Global AIDS Response Progress Reporting 2012: Bhutan

FOREWORD

Bhutan is one of the few counties in South Asia that continue to experience a low HIV prevalence, below 0.1%. However, the factors that would expedite the spread of HIV are continuously becoming evident. This includes, among others, the high incidence of sexually transmitted infections (STI), low consistent condom use, high levels of casual sex and needle sharing among those who inject drugs. In response to this, the Ministry of Health had quickly embarked on an HIV/AIDS nationwide prevention and awareness program in the early phase.

Today, more evidences have been generated showing an increasing and emerging risks and vulnerabilities to HIV infection in the country. To effectively respond to these changing needs and realities, MOH in collaboration with its implementing partners have embarked on a new strategy, the National Strategic Plan on the Prevention and Control of STIs and HIV/AIDS, 2012-2016. It highlights strategic interventions need to control the epidemic incorporating both the national and international best practices to mitigate the impact of the epidemic on individual and national level.

This report aims to contribute to the Global AIDS Response Progress Report 2012. This is the first time that Bhutan is contributing to this global initiative and puts Bhutan now on the map of HIV/AIDS in the world. It provides information on the progress towards the achievement of the new targets stated in the 2011 Political Declaration on HIV/AIDS and in MDG 6 target 7. More importantly, it provides an overview of the trend of the HIV epidemic over time and the effectiveness of the national response, to date.

We would like to take this opportunity to thank all our developmental partners for their valuable support in developing this important report.

(Nima Wangdi)
Secretary
Ministry of Health

Secretary
Ministry of Health
Thimphu· Bhutan

ACKNOWLEDGMENT

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Moreover, we would especially like to thank the people who provided their valuable time and contribution in enabling the completion of this report.

We would also like to thank the UNAIDS Country Office in Kathmandu, Nepal for providing technical support, as well as our national and international development partners for their support and commitment in ensuring that this report is in line with the Bhutan's National Strategic Plan II for STIs, HIV and AIDS, 2012–2016 and other key national and international pacts.

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
BCC	Behavioural Change Communication
BHU	Basic Health Unit
BNCA	Bhutan Narcotics Control Agency
BSS	Behavioural Surveillance Survey
DOPH	Department of Public Health
DOTS	Directly Observed Treatment Short Course
FSW	Female Sex Worker
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GNH	Gross National Happiness
HISC	Health Information Service Centre
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IBBS	Integrated Biological Behavioural Surveillance
IEC	Information, Education and Communication
JDWNRH	JigmeDorjiWangchuck National Referral Hospital
MARP	Most-at-Risk Population
MCTC	Mother-to-Child Transmission
MDG	Millennium Development Goal
MoH	Ministry of Health
MSM	Men who have Sex with Men
MSTF	Multi Sectoral Task Force
NACP	National STI, HIV and AIDS Prevention &Control Programme
NCPI	National Commitments and Policy Instruments
NGO	Non-Government Organization
NHAC	National HIVAIDS Commission
NSP	National Strategic Plan
OI	Opportunistic Infection
ORC	Outreach Clinic
PMTCT	Prevention of Mother-to-Child Transmission
PWIDs	People Who Inject Drugs
RBA	Royal Bhutan Army
RBG	Royal Body Guard
RBP	Royal Bhutan Police
RENEW	Respect Educate Nurture and Empower Women
RHU	Reproductive Health Unit
RNR	Renewable Natural Resource
SBN	Sexual and Behavioural Network
STI	Sexually Transmitted Infection
TB	Tuberculosis

TOT	Training of Trainers
UN	United Nations
UNAIDS	Joint United Nations Programme on HIVAIDS
UNDP	United Nations Development Programme
VCT	Voluntary Counselling and Testing
VHW	Village Health Worker
WB	World Bank
WHO	World Health Organization
YDF	Youth Development Fund

1. EXECUTIVE SUMMARY

A. Inclusiveness of the stakeholders

The National STIs and HIV AIDS Prevention and Control Programme(NACP), under the Department of Public Health, led the preparation and submission of this report, with technical support from UNAIDS, Nepal. The report was prepared through desk reviews of current literature and discussions with key persons involved in the epidemic response at both the national and sub-national levels. A consultative meeting with key stakeholders and implementing partners from various sectors was organised for the National Commitments and Policy Instruments (NCPI) review. Their valuable experiences and knowledge contributed immensely to understanding the ground realities and devising future strategies.

B. Status of the epidemic

Bhutan is a low HIV prevalence county with different existing and emerging risk factors and vulnerabilities. The first case of HIV was detected in 1993 through a routine medical screening. Ever since, the cumulative number of HIV cases detected as of January 2012 stands at 270. Of these, 45 people are reportedly dead and 225 people are known to be living with HIV (PLHIV). Current evidence shows that the most predominant route of HIV transmission is heterosexual intercourse (90%), followed by mother-to-child transmission (MCTC) (8.1%) and less than 2 per cent of the transmission is through blood transfusion and injecting drug use.

