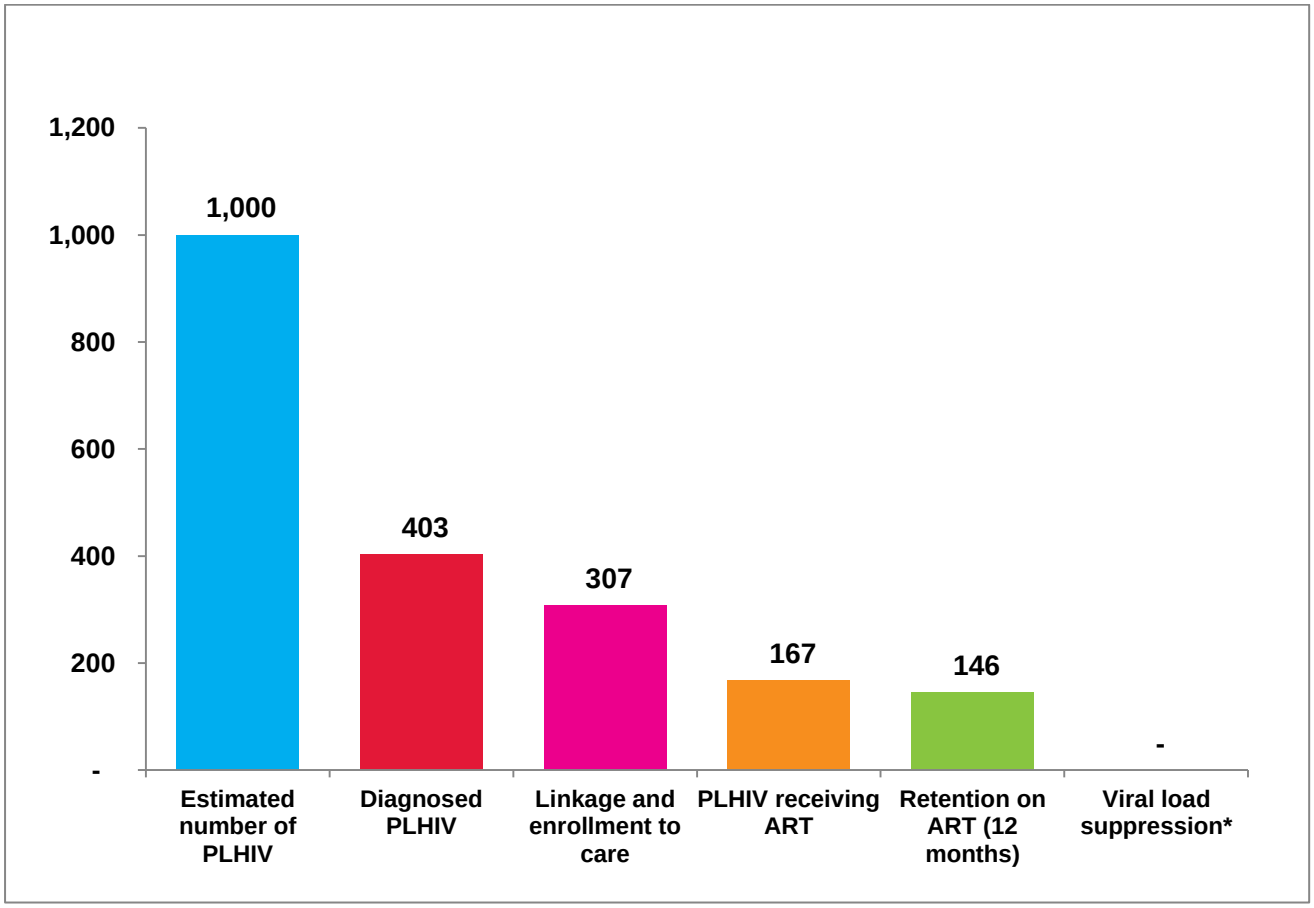
HIV testing in TB patients was initiated in 2013, and 60% (162/272) patients have been screened. This underscores the need for provider initiated testing and counseling (PITC) for TB patients. PITC must also be scaled up at all STI service provision sites to enhance case detection. Currently, the PITC approach is used in ANC settings and coverage is over 90%. In 2014, 11281 ANC women attendees received an HIV test. A rapid test which allows for combined screening for hepatitis B virus, syphilis and HIV is used at both the BHU and district

