National HIV, AIDS and STI Strategic Plan 2017-2023

"On Fast-Track to Ending AIDS"

National HIV/AIDS and STIs Control Programme (NACP),
Department Of Public Health, Ministry of Health

ACKNOWLEDGMENT

The National HIV, AIDS and STI Control Programme (NACP) acknowledge the contributions of each person who, in diverse ways contributed to the successful development of the National HIV/AIDS and STI Strategic Plan III. The inputs and contents of this strategic plan were derived from several participatory consultations held with key stakeholders and beneficiaries. We wish to express our gratitude to the various organizations that contributed towards the development of the Strategic Plan. We also wish to extend our sincere appreciation to the members of the Task Team for their guidance and technical support. Finally we extend our appreciation to the WHO country office and UNAIDS for mobilization of technical support.

FOREWORD

Coinciding with the historic year of the royal birth of His Royal Highness Gyalsey Jigme Namgyel Wangchuck, the National HIV, AIDS and STI Control Programme (NACP) is pleased to publish the National Strategic Plan III (2017-2023) which marks a milestone in our nation's response to the HIV/AIDS epidemic. This seven-year strategy reflects the progress made in achieving a clearer understanding of the challenges posed by the epidemics and also the increasing unity of purpose among all the stakeholders, who are driven by a shared vision to attain the highest impact towards our long-term vision of ending the AIDS epidemic as public health threat in Bhutan.

The National Strategic Plan III outlines key interventions to bring the country close to the realization of its vision. Since the detection of first case in 1993, much has been done and much achieved. Building on strong leadership of our benevolent Kings and political commitments, the NSP III highlights the collective and effective interventions to break the HIV and AIDS chain. The NSP III adjusts to the changing international environment and scientific evidence. It adheres to the Sustainable Development Goals (SDG) of 2015 and to the Political Declaration on Fast-Tracking the AIDS response of 2016, adopted by the UN General Assembly, UNAIDS strategic guidance on Fast Tracking to Zero and Ending AIDS, and WHO's new HIV and STI treatment guidelines.

The National Strategic Plan III will be implemented by all sectors of government and civil society, under the technical guidance of the National HIV/AIDS and STI Control Programme with high level leadership from the National AIDS Commission (NAC) to accelerate the scale up of HIV prevention, care and treatment services and ensure collecting robust strategic information to monitor and guide the national response. It is through this comprehensive plan that interventions to reduce the morbidity and mortality of HIV/AIDS and STI can be implemented. Guided by this Strategic Plan, we now have a common responsibility to combine our individual and collective resources to ensure an AIDS free society for our future generation.

Tashi Delek!

Dr. Ugen Dophu

Secretary

Ministry of Health

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Acronyms

ADR	Antiretroviral drug resistance
AHP	Adolescent Health Programme
AIDS	Acquired Immunodeficiency Syndrome
AMR	Antimicrobial resistance
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral (drugs)
BCC	Behavioural Change Communication
BHU	Basic Health Unit
BNCA	Bhutan Narcotic Control Agency
BSS	Behavioural Surveillance Survey
CBO	Community-Based Organization
CCM	Country Coordination Mechanism
DIC	Drop-in Centre
DOPH	Department of Public Health
DOTS	Directly Observed Treatment Short Course
DYS	Department of Youth and Sports
DVED	Drug, Vaccine and Equipment Division
ELISA	Enzyme linked immunosorbent assay
EPI	Expanded Programme on Immunization
EQAS	External Quality Assurance System
GNHC	Gross National Happiness Commission
HBsAg	Hepatitis B Surface Antigen
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HISC	Health Information Service Centre
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPV	Human Papilloma Virus
IBBS	Integrated Biological Behavioural Surveillance

IEC	Information, Education and Communication
JDWNRH	Jigme Dorji Wangchuck National Referral Hospital
MCH	Maternal and Child Health
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MNCH	Maternal Neonatal Child Health
MoE	Ministry of Education
MoH	Ministry of Health
MoIC	Ministry of Information and Communication
MoLHR	Ministry of Labour and Human Resources
MSM	Men who have Sex with Men
MSTF	Multi Sectoral Task Force
NACP	National HIV/AIDS and STI Control Programme
NCWC	National Commission for Women and Children
NEQAS	National External Quality Assessment System
NGO	Non-Government Organization
NHAC	National HIV/AIDS Commission
OI	Opportunistic Infection
OPD	Out-patient Department
ORC	Outreach Clinic
OST	Opioid Substitution Therapy
PCR	Polymerase Chain Reaction
PEP	Post-Exposure Prophylaxis
PMTCT	Prevention of Mother-To-Child Transmission
PrEP	Pre-Exposure Prophylaxis
RBA	Royal Bhutan Army
RBG	Royal Body Guard
RBP	Royal Bhutan Police
RDS	Respondent Driven Sampling
RENEW `	Respect Educate Nurture and Empower Women
RHU	Reproductive Health Unit
SRH	Sexual and Reproductive Health

STI	Sexually Transmitted Infection
TB	Tuberculosis
TOT	Training-of-Trainers
TPHA	Treponema Pallidum Haemagglutination Assay
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
VCT	Voluntary Counselling and Testing
VHW	Village Health Worker
WB	World Bank
WHO	World Health Organization
YDF	Youth Development Fund
YFHS	Youth Friendly Health Services

EXECUTIVE SUMMARY

The National HIV/AIDS and STIs Control Programme (NACP), Ministry of Health, initiated the development of the new National Strategic Plan III for 2017 - 2023. The process included a desk review and consultations with stakeholders to make an independent, external review of the Bhutan national AIDS response over the last 5 years, and support the Bhutanese authorities and civil society to develop a national strategy to Fast-Track the national HIV response by 2020, towards ending the AIDS epidemic by 2030.

The National Development Policies, Health Policy Implementation and Management:

The Royal Decree on HIV and AIDS issued by His Majesty the Fourth King on the 24th of May 2004, which serves as the guiding principle in the fight against HIV and AIDS, calls for all members of the society to help prevent HIV and AIDS and provide care and compassion to those infected. Under the vision of the Kings and the Five-Year Plans developed by the National Planning Commission (Gross National Happiness Commission) Bhutan is pursuing the developmental philosophy of Gross National Happiness (GNH), which upholds strong principles of equality and rights for all human beings.

The constitution of the Kingdom of Bhutan guarantees free access to basic public health services in both modern and traditional medicines and security in the event of sickness and disability or lack of adequate means of livelihood for reasons beyond one's control. The National Health Policy provides the general direction to guide the government in achieving the national and international health goals within the spirit of social justice and equity.

The National HIV/ AIDS and STIs Control Programme (NACP), Ministry of Health, is accountable for the implementation of the National HIV, AIDS and STI Prevention and Control Strategic Plan through the public health service infrastructure at national, regional and local levels. Its implementation takes place in coordination with other public entities, and includes services provided by civil society and non-governmental organizations.

The national health system provides services through health facilities, which include a national referral hospital and 4 other regional referral hospitals, 21 district hospitals and 207 Basic Health Units. BHUs have also outreach clinics, which are visited by BHU staff according to established schedule. BHUs also link with the voluntary village health workers (VHW) in the communities.

National STI, HIV and AIDS Strategic Plans

The National Strategic Plans guide the HIV/AIDS and STI response in the country. The period of the NSP III is 2017-2023, to synchronize with the implementation of the 12th Five Year National Development Plan. NSP III implementation will be reviewed during the midyear of its implementation (2020) for relevance and effectiveness in achieving the targets, and will be adjusted as necessary. The NSP III aims to inform national, district, community-level stakeholders and implementing partners of the strategic directions, which are to be taken into consideration when developing their respective strategies and implementation plans for HIV, AIDS and STI response.

The NSP III 2017-2023 was developed through a comprehensive consultation process. It builds on the successes of the previous strategies and addresses the challenges identified in the Mid Term Review of the NSP II 2012-2016 and in the consequent consultation process. It draws on the lessons learnt from the current Global Fund grants' implementation, and places strong emphasis on strengthening the multi-sector and civil society collaboration and engagement.

The Strategic Directions reflect the priorities identified in the consultation process and the lessons learned from the previous NSP II. The strategic directions for the NSP III are:

1. Prevention of HIV transmission through outreach and in-reach
2. Universal access to HIV and STI testing and screening.

3. Comprehensive continuum of care for PLHIV and people with STI and TB/HIV co-infection
4. Strategic information for evidence informed programming.

Crosscutting strategies:

1. Development of synergies: Governance, Partnerships and Programme management
2. Improving Health and Community systems for health including resource mobilization for sustainability of HIV response.

Bhutan's International commitments:

The NSP III adjusts to the changing international environment and scientific evidence. It adheres to the Sustainable Development Goals (SDG) of 2015 and to the Political Declaration on Fast-Tracking the AIDS response of 2016, adopted by the UN General Assembly, and adopts UNAIDS strategic guidance on Fast Tracking to Zero and Ending AIDS, and WHO's new treatment guidelines.

In the NSP III Bhutan commits to Fast Tracking the HIV and AIDS response through task sharing and muti-sector approach. The first phase of the NSP III, during 2017-2020, aims to reach the 90-90-90 targets: 90% of key populations tested for HIV and knowing their results, 90% of people infected with HIV placed on ART, and 90% of these adhering to treatment resulting in suppressed viral load. The first fast tracking phase also aims to reach 90% of key populations with effective prevention.

Bhutan also commits to "Ending AIDS" by 2030 through achieving the 95-95-95 target: 95% of key populations tested for HIV and knowing their results, 95% of people infected with HIV placed on ART, and 95% of these adhering to treatment resulting in suppressed viral load.

The strategic directions reflect the status of the epidemic in Bhutan:

- The HIV epidemic in Bhutan is primarily driven by sexual transmission. The increase in HIV infection diagnoses from 2006 onwards can be attributed to investment in scaling up of HIV prevention, testing and control, which indicates progress in programme implementation.
- The overwhelming majority (90%) of people living with HIV, including the newly diagnosed, continue to be infected through unsafe sexual practices, followed by vertical transmission (8%). Geographically, HIV cases have been reported from all 20 districts, with the majority of reported cases in the urban towns of Thimphu, Phuntsholing and Samdrupjongkhar.
- Reflecting the drivers of the epidemic, key and vulnerable populations remain the focus of the National HIV Strategic Plan. These populations include female sex workers, clients of sex workers, transgender people, gay men and other men who have sex with men, people who inject drugs, incarcerated people, mobile, migrant and displaced populations, young people and uniformed services. Pregnant women are the focus of the National Strategic Plan, aiming at **elimination of vertical transmission**
- Innovative service delivery approaches include intensified testing to reach key populations through facility-based outreach and community-led in-reach; linking testing to treatment and retention with referral systems and case management that will be introduced systematically in all facilities; introducing test for triage, initiated through community-led HIV screening; continuum of care in an integrated systems for health approach, which includes both facility based and community health services; and updating the capacity and competence of health service providers, including task sharing.
- The strategies and interventions developed through consultations build on an increasing collaboration between the government and the civil society organizations, linking the facility-based health services with community level service provision, and ensuring the quality of these services through extensive training and capacity building of the community-based organizations and of all service providers.

Development synergies: governance, partnerships and programme management

- NSP III will be implemented within Bhutan's 12th Five year framework. The leadership in responding to the epidemic continues to be provided by the Ministry of Health. The engagement from non-health sectors, NGOs, civil society organization, informal networks, private sector, bilateral and international agencies will be strengthened. Adequate resources and technical support are required to strengthen the management and human capacities of the health services and of civil society organizations, the crucial partners in the NSP III implementation.
- Sustained domestic funding of the national response to HIV and AIDS has to be secured. Resources will be allocated aligned to the priority areas and programmes identified in NSP III, including strengthening of the critical enablers, health and community systems' capacity and quality of services, and addressing the prevailing stigma and discrimination.
- Implementation of the NSP will be monitored and evaluated through the national HIV/STI monitoring and evaluation framework, coordinated by the NACP and the Policy and Planning Division, MOH. Information from monitoring and evaluation will be used to ensure that the HIV and AIDS response achieves high levels of accountability and efficiency, and to help determine whether adjustments are required and to facilitate corrective action. Monitoring and evaluation will provide quality information and evidence for future programming and facilitate reporting to global platforms, such as Global AIDS Progress Report, Universal Access and the SDGs.

1. BACKGROUND:

1.1 Bhutan's National Vision and Leadership

Bhutan's response to the HIV/AIDS epidemic started long before the first HIV case was detected in 1993. In order to counter the spread of the global AIDS epidemic, the Government implemented several activities. A Short-Term Plan was developed and started to be implemented in 1989. It progressed to a three year Medium-Term Plan I (1990-1993). The World Health Organization was instrumental in providing technical and financial support through the Global Programme for AIDS (GPA) until 1996. Following the Medium Term Plan, a five year Mid-Term Plan II (1995- 1999) was developed and implemented under the Health Sector Programme Support (HSPS) I and HSPS II, supported by Danida. The latest NSP II has covered the years 2012-2016.

