

National Strategic Plan for the Prevention

And

Control of STIs and HIV and AIDS



Royal Government of Bhutan

2008

Foreword

The HIV and AIDS epidemic presents a development challenge to our nation. While the number of Bhutanese who have been detected with HIV still remains low, the potential for a widespread epidemic remains a real threat. Experience from countries around the world shows the devastating social and economic impact caused by the HIV and AIDS epidemic. There is much to be done if we are to slow down the spread of infection.

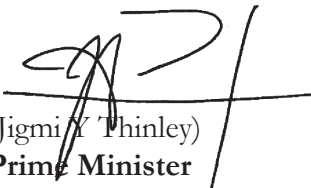
The Royal Decree on HIV and AIDS issued on May 24, 2004 reflects the deep concern of His Majesty the Fourth King over the growing problem of HIV and AIDS in the Kingdom. The Royal Government of Bhutan has accorded a high priority to addressing this issue. The response to HIV and AIDS in Bhutan has also been guided by the principle of Gross National Happiness.

The *National Strategic Plan for the Prevention and Control of STIs and HIV and AIDS* recognizes that while much has already been achieved, there shall need to be an increase in activities if we are to prevent the further spread of HIV. This strategic plan provides us with clear directions for the coming years. Prevention programmes shall need to be targeted at those members of our society who may be at increased risk of HIV transmission, including the youth, while simultaneously ensuring that educational messages and other programmes reach the broader population.

If we are to stop the spread of HIV and AIDS then all members of our society have an important role to play. This strategic plan has been developed to ensure that a broad range of partners are active in the fight against HIV and AIDS. While government ministries play an important role, so do non-government organizations, the private sector, the media, religious organizations and our international development partners. Individuals, families and communities can and must make deliberate contributions toward reducing the impact of HIV and AIDS.

Importantly, people who have acquired HIV deserve the support and compassion of the community. Stigma and discrimination towards people with HIV and AIDS have no place in our society. This strategy recognises the government's commitment toward ensuring that the health care needs of people living with HIV and AIDS are met, including their need for life prolonging treatment.

With ongoing commitment from all key players, and leadership at the national, dzongkhag and gewog levels, together we can lessen the impact of the HIV and AIDS epidemic in Bhutan.



(Jigmi Thinley)
Prime Minister

Royal Government of Bhutan

Executive Summary

The *National Strategic Plan for the Prevention and Control of STIs and HIV and AIDS* (NSP) is intended to guide the nation's response to the epidemic. It aims to ensure a well coordinated effective and efficient response from the Ministry of Health/National STI and HIV and AIDS Prevention and Control Programme and other ministries, organizations and stakeholders. As no single sector can by itself overcome the epidemic, HIV and AIDS should not be viewed as a health problem but as a development crisis. A national concerted effort involving the contributions of multiple sectors and stakeholders shall be the key to fighting the HIV and AIDS epidemic in Bhutan. This framework shall serve as a basis for developing individual sectoral plans.

Given the potentially devastating social and economic impact of HIV and AIDS at the individual, family, community and national levels, the epidemic is well deserving of continued attention from the Royal Government of Bhutan and the international community.

The NSP addresses the realities of the evolving epidemic of HIV and AIDS and other sexually transmitted infections (STIs) in Bhutan. It builds on lessons learned and outlines strategic actions required to further enhance the nation's response to HIV and AIDS. The strategic plan has been closely guided by the National HIV/AIDS Commission -a multi-sectoral body functioning at the highest level and chaired by the Minister of Health. The plan engages the cumulative effort of stakeholders from beyond the Ministry of Health. It takes into consideration social, cultural and economic factors affecting individuals, families, societies and the nation at large.

Bhutan's response to the pandemic started long before the first HIV case was detected in the Kingdom. In order to counter the spread of the global AIDS epidemic, the Royal Government implemented several planned activities. A Short-Term Plan was developed and implemented in 1989, which progressed to a three year Medium-Term Plan I (1990-1993).

WHO was instrumental in providing technical and financial support through the Global Programme for AIDS (GPA) until 1996. Following this, a five year Mid-Term Plan II (1995-1999) was developed and implemented under the Health Sector Programme Support (HSPS) I and HSPS II supported by Danida. Currently, the programme is supported by the World Bank and the Global Fund. In addition to this, some assistance is also received from UNFPA, UNICEF, UNDP and WHO.

The first case of HIV was reported in the Kingdom in 1993. As of February 2008, the National STI and HIV and AIDS Prevention and Control Programme reports a cumulative total of 144 HIV infected cases, with both sexes being almost equally affected. So far, 26 deaths (18 males and 8 females) have been reported among the infected Bhutanese population. The most common route of transmission is the heterosexual route (88.9 percent) followed by mother-to-child transmission (9 percent). The first mother-to-child transmission in Bhutan was reported in 2001 while the first case of HIV infection (probably) acquired through intravenous drug use was detected in January 2006.

While the numbers appear to be low, there are a range of factors that could facilitate transmission and fuel the spread of a widespread epidemic. These factors include high rates of STIs, relatively high rates of unprotected sex and partner concurrency (i.e. the tendency for Bhutanese men and women to have more than one partner at the same time). Although further research is needed to understand the role of sexual networks, it is clear that this factor shall play a role in the epidemic spread of HIV. In addition, rapid economic development has come hand in hand with an increasingly mobile population that engages in trade with higher prevalence countries. For example, neighbouring states in India and Nepal are experiencing concentrated epidemics with clusters of cases occurring in border areas. Finally, Bhutan has a young population as in other parts of the world; the majority of new cases of HIV tend to occur among young people.

The Royal Decree on HIV and AIDS issued by His Majesty the Fourth King on the 24th of May 2004 serves as the guiding principle in the fight against HIV and AIDS. The Royal Decree calls for all members of the society to help prevent HIV and AIDS and provide care and compassion to those infected.

Prevention shall thus continue to be the main stay of the NSP. The current focus is geared towards strengthening institutions and capacity of service providers; care, support and treatment of HIV and AIDS and STIs; voluntary counselling and testing; improving strategic information through research and surveillance; and, monitoring and evaluation. Support for these activities is being generated through the national programme, the World Bank and a recent grant from the Global Fund.

In order to maintain this low HIV prevalence status, intensifying preventive measures and interventions among the vulnerable populations is of greatest priority. Strengthening care, support and universal access to treatment for people living with AIDS are also important components. Providing care and compassion for infected persons shall ensure that they shall not go underground fuelling its spread. Addressing these components can produce the most impact of slowing and ultimately reversing the spread of HIV infection.

As prevention programmes need to increase their reach and effectiveness, population groups at high risk shall be identified and targeted. Interventions shall be multi-faceted, and include the use of outreach activities, peer education, life skills education, communication campaigns and community mobilization. In addition to working with populations most at risk, other target groups shall include the general population, young people in school, out-of-school youth, and migrant and mobile populations.

A multi-sectoral approach has characterized the response to HIV and AIDS in Bhutan. The National HIV/AIDS Commission coordinates the response at the national level. At the dzongkhag (district) level, multi-sectoral taskforces facilitate the coordination of activities. A multi-sectoral response recognizes that to effectively control the HIV epidemic all sectors need to be active partners.

The NSP recognizes the need to place HIV and STI on the agenda of multiple sectors. It defines clearly the roles and responsibilities of all partners, including non-government and community-based organizations that can play a critical role in reaching populations from all walks of life particularly those groups considered most at risk.

In addition to the focus on HIV prevention, the strategy has identified the importance of providing for the health care needs of people living with HIV and AIDS. The government is committed to providing antiretroviral treatment to people with HIV. The involvement of individuals, families and communities in the care and support of people with HIV is considered crucial.

The NSP also recognizes the need for people living with HIV and AIDS to play a more proactive and supportive role. It aims to build upon activities already undertaken to facilitate support networks among people with HIV. Ideally, people with HIV shall be encouraged to form their own self-help groups and to advocate on their own behalf, as well as to be involved in all aspects of programme planning, implementation, monitoring and evaluation.

Creating a supporting environment enables much of the actions outlined within this strategic plan to be implemented. Importantly, a supportive environment needs to be one in which people living with HIV and AIDS do not fear they shall be stigmatized or discriminated against.

This strategy has been built on available evidence. Where there is inadequate information, mechanisms have been identified to remedy the situation. Developing HIV and AIDS research capacity can ensure that programmes are evidence-based. Monitoring and evaluation mechanisms shall ensure keeping track on progress of activities and shall assist in building a strong evidence base.

A preliminary analysis of the financial needs in implementing the NSP has been identified. The successful implementation of this strategy shall require the allocation of adequate resources.

Bhutan's overall STI and HIV and AIDS prevention and control approach is to achieve the MDG of reversing and halting the spread of HIV and AIDS by 2015. This goal is in tandem with the national long term goal of Gross National Happiness.

The NSP aims to:

- 1) Integrate STI and HIV prevention into the core activities of multi-sectoral partners;
- 2) Create a supportive environment that facilitates the implementation of programmes and services, and reduces stigma and discrimination towards women and men living with or affected by HIV and AIDS;
- 3) Improve the quality and coverage of the national response to HIV and AIDS and STIs.

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List of Abbreviations and Terms in Dzongkha

Abbreviations

ABC	Abstain, Be faithful and use Condoms
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral
BHU	Basic Health Unit
BNCA	Bhutan Narcotic Control Agency
CBO	Community-Based Organization
CCM	Council of Ministers
CSW	Commercial Sex Worker
FYP	Five-Year Plan
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GNH	Gross National Happiness
GPA	Global Programme for AIDS
HISC	Health Information Service Centre
HIV	Human Immunodeficiency Virus
HSPS	Health Sector Programme Support
IDU	Injection Drug Use
IEC	Information, Education and Communication
IMTRAT	Indian Military Training Team
JDWNRH	Jigme Dorji Wangchuck National Referral Hospital
KAP	Knowledge, Attitude and Practice
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MoE	Ministry of Education
MoH	Ministry of Health
MoIC	Ministry of Information and Communication
MoLHR	Ministry of Labour and Human Resources
MSM	Men who have Sex with Men
MSTF	Multi-Sectoral Task Force
MTCT	Mother-To-Child Transmission
MTP	Medium-Term Plan
NAC	National AIDS Committee

NACP	National STI and HIV and AIDS Prevention and Control Programme
NCWC	National Commission for Women and Children
NGO	Non-Government Organization
NHAC	National HIV/AIDS Commission
NSP	National Strategic Plan for the Prevention and Control of STIs and HIV and AIDS
OI	Opportunistic Infection
ORC	Outreach Clinic
PEP	Post-Exposure Prophylaxis
PLWHA	People Living With HIV and AIDS
RBA	Royal Bhutan Army
RBG	Royal Body Guards
RBP	Royal Bhutan Police
RCSC	Royal Civil Service Commission
RGoB	Royal Government of Bhutan
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
STP	Short-Term Plan
SW	Sex Worker
TB	Tuberculosis
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VAW	Violence Against Women
VCT	Voluntary Counselling and Testing
VHW	Village Health Worker
WB	World Bank
WHO	World Health Organization

Bhutanese terms

Chimi	People's representative and member of the National Assembly
Dzongda	District Administrator
Dzongkhag	Administrative unit equivalent to district
Gewog	Block
Gup	Elected leader of the gewog
GYT	Gewog Yargye Tshogchung – Block Development Committee

SECTION 1: INTRODUCTION

1.1 Country profile

Bhutan is a small Kingdom situated in the eastern Himalayas. The country is surrounded by North-Eastern states of Assam and West Bengal (India) in the east, west and south and China in the north. The country's borders are porous, with thriving commerce and trade. The nation is home to an estimated population of 634,982 who live in scattered rural settlements along a characteristically rugged terrain.

Demographically, Bhutan is characterized by a high but gradually declining fertility rate and a declining mortality rate, leading to very rapid population growth. According to the Population and Housing Census of Bhutan 2005, the overall male to female ratio was 111 males per 100 females. About one third of the Bhutanese population is below 15 years of age; about 60 percent belong to the economically active age group (15-64 years) while only a little less than 5 percent is older than 64 years. The social structure, value system and lifestyle of the Bhutanese people have been primarily influenced by strong Buddhist traditions deeply rooted in historical and spiritual experiences. Family bonds are strong and extended family is still the norm where members support each other in times of problem, illness, aging and death.

With almost 70 percent of the people living in rural areas, Bhutan is primarily an agricultural economy. More dynamic sectors such as electricity production, construction and tourism to a limited extent now contribute to Bhutan's healthy economic growth of more than 6 percent 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.

The impact of globalization is pervasive; it has not spared the country. Rural to urban migration and unemployment, especially among the youth, represent some of the current serious challenges.

The country is administratively divided into three regions (Western, Central and Eastern) and 20 Dzongkhags (districts) that are further divided into 205 Gewogs (blocks).

Bhutan has been preparing for democratisation over several decades. In 1953 the National Assembly was established and later a Royal Advisory Council and a Council of Ministers (CCM). The process of gradual decentralisation started in 1981. The country's first Draft Constitution was issued in 2005 and since then updated into the existing Draft Constitution of 2007. It shall take the country into parliamentary democracy and provides for three branches of government represented by the legislature, the judiciary and the executive. Elections for the National Council (Upper House) took place on 31 December 2007 (in 15 Dzongkhags) and 29 January 2008 (in the five remaining Dzongkhags), and elections for the Parliament (Lower House) shall take place on 24 March 2008. Sub-national elections for the Dzongkhags and Gewogs are expected to take place in the last quarter of 2008.

1.2 Policy development context

The principle of Gross National Happiness (GNH) guides Bhutan's distinctive approach to development and has four pillars: the promotion of equitable and sustainable socio-economic development, the preservation and promotion of cultural values, the conservation of the natural environment, and the establishment of good governance. The principle emphasizes the need to find an appropriate balance between material, spiritual, emotional and cultural well-being.

Bhutan 2020: A Vision for Peace, Prosperity and Happiness translates the notion of GNH into a series of national objectives or precepts that guide policy-making and are central to all government programmes.

Bhutan's *Poverty Reduction Strategy Paper, 2002-2007*, is built on the long-term vision of Bhutan. It consists of the Ninth Five-Year Plan (FYP) for national development and a Cover Note that delineates several key areas including a medium term expenditure framework, sectoral strategies and a poverty monitoring and evaluation plan. The paper defines a comprehensive poverty reduction strategy that is consistent with the Millennium Development Goals (MDGs). It addresses cross-cutting issues, such as gender, environment, improved governance and decentralization. Recognizing that a healthier and better educated population is more productive and happy, the paper gives great importance to the social sectors, especially to health and education which are allocated 24 percent of the total budget.

The Draft Tenth FYP for 2008-2013 is now available. The plan is based on achieving the MDGs and the long term goals articulated in the Vision 2020 document including GNH, and it has adopted poverty reduction as the overarching theme and primary goal. HIV and AIDS has been identified as one of the important cross-cutting development themes that shall be addressed through various strategic initiatives over the plan period. According to the Draft Main Document, "... these [the cross-cutting development themes] are regarded to be particularly pertinent for the Tenth Plan period in view of their all-round importance and relevance across all sectors and given the context of the introduction of democracy in the country".

1.3 Health care services

Bhutan continues to pursue the primary health care approach to reach the nation's scattered population with basic minimum health care. In the absence of private medical practice, the government is the sole provider of health care. Though basic health care in Bhutan is provided free of cost, limited cost sharing for advanced medical technologies, secondary and tertiary dental services is practiced. Pharmacies are nominally private but operate under strict licensing arrangements in accordance with the Medicines Act of the Kingdom of Bhutan 2003 and the Medicines Rules and Regulations 2005.

Within a span of four decades the nation's health system has made remarkable progress. Today 90 percent of the population has access to basic health care services delivered

through a network of 29 hospitals, 176 Basic Health Units (BHUs) and 514 Outreach Clinics (ORCs). Life expectancy was estimated at 66 years in 2000. The infant mortality rate fell from 70.7/1,000 live births in 1994 to 40.1 in 2005. Although statistically difficult to ascertain, existing data suggest that maternal mortality fell from 770/100,000 live births in 1984 to 255 in 2000.¹ Dynamic leadership, highly committed government, generous support of development partners and dedicated efforts of health workers, all have contributed to the dramatic progress in the health sector.

The health care delivery system is three-tiered and manned 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.

