BHUTAN

SKPA-2 Baseline Assessment Report

March 2023

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
AFAO	Australian Federation of AIDS Organisations
AFHS	Adolescent Friendly Health Services
APCOM	Asia Pacific Coalition on Male Sexual Health
CBSS	Community Based Support System
CBT	Community Based Testing
CPA	Chithuen Phendhey Association
CSO	Civil Society Organizations
DIC	Drop-in Center
DHIS-2	District Health Information Software-2
ELISA	Enzyme-linked immunosorbent assay
ePIS	electronic Patient Information System
FSW	Female Sex Workers
GDP	Gross domestic product
Global Fund	The Global Fund to Fight AIDS, Tuberculosis, and Malaria
GONGO	Government Organized Non-government Organization
HCT	HIV Counselling and Testing
HISC	Health Information and Service Center
HIV	Human Immunodeficiency Virus
HSS	HIV Sentinel Surveillance System
IBBS	Integrated bio-behavioral survey
KP	Key Populations
KPO	Key Population-led organizations
LGBT+	Lesbian, Gay, Bisexual, Transgender
MAC	Malaysian AIDS Council
MoU	Memorandum of Understanding
MSM	Men who have sex with men
MSTF	Multi Sectoral Task Force
NACP	National HIV/Hepatitis and STI Control Program
NGOS	Non-governmental organizations
ORW	Outreach Workers
PLHIV	People Living with HIV
PrEP	Pre-exposure Prophylaxis
PWID	People who inject drugs
RCDC	Royal Center for Disease Control
RGOB	Royal Government of Bhutan
SAHRA	South Asia Human Rights Association
SKPA	Sustainability of HIV Services for Key Populations in South-East Asia
SOGIESC	Sexual orientation, gender identity and expression and sex characteristics
STI	Sexually Transmitted Infections
TB	Tuberculosis
TG	Transgender people
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
U=U	Undetectable=Untransmittable

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EXECUTIVE SUMMARY

Sustainability of HIV Services for Key Populations in South-East Asia (SKPA)-2 is a three-year (1 July 2022 to 30 June 2025) multi-country program funded by the Global Fund to Fight AIDS, Tuberculosis, and Malaria (the Global Fund). The program aims to improve the sustainability of evidence-informed, prioritized HIV services for key populations in Bhutan, Mongolia, the Philippines and Sri Lanka. There are four program objectives:

1. Accelerate financial sustainability
2. Improve strategic information availability and use
3. Promote programmatic sustainability
4. Remove human rights- and gender-related barriers to services

Between July and December 2022, SKPA-2 conducted a rapid baseline assessment in each of the four countries, to better understand the financial landscape, strategic information needs, policy and regulatory barriers, human rights and gender situation and country readiness for the sustainability of services for key populations. The assessments included a desk review and key informant interviews with government, civil society and key population stakeholders.

The following summarizes key findings for each of the SKPA-2 objectives and key issues and recommendations (in bold) from the baseline assessment in Bhutan. Detailed findings, issues and recommendations are included in the main report.

Key findings

Objective 1: Accelerate financial sustainability

- The Royal Government of Bhutan currently funds around 50% of the current resource requirements of the National HIV Strategic Plan and government co-financing has increased over time, but Bhutan remains highly dependent on donor funding for HIV services for key populations. Planning for the financial sustainability of these services will be critical as the country transitions from external funding. Accurate costing data and modelling is critical to ensure cost-effective investment in scale-up of priority HIV services.
- The government recognizes the importance of key population-led organizations in HIV service delivery, but has yet to establish mechanisms to fund civil society organizations to deliver services to key populations. There is no regulatory framework, law or policy for partnership between the Ministry of Health and these organizations to deliver health services or that permits the purchasing of HIV services from civil society organizations.
- There has been no direct government funding for civil society organizations, except through the Global Fund national grant. Civil society organizations are largely expected to mobilize their own resources through external grants or community fund-raising activities.
- In the online sustainability pulse check survey of Bhutan stakeholders, around 60% of stakeholders saw government only being in a position to expand HIV services for key populations without reliance on external donors within 5-10 years, and 63% believed government should fund civil society organizations to deliver services including PrEP.

Objective 2: Improve strategic information availability and use

- New evidence has shown that Bhutan has an HIV epidemic where a large number of new infections are linked to sex work and there is a risk of increased transmission among men who have sex with men.
- Population-based surveys have also ensured that data on HIV prevalence, size estimates and risk behaviors are available for most key populations. However, because Bhutan has a low-level epidemic, there are significant levels of uncertainty around surveillance-generated estimates. There are also key gaps in epidemiological data including a lack of HIV cascade data disaggregated by key population, of population size estimates for people who use drugs and people who inject drugs, and of data on prisoners and HIV.
- There is scope to make better use of program data to identify areas for improvement in service delivery, to target outreach, and to monitor service coverage and individual client service uptake and linkage to care. There is also scope to strengthen program data validation and quality verification practices.
- Key population organizations see community-led monitoring (CLM) as an important mechanism for reporting incidents of stigma, discrimination and harassment, as well as providing a basis for constructive dialogue with government on service quality, but highlight the need for community-led monitoring to be adopted on a routine basis. Around half (53%) of stakeholders surveyed have engaged in a CLM process already.
- Confidentiality concerns deter HIV service users from providing sensitive personal information and protections built into the system limit the ability of staff to monitor whether an individual testing positive has been linked to treatment. Bhutan may benefit from adopting a unique identifier code system for key populations to address data privacy concerns in HIV services.

Objective 3: Promote programmatic sustainability

- Current HIV testing policies and algorithms limit case detection and Bhutan is exploring other options to expand case detection. HIV self-testing shows promise, but future scale up and sustainability beyond Global Fund support will require procurement of kits to be included in government procurement budgets and systems.
- Physical and virtual outreach services are essential to increase coverage, but key population organizations have very few outreach workers. Some organizations are using virtual interventions to compensate for limited physical outreach coverage. Lack of hotspot mapping and local population size estimates also limit ability to plan and deliver targeted services.
- The introduction and scale up of PrEP, which is anticipated following the evaluation of a demonstration project, will require efforts to increase awareness among key populations and inclusion of PrEP drugs in the government procurement system.
- The effectiveness and sustainability of HIV services for key populations will require efforts to strengthen the capacity of key population-led organizations and their engagement in policy and decision-making processes, as well as systems to register and accredit non-government organizations that deliver HIV services.

Objective 4: Remove human rights- and gender-related barriers to services

- Existing laws adversely affect key populations' access to HIV-related services in Bhutan. Sex workers and people who inject and use drugs are criminalized, transgender people do not have legal recognition, and people living with HIV can be prosecuted for alleged transmission of HIV.
- Societal stigma and discrimination towards key populations and people living with HIV is widespread and a significant barrier to accessing health services and securing employment. Key populations report multiple instances of stigma and discrimination in health facilities and that healthcare providers lack the knowledge and skills required to meet their health needs.
- Women in Bhutan are adversely affected by gender norms, gender-based violence and inadequate legal protections. Women living with HIV face additional stigmatization, and economic dependence on male partners limits their access to information and services. Despite existing legal frameworks, levels of domestic violence remain high. Sex workers face harassment and violence from partners, clients and law enforcement personnel, but, as sex work is illegal, it is difficult for them to report abuse.
- In general, there is an absence of mechanisms to report human rights violations for all key populations.
- The majority (58%) of stakeholders surveyed in the sustainability pulse check survey believe key populations are not adequately represented in planning and decision-making forums.

Key issues and recommendations

The need to focus on key populations – Appropriate planning and allocation of resources and delivery of a targeted package of services could enable Bhutan to maintain its low-level epidemic or even eliminate it. Development of the new National HIV Strategic Plan in 2023 presents an opportunity for Bhutan to focus on key populations and a cost-effective package of services.

- Bhutan should use the next National HIV Strategic Plan to sharpen the focus on key populations and introduce a core package of services for key populations that includes PrEP.

The need to ensure sustainable financing for priority HIV services for key populations – The existing financing gap for Bhutan's national response to HIV will increase as external funding decreases. Without a sustainable financing strategy, priority HIV services for key populations – which are highly dependent on external funding – will cease.

- The Ministry of Health should consider developing a financial sustainability model, following one of the two options presented in this report.

The need to scale up implementation and coverage of priority HIV services for key populations – Priority HIV services for key populations are not maximizing their potential due to limited implementation and coverage. Greater efforts are needed to scale up alternative approaches to delivery of HIV testing and to make use of opportunities provided by virtual interventions. Planning for introduction and roll out of PrEP needs to start now.

- Take testing to scale through increased access to HIV self-testing and community-based testing. Enable more private pharmacies to stock self-testing kits, and increase the supply of accredited diagnostic services.
- The NACP and Ministry of Health should work with partners to improve coverage of virtual interventions and integration with other services.
- The NACP and Ministry of Health should work with partners to plan activities required to achieve increased PrEP awareness and acceptance and support roll out.

The need to strengthen civil society organization involvement in delivering priority HIV services for key populations – The baseline assessment makes a strong case for the government to support capacity building and to institute registration and accreditation systems to enable key population-led organizations to fulfil their potential to deliver key HIV services.

- Expand civil society organization involvement in HIV service delivery through capacity building and training, development of key population service packages to be delivered, and accreditation.

The need to improve collection and use of epidemiological and program data – Improved data collection and use is essential to monitor the HIV epidemic and the response. Specific weaknesses that need to be addressed include gaps in epidemiological data and lack of accurate data for monitoring community-based and outreach services and linkage to care. Improved availability of data, for example, through local hotspot mapping, provides an important opportunity for more effective targeting and implementation of outreach and other services for key populations.

- National partners should take steps to address key gaps in epidemiological data and to strengthen data collection and use for outreach and other services for key populations, and integrate community-led monitoring into the national HIV M&E system.

The need for client feedback to be used for service quality improvement – Existing community-led monitoring and government-led monitoring lack the feedback mechanism required to maximise service quality improvement.

- Partners should establish a feedback mechanism that captures and reviews feedback from key population service users and that is used to improve service quality.

The need to eliminate barriers to accessing essential HIV services for key populations and people living with HIV – Criminalization of sex work and drug use undermine the national HIV response by preventing sex workers and people who use drugs from seeking services. Stigma and discrimination in society and in health facilities, as well as gaps in healthcare provider knowledge and skills, are a significant barrier to accessing HIV services for key populations and people living with HIV.

- Promote a legal and policy environment that supports access to HIV-related services for key populations and people living with HIV including through building the advocacy and communication capacity of key population organizations and increasing key populations' awareness of their rights.

- Develop clear strategies and concrete actions to reduce societal stigma and discrimination and build the capacity of health care providers to meet the health needs of key populations and people living with HIV through training that includes anti-stigma, gender- and rights-related components.
- Develop measures to mitigate gender-specific issues including sensitizing service providers on gender norms and gender-based violence, and establishing medical and legal referral mechanisms and user-friendly health services for sex workers.

1. Introduction and country context

BASELINE ASSESSMENT OBJECTIVES AND METHODOLOGY

At the start of the program cycle in Quarter 1 and 2 of Year 1 (July to December 2022), SKPA-2 commissioned a team of independent regional and national consultants to conduct a rapid baseline assessment in each of the four countries, to understand the extent to which these countries are able and ready to provide domestic financial support for HIV service delivery for key populations. The consultant team developed the assessment methodology and data collection tools, which were circulated to all stakeholders for comment and revised accordingly[1].

The assessment was designed to help host country governments and partners, SKPA-2 implementers and the SKPA-2 Regional Steering Committee better understand the financial landscape, strategic information needs, operational policy and regulatory barriers, and the human rights and gender situation. The assessment also examined the extent to which each country is prepared for the financial sustainability of services for key populations.