Several factors contribute to Bhutan's vulnerability. Demographically, 60 per cent of the country's population is aged below 25 years. Growing trade with neighbouring regions such as north-eastern India, Nepal, and Bangladesh has led to high levels of cross-border mobility. Several neighbouring states in India face "concentrated" HIV epidemic, and with mounting evidence of high-risk practices in Bhutan, it is imperative to acknowledge that the epidemic is rapidly changing in Bhutan. The following evolving trends have been documented by population-based studies and programme reports:

- Increasing practice of multiple sexual partners
- High incidence of Sexually Transmitted Infections (STIs) among high-risk population
- Growing commercial sex work and high STI rates among female sex workers (FSWs)
- Evidence of men who have sex with men (MSM) and associated high-risk behaviours
- Growing evidence of drug use and unsafe injection of drugs
- High-risk behaviours in bridge populations comprising truckers, taxi drivers and non-Bhutanese migrants

C. Policy and programmatic response

Recognizing the possible future consequences of the HIV epidemic on individual and national development, the Government of Bhutan established the NACP in 1988, long before detection of the first HIV case. Five years later, in 1993, a National AIDS Committee (NAC) was set up to oversee and coordinate multi-sectoral efforts to ensure a harmonized response to the epidemic. This was subsequently followed by Royal Decrees, which provided the much needed political leadership and commitment. Treating the Royal Decrees as guiding principles in the fight against HIV in Bhutan, NACP initiated the National Strategic Plans for HIV AIDS and STI in Bhutan: NSPI 2008–2013 and NSP II 2012–2016. The proposed NSP II, incorporating lessons learnt from national and international experiences as well as recommendations from various reviews, was recently launched on December 1, 2011. The strategy proposes the use of strong and coordinated partnerships to prevent the spread of HIV, and mitigate the impact of the epidemic, and to create a supportive environment for people living with or affected by HIV and AIDS.

Table 1: Status of Global AIDS Response Progress Indicators

Indicator #	Indicators Titles	Value of		Data Source
		2012	Baseline	
Target 1. Reduce sexual transmission of HIV by 50 per cent by 2015				
Indicators for the general population				
1.1	Young people: knowledge about HIV prevention		Female: 21%	Multiple Indicator Survey, 2010
1.2	Sex before the age of 15		Female = 3.7%	
1.3	Multiple sexual partners		0.3%	
1.4	Condom use during higher risk-sex		20.4%	
Indicators for sex workers				
1.7	Sex workers: prevention programmes		18.2%	Behavioural Surveillance Survey (BSS) 2008
1.8	Sex workers: condom use with new commercial sex partners		37.5%	
			NA	
Target 2. Reduce transmission of HIV among people who inject drugs (PWIDs) by 50 per cent by 2015				
2.2	PWIDs: Condom use		53.7%	BSS 2008
2.4	PWIDs: HIV testing		28.2%	BSS 2008
2.5	PWIDs: HIV prevalence		NA	
Target 4. Have 15 million people living with HIV on antiretroviral therapy (ART) by 2015				
4.1	HIV treatment: ART		64	Program data
4.2	HIV treatment: 12 months retention		89%	ART data

2. INTRODUCTION

A. Country background

Bhutan covers an area of 38,394 sq. km[1]and is wedged between China in the North and India in the south on the southern slopes of the Eastern Himalayas. The north to south mountain band divides the country into three distinct regions with three major ethnic groups: Ngalops, Sharchops and Lhotshampaswho live in the Western, Eastern and Southern parts of the country, respectively. For administrative purposes, Bhutan is divided into 20 districts (dzongkhags) and 205 Gewogs (blocks).

Demographically, Bhutan is characterized by a high but gradually declining fertility rate and a declining mortality rate. According to the Dzongkhags Population Projection 2006–2015, the population is projected to reach approximately 757,042 in 2015, an increase of 19 per cent from the base population of 634,982[2] in 2005. The overall male-to-female ratio is estimated at 111 males per100 females. Approximately33 per cent of the Bhutanese population is aged below 15 years, and nearly 60 percent belongs to the economically active age group (15–64 years), whereas slightly less than 5 per cent of the population is older than 64 years.

Bhutan is largely an agrarian economy, with 79 percent of its population engaged in agriculture and livestock farming. According to Renewable Natural Resource(RNR) statistics 2000, only approximately 7.8 percent of the land is arable. Furthermore, due to the steep terrain, the use of farm mechanization remains limited and traditional farming practices are followed. In recent years, the contribution of secondary and tertiary sectors including electricity generation, construction and tourism has increased Bhutan's economic growth to a healthy rate of over 6 percent per year. Modern economic development is largely limited to the public sector as Bhutan's private sector is relatively underdeveloped. However, with a rapidly growing educated workforce, private sector development is becoming a compelling necessity.

The overall development has been guided by the concept of gross national happiness (GNH). It aims to balance spiritual and material advancement through sustainable and equitable economic growth and development, preservation and sustainable use of the environment, preservation and promotion of cultural heritage, and good governance

B. Health sector

[1]National Statistics Bureau (2007).Bhutan Living Standard Survey, 2007.RGOB, Thimphu

[2]National Statistics Bureau (2005).Dzongkhags Population Projection 2006–2015, 2008 RGOB, Thimphu

Bhutan continues to pursue the primary health care approach to provide basic minimum health care to the nation's scattered population. In the absence of private medical practice, the government is the sole provider of health care services. Pharmacies are generally privately owned; however, they operate under strict licensing arrangements in accordance with the Medicines Act of the Kingdom of Bhutan 2003 and the Medicines Rules and Regulations 2005. Within a span of four decades, the nation's health system has made tremendous progress: 90 per cent of the population now has access to basic health care services delivered through a network of 29 hospitals, 176 Basic Health Units (BHUs) and 514 Outreach Clinics (ORCs). The infant mortality rate has fallen from 70.7 per 1,000 live births in 1994 to 40.1 in 2005. Maternal mortality fell from 770 per 100,000 live births in 1984 to 255 in 2000.