[1] This was launched in 1998, operational as of 2004 and at the end of 2013, its total value was approximately USD 20.6 million. Most investment from the Fund focusses on co-financing of vaccines with GAVI leading to the immunisation of 13,122 children in 2013 (Annual Progress Report of the Bhutan Health Trust Fund, 2012-2013). Discussions on how ART can be funded through this Fund as of 2016 are currently being held.

hospital level. All ANC attendees are screened on their first visit[2]. Confirmatory testing is performed only in the Public Health Lab (PHL) for quality assured diagnosis at the JDWNRH. Turn-around time for confirmation is approximately two weeks. When the PHL detects a positive case, they contact the Care and Treatment Unit also located in JDWNRH. This unit then coordinates for the provision of treatment care and support for the patient at the district or BHU levels.

As shown in figure 7, although the estimated number of people in need of treatment is less than 1,000 (based on all PLHIV), currently there are only 167 PLHIV, including 10 children below the age of 15, on ART (*coverage based on 1,000 is 16.7%, however based on the 403 reported cases the coverage is 41.4%*). Recently, the HIV treatment guideline has been updated as per the recommendations from the WHO global guideline, and the CD4 eligibility criteria has been changed to 500mm[3]. The new guideline also recommends that sero-discordant couples, TB/HIV co-infected person, pregnant women and children less than 5 years as eligible for treatment irrespective of CD4 criteria (see Figure 6 for the Treatment Cascade in Bhutan)[3].

Figure 7: Treatment Cascade in Bhutan



Source: National AIDS Control Programme(NACP), PLHIV data base, 2014.

[2] According to the National Health Survey (2012), 97.9% of women received at least one ante-natal care visit during their most recent pregnancy, and 73.7% of all births in the two years preceding the survey occurred in health facilities.
[3] National HIV/AIDS Treatment Guideline 2015

According to the data, entry into treatment is delayed; with only 23.5% of the people living with HIV (PLHIV) who had initiated ART with CD4 counts below 200mm^3 cells in 2014. This has implications, not just for individual health outcomes, but also for the ongoing rate of transmission. The retention of PLHIV in the treatment system, after 12 months, was 87.2%.

A major constraint is the lack of ability to undertake virological monitoring of patients on ART. This is also a key barrier for the roll-out of the WHO 2013 ART Treatment Guidelines, where the monitoring of virological outcomes are pivotal to establishing treatment efficacy.

IV. MAJOR CHALLENGES AND REMEDIAL ACTIONS

a. Populations with low access to prevention and treatment services

Despite policies and an inclusive National HIV Strategy, there are individual, societal, legal, and health system related barriers in Bhutan that negatively impact on access to prevention and treatment services for those who are the most vulnerable or at risk.

- Provisions under the Penal Code (2004) Section 213 criminalizes sodomy, or any other sexual conduct that is against the "order of nature". Such a punitive law impedes the access to preventive care and treatment services for gay men and other MSM. It is recognized that the lack of legal recognition of same-sex relationships and of transgender status contributes to low self-esteem and social marginalization.

- For sex workers the Penal Code Section 375 on "Promotion of Prostitution" states, that anyone who contacts a person for the purpose of prostitution, or encourages, induces or otherwise causes another to become or remain a prostitute, is guilty of the promotion of prostitution. Section 377 of the Penal Code: "patronizing a prostitute" states that it is an offense to give money, property or other forms of gratification to a person to engage in a sexual act. There is no documentation to date of anyone being prosecuted under these provisions of the Penal Code, but their very existence is likely to contribute to fear, prejudice and exclusion.

- In the context of PWID, the current policy environment is mostly focused on demand reduction, with no harm reduction programming in place.