The specific objectives were to:

1. Establish regional and country-specific baselines against which progress can be measured (during an end-of-program evaluation in Year 3) with respect to increased domestic financing of programs and services for key populations.
2. Assist countries in planning for and implementing comprehensive, sustainable, rights-based policies, programs and services for key populations.
3. Fine tune the SKPA-2 Theory of Change and develop more nuanced, country-specific pathways to sustainability.
4. Examine the extent to which key populations and people living with HIV are meaningfully engaged in their country's national HIV responses.
5. Identity opportunities and approaches where political, bureaucratic and community interests most closely align and can be mobilized through the SKPA-2 program.
6. Determine ongoing technical assistance needs for the principal recipient and subrecipients, particularly regarding financial sustainability, human rights and gender[2].

The baseline assessment consisted of four phases of work: 1) inception planning; 2) data collection; 3) data analysis; and 4) production and dissemination of the reports.

Phase 1: Inception planning

- **Assessment team recruited:** A team of 13 external independent consultants were recruited. This included a Regional Team Leader and a Human Rights and Gender Specialist, together with national consultants with expertise in the areas of the four program objectives.
- **Working group established:** An internal SKPA-2 working group was established to oversee the process and ensure coordination with country activities.
- **Desk review:** Subrecipients, consultants and the working group sourced and reviewed a range of relevant documents to help formulate the assessment questions and data collection needs.

[1] More detailed information about the baseline assessment questions and data collection tools can be found in the annexes to the overarching report for the baseline assessment.
[2] AFAO has earmarked funding to be programmed at the end of the baseline to support technical assistance and additional activities under Objectives 1 and 4.

- **Data collection tools developed:** Data collection tools, including structured key informant interview guides, were developed for each of the SKPA-2 objectives, and reviewed by the consultants and regional technical assistance providers.
- **Stakeholder identification:** SKPA-2 subrecipients and national consultants identified local stakeholders to be interviewed.

Phase 2: Data collection

- **Key informant interviews and focus group discussions:** Between 10-14 October 2022, the national consultant team in Bhutan conducted key informant interviews with 36 stakeholders including the Royal Government of Bhutan, non-governmental organisations, and key population-led organisations. Information generated by these interviews provided a primary source of data to inform the baseline situation in the country for each SKPA-2 objective.
- **Sustainability Pulse Check Survey:** Using Google Forms, a sustainability pulse check survey was conducted online, engaging a cross-section of key stakeholders from the four countries and responses were received from 60 stakeholders. The survey was designed to support both baseline and end of project needs, and indicators can be disaggregated by country, objective and stakeholder group (governments, civil society organizations, key populations, and multilateral organisations).

Phase 3: Data analysis

- **Data analysis:** Data collected was analyzed iteratively throughout the process, with fact-checking and verification occurring where required. Survey results were analyzed using R and Power BI for dashboard development. Dashboard results can be accessed online. https://www.afao.org.au/our-work/international-program/dashboard/
- **Revision of SKPA-2 Theory of Change:** As part of the data analysis, the baseline assessment team tested the assumptions in the SKPA-2 Theory of Change and constructed more detailed causal pathways and milestones for each country.

Phase 4: Report production and dissemination

- **Country presentation of preliminary findings:** During each country assessment visit, preliminary findings were presented to local stakeholders to verify the data and to discuss the key findings. This meeting took place in Bhutan on 14 October 2022. Further feedback meetings to review the draft reports were organized in February 2023.
- **Dissemination:** The four country reports and overarching baseline report were presented to the Regional Steering Committee at its meeting on 31 January 2023. Following this, the reports were circulated widely to stakeholders for comment and review. This process allowed for verification of key findings and recommendations. The reports were finalised by the end of February 2023.

The limitations of the baseline assessment fall into two categories: limitations related to the data collection process and limitations related to the data itself. The short timeframe for field visits and data collection and analysis was a key challenge and, while many of the program's partners are working at subnational level, the scope of work was limited to collecting baseline data at national level due to practical considerations. Much of the quantitative data gathered by the baseline assessment is from the year 2021, although some of the data used is from previous years. Some of the baseline data collected were sourced from the published literature, compiled by governments and development partners, and thus reflect their indicators and timelines. The situation in each country also changes quickly, and some of the findings and recommendations in the baseline assessment may be out of date or already in the process of being addressed.

This report is based on information gathered during the field visit to Bhutan in October 2022 and in follow-up meetings and discussions. The audience for the report includes national policymakers, healthcare workers, key populations, people living with HIV and communities most affected by HIV, regional and country technical partners, the Country Coordinating Committee, other local and international organizations implementing HIV programs, multilateral and bilateral donors, and the Global Fund. The baseline assessment team hopes that the findings will contribute to existing knowledge and enhance understanding of the opportunities and challenges facing Bhutan.

Readers are encouraged to read this report in conjunction with the overarching report for the baseline assessment, and may also be interested in the challenges faced and recommendations made in the other SKPA-2 program countries, which are reflected in the corresponding reports for those countries.

HIV SITUATION IN BHUTAN

Bhutan is a lower-middle-income country with a GDP per capita of $3,359 (2021) and a population of around 730,000[3]. Bhutan's first case of HIV was detected in 1993 and the epidemic has remained at a low level, with national HIV prevalence among adults estimated at around 0.2% in 2021. There were an estimated 66 new HIV infections in 2021, a 25% decline since 2010. In the same year, there were an estimated 53 AIDS-related deaths, a decline of 29% since the Royal Government of Bhutan started providing antiretroviral treatment in 2004.

By 2021 the total number of people in Bhutan ever infected with HIV was estimated at 1,340. However, as of August 2022, the number of cases ever diagnosed was 835 (433 males; 402 females), only 55.5% of the estimated total number of people living with HIV. Of the total of 835 cases ever diagnosed, 608 (96.8% of the 628 people currently living with HIV[4]) are enrolled in antiretroviral treatment. Of the 608 enrolled in treatment, 450 (90%) have achieved viral load suppression (AIDS DataHub)[5]. Analysis of the cascade shows that the main gap in reaching the 95-95-95 targets in Bhutan is the first 95, the proportion of people living with HIV who know their status. A retrospective analysis of CD4 counts at initiation of treatment showed that most HIV cases are diagnosed years after infection. Consequently, many have a low CD4 count and are already immune compromised – with high viral load and high potential for onward transmission[6] - when they are diagnosed.

To enhance understanding of the epidemic, an HIV Sentinel Surveillance System (HSS) was developed and launched in 2021[7]. The study recruited 119 high-risk women (including sex workers), 133 men who have sex with men, 29 transgender women, and 66 transgender men. Based on the findings of the pilot, which detected one case of HIV among the sample population, HIV prevalence among key populations in Bhutan was estimated to be below 4% (averaged across all risk groups). However, other indicators suggest there is high potential for sexual transmission of HIV. These include the rising incidence of sexually transmitted infections (STIs), low condom use in all types of partnerships, and high levels of multiple sex partners, particularly linked to sex work. The role of sex work in Bhutan's epidemic was highlighted in a 2022 National HIV/Hepatitis and STI Control Program (NACP) report,[8] which sought to retrospectively attribute risk behavior to each reported HIV infection between 1993 and 2021. It concluded that over 80% of infections reviewed involved heterosexual HIV transmission, and around two thirds of these were linked to sex work.

These findings have led Bhutan to focus more on key populations at higher risk for HIV infection, including female sex workers, and this is reflected in both the country's National HIV Strategic Plan (2017-2023) and its Global Fund HIV/TB Tailored for Focused Portfolios Funding Request (2021-2024).

[3] https://www.worldbank.org/en/country/bhutan/overview)
[4] https://kuenselonline.com/forty-new-hiv-cases-detected/
[5] Bhutan | HIV/AIDS Data Hub for the Asia-Pacific Region
[6] Khandu et al. 2021 Immun Inflamm Dis. 2021 Sep;9(3):883-890. doi: 10.1002/iid3.444. Epub 2021 May 4
[7] HIV Sentinel Surveillance among Key Populations in Bhutan, 2021.
[8] Khandu et al. 2022. AIDS Res Treat. 2022 Jul 9;2022:2137164. doi: 10.1155/2022/2137164

HEALTH AND HIV FINANCING ENVIRONMENT

Bhutan's health budget in financial year 2019-2020 was around 4.5% of GDP, an increase from 4% of GDP in FY 2018-2019. The government uses pooled tax-based government funding to support free comprehensive health care services for all citizens and for all foreigners residing in the country[9]. In 2019-2020, the government financed around 73.4% of all health expenditure; in the same period, out-of-pocket expenditure accounted for around 15.4% of total health spending.

The government currently funds around 50% of the current resource requirements of the National HIV Strategic Plan, and government co-financing has increased over time (Figure 1).

Figure 1: Royal Government of Bhutan actual and projected domestic financing of the HIV response. 2018 to 2024.

$900,000
$800,000
$700,000
$600,000
$500,000
$400,000
$300,000
$200,000
$100,000
$0

USD

$550,000 **$560,000** **$590,000** **$682,142** **$692,142** **$702,142** **$782,142**

2018 2019 2020 2021 2022 2023 2024

YEAR

Source: Source: National HIV, AIDS & STIs Control Program, MoH 2022: "Ensuring long term programmatic and financial sustainability of HIV and AIDs response for the key population in Bhutan"

[9] National HIV, AIDS & STIs Control Program. 2022. Ensuring long term programmatic and financial sustainability of HIV and AIDS response for key populations in Bhutan.

The amount required to fund the national response in the National HIV Strategic Plan in 2023 is US$1,445, 648. Total funding for Bhutan's HIV response for the period July 2022-June 2023 is US$1,241,416, of which US$702,142 (63%) will be funded by domestic resources. Other financial support comes from international partners including the Global Fund (with expected combined country and regional grant funding of US$448,204 in 2022-2023), followed by the World Bank, the World Health Organization and UNICEF (combined support of around US$91,000 in 2022-2023)[10]. Even with these significant government and partner contributions, there is a funding gap of US$204,232 or 14% of the budget for the National HIV Strategic Plan in 2022-2023. In addition, external funding for Bhutan's national HIV response is declining. For example, Global Fund support has steadily decreased from a peak of US$3.2 million in Round 6 to US$1.05 million for the current national grant covering the period July 2021-June 2024.