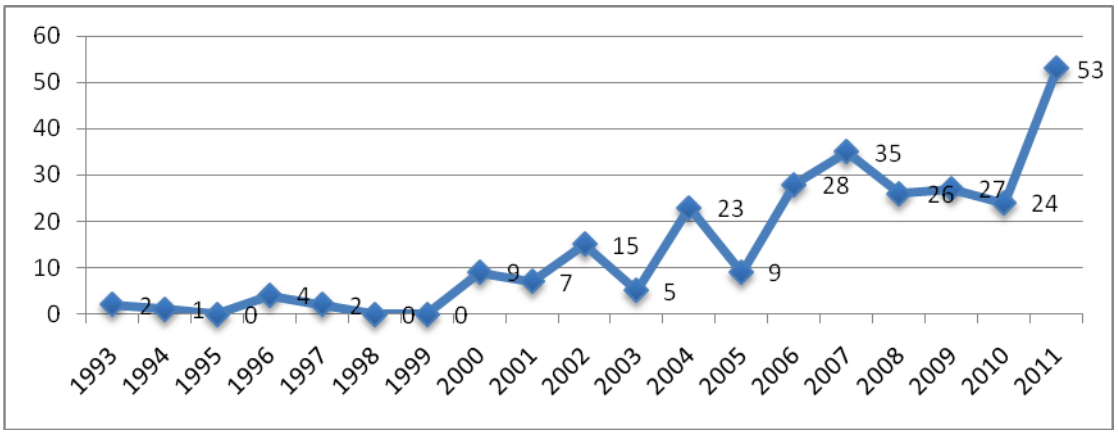
The health care delivery system is three-tiered and managed by trained health care providers at all levels. It is through this structure that STI and HIV services are also delivered. At the highest level is the JigmeDorjiWangchuck National Referral Hospital (JDWNRH) in Thimphu, along with regional referral hospitals at Gelephu in the Southern region and Mongar in the Eastern region. The district hospitals located in the district headquarters represent the middle level and BHUs linked to these hospitals represent the lowest level. Mobile clinics are regularly conducted in rural areas. Additionally, more than 1,000 Village Health Workers (VHWs) participate actively in outreach activities. In Thimphu and Phuentsholing (a business town on the Indian border), there are two stand-alone Health Information and Counselling Centres (HISC),which provide comprehensive STI and HIV services including outreach to high-risk and vulnerable populations.

3. OVERVIEW OF THE AIDS EPIDEMIC

A. Epidemiological profile

Although UNAIDS estimates that Bhutan has over 500 HIV infection cases, the official reported cases stand at 270 as of January 2012. Since the first detection of HIV in 1993, the number of cases reported annually has increased substantially. Since 2004, over 83 per cent of the total HIV cases (N=225) have been reported.

Figure 1: Total number of HIVAIDS cases detected since 1993



As in any developing country, the HIV epidemic in Bhutan is predominantly among the economically productive age group, with 87.4per cent of people living with HIV (PLHIV) aged between 20–49 years and 20 per cent between the ages of 15–24 years. Women represent 50 per cent of all cases detected and while the majority of infected women are aged below 30 years, a majority of the infected men are aged between 25 and 39 years. Overall, over half of the PLHIV (59%) are aged between 25–39years.

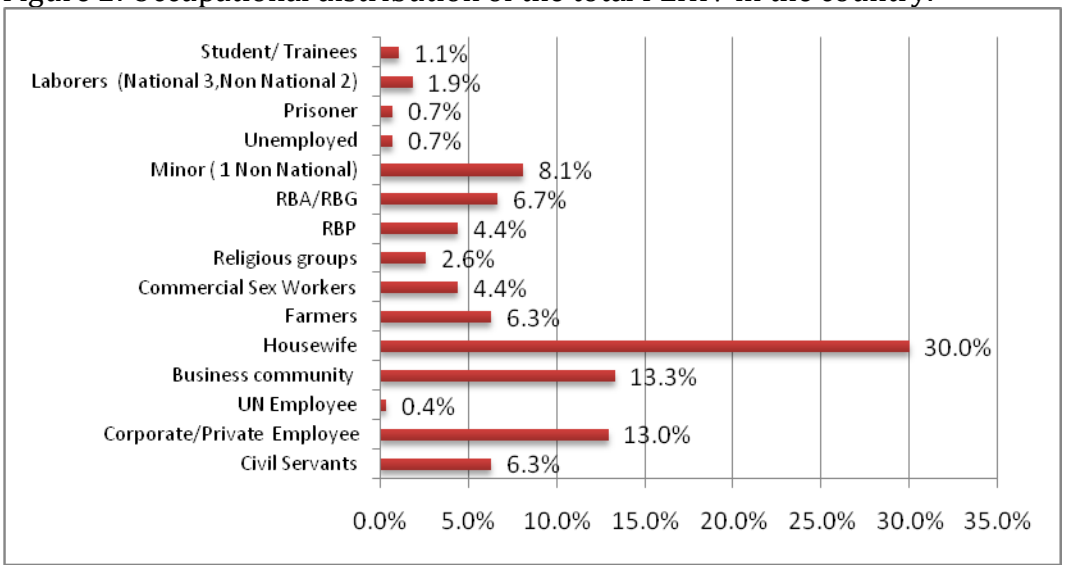
Table 2: Distribution by age group of total PLHIV in the country