- Migrant workers have been found to not accessing health services adequately. Key reasons include: their work schedules, high mobility, and differences in language and culture. Specific efforts need to be made to reach these populations close to where they live and work, e.g. in the vicinity of large construction and hydropower projects, cross-border sites etc. Health education material and service delivery may have to be tailored in Bengali, Assamese or other dialects.

b. Human rights and gender inequalities that impede access to health services

Bhutan is a signatory to two human rights instruments: the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of Discrimination against Women (CEDAW). Bhutan generally maintains a good record on human rights issues in relation to HIV, with no documented rights abuses or prosecutions of MSM, PWID and FSW, although a recent APCOM and UNDP report categorized Bhutan's legal system as "moderately prohibitive"[4]. Like many low and middle income countries in the Asia and Pacific Region, Bhutan does not provide specific protection under anti-discrimination or human rights laws for MSM, transgender people, sex workers and PWID leaving them vulnerable to abuse, victimization and neglect.

[4] APCOM and UNDP (2010), 'Legal environments, human rights and HIV responses among men who sex with men and transgender people in Asia and the Pacific', page 113.

In addition to its international commitments, the Constitution of the Kingdom of Bhutan 2008 is grounded in the fundamental principles of human rights. Article 9 (17) states that "the State shall endeavor to take appropriate measures to eliminate all forms of discrimination and exploitation against women, including trafficking, prostitution, abuse, violence, harassment and intimidation at work, both in public and private sphere".

With gender equality identified as a cross-cutting theme in Bhutan's 11th Five Year Plan (2013-2018), the Royal Government of Bhutan, with the National Commission for Women and Children (NCWC) formulated the National Plan for Gender, with the aim of mainstreaming gender into all development plans and programmes. Progress has been made in reducing gender gaps in Bhutan, and the engagement of women has always been encouraged in Bhutan's development planning process. Despite this, women in Bhutan continue to face subtle societal and cultural biases. The National Health Survey (2012) reported that 6.1% of currently married women experienced physical violence by an intimate male partner in the year preceding the survey. Sexual violence by husbands of currently married women was reported at 2.1%, while non-partner physical violence rates were 6.3% (with higher rates for women aged between 10-19 years at nearly 13%). Gender violence (GV) also contributes to a higher HIV vulnerability. This points to the need for community information and education, and the integration of approaches to prevent GV into HIV services, and vice versa.

c. Health and community systems

In the absence of a private medical system, the Royal Government of Bhutan is the sole provider of health services. Pharmacies are privately owned, but operate under strict licensing arrangements in accordance with the Medicines Act of the Kingdom of Bhutan, 2003, and the Medicines Rules and Regulations of 2005. Bhutan aims to deliver sustainable primary health care to its citizens. The following are the key challenges to improve the health and community system:

- Limited number of community organizations in the country
- Limited community voices participating in policy and programme development of the HIV response.
- Limited experience with peer educators, outreach- and in-reach workers.
- Lack of self-help groups or CBOs addressing the needs of vulnerable populations.

d. Treatment Care and Support Services

- Scaling up of HIV testing facilities to increase the treatment coverage, which is currently only 15%.
- Facilities for Early Infant Diagnosis (EID) are urgently needed to monitor HIV among infants born from HIV positive mothers.
- Due to the unavailability of viral load equipment, virological monitoring of patients on ART is not possible. This can be a bottleneck for monitoring the treatment adherence and appropriate regimen of people on ART.
- Revising the current NSPII which ends in 2016, to reflect the global 90-90-90 targets by 2020, in order to having ended AIDS in Bhutan, by 2030

V. SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

HIV funding landscape in Bhutan

Bhutan views health expenditure as a long term investment in human capital. A substantial proportion of the total budget outlay is allocated to health - 8% for the fiscal year 2012-2013. The total need estimated for a successful implementation of the NSP II as per the National Operational Plan for HIV/ AIDS and STI is US$ 8.55 million for the period of five years (2012-2016). Over 41% out of the total current funding for the HIV programme is being provided domestically while the rest is being contributed by external donors such as the Global Fund and UN organizations. All recurrent expenditures are exclusively funded by the government, both at the national and sub national level. The recurrent expenditures of the government contributions are in the form of personnel salaries and emoluments, facilities maintenance, and other logistic and administration costs. Such a system has been put in place to ensure functioning and sustainability of the programmes.