The Royal Decree on HIV and AIDS issued by His Majesty the Fourth King on the 24th of May 2004 serves as the guiding principle in the fight against HIV and AIDS. The Royal Decree calls for all members of the society to help prevent HIV and AIDS and provide care and compassion to those infected. The national response to HIV and STI has been guided by the National Vision 2020 document (*"Bhutan 2020: Vision for Peace, Prosperity and Happiness"*), based on principles of universal access, human rights, and engaging the key sectors to combat the epidemic. Under the vision of the Kings and the Five-Year Plans developed by the Gross National Happiness commission, Bhutan is pursuing the developmental philosophy of Gross National Happiness (GNH), which also upholds strong principles of equality and rights for all human beings.

Standing as a testament to the Government's commitment to the provision of free and quality universal health care**,** the constitution of the Kingdom of Bhutan states "the state shall provide free access to basic public health services in both modern and traditional medicines" and "the state shall endeavour to provide security in the event of sickness and disability or lack of adequate means of livelihood for reasons beyond one's control". The National Health Policy then provides the general direction to guide the government in achieving the national and international health goals within the spirit of social justice and equity.

1.2 Bhutan's Global and Regional Commitments:

Bhutan's HIV response has been in line with and guided by the global and regional policies, to which Bhutan has committed. These include UN General Assembly Political Declarations and Resolutions, as well as UNAIDS and WHO Strategies and guidelines. The global environment for national strategic plan development has considerably changed during the five-year period of the National Strategic Plan 2012-2016. In September 2015, the Member States of the UN General Assembly unanimously adopted the **Sustainable Development Goals**, which replaced the Millenium Development Goals, and include a global target (3.3) to end the AIDS epidemic by 2030.

Consequently, the UNAIDS Programme Coordinating Board, in October 2015, adopted the **UNAIDS Strategy 2016-2021 "On the Fast-Track to End AIDS**" as global guidance. The Strategy aims to achieve the 90-90-90 treatment targets, to accelerate combination prevention, to achieve zero discrimination and eliminate new infections among children by 2020, leading to ending AIDS as public health threat by 2030. The UNAIDS Strategy recognises the need for locally tailored responses within a framework that fosters regional and local leadership and accountability.

The Fast-Track strategy aims at rapidly scaling up effective HIV services by 2020. The global Fast-Track targets include:

1. 75% reduction of new infections from 2010 to 2020 (leading to 90% reduction by 2030)
2. Achieving the 90-90-90 treatment target by 2020; and 95-95-95 by 2030

3. Achieving zero discrimination by 2020
4. Elimination of new infections among children by 2020

The principles of the Fast-Track approach are:

- Ambition: ensuring leadership, political commitment, ambitious national targets
- Focus: investing in services in locations and populations most affected
- Change: scaling up effective response, innovating, community based approaches
- Saturation: investing in high-impact services with intensity and quality
- Human rights: ensuring people-centred effective and equitable HIV responses

The UN General Assembly, on 8 June 2016, unanimously adopted the **Political Declaration on HIV and AIDS: "On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030".** At the Regional level the Member States of UNESCAP, at a Ministerial meeting in January 2015, committed to ending AIDS in their countries and endorsed a Regional Framework to fast-track the HIV response. The WHO's new treatment guidelines of 2015 advise starting the treatment for all people diagnosed with HIV irrespective of their CD4 status.

1.3 Milestones of STI, HIV and AIDS Prevention Programme:

1988: Established STI/HIV programme under the Department of Health, Ministry of Health & Education

1993: The first HIV case in Bhutan detected

1999: Royal patronage for HIV response

2001: Multi Sector Task Force established in all dzongkhags (districts) after successful piloting in Chukha dzongkhag

2002: The first case of Mother-to-Child Transmission of HIV detected

2004: Royal Decree on HIV/AIDS issued by His Majesty the 4th King of Bhutan

2004: National AIDS Committee upgraded to National HIV/AIDS Commission (NHAC) during the 220th session of the coordination committee meeting of the Council of Ministers held in February 2004

2004: ART first introduced in Bhutan

2005: CD4 cell count facility introduced

2005: Free standing VCT established in Thimphu and Phuntscholing

2006: First ART treatment and VCT guidelines developed

2006: VCT introduced in all hospitals in 2006 with rapid test facilities

2008: Global Fund Round 6 grant support to Bhutan

2010: Formation of the Positive Network – Lhaksam

2012: National HIV, AIDS and STI Strategic Plan-II (Revision): Focus on key populations

2013: Transitional Funding Support from the Global Fund

2013: HCT services integrated to Basic Health Units

2015: New Funding Model grant from the Global F2und

2. SITUATION ANALYSIS

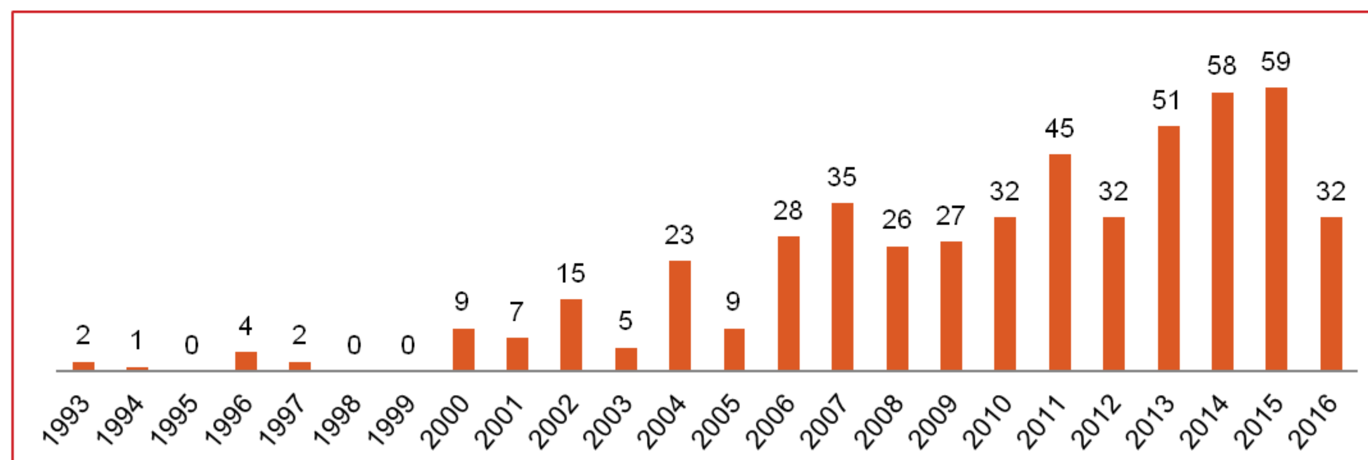
2.1 Health Outcomes

The Life expectancy at birth in Bhutan has increased significantly since 1950s, from 36.1 years to 66.3 years (66.8 years for females and 65.6 years for males) at present. The crude death rate for both males and females is estimated at 6.2 deaths per 1000 population in 2015, against 13.4 deaths per 1000 in 1984. From 1984 to 2012, the infant mortality rate has declined from 102.8 deaths per 1000 live births to 30. During the same period, under-5 mortality has declined from 162.4 to 37.3 per 1000 live births. Specifically, national stunting prevalence has declined from 33.5% in 2010 to 21.2% in 2015. Bhutan declared Universal Childhood Immunization in 1991 and has sustained immunization coverage of above 90 percent. Maternal and child mortality have been reduced and the burden of communicable diseases such as HIV, Tuberculosis and Malaria has been largely reduced. While the MOH continues its battle against the traditional communicable diseases, lifestyle related non-communicable diseases' incidences are increasing and contribute significantly to the disease burden. The epidemiological transition, emerging infectious diseases and adverse health impacts of climate change, has left the health sector battling a complex and wider array of health challenges

2.2 HIV and AIDS Epidemiology

As of June 2016, NACP reported a cumulative of 492 (male 252 and Female 240) HIV cases. Till that date there have been a total of 86 reported deaths due to AIDS related complications, of which 29 have died while on treatment. Currently, there are 386 registered people living with HIV (PLHIV), excluding 19 non-Bhutanese who have left the country and one Bhutanese living outside the country. Of the registered total living with HIV approximately 57% are enrolled in lifelong Anti-Retroviral Therapy (ART). The historical trend in all newly diagnosed cases, since the first two cases were detected in 1993, has been slowly increasing. The increase in HIV infection diagnoses from 2006 onwards can be attributed to investment in scaling up of HIV prevention, testing and control, which indicate progress in programme implementation.

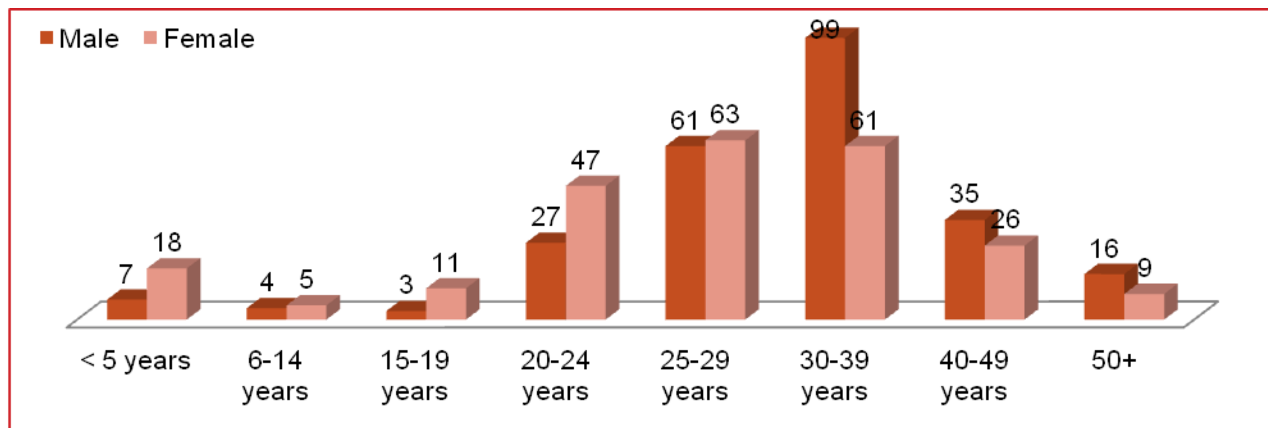
Figure 1: Historical trend of new HIV cases



Exposure Category: The overwhelming majority (90%) of people living with HIV, including newly diagnosed, continue to be infected through unsafe sexual practices, followed by vertical transmission at 8%. The first vertical transmission in Bhutan was reported in 2001, while the first case of HIV infection (probably) acquired through injecting drug use was detected in January 2006. Under the Global Fund grants, targeted surveys are underway to assess the HIV vulnerabilities of key affected population groups, ie; MSM, TG, Injection Drug Users, Female Sex workers and other bridging populations.

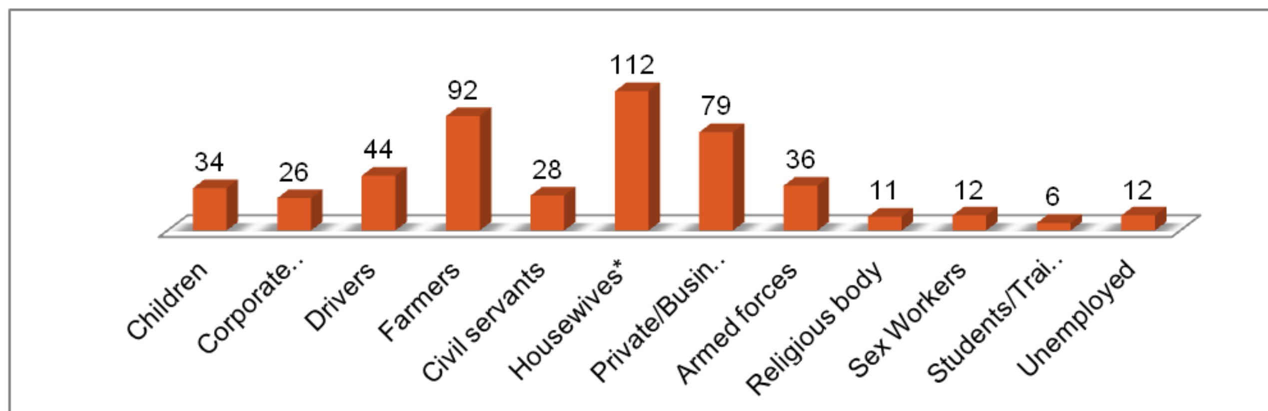
Age: Across all cumulative cases, individuals diagnosed in their thirties (30-39 year olds) constitute the largest proportion of cases (32.5%). More than four fifths (88 percent) of all reported cases have been in the most productive age group of 20 to 49 years. Only 5% of the reported cases have been in the 50+age category.