ORCs -regularly scheduled mobile clinics- extend the reach of both BHUs and hospitals to rural communities. In addition, more than 1,000 Village Health Workers (VHWs) participate actively in outreach activities. VHWs are regarded as an integral part of the health care system and are an important link between communities and health services. In addition to curative services, all levels provide preventive, promotive and emergency services.

HIV and sexually transmitted infection (STI) prevention, treatment, care and support is extended to various levels of the health care system. The BHUs and ORCs provide HIV information and education, syndromic treatment of STIs, counselling and referral for HIV testing. Starting in 2008, with support from the Global Fund, there are plans to extend voluntary counselling and testing (VCT) competencies to strategically selected BHUs. At the district hospital level, HIV testing, screening for syphilis, antiretroviral (ARV) treatment monitoring, counselling, and, follow-up activities are conducted. While the JDWNRH and the regional hospitals are responsible for the initiation of ARV treatment, follow-up actions are carried out at the district level.

1.4 Situational analysis

1.4.1 Current HIV and AIDS situation in Bhutan

The first case of HIV was detected in the Kingdom in 1993 through routine medical screening. Since then, infected cases detected through various clinical and laboratory testing programmes have continued to increase. As of February 2008, the National STI, HIV and AIDS Prevention and Control Programme (NACP) reports a cumulative total of 144 persons who have tested positive for HIV. A total of 26 deaths have been reported among the infected Bhutanese population (18 males and 8 females; 24 AIDS related and 2 from other causes). The first AIDS case was officially registered in 1994. Currently, there are 109 people living with HIV and AIDS in the country (105 Bhutanese and 4 non-Bhutanese), 9 left the country. These cases are spread across 15 of Bhutan's 20 districts.

¹ Ministry of Health, *Annual Health Bulletin 2006*.

The current surveillance system does not adequately measure prevalence and incidence of HIV and AIDS among high risk groups. Therefore, it is likely that the above statistics do not reflect the true magnitude of the problem. The data available represent HIV infected cases that have been identified through sentinel surveillance (26%), medical screening (23%) and contact tracing (21%), blood donor screening (12%), vertical transmission (9%) and self-initiated voluntary testing (9%). A large number of HIV cases were detected only after developing health problems and not detected during the early phase of HIV infection. Reluctance of persons to come forward for voluntary HIV testing may be associated with fear, denial and high levels of stigma and discrimination.

1.4.2 Epidemiological situation of HIV and AIDS in Bhutan

Bhutan is currently experiencing a low level epidemic, and there are not any known risk groups with prevalence rates of more than 5 percent. According to the results of the third biennial HIV Sentinel Surveillance Survey, 2006, the prevalence of HIV in the surveyed population was 0.05 percent (or 6 HIV positive cases among 11,775 adults). The prevalence among women attending antenatal clinics (ANCs) was estimated to be 0.02 percent, a rate still comfortably under that of 1 percent that characterizes generalized epidemics.

Table 1: HIV prevalence by sentinel population group

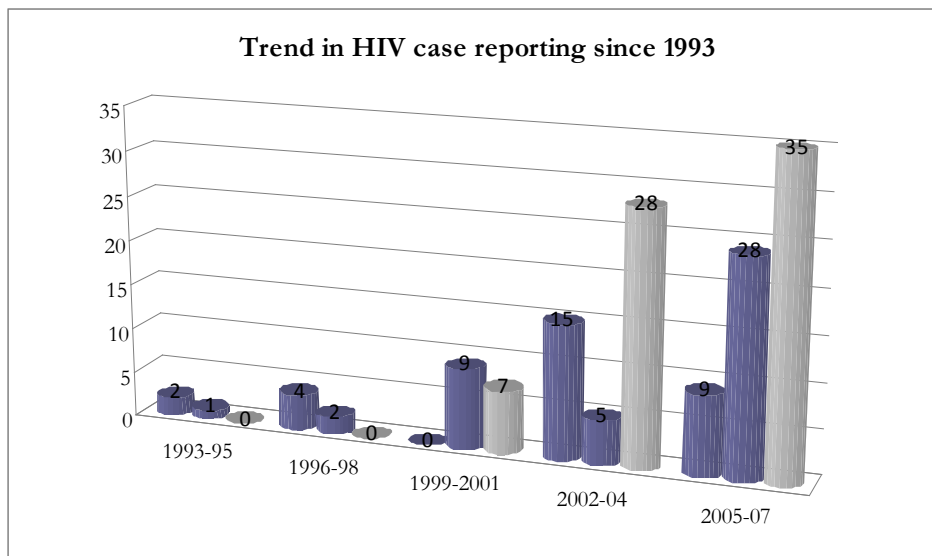
Sampled population groups*	HIV Test		
	Number of tests done	Total HIV positive	Prevalence
ANC attendees	4,831	1	0.02%
STI patients	868	0	0%
TB patients	188	0	0%
Total surveyed population	11,775	6	0.05%

* HIV tests were conducted on blood samples from all ANC attendees, STI and TB patients.

Source: HIV/RPR Sentinel Sero-Surveillance Report 2006

Because the sentinel survey methodology relies on passive case reporting (all tests done at facilities during a period of few months), it cannot produce sufficient sample sizes in the groups typically considered to be most-at-risk of HIV such as sex workers (SWs), injecting drug users and men who have sex with men (MSM). Despite a series of preliminary qualitative studies, epidemic trends in these groups remain poorly understood.

An increasing trend in HIV case reporting can be observed since 1993. Of the 144 cases reported to date, 3 were identified in the three-year period 1993-1995, 6 in the period 1996-1998, 16 were identified between 1999 and 2001, 43 in the period 2002-2004, and the rest have been reported from 2005-2008 (up to February 2008). Although reporting practices have also varied across this period of time, this data does suggest that cases of HIV are on the rise in Bhutan.



1.4.2.1 Modes of transmission

Similar to other countries in the region, the dominant mode of HIV transmission is heterosexual, which accounts for 88.9 percent of all infections. Little is known about the types of sexual transmission among MSM as strong social and cultural taboos stigmatize such relations. These factors make it difficult to rule out HIV due to homosexual/bi-sexual encounters.

The first mother-to-child transmission (MTCT) in Bhutan was reported in 2001. This vertical route of transmission accounts for 9 percent of the cases reported since the start of the epidemic. As of February 2008, thirteen cases of vertical transmission have been documented. Information about the children's serological status was collected after the parent's diagnoses.

In 2006, the first two cases of infection through injection drug use (IDU) were reported. Currently, less than 2 percent of HIV infections is due to IDU but the possibility of sexual transmission cannot be ruled out.

Table 2: Modes of HIV transmission

Modes of transmission	% of all reported cases
Heterosexual	88.9
Vertical transmission	9
IDU (probable)	1.4
Blood transfusion (outside Bhutan)	0.7
Homosexual	Not reported

Source: NACP, February 2008

1.4.2.2 Distribution of HIV and AIDS by occupation

In sentinel surveillance data from 2006, two occupational groups emerged with higher than average rates of HIV infection. The armed forces were estimated to have a prevalence rate of 0.11 percent and the ‘others’ category that includes clinical suspected patients, drivers, businessmen and mobile population a rate of about 0.07 percent. Both groups are also experiencing higher rates of STI infection relative to the general population, suggesting underlying behavioural patterns that may put them at increased risk of HIV.

Table 3: HIV prevalence by occupational group

Occupational groups	HIV Test		
	Number of tests done	Total HIV positive	Prevalence
Armed Forces	2,616	3	0.11%
Migrant workers	586	0	0%
SWs	1	0	0%
Others *	2,685	2	0.07%

* Others include clinical suspected cases, drivers, businessmen and mobile populations

Source: HIV/RPR Sentinel Sero-Surveillance Report 2006

Case reports provide somewhat more information on the risk of HIV infection by occupation. HIV infections have been reported in various occupational groups across the country. The cases reported range from government and corporate employees, to business people, farmers, members of religious groups, housewives (who represent almost one quarter of all detected cases) to SWs. Although, at present, it is unclear which occupational groups are most infected in Bhutan, the risk is potentially widespread. The epidemic cuts across all sections of society, putting every Bhutanese at risk.²

Table 4: Number of HIV reported cases by occupation

	Occupational category	Number of HIV reported cases
1	Civil servant	12
2	Corporate employee	8
3	Employee of international organizations	1
4	Business/Private sector	21
5	Housewife	35
6	Farmer	12
7	SW	10
8	Royal Bhutan Police (RBP)	7

safer sexual relations, unwanted sex put women and girls at very high risk. More research is required to comprehensively understand the gender dynamics involved in the HIV and AIDS epidemic.

1.4.3 Trends of sexually transmitted infections

Rates of other STIs are high in Bhutan, suggesting there is an underlying pattern of risk behaviour that may accelerate the spread of HIV and AIDS. Approximately 2,000 STI cases are reported annually in Bhutan, and the most prevalently reported STIs are syphilis and gonorrhoea. The results of the 2006 Sentinel Surveillance Survey, which included testing for syphilis (RPR and TPHA positive), indicated a prevalence of syphilis of 1 percent among ANC attendees, 2.3 percent among armed forces, and 2 percent among STI patients. Past studies have reported rates as high as 5 percent in the armed forces. Syphilis rates as high as 13 percent have been documented in community based surveys of specific populations (Laya). Due to limitations in the sentinel surveillance methodology, rates of STIs among SWs remain unknown.

On the whole, it has been difficult to reflect the true magnitude of STI problems in Bhutan. It is assumed that STI cases within the country are grossly under-reported as reporting systems for STIs are weak. Moreover, due to the stigma associated with STIs many people are known to resort to self-treatment or seek treatment from IMTRAT (Indian Military Training Team) hospitals and bordering towns in India.

Table 6: Syphilis prevalence by sentinel population group

Population Groups	RPR		TPHA	Prevalence	
	Number of tests done	Total positive	Total positive	RPR	TPHA
ANC attendees	4,586	109	44	2.3%	1%
Armed Forces	2,515	77	58	3.06%	2.3%
STI patients	840	35	15	4.1%	2%
TB patients	170	6	3	3.5%	2%
Migrant workers	586	28	0	4.7%	0%
SWs	1	1	0	100%	0%
Others *	2,547	82	37	3.2%	1.45%
Total	11,245	338	157	3.0%	1.4%

* Others include clinical suspected cases, drivers, businessmen and mobile populations

Source: HIV/RPR Sentinel Sero-Surveillance Report 2006

1.4.4 Knowledge, Attitude and Practices

Before the inception of the NACP, ad-hoc campaigns were used to inform and educate the Bhutanese population. The reproductive health needs including HIV and AIDS prevention

took a new turn after 1999. Her Majesty the Queen, Ashi Sangay Choden Wangchuck, in her capacity as UNFPA Goodwill Ambassador, has since spearheaded nationwide advocacy campaigns in 20 districts taking the message of HIV and AIDS personally to the remotest corners of the country involving all sections of the Bhutanese population.

A study conducted by the Youth Development Fund and the Ministry of Education (MoE)³ shows that more than 64 percent of youth in the non-formal education sector were sexually active as compared to 40 percent of youth in the formal education system above the secondary education level. Among them, 82 percent claimed to practice safe sex and 80 percent said that they had been provided with information on STIs and AIDS, on pregnancy and sexual relationships. A little over 30 percent of the surveyed population felt that they had totally adequate or just adequate knowledge on sexual health.

A study⁴ conducted among out-of-school youth, however, reflects a mismatch between their level of awareness and behaviour with regard to condom use. Among boys and girls exposed to multiple partners, only 60 percent used a condom during the last sexual encounter. Another study reports that although 90 percent of respondents knew that condoms could prevent HIV, only 36 percent knew that condoms could prevent STIs.

The relaxed attitude of adolescents towards sex and sexuality compounded by low condom use and emerging problems of alcohol and drug abuse make them highly vulnerable to HIV infection. The continuing spread of HIV infection can present a serious obstacle to the nation's development as almost 60 percent of the nation's population is less than 25 years. There is a further need to study attitudes and behaviours related to STIs and HIV and to target youth with Behavioural Change Communication strategies.

1.4.5 Violence against adolescents and women

In the midst of socio-economic progress and rapid modernization, there is widening economic disparity between groups, regions, and sexes in Bhutan. This has placed mounting social and economic pressures on young girls and women. Because of their economically disadvantaged position, many women and girls have been exposed to sexual exploitation, domestic violence and prostitution.

Because issues of violence against women (VAW) have seldom been discussed or written about, it is very difficult to assess the true magnitude of the problem in Bhutan. There is no established system for systematic collection of data on VAW.

Living in a “culture of silence”, most women in Bhutan are less likely to report rape, domestic or other incidents of violence. Reluctance to report violence may stem from a variety of reasons, for example, economic dependence, fear of conviction, retaliation, shame, and absence of alternatives. However, a National Consultation of Violence against Women and Children indicated that violence in Bhutan takes place in various settings such as in the

³ Youth Development Fund and Ministry of Education, *The situation of Bhutanese Youth, 2005-2006*.

⁴ Information, Education, Communication for Health, Ministry of Health, *Exploratory study on HIV/AIDS issues affecting out of school youth in Bhutan, 2005*.

workplace, schools and institutions, homes and families, and communities. These factors significantly enhance the vulnerability of women and girls to the HIV epidemic.

Gender based violence is now being accepted as a growing concern and is gaining focus due to increased coverage by the media and actions taken by agencies like the National Commission for Women and Children (NCWC) and RENEW (Respect, Educate, Nurture, and Empower Women). There are an increasing number of organizations playing a key role in dealing with issues related to VAW. These include the RBP, the Royal Court of Justice, the health sector, and more recently the NCWC and RENEW.

1.4.6 Summary of risk factors accelerating the HIV and AIDS epidemic in Bhutan

While Bhutan has not experienced the first hand devastating impact of AIDS that is transforming South East Asia, the fact remains that HIV knows no borders and that it brings with it enormous human suffering. There are a number of factors suggesting that the potential for spread in the country is significant:

- *The nation's borders are porous* - Countries experiencing an alarming spread of HIV and AIDS surround Bhutan. For example, there are major epidemics among injecting drug users and CSWs in neighbouring North-Eastern Indian States. Cross border collaboration is far less than optimal. There is no system of communication between cross border districts for exchange of information or notification of disease or initiation of control measures. There is an increasing mobility of people both within and outside Bhutan.
- *Bhutan's large youth population is most vulnerable to HIV and AIDS* - Global and local experience shows that youth are most vulnerable to HIV and almost 60 percent of Bhutan's population is below the age of 25 years. It is possible that increasing globalisation, together with Bhutan's growing unemployment and rural-urban migration, significantly increase high risk behaviours (unprotected sex and/or IDU) among the youth.
- *High risk sexual practices (multiple and/or concurrent partners, intergeneration and transactional sex) are thought to be common* - The dominant mode of HIV transmission is heterosexual and STIs are present throughout the country, with very high STI rates among certain groups and in certain regions of the country.

Other risk factors include:

- Increasing number of SWs;
- Emerging problem of substance abuse;
- Low awareness about transmission and protection measures;
- Low literacy rates, especially among rural women;
- Denial, stigma and discrimination;

- Low rates of condom use and limited negotiation power for condom use, which hampers the translation of knowledge to appropriate change in behaviour.

1.5 Response analysis

Bhutan's response to the pandemic started long before the first HIV case was detected in the Kingdom. Realizing the devastating consequences of the HIV and AIDS epidemic and recognizing the enormous potential of HIV to cross national borders, the Royal Government of Bhutan (RGoB) initiated the NACP under the Health Department in the year 1988. Prior to this, Sexually Transmitted Diseases (STDs), though managed through various health facilities, were not targeted with active prevention measures.

1.5.1 National commitment to control the spread of HIV and AIDS

In order to counter the spread of the global AIDS epidemic several planned activities have been implemented over the years. A Short-Term Plan (STP), with a focus on prevention, capacity building, establishment of testing facilities and case detection, was developed and implemented in 1989. The STP progressed to a three year Medium-Term Plan (1990-1993, i.e. MTP-I) with a major focus on condom promotion, strengthening of infrastructure, training of health workers, strengthening programme monitoring and evaluation, and preparing groundwork for HIV care and management.

A second plan was written in 1995 (MTP-II). This five year MTP (1995-1999) is an articulation of the government's strategies and policies in relation to STIs and HIV and AIDS. It provides a multi-disciplinary framework involving various government ministries and the private sector to prevent further spread of HIV and AIDS in the Kingdom.