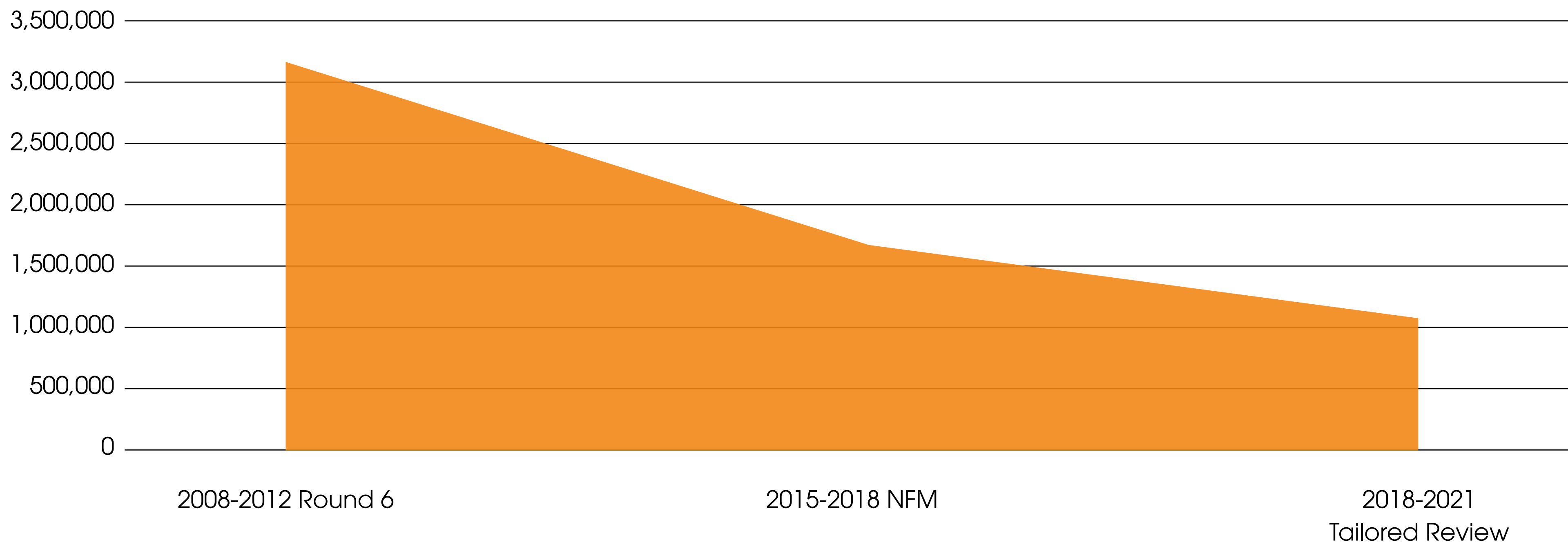
Approximately 60-70% of Global Fund funding is earmarked for procurement of essential drugs and commodities. The Global Fund also funds HIV prevention, treatment, HIV testing and viral load testing for key populations in six priority districts, while the government funds prevention, treatment, HIV testing and viral load testing in all 20 districts (for general population in all 20 districts and key populations in the remaining 14 districts) and recurrent expenditures including staff salaries, facilities maintenance, logistics and administration costs in all districts. Health Information Service Centers, established as key population friendly service centers, have been funded by the Global Fund and established in the six Global Fund districts.

Although health services are provided free of cost by the government, service users incur some costs in accessing care and treatment. In a 2022 community-based monitoring study, 19% of key population members said that, despite free health care, some HIV services, especially viral load testing and CD4 counts, involve travel and other out of pocket expenses which some key population members find unaffordable. For key populations living in rural areas, travel and accommodation are a significant barrier to use of hospital-based HIV services.

The NACP has conducted several analyses of financial sustainability, including an assessment in 2021-2022 with support from SKPA-1. Figures 1 and 2, based on this assessment, show that while external funding has been declining, government contributions have steadily increased and are forecast to grow by a further 10% between 2023 and 2024.

[10] NACP (2022). Ensuring long term programmatic and financial sustainability of HIV and AIDS response for key populations in Bhutan

Figure 2: Global Fund HIV allocations to Bhutan, 2012-2022.



Source: MoH, Bhutan: "Assessment of the Financing Environment of NACP and Other HIV/AIDS-related CBOs/NGOs For Ensuring the Long-Term Sustainability of the Targeted HIV/Aids Services in Bhutan for The Key and Vulnerable Population", Dec 2021

In 2023, Bhutan will release its next National HIV Strategic Plan 2023-2029 and will apply for the next Global Fund HIV country grant covering the period 2025-2028. These will be critical to determine the government financial commitment required and the steps needed to reduce the funding gap.

INVOLVEMENT AND FUNDING OF THE KEY POPULATION-LED CIVIL SOCIETY SECTOR

The key population-led civil society sector is at a relatively early stage of development and currently comprises the following:

Lhaksam, the National Network for People Living with HIV, was established in 2010. Lhaksam is the only subrecipient under the Global Fund country HIV program. It has a budget of US$113,727 under the 3-year grant, which makes a small contribution to core costs and, in the past, has received funding from small international donors. Lhaksam implements income generation activities including growing fruit and making bricks.

Pride Bhutan was established in 2014 as a lesbian, gay, bisexual, transgender (LGBT+) community organization, under the auspices of Lhaksam, and is now an independent organization. Pride Bhutan has a budget of US$44,286 for direct expenses under the current Global Fund grant and has also received support from the South Asia Human Rights Association (SAHRA), the Netherlands Embassy and Helvetas Swiss Inter-Cooperation Bhutan. Pride Bhutan works closely with **Queer Voices of Bhutan**, established in 2018 as an online advocacy group that raises awareness about LGBTIQ+ issues. Because it is not a legal entity, Queer Voices of Bhutan does not receive any support from government or the Global Fund but it does receive some activity-specific funding from the Canadian and Netherlands Embassies. The Pride Bhutan office also houses the **Red Purse Network**, a sister network to Pride Bhutan, established in 2019 to provide services to female sex workers.

Chithuen Phendhey Association (CPA) was formally registered as civil society organization in 2011 and provides social support interventions for people who use alcohol and drugs. It is not a key population-led organization and does not implement HIV prevention activities, although they have an interest in risk behaviour and alcohol use, including by clients of sex workers. It is a relatively new actor in the HIV prevention arena and does not have access to people who inject drugs, since this group is hard to reach. Chithuen Phendhey Association was involved in implementing community-led monitoring and mental health training under SKPA-1.

Most of these organizations deliver peer outreach services, provide information on HIV and STIs, distribute condoms, lubricant and HIV self-testing kits, provide referrals for HIV and STI testing at the nearest government health center or Health Information Service Center and, in the case of Lhaksam, also provide care and support to their members.

Engagement with the NACP has been facilitated through SKPA-1 and SKPA-2. Lhaksam, Pride Bhutan and Chithuen Phendhey Association are represented on the Global Fund Country Coordinating Mechanism and were consulted in the development of the current National HIV Strategic Plan 2017-2023. These organizations are engaged in estimating the size of their key populations and advising on an appropriate response, but are less involved in detailed national program design or budgeting.

The NACP 2022 report "Ensuring the long term programmatic and financial sustainability of the HIV and AIDS response for key populations in Bhutan" identifies four priority areas for action: 1) HIV and STI service delivery; 2) health system and HIV; 3) financial resources; and 4) enabling environment. Civil society organizations have a clearly defined role in the first two priority areas, as active partners in the delivery of community-based services as well as in advocacy.

However, even with a defined role in the national response, the sustainability of these organizations is not guaranteed. There has been no direct government funding for these organizations, except support to Lhaksam and Pride Bhutan through the Global Fund national grant. Civil society organizations are largely expected to mobilize their own resources through external grants or community fund-raising activities. These organizations are exploring income generation ideas but, if they were compensated appropriately for the services they provide for key populations, they could focus their efforts on strengthening their capacity and increasing the scale and quality of the services they deliver.

2.

Key findings by objective

OBJECTIVE 1: ACCELERATE FINANCIAL SUSTAINABILITY

Government recognizes the importance of key populations but has yet to establish mechanisms to fund civil society organizations to deliver services to key populations

The NACP has recently developed a Comprehensive Package of Services for HIV(2022), that includes interventions targeting key populations[11] (Annex 1). It recognizes and reflects the critical role that key population-led organizations play in reaching these often-hidden populations.

The NACP has been pragmatic in working with key population organizations to deliver HIV services to key populations and has an agreement with Pride Bhutan whereby NACP provides salaries for outreach workers and some support for utilities, financed by the Global Fund.

However, there is currently no regulatory framework, law or policy for partnership between the Ministry of Health and civil society organizations to deliver health services or, more specifically, that permits the purchasing of HIV services from civil society organizations. In 2021, Bhutan's parliament passed the CSO Amendment Bill, which acknowledges the important contribution of civil society organizations to communities and proposes that government provides adequate resources to these organizations. Developments like this could pave the way for new regulatory frameworks that allow government to contract out some HIV services to registered civil society organizations with the capacity to reach key populations. SKPA-2 may represent a significant opportunity to help shape related policy and implementation arrangements.

Planning for transition to ensure the financial sustainability of HIV services for key populations needs to start now

Currently, Bhutan is dependent on donor funding for HIV services for key populations. Planning for the financial sustainability of these services will be critical as the country transitions away from external funding. A key consideration will be determining budget allocations for key population services and the role of key population-led organizations in advocacy and community service delivery.

Two potential options are suggested, below. Option A represents a business-as-usual scenario for the government, i.e., direct funding. Option B proposes an alternative model, similar to that of Malaysia, which involves social contracting.

Pathway to Financial Sustainability - Option A:
Fill gaps in domestic financing through direct funding of key population HIV services.

With the RGoB funding all services in 14 districts outside of the 6 supported by the Global Fund, there is already a strong investment in the national HIV response by government.

Elements missing from the current domestic budget in the 14 districts include support for Health Information Service Centers, which are supported by the Global Fund in six districts covered by the national grant. At present the six HISCs provide targeted HIV and STI (hepatitis B and syphilis) testing through outreach and services at the center. Outreach workers, usually from the same key population community, seek to reach their own community

[11] Government of Bhutan. 2022. Comprehensive service package for HIV/AIDS and STIs: A Guidance manual, pp 15-17

with prevention packages including assisted self-testing, or through referrals to the HISC for testing. The treatment is provided through districts hospitals and three regional referral hospitals. There is already discussion at high levels of integrating HISCs into the mainstream health system. This will deliver a cost saving but needs careful planning to ensure the needs of key populations are met, including strong linkages between community outreach efforts and case detection, and treatment, care and support. At the same time, with PrEP at the pilot stage, funding will be needed to procure, store and distribute PrEP so the service is available at an appropriate level to those who need it.

Key population led service providers such as Pride Bhutan are currently engaged through the national grant as outreach service providers. Rather than channelling funding to the organisation through a contract, they receive some support for expenses like utilities and salaries through an MOU, and do not manage funding directly.

An option would be for government to simply expand this approach, directly funding key population HIV services at appropriate coverage levels. Importantly, this would include expanding government staff to incorporate existing outreach and other workers from key population organisations. This could be done either by 1) creating a new cadre in the health worker system for community HIV workers, with relevant accreditation/training requirements (this would be a big change and not something that would easily be achieved in the life of project); or 2) engaging outreach workers and peers on an allowance basis, which is what is currently happening in the national grant. This would be the easiest pathway to engaging them, but they would not have the benefits of a full-time employee.

This pathway to financial sustainability (**option A**) recognises there is already a strong investment from the RGoB, and that extending this investment through existing government health financing mechanisms may be the path of least resistance to sustainable financing of the HIV program.

It would require some incremental changes such as getting PrEP on the national formulary, developing stronger forecasting of commodities and staffing, and including individual key population service providers in the national HIV budget. This model (direct government delivery of priority key population HIV services), though simple, has significant limitations. They include a lack of independent, strong key population organisations to advocate to government and help ensure that the HIV response is in tune with community needs; and the importance of preserving the multisectoral aspect of HIV programming on the principle that while health sector responses are essential, HIV also needs to be addressed effectively outside the health sector, in workplaces, the education sector, via legal reform and elsewhere. Other considerations are that key populations generally greatly prefer to attend services provided by key population organisations, an important consideration in Bhutan given that sex work is illegal, and stigma is perceived to be a barrier for some. The cost of providing some services by key population led organisations is also lower than the cost of achieving the same service provision by government services.

An alternation pathway to sustainability is explored below, under "Option B".

Pathway to Financial Sustainability - Option B:
Establish an entity to coordinate HIV service provision by CSOs for key populations

A second possible pathway is for government to provide support to key population organisations so they can deliver services to key populations. This would ensure that the voice of civil society in the response is preserved, that sensitive services are delivered by trusted partners of key populations, that the national program can reach hard to reach people who do not want to seek government services, and that CSOs would be enabled to deliver services which in some cases, they provide more efficiently and effectively than government.