Figure 2: HIV case distribution by age



Location and occupation: Geographically, HIV cases have been reported from all 20 districts, with the majority of reported cases from the urban towns of Thimphu, Phuntsholing and Samdrupjongkhar. Analysis of the reported cases indicates that significant number (58%) of reported cases has identified their profession as farmers, housewives and private sector employees. The category housewives may include also full- or part-time sex workers who may not wish to be identified as sex worker.

Figure 3: HIV cases occupational distribution:



2.3 Systems for Health:

2.3.1 Health System

The national health system provides services through health facilities, which include a national referral hospital and 4 regional referral hospitals, 21 district hospitals and 207 Basic Health Units (23 BHU I and 184 BHU II). BHU category I has 3-4 staff, including a doctor and nurses, BHU category II has 2 health workers. BHUs have also outreach clinics which will be visited by BHU staff according to established schedule. BHUs also link with the voluntary Village Health Workers (VHWs) in the communities. Services provided depend on the qualifications of staff.

The NACP is accountable for the implementation of the National HIV, AIDS and STI Strategic Plan through the public health service infrastructure at national, regional and local levels. Its implementation takes place in coordination with other public entities, and includes services provided by civil society and non-government networks. NACP has established six HIV Information and service centres (HISC), which offer VCT services and STI testing (syphilis and hepatitis), conduct frequent outreach advocacy events and coordinate with other entities, such as narcotics centres.

The National Tuberculosis Programme (NTP) is implementing TB/HIV activities in all districts. In 2015 60% of TB patients were tested for HIV, whereas only those people living with HIV and symptomatic of TB were screened for TB. 6-7 people living with HIV are diagnosed with TB annually. Currently Isoniazid prevention therapy (IPT) is being provided for all people living with HIV.

Health system has limited capacities to address specific treatment and care needs of key and vulnerable populations. The access of key and vulnerable populations to voluntary testing facilities and STI/HIV services is limited, the programme needs to urgently reach hot spots and to increase its focus on key and vulnerable populations and to deliver the (WHO recommended) 'comprehensive package' of services essential for prevention of HIV. Standard protocols for care and support need to be developed to provide adequate care and support services to PLHIV by investing more in Health and Community Systems for Health.

Health system and HIV services are mostly facility based. The system has limited outreach or linkages to key and vulnerable population groups. The MSTFs, which were established to support the HIV programme at district level, are often not effective and lack community participation and resource mobilization. Stigma, discrimination, and legal barriers pose a wider response problem for implementing interventions among key and vulnerable populations. These groups are a hidden population with no formal networks. There is limited opportunity to engage community members during the implementation of the programme. Capacity, financial and human resource limitations within the CSOs affect their active participation in delivery of services.

2.3.2 Community Systems

There are only 47 community-based organizations in the country working with various mandates across social and economic sectors. Majority of the CSOs lacks experience and capacity in delivery of HIV prevention services to key and vulnerable populations through peer groups and self-help groups. Collective voice from the CSOs to influence policy and programme implementation and inceptions, as well as the experience of peer educators and outreach workers, are limited. There is a lack of self-help groups or CBOs addressing the needs of key and vulnerable populations. Collaboration between the government and civil society networks in a prevention/treatment continuum, including 'task sharing', is necessary to address the crucial HIV programme challenges, such as the lack of sufficiently reaching and testing key and vulnerable populations; entering only a part of HIV positive persons on ART, ensuring continuum of care, and not retaining those in treatment to achieve an undetectable viral load.

The government health services and civil society networks working with and for key and vulnerable populations and their partners need to find solutions that increase demand for services: Identifying and reaching these populations to prevent HIV; recommending HIV screening and testing for 'case finding' and 'case management', by providing ARV, and retaining people on ART. Capacity in district hospitals and BHUs is limited due to their multiple duties, particularly counselling competence needs to be improved.

2.4 Strategic information, monitoring and evaluation, and research

2.4.1 Monitoring and Evaluation

The HIV programme has a separate monitoring system which is not integrated with the District Health Information System thus posing challenges in reporting at the national level. Proposals to improve the system include: Dedicated HIV M&E unit within the NHAC Secretariat for M&E, which monitors the national health response; Integration of HIV indicators with the national HMIS system; Development of treatment compliance

monitoring system including referral and monitoring forms; Development of monitoring and data collection forms for the key population interventions currently being implemented under the Global Fund grant; Capacity building of M&E units at implementing levels (district and programme level) to record, compile, report and analyze data effectively, including analysis of gender and age specific issues; Effective coordination across the public health system to improve and establish more effective data collection mechanisms including HIV surveillance system; Allocation of adequate resources, both financial and human, to be able to fulfill the M&E mandate; Institutionalizing systematic data quality assurance mechanism within the current data collection system.

Ministry of Health is piloting a comprehensive ICT system upgrade which should be able to help and guide improving the HIV and STI strategic information. However, implementing such a comprehensive information system, including the capacity building of the staff, will take its time. Other incremental improvements in the present information system will have to be designed for the NSP III period.

A national progress report is produced based on a standard quarterly report submitted by all stakeholders implementing HIV activities. Reporting includes output and process indicators for the national monitoring framework. The national progress report is a key tool for assessment of the implementation of the national response. The data are disaggregated by gender and capture data at the district level. However, many key data are not captured, the STIs and HIV/AIDS monitoring and evaluation system needs to be updated.

2.4.2 Strategic Information and Research

Data on HIV risk behaviors among KPs, bridge and vulnerable populations is relatively limited in Bhutan, and where it exists, it is often outdated. This creates challenges for evidence based programming, resource mobilization and advocacy. Under the Global Fund's regional and national grants, two national level studies have been conducted, as well as the IBBS in 2016:

- A MSM and transgender size estimation and mapping (Draft), 2012
- A study of stigma and discrimination among MSM and transgender populations, 2013

While substance use is a major public health concern in Bhutan (high levels alcohol and substance use), there are no size estimates of people who inject drugs (PWID), although the NACP estimates that there are about 1,900 people who use drugs (PWUD), excluding alcohol users. One major cross-cutting issue related to HIV risk in Bhutan across the entire population is concurrent sexual partnerships. A Rapid Assessment on Sexual Behaviour and Networks in Thimphu (Johns Hopkins, 2012) highlighted the potential for an explosive HIV epidemic in Bhutan. Overall, 60% of men and 36% of women interviewed reported multiple sexual partners. Over a third (34%) of men and 10% of women reported sex within commercial networks, and 45% of men and 22% of women reported sex within casual networks, within the past 12 months. About 46% of men and 19% of women reported concurrent sexual partnerships ($p < 0.01$) and a large proportion of them had multiple concurrent partnerships.

The preliminary results of the IBBS conducted in 2016 indicate that, even if most of the members of the key groups included in the study were aware of HIV and AIDS, very few had the comprehensive knowledge of how to prevent HIV transmission. The results also indicate very low use of condoms, except by migrant workers visiting sex workers abroad. In addition, the percentage of population aged 15-24 years having comprehensive correct knowledge on HIV/AIDS was 23.2 % (the National health survey of 2012). There is clearly a need to address the knowledge gap, and ensure access and use of condoms in high risk sex. It is also important to ensure that HIV prevention is included in the life skills educational programmes in schools, and also provided to out-of-school children and adolescents, including effective use of social media for delivering the messages.

2.5 Financial landscape

Bhutan's HIV, AIDS and STI programme is dependent on foreign aid. The biggest investment in the HIV response comes from the global funding mechanisms and external development partners, which provided a significant proportion of the total HIV funding in Bhutan. The Political Declaration of the 2016 UNGA High Level Meeting (HLM) on AIDS recommends that countries substantially increase their domestic contribution to HIV response. The Government of Bhutan has indeed increased its investment in HIV over the last years. Further increase in domestic investment in HIV is required to ensure the sustainability of the HIV, AIDS and STI response.

The Government of Bhutan incurs spending on HIV prevention, care and treatment programmes through the Ministry of Health, NACP. The government funding flows also through the local governments for the human resource and recurrent costs of district level services. The Ministry of Health covers the skills development and awareness training, the programme expenses, management and monitoring at central level, and procurement of medicines. ARTs are procured through the support from the Global Fund. Out of pocket expenditure is negligible, since the government is providing health services free of charge to all Bhutanese, including referrals for services to other countries if necessary

Building up and acceleration of HIV and AIDS response in Bhutan has been supported with financial and technical support from external donors as well as from UN and other international organizations. From 2004 to 2010, the National AIDS Control Programme received the International Development Assistance (IDA) grant from the World Bank amounting to USD 5.7 million. The grant primarily focused on scaling up HIV prevention and control programmes through partnership building, health systems strengthening to scale-up HIV diagnostics and treatment services, and improving strategic information for evidence based program planning.

Following the World Bank Grant, the National Programme also secured continuous funding support from the Global Fund to fight HIV, TB and Malaria starting with Round 6 in 2008. Till date Bhutan has received a total of USD 11.5 million from Global Fund. These funds are channeled through the National Programme as Primary Recipient (PR) and civil society organizations and other government-implementing partners as Sub-Recipients (SR). The government under the 11th Five Year Plan health allocation has covered majority of the overhead costs for service delivery.

Ministry of Health has also received funding from the Global Fund through the Regional Grant, which has been managed by UNDP-Asia Pacific Regional office as PR. These funds are earmarked to support key population activities. UN system agencies have provided technical support and some funding in their mandated areas for the STI, HIV and AIDS Programme. UNFPA supports the sexual and reproductive health activities, including the adolescents and youth groups, UNICEF supports activities for children, and WHO the treatment and technical assistance.

With a GDP per capita at USD 2611.74 and Human Development Index 0.605 (2014 Human Development Report) increasing domestic investment will be problematic, and continued global solidarity is required. The development aid has been getting tighter from donor countries and from the international financing mechanisms, such as the Global Fund, as global priorities are shifting to support countries with the highest HIV burden.

3. DEVELOPMENT OF THE NATIONAL STRATEGIC PLAN III

3.1 The Process of NSP Development

The National STI, HIV and AIDS Prevention and Control Programme, Ministry of Health, initiated the development of the new National Strategic Plan III for 2017 - 2023. An international and a national consultant were recruited, with support from UNAIDS, WHO and The Global Fund, for the assignment. The objective of the process was **"To Conduct an Independent, External Review of the Bhutan National AIDS Response over the last 5 years, and support the Bhutanese authorities and civil society to develop a national strategy to Fast-Track a national HIV response by 2020, towards ending the AIDS epidemic by 2030".** The development of the NSP III began in August of 2016 with the desk review of the progress made under the NSPII, and extensive consultations took place during August and September through national, regional and community consultation workshops to formulate potential priorities and strategies for the NSP III (Annex : List of Participants)

The process included review of the reports and other information, and extensive consultations with key government and non-governmental experts and civil society representatives. The initial desk review of relevant documents related to the National HIV response, which included the report of the Midterm review of the national HIV response and of the NSP II, was conducted and the report was presented to NACP prior to its introduction to the first National Stakeholders' Consensus meeting, which kick-started the NSP III development process., Following the first Stakeholders' Consensus meeting, bilateral meetings were held with key potential partners in Government (MOH, MOE, MOLHR, GNHC), NGOs (Dratshog, Lhaksam, RENEW, Tarayana, YDF, CPA), and Multilateral organizations (WHO, UNDP, UNICEF). The two regional consultations in Phuntsholing and Gelephu provided the opportunity to extensively consult with the district health officers of all 20 districts. During the workshops the participant's reflected on the past and current implementation of NSP II and identified challenges, gaps and potential service delivery mechanisms for NSP III. Two rounds of community consultations with LGBT, and PLHIV were also held to understand challenges and opportunities from the key and vulnerable populations' perspectives. (Annexure: Detailed Findings from the consultation meetings)

The technical working group of experts established at the inception of the NSPIII, composed of UNDP/UNAIDS, WHO, UNICEF, YDF, Lhaksam, DRA, NACP, PPD and MOH, provided guidance and recommendations during the development of the NSP III.