WHO provided technical and financial support through the Global Programme for AIDS (GPA) till 1996. The five year MTP-II was developed and implemented under the Health Sector Programme Support (HSPS) I and HSPS II supported by Danida.

In 1993, a National AIDS Committee (NAC) was established to oversee and coordinate multi-sectoral efforts in order to ensure focus of a common goal through a harmonized approach. Following the directives from the CCM, the existing NAC was restructured to form the National HIV/AIDS Commission (NHAC) in 2004. This Commission closely guides HIV and AIDS policy formulation and advises on strategic responses. The Commission members comprise of representatives of different ministries and organizations.

Currently, the World Bank (WB) supports the RGoB's efforts to tackle the rapidly emerging issue of HIV and AIDS in Bhutan with a grant of US\$ 5.7 million (covering the period 2004-2009). It aims to contribute to the overall goal of maintaining Bhutan's low level HIV and AIDS epidemic status, by encouraging safe sex through the use of condom and improving management and treatment of STIs among highly vulnerable populations and the general public. Additional support is provided by the Global Fund as well as UNFPA, UNICEF, UNAIDS, UNDP and WHO.

1.5.2 Review of existing programme interventions

The NACP functions under the following policy directives:

- A broad based multi-sectoral approach since 2001 with involvement of line ministries in 2004;
- An integrated and decentralized approach since 2004;
- Mandatory screening of all blood and blood products for HIV, Hepatitis and Syphilis;
- Universal precaution in all health care settings;
- Prophylactic Antiretroviral Therapy (ART) to HIV positive pregnant women since 2001;
- Counselling & psychological support since 2001;
- ART for people living with HIV and AIDS (PLWHA) since 2004;
- Rehabilitation of HIV positive Bhutanese SWs since 2004;
- Counselling and informed consent required for HIV testing of any individual (except for blood donors);
- Confidentiality of the HIV test results and of status for all PLWHA;
- Partner notification by the person with HIV infection or with her/his consent by the health care provider, or through the combined efforts of both. If at all, the infected person refuses or does not consent to notify the partner, the health sector shall notify the partner;
- Contact tracing of individuals who may have been exposed to HIV through the index case.

1.5.2.1 Blood safety

A health policy for blood safety built on WHO policy guidelines has been in place since 1990. The policy also incorporates the rational use of blood and blood components with clear-cut guidelines and criteria for blood transfusion. Workshops for infection control have been conducted; manuals and guidelines on nosocomial infection control procedure have been prepared and distributed to every hospital and BHU.

In Bhutan, blood donation is voluntary and given on a replacement donation basis with no monetary compensation offered to blood donors - mostly relatives of patients. The mobile blood donors approach is often used due to storage and other logistic problems. At present, blood transfusion and storage facilities are limited to selected district hospitals where all donated blood is screened with the rapid HIV test kit. The need for blood transfusion service in Bhutan has not been very high. It is estimated that only 1500-2000 units of donated blood per year are being used even at the JDWNRH. The feasibility of setting up blood bank services in every district hospital is being studied to ensure blood safety.

However, there is a need for more specialists in blood banking and trained laboratory staff. Donor education about risk behaviour accompanied by self-deferring system although being performed also needs further emphasis.

1.5.2.2 Prevention of mother-to-child transmission

Interventions to prevent vertical transmission include provision of information to pregnant women concerning risk of vertical transmission and provision of health care services by integrating STI screening with ANC service. Attendees of ANCs are offered counselling and testing services. As a policy, provision of peri natal prophylaxes of AZT (Zidovudine) for pregnant women with HIV has already been in place since 2001.

1.5.2.3 Sentinel surveillance

HIV sentinel sero surveillance was initiated for the first time in 1989 with the objective of studying and monitoring the trend of HIV infection in the country. Till 1996, HIV sentinel surveillance was conducted once a year among population groups deemed at higher risk of HIV infection. Following WHO's recommendation, HIV sentinel surveillance was stopped from 1996 to 1999 as the survey costs far outweighed benefits since the HIV prevalence was significantly low during that period.

Rising cases of HIV in the recent years have highlighted the need to reactivate HIV sentinel surveillance activity. The activity was reactivated in 2000 and carried out every alternate year for a period of six months at selected sentinel sites. From 1989-2004, a total of 108,953 samples have been tested. Out of these samples only 4 samples tested positive for HIV antibodies.

Given the rising number of HIV infections in the country since 2006, the activity is now carried out every year for a period of 3 months. The number of sites has increased from 15 in 2004 to 26 in 2006. Besides occupational data of the surveyed population as in past surveys, the 2006 sero surveillance survey included demographic data such as sex, age, marital status and education level.

The third biennial 2006 HIV sentinel surveillance survey report highlights the findings of the survey and shows trends among various groups as well as geographical distribution of HIV in the Kingdom. The survey period was for 5 months from 15 March to 15 August 2006. A total of 11,775 samples were collected from 26 sentinel sites covering all the twenty Dzongkhags.

The sentinel population groups comprised of pregnant women attending ANCs, SWs, armed forces, STI patients, TB patients, migrant workers and others (clinically suspected patients, drivers, businessmen and mobile populations).

1.5.2.4 Condom promotion

Condom promotion as a family planning measure existed long before the initiation of the NACP in 1988. The national response to STIs and HIV and AIDS includes the promotion of condoms through various awareness-raising campaigns demonstrating their proper use and display of condom boxes in hotels and strategic locations of districts. Condoms are also accessible and available free of cost in all health centres of the nation and through VHWs in the districts. The condom supply increased from 18,000 gross in 2001 to more than 21,000 gross in the Ninth FYP.

However, condom use appears to be still low although there is no reliable data available in this respect. There is a need for behavioural surveillance studies, and more evidence-based planning and action. The feasibility of social marketing for condoms is being studied and more outlets for condom distribution are being identified. Besides increasing accessibility of condoms and instituting measures to promote awareness, prevention and care services need to empower women and girls with condom use negotiating skills. As the behaviour of men is central to successful preventive and care programmes in a heterosexual epidemic like Bhutan's, programmes should equally target men and boys.

1.5.2.5 HIV Testing and Counselling

The rapid test for HIV detection is conducted in all district hospitals. Confirmatory tests such as ELISA are available at the national and regional referral hospitals. All positives detected through the rapid test are referred from districts to the referral hospitals. Facilities for the pre- and post-test counselling were started only in 2001. At present, the programme faces an acute shortage of trained personnel in the area of HIV and AIDS counselling. Up to date, more than seventy health workers have been trained in HIV and AIDS counselling, including six persons who have undergone a training of trainers outside the country. With decentralisation of the STI and HIV and AIDS activities to the districts, it is imperative that more counsellors be trained and be posted in all 20 district hospitals.

HIV testing is voluntary and free in Bhutan. Strict confidentiality is being maintained during the testing process and for individuals who are detected with HIV infection. Since 2004, the use of ARV drugs was approved for the infected population. Despite these incentives, the number of Bhutanese coming forward for voluntary testing remains small; only 9 percent of the cases were detected through VCT. People are reluctant to be tested unless symptoms develop. This could be attributed to fear, denial and stigma attached to the HIV infection. Available information suggests that most of the diagnosed individuals were infected 5 to 7 years ago. There is a further need to strengthen pre- and post-test counselling services and advocate the benefits of testing.

Table 7: Number of cases by mode of diagnosis

	Modes of diagnosis	Number of cases
1	Medical check-up/screening	33
2	Blood Donor Screening	18
3	Survey/sentinel	37
4	Contact Tracing	30
5	Voluntary Testing	13
6	Mother-to-child transmission	13
Total		144

Source: NACP, February 2008

1.5.2.6 STIs management and referral

A high prevalence of STIs in Bhutan has been documented. It is estimated that each year, approximately 2,000 patients receive STI treatment in the various health facilities. Since private practice is non-existent in Bhutan, health care providers at the national and district levels are responsible for treating all STI patients. Treatment is available from every health care setting, from district hospitals down to BHUs, free of cost.

A syndromic approach to management of STIs was introduced in the early nineties. However, the capacity of health workers to diagnose, manage and report STIs needs to be further strengthened. The records maintained are of poor quality and absent in some settings; therefore, the number of STI cases from surveillance system might be grossly under-reported. Anecdotal evidence points to the fact that self-medication among STI patients and treatment in IMTRAT health care facilities or in border clinics are common practices to conceal identity. While there were only 50 reported cases of STIs in the year 2000 at the JDWNRH in Thimphu, the Indo-Bhutan Friendship hospital (located in the same place but run by Indian military personnel) recorded more than 1,000 patients with STIs for the same year.

STIs are important co-factors that facilitate the spread of HIV. Therefore, in a low prevalence country like Bhutan, focus on controlling STIs can be an effective strategy for reinforcing prevention and ensuring that conditions remain unfavourable for HIV transmission. Investing in prevention programmes shall be the most cost effective strategy. Declining STI trends could possibly be an indication that prevention programmes are working while increasing trends could indicate the risk for rapidly spreading HIV.

Priority needs to be given to strengthening STI surveillance through reporting based on symptoms, analysis of data from sentinel sites and through monitoring of RPR prevalence among ANC attendees. In addition, behavioural surveys need to be carried out to assist in the planning and implementation of interventions among population groups with high-risk behaviours.

1.5.2.7 Treatment, care and support of people living with HIV and AIDS

The Royal Edict issued in 2004 by His Majesty the Fourth King, Jigme Singye Wangchuck, calls for compassion and non-discrimination of people affected and infected by HIV. This Royal Edict forms the basis of Bhutan's guiding principle and actions to control the spread of HIV and AIDS in the country. The health care system is actively involved in the treatment, care and support of PLWHA. In order to combat stigma and discrimination, the identity of infected persons is maintained in strict confidentiality. As mentioned earlier, a policy to offer AZT (Zidovudine) to infected pregnant women has been in place since 2001. Since 2004, treatment is also available for all infected persons based on the CD4 count.

Facilities for CD4 count analysis are available at the JDWNRH in Thimphu and the Mongar Regional Referral Hospital in the East. Currently, 21 infected persons are receiving ART; treatment for opportunistic infections (OIs) and counselling services are continuously being provided. As of 2005, due to an increased number of infections diagnosed among housewives, the NHAC mandated spouse/partner reporting.

An increase in HIV transmission poses a significant burden on the health care system and has detrimental economic and social impacts. For the period of July 2007 to June 2008, the cost for purchase of ARV drugs amounts to a total of around Nu. 700,000. With an increasing number of patients on ART, the financial burden of meeting a lifetime treatment and care costs of people with HIV shall be considerable. With the number of new infections continuing to rise year after year, it shall be impossible to provide ARV treatment to all who need.

Another important challenge is that of maintaining strict confidentiality as all those treating and caring for the HIV infected persons shall need to know the positive serological status of receiving ART.

There is much apprehension even among health workers to adopt universal precautions despite high HIV and AIDS awareness and trainings. Post-infection measures following accidental injury in health care settings is another area that needs to be addressed.

Currently, limited human resources are available to monitor the effects of drugs on the immune system after the CD4 count. There is also limited capacity to deal with the complications of the ART and issues related to the resistance of first line/generation ARVs.

Although some HIV positive cases have been taken care of by their family, the general attitude regarding acceptance of HIV/AIDS infected people has been rather mixed. Surveys reveal that the tendency to stigmatize the HIV/AIDS infected population was less among the more educated population. However, stigmatization and discrimination has been a key issue during the nationwide HIV and AIDS advocacy campaigns spearheaded by Her Majesty the Queen, Ashi Sangay Choden Wangchuck. This tendency to stigmatize was witnessed at district multi-sectoral forums as well as among the general population. Although few people

have expressed the need for segregation and isolation of the infected population in several forums, PLWHA in Bhutan have not yet reported such discriminatory attitudes or treatment either by members of the family or the community.

1.5.2.8 Information, Education and Communication

In the past, Information, Education and Communication (IEC) programmes have been mainly addressing the knowledge and awareness component for the prevention of HIV and AIDS. Promotion of the ‘Abstain, Be faithful and use Condoms’ (ABC) approach, which spells out abstinence, be faith full and consistent and correct condom use, has been a major approach. The general population has been educated on various modes of HIV transmission and prevention through the use of mass media, small media and inter-personnel communication. During recent years, the advocacy campaigns have disseminated important messages on HIV and AIDS through infotainment (entertainment and information).

There is however mounting evidence that current approaches need to be reviewed. An evaluation of the IEC materials in 2000 showed poor recall of IEC messages. In order to ensure that messages reach the desired population, there is a need to further stratify messages and identify the most appropriate modes of communicating information according to the target populations. Greater emphasis needs to be put on Behaviour Change Communication.

The ABC approach currently promoted in Bhutan may have disregarded girls and women in certain situations. It misses the point for girls and women who are coerced into sexual activity, for wives whose husbands have multiple partners, for women who are forced to rely on multiple partners for economic survival, for men who refuse to cooperate on condom use. Furthermore, married couples often do not use condoms because condoms indicate lack of trust or they want to have children, etc.

The rising rates of HIV infection among girls and women require prevention strategies that address their specific needs and realities. Increased bargaining power for safer sexual relations, dealing with domestic violence, and safe ways for women to financially support themselves are some vital areas that need to be addressed. As per the Draft Tenth Plan Main Document, mainstreaming gender into health sector policies and programmes shall be given importance and STI and HIV and AIDS shall be one of the priority areas regarding women’s health over the Tenth plan.

1.5.3 Achievements, challenges and opportunities

A review of the national response to the HIV and AIDS epidemic points out to the following major achievements, challenges and opportunities.

Major achievements

- Public awareness on HIV and AIDS enhanced with support from the highest level;

- HIV surveillance system established (sentinel);
- Screening of blood donors made mandatory since 1990 (till date no infection reported through blood transfusion that occurred inside the country);
- Training for health care workers provided in counselling, treatment and care;
- Decentralization and integration of the HIV and AIDS activities;
- NHAC established;
- Efforts to involve PLWHA in the response;
- Initiation of prevention of MTCT; and,
- 100 percent access to ART.

Major challenges

- Weak technical and management capacity of the programme, given limited/trained human resources;
- Limited implementation capacity in sectors other than health;
- Lack of collaboration and coordination between stakeholders; duplication of efforts;
- Lack of community empowerment, mobilization and ownership of programmes;
- Limited coverage of basic prevention and care services including VCT and prevention of MTCT; increased possibilities of MTCT once the epidemic matures;
- Rising levels of HIV/TB co-infection;
- Prevalence of HIV related denial, stigma, myths, and misconceptions contributing to lack of openness and continued spread;
- Relaxed sexual mores, low condom utilization and slow positive behavioural change;
- Individual versus public safety;
- Sustainability issues, including funding the costs of providing comprehensive treatment and care in the context of resource scarcity.

Opportunities

- Strong political commitment;
- Early stage of epidemic;
- Small size population;
- Free and well functioning primary health care services.

SECTION 2: STRATEGIC FRAMEWORK

2.1 Strategy development process

The *National Strategic Plan for the Prevention and Control of STIs and HIV and AIDS* (NSP) was developed in collaboration with government and non-government agencies and development partners. The development of the NSP was overseen by the NHAC. The NACP led the implementation process.

A comprehensive process was undertaken to build broad consensus among partners as to the strategic directions required over the coming years. The process included joint consultative workshops, field visits, meeting with members of the NHAC, and one-on-one consultations with multi-sectoral partners. Drafts of the NSP were reviewed by members of the NHAC and other stakeholders. The development aimed to ensure that the final strategy truly reflects the aspirations of all partners engaged in the response to HIV and AIDS in Bhutan.

2.2 Guiding principles

Bhutan's early response to the HIV and AIDS epidemic is attributed to the visionary leadership of His Majesty the Fourth King, Jigme Singye Wangchuck, who has always accorded top priority to the nation's HIV and AIDS prevention efforts. The nation's response to the HIV and AIDS epidemic is guided by the Royal Decree (Kasho) issued on May 24, 2004.