Age Groups (in years)	Male	Male %	Female	Female %	Total	Total %
<5	4	3.0%	14	10.4%	18	6.7%
5–14	2	1.5%	2	1.5%	4	1.5%
15–19	1	0.7%	9	6.7%	10	3.7%
20–24	11	8.1%	33	24.4%	44	16.3%
25–29	41	30.4%	32	23.7%	73	27.0%
30–39	54	40.0%	34	25.2%	88	32.6%
40–49	21	15.6%	10	7.4%	31	11.5%

50+	1	0.7%	1	0.7%	2	0.7%
Total	135	100.0%	135	100.0%	270	100.0%

Analysis of the current data indicates that out of the total number of 135 female PLHIV, the majority (60%) are housewives. Private sector employees and the business community accounts for approximately 26 per cent of all detected cases, whereas the uniformed personnel (Royal Body Guard (RBG)/Royal Bhutan Army (RBA)/Royal Bhutan Police (RBP)) account for 11.1 per cent of all detected HIV cases.

Figure 2: Occupational distribution of the total PLHIV in the country.

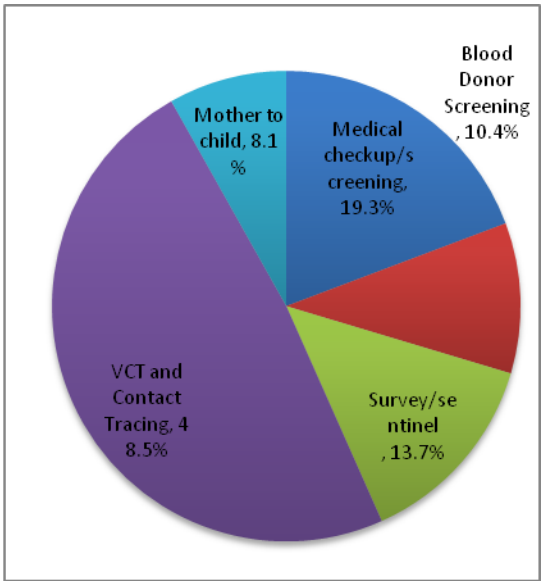


It is important to note that ever since the voluntary counselling and testing (VCT) services and other preventive, treatment and care components have been integrated with the health delivery system, the annual reported cases have substantially increased and over 50 per cent of the HIV cases (N=114) were reported between 2007 and June 2010. Current evidence shows that the most predominant route of HIV transmission is heterosexual intercourse (90%), followed by mother-to-child transmission (MCTC) (8.1%), and less than 2 per cent of HIV transmission occurs through blood transfusion and injecting drug use.

Table 3: Mode of transmission

Mode of Transmission	**No of PLHIV**	**Total percent**
Mother to child	22	8.1%
Intravenous drug use (probable)	3	1.1%
Blood transfusion (outside)	2	0.7%
Heterosexual route	243	90.0%
Total	270	100.0%

Figure 3: Mode of detection



With the decentralization of HIV services, facilities for VCT for HIV are available in all district hospitals and in the stand-alone HISCs located in Thimphu and Phuentsholing. Confirmatory tests are available at the National Referral Hospitals in Thimphu. Analysis of the care and treatment data shows that a majority of the HIV cases (48.5%) have been diagnosed at the VCT centres and through contact tracing.

In addition to expanding and integrating VCT services, the Ministry of Health recognized the importance of integration of HIV prevention, care and treatment in antenatal clinic (ANC) service delivery and issued national guidelines for prevention of mother-to-child transmission (PMTCT) and paediatric treatment in 2006. These were subsequently included in the HIV care and treatment guidelines, thereby strengthening the PMTCT through the decentralized ANC service delivery system.

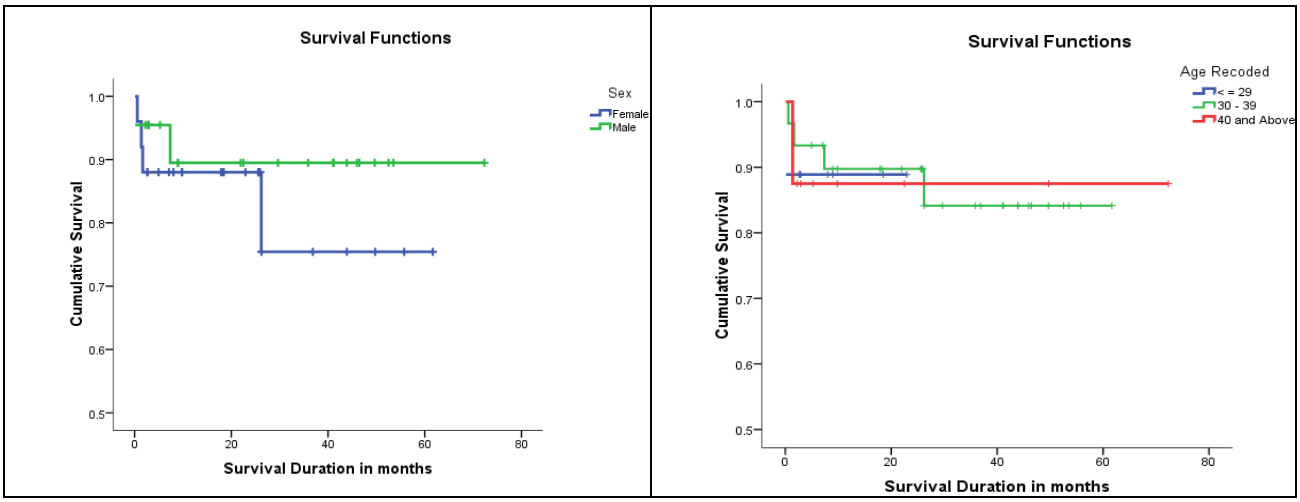
Antiretroviral therapy (ART) data from the care and treatment unit at the JDWNRH indicates that as of January 2012, the total number of PLHIV ever on ART was 78,out of which 15 died while on ART. The total number of PLHIV successfully taking ART is 63.