3.2. The 2013 Mid-term review of National Response to HIV findings and recommendations

The National STI, HIV and AIDS Strategic Plan II 2012-2016, which drew upon experiences of earlier Strategies, built on the Millennium Development Goals (MDG) and the UN General Assembly 2006 and 2011 Political Declarations on AIDS, and had set its targets to achieve by 2016, compared to 2010, to:

- Reduce new HIV infections by 50%
- Reduce AIDS related deaths by 25%
- Reduce new infections in children by 90%

The 2013 Mid-term Review of National Response to HIV in Bhutan, and of the National STI and HIV Strategy 2012-2016, while recognizing Bhutan's achievements in the implementation of the NSP II, identified challenges**.** These were reflected in the Bhutan Annual Country Progress reports, and include:

- Cohesion, integration, availability and quality of HIV and STI prevention and response services
- Capacity constraints in both health sector and community based organizations
- Participation of key populations, people living with HIV and networks of CBOs
- Integration of community services with health sector services, continuum of care

- Strategic Information, data quality and use, monitoring and evaluation
- Human rights, stigma and discrimination, legal barriers

The Mid-Term Review and the progress reports made recommendations which include:

- Focusing and intensifying good quality services for key populations in key locations
- Improving the scope and scale of HIV prevention, scaling up HIV and STI testing
- Eliminating vertical transmission of HIV and keeping mothers well and alive (eVT)
- Expanding treatment, recognizing that treatment is also prevention
- Integrating HIV and STI services into the general health services
- Adopting zero tolerance to discrimination
- Addressing special needs of adolescents and mobile populations
- Strengthening of partnerships between government and civil society

A range of critical programme- and social enablers were identified and proposed for prioritised investments in improving the HIV and STI response in Bhutan:

- Improving and integrating HIV-competent government services 'outreach,' and community services 'in-reach' in a well-governed systems-for-health approach;
- Addressing gender violence, and promoting social protection and social cohesion; adopting zero tolerance for discrimination; revoking punitive laws;
- Promoting leadership, coordination and cooperation among implementers; establishing accountability mechanisms at all service levels;
- Investing in collection, generation, analysis, 'translation' and use of relevant, high-quality strategic information, and using modern information and communication technology.

3.3. Programme performance findings from the desk review and consultations:

- Progress has been achieved: Commendable work has been done, important results have been achieved in the STI and HIV and AIDS response in Bhutan and in the implementation of the NSP II. The programme governing structures and modalities have been strengthened at central and district levels. The services have been expanded and integrated at district and local level, including through strengthening the health system at central, district and local level. PMTCT services have been decentralized to all ANC, and practically all pregnant women attend the ANCs and deliver in the facility. TB/HIV service coordination has been established and covers both services. First-line ARVs have been included on the essential drugs list.
- The rapidly expanded testing has resulted in increasing numbers of people living with HIV and people introduced to ART, following the revised criteria (CD4 count revised to 500 mm3). The coverage of ART of all diagnosed and registered PLHIV has reached 57% (it still remains at around 40% of all people estimated to be living with HIV). The adherence to treatment is high. Testing still needs to be expanded to meet the fast-tracking targets.
- Civil society engagement has improved after the establishment of Lhak-sam, the organization of people living with HIV, and expanding its support to an increasing number of its members. Other networks of civil society are increasingly engaged in the HIV response, particularly in the prevention, and their participation is to be expanded.

3.4 Recommendations made to improve competencies and pre-requisites for NACP and its partners:

- The capacity for programme implementation needs to be strengthened, both at programme management and implementation levels. Programme management at NACP and at district level multi-sector coordination (MSTF) needs to be consolidated. Health workforce capacity and competence needs

strengthening, including development of standard training programmes and guidance. Supply management and logistics needs to improve to prevent stock-outs of drugs and diagnostics. Strengthening laboratory capacity with Viral Load testing, and logistics of referrals, needs to be expedited.

- Services are mainly facility-based. Engagement of people living with HIV and other networks needs to be improved. Community testing should be explored and gradually expanded. Linkages between health facilities and community in-reach and out-reach need to be improved to guarantee continuum of care and more efficient case finding and case management.
- Complete knowledge of HIV prevention is low according to the IBBS conducted in 2016, and needs to be addressed. Special attention should be given to ensure adolescents and mobile populations have access to prevention and care. Access to prevention services, including condoms, needs to be improved. IBBS 2016 did not find any HIV cases among the key populations tested, additional research is called for to determine the course of the epidemic
- Strategic information is a major challenge to be addressed. Surveillance and M&E systems do not provide the information needed for assessment of the key population numbers or the locations. The baselines are largely missing and the information on the indicators established is not available. The quality of the information collected and its analysis and use for programme monitoring and development needs strengthening. It is not integrated fully in the HMIS. Surveillance systems need to be strengthened.
- Revision of prohibitive laws, changing the attitudes of health service providers and people require extensive targeted interventions and media coverage with positive messages, including in social media. Innovative use of mobile technology would improve information sharing and service provision.
- Financing of the response has depended on external donor funding, which is gradually diminishing. Domestic financing has to gradually increase. CSOs in particular are exposed to financing decrease, and new sources of funding need to be explored, including Health Trust Fund.

4 National Strategic Plan III (2017-2023)

4.1 Strategic Results Framework

The National Strategic Plan on HIV, AIDS and Sexually Transmitted Infections (2017 – 2023) is the strategic guide for the national response to HIV, AIDS and STIs for the next seven years. Its period is extended to 2023 in order to synchronize with the planning period of the 12th Five Year National Development Plan. NSP III is built on the achievements of the previous Strategic Plans and programme implementation experiences, and addresses the challenges experienced in the implementation of the national response. The NSP III fast track and focus investments of a scope, scale, intensity, quality, speed and innovation to have the biggest impact, to achieve NSP III goal and objectives. Interventions that have worked well are scaled up and the quality of service delivery is improved, while at the same time proven new interventions are to be implemented.

The intention is to respond to the changes in the HIV and STI epidemics during the plan period. Therefore the NSP III implementation will be reviewed during the midyear of its implementation (2020) for the relevance and effectiveness in achieving its targets, and will be adjusted as necessary. The NSP III aims to inform national, district and community-level stakeholders and implementing partners on strategic directions to be taken into consideration when developing their respective strategies and implementation plans for HIV, AIDS and STI response. The strategic directions are aligned with the overall framework for the national response:

Vision: Ending the AIDS epidemic as public health threat in Bhutan

Goal: To achieve 90-90-90 global targets for HIV response by 2020, and continue through the planning period, towards ending of the HIV epidemic by 2030

Objectives:

1. To increase coverage of comprehensive package of HIV prevention services
2. To reduce new HIV infections from 2010 to 2020 (leading to 90% reduction by 2030)
3. To achieve 90% Test and Treat targets by 2020 (leading to 95 % by 2030)
4. Retain 90% PLHIV on treatment, resulting in undetectable Viral Load
5. To eliminate new infections among children by 2020,
6. To enhance strategic information
7. To build sustainable and cost effective systems for health, integration of HIV/STI services
8. To achieve zero discrimination by 2020

4.2 Guiding Principles

In addition to adhering to the global and regional principles for achieving the Sustainable Development Goal, the NSPIII includes the following national guiding principles.

- **Respect for human rights**: The National Strategic Plan mirror the constitution of Bhutan as guiding principles of universal human rights and dignity for all. Informed consent will form the backbone of the HIV program (unless anonymous unlinked for screening purposes), and each HIV test result will maintain confidentiality.

- **Prioritization:** The strategy is based on a prioritized approach in order to remain effective. Implementation of strategies and coverage will be conditional on the availability of resources;

- **Evidence informed**: The priorities are based on sound evidence from epidemiological, public health and social research;

- **Inclusion**: The strategy was developed with inputs from all relevant stakeholders, including civil society, PLHIV and other affected communities, NGOs, and development partners;

- **Results based**: The strategy includes specific, measurable and realistic objectives with targets based on the Universal Access principles and other international and national commitments.

- **Meaningful involvement of people living with HIV and Key population**: The experience, insights and efforts of people affected by HIV, including women, young people and key populations, are valuable resources in the national response and as members of decision-making bodies. The NSP recognizes the importance of the participation of communities in the design, implementation and evaluation of services.

- **Multi-sectoral partnerships:** The response needs to be holistic and multi-dimensional. National response to HIV and AIDS is therefore multi-sectoral and involves strong and growing partnerships between the government and key government ministries, civil society and the private sector. Existing partnerships will be strengthened and new mechanisms will be established on the basis of equality and mutual respect at all levels

4.3 Strategic Directions

The National Strategic Plan III was developed to adjust to and to benefit from the achieved understanding of the epidemic in Bhutan, and to build on the experiences in the national programme implementation and on the scientific advances in addressing the epidemic. The relevant strategic directions also reflect the recent WHO guidelines on HIV and STI treatment guidelines and Impact monitoring recommendations. Thus based on both the international and national key recommendations and findings, four targeted strategic directions and two crosscutting strategies were developed to achieve the national vision of ending AIDS:

1. **Prevention of HIV transmission through outreach and in reach.**
2. **Universal access to HIV and STI testing and screening.**
3. **Comprehensive continuum of care for PLHIV and people with STI and TB/HIV co-infection**
4. **Strategic information for evidence informed programming.**

Crosscutting strategies:

2. **Development of synergies: Governance, Partnerships and Programme management**
3. **Improving Health and Community systems for health, including resource mobilization for sustainability of HIV response**

Figure 4 Results Framework for national Strategic Plan III

Objectives	1. To increase coverage of comprehensive package of HIV prevention services 2. To reduce new HIV infections from 2010 to 2020 (leading to 90% reduction by 2030)	3.To achieve 90% Test and Treat targets by 2020 (leading to 95% by 2030)	4. Retain 90% PLHIV on treatment, resulting in undetectable Viral Load 5.To eliminate new infections among children by 2020.	6.To enhance strategic information
Strategic Direction	1. Prevention of HIV transmission through outreach and in reach	2.Universal access to HIV and STI testing and screening	3.Comprehensive continuum of care for PLHIV and people with STI and TB/HIV co-infection	4. Strategic information for evidence informed programming.
Global /national Targets	Identify, reach, recommend and test 90% of the population at risk Improve knowledge about HIV and unsafe behaviours	Test 90% of the key and vulnerable populations	Treat 90% of those diagnosed as HIV positive	Operational research and epidemiological researched conducted
		ANC attendees receiving HIV test.	Zero vertical transmission of HIV and keeping mothers alive and well.	Surveillance System established including Early Warning system
				Design and implement operational research to inform polices and programme.

4.3.1 Strategic Direction 1: Prevention of HIV transmission through outreach and in-reach.

Prevention strategic direction draws evidence from the program implementation experiences and the recent National Health survey of 2012, which found the comprehensive correct knowledge of HIV/AIDS to be at 23.2 % amongst the 15-24 year and only 16.8 for the wider age category of 10-78 years. HIV transmission in Bhutan is predominantly sexual (90%). Prevention is the key to reducing the transmission, recognizing that effective treatment is also prevention. Key and vulnerable populations remain the main focus of the NSP III (2017-2023). In Bhutan these include female sex workers (FSW), transgender people (TG), gay men and other men who have sex with men (MSM), people who inject drugs (PWID), incarcerated and mobile and migrant populations, with special attention to young vulnerable people. Males and Females at higher risk for HIV, such as the clients of FSW and their female partners, and MSM, are another priority group. They are perceived as hard to reach through 'outreach,' and are not attracting sufficient attention in service provision. Programme and service coverage for the key and vulnerable populations must include targeted service packages that address their specific prevention and harm reduction needs; including addressing sexual exploitation and violence.

Through both 'outreach' and 'in-reach,' these populations, including young people, need to access services through programmes that address HIV prevention, sexual exploitation and violence; eVT programme, and other health services, including sexual and reproductive health and rights services. A gradual introduction of PrEP could be achieved with active retention monitoring and counselling support. PrEP could potentially help reverse HIV rates among TG, and gay men and other MSM, if introduced.

People who are mobile may not receive appropriate HIV services, due to their specific characteristics of being away from their communities for much of the year. Evidence-informed investments must be made in programmes that are developed and implemented for and by these mobile populations and their families, including in workplace programmes, as well as programmes for labour migrants and nomadic tribes. It is necessary to identify those at higher risk as a priority. This also needs to be seen in the context of the overall Right to Health of migrants.

People in closed and displaced settings need attention. Vague punitive laws may lead to arresting drug users, sex workers, and transgender women who may end up in prisons and custodial institutions, where they are exposed or expose others to HIV, STI and TB, and might be cut off from the services they rely on outside the detention centres. Displaced people after natural disasters may not have access to services, and may be vulnerable to sexual violence, or may resort to sex work for survival; increasing the risk for HIV transmission.

Uniformed services, prison staff, police, law enforcement and other uniformed services are the frontline contact of many key and vulnerable populations. It is important that those employed in the uniformed services are adequately trained on HIV and STI issues, in order to provide supportive and protection services to key populations, and to enhance their own safer sexual practices.

In addition to the targeted interventions for HIV prevention improving programmatic and social enablers are also reflected in the strategic direction 1. Human rights, gender, justice, equity and inclusion are centrepieces for an effective HIV response. The key and vulnerable populations and people living with HIV continue to experience prejudice and discrimination, including in the health services. Many of them require extensive social protection and support. Gender norms in traditional societies may prevent them from reaching their potential as members of society. Women and girls may be subjected to sexual violence. Social Programme Enablers include social protection, nutritional support, testing of OIs among HIV patients, preparation of guidelines, protocols and standard operating procedures, and legal and policy reviews.