Royal Decree

"It is of great concern to the nation that the problem of HIV/AIDS is growing in Bhutan. Apart from the pain and suffering that the unfortunate victims face there is a long-term risk that the socio-economic development of the country can be affected if the disease spreads among our small and vulnerable population. It is critical that we do everything possible and stop the spread of HIV/AIDS. It is the responsibility of every Bhutanese to try and contain this problem. It is also important that those who are found to be HIV/AIDS positive are treated with understanding and compassion. We must ensure that they do not face any discrimination in our society"

(Translated version)

The NSP shall be guided by the following principles:

- HIV and AIDS prevention and control is more than a health issue. It represents a development crisis. A multi-sectoral, interdisciplinary and holistic approach is therefore the key to effective prevention and control;
- All Bhutanese women and men must be empowered with knowledge and skills to protect themselves from HIV infection and made aware of their own responsibility in HIV and AIDS prevention;

- Prevention constitutes the primary focus of the NSP. The multi-sectoral response shall pay emphasis to the general population, the youth and other selected vulnerable target groups;
- Resources shall be allocated on the basis of the degree of vulnerability of each group and community;
- Roles and responsibilities of different actors in the multi-sectoral response shall be clearly identified and communicated to all involved. Lessons learned at various levels shall be used to enhance coordination;
- Capacity building, integration, community mobilization, empowerment, leadership and mainstreaming, coordination and networking are critical areas that must be addressed;
- PLWHA shall be guaranteed equal access to basic health care and other services;
- The rights and responsibilities of people living with or affected by HIV and AIDS, and especially the right to confidentiality, should be protected. It is also equally important to protect the general public from reckless transmission through appropriate legal measures. Spouse/partner notification shall be mandatory;
- Participation of communities and other target groups as well as PLWHA in the development, implementation, monitoring and evaluation of programmes and services shall also be emphasized;
- Gender issues shall be addressed in all areas of prevention, treatment, care and support programmes and services;
- The strategy shall be reviewed and modified based on data provided from monitoring and evaluation process, changes in epidemiological situation, findings of research.

2.3 Coordinating bodies

2.3.1 National HIV/AIDS Commission

At the national level, the NHAC, constituted in 2004, functions as the coordinating body for the national response to HIV and AIDS prevention and control.

The roles and responsibilities of the NHAC are as follows:

- Formulate policies on prevention and control of STIs and HIV and AIDS;
- Facilitate linking of national HIV and AIDS plan and policies with other important policy-making processes;
- Function as the coordinating body for the national response to HIV and AIDS prevention and control;
- Mobilize active commitment and collaboration of public/private sectors, civil society and communities.

The NHAC includes members representing different government ministries, civil society as well as the private sector. The Minister of Health acts as the Chairperson and the Department of Public Health serves as the Secretariat.

The NHAC needs to meet at least every six months. The Chairperson may call for additional meetings as and when required.

2.3.2 National STI and HIV and AIDS Prevention and Control Programme

The NACP, under the Department of Public Health in the Ministry of Health (MoH), acts as the key coordinator for the HIV and AIDS response under the guidance of the NHAC. The programme is also responsible for leading and managing implementation of the following specific health components: (i) Surveillance of HIV and STIs, (ii) Establishment of counselling and VCT services, (iii) Developing care and treatment standards and coordinating clinical management of STIs and HIV care, (iv) Carrying out operational research, and (v) Monitoring and evaluation.

Strengthening the programme in terms of skilled personnel and facilities is critical to effectively fulfil its responsibilities as Secretariat to the NHAC and to coordinate and support implementation of this strategic plan.

With the on-going decentralisation process, it is expected that, over the next five years, local governments shall have increasing roles and responsibilities in planning and management of development programmes and central sectoral agencies shall provide policy direction and technical support.⁵ Accordingly, and with the decentralisation of HIV and AIDS related services, the NACP's role is expected to become increasingly limited to policy formulation, advice and coordination.

2.3.3 Dzongkhag multi-sectoral taskforces

Her Majesty the Queen, Ashi Sangay Choden Wangchuck, UNFPA Goodwill ambassador has paved the way for a coordinated multi-sectoral response to the epidemic and the creation of multi-sectoral taskforces (MSTFs) at the dzongkhag level. By 2001, MSTFs were established in all twenty Dzongkhags with the mandate to address health issues, particularly HIV and AIDS preventive and promotion activities and reproductive health. MSTFs have an important role to play in planning, implementation, monitoring and evaluation of HIV and AIDS and STIs prevention, care and treatment. They are a driving force for expanding the response and conducting effective HIV and AIDS activities.

The key responsibilities of the MSTFs are:

- Coordinating, implementing and monitoring the approved work plans;
- Supporting and collaborating with local communities and non-government organizations (NGOs) in implementing HIV and AIDS activities in their Dzongkhag;
- Facilitating participation of PLWHA.
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⁵ GNH Commission, *Draft Tenth Five Year Plan [2008-2013], Vol. I: Main Document*, 2008.

The Dzongda (district chief) is the Chairperson of the MSTF. Members of the MSTF includes Dzongkhag officials of the health sector and other government sectors, gups/chimis (elected representatives), NGOs, community based organizations (CBOs) including religious leaders, private sector, PLWHA and community leaders.

2.3.4 Gewog multi-sectoral taskforces

At the sub-district level, the administrative unit is called gewog or block. Each gewog has about 2,000 to 4,000 people and is headed by the gup (elected community leader). Each of the 205 gewogs has a council known as Gewog Yargye Tshokchung (GYT), which is chaired by the gup who is also the Chairperson of the gewog MSTF.

Gewog MSTFs and CBOs are responsible for implementing the response at the gewog level.

The BHU staffs provide the necessary technical support and are responsible for the health sector response.

2.4 Overview of the strategy

The NSP shall guide the STI and HIV and AIDS response in Bhutan, in line with the Government's Tenth FYP 2008-2013. The NSP shall build on past achievements, learn from existing gaps and focus on scaling-up existing cost effective prevention interventions to ensure appropriate reach.

The scope of the NSP extends beyond the medical response. The strategic framework also strives to ensure a multi-sectoral approach that is innovative, interactive and deliberative with the aim of improving collaboration between government sectors, NGOs, international organizations, communities, institutions, private sector and the media.

Overall goal

Bhutan's overall STI and HIV and AIDS prevention and control approach is to achieve the MDG of reversing and halting the spread of HIV and AIDS by 2015. This goal is in tandem with the national long term goal of GNH.

Vision

Prevent and contain the spread of HIV and AIDS through well coordinated, harmonized, strong partnerships and mitigate the impact of the epidemic by creating a supportive environment for people living with or affected by HIV and AIDS.

Strategic goals

1. Integrate STI and HIV prevention into the core activities of multi-sectoral partners;

2. Create a supportive environment that facilitates the implementation of programmes and services, and reduces stigma and discrimination towards women and men living with or affected by HIV and AIDS;
3. Improve the quality and coverage of the national response to HIV and AIDS and STIs.

Main strategies

- Promotion of safe sex behaviours;
- Condom use promotion including condom social marketing;
- Ensuring clear accurate information concerning HIV and AIDS and STIs, and increasing 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 VCT;
- Prevention 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 children infected and affected;
- Decentralization of ARV treatment to Dzongkhags;
- Enhancing coordination and collaboration between stakeholders;
- Generating local evidences/information on HIV vulnerabilities in Bhutan;
- Capacity building, integration of STI and HIV and AIDS interventions within health sector, community mobilization and empowerment, leadership and mainstreaming, coordination and networking.

Target populations

As mentioned above, the NSP shall primarily focus on prevention targeted at the general population, with additional focus on population groups considered most at risk:

- Youth (both boys and girls in and out-of-school)
- SWs and their clients
- MSM
- Uniformed personnel
- Mobile and Migrant workers
- Substance abusers
- Prisoners
- Women and men working in the tourism industry

2.5 Implementation of the strategy

To advocate for the implementation of the NSP and to facilitate coordination, three key activities have been identified. The aim of these activities is to ensure the strategy has relevance to the planning and implementation of HIV and AIDS and STI programmes across all sectors.

An **annual national advocacy** workshop shall be held. The annual workshops shall provide an opportunity for all multi-sectoral partners to plan for the implementation of actions and review progress made. The workshops shall facilitate communication and coordination.

All multi-sectoral partners shall develop annual work plans. Annual work plans shall need to identify actions against the key priorities outlined in the NSP. They shall need to identify objectives, activities, timeline, and performance indicators. The NHAC shall review anything related to Policy matters of the Annual work plans to ensure there is coordination among all partners.

The implementation of the NSP shall be promoted through **logo branding** of all associated activities. This ensures the NSP and the NACP are promoted as a comprehensive and integrated programme.

Importantly, while the NSP provides the overarching framework, there are a range of other HIV and AIDS and STI policies and guidelines that shall further guide implementation. Key documents include:

- Technical Strategy for Prevention and Control of STIs;
- Manual for the Dzongkhag MSTFs for STI and HIV and AIDS Prevention and Control;
- Behaviour Change Communication Strategy;
- National HIV/AIDS and STI Prevention and Control Project: Operational Manual; and,
- Condom Social Marketing Plan.

These documents need to be considered by partners when implementing programmes and services.

SECTION 3: PRIORITY AREAS AND STRATEGIES

The following five areas have been identified as priority areas for the implementation of the NSP:

1. Enhancing the prevention of STI and HIV transmission
2. Enhancing access to treatment, care and support for people living with HIV and AIDS
3. Creating a supportive environment for women and men living with or affected by HIV and AIDS
4. Creating an enabling environment for successful implementation of the national response to HIV and AIDS and STIs
5. Generating strategic information for evidence-based action

3.1 Enhancing the prevention of STI and HIV transmission

3.1.1 Preventing the transmission of STI and HIV among the general population

While HIV prevalence remains low in Bhutan, the epidemic cuts across all sections of society putting every Bhutanese woman and man at risk regardless of occupation and background. A range of social and cultural factors have contributed to the generalised nature of the epidemic. Some of these factors include early sexual debut, relatively high rates of casual and unprotected sex, multiple sexual partners and increased mobility of the population both within and outside the country.

HIV and AIDS has steadily penetrated Bhutan's rural communities that comprise 70 percent of the nation's population –the people currently living with HIV and AIDS are spread in 15 of Bhutan's 20 districts. Therefore, mainstreaming HIV and AIDS prevention and control interventions in the country's rural development programmes can be a strategic step to avoid the further spread of the epidemic in rural communities.

Prevention programmes need to enhance the level of awareness and knowledge on HIV and AIDS, and encourage safe behaviours. Particular attention shall be given to the adequacy and appropriateness of prevention interventions to women, considering almost half of the reported HIV and AIDS cases to date are women and half of the infected women are housewives. Additionally, there is a need to involve women and men in the general population towards creating a supportive environment and reducing stigma, discrimination and other barriers that hinder prevention, intervention and care.

Objectives

- To prevent the transmission of STI and HIV among women and men in the general population;
- To ensure that women and men in the general population have adequate access to STI and HIV and AIDS information and prevention services

Selected strategies

3.1.1.1 Increasing access to STI and HIV prevention services

Target interventions:

- Awareness raising and promotion of improved health care seeking behaviour for STI treatment and effective use of STI services
- Training of health workers in syndromic management of STIs (pre- and in-service training)
- Enhancing access to STI and HIV detection and treatment
- Ensure access to services by victims of sexual abuse, including post-exposure prophylaxis (PEP) treatment
- Strengthening STI and HIV surveillance

3.1.1.2 Promoting safe sex behaviours

Target interventions:

- Awareness raising and promotion of safe sex practices by MSTFs
- Community-based education programmes on sexuality and gender, sexual and reproductive rights, negotiation skills

3.1.1.3 Increasing access to female and male condoms

Target interventions:

- Condom promotion through public campaigns
- Condom promotion to specific target groups
- Condom social marketing
- Research on innovative mechanisms to increase access to condoms and implementation of such mechanisms
- Condom quality control

3.1.2 Preventing the transmission of STI and HIV among vulnerable groups

Even though Bhutan projects a generalized epidemic pattern, prevention interventions need to target populations considered most at risk. This is deemed necessary to rapidly curb the epidemic and mitigate its impact. Further, this shall ensure the effective use of resources. The focus on vulnerable groups shall also have a positive impact on HIV and STI prevention as a whole, as they are also expected to pass on the information and reach out to other people in the society. The NSP prioritizes segments of the population who are infected and affected most and who are highly vulnerable to the HIV infection. The lack of baseline information in relation to location, actual numbers at risk and their behavioural practices limits effective interventions among these population groups. Priority shall be given to the following population groups:

- Youth (both girls and boys in and out-of-school)
- SWs
- MSM
- Uniformed personnel
- Mobile and migrant populations
- Substance abusers
- Prisoners
- Women and men working in the tourism industry

Objectives

- To prevent the transmission of STI and HIV among women and men in vulnerable groups;
- To ensure that women and men in vulnerable groups have adequate access to STI and HIV and AIDS information and prevention services, and the required skills to put into practice the information

3.1.2.1 Young people

About a third of the Bhutanese population is under 15 years of age and almost 60 percent under 25. Given the host of social, economic and cultural factors that increase young people's vulnerability to HIV and AIDS, the youth warrants special focus of preventive programmes. The lack of youth friendly health services limits access to adequate and correct health information, including proper sexual information. A study⁶ conducted among high school students revealed that although awareness on HIV was high, there were misconceptions about how it is transmitted and not transmitted.

The youth population between the ages of 15 to 24 years is highly affected by the epidemic. According to the epidemiological data of the reported HIV and AIDS cases, about 30 percent of detected cases are young Bhutanese less than 25 years, out of which the large majority are girls. As a large number from this age group are in schools, targeted Behavioural Change Communication and integration of HIV and AIDS preventive issues in the school curriculum are seen as crucial to effectively control the spread of HIV among youth in the school community.

Targeting education programmes for out-of-school young women and men is equally important, as increasing number of young people drop out of school after the tenth grade. A survey conducted among out-of-school youth in 2005⁷ revealed the mean age at first sex as 16 years for males and 18 years for females. Both sexes reported their first sexual experience as early as 10 years. The survey also revealed that both sexes have multiple sexual partners, ranging from 1 to 8 partners within the previous three months. Condom use during the last sexual encounter was 60 percent for both sexes. These factors increase the vulnerability of

6 See Ministry of Health, *Annual Health Bulletin 2006*, p. 35.

7 Information, Education, Communication for Health, Ministry of Health, *Exploratory study on HIV/AIDS issues affecting out of school youth in Bhutan*, 2005.

young people in Bhutan. It is important to involve young women and men in designing and implementing strategies to prevent and control the spread of HIV and AIDS in this special group.

Target interventions:

- Behaviour Change Communication programmes
- Implement reproductive health and life skills education (including negotiation skills) in all schools and educational institutes
- Peer-based education programmes
- Availability of youth friendly reproductive health services at all levels -both health and social services, including appropriate counselling services
- Condom promotion

3.1.2.2 Sex workers

Prostitution is not a legal trade in Bhutan. The Penal Code of Bhutan, 2004 provides penalties to people engaged in prostitution, who include both the SWs and the clients. On account of the legal implications, although sex work exists in Bhutan, it is largely hidden and not an organized network. Due to these factors, it has been difficult to extract in-depth information and define the true magnitude of sex work in Bhutan. Local sources however reveal that over the years the number of SWs has risen primarily in urban areas and along border towns. Anecdotally there are also reports of Bhutanese SWs operating in the interior districts of the country. This correlates well with the steady rise of STIs and HIV in the country.

A situation assessment⁸ carried out in 2005 in Phuentsholing (the largest border town) noted about 50 SWs operating on both sides of the border. Majority of the SWs were from India and Nepal. The number is however believed to be much larger than that which is being reflected. The assessment also noted that condom use ranged from low to nil. This is a matter of serious concern since this behaviour represents a potential threat for spreading HIV and AIDS.

Limited qualitative studies initiated by the NACP in urban centres reveal that most of the SWs were young girls, mostly in their teens, some as young as 14 years of age. Girls in the trade ranged from divorcees, single mothers, unmarried girls to school drop-outs. Several of them belonged to remote district villages and were living unsupervised in urban centres. There have also been informal reports of female school students engaging in sex work.

Poverty, broken homes, lack of parental guidance, the desire for modern amenities, clothes and a luxurious urban life are some of the reasons cited for taking up the sex work. Karaoke bars, discotheques, night clubs and restaurants were cited as common pick-up points. In the absence of brothels, hotels and lodges were common operation venues. The potential clients included men from various social strata and occupational background inclusive of business men, military personnel, government and corporate employees as well as non-Bhutanese across the borders and foreign tourists.