Table 4: Total Number of PLHIV on ART

1.	**Total cases put on ART Treatment**	**78**
2.	Total Deaths after ART	15
3.	Total Living with ART	63

Out of the 15 ART patients who died, 23.5 per cent were 29 years old or younger. Age-wise analysis of deaths showed that the total number of persons dying during ART included 16.7 per cent of those in the age group of 30–39 years and 30 per cent of those in the age group of 40 years or older. More women were on ART (56.3%) as compared to men. The proportion of deaths while on ART was 22.2 per cent for women and 18.5 per cent for men. Though a higher number of women than men had died, the difference was not statistically significant. Despite the missing information, the mean survival time of patients on ART was 62.2 months (95% CI: 54.6 and 69.8).

Figure 5: Survival curve by sex and age



Of the 63 patients on ART, only one had tuberculosis (TB). Approximately 16 per cent of the patients had CD4 <100 cells× 10^6 l at the baseline. The median CD4 cell count was 163 with 182 and 189 cell counts at 12 and 24 months, respectively. Though the numbers were small, the results are comparable to Indian findings.

B. Risk and vulnerability

In light of recent evidence, HIV in Bhutan must be primarily considered to be a Sexually Transmitted Infection (STI). STIs are important biomarkers of high-risk behaviour for HIV transmission. In countries with low HIV prevalence, like Bhutan, focus on controlling STIs can be an effective strategy for reinforcing prevention and ensuring that conditions remain unfavourable for HIV.

There is growing evidence of high-risk behaviours among specific population groups, which threatens to jeopardize the current response to control the transmission of STI and HIV. PLHIV have been detected in 18 of the 20 districts and in most occupational groups, including female sex workers (FSWs), people who inject drugs (PWIDs), truck drivers, monks, prisoners, armed forces, police, business owners and employees, farmers and housewives. Notably, almost half of the PLHIV have been detected in Thimphu and Phuentsholing.

Risk behaviours for the transmission of STIs and HIV in Bhutan include prevalence of STIs, high levels of casual sexual encounters, consistently low condom use, increasing transactional sex, risk of drug use, and high mobility.

Multi-partner sex practices and low condom use:
Sexual norms are perceived to be relaxing, with multiple concurrent relationships and casual sexual encounters becoming increasingly common. A rapid assessment on Sexual Behaviours and Networks (SBN) in Thimphu between October 2009 and January 2010 noted a higher concurrency of sexual practice in Thimphu. Extramarital and premarital

sex was common among males and females in both urban and rural settings in Bhutan. Among those who engaged in extramarital or premarital sex, the number of sexual partners other than their spouses ranged from 2.2 to 2.7 during the six months prior to the assessment.[3]Condom use during the last high-risk relationship between bar girls and patrons of hot spots (male and female) was only approximately 50 per cent and consistent condom use for bar girls and patrons of hot spots was 33 per cent and 40 per cent, respectively.

Reports of high rates of Sexually Transmitted Infections (STIs)

The WHO bulletins for 2008 and 2009 reported STI cases (excluding HIV) to have increased from 1,243 cases in 2008 to 1,745 in 2009. A rapid assessment on SBN in Thimphu[2] showed that 20 per cent of male and 29 per cent of female respondents reported having one episode of STI during the six months prior to the assessment.

Growing commercial sex work and high STI rates among FSWs

Sex work has been reported in the border town of Phuentsholing and is perceived to be spreading to Bhutan's interior districts. The construction of hydropower plants and expansion of road networks has led to a growing demand for paid sex by immigrant workers, truckers, and transport workers. This has also led to a rise in the incidence of STIs among FSWs. In a survey conducted by WB in 2006, 72 per cent of the surveyed FSWs in Phuentsholing tested positive for syphilis. Moreover, the sex industry operates in an informal setting, thereby creating additional challenges for providing services to this population.

Evidence of men having sex with men (MSM)

The general population survey 2006 showed that 1.7 per cent of the surveyed men in urban areas reported same-sex activity during the past year. The rapid assessment on SBN in Thimphu[2] found that 2 per cent of the men reported that their first sexual partner was someone of the same gender. There are currently no known MSM cruising sites; however, there is evidence from the rapid assessment on SBN in Thimphu[2] that bars, restaurants and cafes serve as venues for men to pick up other men. Sexual risk behaviour is not yet understood and currently no program interventions for MSMs are in existence.