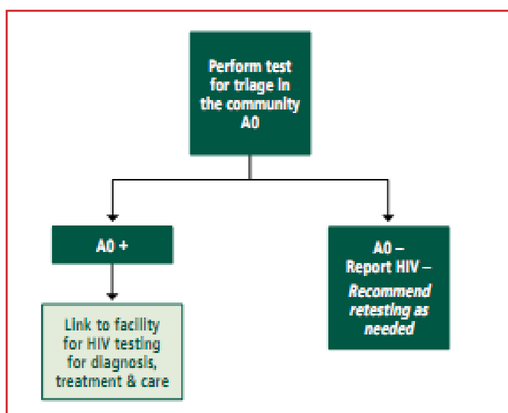
Interventions:

1. Identify and reach populations **most at risk** with targeted interventions to prevent HIV through outreach and in-reach.
2. Identify and reach **mobile, floating and migrant populations including nomads** with targeted prevention intervention package of services.
3. Empower **youth, in- and out of school**, through integration of life skills education in collaboration with other implementing partners and informal youth networks.
4. Increase access to condoms and prevention services in appropriate settings.
5. Use effective communication channels, including social media and entertainment education on HIV prevention to enhance comprehensive knowledge.
6. Address prejudice and discrimination within and outside the community.
7. Enhance critical programme and social enablers (Policies, Legislation)
    a. Regular reviews to ensure that occupational health & safety of health workers -access to universal precautions, and post-exposure prophylaxis
    b. Consider "safe haven" laws for healthcare providers who provides services to minors
    c. Key population related legislative review
8. Institutionalize collaboration and guidance to provide support for PLHIV in difficult circumstances

4.3.2 Strategic Direction 2: Universal access to HIV and STI testing and screening.

Recognizing that targeted testing of key and vulnerable populations is key to increasing the programme coverage and improving access to universal access to HIV services. The average CD4 count of newly registered HIV cases today is about 300/mm3. Around 30% of all registered people living with HIV have CD4 counts above 500/mm3, and are thus not yet enrolled in ART as per the existing guidelines. With the expected change of eligibility to treatment along the new WHO guidelines (Test and Treat), these HIV positive people will have to be enrolled in ART. As of August 2016 only 1 person is on second line ART. Resistance testing is not available in Bhutan, specimen are forwarded to laboratories abroad. Viral Load testing, not yet available, will be initiated when the gen-expert for VL testing machine arrives. While the voluntary testing and counselling may take place at BHU and district hospital level, the confirmatory testing takes place at central laboratory, which forwards the HIV positive findings to the Treatment and Care unit at JDWNRH. The time lapse for confirmatory testing is approximately two weeks.

A critical aspect of testing is linkage to treatment and retention in care of those testing positive in close collaboration with community organizations and implementing partners. This approach necessitates strong referral systems and case management. The case manager will support an HIV positive person, who could be symptom free and not understanding the importance of adherence when feeling relatively well or living with alcohol or substance dependence. Test for triage is a community-based HIV testing approach involving trained lay providers, supported by health professionals, conducting a single HIV Rapid Diagnostic Test (RDT). The providers then promptly link individuals with reactive test results to a facility for further HIV testing and to treatment. Individuals with non-reactive test results are informed of their results, referred and linked for appropriate services to prevent HIV, and recommended for re- testing according to HIV risk.



The testing strategy under the strategic direction 2 will be three-prong approach:

I. Facility based, in clinical settings, TB care sites, or through stand- alone testing and counselling centres. All ANC facilities will test all pregnant mothers, if found HIV+ introduce the mothers to B+ ART for life. Children born to HIV+ mothers will be tested early and if necessary entered in ART. All populations will be offered testing at health facilities.
II. Community assisted or led testing based in-reach by outreach workers with support by health professionals in HISC and health facilities, including using mobile units, focusing on entertainment sites and hotspots, also on remote sites and mobile populations.
III. Screening for HIV and STI through opt-out will be based on protocols and provided to all blood product and organ donors, pregnant mothers, and surgical patients undergoing invasive procedures.

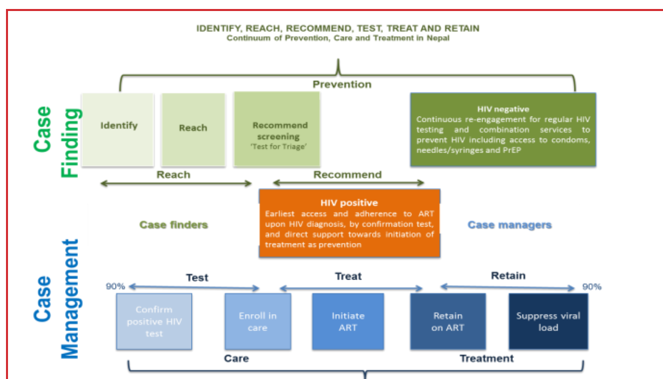
Interventions:

1. Testing key and vulnerable populations through community-led or assisted testing.
2. Testing key and vulnerable populations including youth through comprehensive targeted mobile testing and health camps.
3. Provider initiated testing and counselling (PITC) in STI , TB clinics, Clients of harm reduction programme and Sexual contacts of HIV infected persons .
4. VCT services through HISC and other health facilities.
5. Routine screening of.
    - All pregnant mothers through opt-out antenatal screening
    - All donated blood, blood products, organs
    - All patients undergoing surgical procedure
    - Drug rehabilitation centres and prisons

4.3.3 Strategic Direction 3: Comprehensive continuum of care for PLHIV and people with STI and TB/HIV co-infection

Continuum of care is indispensable for effective HIV and STI response. The graph below illustrates case finding' and 'case management' in the continuum of identifying, reaching, recommending, testing, treating and retaining people on ART (IRRTTR), including through task sharing. These principles and practices lie at the centre of, and will be applied to each of the strategic directions of this NSP. The services include those provided by the community service organizations and community engagement. The government and civil society networks and community services complement each other seamlessly throughout the case-finding-case-management continuum.

Figure 6 Identify, Reach, Recommend, Test, Treat and Retain



IRRTTR strategy includes an effective retention component through ***public-private partnerships between government and civil society***, task sharing between professional health care providers and trained lay care providers, and by adjusting traditional service models to more active case finding and case management, and harmonizing and integrating HIV and STI response, including coordinated response to co-infections such as TB/HIV.

The 2016 ART coverage of 244 persons in Bhutan is around 25% of all estimated PLHIV, and around 57% of the registered PLHIV. There is a pool of undiagnosed PLHIV, as well as another large number of those testing positive, who have not been initiated ART because their CD4 count is still above 500/mm3. Identifying and reaching those undiagnosed; recommending testing, including community testing and provider initiated testing and counselling (PITC); decentralising treatment monitoring, and case management, are all essential to increase detection.

The Treatment and Care Unit at JDWNRH coordinates the treatment and follow-up of people living with HIV. Once the ART is stabilized, the ARVs will be distributed through the district hospitals, where each patient may receive ARVs for maximum 3 months. They will also have to return for CD4 testing every six months to district hospital. HIV screening for pregnant women is available in all ANCs. Delivery of coordinated care and treatment services needs to be strengthened to address the capacity and human resource constraints.

With the change of the testing and treatment procedures it is important to provide updated treatment recommendations for HIV, emphasizing when to start treatment; what treatment to start; the use of laboratory monitoring tools; and managing treatment failure, switches, and simplification. Regimens need to be selected or changed based on resistance test results with consideration of dosing frequency, pill burden, adverse toxic effect profiles, co-morbidities, and drug interactions; including paediatric ART.

An effective programme to eliminate vertical HIV transmission and keeping mothers well and alive is a priority that needs special efforts and key investments to reach acceptable coverage levels to approach the target of eliminating new HIV infections in children by 2020. Paediatric ART coverage needs to be improved. The scale-up of testing is expected to reach 90% by the end of 2020 through intensified case finding, which is possible as practically all pregnant women attend ANC and most deliver in health facilities. In line with international guidance, all HIV positive pregnant women will receive ART for life (option B+), regardless of their CD4 count, prior to the Test and Treat of all people living with HIV approach is introduced in 2017. Good quality early infant diagnosis and paediatric ART are important priorities

Interventions:

- Treating all PLHIV regardless of CD4 count
- Retaining and monitoring PLHIV on treatment, resulting in undetectable viral load
- Full integration of Option B+ at district level for zero vertical transmission

4.3.4 Strategic Direction 4: Strategic information for evidence informed programming.

To address the challenges for evidence-informed programming, resource mobilization, and advocacy, the gaps in the strategic information collection, analysis, dissemination and use, several actions to be taken include: Investments in improving surveillance; Integration of HIV indicators within the national HMIS system; DHIS to include treatment compliance monitoring system, including referral and monitoring arrangements; Capacity building of M&E at implementing levels to record, compile, report and analyze data effectively, including analysis of gender and age specific information; Improving and establishing more effective data collection mechanisms, including HIV and STI surveillance; Allocation of adequate resources, both financial and human, to

be able to fulfill the M&E mandates; Institutionalizing a systematic data quality assurance mechanism within the current data collection system, and; Operational research on HIV and co-infections.

Interventions:

1. Collaborative research to inform national program (retrospective studies, In-depth research to understand phenomenon of drug use &sex work a study on HPV HIV/cervical cancer)
2. Instituting population based first and second generation surveillance system for monitoring HIV and STI epidemic
3. Developing system for monitoring early warning indicators (EWIs)
4. Continuous monitoring of targeted intervention programme
5. Periodic evaluation, Mid-term evaluation 2020 of programme performance

5. CROSSCUTTING STRATEGIES

5.1 Development of Synergies: Governance, Partnership and Programme Management

An adequate HIV response is not only about health sector capacities and competencies to deliver medical services but a multitude of national development sectors will have to contribute, from education to social protection and local government. Roles and expected contribution from government's development sectors and their inter-sector responsibilities will be reviewed and updated, under the leadership of the Gross National Happiness Commission (National Planning Commission). Participation of key government ministries and their contributions to the HIV response will be ensured through their participation in governance and coordination mechanisms, led by the NACP. Each of the development sector ministries and agencies are expected to include HIV relevant responses in their plans and budgets.

Development partners have provided the major part of the investments in HIV response in Bhutan, and are expected to continue this for Fast-Tracking the response. In addition to their HIV specific programmes, their HIV related systems' improvement, including their inter-country and regional activities, will be reviewed and adjusted to support Bhutan's HIV response. Regional funding for HIV response in Bhutan from programmes will be enlisted for potential technical assistance and financial support. It is expected that the Global Fund will continue its financial support through country and other grants. The UN Country Team will serve as an entry point for the provision of strategic technical assistance towards the implementation and monitoring of the NSP III.

The Gross National Happiness Commission (National Planning Commission) acts as the overall coordinator for all national plans and strategies. The Commission establishes the National Five -year development plans (FYP) in consultation with government ministries and entities, and establishes the overall national budget and allocation of budgetary resources for all sectors and entities based on their plans and negotiated priorities. The districts will be provided budgets for implementation of their activities, including the health sector expenditure under the district plans.

The next 5-year plan, covering the fiscal years 2018-2023 provides the framework for health sector plans and strategies for the 5-year period. Until now, these sector plans have covered periods differing from the national development plan. It is now proposed that these plans be harmonized with the national development plan. Thus, the NSPIII has been developed to cover the period 2017- 2023, and after that to synchronize with the 5-year periods of the national development plans.

5.1.1 Partnerships

NSPIII calls for fast-tracking and significantly scaling up an effective national response to STI and HIV, which requires strong participation of local communities and community-based approaches to contribute towards key

results. While government remains the major player, several NGOs and CBOs have been established and are strong partners in the national response, such as RENEW, YDF, CPA, and Lhaksam. The number of NGO and community-based partners is expected to increase.

NSP III will be implemented based on broad partnership between government, NGOs and CBOs. NHAC and NACP coordinate the partnership between government at all levels, civil society, international organizations and involvement of the private sector in the national HIV and STI response. NSPIII includes greater participation from vulnerable populations, including youth, in implementing the national response. Partnerships have a number of components that are integrated across NSP III strategies and activities:

1. Inclusion – systematic inclusion of civil society (NGO/CBO) in coordinating mechanisms/bodies designing, reviewing and supporting the national response.
2. Participation – establishment of partnership and referral arrangements linking government and civil society organisations and the programmes they operate within the national response
3. Suppport to the formation of networks and self-help groups among vulnerable populations, including sex workers, gay men and other men who have sex with men, people who use drugs, people living with HIV, and other populations as required.

5.1.2 Governance.

The National Health Policy of Bhutan has established the governance structures and responsibilities for the governance of the response. The Policy has been in force, with revisions, for more than 10 years. With the evolving epidemic, scientific break troughs, and lessons learned, the governance structures may have to be adjusted to fast-tracking mode towards ending the epidemic. The Policy will be reviewed and revised as appropriate.