Well capacitated key population-led civil society organisations and networks can enrich the response to HIV while reducing the burden on the government to coordinate with a range of diverse organisations. To address these concerns "the Malaysia model" may provide a relevant case for the RGoB to study as an alternative to direct funding of services. The text box adjacent illustrates how the Malaysian AIDS Council was established over 30 years ago as a government organized non-governmental organization, to serve the coordination needs for civil society organisations working on HIV in Malaysia.

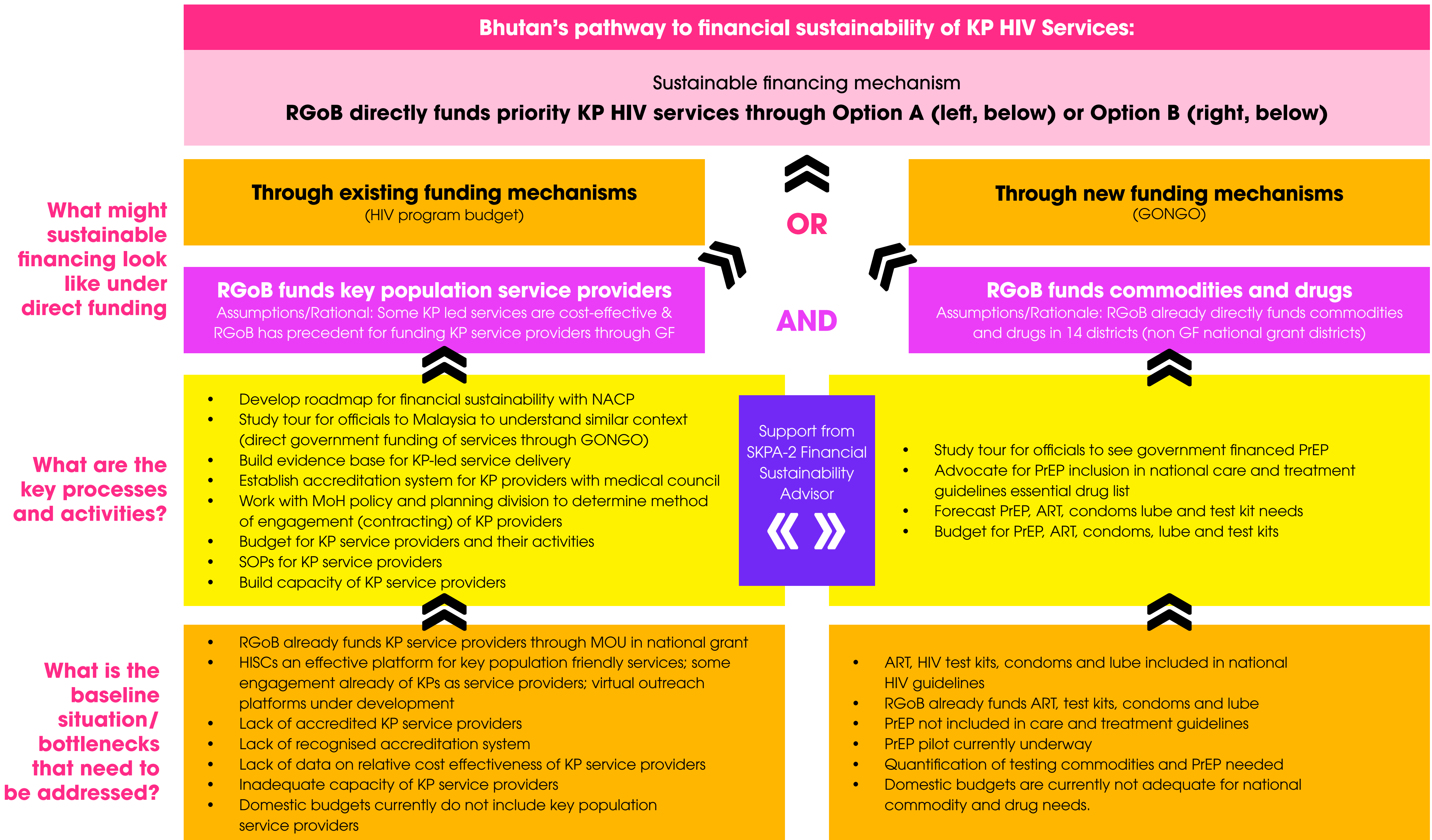
The Malaysian Aids Council (MAC) was initiated in 1989 as an initiative of the MoH to serve as an umbrella organisation to support and coordinate the efforts of nongovernment organisations working on HIV and AIDS in Malaysia. Nearly all sources of funding for HIV activities (domestic and international) are channelled through this "government organised nongovernment organisation". MAC is led by an executive committee comprised of ten elected representatives from its partner organisations that in turn represent a diverse range of associations and committees. At present there are over 40 partner organisations. Through the MAC, the government supports and actively funds civil society to carry out a variety of activities and engages civil society in the funding dialogue. MAC leads advocacy efforts, and regularly and consistently monitors its CSO members and their programmes and provides technical assistance to its partners wherever possible.

Going further down this route may require a study tour to Malaysia followed by a regulatory framework review to assess the need to amend relevant legislation and policies. Then each programme can explore the services to be contracted out during the development of a more detailed roadmap for partnership between relevant CSOs and the Ministry of Health. This may require investing in high level policy advocacy on the critical roles CSOs can play in developing society, improving communities and promoting key population participation. Another feasible alternative to Malaysia is Thailand, where government has also formally recognized and invested in CSOs as accredited HIV service providers.

An important consideration in designing a mechanism to fund services to be delivered by CBOs is that the true cost of providing key population led services is greater than the cost of the drug or commodity: service delivery requires staff, rent, utilities, fuel, administration to manage money, supplies, strategic information, and so on. The position of the National AIDS Control Program appears to be that key population organisations will need to cover these costs themselves. Of the 48 CSOs in Bhutan, Lhaksam is the only NGO working to network people living with HIV/AIDS. Lhaksam works closely with the MoH in prevention and control of HIV. These partnerships – between government and CSOs working on HIV - exist, but have not yet been utilised in a contracting context outside the Global Fund program. This would need to be considered and further developed if a Malaysia or Thai model was adopted.

Figure 3. Pathways to Financial Sustainability

Option A (left of the diagram): Fund KPO service delivery through existing mechanisms, and Option B (right of the diagram): Consider a new government funding mechanism to preserve the voice of civil society in the response.



Financial technical support needs to be aligned with Bhutan's budget cycle

It is important that the voice of key populations is reflected in budgeting and planning, and that technical support designed to assist key population organisation sustainability is aligned to the budget processes. For KPOs to make an effective contribution to planning that, it is important to understand the budget preparation process and cycle.

Annual budgeting in Bhutan works through two complementary processes: (i) Top down: where prescribed budget ceilings for both capital and current expenditure are communicated to line ministries and programs alongside policies and guidelines for budget preparation; and (ii) Bottom up: where, following the budget call notification guideline, line ministries and programs, including the NACP, prepare a budget proposal, keeping within the overall budget ceiling.

In January and February, the NACP starts this process by preparing a work plan and the corresponding budget estimate. It works with the Department of Public Health to prepare a budget which covers both domestic and Global Fund funding, which is then submitted to the Ministry of Health's Policy and Planning Division after a rigorous review. This proposed budget estimate is then incorporated into the Multi Year Rolling Budget (MYRB) and the financial committee of the Ministry of Health approves the proposed budget for submission to the Ministry of Finance by 20th February. During March and April, joint budget reviews take place between the Ministry of Health's Policy and Planning Division and the Ministry of Finance. The budget is then presented to parliament by the Ministry of Finance in May. Parliament approves the budget for implementation in July, and funds are then disbursed to different ministries and programs.

Costing and modeling can help guide cost-effective investment in scale up of priority HIV services

SKPA-1 supported Bhutan to collect data on the cost of different services: these cost data helped inform the country's use of the Optima HIV model in the analysis of efficiency, sustainability and impact of key population HIV services. SKPA-1 support involved a technical working group in-country and a national consultant working with the NACP and other key population stakeholders. The process helped to highlight the need to take priority services for key populations to scale, and this was further reinforced by an independent technical review of the preliminary analysis. The final outputs are expected in early 2023 and the NACP expects to use the results to help guide cost-effective investments to reach the 95-95-95 targets. Once the analysis is complete, further cost data will be collected and incorporated as needed. The outputs of both costing and modeling efforts will contribute to the development of the next National HIV Strategic Plan and guide the further expansion of services, particularly to address the gap in reaching the first 95 target.

OBJECTIVE 2: IMPROVE STRATEGIC INFORMATION AVAILABILITY AND USE

Bhutan has new insights into the importance of key populations in its epidemic but also has key data gaps

Bhutan's current National HIV Strategic Plan, developed in 2016, identifies key and vulnerable populations as a priority, including female sex workers, clients of sex workers, transgender people, men who have sex with men, people who inject drugs, incarcerated people, mobile, migrant and displaced populations, young people and uniformed personnel. Insights gained in recent years will enable a sharpened focus in the next National HIV Strategic Plan and have laid the groundwork for stronger prevention services for those most at risk of HIV in Bhutan, together with the enhanced treatment, care and support systems needed to help retain people living with HIV on treatment and achieve sustained viral load suppression.

Data on HIV prevalence, size estimates and risk behaviors are available for most key populations (see Table 1). This is due to the NACP's strong leadership in implementing population-based surveys, such as Integrated Bio-Behavioural Surveys (IBBS), and population size estimation studies, and to the routine HIV counseling and testing system, which each year for the past few years has identified 40 to 60 new people living with HIV. However, because Bhutan has such a low-level epidemic, there are significant levels of uncertainty around surveillance-generated estimates.

Table 1: HIV prevalence, 95-95-95 status, and population size estimates

Indicators and groups		HIV Prevalence (June 2021)	Number of new Infections (July 2021 – June 2022)	95: PLHIV (in each sub-population group) know their HIV status (%, all ages) (June 2022)	95: PLHIV (in each sub-population) who know their HIV status are on treatment (%, all ages) (June 2022)	95: PLHIV (in each sub-population) who are on treatment achieve viral Load Suppression (%, all ages) (June 2022)	PLHIV Population size estimate
1	All Adults	0.2%	N/A	63.55%[12]	96.82%	39.97%	1314
2	Men who have sex with men	1.5%	N/A	N/A	N/A	N/A	1726
3	Sex workers	3%	N/A	N/A	N/A	N/A	597
4	People who use drugs/inject drugs	N/A	N/A	N/A	N/A	N/A	N/A
5	Transgender people	3%	N/A	N/A	N/A	N/A	302

Source: AIDS DataHub, National program data.

[12] National HIV, AIDS & STIs Control Program. 2022. Ministry of Health, Bi-annual News Release on HIV Situation, June 2022.

Estimates from the 2021 IBBS show the highest HIV prevalence in 2021 was among female sex workers and so-called "high-risk women"[13] at 3% and 2%, respectively, reflecting their risk of exposure to HIV through unprotected sex with multiple clients or partners. HIV prevalence is also high among transgender people at 3%. Prevalence among men who have sex with men is lower at 1.5%, but there are concerns that this could increase, based on data on risk behaviors and the rapid growth of HIV epidemics among this population in other countries in the region[14].

As Table 1 shows, there are key gaps in the epidemiological data. First, there is a lack of HIV cascade indicator data disaggregated by key population groups. Second, there is no population size estimate for people who use drugs and people who inject drugs. Third, there are no data for prisoners and HIV.

The historical analysis of HIV infections in Bhutan referred to earlier in this report linked an estimated 0.23% of infections to injecting drug use, but lack of data and the challenges in reaching this key population has resulted in a lack of targeted services for people who use or inject drugs. During Year 1 of SKPA-2, a population size estimate of this key population group will be conducted, and this will determine the need for strengthened engagement with and services for this key population.