Growing evidence of drug use and risk behaviour

Two studies conducted in 2005–06 [N = 200] and 2009 [N = 991] confirmed the presence of injecting drug use with 19 per cent and 11 per cent of the respondents of the respective surveys reporting to be injecting drugs. The National Baseline Assessment 2009 (NBA) found PWIDs in 8 out of 14 Dzongkhags (total 20 districts). Sharing of needles and syringes was found to be common with 45 per cent and 19 per cent of respondents of the 2005–06 and 2009 surveys respectively reporting to have shared needles. The 2005–06 survey also found condom use to be low, with 38 per cent and 55 per cent of the respondents reporting use of condoms with regular and

[3]Ministry of Health, Royal Government of Bhutan, *General Population Survey for HIV AIDS*, Thimphu, 2008.

commercial partners respectively during their last sexual encounter. STIs were reported by 8 per cent of the respondents who reported abnormal genital discharges.

The trends were reaffirmed by the NBA, which revealed low condom use and high STI rates among drug users, with 15 per cent and 34 per cent of the sexually active male and female drug users respectively reporting to have symptoms of STIs. Seeking treatment of STIs was rare and only a few drug users ever accessed treatment.

Higher risk behaviour among bridge populations

The Behavioural Surveillance Survey (BSS) 2008 among the general population showed that a high percentage of truckers, taxi drivers and non-Bhutanese migrants frequented FSWs during the past 12 months. Condom use during the last sexual encounter with a FSW was at 34.5 per cent among non-Bhutanese immigrant workers in Thimphu. Awareness of and access to health services was found to be low among these population groups, with almost 56 per cent of migrant workers who reportedly had an STI during the past one year reporting to "do nothing" or "seek advice from friends".

Growing evidence risk behaviour among youth

Four out of five out-of-school youth reported having had sex during the past 12 months (83.3%males, and 81.5% females). The proportion was lower among secondary/higher secondary and college/institution students, with 35.1 per cent of the males and 12.5 per cent of the females reporting to have engaged in sexual activity during the past year. Of the out-of-school youth who had reported to have had sex, 38.1 per cent of the respondents reported to have had two or more sexual partners during the last 12 months (39.8% among males, 36.6% among females), whereas 51.3 per cent of the secondary/higher secondary and college/institution students who had reported to having had sex reported multiple sex partners, that is, two or more partners during the last 12 months (61.7% among males, 16.7% among females). In the armed forces, 44.7 per cent of the respondents reported to have had two or more sexual partners during the past 12 months, of which 41.5 per cent did not use a condom during their last sexual encounter.[4]

[4]New Era, *Knowledge, Attitude, Practice and Behaviour Study on HIV/AIDS/STI Among Uniformed Personnel, In School and Out of School youth in Bhutan - 2009*, April 2010.

4. NATIONAL RESPONSE

A. Leadership and political commitment

Recognizing the consequences of the HIV AIDS epidemic on individual and national development, the government initiated the National STI and HIV AIDS Prevention and Control Programme (NACP) in 1988. Five years later in 1993, a National AIDS Committee (NAC) was established to oversee and coordinate multi-sectoral efforts in order to ensure a harmonized response to the epidemic. The NAC was later restructured to form the National HIV and AIDS Commission (NHAC) as the coordinating body in the national response with the mandate of formulating policies on the prevention and control of STDs and HIV AIDS, as well as mobilizing commitment and collaboration of public/private sectors, civil society and communities. The commission includes 11 members from different ministries, civil society and the private sector. The commission meets a minimum of twice a year to review the implementation of the National Strategic Plan (NSP) and to provide policy directions.

Prevention and treatment activities for HIV have been planned and implemented over the years through the Short-Term Plan (STP). These activities focus on prevention, capacity building, establishment of testing facilities and case detection. In 1990–93, the STP was converted into a three-year Medium-Term Plan (MTP-I), focusing on condom promotion, strengthening of infrastructure, training of health workers, strengthening programme monitoring and evaluation, and preparing ground work for HIV care and management. The second Medium-Term Plan(MTP-II) was developed in 1995 with financial assistance from WHO and Danida, and included a multi-disciplinary framework to involve various government ministries and the private sector to prevent the spread of HIVAIDS in the country. [5]

In a feature unique to Bhutan, apart from the coordinated government efforts, the testimony of commitment to stem the spread of HIV is the explicit top-level initiative from the Royal Family. On May 24, 2004, the Fourth King, His Majesty JigmeSingyeWangchuk, issued a Royal Decree to participate in the HIV prevention and to respect the rights of PLHIV. During the same year, the Royal Edict broadened the scope of the organizational and individual-level participation in HIV prevention. Further, with the growing rate of infection among the younger generation, the Fifth King, His Majesty JigmeGesarNamgyelWangchuck, in 2005, proclaimed to the nation,

[5] National Strategic Plan for Prevention and Control of STIs and HIVAIDS (2008). Department of Public Health, MoH,Thimphu, Bhutan.

"HIV AIDS is no exception. The youth will use their strength of character to reject undesirable activities; their compassion to aid those afflicted and their will to prevent its spread." Her Majesty, the Queen AshiSangayChodenWangchuck,also works with the grass-root communities for HIV prevention and reproductive health.

Along with political leadership and commitment, the NSPs guide the efforts to prevent and control HIVAIDS and STI in the country through coordinated partnerships. The most recently endorsed NSPII (2012–2016) builds on past achievements, existing gaps, and focuses on scaling up of existing prevention interventions, and making them more cost effective in order to ensure accessibility to underserved and unreached most-at-risk populations (MARPs).