National AIDS Commission was established for policy coordination with high level representation of numerous Ministries and government entities, civil society representatives and other partners. An annual, high-level "State of the HIV Epidemic" review and consultation will be convened, as a national platform for reporting and assessing fast-tracking progress. The roles and responsibilities of the NHAC include: Formulate policies on prevention and control of STIs and HIV/AIDS; Facilitate linking of national HIV and AIDS plan and policies with other important policy-making processes; Function as the coordinating body for the national response to STI and HIV/ AIDS prevention and control, and; Mobilize active commitment and collaboration of public/private sectors, civil society and communities. The NHAC includes members representing different government ministries, civil society as well as the private sector. The Minister of Health acts as the Chairperson and the Department of Public Health serves as the Secretariat. The NHAC will continue to meet every six months to review policies and provide direction to the national response.

Bhutan Country Coordinating Mechanism (for GFATM supported projects)

The Country Coordinating Mechanism (CCM) has been a cornerstone of the Global Fund architecture since the organization was created in 2001. CCMs embody the Global Fund's key principles of country ownership and partnership through multi-stakeholder collaboration. CCMs are responsible for mobilizing resources at the country level by organizing and submitting proposals to the Global Fund that reflect a gap analysis of national strategic plans. They also provide oversight to grant implementation to ensure successful outcomes. The CCM of Bhutan comprises members from a broad range of expertise and capacities including development partners, MoH, and people affected with the three diseases. Under the leadership of the CCM, technical working groups have been formed for each disease component to review health system strengthening issues with expertise from procurement and supply, laboratory surveillance and Human Resource Development.

5.1.3 Programme Management

Ministry of Health

Ministry of Health will continue to lead the health sector response to STI and HIV and AIDS prevention, treatment, care and support. MoH will provide technical guidance to other stakeholders in the implementation of NSP III and is responsible for implementing many of the activities through NACP and other units, which include Research and Epidemiology Section, Health Information Unit and Information Technology Unit under the Policy and Planning Division, Department of Public Health, and Medical Services Department.

The National HIV/AIDS and STI Control Programme of the Ministry of Health

The Programme was established for the execution, coordination and monitoring of the National HIV and STI Policy, Strategy and Action Plan, to implement the endorsed policy and programmes at central and district levels, through health infrastructures, including community health volunteers. The Programme is coordinating with the other MoH entities, particularly with the TB and SRHR Programmes, to ensure integrated service provision at health facilities, and to develop guidance, including review and revision of guidelines, standards and protocols.

The Programme maintains and, where necessary establishes, functional technical and thematic working groups comprised of multiple sectors of government and non-government members. Its monitoring and reporting capacities will be improved, including improvement of reporting and electronic information systems. The programme is also responsible for leading and managing implementation of specific health components: (i) surveillance of STIs and HIV, (ii) establishment of counselling and VCT services, (iii) developing care and treatment standards and coordinating clinical management of STIs and HIV care, (iv) carrying out operational research, and (v) monitoring and evaluation.

Dzongkhag (district) health services

Dzongkhag health services are responsible for coordinating the implementation and monitoring of HIV and AIDS prevention and control related activities at the dzongkhag level. Major responsibilities include: a) Facilitate and implement interventions in the dzongkhag; b) Coordinate activities for the dzongkhag and MSTF; c) Monitor activities performed by local entities; c) Provide technical assistance to other implementing agencies and the dzongkhag MSTF; d) Support the central level in data collection and surveillance.

The District Health Officer is in charge of the health sector response and reports to the Dzongda, and provides secretariat services for MSTF. The District Health Officer also looks after the community and public health affairs. The District Medical Officer is in charge of the curative health services and is also advisor to the district health sector.

The Multi-Sector Committees (MSTF) have been established at district level for coordination of the HIV and STI activities. These Committees are not equipped to implement HIV programmes, which is the function of the hospitals and other health service units under the leadership of the MoH. The mandate of the MSTFs is to address health issues, particularly STI and HIV/ AIDS preventive and promotion activities and reproductive health, coordinating STI and HIV activities at district and gewog levels, supporting local communities and NGOs implementing STI and HIV/ AIDS activities and facilitating participation of people living with HIV.

MSTFs have an important role to play in planning, implementation, monitoring and evaluation of STI and HIV prevention, care and treatment services. The Dzongda (Governor) is the Chairperson of the MSTF. Members of the MSTF include Dzongkhag officials of the health sector and other government sectors, gups/chimis (elected representatives), NGOs, community based organizations (CBOs) including religious leaders, private sector, people living with HIV and community leaders. They are a driving force for expanding the response and conducting effective STI and HIV activities.

At the sub-district level, the administrative unit is called gewog or block. Each gewog has about 2,000 to 4,000 people and is headed by the gup (elected community leader). Each of the 205 gewogs has a council known as Gewog Yargye Tshokdoge, which is chaired by the Gup who is also the Chairperson of the gewog MSTF. Gewog MSTFs are responsible for coordinating and monitoring the response at the gewog level. BHU staff provides the necessary technical support and are responsible for the health sector response, and ensure good coverage of STI and HIV activities in the Gewog, in particular knowledge, awareness and access to services and commodities.

5.2 Improving health and community systems for health

The Bhutan public health system ranges from the central referral hospitals and district level hospitals to the Basic Health Units, covering the country. However, the capacity remains limited to cover all the needs of the population. The outreach services to the community, essential for an effective HIV response, remains to be improved. The community level workers (Village Health Workers) and informal community networks play an important role in HIV response, through in-reach.

The hospitals and other facilities are the backbone for HIV and STI diagnostics and treatment. Integration of HIV and STI services within the system, particularly with the TB, SRHR, and MCH will be improved. Screening of donated blood will continue; STI testing and treatment, including elimination of congenital syphilis will continue; addressing the HIV co-infections will be improved. Evidence gathering through surveillance and surveys, including monitoring of drug resistance will be expanded.

Coordination between HIV and TB programmes will be strengthened for better collaboration in order to provide better counselling services to TB patients and increase routine HIV testing among TB patients. Linkages with TB programme and referrals within the HIV programmes, as well as the linkages to other health programmes will be strengthened. Standard referral procedures will be implemented in order to facilitate referrals to other facilities.

Procurement and supply chain management (PSM), logistics and supply of diagnostics and medicines, will be improved. Strengthening of Procurement and Supply Management includes development of emergency warning system and procurement procedures to avoid stock-outs, development of Standard Operational Procedures for management and monitoring of supplies, regular bi-annual forecasting and revision of national policy, alongside with capacity building and implementation of Logistics Management Information System.

The capacity of laboratory services will be improved, quality assurance and maintenance of equipment will be improved; training of laboratory personnel in new technologies will be introduced. There is a need to strengthen laboratory services with increased capacities to diagnose STIs and OIs, establishing viral load testing and organizing HIV-DNA-PCR testing, TB/HIV co-infection detection, and staff capacity building.

The need to scale up STI and HIV and AIDS prevention, treatment and care places significant pressure on health workers and communities. More skilled personnel are needed for delivery of quality health and social support services, including upgrading the Village Health Workers' skills and addressing their remuneration issues, as well as maintaining existing outreach workers in HISC and their capacity building. Counseling training is available only at the Nursing and Public health Institute, the specialized counseling skills, such as risk reduction counseling, psychological support, de-addiction counseling are limited, and will be improved.

The community services will be integrated in the systems for health approach, including integrated social services to ensure the continuum of care "identify, reach, recommend, test, treat and retain" though community 'in-reach 'approaches, and relevant public-private partnerships to reduce the fragmentation of the services. For Fast-Tracking of the response towards ending the AIDS epidemic, new ways of working and task sharing must be adopted.

Community competence in case finding, to identify reach and recommend testing and treatment is an innovative way of working in and with communities, to identify community strengths and stimulate positive attitudes and actions to increase HIV testing of their own community members through in-reach. This is based on the core principle that communities can apply their own intrinsic skills and competencies rather than focusing on deficits and weaknesses and reliance on external experts and support. Community-based support mechanisms will be enhanced, including home based care.

Case management approach will create a performance-based basic programme modality, with improved clarification of roles and responsibilities, and expanded competencies, in support of the Bhutan's IRRTTR paradigm. Standardization of the community in-reach workers' results-oriented job descriptions and remuneration are important in order to create a more effective and efficient network of community in-reach workers that is fully part of a comprehensive systems for health.

Task sharing, adopting the 2015 WHO Consolidated Guidelines on HIV Testing Services, which recommend that lay providers, who are trained, can conduct safe and effective HIV testing services, using rapid diagnostic tests. Task sharing, rational redistribution of tasks between cadres of health-care providers with longer training and other cadres with shorter training, including trained lay providers, is pragmatic response to increasing the effectiveness and efficiency of all available personnel and to enable the existing workforce to reach and serve more people.

Services delivered by trained Village Health Workers can be both welcome and important, providing information and skills that facilitate safer behaviours. These lay providers based in the community can provide HTS, link people to treatment and prevention services, provide continuum of care and support. Their role can help to reduce prejudice, expand the coverage of HTS and improve the uptake of services.

Innovation is essential for Fast-Tracking the HIV response. One important component will be the implementation of eHealth and mHealth networks throughout Bhutan This will revolutionize and influence how health services are delivered. eHealth and mHealth recognize the transformative potential that information and communication technologies (ICT) hold for the healthcare system in Bhutan. Specifically, mobile telecommunication technologies will open new opportunities for innovation in health data collection, supply chain management, and patient monitoring and treatment. Moreover, mHealth offers the opportunity to improve health literacy through the use of mobile phones that offer access to healthcare systems with the press of a button.

eHealth will support the prevention of duplicate HIV testing, and link patient records across service providers, through installation and use of unique personal identification. Such technological innovation will improve case management; tracking drugs, supplies and services; minimizing duplication; training healthcare workers; supporting patients and educating the public; as well as diagnostic applications; training applications; distance learning courses; and public outreach and in-reach applications, including awareness and testing campaigns.

6. MONITORING AND EVALUATION

The National HIV and STI Strategic plan III recognizes that establishing effective systems for monitoring and evaluation (M&E) is a vital component for successful implementation of the strategic directions. Reflecting the "Three Ones Principle", a comprehensive national HIV/AIDS and STI monitoring, evaluation and research plan needs to be developed in line with the core indicators identified in the NSP III. The objective of the National ME&R plan is to provide timely and accurate strategic information to guide the planning of the national response to HIV/AIDS and STI, and to coordinate stakeholders towards one agreed country-level monitoring and evaluation system. The development of the M&E&R Plan must be participatory involving wider stakeholders and facilitate the Global Response Progress Reporting synchronized with national indicators. The partners involved in the implementation of the NSP III will continue to operate their own systems for programme monitoring and evaluation using standard common indicators. The targets set forth are aligned with the goal of the Fast Tracking and Ending AIDS.

Indicators and Targets:

1. Reduce 75% of new HIV infections;
2. Identify, recommend and test 90% of the key and vulnerable populations;
3. Treat 90% of those diagnosed as HIV positive;
4. Retain 90% of those on ART;
5. Retain 90% PLHIV on treatment, resulting in undetectable Viral Load
6. Zero vertical transmission of HIV and keeping mothers alive and well

In addition to the improving existing M&E system, included in the NSP III are broad interventions to build strategic evidence to inform the national programmes such as mapping of key populations; routine monitoring of overall programme coverage; monitoring of treatment services, including instituting early warning system; and operational research to increase the effectiveness of prevention, treatment, care and support programmes.

The mid-term review of the National Strategic Plan implementation will be conducted during 2020. The review will focus on the progress towards achieving the global and national targets and how the available inputs have been used and what outputs and short terms outcomes have been reached. The review will also focus on challenges, interactions between various key implementing partners, and produce evidence for programme adjustment as necessary.