⁸ See Ministry of Health, *Annual Health Bulletin 2006*, p.37.

Research also revealed that awareness and knowledge on the health implications such as STI and HIV and AIDS was fairly high among the SWs. However, condom use among this group was found to be low and inconsistent. This was largely attributed to poor negotiation skills with their clients. Although many were aware of the hazards of unprotected sex, some were left with little choice when male clients refused to use condoms. A few however reported inaccessibility as the reason for not using condoms. Most of the young girls were also aware that treatment services were available. Long waiting lines, lack of privacy and short consultation time with doctors were challenges pointed out by the SWs. Sex work commonly overlapped with smoking, alcohol and drug abuse increasing their risk and vulnerability to diseases many fold.

The existing hospital based services are very treatment oriented and does not address preventive, safe sex and behaviour change practices. Health information service centres (HISC) have recently being piloted in the urban centres in Thimphu and Phuentsholing to provide effective prevention, counselling and treatment services to SWs reluctant to use the services available for the general population. Health authorities face major challenges dealing with sex trade and its health implications, some of which are beyond the reach of health such as cross border issues.

SWs are an extremely vulnerable population group. They play a vital role in transmitting HIV and STIs to the general population and fuelling the HIV and AIDS epidemic. Main risk factors include the criminal character of commercial sex, violence and trafficking, risk sexual behaviours, social stigma and the marginalized social status of SWs. Comprehensive and tailored packages of interventions should be in place to address their special needs.

Apart from focusing on HIV and AIDS and STI prevention activities, the NSP needs to address social and development issues, root causes leading to sex work in Bhutan. Collaboration and cooperation between different institutions and programmes that come into contact or offer services to this vulnerable group need to improve.

Target interventions:

- Increase awareness about STIs and HIV and AIDS among SWs and their clients
- Empowerment and rehabilitation programmes for SWs
- Capacity building of NGOs and relevant organizations
- Support peer-based education programmes including for strengthening negotiation skills
- Expand pilot outreach counselling and referral services
- Condom promotion
- Ensure condom access and availability at all times in karaoke bars, discotheques, restaurants, hotels and lodges
- Enhance cross border collaboration regarding prostitution and trafficking, and exchange of information on HIV and AIDS

3.1.2.3 Men who have sex with men

Almost 90 percent of HIV in Bhutan is transmitted through the heterosexual route. Homosexual transmission has not been reported to date and little is known about this form of sex in Bhutan. Moreover, information on patterns of sexual activity is limited and anecdotal. Silence, stigma, denial and taboo surrounding the subject may possibly be some of the reasons why there are no visible networks of MSM in Bhutan, which makes it difficult to reach out to this group. Hence no special services exist for this population group.

Despite limited information on MSM practices, this group remains an important target population for prevention programmes. It is evident from experiences in other countries that such men are most likely to be disproportionately impacted by HIV and AIDS. Implementation of the NSP can assist in identifying the extent, nature and risks associated with same sex behaviour in Bhutan.

Target interventions:

- Qualitative study to assess the extent and nature of, and associated risks with same sex behaviour
- Create a supportive environment for effective programmes
- Capacity building of NGOs and relevant organisations
- Counselling programmes and access to VCT services
- Awareness raising and distribution of condoms in male dominated communities

3.1.2.4 Uniformed personnel

This group is widely recognized as one of the population groups most vulnerable to HIV and STIs. The highly mobile nature of their profession due to assignment or postings away from home and families often results in increased risk behaviours and contact with SWs. Uniformed services in Bhutan include the RBA, RBG and RBP. They roughly represent about 15,000 of the nation's population. People employed by security companies should also be considered as uniformed personnel.

A cumulative total of 144 Bhutanese were detected with HIV infection by February 2008. Among the infected population, the uniformed personnel rank the third highest after housewives and people from the business community.

A survey conducted among the armed forces with a sample size of 345 reported that 5.3 percent tested positive for syphilis and 6.3 percent for hepatitis B. Another study among 2,300 armed forces personnel in 2006 reported that 2.1 percent screened positive for syphilis. As STIs are important co-factors that facilitate the spread of HIV, measures to enhance awareness and reduce risky behaviours among members of the armed forces are crucial to prevent further infection in this population group.

Target interventions:

- STIs and HIV and AIDS education programmes, including Behaviour Change Communication
- Training in IEC related to STIs and HIV and AIDS
- Integration of STI and HIV and AIDS education in the training curriculum
- Promotion and distribution of condoms

3.1.2.5 Mobile and migrant populations

Growing economic development within the country, particularly during the recent years, has resulted in highly mobile population both within and outside the country. The National Population and Housing Census conducted in 2005 revealed that more than a sixth of the population had migrated from rural villages to urban centres. Approximately 20,000 people working as drivers and handy boys in private and public transport services significantly add to this group.

With a booming construction industry, Bhutan is heavily dependent on a workforce imported largely from neighbouring India and Nepal. Every year, nearly 30,000 workers are recruited in the construction industry.

Being mobile is not a risk factor for HIV and AIDS in itself. However, encountered situations and engaging in risky behaviours during mobility and migration are important factors increasing vulnerability to HIV. Migrants and mobile populations who are absent from their families and communities for long periods of time are identified as likely clients of SWs. Many young girls who migrate to urban centres in search for better economic gains land up in the sex trade. There are also many young girls coming from rural areas who work as domestic helpers for urban families; these girls are known to be vulnerable to sexual abuse. The mobile and migrant groups have little or no access to information about HIV and STIs prevention and could possibly fuel the growing HIV and AIDS epidemic in Bhutan.

The different groups of mobile and migrant populations that need to be targeted in Bhutan include:

- workers in the transport industry (including taxi drivers);
- those traveling abroad for conferences, studies and trade (including students, civil servants and business travelers);
- migrant workers in the construction industry;
- tourist guides and migrant tourism workers;
- domestic helpers, mainly young girls; and,
- rural-urban migrants.

A comprehensive package to prevent and control HIV and AIDS is required through collaborative efforts among stakeholders. Research among relevant organizations is required

to identify the determinants of high risk behaviours in order to determine the most effective entry points and appropriate methods of educating this population group.

Target Interventions:

- Collection of information and research on HIV and AIDS and migration
- Awareness raising on STIs and HIV and AIDS among women and men in mobile and migrant groups and among employers of mobile and migrant workers
- Introduce counselling programmes
- Condom promotion and condom distribution in areas frequented by mobile and migrant groups (e.g. border areas, truck/taxi/bus stops)

3.1.2.6 Substance abusers

HIV incidence has a direct relation with substance abuse, especially in respect to certain risky injection practices such as needle and syringe sharing. Moreover, substance abusers are also commonly known to engage in risky sexual behaviours. Substance abuse must be understood here as abuse of drugs and/or any other harmful substances, including alcohol.

Drug abuse is a relatively recent phenomenon in the Bhutanese society. Although the true magnitude of drug abuse in the country is not known, it is assumed to be less serious than in neighbouring countries. However, there are indications from the RBP records that the drug abuse problem is on the rise.

At a workshop conducted by the MoE in 2004, the police reported 356 drug arrests made in Thimphu city between 1998 and 2004. This represents a significant rise since 1998 and 1999 when just 40 cases were reported. The offenders were almost entirely male and 61 percent were under 20 years of age and as young as 8 years old. It was pointed out that three out of ten were unemployed youth and four out of ten were students. However, most drug abuse goes undetected as users are mostly apprehended when use is linked with other crimes.

Limited studies show that adolescents engage in substance use because of a lack of guidance, problems at home and the easy availability of the drugs and inhalants. Curiosity and peer pressure are other reasons cited.

The range of drugs used includes glue and other volatile substances, marijuana, and pharmaceuticals drugs. The drug use is often combined with alcohol consumption. Injecting drug use in conjunction with needle sharing has been reported. Data from a rapid assessment conducted in 2006⁹ showed that among the 200 surveyed participants (188 men and 12 women), 19 percent ever injected drugs. So far, two cases of HIV infection through IDU have been reported but the possibility of sexual transmission cannot be ruled out.

IDU may not currently be a significant problem in Bhutan. However, this can rapidly change in the near future. There is a significant risk of a rapid spread of the HIV infection among and from intravenous drug users.

9 REWA, *Rapid Situation and Response Assessment*, 2006.

Tackling issues around the area associated with IDU is an important strategy. Early interventions addressing HIV transmission between and from substance abusers, and in particular intravenous drug users, shall be critical in limiting the spread into the general population. Currently, interventions need to be enhanced both in terms of capacity and their focus on the needs of the community. Harm reduction programmes need to be introduced. Furthermore, coordination between programmes and interventions for the prevention and control of substance abuse and of STIs and HIV and AIDS needs to be strengthened.

Target interventions:

- Collaboration and cooperation between stakeholders involved in treatment, care, support and referral of substance dependent persons
- Address harm minimization and demand reduction
- Support public campaigns
- Collection of information and research on IDU and sexual behaviours among substance abusers
- Peer-based education programmes
- Outreach services including awareness raising, counselling and VCT services
- Treatment and rehabilitation programmes; involvement of NGOs & establishment of rehabilitation centers.

3.1.2.7 Prisoners

There is no information available in Bhutan regarding the vulnerability of prisoners to STIs and HIV and AIDS. So far, two HIV infected prisoners have been reported. Worldwide, (injecting) drug use and sex (either between men or sexual abuse of female prisoners) are common practices in prisons. Therefore, it is important to tackle such issues prisons of Bhutan as well. Equally important areas include access to STI and HIV and AIDS prevention information and access to condoms for prisoners. Issues related to hygiene in the prisons shall also need to be addressed. Close collaboration with the TB programme shall be required.

Target interventions:

- Qualitative study on IDU and sexual behaviours in prisons
- Increase awareness among key decision-makers and prison staff about the vulnerability of prisoners to STIs and HIV and AIDS
- Awareness raising on STIs and HIV and AIDS among prison staff and prisoners, and dissemination of appropriate IEC materials for prisons
- Peer-based education programmes
- Ensure STI and HIV and AIDS related services are available for prisoners, including VCT, care and support services
- Collaboration between the NACP and the TB Programme regarding target interventions for prisoners
- Condom distribution

3.1.2.8 Women and men working in the tourism industry

The growing tourism industry is contributing to the economic growth of the country. HIV and AIDS, however, could pose a threat to the industry's development. For the last four years, the Bhutanese tourism industry has been witnessing a sharp and steady increase in the number of tourists visiting the country. With an increasing number of tourists, people working in the tourism industry are considered to be at increasing risk of HIV infection. Such people include tour operators, travel agents, tourist guides, hotel and restaurant workers, handicraft dealers, etc.

Globally, the tourism sector is often associated with casual sex, often unprotected, and drug and alcohol use. However, limited information is available regarding the relationship between HIV and AIDS and tourism in Bhutan. Tourist guides have often been pointed out for their particular vulnerability to STIs and HIV because they are frequently mobile and away from their families for extended periods of time during the tourist seasons. Tourist guides can therefore easily be considered as part of the mobile populations group for prevention interventions. This is also valid for migrant tourism workers who are away from home during the tourist seasons. However, anecdotal reports suggest that other tourism workers may also be vulnerable to STIs and HIV and AIDS. For example, it appears that hotel employees are sometimes subject to harassment by foreign tourists. Because of their frequent contact with tourists, hotel and restaurant employees such as women and men at the front desk, housekeeping staff, waiters and waitresses, and their families are likely to be affected by HIV and AIDS.

The tourism industry shall therefore be encouraged to ensure a safe environment for both female and male tourism workers and take responsibility to provide them with adequate HIV prevention.

Target interventions:

- Identify areas of risk for female and male workers within the tourism industry
- Support workplace education programmes
- Ensure availability and access to support services, including counselling
- Integrate STI and HIV and AIDS education in the curriculum of the hotel and tourism management training

3.1.3 Preventing the transmission of HIV in health care settings

Based on the National Blood Policy of Bhutan proclaimed in 2007, all blood and blood products shall be screened for HIV and hepatitis B at every health care setting. Voluntary blood donations shall be encouraged. The MoH shall be responsible for integrating the blood safety policy into all levels of the health care system.

The MoH stresses on universal precaution procedures as a standard routine practice in all health care settings around the nation. Universal precaution shall continue to be promoted

as a part of infection control measures. There shall be adequate provision of safety gears such as gloves, gowns, and other paraphernalia. Adequate infection control equipment such as autoclave, needle cutters, waste bins, etc., shall be supplied. Periodic and continuous education shall be implemented in order to ensure capacity in disposal, decontamination and infection control in the health care settings. Strong collaboration with the Infection Control and Waste Management Programme and the Drugs, Vaccine and Equipment Division shall therefore be necessary.

Objective

- To prevent the transmission of HIV in health care settings

Target interventions:

- Implementation of the National Blood Policy of Bhutan 2007 and integration into all levels of the health care system
- Injection safety
- Training of health workers in blood safety and infection control measures
- Promotion of universal precaution, including appropriate disposal of medical waste and sharps
- Ensure adequate supply of safety gears and infection control equipment items
- Strengthen collaboration with the Infection Control and Waste Management Programme and the Drugs, Vaccine and Equipment Division
- Develop protocol for reporting of occupational accidents of health workers
- Ensure PEP treatment as an emergency measure for health workers accidentally exposed to needle stick injury
- Blood donors education
- Monitoring and Control

3.1.4 Preventing mother-to-child HIV transmission

The first MTCT in Bhutan was identified in 2001. Currently, 13 cases have been reported. Prevention of MTCT has been actively integrated into reproductive health services delivered through the existing health care infrastructure.

There shall be regular HIV and AIDS training for health care workers who are responsible for family planning, antenatal care, birth delivery and newborn care. Pregnant mothers shall continue to be offered HIV testing through an opt-out approach at all ANCs. HIV positive pregnant mothers shall be followed-up and support shall be coordinated in the community by health service providers.

All pregnant mothers who are HIV positive should have access to ART. In a further effort to reduce HIV infections in Bhutanese infants and young children, breastfeeding shall not be

recommended to HIV infected mothers. The Government shall provide support for infant formula and ensure that alternative feeding is made safe, sustained, and accessible for HIV positive mothers. For those mothers who strongly intend to breastfeed their children, their choice shall be respected.

Objective

- To prevent the transmission of HIV from infected mother to child

Target interventions:

- Strengthen health workers capacity to provide safer delivery practices, infant feeding counselling and support
- Ensure access to VCT
- Ensure adequate number of trained staff and supply of testing kits for VCT
- Ensure standard protocol and routine HAART are available for all pregnant women found positive
- Care and support for infected women and their family
- Young women education on reproductive health, sexual and reproductive rights, negotiation skills
- Ensure essential care and support services including family planning and other reproductive health services for HIV positive women
- Integration of STI case management prevention and care in antenatal care

3.1.5 Increasing access to HIV counselling and testing

Testing for HIV is recognized as a key element in the prevention of HIV transmission. It is also an entry point for treatment and care services. VCT refers to the process of giving people counselling before and after a HIV test. The process helps people prepare for and understand their test results. Those who test negative can learn ways to avoid becoming infected, and those who are positive can learn how to live longer, healthier lives and prevent transmission to others. Counselling and testing can be patient-initiated or provider-initiated. Either way it is important that patients provide informed consent to undergo a HIV test, and that the confidentiality of patients is strictly maintained.

HIV testing and counselling can be accessed at a hospital or at a HISC. BHUs can provide information, education and basic counselling on HIV, and refer patients where required.

There is a HISC in Thimphu and another one in Phuentsholing. The model of service delivery adopted by HISCs extends beyond just the provision of counselling and testing to identifying risk within their geographic area, outreaching to population groups at risk and strengthening partnerships with local entertainment venues to create a supportive environment for the prevention of HIV transmission. The model could further be enhanced by adopting a peer

education approach to working with population groups considered most at risk. The model used by the current centres should be adopted if further centres are established in response to an identified need.

A routine offer of HIV testing shall continue to be made to pregnant women, TB patients, and STI patients. The partnership between the TB programme and the NACP needs to be strengthened to ensure there is routine screening of people with HIV for TB, and screening of people with TB for HIV. The right of the clients to choose not to undergo a HIV test shall be respected.