B. HIV prevention, treatment, care and support strategies

Although prevention efforts have been conducted since 1988, the programme review of 2011 was the first systematic nationwide effort to assess the national response and highlighted key findings that necessitated for adjustments in the national response. Thus, in light of the recommendations, NSP II focuses on reaching the key affected populations and MARPs with the following guiding principles as the foundational pillars:

1. The "Three Ones"

The country is committed to apply the 'Three Ones' principle being promoted by UNAIDS. Currently, there is one action framework on HIV AIDS; one AIDS coordinating authority; and one agreed national monitoring and evaluation framework.

2. Universal access and the millennium development goal on HIVAIDS

Reaching the Millennium Development Goal 6 on HIVAIDS—to halt and reverse the spread of the epidemic by 2015—requires far greater access to STI and HIV prevention and treatment services than are currently available for most-at-risk, at increased risk, and vulnerable populations.

3. Rights and public health

The protection of human rights, both of those vulnerable to infection and those already infected, is not only ethical, but also produces positive public health results on STI and HIV. In particular, the following points have also become increasingly clear:

- National and local responses will not work without the full engagement and participation of those affected by HIV, particularly the PLHIV
- The human rights of at-risk and vulnerable populations must also be respected and fulfilled for the response to STI and HIV to be effective.

4. Evidence-based and results-oriented programming

NSP II utilises the two fundamental principles of "evidence-informed programming" and "result-oriented" programming. NSP II aims to increase the understanding and realization of the importance of translating evidence-based HIV prevention

programmes into practice. Being result-oriented, NSP II is focused on achieving results at two levels: in outcomes, that is, in terms of behaviour change and patterns of service use, and in impact, that is, in terms of reduction in new STI and HIV infections

5. Cost effectiveness, cost efficiency and prioritisation in the context of Bhutan

Currently, in-country resources devoted to the national response to STI, HIV and AIDS are limited, and key external resources will end soon. Therefore, NSP II ascribes high importance to resource allocation. Prevention interventions that target MARPs are proven to be more cost effective compared to those targeting the general population. Recent work in Asia using the Asian Epidemic Model strongly indicates that the major routes of STI and HIV transmission remain concentrated in population groups that practice high-risk behaviours and their sexual partners.

6. Gender equity

NSP II is responsive to the gender needs of both males and females, and provides specific recommendations including responding to gender-based stigma and discrimination towards FSWs and MSM, reviewing the criminalisation of female sex work and sodomy (unnatural sex acts) and enhancing access to sexual and/or reproductive health services for adolescents, women, and MSM. The 2011 review provides recommendations related to gender, which are also included in NSP II, including recruitment of female counsellors, outreach and peer workers to work effectively with most-at-risk and vulnerable women, and the inclusion of gender-specific indicators to ascertain gender-related impact of the national response. NSP II also includes provisions for the effective inclusion of women and men who have sex with men among key stakeholders in national response program design, implementation and review.

In light of the guiding principles, NSP II has five main strategic priority areas that comprehensively address the current epidemiological situation in the country as well as regional recommendations:

- Strategic priority I: STI and HIV AIDS prevention efforts for potentially vulnerable general population and MARPs, and targeted interventions for the key affected populations
- Strategic priority II: Treatment and care for people living with/affected by HIV AIDS (PLWHA).
- Strategic priority III: Institution strengthening
- Strategic priority IV: Strategic information, M&E and research
- Strategic priority V: Partnership and coordination

C. Enabling Environment

Multi-sector partnership has been the corner stone of the country's response to HIV AIDS. Thus, in light of the past experiences and positive evidence, the NSP II calls for strong participation of local communities and community-based approaches for scaling-up actions, and responding in a more effective way to obtain key results. Building on the

current partnerships with government ministries, civil society and international organizations, the future strategies promote increasing involvement of these stakeholders in the national response through:

- Inclusion: systematic inclusion of civil society (NGOs, CBOs) in coordinating mechanisms/bodies responsible for designing, reviewing and supporting the national response
- Participation: establishment of partnership and referral arrangements to link government and civil society organisations and the programmes they operate to the national response
- Support to the formation of networks and self-help groups among key affected populations including sex workers, MSM, PWIDs, PLHIV, and other affected populations

Population	Constituency	Implementing Partners
Youth Population	Government Consistency	Royal University of Bhutan Royal Institute of Health Sciences
MARPs and High-risk Population	Government Constituency	Ministry of Health (MoH) Ministry of Labour and Human Resources (MoLHR) Ministry of Works and Human Settlement (MoWHS) DratshangLhentshog Bhutan Narcotic Control Agency (BNCA)
	NGO and Private	Bhutan Chamber Of Commerce and Industries (BCCI) Youth Development Fund (YDF) RENEW Lhaksam (Positive network)
	Armed Forces	RBA, RBG and RBA
General Population	Ministry of Education Ministry of Information and Communication (MoIC) National Commission for Women and Children (NCWC) Dzongkhag health services National Women's Association of Bhutan (NWAB)	

5. FINANCING

A. Financing the national response

In the past, the main financial support for the NACP was provided by the World Bank Project (2004–2011, total budget of USD 6.16 million) that ended in June 2011. The GFATM Round 6, (2008–2012, total budget of USD 3.5 million) will also end in 2012. UN organizations including UNDP, UNAIDS, UNICEF, UNFPA and WHO have also provided funding for the national AIDS response; however, a part of it was provided directly to the implementing agencies, and not routed through the Ministry of Health (MOH). Government funds to support STI, HIV and AIDS are estimated to be at USD 200,000 per year. There is no major financial commitment to NACP apart from government funds for the period after 2012.