Figure 7 Core indicators Framework

Strategic Direction		1.Prevention of HIV transmission through outreach and in reach				
No	**Indicator**	**Purpose**	**Numerator**	**Denominator**	**Data Source**	**Disaggregation**
1.1	Percentage of people reached by prevention communication	Coverage of IEC	Number of people who recall being reached by two or more communications about HIV prevention	Total population	NH surveys	Districts, gender, age
1.2	Percentage of young women & men (15–24 years) who correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions about HIV transmission	Comprehensive knowledge	Number of respondents aged 15-24 years who gave the correct answer to all five questions	Number of all respondents aged 15–24	NH surveys	District and gender
1.3	Percentage of men and women aged 15–24 reporting the use of a condom with non regular sexual partner at last sex	Measure success of prevention programmes	Number of young women and men reporting condom use at last sex	Total number of young men and women survey	NH surveys	Districts , gender, age
1.4	% women and men aged15–49 years who have had sexual intercourse with more than one partner in the last 12 months	Measure success of prevention programmes	Number of women and men reporting more than one sexual partner in the last month	Total number of young men and women surveyed	NH surveys	Districts , gender, age

1.5	% young women and men aged 15–24 who had sexual intercourse before age 15 (age at sexual debut)	Measure sexual debut of young people	Number of young women and men reporting their first sexual act below the age of 15	Total number of young men and women surveyed	NH surveys	Districts, gender, age
1.6	Male condoms distributed as part of prevention programme	Reach of condom distribution programme			Stock records	Districts and gender

Strategic Direction		2.Universal access to HIV and STI testing and screening				
No	Indicator	Purpose	Numerator	Denominator	Data Source	Disaggregation
2.1	HIV prevalence among women and men aged 15–24	Monitor trends in HIV prevalence	Number of men and women testing HIV- positive	Total number of men and women tested	DHIS	Districts, gender, age
2.2	HIV prevalence in key populations	Monitor levels of infection in these groups over time	Number of key populations testing HIV-positive	Total number of people (key populations) tested	DHIS	By key population
2.3	Percentage of Hepatitis C infection among key populations		Number of key population infected with Hepatitis C	Number of key population enrolled in the care programme	Vertical system	By key population, Age and gender
2.4	Number (and percentage) of men and women 15–49 counselled and tested for HIV	Reach of the HCT programme	Number of people who have been tested for HIV	Total number of people in the population	DHIS, mobile HCT reporting system	Districts, gender, age
2.5	Number (and percentage) of key population	Reach of target intervention	Number of key population who have been tested for HIV	Number of key population who	Vertical system	By key population

	counselled and tested for HIV			have been tested for HIV		
2.6	Number and percentage of registered TB patients who tested for HIV	Uptake of HIV testing by TB patients	Total number of patients registered over a given period, who are tested for HIV during their TB treatment	Total number of TB patients registered over the same given time period	TB Register, DHIS	Districts, gender, age
2.7	Percentage of antenatal care attendees positive for syphilis	Prevalence of STI	Number of syphilis positive cases	Total number of pregnant mother screened for syphilis	ANC records	District age

Strategic Direction	**3. Comprehensive continuum of care for PLHIV and people with STI and TB/HIV co-infection**					
.No	Indicator	Purpose	Numerator	Denominator	Data Source	Disaggregation
3.1	Percentage of PLHIV (adult and children) receiving antiretroviral therapy	ART coverage	Number of adults and children currently receiving ART in accordance with the nationally approved treatment protocol	Estimated number of adults and children living with HIV	Cohort Surveillance	Age gender and districts
3.2	Percentage of key population receiving ART	ART coverage for key population	Number of key population currently receiving ART	Number of key population living with HIV included in the sample	ART cohort records	Age and key population
3.3	Percentage of PLHIV known to be on treatment 12 months after initiation of ARV	Monitor adherence	Number of adults and children who are still alive and on ART at 12 months after initiating treatment.	Total number of adults and children who initiated ART who were expected to achieve 12-month outcomes within the reporting	ART cohort records	Age and gender

				period.		
3.4	Percentage of PLHIV with late diagnosis (first CD4 cell count <200 cells/μL)	Trend in diagnosis	Number of PLHIV with late diagnosis in reporting year	Total number of PLHIV with first CD4 cell count in reporting year	ART cohort records	Age and gender
3.5	Patients alive and on treatment	Retention in care	ART patients alive and on treatment at six, 12, 24, 36, 48 and 60 months	Total number of patients starting ART treatment	ART cohort records	ART cohort records
3.6	Percentage of people on ART tested for viral load (VL) with undetectable viral load in the reporting period	Continuum of care	Number of people on ART tested for viral load in the reporting period with undetectable viral load (i.e. ≤ 1000 copies)	Number of people on ART tested after 12 months therapy for VL during the reporting period	ART cohort records	ART cohort records
3.7	Viral load suppression 12months	Continuum of care			ART cohort records	ART cohort records
3.8	Proportion of HIV positive pregnant women initiated on ART	Vertical transmission	Positive pregnant mother initiated on ART	Total positive pregnant mother	PMTCT data	Age and Districts
3.9	Percentage of adult and children newly enrolled in HIV care starting isoniazid preventive therapy (IPT)	HIV/TB program	Number of adults and children newly enrolled in HIV care who also start (given at least one dose) IPT during the reporting period	Number of adults and children newly enrolled in HIV care during the reporting period	HIV/TB data	Age, gender and districts

7. RESOURCE MOBILIZATION FOR SUSTAINABILITY OF HIV RESPONSE

7.1 Sustainable Financing of NSP

Since the introduction of allopathic health system in 1961 coinciding with the second 5th Five year Plan, the allocations to social sectors like health have been a priority in Bhutan, with approximately 7% to 8% of the total outlay to provide equitable and free healthcare services. External resources play an important role in financing healthcare services including public health services. The total expenditure of the NSPII was approximately USD 10 Million over the five years. The expenditure is expected to increase for fast tracking the response during the NSPIII period. Domestic financing has been about 44% of the total budget, including the capital expenditure.

The present Global Fund grant of USD 5.7 million will expire by 2018, support from other donors including UN system is expected to become smaller as country transitioned to middle income coutry. The reliance on external funding to finance all health services has contributed in achieving many of the Millennium Development Goals. However, as Bhutan graduates from low income (LI) country to lower middle (LMI) income country, the external resources in health sector are expected to decline, and sustaining the current practice of free health care especially in light of the rising health care expenditure needs in-depth examination.

While the NSP III is specifically managed by the NACP, majority of the activity costs will be directly incurred within the overall health sector budget. While donor grants and external aid will continue to be a critical funding source for many of the interventions outlined in the NSPIII, international evidence suggests that domestic funding for health services is the key to long-term sustainability. In addition, while substantial donor funding may be available to support the scaling up of many NSP III-related interventions, planning for transition to the national funding and integration with existing programs would be vital for long-term sustainability. Thus, increasing the domestic financing is imperative for fast tracking and sustaining the response. Use of the Health Trust Fund mechanism for funding the response will be explored.

ANNEXURE 1: GLOSSARY OF TERMS

Biological surveillance: the collection and use of biological markers to inform surveillance, in this context, HIV surveillance systems. This term is replacing the term sero-surveillance because biological specimens other than serum are increasingly being collected routinely.

Case finding: case finding refers to activities related to identifying key populations, reaching key populations with prevention combination, offering HIV testing services and facilitating enrolment in care and treatment services

Case finders: those who facilitate case finding through offering prevention and testing services such as peer educators, outreach workers, peer influencers, counsellors, and female community health volunteers

Case management: management of services within clinical settings which provides HIV testing, care and treatment, monitoring ART adherence and viral load suppression, psycho social support, ensuring early management of co-infections

Case Managers: are those who provide case management services such as paramedics, doctors, lab technicians, and treatment adherence counsellors and educators

Combination HIV prevention: the combination prevention approach seeks to achieve maximum impact on HIV prevention by combining behavioural, biomedical, and structural strategies that are human rights-based and evidence-informed, in the context of a well-researched and understood local epidemic.

Community systems strengthening: the term 'community systems strengthening' refers to initiatives that contribute to the development and/or strengthening of community-based organisations in order to increase knowledge of and access to improved health service delivery. It usually includes capacity-building of infrastructure and systems, partnership-building, and the development of sustainable financing solutions.

Comprehensive HIV prevention, treatment, care, and support: comprehensive HIV prevention, treatment, care, and support includes tailored HIV prevention strategies, clinical care, adequate nutrition, psychological support, social and daily living support, involvement of people living with HIV and their families, and respect for human rights and legal needs.

Continuum of prevention: the term 'continuum of prevention' refers to a complement of HIV information support, and services that responds to the evolving behaviours, risks, vulnerabilities, and opportunities of individuals as they progress through various stages of their lives.

Concentrated epidemic: HIV has spread rapidly in a defined subpopulation (such as men who have sex with men, sex workers, transgender people, people who use drugs or people in prison or other closed settings) but is not well established in the general population. This type of epidemic suggests that there are active networks of people with high risk behaviours within the subpopulation. The future course of the epidemic is determined by the nature of the links between subpopulations with a high HIV prevalence and the general population. Numerical proxy: HIV prevalence is consistently over 5% in at least one defined subpopulation but is below 1% in pregnant women attending antenatal clinics.

Confirmed: to issue an HIV status, initially reactive test results need to be confirmed according to the national validated testing algorithm.

Critical enablers: critical enablers are "activities that are necessary to support the effectiveness and efficiency of basic programme activities". Programmes that are critical enablers "should be primarily assessed in terms of their

effectiveness in increasing the uptake, equitable coverage, rights-based delivery and quality of basic programme activities." Critical enablers also "overcome major barriers to service uptake, including social exclusion, marginalization, criminalization, prejudice and inequity."

Coverage: the extent to which a program is being implemented in the right locations (geographic coverage) and is reaching its intended target population (individual/population coverage).

Decentralization: the process of delegating or transferring significant authority and resources from the central ministry of health to other institutions or to field offices of the ministry at other levels of the health system (provincial, regional, district, sub-district, primary health-care post and community).

Development synergies: development synergies are "investments in other sectors that can have a positive effect on HIV outcomes". Some key development sectors—such as social protection, gender equality, health systems—present opportunities for synergies in multiple contexts. Development synergies "tend to have a broader range of impacts across health and development sectors. Although development synergies can have a profound impact on HIV outcomes, their primary objective is not typically related to HIV. Maximizing the HIV-related benefits and minimizing the HIV-related harm of development synergies would make them HIV-sensitive. The most relevant development synergies for HIV will vary according to epidemic and social contexts."

Early infant diagnosis: testing of infants to determine their HIV status, given that HIV can be acquired in utero (during pregnancy), peri-partum (during delivery), postpartum (through breastfeeding) or via parenteral exposure.

E-health: eHealth is the transfer of health resources and health care by electronic means. It encompasses three main areas:

- The delivery of health information, for health professionals and health consumers, through the Internet and telecommunication.
- Using the power of IT and e-commerce to improve public health services, e.g. through the education and training of health workers.
- Using e-commerce and e-business practices in health systems management.

Evidence and evidence-informed: in the context of research, treatment, and prevention, evidence usually refers to qualitative and/ or quantitative results that have been published in a peer-reviewed journal. The term 'evidence- informed' is preferred to 'evidence-based' in recognition of the fact that several elements may play a role in decision-making, only one of which may be scientific evidence. Other elements may include cultural appropriateness, concerns about equity and human rights, feasibility, opportunity costs, etc.

External quality assessment (EQA): inter-laboratory comparison to determine if the HIV testing service can provide correct test results and diagnosis.

Generalized epidemic: HIV is firmly established in the general population. Although subpopulations at high risk may contribute disproportionately to the spread of HIV, sexual networking in the general population is sufficient to sustain the epidemic. Numerical proxy: HIV prevalence is consistently over 1% in pregnant women attending antenatal clinics.

Harm reduction: the term 'harm reduction' refers to policies, programmes, and approaches that seek to reduce the harmful health, social, and economic consequences associated with the use of psychoactive substances. For example, people who inject drugs are vulnerable to blood-borne infections such as HIV if they use non-sterile injecting equipment. Therefore, ensuring adequate supplies of sterile needles and syringes helps to reduce the risk of blood-borne infections. Harm reduction is a comprehensive package of evidence-informed programming for people who use drugs. The nine components in the package are: opioid substitution therapy; HIV testing and counselling; HIV care and antiretroviral therapy for injecting drug users; prevention of sexual transmission;

outreach (information, education, and communication for people who inject drugs and their sexual partners); hepatitis diagnosis, treatment, and vaccination (where applicable); and tuberculosis prevention, diagnosis, and treatment.

HIV status: a collection of results from one or more assays. An HIV status is similar to HIV diagnosis. It refers to reports of HIV-positive, HIV-negative or HIV-inconclusive, whereas HIV diagnosis generally refers to HIV-positive diagnoses and in some cases HIV-negative diagnoses.

HIV test result: the result from a single test on a given assay.

HIV treatment cascade: the term HIV treatment cascade is used to refer to the chain of events that are involved in an HIV -positive person receiving treatment until his or her viral load is suppressed to undetectable levels. Each step in the cascade is marked by an assessment of the number of people who have reached that stage, making it possible to determine where gaps might exist in the treatment of people living with HIV. It emphasizes the need to focus on all the required steps in order to suppress the virus in the cohort of people living with HIV. The stages of the HIV treatment cascade are as follows: the number of people living with HIV; the number who are actually linked to medical care; the number who start HIV treatment; the number who adhere to their treatment regimen; and, finally, the number who suppress HIV to undetectable levels in their blood.

Indicator condition-guided HIV testing: a focused approach to test people more likely to be infected with HIV who are identified through indicator conditions, such as STIs, lymphoma, cervical or anal neoplasia, herpes zoster and hepatitis B/C. These conditions occur more frequently in HIV-infected people than in uninfected people, either because they share a common mode of transmission with HIV or because their occurrence is facilitated by the characteristic immune deficiency associated with HIV infection.