Objective

- To increase access of women and men in the general population and in vulnerable groups to HIV counselling and testing

Target interventions:

- Extension of VCT services to cover broader targeted group
- Training of health workers, especially at local levels, in HIV and AIDS counselling
- Ensure adequate supply of HIV testing kits
- Collaboration between the NACP and the Drugs, Vaccine and Equipment Division
- Promote use of VCT services and benefits of testing
- Continue routine offer of HIV testing to pregnant women, TB and STI patients
- Strengthen partnership between the NACP and the TB programme
- Ensure protection of fundamental rights, such as freedom of choice and informed consent to undergo a HIV test, and confidentiality of test results and status of HIV infected persons

3.2 Enhancing access to treatment, care and support for people living with HIV and AIDS

As of February 2008, there is a total of 109 officially reported PLWHA in the country, out of which 21 are receiving ARV treatment. ARV treatment has been available for all infected pregnant mothers since 2001 and all PLWHA since 2004 based on results of the CD4 count.

3.2.1 Using standardised treatment for people living with HIV and AIDS

Objective

- To ensure the use of a standard national protocol for the treatment and care of PLWHA

Target interventions:

- Implement standard national protocol for treatment and care of PLWHA
- Ensure adequate resources are allocated for ARV and OI drugs
- Train health workers in clinical management

3.2.2 Decentralizing treatment and service options

Objective

- To decentralise treatment and service options for PLWHA

Target interventions:

- Develop and implement standard guidelines for palliative care
- Support training of health workers in clinical management
- Establish strong partnership with NGOs, CBOs and religious institutions and support them to provide alternative care and support services to PLWHA
- Develop capacity of health workers to provide basic medical and counselling services

3.3 Creating a supportive environment for women and men living with or affected by HIV and AIDS

People infected and affected by HIV and AIDS need access to appropriate services, which includes access to treatment, care and support services. In addition to ensuring access to appropriate services, empowering PLWHA enables them to help themselves.

Objective

- To create a supportive environment for women and men living with or affected by HIV and AIDS

Selected strategies

3.3.1 Empowering women and men living with HIV and AIDS

PLWHA can play an important role in the national response to HIV and AIDS. The empowerment of PLWHA enables them to help themselves by developing social and support networks, and advocating on their own behalf. PLWHA can also promote a greater understanding of HIV and AIDS within their community.

A key challenge in empowering PLWHA is to ensure the existence of a supportive environment. A supportive environment shall assist PLWHA who choose to disclose their HIV/AIDS status to family members and others within their community.

Given the small number of PLWHA, initiatives to support them are at an early stage. Networks of PLWHA are being facilitated under projects funded by the WB. Such initial initiatives to foster networking among PLWHA and build their social and support networks should continue. Where feasible, such initiatives need to encompass people with HIV/AIDS living in rural areas. Over time, PLWHA should be encouraged to form their own self-help group, with appropriate support from health services. The capacity of PLWHA shall also need to be built so that they can participate in a meaningful way in HIV and AIDS planning, policy development, as well as in programme implementation/service delivery.

3.3.2 Community participation in HIV and AIDS care

Achieving the objectives outlined within the NSP requires the participation of individuals, families and communities. Improving understanding, facilitating behaviour development and change, providing services, encouraging understanding, compassion and support to mitigate impact - all require the active involvement of people at dzongkhag and gewog levels. Providing training and support to families and communities impacted by HIV and AIDS and to care providers can help build a supportive environment for PLWHA.

3.3.3 Ensuring care and support to children infected or affected by HIV and AIDS

Unlike other countries, there are no orphanages in Bhutan. This can be attributed to the nation's traditional extended family structure and strong family bonds where members support one another in times of illness, death and other adversity. The current HIV and AIDS epidemic documents 3 orphans who are receiving care and support from members of their extended family. But with rapid urbanization, close family ties are slowly changing to a nuclear family structure particularly in urban areas. There is therefore a need to ensure continued community support of children infected and affected by HIV and AIDS.

As is evident from countries in the region and abroad, the HIV and AIDS epidemic has tremendous potential to produce large number of orphans and vulnerable children. Based on lessons learned from other countries, there shall be a need to put in place mechanisms for both care and support and reducing the vulnerability of this population group.

3.3.4 Improving acceptance of women and men living with HIV and AIDS

Reducing stigma surrounding HIV and AIDS can improve the uptake of support services such as VCT but is also of crucial importance to increase acceptance and integration of PLWHA in the society. We should all be guided by the Royal Decree issued in 2004 by His Majesty the Fourth King who calls for understanding and compassion and non-discrimination of PLWHA.

Target interventions for creating a supportive environment for PLWHA:

- Community-based care and support for people living with or affected by HIV and AIDS, including children
- Support the involvement of the Dzongkhag and Gewog for HIV and AIDS care

- Training and support to families, communities and care providers
- Ensure access to social services
- Decrease discrimination and reduce stigma
- Support information campaigns among the public and communities on acceptance of PLWHA
- Continue initiatives to empower PLWHA
- Ensure participation and involvement of PLWHA in designing, implementation and policy decisions affecting them
- Ensure protection of fundamental rights of PLWHA

3.4 Creating an enabling environment for successful implementation of the national response to HIV and AIDS and STIs

The successful implementation of a response to HIV and AIDS requires an enabling environment. The social environment in which activities are planned and implemented shall demand better community attitudes towards people who are vulnerable and PLWHA.

Objective

- To create an enabling environment for successful implementation of the national response to HIV and AIDS and STIs

Selected strategies

3.4.1 Sustaining strong political and administrative leadership

Political commitment from the highest level and effective leadership are critical in the fight against AIDS. The HIV and AIDS epidemic can be successfully tackled only when prevention and control interventions are taken as priority development agenda and effectively integrated into the core functions of all development partners. Unless leaders at all levels provide the required guidance and are made accountable in their respective agencies, the epidemic shall continue to spread causing incalculable damage. Leadership and mainstreaming should be considered as a critical strategic issue to be promptly addressed.

Bhutan has a tradition of enlightened leadership demonstrated through the Royal Edict issued by His Majesty the Fourth King. The Royal Edict spells out the responsibility of all individuals in the fight against HIV and AIDS and urges compassion and support towards all people infected and affected by HIV and AIDS. Vibrant and appropriate leadership at all levels and in all sectors is required to ensure effective control of the HIV and AIDS epidemic.

3.4.2 Engaging and coordinating the response of multiple partners

Partnerships between all sectors are critical to creating an enabling environment as HIV and AIDS is a development crisis. It requires the active and continued involvement of all sectors at all levels. The involvement of a wide range of actors -government and non-government agencies, private sector, community, families, individuals, international agencies- requires effective and efficient coordination mechanisms and modalities in problem identification, information sharing, planning, implementation, monitoring and evaluation.

Coordination and networking between stakeholders and programmes avoids resource wastage and duplication of efforts, enhances success through documentation and dissemination of best practices and research findings, and ensures a smooth flow of funds.

Bhutan has already taken initiatives to coordinate and facilitate multi-sectoral response at different levels. However, lack of clarity of roles and mandates among stakeholders, poor management and information systems, inadequate monitoring and evaluation and lack of transparency and accountability are current challenges. Institutional arrangements should be reviewed to bring effective coordination and synergy.

At the national level, the NHAC is the key coordinating body. The NHAC has a key role to play in monitoring the implementation of the NSP. Regular meetings of the NHAC shall be required.

At the dzongkhag level, MSTFs are the key coordinating bodies. Their roles and responsibilities have been clearly outlined in a manual developed in 2005. MSTFs play a critical role in coordinating community participation and in local planning, implementation, monitoring and evaluation.

3.4.3 Capacity building for relevant implementers and stakeholders

The capacity to respond to HIV and AIDS in Bhutan has progressed enormously. However, the development of capacity is an ongoing priority particularly as new challenges emerge, new sets of knowledge and skills may be required. Building the capacity of those involved in the delivery of HIV and AIDS services is critical.

Within the health sector, there needs to be ongoing development of skills in prevention, treatment, care and support.

MSTFs are an important strategy for planning responses at the local levels. Further capacity development in prioritization and management shall further enhance their capacity to develop local response.

Capacity development of other multi-sectoral partners shall assist them to manage and implement the interventions outlined in the NSP.

NGOs such as RENEW, the Youth Development Fund and Tarayana Foundation are in a good position to reach marginalized populations such as SWs and substance abusers but they lack the technical, financial, and often, managerial capacity to design, implement, monitor and evaluate HIV and AIDS interventions. Another key priority is therefore developing the capacity of NGOs and CBOs in HIV and AIDS programme management. Building their capacity aims to facilitate their increased involvement in the response to HIV and AIDS.

Developing research capacity is critical. Research provides the evidence to inform the development of interventions. Research capacity within the MoH and academic institutes as well as of other relevant stakeholders such as NGOs needs to be developed.

3.4.4 Engaging the media

The media has a responsibility to ensure they accurately report on HIV and AIDS issues. Increasing awareness on and understanding of HIV and AIDS among media workers, as well as their engagement in the response to HIV and AIDS in Bhutan, can assist in ensuring correct HIV and AIDS messages are effectively communicated to the population. Ethical issues regarding confidentiality, privacy, correct information, etc. shall need to be addressed. There are a range of media outlets in Bhutan including Kuensel, Bhutan Times, Bhutan Observer, Bhutan Post, Bhutan Broadcasting Service, Kuzoo FM, and Radio Valley. All forms of media can play an important role in educating the community about HIV and AIDS.

3.4.5 Further developing health service infrastructure including effective laboratory

The expansion of HIV and AIDS and STIs services in the coming years shall demand infrastructure development. The quality of care is an essential element to build trust with the community. The MoH shall set up standard facility, equipment, and quality control system for hospital laboratories in line with the needs identified in the NSP as well as to comply with the National Health Development Plan.

3.4.6 Ensuring a supportive legal and policy environment

It has been widely recognised that the success of various HIV and AIDS interventions is directly proportional to the degree to which fundamental rights are protected and promoted in the context of these interventions. The promotion and protection of fundamental rights of people living with and affected by HIV and AIDS (e.g. right to non-discrimination and equality before the law, right to health, education, work, etc.) is an integral component of all responses to HIV and AIDS. It is therefore essential to ensure that the existing legal and policy framework in the country protects these fundamental rights of people living with and affected by HIV and AIDS and does not represent a barrier to the acceptance and integration of PLWHA. For prevention and control efforts to be effective, it is also important that laws and policies are supportive of such efforts and conducive to implementation of prevention and control activities. On the other hand, PLWHA must also be made aware of their responsibilities in the response to HIV and AIDS and be held responsible for their actions.

3.4.7 Mobilizing and sustaining resources

The successful implementation of the NSP requires financial and technical resources. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the WB are two major donor sources that are providing funding for implementation of HIV and AIDS programmes. There shall be a need to identify continuous and dedicated funding to support the implementation of priorities. Clear accountability mechanisms shall ensure that resources are used effectively, efficiently and transparently. Optimal financing mechanisms shall be developed to allow resources to quickly flow through to the most appropriate bodies. Private sector partnership in the identification and mobilization of resources shall also be critical.

Target interventions for creating an enabling environment:

- Broaden the involvement of the partners to join the STI and HIV and AIDS response
- Coordinate the engagement of multiple partners at all levels through appropriate coordination mechanisms
- Create forum for continuous knowledge and information sharing with the media
- Develop ethical guidelines for reporting on HIV and AIDS issues by all forms of media
- Train media workers to develop effective awareness programmes on HIV and AIDS
- Set up core body to assess the demand and provide capacity building for all the partners and sectors at all levels
- Support the requirements in infrastructure, equipment and medicine resulting from expansion of HIV and AIDS and STI services, including for effective laboratory services
- Review and amend, if necessary, existing laws and policies
- Identify reliable and affordable sources of supply of ARV drugs
- Assessment of the resources required and resources management

3.5 Generating strategic information for evidence-based action

A comprehensive strategic information system is crucial to generate continuous, accurate and timely information from multiple sources. Additionally, it can strengthen the evidence base for effective HIV and AIDS policies, improve governance, mobilize new resources and ensure accountability for their use.

The various programme monitoring and surveillance activities are highly complementary and in conjunction with operational research serve to generate key strategic information required for evidence-based planning and programming.

Objective

- To generate strategic information for evidence-based action

Selected strategies

3.5.1 Strengthening STI and HIV surveillance

STI surveillance is an important programme component that needs strengthening. Countries in the region that have successfully responded to HIV epidemics have included strong STI services with ongoing STI surveillance.

The STI surveillance in Bhutan consists of:

- (1) Syndromic STI case reporting from all health facilities;
- (2) Laboratory-based reporting of key STI etiologies (syphilis, gonorrhoea) from the national, regional and district hospitals; and,
- (3) Antimicrobial sensitivity testing in selected sites.

HIV/RPR sentinel sero surveillance currently occurs annually at 26 surveillance sites. Surveillance involves HIV screening at ANCs, and among TB and STI patients. Ongoing HIV sentinel surveillance is required at selected sites. The existing screening of patients accessing health services provides useful surveillance information.

3.5.2 Confidential HIV infection case reporting

Existing surveillance does not serve the purpose of monitoring trends over time in a sentinel population, due to the low prevalence of HIV. Moreover, it can give a false sense of security as only a small proportion of the population is tested in certain parts of the country during a specified period of time. As VCT services expand, and as the uptake for HIV testing increases, VCT data should provide more detailed and representative information about HIV prevalence and modes of transmission. Early confidential reporting of HIV infected individuals facilitates the provision of care and support to PLWHA to improve their longevity and quality of life. Moreover, it helps in positive prevention among people living with HIV, limiting further transmission. All HIV infection cases should be confidentially reported. Minimal information shall be collected from HIV cases including age, sex, occupation, education, risk factor, date and clinical stage at diagnosis, CD4 if available, OIs and whether treated with ARV drugs or not.

3.5.3 Conducting behavioural monitoring and surveys

Regular behavioural monitoring needs to occur as a part of service provision for selected population groups accessing health services. This can occur through the use of simple tools that ask service users questions regarding their behaviour.

In addition to ongoing behavioural monitoring, behavioural surveys can provide information

about the trends in high risk behaviours, risk situations and vulnerability, which serve as an early warning of the extent of impending HIV infection. Such surveys shall help in tracking behaviours that spread HIV and can be used to inform the design of interventions and to measure the impact of ongoing prevention and care activities. Behavioural surveys should be carried out twice during the implementation of the NSP. Consideration needs to be given to surveys among young women and men, uniformed personnel, and other population groups considered most at risk.

3.5.4 Carrying out operational research

The routine health and management information system should not be overburdened for special information needs. Operational research shall be carried out for special information needs. For example, operational research may be undertaken to understand the existing barriers to accessing HIV/STI testing services or to learn about the reasons for low condom use in certain groups.

Research questions should be carefully identified in consultation with programme managers to ensure that the research is operational, with rapid analysis of data allowing for quick application where necessary at policy, programme and service levels.

The capacity to undertake research needs to be developed. There needs to be greater capacity in relation to surveillance and implementation of social research such as behavioural surveys.

Capacity within the MoH needs to be developed, as well as capacity of academic institutes and other relevant stakeholders.