Better use of strategic information, in particular program data, can identify areas for improvement in service delivery

The Ministry of Health requires all health facilities to report aggregated data to the Health Research and Epidemiology Unit, which generates periodic and annual reports. The Health Information System uses the DHIS-2 platform. Case-Based Surveillance is also now carried out to collect detailed information including contact tracing once an individual tests positive. Data is collected through both electronic and paper-based formats (with paper-based systems most common at primary health care level). Quarterly STI case reports submitted by health facilities are also paper based.

The Comprehensive Service Package for HIV/STI and AIDS Guidance Manual provides instructions for collecting data. All key population organizations collect data and submit routine reports to the NACP Data collected is based on global reporting and the Global Fund Performance Framework in the national grant.

[13] The term "High risk women", is defined as "women employed at or frequenting entertainment establishments and is used as a proxy for women likely to engage in sex work or have high numbers of sexual partners" is used in Pride Bhutan's 2020 report "Mapping and population size estimation of men who have sex with men, transgender persons, and high-risk women in Bhutan"
[14] Reddy (2022). Technical review of the findings from Optima Modelling in Bhutan: Bridging the gaps to reach 2030 goals. Report prepared for AFAO and NACP, SKPA-2

Table 2: Coverage of key HIV services by key population

Indicators and groups		HIV prevention coverage[15]	Number of people on PrEP (received any time in last 12 months)	% of KP reached with prevention interventions provided by key population-led organizations	Number and % of people who received HIV testing in last year (HIV testing coverage)	Number of people who received HIV self-testing in last year	Avoidance of health care due to stigma and discrimination
1	Men who have sex with men	26% (Pride)	0	23%	450 (26%)	52	N/A
2	Sex workers	49%	N/A	48%	285 (48%)	56	N/A
3	People who use drugs/inject drugs	N/A	N/A	N/A	N/A	50 (CPA)	N/A
5	Transgender women + men[16]	55%	N/A	50%	197 (65%)	42	N/A

Source: AIDS DataHub, National program data

In order for Bhutan to know its epidemic and evaluate its response, program data needs to be used effectively to complement epidemiological data. Table 2 shows there is room for improvement, particularly in HIV prevention and HIV testing service coverage. For example, only 26% of men who have sex with men and 48% of sex workers were reached by prevention interventions or had an HIV test in the last year. HIV prevention and testing coverage was slightly higher for transgender people, at 55% and 65% respectively. No key populations received pre-exposure prophylaxis (PrEP) as this intervention is yet to be rolled out in Bhutan. There is currently no information available on the avoidance of health care due to stigma and discrimination, but data will be collected through a Stigma Index study, supported by WHO and SKPA-1, and through community-led monitoring, both of which are expected to take place in 2023.

[15] Prevention coverage is measured as the percentage of people in a key population who report having received a combined set of HIV prevention interventions in the past three months (at least two out of three services): (1) given condoms and lubricant; (2) received counselling on condom use and safe sex; (3) tested for STIs (for transgender people, sex workers, gay men and other men who have sex with men) or received sterile needles or syringes (for people who inject drugs).
[16] Initial question in the toolkit only specified transgender women, however program data reported both, so the question here has been modified to reflect this.

Review of a range of survey data and reports has also highlighted potential missed opportunities in use of program data. Specific issues identified include:

- Shortcomings in use of data to target outreach services and monitor service coverage among outreach clients.
- Lack of systematic mapping to identify hotspots and to estimate the number of people from key populations who frequent these hotspots. This limits the ability to plan outreach efforts to ensure adequate coverage.
- Inability to verify receipt of key prevention services including testing or linkage to treatment after initial contacts. Referrals for confirmatory testing are often the last data point collected by outreach workers, and Health Information Service Centers do not systematically collect data on ART linkage or follow up case management.
- Due to concerns about confidentiality, individual-level data is not kept by Pride Bhutan or Red Purse outreach workers. This limits the ability to verify who has received which service(s), and which individuals are yet to utilize HIV testing, among other services.
- Difficulty in determining key population utilization of HIV testing at Health Information Service Centers due to widespread use of the 'general population' group on HIV testing registers at these centers, due to use of services by the general population or concerns about confidentiality.

Community-led monitoring should complement government-led monitoring

Community-led monitoring was introduced in Bhutan in 2020 under the SKPA-1 program as a demonstration project led by the Save the Children, with support from APCOM. Two rounds of community-led monitoring were conducted by trained members of key population organizations and a report was produced. In the absence of a dedicated reporting system for stigma and discrimination or a community feedback system more generally, key population organizations see community-led monitoring as an important mechanism for reporting incidents of stigma, discrimination and harassment. Key population organizations also report that community-led monitoring provides an important basis for constructive dialogue with government and other stakeholders on service quality. The NACP has indicated that data collected from the initial rounds of community-led monitoring has been used to inform strategic planning at national level and to improve services at health facility level.

The NACP is considering the integration of client feedback into an online reservation system and, through indicators, into the national monitoring and evaluation system. This initiative is commendable, as it seeks to cost-effectively leverage information technology to automate client feedback on HIV services. Initial design discussions on a formal feedback mechanism indicate that the feedback may go directly to the Quality Assurance and Standardisation Division of the Ministry of Health with redress dependent on review of the nature and severity of the complaint

as per the guidelines of the division and serious cases escalated to the Medical Council for action.

However, a formal feedback mechanism linked to the national monitoring and evaluation system will be government-led and, as such, is different from community-led monitoring, where key populations oversee the collection, management, analysis and use of data. Key population organizations have highlighted the need for community-led monitoring to be adopted on a routine basis.

Program data quality could be more systematically assessed and improved

The current national reporting system involves periodic review of data from quarterly reports and annual progress reviews to track progress and to inform the development policy and strategic plans. Progress reports are submitted to the Ministry of Health and the Government Performance Monitoring Department under the Prime Minister's Office. The National HIV/AIDS Commission meets twice a year to review the HIV situation and make policy decisions. The NACP also submits quarterly reports to the Global Fund as per the Performance Framework.

These reports provide an opportunity to identify quality and program issues highlighted by performance indicators. Other checks include visits to health facilities and key population organizations that deliver services by NACP Monitoring and Evaluation Officers to physically verify the data collected. Within key population organizations, supervisors check the data collected by their subordinates. The Country Coordination Mechanism Oversight Committee also conducts its own monitoring and supervision of implementing agencies.

However, according to key informants from the NACP and the Health Research and Epidemiology Unit of the Ministry of Health, data validation and data quality verification practices, including onsite supervision, are still poor and are not conducted regularly. This is due in part to a lack of tools and templates to guide and simplify data quality checks and in part to challenges in data validation using the current electronic reporting system. The electronic Patient Information System (ePIS) that is being developed through a government flagship project may help to address this by bringing all reporting into a single health information system. Specifically, the NACP is in the process of uploading three years' retrospective data into the system. NACP will need to create guidance and protocols for the ePIS. Once the system is rolled out, it will be important to validate client-level service data and use this data to monitor linkages between community and health facility service providers, to support effective cascade monitoring.

Confidentiality and privacy concerns in individual-level data

When a new HIV case is detected, the laboratory informs the NACP and the Care, Service and Treatment Unit and this unit then follows up, carrying out further counseling, tests, enrolment on treatment, and contact tracing. To protect client identity and ensure confidentiality, client data are only available to the NACP and the Care, Service and Treatment Unit.

Key population organizations are not part of the Health Information System, but report directly to the NACP. These organizations also maintain client data, but their information

systems differ, depending on the information technology skills of their staff. Confidentiality is protected through limiting database access and securing data through use of passwords.

HIV testing registers at Health Information Service Center level are designed to capture some personal identifying information and indicate which key population group the individual receiving testing belongs to. In the register reviewed for the baseline assessment (the finding could be an exception rather than the norm) the majority of HIV testing clients in 2022 were categorized as belonging to the general population. In discussions with Health Information Service Center staff this was attributed to the reluctance of key populations providing personal identifying information to identify themselves as belonging to a key population. Confidentiality protections built into the system also appear to limit the ability of staff to monitor whether an individual testing positive has been effectively linked to treatment. In many cases, Health Information Service Center counselors actively support these referrals, but documentation is lacking about the receiving treatment center and the date the referral was completed, limiting counselors' ability to proactively manage referrals.

Many countries are establishing a national unique identifier code for key populations as a way to address data privacy concerns in HIV services. Bhutan is a small country where people are very connected and stigma is real, so may benefit from adopting a similar system that could be integrated into the upcoming electronic Patient Information System as well as in Health Information Service Center and outreach paper registers and data collection tools. This may help to provide HIV service clients with the confidence to provide sensitive personal information, for example, about key risk behaviors, which would enhance program monitoring and support interventions such as index testing. It would be valuable to explore use of UICs for all clients, not just key populations as focusing on key population members tends to highlight their status and can add to stigma and discrimination.

OBJECTIVE 3: PROMOTE PROGRAMMATIC SUSTAINABILITY

Current HIV testing policies limit case detection but HIV self-testing shows promise

Bhutan currently follows a three-test algorithm for HIV testing, whereby rapid tests are used for the first test, and a second confirmation test is undertaken through both a Gelatin particle agglutination test and a 4th generation ELISA test. Bhutan Medical and Health Council regulations require any medical procedure (including testing) to be carried out by licensed and approved personnel. A few private diagnostic centers provide HIV testing as part of their diagnostic service. All reactive samples are referred to Royal Center for Disease Control (PCDC) for confirmatory testing.

Facility-based HIV testing is available at Health Information Service Centers, which offer tests for HIV, Syphilis and Hepatitis B as part of voluntary counseling and testing services for walk-in clients. Health Information Service Centers have been established in six major urban centers through the national grant. Primary health care centers and hospitals also offer facility-based testing for HIV, Syphilis and Hepatitis B. To bridge the gap in the first 95, the NACP is exploring other options for expanding case detection. Sexual partner testing or index testing is in place in Bhutan and the NACP is also keen to integrate provider-initiated testing into in-patient services and other service points at hospitals.

HIV self-testing was introduced as a demonstration project under SKPA-1 in 2021. The project showed that HIV self-testing was highly acceptable, and this approach has since been integrated into national testing guidelines. An oral HIV self-testing kit has been registered in Bhutan and is currently being procured by the NACP with support from the Global Fund national grant. Self-testing kits have been made available to the six Health Information Service Centers, which are distributing the kits to key population organizations as required, within and beyond the six priority Global Fund districts. The key population organizations have been trained on the use and interpretation of the kits. No new cases of HIV have yet been detected through HIV self-testing, raising questions about whether this approach can reach new high-risk individuals, but this may change as self-testing is scaled up and included in the routine HIV service package. Sustainability of self-testing beyond current Global Fund support will require procurement of kits to be included in government procurement budgets and systems.

Community based testing (CBT) was also introduced under SKPA-1 through key population organizations. However, because of Medical and Health Council regulations, the focus has shifted from community-based testing to assisted self-testing. This shift also reflects the findings of the HIV self-testing pilot, which showed that first time testers preferred assisted self-testing to unassisted self-testing. Social network-based approaches are being used to access individuals in unknown high-risk networks. This will require careful monitoring to ensure that assisted self-test results are being received and new individuals at risk are able to access these tests and are then managed appropriately through the care cascade from the community entry point. At the same time the system for non-assisted self-testing can be developed, including strategies for effective virtual outreach, reporting of results and monitoring and evaluation.