a. Global Fund

The Global Fund remains the major financial resource for HIV in Bhutan, since 2008. The emphasis of the Global Fund's support in Bhutan's HIV programme is to reach the key affected populations, vulnerable groups including HIV testing and treatment. The Global Fund finances 100% of the provision of ART, and a funding proposal, in the form of a concept note, is pending approval for an amount of 2.4 million over the next three years; ending in 2017.

In addition to the country grant, the Ministry of Health is also a sub-recipient of the Multi-country South Asia grant. UNDP Thailand is the Principal Recipient of the grant, which focuses on advocacy and human rights and community systems strengthening of the LGBT in Bhutan.

b. UN agencies and UNAIDS secretariat

The UN agencies in Bhutan are supporting national priorities in line with United Nations Development Framework (UNDAF).

The World Health Organization (WHO) 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. The WHO also supports capacity building in the adaptation of WHO recommended tools of agreed interventions at the country level.

The UNICEF extends technical support to NACP in the area of PMTCT to eliminate the vertical transmission of HIV, and VCT. The agency trained health care providers on PMTCT and VCT functioning at all level. UNICEF acts as a 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 supported NGOs (RENEW and Lhak-Sam) in building institutional capacity over the years.

The UNDP through the Multi-South Asia Global Fund is working with the NACP to build capacity of health workers to cater to male sexual health, advocacy with focus on equitable access to services and decriminalization and stigma and discrimination and building strategic information. The project is also working with Lhak-sam to build skills for service delivery, advocacy, social mobilization and leadership. The UNDP Bhutan country office has a HIV focal person who provides technical support to NACP and Lhak-sam to carry out the project.

UNAIDS, through its country office in Nepal, has provided technical support to NACP in the area of strategic information, resource mobilization, drafting a Global Fund Concept note, and for the coordination of HIV activities through other UN partners. UNAIDS has also worked in capacity building for increased and improved engagement of civil society, particularly with PLHIV networks.

VI. MONITORING AND EVALUATION ENVIRONMENT

a. Challenges and gaps

There were efforts to set up a functional national HIV and AIDS M&E system but the attempt is yet to be completed. Initiatives have been undertaken by various entities to provide necessary information to guide the planning and programming of the national response to HIV. Despite these achievements, the National Programme is faced with the following:

i. Most of the key agencies concerned with M&E required further resources to establish and implement a complete, functional and coordinated M&E system. A responsive national M&E system still needs to be established.
ii. The existing national support structure for M&E presents serious gaps in terms of functionality and sustainability. There were limited numbers of M&E officers. An M&E unit is not yet functional, although a national-level M&E core team exists under the PPD, MOH, and linkages to the programme level monitoring.
iii. Although there is a national M&E plan, its work plan needs to be implemented with appropriate resources allocation; both human and financial.
iv. There is no systematic dissemination, and no efforts to analyse, communicate and use strategic findings and information. Limited copies of reports were issued and the utilization of the information was not followed up.
v. Data on HIV-related risk behaviours among vulnerable populations is limited in Bhutan, and where this exists, is often outdated. This creates challenges for evidence-informed programming, resource mobilization, and advocacy. Further investments in improving surveillance and strategic information are urgently required.

b. Recommendations

i. Integrate HIV indicators with the national HMIS system (possibly when the DHIS is planned). The DHIS to include treatment compliance monitoring system, including referral and monitoring forms.

ii. Capacity building of M&E unit at implementing levels (districts and programme levels) to record, compile, report and analyze data effectively, including analysis of gender and age specific issues.

iii. Effective coordination across the public health system to improve and establish more effective data collection mechanisms, including HIV and STI surveillance system.

iv. Allocation of adequate resources both financial and human to be able to fulfill the M&E mandates. Institutionalize a systematic data quality assurance mechanism within the current data collection system, with appropriate allocation of resources and work.

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