Integration: the co-location and sharing of services and resources across different disease areas. In the context of HIV, this may include the provision of HIV testing, prevention, treatment and care services alongside other health services, such as TB, STI or viral hepatitis services, antenatal care (ANC), contraceptive and other family planning services and screening and care for other conditions, including non-communicable diseases.

In-reach: community members or members of networks reaching other members within the community with services to prevent HIV, and offer treatment, care and support services

Investment approach: this approach maximizes the returns on investment in the HIV response. It allocates resources towards combinations of interventions that will achieve the greatest impact, and it enhances equity and impact by focusing efforts on key locations and populations with the greatest needs. An investment approach also improves the efficiency of HIV prevention, treatment, care and support programmes. It does this by using empirical evidence and modelling to identify priorities and gaps, as well as enabling countries to secure sustainable funding for HIV programmes. Finally, an investment approach provides the framework to align government domestic funding strategies for the medium and long term with donor-supported efforts.

Investment case: an investment case is a document that makes the case for optimized HIV investments. At its core, it is a description of returns on investment in a country's optimized HIV response over the long term (typically more than 10 years). It summarizes the state of the epidemic and the response, describing the prioritized interventions to be implemented— and the populations and geographic areas that should be focused on—in order to achieve the greatest impact, indicating the resources required. It also outlines the main access, delivery, quality and efficiency issues to be addressed in order to improve HIV services, and it describes what will be done to address these issues. Finally, it includes an analysis of (and plan for) realistic and more sustainable financing of the HIV response, incorporating increases in domestic financing where relevant. An investment case is a means of demonstrating national leadership in the response. It has the capacity to unite diverse stakeholders, including the ministries of finance, health, development and planning, civil society, people living with HIV and

international partners. It articulates a common effort to identify programmatic gaps and bottlenecks, and to create a road map for action.

Key populations: defined groups who, due to specific higher-risk behaviours, are at increased risk for HIV irrespective of the epidemic type or local context. These guidelines refer to the following groups as key populations: men who have sex with men, people who inject drugs, people in prisons and other closed settings, sex workers and transgender people.

Lay provider: any person who performs functions related to health-care delivery and has been trained to deliver specific services but has not received a formal professional or paraprofessional certificate or tertiary education degree.

Loss/lost to follow-up: this term refers to patients/research participants who at one point in time were actively participating in a clinical research trial, but who have since become lost at the point of follow-up. It also can refer to people who have registered to receive some kind of health service or commodity at a point in time, but who have not done so until completion, instead dropping out of care/treatment.

mHealth: mHealth is a component of eHealth. To date, no standardized definition of mHealth has been established. For the purposes of the survey, the Global Observatory for eHealth (GOe) defined mHealth or mobile health as medical and public health practice supported by mobile devices, such as mobile phones, patient monitoring devices, personal digital assistants (PDAs), and other wireless devices. mHealth involves the use and capitalization on a mobile phone's core utility of voice and short messaging service (SMS) as well as more complex functionalities and applications including general packet radio service (GPRS), third and fourth generation mobile telecommunications (3G and 4G systems), global positioning system (GPS), and Bluetooth technology.

National AIDS Spending Assessment (NASA): NASA describes the flow of resources spent in the HIV response from their origin to the beneficiary populations. It provides decision-makers with strategic information that allow countries to mobilize resources, and have a stronger accountability and a more efficient and effective programme implementation. NASA is a tool within the national monitoring and evaluation framework and is a recommended measurement tool to track HIV spending at the country level.

Negative predictive value: the probability that a person with a negative test result is not infected with HIV, that is, "true negative".

Non-reactive test result: a test result that does not show a reaction, indicating the presence of antibodies.

Opioid substitution therapy (OST): opioid substitution therapy is the recommended form of drug dependence treatment for people who are dependent on opioids. It has proved to be effective in the treatment of opioid dependence, in the prevention of HIV transmission, and in improving adherence to antiretroviral therapy

Out-reach: public, private and community services reaching out to key populations with prevention, care and treatment services.

Pre-test information: a dialogue and the provision of accurate information by a trained lay provider or health worker before an HIV test is performed.

Private services: any service outside the public sector that provides prevention, care and treatment services at the community, district, regional and central levels

Private for profit: private clinics or hospitals or medical corporates, which provide HIV prevention, care and treatment services based on profit and/or business model

Private for non-profit: not for profit non-government organisations (NGO), community based organisations, networks of key populations providing prevention, care and treatment services

Public services: services provided by the state such as health centres, hospitals, laboratories, which are managed by the ministry of health and other government ministries/sectors at community, district, regional and central level.

Prisons and other closed settings: prisons and other closed settings refers to places of detention that hold people who are awaiting trial, who have been convicted or who are subject to other conditions of security. These settings may differ in some jurisdictions, and they can include jails, prisons, police detention, juvenile detention, remand/pre-trial detention, forced labour camps and penitentiaries. There is a need to be inclusive in the language used to describe prisoners and other incarcerated people. Universal access to HIV prevention, treatment, care and support ideally should extend to these settings.

Post-exposure prophylaxis (PEP): post-exposure prophylaxis refers to antiretroviral medicines that are taken after exposure or possible exposure to HIV. The exposure may be occupational, as in a needle stick injury, or non-occupational, as in unprotected sex with a partner with HIV infection. The latter is sometimes referred to as N-PEP.

Pre-exposure prophylaxis (PrEP): pre-exposure prophylaxis (PrEP) refers to antiretroviral medicines prescribed before exposure or possible exposure to HIV. PrEP strategies under evaluation increasingly involve the addition of a post-exposure dosage.

Provider-initiated testing and counselling (PITC): the term 'provider-initiated testing and counselling' is used for HIV testing and counselling recommended by a health-care provider in a clinical setting. It is defined in contrast to client-initiated testing, where a person takes the initiative to seek information on his or her HIV status. Testing for diagnostic purposes may be recommended for all adults, adolescents, or children who present to health facilities with signs or symptoms that could indicate HIV infection. HIV testing may be recommended as part of the clinical evaluation of patients with sexually transmitted infections and during pregnancy in order to identify the need for antiretroviral treatment or prophylaxis. Regardless of the type of testing or location, all HIV testing should always be carried out under conditions respecting the three Cs—confidentiality, informed consent, and counselling.

Positive predictive value: the probability that a person with a positive test result is infected with HIV, that is, 'true positive'.

Quality assurance (QA): a part of quality management focused on providing confidence that quality requirements will be fulfilled.

Quality control (QC): a material or mechanism which, when used with or as part of a test system (assay), monitors the analytical performance of that test system (assay). It may monitor the entire test system (assay) or only one aspect of it.

Quality improvement (QI): a part of quality management focused on increasing the ability to fulfill quality requirements.

Quality management system: a system to direct and control an organization with regard to quality.

Rapid diagnostic test (RDT): in vitro diagnostic of immune chromatographic or immune filtration format for, in the case of HIV diagnosis, the detection of HIV-1/2 antibodies and/or HIV p24 antigen.

Repeat testing: refers to a situation where additional testing is performed for an individual immediately following initial test results, within the same testing visit, using the same assays and, where possible, the same specimen.

Retesting: there are certain situations in which individuals should be retested after a defined period of time: (1) HIV-negative people with recent or on-going risk of exposure, (2) people with an HIV-inconclusive status and (3) HIV-positive people before they enroll in care or initiate treatment. Reasons for retesting before initiation of care or treatment include ruling out laboratory or transcription error and either ruling in or ruling out seroconversion.

Reproductive health: reproductive health "is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. It implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility that are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant"

Self-testing (HIVST): a process in which an individual who wants to know his or her HIV status collects a specimen, performs a test and interprets the result by him- or herself, often in private. Reactive test results must be followed by additional HIV testing services.

Sensitivity: denotes the probability that an HIV assay will correctly identify all specimens that contain HIV-1/2 antibodies and/or HIV p24 antigen.

Sentinel surveillance: a type of surveillance that is conducted through selected sites among populations of particular interest or that may provide approximations of prevalence for a larger population, for example, in antenatal clinics.

Seroconversion: when an individual first produces a quantity of HIV antibodies sufficient to be detectable on a given HIV serological assay.

Sero-discordant couple: a couple in which one partner is HIV-positive and one partner is HIV-negative.

Strategic Behavioural Communication (SBC): is an interactive process with individuals and communities to develop tailored communication strategies, messages and approaches using a mix of communication channels and activities to promote healthier behaviours and support individual, community and societal improvement towards safer, less risk-taking behaviours. SBC supports the continuum of Reach, Recommend, Test, Treat and Retain (RRTTR) with strategic communication. It lends communication expertise to advocacy, social and community mobilization, and community action, to deliver consistent messages through multi-layered approaches and channels for maximum effectiveness.

Task sharing: the rational redistribution of tasks between cadres of health-care providers with longer training and other cadres with shorter training, such as trained lay providers.

Test for triage: a community-based HIV testing approach involving trained and supported lay providers conducting a single HIV RDT. The lay providers then promptly link individuals with reactive test results to a facility for further HIV testing and to an assessment for treatment. Individuals with non-reactive test results are informed of their results, referred and linked for appropriate HIV prevention services and recommended for retesting according to recent or on-going HIV risk and national guidelines.

Test and treat: a term used as a way of referring to voluntary HIV testing and the offer of antiretroviral therapy after diagnosis, irrespective of WHO clinical stage or CD4 cell count. The voluntary nature of both testing and treatment should be emphasized to ensure that individual autonomy is respected. Where test and treat is offered, it is necessary to establish strong support for adherence in order to keep people on lifelong treatment. In

addition, test and treat strategies always should be supplemented by strong combination HIV prevention, including risk reduction counselling, condom provision and/or PrEP. In settings where it is recommended, test and treat also can include referral to male circumcision services for men who test negative for HIV.

Testing strategy: generically describes a testing sequence for a specific objective, taking into consideration the presumed HIV prevalence in the population being tested.

Treatment as prevention (TasP): refers to prevention methods that use antiretroviral treatment (ART) to decrease the risk of HIV transmission. TasP works by using ART to reduce the HIV “viral load,” or the amount of HIV in the blood. A low viral load helps keep a person living with HIV healthy and greatly reduces the chance of HIV transmission to others.

Verified: people diagnosed HIV-positive are re-tested and their HIV diagnosis is verified before they initiate care or treatment.

ANNEXURE 2: LIST OF DOCUMENT REFERENCED

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ANNEXURE 3: LIST OF ORGANIZATIONS AND PEOPLE CONSULTED:

STAKEHOLDERS			
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1	Dr. Ornella Lincetto	WR	WHO
2	Dr. Ruben T.del Prado	Country Director	UNAIDS
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12	Mr. Phurpa Tenzin	Asst. Program Officer	NTCP, DoPH
13	Mr. Passang	RHP(Manager)	Dratshang Lhentshog
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3	Mr. Deki Phuentsho	DHO	Mongar
4	Mr. Karchung	DHO	Zhemgang
5	Mr. Namgye	DHO	Panbang, Zhemgang
6	Mr. Dorji Gyeltshen	DHO	Trongsa
7	Mr. Dawa Gyeltshen	DHO II	Samdrup Jongkhar
8	Mr. Singye Dorji	DHO II	Trashi Yangtse
9	Ms. Choki Wangmo	DHO	Bumthang
10	Mr. Tshewang Dorji	Dy. Chief DHO	Trashigang
11	Mr. Tashi Dawa	DHO	Tsirang
12	Mr. Tshering Penjor	DHO	Sarpang
13	Mr. Rinchen Dorji	DHO	Gasa
14	Mr. Samten	DHO	Haa
15	Mr. Gyembo Dorji	Dy. Chief DHO	Thimphu
16	Mr. Gopal Hingmang	Sr. DHO	Chhukha
17	Mr. Tashi Norbu	DHO	Punakha
18	Ms. Dechen Mo	Sr. DHO	Paro
19	Ms. Thinley Choden	DHO	Samtse
20	Mr. Kinga	ADHO	Wangdue Phodrang
21	Ms. Lemo	Sr. HA	Darla BHU, Chhukha
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24	Ms. Dhan Maya Tamang	Sr. HA	Samtse Hospital

Annexure 4: Members of the Technical task team

Task Team Memebers			
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1	Ms. Sangay Wangmo	NPO	UNDP/UNAIDS
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4	Ms. Srijana Ghaley	Program Officer	YDF
5	Mr. Wangda Dorji	Executive Director	Lhak-Sam
6	Mr. Choki Dorji	Regulatory Officer	DRA
7	Mr. Namgay Tshering	Program Manager/Offtg. Chief	NACP, CDD, DoPH
8	Ms. Kinley Zam	PO	PPD, MOH