Physical and virtual outreach services are essential to increase coverage, but key population organizations have very few outreach workers

Although Bhutan has recently identified the central role of sex work in HIV transmission, inadequate resources have been allocated to interventions for sex workers and as noted earlier in this report, fewer than half received prevention or testing services in the past year. At the same time the COVID-19 pandemic has disrupted outreach activities due to repeated lockdowns and closure of entertainment venues. In addition, the illegality of sex work and targeting by the authorities have driven sex workers underground, making it even harder to deliver HIV services to them.

The Red Purse Network of Sex Workers has just a single outreach worker, who conducts outreach in partnership with a transgender woman from Pride Bhutan. Although the Red Purse Network is aware of hotspots it does not use hotspot mapping or local population size estimates to plan activities. The outreach worker highlighted the difficulties in providing services to sex workers, who are highly mobile and often do not wish to be identified as sex workers. In addition, pimps, for example hotel workers or madams, are often important gatekeepers who are not generally supportive of outreach services. Reaching under-age and male sex workers is particularly challenging. Other challenges include targets that give priority to identifying new sex workers and encouraging them to access HIV testing, so follow-up services are given less attention, and limited access to condoms from mainstream health facilities. Health Information Service Centers provide easier access to condoms and offer mobile testing at hotspots but do not cover the whole country.

Pride Bhutan has four outreach workers (including one transgender woman). Again, a lack of hotspot mapping and local population size estimates limit ability to plan and deliver targeted services to men who have sex with men and transgender populations. To compensate for their limited physical outreach coverage, both Pride Bhutan and Queer Voices of Bhutan are very active in virtual interventions.

Lhaksam has around 270 members and provides an important package of interventions and support for people living with HIV. Many come from an impoverished background, and it may be that they are more motivated to join the network because of the material support provided. The NACP would like to see all those diagnosed with HIV linked to Lhaksam, but stigma and fear of disclosing HIV status is a major barrier to the involvement of some people living with HIV. In some cases, health facilities may refer people who have tested positive to Lhaksam. This is not feasible for key population organizations as privacy and confidentiality protocols mean that the status of newly diagnosed people living with HIV is not reported back to referring organizations or outreach workers.

Clients of sex workers have an important influence on condom use in sex work and CPA may be able to effectively address this in their outreach work as well as make use of the upcoming population size estimation study of people who inject drugs to design targeted services.

As outreach services are a key entry point for prevention and testing among hard-to-reach key populations, stakeholders interviewed for this assessment emphasised the need to strengthen strategic behavioral communication and expand

virtual outreach and strengthen linkages with other services, as well as for more systematic engagement of key populations in outreach teams that are linked to health facilities such as Health Information Service Centers. Approaches to this engagement are discussed under objective 1 recommendations.

Integrating PrEP into the key population service package

PrEP is not included in the current National HIV Strategic Plan and has not yet been introduced into Bhutan, although it is included in the country's HIV treatment guidelines. The NACP would like to introduce PrEP for key populations and has participated in target setting for 2025 with the UNAIDS Regional Support Team. A demonstration project to affirm the feasibility and acceptability of PrEP is planned under the Global Fund national grant with a budget of US$11,371. Following the evaluation of this demonstration project, indicators will be selected, and recommendations made for scale up.

Much needs to be done to prepare for the introduction of PrEP. Consultations with stakeholders highlighted low awareness of and interest in PrEP and, while some key population organizations support its inclusion in the HIV prevention package, others have reservations, believing that PrEP would lead to declining condom use and increased STI transmission.

As yet, no discussions have been held with the NACP about procurement of PrEP for the demonstration project and future scale up. To include PrEP in the national formulary (the government procurement system), the NACP will need to send a request to the Essential Drugs Program, within the Essential Medicines and Technology Division of the Department of Medical Services. The Essential Drugs Program would then table a proposal for PrEP inclusion in the national formulary for review by the National Medicines Committee.

Stronger key population-led organizations, and a framework for their engagement in policy development, would contribute to a stronger national HIV response

As a member of the Country Coordinating Mechanism, Pride Bhutan has the opportunity to network with government including the NACP, to raise concerns and to inform the development of LGBT-friendly policies and acts.

While Pride Bhutan has good relations with government agencies, it believes it has not been adequately engaged in national HIV/AIDS planning and decision-making processes, such as the development and prioritization of Five-Year Plans. Pride Bhutan describes its involvement as "activity driven", mainly for Global Fund-related processes, citing community-led monitoring, HIV self-testing, and outreach activities. Pride and other community representatives also commented that engagement is often based on personal connections or donor priorities rather than national leadership and noted that engagement is limited by the lack of frameworks and institutionalized mechanisms for people living with HIV and key population networks to engage with national and sub-national policy, planning and programming, and decision-making processes.

There is a history of collaboration between Pride Bhutan and the NACP. This includes an agreement under the current Global Fund national grant to implement selective outreach activities until 2024. These activities include distribution of self-test kits, referrals for confirmatory testing and distribution of condoms, lubricants and communication materials. Under the agreement, NACP provides a salary for one outreach worker and some direct funding of outreach and office costs. Despite being the strongest key population-led network, Pride Bhutan is under-funded and relies on donations and member support to cover its overhead costs. Pride's allocation under the national grant is budgeted to fall from around US$32,000 in 2022 to US$18,532 in 2023 and 2024. There is a considerable mismatch between this budget and what Pride requires to fulfil its role in the National HIV Strategic Plan 2022-2024. During this period, Pride Bhutan estimates that it needs US$466,897, of which only 20% is currently budgeted for. Pride is not yet registered with the Civil Society Authority, and this is a barrier to accessing other funds. Under SKPA-1, Save the Children supported Pride's application for registration in late 2021. Pride Bhutan and Lhaksam highlighted the need for adequate government funding to cover their overhead costs and to ensure their sustainability and to secure additional funding through building relationships with philanthropic and religious organisations.

In addition, the effectiveness and sustainability of key population-led organizations will depend on building their capacity in the areas of financial management, administration, leadership, data collection and utilization, and there are relevant training institutes in Bhutan which can support this.

Registration and accreditation are important for the sustainability of key population-led services

Sustainability requires key population-led services being recognised and accredited as well as strong key population-led organizations. Currently key population-led organizations provide information, education and communication, condoms and lubricant, and referrals to STI and HIV services, but more complex services such as testing, treatment, use of portable CD4 count machines and counselling require trained staff.

To enable civil society organizations to deliver these services, the NACP, with support from SKPA-2, is in the process of instituting an accreditation system for key population service providers and developing a tailored curriculum in collaboration with the Faculty of Nursing and Public Health at the Khesar Gyalpo University of Medical Sciences of Bhutan, although it has yet to conduct a training needs assessment for civil society organizations In addition, SKPA-2 is planning to work with the University to revise the curriculum for health care providers to add essential components of the HIV, STI and Hepatitis program for key populations with a focus on challenging stigmatizing attitudes among health providers.

The capacity of key population-led organizations would also need to be accredited by Bhutan Health and Medical Council before they can implement activities such as HIV self-testing. A complete set of guidelines and manuals would need to be developed for these organizations to achieve this accreditation.

OBJECTIVE 4: REMOVE HUMAN RIGHTS AND GENDER-RELATED BARRIERS TO SERVICES

Bhutan has the unique distinction of pursuing a developmental philosophy of Gross National Happiness, which upholds strong principles of equality and rights for all. The country provides critical protections for people living with HIV and has also taken important steps to protect vulnerable members of key populations. As far back as 2004, a Royal Decree on HIV/AIDS, issued by His Majesty the Fourth King, called on all members of society to help prevent HIV and to provide care and compassion to people living with HIV. More recently, Bhutan has taken other important steps. In 2021, Amendment 213 to Bhutan's Penal Code decriminalized same-sex sexual relations, thereby facilitating access to HIV services for men who have sex with men and other members of the lesbian, gay, bisexual and transgender (LGBTI) community. There is an initiative to include the needs and priorities of the LGBTI community in the National Gender Equality Policy and some members of parliament have proposed converting the National Gender Equality Policy into an Act.

While progress has been made, the baseline assessment identified several critical barriers that impact key populations' access to HIV-related services in Bhutan.

Gaps remain in legal and policy frameworks

Two critical key populations, sex workers and people who use and inject drugs, are still criminalized in Bhutan. According to Chapter 16 of the Penal Code, sections 373 and 380, sex workers, brothel owners and clients are all criminalized in Bhutan, and the Narcotic Drugs, Psychotropic Substances and Substance Abuse Act of Bhutan 2015 criminalizes drug use. Transgender people do not enjoy legal recognition in Bhutan, and this complicates access to appropriate health and HIV services for this especially vulnerable population. The Penal Code also renders people living with HIV vulnerable to prosecution for alleged HIV transmission. Section 410 states that: "A defendant shall be guilty of the offence of criminal nuisance, if the defendant knowingly or recklessly creates or maintains a condition including spreading of a dangerous disease that injures or endangers the safety or health of the public."

Societal stigma and discrimination against people living with HIV and key populations persist

Members of key populations report that they experience social stigma, including from family members. They also report that key populations are widely viewed as carriers of HIV and are, therefore, ostracized from society. Key informant interviews suggest that people who use drugs and transgender people experience some of the highest levels of stigma and discrimination. Societal stigma and discrimination make it difficult for people living with HIV to disclose their HIV status, including the family members, and this has an adverse effect on their mental health.

Key populations and people living with HIV also report that they experience economic hardship due to discrimination in the hiring process and consequent difficulties in securing employment. Although the Labour and Employment Act of 2007 includes provisions to prevent discrimination in the workplace, community

members widely report that employers are reluctant to hire people from key population communities.

Stigma and discrimination exist in the context of health services

Members of all key populations report multiple instances of stigma and discrimination in health facilities, including in HIV-specific service delivery points. Transgender people in particular report being afraid that health service providers would discover that they were transgender. People who use drugs commented that health services were not accessible due to discrimination from service providers, and that people who attempted to quit drugs but later relapsed were frequently refused services by healthcare providers or else subjected to long delays in accessing treatment. Mistreatment by healthcare providers was also cited by sex workers, some of whom reported that service providers and the police sometimes demand sex for free.

Community experience of stigma and discrimination is poorly understood

Government stakeholders and civil society service providers sometimes blame key populations for their poor access to HIV-related services, citing low literacy rates, lack of awareness and self-stigma as barriers. Some stakeholders do acknowledge the impact of societal stigma on key populations, especially in rural areas, but most do not acknowledge the existence of stigma and discrimination in healthcare settings.

Many healthcare providers lack the knowledge and skills required to meet the health needs of key populations

Community members report that service providers do not have an adequate understanding of the health needs of key populations. This is particularly the case for people who use drugs and the LGBTQI community, especially transgender people. With respect to the latter, healthcare providers lack knowledge about hormone therapy.

Violence and lack of recourse

Sex workers commonly experience harassment from law enforcement agencies and personnel, and violence from partners, family and clients. Since sex work is illegal, it is difficult for sex workers to report abuse. In general, there is an absence of mechanisms to report human rights violations for all key populations.

Gender norms, gender-based violence and inadequate legal protections adversely affect women in Bhutan

Women living with HIV in Bhutan experience additional stigmatization due to traditional gender norms. Women are expected to be decent, loyal, dedicated and to not engage in extramarital sex and, consequently, women living with HIV are often branded as promiscuous.

Further, unequal gender power relations mean that women living with HIV are sometimes prevented from accessing health services by their male partners. Economic dependency on male partners and lower literacy rates among women also affect women's access to HIV information and services, including on-line services.

According to the Domestic Violence Prevention Act of Bhutan 2013, domestic violence is a criminal offence, and the Penal Code of Bhutan (section 199 and 200) recognizes marital rape as a crime. However, marital rape is considered a petty misdemeanour, punishable by imprisonment of between a minimum of one month and a maximum of one year. Despite the existing legal framework, levels of domestic violence remain high. According to the National Study on Women's Health and Life Experiences undertaken by the National Commission for Women and Children in 2017, 44.6% of women in Bhutan have ever experienced intimate partner violence.