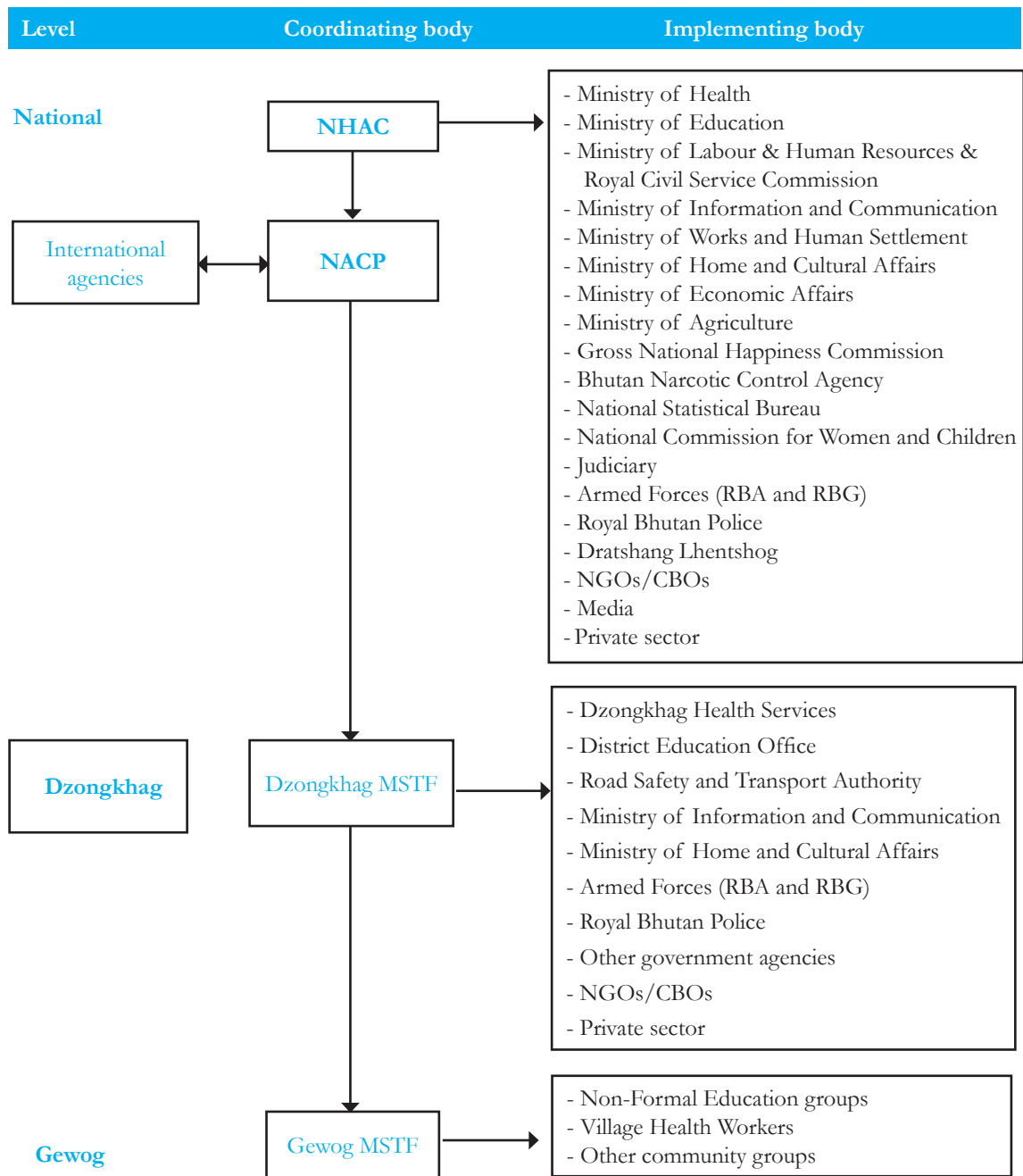
Target interventions for generating strategic information:

- Adjustment of the targeted population for surveillance and methodology
- Capacity building of health workers to diagnose, manage and report STIs
- Adjustment of the targeted population for behavioural monitoring and survey
- Regular behavioural monitoring and conduct behavioural surveys
- Review and strengthen the confidential system for PLWHA reporting
- Set up the coordinating centre for collecting information and analysing information collected through the related research
- Capacity building to undertake operational research and behavioural surveys

SECTION 4: ORGANIZATIONS AND INFRASTRUCTURE

The NSP recognises the importance of the involvement of all partners, both government and non-government organizations. The roles of different constituencies are outlined in each programmatic area and shall be further detailed by specific partners in the rolling five-year operational plans.

The flow chart below summarises the organizations involved in the implementation of the NSP.



4.1 The role of organizations

The NSP calls for significantly scaled-up action. HIV and AIDS is not just a health issue; an effective response requires a range of social, economic and cultural responses. A key objective of the NSP is ensuring that STI and HIV prevention is incorporated into the core business of multi-sectoral partners.

Below is an outline of the roles and responsibilities that some of the key players shall have in the response to HIV and AIDS. During the implementation of the NSP, other ministries, agencies and organizations than those listed below may be identified as being able to make a valuable contribution to the HIV and AIDS response. Their contribution shall be welcome and encouraged.

It shall be the responsibility of the all the Ministries to appoint a focal person. Formally recognising within the focal person's job description her/his responsibilities in HIV and AIDS, can assist in ensuring that HIV and AIDS education is incorporated into the core business of ministries.

The multisectoral involvement shall ensure a wider reach for prevention activities. The Ministries shall also ensure that their staffs are educated on prevention.

Ministry of Education

The MoE has a critical role in supporting young people to adopt safe lifestyles in a changing social context and increasingly global culture. Its target population shall be both young women and men in school and out-of-school.

Its responsibilities shall include:

- Integrating life-skills into reproductive health education;
- Strengthening counselling programmes;
- Implementing peer-based education programmes and scouting;
- Implementing other youth-oriented activities.

The Ministry shall be responsible for implementing strategies aimed at enhancing the prevention of HIV and STI sexual transmission and the prevention of HIV transmission among young women and men, who are the focus of its mandate.

Royal University of Bhutan

The Royal University of Bhutan shall:

- Integrate HIV and AIDS education into the training curriculum of colleges & institutes

- Implementing peer-based education programmes;
- Implementing other youth-oriented activities.

Ministry of Labour and Human Resources and Royal Civil Service Commission

The Ministry of Labour and Human Resources (MoLHR) and the Royal Civil Service Commission (RCSC) shall:

- Undertake prevention activities for formal (e.g. civil servants, corporation employees) and non-formal employees, including migrant workers;
- Facilitate workplace education and develop appropriate support systems;
- Play a key role in ensuring non-discrimination against employees on the basis of real or perceived HIV status.

The MoLHR shall also:

- Encourage employers of migrant workers to implement prevention activities;
- Integrate HIV and AIDS education into the training curriculum of the Vocational Training Institutes;
- Ensure availability and access to condoms in the Vocational Training Institutes.

The key strategies to be pursued shall be enhancing the prevention of HIV and STI sexual transmission, with a focus on migrant workers.

Ministry of Agriculture

The Ministry of Agriculture shall:

- Undertake prevention activities for all the farmers
- Encourage farmers to avail testing and counselling services

Ministry of Information and Communication

The Ministry of Information and Communication (MoIC) shall:

- Continue to facilitate and implement HIV prevention activities for transport workers through the Road Safety and Transport Authority;
- Ensure availability and access to condoms in areas frequented by the transport workers (e.g taxi, bus and truck stops).

The MoIC in collaboration with the MoH shall:

- Support the implementation of key strategies that shall include public campaigns and public communication through all kinds of media channel;
- Further develop forums for sharing HIV and AIDS knowledge and information among media workers;

- Address training needs of media workers in the area of HIV and AIDS and develop ethical guidelines for reporting on HIV and AIDS.

The series of messages disseminated to the public shall be in line with HIV and AIDS prevention and safe sex behaviours, condom use and access, as well as awareness on substance abuse and rehabilitation.

Ministry of Works and Human Settlement

The Ministry of Works and Human Settlement, through the Department of Roads, shall continue to facilitate and implement prevention activities for the national workforce. Cooperation with the MoLHR in on-the-job education for awareness and prevention of STIs, HIV and AIDS shall be required.

Ministry of Home and Cultural Affairs

Through all the twenty Dzongkhag administrations, the Ministry of Home and Cultural Affairs shall ensure proper functioning of the MSTFs and ensure that all the interventions on STIs and HIV and AIDS at the local levels are implemented.

Ministry of Economic Affairs

The Ministry of Economic Affairs, in collaboration with the Bhutan Chamber of Commerce and Industry, the Bhutan Tourism Council, the Association of Bhutanese Tour Operators, Hotel Association, business communities, including hotels and pharmacies shall:

- Implement HIV and AIDS prevention activities and promote supportive environments;
- Encourage the private sector such as hotels, pharmacies and grocery stores, to be sources of HIV and AIDS information and condom distribution, or condom retailers;
- Ensure access to information and services for STIs and HIV and AIDS on a regular basis for workers in the entertainment establishments and hotels.

The Hotel and Tourism Management Training Institute shall integrate HIV and AIDS education into its training curriculum.

Gross National Happiness Commission

Given its coordinating role in planning, monitoring and evaluation (M&E), the GNH Commission shall be responsible for ensuring:

- Mainstreaming of STI and HIV prevention into sectoral plans;
- Inclusion of adequate indicators in the National Monitoring and Evaluation System

(which is currently under development) to monitor and evaluate achievement of the goals and objectives identified in the NSP;

- Allocation of adequate resources for successful implementation of the national response to HIV and AIDS and STIs by all sectors and at all levels.

The GNH Commission shall also be involved in the costing initiative of HIV and AIDS related interventions (as part of the UNDP Regional Programme *'HIV, Human Development and Mobility in Asia and the Pacific Phase II'*).

Bhutan Narcotic Control Agency

As per the Narcotic Drugs, Psychotropic Substances and Substance Abuse Act 2005, the Bhutan Narcotic Control Agency (BNCA) is responsible for developing and implementing the national drug control strategy, strengthening operational skills and know-how of and cooperation between different stakeholders in the prevention and control of substance abuse in the country.

The BNCA shall therefore have an important role to play in supporting programmes and activities aimed at enhancing the prevention of STI and HIV transmission among abusers of narcotic drugs, psychotropic substances and/or any other harmful substance.

National Statistical Bureau

The National Statistical Bureau shall have a role in:

- Conducting/assisting stakeholders to conduct research in the area of HIV and AIDS;
- Building the capacity of stakeholders to undertake operational research in the area of HIV and AIDS;
- Integrating HIV and AIDS related aspects into national surveys.

National Commission for Women and Children

The NCWC is responsible for coordinating and monitoring implementation of activities related to women and children under relevant international and regional conventions, and for establishing a complain mechanism for any violation of women's and children's rights.

The NCWC shall:

- Collaborate whenever necessary with other stakeholders involved in HIV and AIDS and STI related activities targeting women and youth;
- Ensure protection of fundamental rights of women and children living with or affected by HIV and AIDS;

- Collaborate with other relevant stakeholders regarding effective gender mainstreaming in HIV and AIDS and STI programmes as per the National Plan of Action for Gender.

Judiciary

The Judiciary shall guarantee the protection of fundamental rights of PLWHA, such as right to privacy, right to non-discrimination, right to work, right to equal access to education, etc.

Armed Forces (RBA and RBG)

The armed forces shall undertake:

- Provision of HIV and STI related prevention, care and investigation services for military personnel;
- Training of health care providers and care givers in the prevention, diagnosis and management of STIs and HIV and AIDS;
- Collaboration with the MoH in implementing behavioural and sero surveillance among military personnel.

A risk behavioural survey shall be conducted as an integrated procedure in the induction of new conscripts. The statistics and trends of STI and HIV and AIDS behaviours and incidences shall be reported to the NHAC regularly.

Royal Bhutan Police

The RBP is a responsive key player represented on the NHAC at the national level, as well as through participation in the MSTFs at the local level.

The RBP has developed a plan that aims to prevent the transmission of HIV and STI among the police force and their families and to reduce HIV and AIDS associated stigma and social impact. The plan aims to mainstream HIV and AIDS education in the training curriculum and integrate HIV and AIDS related activities in the workplace.

The Thrimshung Women's Group has a good network addressing health and women issues in the police force.

The RBP shall:

- Implement the plan mentioned above;
- Enhance cross-border collaboration regarding prostitution and trafficking and in terms of information sharing on HIV and AIDS;
- Ensure that prisoners have adequate access to HIV and AIDS and STI prevention, treatment, care and support services;

- Collaborate with the MoH regarding prevention and control of STIs and HIV and AIDS in high risk groups such as SWs, substance abusers, etc.

Dratshang Lhentshog

Monastic education is one of the oldest educational systems still operating today. There are more than 35 major Buddhist institutions consisting of schools, colleges, monastic institutions, and retreat centres with a total enrolment of 4,500 monks. Boys generally enter the monastic educational system at a young age.

Religious leaders and monk communities have an important role to play in awareness-raising, prevention education, encouraging tolerance and compassion for PLWHA in the community, and providing direct spiritual support to people and families affected by HIV and AIDS.

Monastic education is highly revered and is considered prestigious in Bhutanese society and the linking of responsible and safe behaviour to Buddhist teachings has already been carried by monks trained in approaching HIV and AIDS from a Buddhist perspective.

Dratshang Lhentshog shall be responsible for:

- Strengthening the role of religious institutions and figures in HIV and AIDS advocacy and prevention, including by utilizing trained monks as counsellors to further decrease the stigma faced by PLWHA and to provide spiritual support to people infected and affected by HIV and AIDS;
- Reviewing the curriculum of the monastic education system to incorporate information on health, including on STIs, HIV and AIDS.

Non-government and community-based organizations

NGOs and CBOs in Bhutan shall continue to play a crucial role in the response to HIV and AIDS by providing community leadership and guidance and by undertaking awareness-raising and advocacy in the interests of affected communities.

These organizations shall work directly with women and men with specific needs that are not easily reached by the public sector, such as marginalized young people, especially out-of-school youth, SWs, substance abusers, MSM, victims of sexual abuse, and PLWHA.

The NGOs and CBOs shall:

- Provide implementation expertise at the community level;
- Advocate for more volunteerism within communities;
- Provide counselling, care and support services for PLWHA and affected people;
- Assist local communities to mobilise human, financial and material resources to support STI and HIV and AIDS interventions (including empowerment and rehabilitation programmes, peer-based education programmes);

- Motivate and support PLWHA to establish self-help groups and participate in other programmes;
- Strengthen community resilience to prevent increased transmission and to reduce discrimination and fear;
- Advocate for protection of fundamental rights of PLWHA.

Media

The media's role within society shall be increasing given the changes occurring in information technology, and in the economic and political infrastructure.

All forms of media (newspaper, radio and television) shall be responsible for disseminating knowledge and accurate information on STIs, HIV and AIDS, condom access and use.

Private sector

The private sector includes associations, large companies, local small businesses and community facilities, including entertainment and food outlets where people gather on a daily basis.

The private sector shall:

- Focus on expanding and accelerating the coverage of HIV and AIDS prevention and support initiatives within the work environment (including promoting gender equality, healthy working environments and social dialogue among employees within their workplaces);
- Ensure that discrimination against workers on the basis of real or perceived HIV status does not take place;
- Contribute to the identification and mobilisation of resources to implement the NSP.

The private sector (pharmacies, hotels, lodges, restaurants, bars and discotheques) shall be encouraged to be sources of HIV and AIDS accurate information (e.g. IEC materials developed by the Information and Communication Bureau) and condom distribution, or condom retailers.

International agencies

The NACP shall work in collaboration with international agencies, including the WB, the GFATM, UN agencies (WHO, UNFPA, UNDP, UNICEF, UNAIDS Secretariat), DANIDA, JICA, etc.

These agencies shall provide financial and technical support for the implementation of the NSP. They shall act on the recognition that HIV and AIDS impacts on people, communities, nations and economies.

Ministry of Health

The MoH shall:

- Continue to lead the health sector response such as in providing STI and HIV and AIDS prevention, treatment, care and support;
- Provide technical guidance to other stakeholders in the implementation of the NSP;
- Be responsible for implementing many of the activities (Research and Epidemiology Section, Health Information Unit and Information Technology Unit under the Policy and Planning Division, Department of Public Health, Information and Communication Bureau, and Medical Services Department).

Dzongkhag health services

Dzongkhag health services shall be responsible for coordinating the implementation and monitoring of HIV and AIDS prevention and control related activities at the dzongkhag level.

Major responsibilities include:

- facilitate and implement interventions in the dzongkhag;
- coordinate activities for the dzongkhag and MSTF;
- monitor activities performed by local entities;
- Provide technical assistance to other implementing agencies and the dzongkhag MSTF; and,
- Support the central level in data collection and surveillance.

As a Secretariat to the MSTF, the District Health Officer is in charge of the health sector response and reports to the Dzungda. The District Health Officer also looks after the community and public health affairs. The District Medical Officer is in charge of the curative health services and is also advisor to the district health sector.

4.2 Resource needs

To effectively implement the NSP, resources have to be identified and mobilized to priority areas. Strategic interventions may be categorized into seven broad areas: mainstreaming activity through in-service training; care, treatment and health interventions for STIs and HIV; procurement for health products; target interventions for vulnerable population groups;

capacity building for all partners including programme management; research and strategic information; and, other programme interventions.

According to this categorization of interventions, the financial support required over the next five years is outlined in the table below.