6. PROGRESS AND CHALLENGES

A. Progress

Through program implementation with support from the WB (2004 to 2011) and the Global Fund Round 6 (2008–2013), general awareness levels about STIs, HIV and AIDS have improved. The health system was strengthened through the development of national guidelines (including guidelines for voluntary testing, ART, opportunistic infection (OI) and STI management, and PMTCT) for service delivery. Both at central and district levels, capacities have been built through trainings and training of trainers (TOT) in blood safety, laboratories, waste management and infection control. HIV has been mainstreamed in the education system through life-skill based STI/HIV prevention education for in-school and out-of school youth and vocational trainees. Multi-sectoral Task Forces (MSTF) have been established in all 20 districts, functioning under the chairpersonship of the district governors, and have worked to raise awareness among the general population and support the implementation of HIV activities.

STI/HIV services were strengthened through training of health care providers and district teams in STI diagnosis and treatment and in HIV AIDS management and care. In all the 20 districts, VCTs have been established and integrated into the hospital settings to provide countrywide HIV counselling and testing, especially to pregnant women. On an average, more than 1,000 people access VCTs per month and the HIV positivity is 0.13% (Data from Q4 2009 and Q1 2010 from 20 VCTs), higher than the estimated adult prevalence. Of the 20 VCTs, two free-standing VCT cum Health Information Service Centers (HISC) have also been set up in Thimphu and Phuentsholing to address the needs of young people and MARPs. Data shows that the average HIV positivity at these centres is 0.5% (12-month data from the year 2009–10). Approximately 1.4 million condoms were distributed in 2009 through various outlets. Currently, ART is provided free of cost to 64 people and a PLHIV support group (Lhaksam) has been established.

Several studies have been undertaken to inform the program:

- A rapid assessment on sexual behaviours and networks in Thimphu, conducted by the Center for Global Public Health (CGPH), University of Manitoba, Canada with support from Government of Bhutan between October 2009 and January 2010
- National Baseline Assessment (NBA) among drug users, 2009
- KABP survey on HIV among uniformed personnel, in and out of school youth, 2009
- Quality assessment for youth friendly health services, 2009
- Health Facility Survey, 2009
- Behavioural Sentinel Surveillance among the general population, 2006 and 2008

B.Challenges and gaps as per the national review

- HIV services in Bhutan are mostly facility based. The system has limited outreach or linkages to vulnerable population and MARP groups. Even the MSTFs[6], which were established to support the HIV program at the district level, are often not effective and lack community participation and resource mobilization.

- The health system has limited capacities to address the specific treatment and care needs of MARPs. The NBA among drug users conducted in the year 2009 found that drug users are not accessing voluntary testing facilities and STI/HIV services. The World Bank Aide Memoire, 2010 indicates that the program needs to reach hot spots and increase its focus on MARPs on an urgent basis.

- The health system is not currently geared to deliver the (WHO recommended) "comprehensive package" of services essential for the prevention of HIV among MARPs.

- The quality of health services needs to be improved. The 2009[7] Health Facility Survey recommends that the VCT/STI services need to be improved. The same survey also found that 60 per cent of the facilities (BHU I and above) did not have adequate STI/HIV Information, Education and Communication (IEC) materials and recommends that these should be made available in all health facilities.

- Services for TB patients need to be improved, including counselling and routine HIV testing, through establishment of better collaborations. This was validated by an external national TB program review conducted in 2010.

- The monitoring system is not integrated with the Health Management Information System (HMIS) and is unable to capture access of MARPs to services adequately

- Assessing the true incidence of STIs in Bhutan remains a challenge, due to the limitations of sentinel surveillance, assumed gross under reporting, as well as non-disclosure of infections and self-treatment by many persons. Additionally, some people also seek treatment from border towns in India, and from Indian Military Training Team hospitals in Bhutan, thereby making the assessment of STI incidence difficult.

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

[7] Health Facility Survey, 2009

7. WAY FORWARD

In the context of low HIV prevalence in Bhutan, STI programming has much to offer in terms of public health. Although currently the burden of disease consequent to STI-related morbidity is probably many times more important than that of HIV (as many as approximately 5,000 new cases of STIs per annum), thereby justifying STI programming as a public health priority in its own right, there are others issues of related importance. These include the continuing and contemporaneous feedback that incident cases of STIs (particularly male urethral discharge) give with regard to monitoring trends in sexual risk behaviour. Additionally, if STI control is implemented effectively, it is highly likely to make a major contribution to HIV prevention.

Given the ambiguity regarding the continuation of external funding in the future, Bhutan needs to consider establishing clear priorities for the future possibilities of a reduction in overall funding, continuation of external funding at current levels, and availability of additional funding. For example, much of the past effort has gone into integrating services for STIs and HIV within the existing services, particularly health services, including the development of guidelines, training, and integration with existing clinics, which is likely to be sustainable; hence, any grant proposal must clearly indicate the focus to be on initiatives that are likely to lead to sustainable capacity development and reaching the underserved.

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