Awareness of gender issues and the specific challenges faced by women is low. This includes key population organizations interviewed for the baseline assessment, which reported that there are no gender issues impacting women members of key populations.

3.

Recommendations

Recommendations in this report are grouped under thematic issues that need to be addressed. The issues reflect the key findings above and the recommendations are intended to help countries consider and address priorities for the national HIV program.

Issue 1: Insufficient focus on key populations and incomplete core package of services

New evidence and strong leadership in the NACP has helped Bhutan to realize that the country has an HIV epidemic where a large number of new infections are linked to sex work and there is a risk of increased transmission among men who have sex with men. Appropriate planning and allocation of resources and delivery of a targeted package of services could enable Bhutan to maintain its low-level epidemic or even eliminate it. Development of the new National HIV Strategic Plan in 2023 presents an opportunity for Bhutan to focus on key populations and a cost-effective package of services.

Recommendation 1: Bhutan should use the next National HIV Strategic Plan to sharpen the focus on key populations and introduce a core package of services for key populations that includes PrEP.

Issue 2: Lack of sustainable financing for priority HIV services for key populations

As the baseline assessment has shown, the existing financing gap for Bhutan's national response to HIV will increase significantly as external funding decreases. Without a sustainable financing strategy, priority HIV services for key populations – which are highly dependent on external funding – would cease, with serious repercussions for individuals and for the country.

Recommendation 2: The Ministry of Health should consider developing a financial sustainability model, following one of the two options presented in this report. SKPA-2 should consider, through Save the Children, placing a senior Financial Sustainability Advisor within the Ministry of Health to assist the government to develop such a model, including mobilizing increased resources. The role of the Financial Sustainability Advisor is outlined in the overarching report, and it is envisaged that this individual would work with the NACP and the Policy and Planning Division of the Ministry of Health to assess different options to achieve the financial sustainability of key population HIV services, including options A and B described in Objective 1 above.

Issue 3: Current data collection practice is not optimal for monitoring outreach and HIV testing services for key populations or the HIV cascade

Improved epidemiological and program data collection and use is essential to monitor the HIV epidemic and the response. Specific gaps and weaknesses that need to be addressed include: the lack of cascade indicator data that is disaggregated by key population; the lack of population size estimates for people who inject drugs; and the lack of accurate data for monitoring community-based and outreach services and linkage to care. In addition, confidentiality and privacy consideration also limit the quality and completeness of data.

Recommendation 3: National partners to take steps to address key gaps in epidemiological data and by strengthening data collection and use for outreach and HIV testing services, including:

Recommendation 3.1: Using local hotspot mapping to identify priority settings and to estimate the number of key populations at each hotspot to inform the design of outreach plans. This can be complemented by online hotspot mapping. Identifying and enumerating male sex workers will require additional capacity.

Recommendation 3.2: Implement unique identifier code system that enhances data quality especially for case management and accurate reporting of key population service access across the HIV cascade. This can then be integrated into the electronic Patient Information System as well as outreach and Health Information Service Center paper registers and data collection tools.

Recommendation 3.3: Revising data collection tools to enable the construction of an HIV prevention to care and treatment cascade at the civil society organization level. Indicators captured and analysed should include linkage to testing, linkage to treatment, PrEP and index testing. This will help organizations to identify important gaps to fill in outreach and encourage a stronger case management approach at individual client level. The unique identifier code system (Recommendation 3.2) will be foundational for activities relating to Recommendation 3.3.

Issue 4: The HIV program is not targeting HIV key populations in the most strategic way possible

Improved availability of epidemiological and program data collection provides an important opportunity to strongly target outreach and other efforts for key populations.

Recommendation 4: Use the new local hotspot mapping (see recommendation 3) to revisit the low ratios of outreach workers to the estimated number of sex workers, men who have sex with men and transgender people. Revisiting target setting to incorporate the need to follow up key populations beyond initial contacts or target certain higher risk segments such as male sex workers, and other intersectionalities such as men who have sex with men who use drugs. Assign mentors such as health workers/officials to support good quality service delivery.

Issue 5: Existing community-led monitoring and government-led monitoring lack the feedback mechanism required to maximise service quality improvement

The NACP has indicated that data collected from the initial rounds of community-led monitoring has been used to improve services at the health facility level and to inform their strategic planning at the national level. However, the second part of the SKPA-2 toolkit – the feedback form – was not implemented. This requires establishment of a feedback system that involves reviewing feedback from key population service recipients and includes indicators for appropriate case management. Such a feedback system provides important linkage between data collection and use of the data for service quality improvement.

To finalise design of the feedback mechanism, discussions are needed with the Quality Assurance Division of the Ministry of Health on redress for complaints. The findings and recommendations of community-led monitoring also need to be disseminated to the NACP and the

Ministry of Health. The two data sources – NACP client feedback and community-led monitoring – should be complementary. A comparative analysis of different findings and key population involvement in the two systems will be informative and should help to guide future investments.

Recommendation 5: Partners should establish a feedback mechanism that captures and reviews feedback from key population service users and that is used to improve service quality.

Issue 6: Priority HIV services for key populations are not yet reaching their potential due to limited implementation and coverage

These priority services include lay provider testing (including HIV self-testing), virtual interventions and integration with other services, and PrEP.

HIV self-testing is a critical strategy to address HIV testing coverage gaps and is also a prerequisite for future Global Fund grants. Pride Bhutan, Red Purse Network and Chituen Phendhey Association have all requested related training for more of their members to support expanded testing access for key populations. Guidelines and mobile apps are available or in development that can be used to develop training materials and job aids for HIV self-testing. To improve access to HIV self-testing, the government has allowed retail pharmacies to sell test kits. However, a halt on issuance of licenses for private diagnostic services means there are only a few that provide laboratory diagnostic tests.

Recommendation 6.1: It is recommended that testing be taken to scale by:

> **Recommendation 6.1.1:** Evaluating the HIV self-testing demonstration project and adapting findings for routine implementation, including monitoring and evaluation tools.
>
> **Recommendation 6.1.2:** Rolling out community-based testing using key population organizations and key population members and training additional providers of assisted HIV self-testing or community-based testing.
>
> **Recommendation 6.1.3:** Enabling more private pharmaceutical retailers to stock self-testing kits.
>
> **Recommendation 6.1.4:** Increasing the supply of accredited diagnostic services.

Recognising that one contact is not enough for effective outreach work, and the widespread use of social media among key populations, key population organizations are using social media to reach their communities, raise awareness and provide information. Virtual interventions provide new opportunities to connect with and follow up the community around uptake of services. All of the civil society organizations consulted for this baseline assessment requested support to strengthen their use of virtual interventions to help access previously unreached high-risk populations. At the same time there are challenges in using virtual approaches to reach some key populations. For example, Lhaksam noted that use of social media is not feasible for many of their members who have low levels of literacy. Likewise, CPA noted that most of their members do not have smart phones and prefer face-to-face services.

To address gaps in coverage and expand reach, Bhutan may wish to consider cost-effective expansion of outreach through mobilizing and engaging additional peers to participate in social networking and recruit members of their networks to access services, using both online and offline approaches.

Recommendation 6.2: The NACP and Ministry of Health should work with partners to improve coverage of virtual interventions and integration with other services. Specific recommendations include:

Recommendation 6.2.1: Conducting an evaluation of current outreach and strategic behavioral communication approaches for sex workers, men who have sex with men, and transgender people. This should lead to capacity building on physical and online outreach, as well as data security. Interpersonal communication skills building should also be considered as online communication differs to traditional in-person communication

Recommendation 6.2.2: Engaging additional and diverse peer educators from within the community in order to achieve sufficient outreach program coverage and to be able to reach different networks within each key population community. Consider consulting or engaging key opinion leaders from within the communities who can help craft as well as champion service promotion messages.

Recommendation 6.2.3: Further develop program standards for the minimum service package for key populations with an emphasis on identification of new HIV cases, developing partnerships with key populations, and promoting service utilization through case management or repeat contacts.

Recommendation 6.2.4: Integrating messaging on U=U and HIV self-testing through promotion of the forthcoming NACP web-based and mobile app to provide virtual access to HIV services. (This will include information and promotion of services including HIV self-testing, counseling, appointments for services, and self-risk assessment. A helpline is also being used to provide information about HIV and related services.)

Recommendation 6.2.5: Helping Lhaksam support people living with HIV and their families by making better use of virtual platforms such as Facebook, Messenger, WhatsApp, WeChat and Telegram for demand creation and service delivery, and for raising awareness of and reducing stigma and discrimination.

Following the demonstration project supported under the national grant, Bhutan will need to plan a range of activities to achieve broader PrEP acceptance and roll-out.

Recommendation 6.3: PrEP should be integrated into the key population service package, and that the following activities should be implemented to support roll-out of PrEP:

Recommendation 6.3.1: Conducting a national consultation on PrEP to raise awareness and to discuss its introduction as well as a demand generation strategy. To inform the demand generation strategy, use the consultation to understand PrEP-related fears and aspirations from each key population group.

Recommendation 6.3.2: Taking steps to register PrEP drugs for use in HIV prevention.

Recommendation 6.3.3: Getting PrEP included in the national formulary list to allow government procurement.

Recommendation 6.3.4: Incorporating PrEP targets into procurement forecasting and budgeting.

Recommendation 6.3.5: Implementing an awareness campaign and targeted trainings to ensure that key populations understand the benefits of PrEP, as well as potential side effects and risks, and help community members take informed decisions.

Recommendation 6.3.6: Considering different service modalities, including review of updated guidance from WHO that includes provisions for integrating PrEP with STI service delivery.[17] Models like this could simultaneously address the low proportion of sex workers receiving STI screening and facilitate the roll-out of PrEP. Then define the role of key population organizations and health workers, and build their capacity to fulfill these roles

Recommendation 6.3.7: Considering a study tour for NACP and key population organizations to Malaysia to observe the operations of the Malaysia AIDS Council and its engagement with the Ministry of Health and key population organizations with regard to PrEP delivery.

Issue 7: Civil society organization involvement in the HIV program for key populations is limited by capacity gaps and lack of accreditation

The baseline assessment makes a strong case for the government to use accreditation and registration processes to enable key population-led organizations to deliver key HIV services.

Recommendation 7: Expand civil society organization involvement in HIV service delivery through capacity building and accreditation. Specific recommendations include:

Recommendation 7.1: Ensuring Ministry of Health endorsement for key population service packages before these are rolled out to key population-led organizations. Although some aspects of care (e.g., viral load testing, portable CD4 count, and distribution of ART) are expected to remain with government health facilities, manuals for civil society organizations providing other HIV services will need to cover these aspects and the two-way referral process. Training manuals and guidelines are required for each community service area.

Recommendation 7.2: NACP leadership in the design of tailored short courses for key population-led organizations to be accredited by the Medical and Health Council, including certification for lay HIV testing providers.

Recommendation 7.3: Building the capacity of key population-led organizations in areas including treatment literacy, counseling, referral, and HIV self-testing. In addition to technical competencies, these organizations also need training and support to develop their organizational and management skills in areas including developing business plans, writing project proposals, mobilizing funds, governance, and financial management.

Recommendation 7.4: Updating the HIV, STI and hepatitis curricula for pre- and in-service training of healthcare providers, including developing and integrating sessions to address and prevent stigma and discrimination at health facilities.