Table 8: Financial resources needed over the next five years

Main areas of intervention	Funding Source	Funds committed (US\$ million)	Financing estimated (US\$ million)	Financing gap (US\$ million)
1. Mainstreaming activity through curriculum	GFATM, WB, UNFPA	1.6	2.0	0.4
2. Care, treatment and health interventions for STIs and HIV	GFATM, WB, UNICEF	0.6	1.8	1.2
3. Procurement for health products	GFATM, WB, RGoB	2.0	2.4	0.4
4. Target interventions for vulnerable population groups	WB, GFATM, UNDP	0.5	1.0	0.5
5. Capacity building for all partners including programme management	WB, GFATM, UN agencies, RGoB	0.5	1.0	0.5
6. Research and strategic information	WB, GFATM	0.4	1.0	0.6
7. Other programme interventions	WB, GFATM, RGoB, UNDP	0.8	2.0	1.2
Total		6.4	11.2	4.8

The WB support for the programme, approximately US\$ 5.7 million, shall end in 2009. Without a plan for sustainability, the HIV and AIDS programme shall face a funding shortage, which may result in a gap in the implementation of STI and HIV prevention programmes. Additional funding shall need to be sought to address the financial gap identified or funds shall need to be reallocated from other budget areas. In addition to financial resource allocations, a review of human resources may need to occur to ensure they are compatible with the priorities outlined within the NSP.

SECTION 5: MONITORING AND EVALUATION

The NSP shall be translated into action by a variety of multi-sectoral partners. To ensure the achievement of the goals and objectives identified within this strategy, effective M&E mechanisms are needed. Effective M&E mechanisms shall assist in ensuring the programme is accountable and transparent.

The NSP provides the general framework for action; more detailed action plans are required to be developed by various sectors and organizations. The NHAC, through the secretariat service of the NACP, shall facilitate action plans development and implementation. The NHAC shall also be responsible for oversight of the implementation and monitoring of the NSP.

To effectively develop, refine and review strategic directions and programmes, to ensure there is responsiveness to a changing situation, regular information is required. The M&E mechanisms outlined below are intended to provide some of the information required to enable regular review of strategic directions.

Monitoring

The NACP shall coordinate the monitoring of activities, which includes the design of the reporting system to be implemented by partners, collecting the information from all partners, analysis of the pooled information and synthesis of recommended actions. Regular summative reports on the progress in implementing the NSP shall be presented by the programme at all NHAC meetings. This information shall form the basis of public dissemination and be used in the development of an annual report by the NHAC. All key players shall provide progress reports on a six monthly basis to the programme.

Evaluation

The evaluation shall include two major activities. These are internal evaluation and external evaluation.

Internal evaluation

The programmes conducted in line with the NSP shall be annually reviewed by a special taskforce composed of representatives of the responsible sectors. Activity performance in each year shall be assessed against identified indicators. The reallocation of resources and a review of the objectives of each programme shall be undertaken and submitted to the NHAC for consideration.

External evaluation

An external evaluation shall be conducted after the first two years of the plan to support any adjustments that are required, and on the fourth year in order to inform the development of the next phase. International consultants shall join the country's review team to conduct the evaluation study. The NHAC shall review the recommendations emerging from the study.

An initial framework for M&E has been drafted and can be found in Annex B. This provides a list of indicative core indicators. The final framework shall probably include fewer indicators that capture the status of the epidemic and the national response to STIs and HIV and AIDS as outlined in the NSP.

ANNEX

Annex A: Partner recommendations for future activities

Partnership consultation on National Strategy Development of Prevention and Control of HIV, 24th November, 2006

Population 1): Youths in and out of schools

1. Strengthen the knowledge and skills on HIV/AIDS & STI of service providers working with the youth in and out of schools	
Activity	Responsible agency
<ol style="list-style-type: none"> 1. Integration of reproductive health into the school curriculum (Class IV-XII) 2. Incorporation of HIV/AIDS life skills education in the curriculum of the 2 teacher training colleges of education 3. Inclusion of HIV/AIDS Life skills as part of the Career and value education periods in schools 4. Capacity building of School Health Coordinators and Non formal education (NFE) instructors on HIV/AIDS and STI 5. Development of NFE's post literacy materials on HIV/AIDS 6. Provision of AV equipment and IEC materials on STIs and HIV/AIDS to all school health clubs and NFE centres 7. Training of youth in schools as peer leaders for counselling 8. Capacity building of focal persons of government and private vocational institutes on HIV/AIDS & STIs 9. HIV/AIDS education incorporated in the winter youth programmes 10. Extension of inter Dzongkhag youth exchange programme, youth forums, youth development and rehabilitation centre 	MoH MoE (CAPSD, DYS, DSE, NFECD, DAHE, YIC) MoLHR-DEL MSTFs NGOs

2. Improve access to information for the youth on HIV/AIDS and STIs	
Activity	Responsible agency
<ol style="list-style-type: none"> 1. Consultation and discussion with youth on making services 'youth-friendly' 2. Institutionalizing youth initiated 'edutainment' programmes on HIV/AIDS and STIs 3. Establishment of youth friendly service centres: hotlines, counselling and information, voluntary testing and treatment of STIs and referral 4. Improved access to condoms for youths 	MoE, DYS, MoH, NGOs, private sector

Population 2): Targeted interventions for youths

Intervention: Education for STI/HIV prevention	
Activities	Responsible Agency
<ol style="list-style-type: none"> 1. Research on sexual behaviour and vulnerability among young people in urban and rural settings 2. Establishing and expanding youth information centres 3. Training of peer counsellors in school 	MoH

Population3): Uniformed services

Strategy 1: Implementing prevention programmes particularly for uniformed services	
Intervention 1: Promote safer sex behaviours	
Activities	Responsible Agency
<ol style="list-style-type: none"> 1. Condoms promotion and increase the access 2. Awareness /Behaviour change on alcohol, STI and HIV and promote health seeking behaviour among troops and families 3. Identify risk groups among uniformed persons 4. Review policies on transfer of those infected and affected and environment within Armed Forces 5. Participation of women association in the Armed Forces 6. Winter youth programme within Armed Forces 7. Develop curriculum for the recruits in Armed Forces Training Centre 8. Promotion of policy on non-discrimination and stigma 	RBA, RBG and RBP, MoH
Intervention 2: Care and treatment and other STI prevention services	
Activities	Responsible Agency
<ol style="list-style-type: none"> 1. Strengthen treatment team in the army health facility 2. Strengthen PMTCT programme in the ANC setting 3. Improve blood safety and infection control in the army 4. Training of counsellors, refresher courses for doctors and nurses 5. Establish pre-departure and post arrival counselling programme for officers and troops going on long-term training 6. Strengthen case reporting and surveillance for the STI and HIV 	Army Hospitals and MoH

Population 4): Sex workers

Intervention: Targeted condom use programme for sex workers (continued)	
Activities	Responsible Agency
<ol style="list-style-type: none"> 1. Organize regular stakeholders meetings including entertainment establishment, health, police, SW representatives at all levels to develop operational plan for targeted condom programme 2. Mapping of SW sites and population size 3. Training of MSTF and SW 4. MSTF to organize targeted condom distribution for SW 5. Training to strengthen capacity for negotiating skills of SW to use condoms 	MSTF MoH MTI

Population 5): Drug users

Intervention: Targeted interventions for drug users	
Activities	Responsible Agency
<ol style="list-style-type: none"> 1. Establish multi-sectoral task force (Narcotic Control Board, Health, Customs, Police, MSTF) to develop plan for prevention of drug related harm 2. Rapid assessment on drug use situation in hot spot area 3. Mapping of IDU sites 4. Training of medical doctors and counsellors (Management of alcohol dependence, drug dependence treatment, health care for injecting related complications) 5. Establishment of drug rehabilitation centres 6. Education on safe needle and syringe sharing 7. Surveillance (Estimation of population size, HIV prevalence surveys) 	MoH RBP Revenue and Customs Dept. NGOs

Intervention: Treatment of sexually transmitted infections	
<ol style="list-style-type: none"> 1. Behaviour change communication for seeking early diagnosis and treatment for STI syndromes 2. STI reporting including contact tracing 3. Training on integrated management of adulthood illnesses which includes syndromic management of STI and HIV and injecting related complications 4. Recommend voluntary HIV counselling and testing to STI clients 	MoH

Population 6): Special Populations

Intervention: Increase information among the target groups (Migrated labours and Tourists)	
Activities	Responsible Agency
<ol style="list-style-type: none"> 1. Awareness and trainings, workshops 2. HIV/AIDS added as part of curriculum for Guides Training course, and other courses offered by the Dept of Tourism (Chefs, language courses HTMTI) 	MTI

Population 7): Role of Religious Body

Intervention: Develop Buddhist framework / Manual	
Activities	Responsible Agency
<ol style="list-style-type: none"> 1. Identify appropriate resource people 2. Review Buddhist texts appropriate for manual – e.g. Vajrasattva 3. Review existing frameworks and manuals for preaching on HIV/AIDS then adapt to Bhutan context 4. Collaborate with NACP in development and pre-testing then dissemination 5. Train trainers to use framework and manual 	<p>National – under Dratshang Lhentshog and Religion & Health Project & Guiding Group established for this project</p> <p>Dzongkhag – Rabdey</p>

Intervention: High-level Advocacy to Lam Netens and Khenpo's	
Activities	Responsible Agency
<ol style="list-style-type: none"> 1. National Workshop [1 day] Thimphu – technical support from NACP 2. National Workshops [5 days] Thimphu [1] Dratshang secretaries & Health in-charge; [2] Nunnery 3. District training; [1] in Dzong for monks [2] in community for gomchen / religious laypersons 4. Collaborate with NACP counselling training 5. Share knowledge and Buddhist perspective with community to reduce stigma & discrimination and raise compassion and support 	<p>National–under Dratshang Lhentshog and Religion & Health Project</p> <p>Dzongkhag – Rabdey</p> <p>Geog–Rabdey with gomchen</p>

Annex B: Framework for integrated Monitoring and Evaluation of the national response to HIV and AIDS in Bhutan

Obj NSP	Type of indicator	Core indicators	Source Of reporting	Data collection	Data Compilation/ analysis	Frequency
Overall Goal: Reverse and halt the spread of HIV and AIDS by 2015						
	Impact	Number of women and men infected with HIV (by age esp young people, sex, mode of transmission, districts)	Routine data	Focal person/ DHSO	NACP/MoH	Quarterly
	Impact	Number of new cases of AIDS reported (age, sex, districts)	Routine data	Focal person/ DHSO	NACP/MoH	Quarterly
	Impact	Number of young women and men aged 15-24 who are HIV infected	Routine data	Focal person/ DHSO	NACP/MoH	Quarterly
	Impact	Percentage of women and men aged 15-49 who are HIV infected	Sentinel surveillance		NACP/MoH	Every 2 years
	Outcome	(Number/percent) of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy (by sex)	ARI monitoring data form the sites	Focal person/ DHSO	NACP/MoH	Quarterly
	Impact	Percentage of most-at-risk populations who are HIV infected (STI patients, SWs & clients, Uninformed services)	Sentinel surveillance		NACP/MoH	Annually
Strategy 1: Enhancing the prevention of STI and HIV transmission						
Behaviour						
	Outcome	Percentage of women and men aged 15-49 and 15-24 who have had sexual intercourse with more than one partner in the last 12 months	General Population survey		NACP/MoH	Every 3 years
	Outcome	Percentage of women and men aged 15-49 and 15-24 who had more than one partner in the past 12 months reporting the use of a condom during their last sexual intercourse	General Population survey		NACP/MoH	Every 3 years
	Outcome	Percentage of most-at-risk populations reporting the use of a condom with their most recent non-regular sex partner (SWs & clients, STI patients Uninformed personnel, truckers; sex; age)	Behavioural surveillance		NACP/MoH	Every 2-3 years
Knowledge						
	Outcome	Percentage of women and men aged 15-49 and young women and men aged 15-24 who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about transmission	General population survey/ other surveys		NACP/MoH	Every 3 year
	Outcome	Percentage of most-at-risk populations who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about transmission (SWs & clients, STI patients Uninformed personnel, truckers; sex; age)	Behavioural surveillance		NACP/MoH	Every 3 years

Prevention (targeted)		Member secretary MSTF's	Routine data	Member secretary MSTF's	NACP/MoH	Quarterly	World Bank
Process/ Output	Number of condoms distributed for HIV prevention		Routine data		NACP/MoH	Quarterly	World Bank
Outcome	Percent of donated blood units screened for HIV in a quality-assured manner		Routine data	Blood bank register	NACP/MoH	Quarterly	UNGASS
Outcome	Number and percentage of most-at-risk populations reached with targeted HIV prevention (SW's & clients, STI patients Uniformed personnel, truckers; sex; age)		Routine data	Armed forces; NGOs; other relevant sectors (e.g. MoLHR, MoEA, MoIC, etc.)	Member secretary MSTF's	Quarterly	UNGASS
STI treatment			Behavioural surveillance		NACP/MoH;		
Outcome	Number of people diagnosed and treated for STIs (age, sex)		Routine data	Focal person/DHO	NACP/MoH	Quarterly;	
Outcome	Percentage of pregnant women tested for syphilis & prevalence		Routine data	Focal person/DHO	Reproductive health	Annually	WHO
Strategy 2: Enhancing access to treatment, care and support for people living with HIV and AIDS							
Counselling and testing							
Outcome	(Number/ percent) of women and men aged 15-49 and young women and men aged 15-24 who received a HIV test in the last 12 months and who know their result		General population survey		NACP/MoH	Every 3 years	UNGASS
Outcome	Percentage of most-at-risk populations who received a HIV test in the last 12 months and know their results (SW's & clients, STI patients Uniformed personnel, truckers; sex; age)		Routine VCT monitoring		NACP/MoH	Every quarter	UNGASS
Prevention of MTCT							
Outcome	(Number/percent) of HIV-positive pregnant women who received antiretroviral drugs to reduce the risk of mother-to-child transmission		Behavioural Surveillance		NACP/MoH	Every 2-3 year	UNGASS
Treatment and ART							
Outcome	(Number/percent) of adults and children with advanced HIV infections currently receiving antiretroviral combination therapy (age, sex)		Routine programme reporting	Focal person/DHO	NACP/MoH	Quarterly	UNGASS
Outcome	Number of estimated HIV positive incident TB cases that received treatment for TB and HIV		Routine data	Focal person/DHO	NACP/MoH	Quarterly	UNGASS
Outcome	Number of estimated HIV positive incident TB cases that received treatment for TB and HIV		Routine data	TB Program/ NACP/ Focal person/DHO	NACP/MoH	Quarterly	UNGASS

Strategy 3: Creating a supportive environment for women and men living with HIV and AIDS						
Strategy 4: Creating an enabling environment for successful implementation of the national response to HIV/AIDS and STI						
Process/ output	Number of HIV prevention sessions/ campaigns conducted by Multi-sectoral Taskforces	Routine data	Member secretary MSTFs	MSTFs	Quarterly	
Process/ output	Number/percentage of schools –grade 7 & above providing life skills based HIV/AIDS education in the last academic year	Routine data	Member secretary MSTFs	MoE/MSTFs	Annually	UNGASS
Process/ output	(Number/percent) of service delivery points where VCT is available	Routine data	Member secretary MSTFs	NACP/MoH	Quarterly	WHO
Process/ Output	Number of health care providers trained in the provision of STI management/ VCT/ prevention of MTCT/ ART, according to national guidelines.	Routine data/ training report	NACP	NACP/MoH	Annually	
Cross-cutting: Keeping Bhutan's commitments toward the global response to HIV and AIDS						
National commitments	National Composite Policy index	Special study		NACP/MoH	Biennial	UNGASS
National commitments	Domestic and International AIDS spending by categories and financing	Financial report		NACP/MoH	Annual	UNGASS

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Ministry of Labour and Human Resources
Ministry of Trade and Industry (now called Ministry of Economic Affairs – Department of Tourism)
Ministry of Works and Human Settlement
Multi-Sectoral Task Forces (Thimphu, Punakha)
National Commission for Women and Children
Office of Attorney General
People living with HIV/AIDS
RENEW
REWA
Road Safety and Transport Authority
Royal Bhutan Army
Royal Bhutan Police
Royal Body Guards
Royal Civil Service Commission
Sex workers (in Phuentsholing)
Tarayana Foundation
United Nations Children’s Fund
United Nations Development Programme
United Nations Population Fund
World Bank
World Health Organization
Young people (in Thimphu)
Youth Development Fund
Youth Development Rehabilitation Centre, Tshimalhakha

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