[17] WHO (2022 revised) WHO Implementation Tool for Pre-exposure prophylaxis of HIV infection

Issue 8: Criminalization of sex work and drug use undermine the national HIV program and limit access to essential HIV services for key populations

Policy-makers need to better understand how the criminalization of sex work and drug use prevent sex workers and people who use drugs from seeking services, including HIV testing. The momentum created by the recent decriminalization of homosexuality provides an excellent opportunity to raise the issue of criminalization of sex work and drug use and garner support of the decision makers in formulating policies aimed to enhance access to sustainable services for these groups. Effective advocacy and communication between decision-makers and key population organizations will be critical. The role of the Human Rights and Gender Advisor is specified in the over-arching report. This position is expected to guide and support the national program and key population-led organizations like Pride Bhutan to advocate on these issues.

Recommendation 8.1: Strengthen the legal and policy environment to support access to HIV-related services for key populations and people living with HIV. Specific recommendations include:

Recommendation 8.1.1: Building the capacity of key population organizations to conduct advocacy, develop and implement advocacy plans, and communicate effectively with relevant stakeholders and to work with policy-makers to develop actionable and feasible recommendations to decriminalize drug use and/or create an enabling environment that promotes easy access to HIV and related services.

Recommendation 8.1.2: Supporting key population organizations and civil society organizations to work with government and legal structures including the police force to raise awareness of the negative impact of criminalization on access to HIV services and HIV infection rates and limit access to HIV services.

Recommendation 8.1.3: Building key population literacy about their rights.

Recommendation 8.2: Eliminate stigma and discrimination towards key populations and people living with HIV through the following activities:

Recommendation 8.2.1: Build on the connections between community organisations in Bhutan and the UNFPA Goodwill Ambassador the Queen Mother that were established during the course of decriminalizing homosexuality (which occurred in 2021), to develop clear strategies and concrete actions to reduce societal stigma and discrimination towards key populations, including in the workplace.

Recommendation 8.2.2: Sensitize and build capacity among healthcare providers to deliver services to people living with HIV and key populations and increase providers' awareness of mental health needs. Capacity building for providers should include integrating anti-stigma, gender, and SOGIESC components into pre-service and in-service training curricula, planned under SKPA-2.

Recommendation 8.3: Develop measures to mitigate gender-specific barriers to accessing HIV services, including the barriers posed by gender-based violence. Specific actions recommended include:

Recommendation 8.3.1: Sensitize service providers in government and civil society organization healthcare settings to the high rates of gender-based violence experienced by women and girls and key populations in Bhutan, the impact of gender norms and gender-based violence on HIV vulnerability and infection rates, and capacitate them to identify possible gender-based violence cases.

Recommendation 8.3.2: Support government and civil society organization services to establish medical and legal referral mechanisms between HIV, sexual and reproductive health and gender-based violence services, including for sex workers. This could include setting up low threshold legal help services and establishing or strengthening reporting mechanisms for gender-based violence survivors.

Recommendation 8.3.3: Rapidly complete the rollout of the Ministry of Health's *National Guidelines for management of victims of intimate partner violence in health care settings*.

Recommendation 8.3.4: Improve access to health services for sex workers by supporting services to develop, disseminate and implement protocols to make services relevant and user-friendly, for example, by extending clinic hours to ensure health services are available at times that are convenient for sex workers.

Issue 9: Inadequate involvement of key population-led organizations in policy, planning and programming

Recommendation 9.1: Strengthen community engagement in national policy-making processes. Specific recommendations are:

Recommendation 9.1.1 Establish standard protocols for key population organizations to engage in national policies, programming and decision-making.

Recommendation 9.1.2: Build the capacity of key population-led organizations to engage in multi-stakeholder settings at the national level.

Recommendation 9.1.3: Continue the key population community forums established under SKPA-1, facilitating information-sharing among key population organizations and mutual support regarding rights, health services, and common challenges.

ANNEX 1: CURRENT SERVICE PACKAGE, BHUTAN

Table 1. Summary and approaches of comprehensive HIV prevention, diagnosis and treatment services for the key population in Bhutan

General HIV/AIDS and STIs prevention packages				
Interventions	**Target population**	**Materials**	**Point of delivery**	**Who will deliver**
HIV/AIDS and STIs awareness and education. ***	MSM/TG/MSW/ FSWs/Clients of Sex Workers, HRW, PWID, Prisoners, PLHIV, uniform personnel, religious personnel, adolescents, migrants, transport workers.	BCC materials in Dzongkha and English (electronic, and paper-based)	Health Centers, HISC, DICs, Mobile testing sites, CBS/NGOs, and at the community level, Youth Centers, AFHS	Clinicians, VCT/HISC Counsellors, MSTF, outreach workers, CBS, HIV related CBO/NGOs, Outreach Workers and Youth etc.
Male condoms***	MSM/TG/MSW/FSWs/ Clients of Sex Workers, PWID, Prisoners, PLHIV, adolescents, migrants and transport workers.	Male condoms	Health Centers, HISC, DICs, Mobile testing sites, CBS/NGOs. Condom vending machines, hotels, entertainment centers, Pharmacy retailers, Youth Centers.	Health workers, community outreach workers, outreach workers, HIV related CBO/NGOs, Outreach Workers and Youth groups etc.
Lubricants***	MSM/TG/MSWs/FSWs & PLHIV.	Water-based lubricants.		
Harm Reduction - Needle and Syringe Program	People who inject drugs	Needles and syringes*	HISCs and DICs,	HISC Counsellors and DIC outreach workers.

General HIV/AIDS and STIs prevention packages				
Interventions	**Target population**	**Materials**	**Point of delivery**	**Who will deliver**
Harm Reduction - Opioid substitution therapy.	People who inject drugs	Buprenorphine and Tramadol.	Regional Referral Hospitals	Clinical staff
Pre-Exposure Prophylaxis (PrEP)	MSM, MSW, TG people, FSWs and negative partner of PLHIV who are at substantial risk of HIV.	ART	Hospitals,HISC	Clinical staff (As per National Treatment Guidelines, 2020
Post- Exposure Prophylaxis (PEP)	HIV-negative people exposed to the risk of HIV infection.	ART	HISC, Hospitals	Clinical staff (As per National Treatment Guidelines, 2020)
Sexually Transmitted Infection (STI) Management.***	Men who have sex with men, male sex workers, transgender people, female sex workers, clients	As per the treatment guidelines	Hospitals and HISCs	Clinical staff or VCT/HISC Counselors.

Differentiated HIV Testing Services for 95% diagnosis of the estimated PLHIV				
Interventions	**Target population**	**Materials**	**Point of delivery**	**Who will deliver**
Provider initiated HIV-Counselling and Testing (HCT). ***	Pregnant mothers, STIs patients, TB patients, other patients undergoing an invasive surgical procedure and those attending OPDs, Walk-in clients.	Rapid test kits.	Hospitals (VCT center, OPD/IPD and then HISCs.	HISC/VCT counsellors or Lab Tech.
Stand-alone HCT services.***	Defined key and vulnerable populations of this document.	Rapid whole blood finger prick test kits and oral HIVST	HISC	HISC Counsellor
Community based mobile HCT. ***	Vulnerable populations	Rapid whole blood finger prick test kits.	HISC	HISC staff supported by community ORWs.
HIV –Self Testing***	Key and vulnerable population	Oral HIVST kits	HISC, CBO, NGO, Pharmacy retailers**, Youth Centers**	Key and vulnerable population

Interventions	Target population	Materials	Point of delivery	Who will deliver
Index Testing.***	Sexual and injecting partners of individuals living with HIV, their biological children, and the biological parents of HIV-positive children	Rapid test kits	HISC and Health centers	HISC/VCT Counsellors and PLHIV Network Organization.
Linkage to care, support and **100%** treatment for 95% viral suppression				
Referral, linkages and follow up. ***	Diagnosed PLHIV	ART drugs	HISCs, Health Centers and community-based testing centers.	Health workers/community home-based care teams including outreach workers
Viral Load Testing including Early Infant Diagnosis. ***	Diagnosed PLHIV on ART	GeneXpert machines and cartridges	-Identified Viral load testing labs. -Viral load sample collection sites	Laboratory and clinical staff including HISC/VCT counsellors.
CD4 testing***	Diagnosed PLHIV and those lost to follow up clients re- entering into continuum of care.	CD4 machine and cartridges	-Identified CD4 testing labs. -CD4 sample collection sites	Laboratory and clinical staff including HISC/VCT counsellors.

**This service may be implemented after obtaining policy clearance as there is no policy on this currently in Bhutan.*
*** The HIVST distribution through retail pharmacy, youth centers and any new outlets may require prior discussions, training and guidelines.*
**** Minimum Services Package for HIV Prevention for Key Populations in Bhutan.*

ANNEX 2. KEY INFORMANTS INTERVIEWED IN BHUTAN

Bhutan: Stakeholders Interviewed			
Name	**Title**	**Organisation**	**Objective**
Lekey Khandu	Program Manager	MOH – NACP	1,2,3,4
Choki Dolkar	Assistant Program Officer	MOH – NACP	1,2,3,4
Sangay Choden	Finance Officer	MOH	1
Dolley Tshering	Senior Program Officer	MOH	1,2,3,4
Tandin Tshering	PPD	MOH	1,2,3,4
Dorji Zangmo	Outreach Coordinator	MOH - NACP	1,2,3,4
Tanzin Dema	M&E Officer	MOH - NACP	1,2,3,4
Yonten Choki Norbu	HISC Counsellor	HISC, MOH	1,2,3,4
Dorji Zangmo	Outreach Worker	HISC, MOH	2,3
Dechen Mo	HISC Counsellor	HISC, MOH	1,2,3,4
Tshewang Dema	Data Asst.	CST	2,3,4

Jurmi Dukpa	Sr. Counsellor	CST	2,3,4
Tenzin Gyeltshen	Executive Director	Pride Bhutan	2,3,4
Ogo Dorji	Program Officer	Pride Bhutan	2,3,4
Wangda Dorji,	Executive Director	Lhak-Sam	1,2,3,4
Dhan Raj Rai	Program Manager	Lhak-Sam	2,3,4
Sonam Dendup	Program Officer	Lhak-Sam	2,3,4
Tashi Tsheten	Coordinator	Queer Voices of Bhutan	1, 2,3,4
Tshewang Tenzi	Executive Director	Chithuen Phendhey Association	1,2,3 4
Dawa Penjor	Program Officer	Chithuen Phendhey Association	1,2,3 4
Sonam Gyamtsho Samdrup	Outreach Coordinator	Chithuen Phendhey Association	3,4
Suneeta Chhetri	Coordinator	Country Coordinating Mechanism (CCM)	1,2,3 4
Khandu Dorji	PPD	CCM - MOF	1,2,3 4
Tsheirng Choden	DMDF	CCM - MOF	1,2,3 4

Kencho Zangmo	Coordinator	Red Purse Network Pride Bhutan Office	1,2,3 4
Karma Choden	Assistant Professor	University of Medical Sciences (KGUMSB)	2,3
Dr. Ripa Chakma	Associate Professor	FNPH, KGUMSB	2,3
Tshering Yangzom	Senior Lecturer	FNPH, KGUMSB	2,3
Respect, Educate, Nurture and Empower Women (RENEW)	Senior Counselor	Respect, Educate, Nurture and Empower Women (RENEW)	2,3
Norbu Dukpa	Staff	Respect, Educate, Nurture and Empower Women (RENEW)	3,4
Sonam Wangdi	Staff	WHO	3,4
Khurshid Alam	Deputy Resident Representative	UNDP	1,3
Jigme Choden	Program Analyst	UNFPA	1,3
Lopen Sherub Dorji	Coordinator	Dratshang Lhentshog	3,4
Kinley Dorji	Staff	National Commission for Women and Children (NCWC)	4
Dasho Karma Dupchu,	Committee Secretary	Women, Children and Youth Committee and Economic and Finance Committee - National Assembly	3,4

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