**BHUTAN**

**Comprehensive Service Package for HIV/AIDS and STIs: A Guidance Manual**



**National HIV, AIDS & STIs Control Program**

**Department of Public Health**

**Ministry of Health**

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# Acronyms

AIDS Acquired Immunodeficiency Syndrome

ANC Antenatal Clinic

ART Antiretroviral Therapy

ARV Antiretroviral (drugs)

BCC Behavioral Change Communication

BHU Basic Health Unit

BNCA Bhutan Narcotic Control Agency

BSS Behavioral Surveillance Survey

CSO Community-Based Organization

CSW Commercial Sex Worker

DIC Drop-in Centre

DOPH Department of Public Health

FSW Female Sex Worker

GNHC Gross National Happiness Commission

HISC Health Information Service Centre

HIV Human Immunodeficiency Virus

HMIS Health Management Information system

HRW High Risk Woman

IBBS Integrated Biological Behavioral Surveillance

IEC Information, Education and Communication

JDWNRH Jigme Dorji Wangchuck National Reference Hospital

KP Key Population

MCH Maternal and Child Health

MoH Ministry of Health

MSM Gay men and other men who have sex with men

NACP National HIV/AIDS and STI Control Program

NCWC National Commission for Women and Children

NGO Non-Governmental Organization

NSP National HIV, AIDS and STI Strategic Plan 2017-2023

ORW Outreach worker

OST Opioid Substitution Therapy

PHC Primary Health Centre

PICT Provided Initiated Counselling and Testing

PEP Post-Exposure Prophylaxis

PMTCT Prevention of Mother-To-Child Transmission

PORW Peer Outreach Workers

PrEP Pre-Exposure Prophylaxis

PWID People who inject drugs

PWUD People who use drugs

RENEW Respect Educate Nurture and Empower Women

SKPA **Sustainability of HIV Services for Key Populations in Asia Program**

STI Sexually Transmitted Infection

TB Tuberculosis

TG Transgender

TGM Transgender Man

TGW Transgender Woman

UNAIDS Joint United Nations Program on HIV/AIDS

UHC Universal Health Coverage

VCT Voluntary Counselling and Testing

VL Viral Load

VHW Village Health Worker

WHO World Health Organization

# BACKGROUND

Since the detection of first case in 1993, there are 741 cases detected as of June 2020. While, the HIV cases detection has increased steadily, there still exist a huge detection gap. UNAIDS has estimated 1300 HIV cases in Bhutan. Underneath a fairly steady and static HIV prevalence, there is an increased risk of proliferating epidemic among key populations forming the main agents in transmission. Sustainability of HIV response depends on addressing the needs of key populations focusing on geographical coverage and hard to reach pockets. The population size estimates report undoubtedly highlights the importance of analyzing sexual transmission route. Whether Bhutan will follow a progression towards a larger epidemic concentrated among key populations or a trajectory towards eliminating HIV by 2030 may hinge upon reaching CSW, MSM, TGW, TGM and other key population with effective programs*.[[1]](#endnote-1)* The program data does not substantiate the exact mode of transmission. The huge number of testing done by the NACP in 2019, yielded only 60 cases out of 80713 total tests.[[2]](#endnote-2)

The HIV/AIDS services are provided through 54 hospitals and 186 primary health care centres. While, the PHC provide mostly public health services, the hospital provides the clinical and patient care services. These three-tiered health care delivery systems, reaches to all the people and all services are provided free of cost including hospital admissions, patient diet and medicines.

In addition, specific HIV/AIDS services are provided vertically from Health Information and Counselling Centres (HISC). These centres have dedicated counsellors providing HIV Testing and Counselling Services. There are 31 HCT counsellors. There are standalone VCT centres (HISC) in high-risk areas and in the low-risk areas, there are dedicated focal person. The VCT centres in the hospital are well integrated with the maternal and child health clinics (MCH) and have dedicated office space with required office equipment. There are six health information and service centres (HISCs) in major urban areas where there high economic activity. In these six centres, there are two health counsellors, supported by peer outreach workers. However, service package review report also highlighted that some of the current peer outreach workers are not from the community. These centres also link the prevention, treatment and care services and acts as a regional nodal agency for HIV/AIDS prevention, treatment and care services.

The current approaches, has not yielded adequate level of testing among the key population. The situation is not only worrying but puts forward a public health concern of neglected issues of the KP groups as well as the vulnerable populations. The low number could possibly due to stigma, discrimination and confidentiality issues that KP groups often encounter. Hence a need for strengthen the measure to increase the access and reach of the HIV/AIDS service package to the key population.

The current HIV prevention services delivered through the above-mentioned facilities includes testing, condoms and lubricants distribution. In addition, educational activities are also conducted through one-to-one education, group education, mass awareness through public campaigns and multimedia channels. Anti-Retroviral Therapy are also provided to all HIV positive cases with an objective to reach 100% treatment for all detected cases. Timely Viral Load and CD4 testing are also provided to ensure the quality of the life of the people living with HIV. The review service package conducted in 2019, highlighted the need to strengthen the services to key and vulnerable population. The review also highlighted the gaps in the provision of services with the NSP andrecommended to provide following critical interventions which are currently not provided:

* Pre-Exposure Prophylaxis and Post Exposure Prophylaxis as per the national HIV/AIDS treatment guidelines.
* Harm Reduction,
* Community-Led HIV Counselling and Testing-Lay provider
* Self-Testing.
* Develop the outreach strategies with clear roles and responsibilities of the implementing.

# Scope of this guidance document

This guidance document highlights on the comprehensive service package for HIV/AIDS in Bhutan and how these services will be delivered to the key population, through out-reach workers. This guidance documents will guide HIV/AIDS program, NGO and other service providers to provide an effective service to the key population and ultimately improve the uptake of HIV/AIDS services by key population.

# GOALS & OBJECTIVES

The current strategy for the national response towards the prevention and control of HIV/AIDS and STIs in Bhutan is to achieve the 90-100-90 targets by 2025 to end the AIDS epidemic by 2030. Aligning with Bhutan’s “*Treat All Policy*” and the New Global targets of 95-95-95, Bhutan strives to achieve 95-100-95 targets by 2030 by implementing the actions proposed in this guidance documents. The document will achieve following objectives:

* To provide comprehensive HIV and STIs prevention services for the key population through community-based HIV continuum of prevention and care services
* To provide clear guidance on the mode of HIV/AIDS and STIs service delivery for the key populations by the HISCs and ORWs (Peer Out-reach Workers).
* To ensure effective management of the ORWs and improve the overall coordination and service linkages for timely testing and treatment.
* To establish the effective monitoring and supervision of the targeted interventions.

# GUIDING PRINCIPLE

The following guiding principles are essential during the provision of the comprehensive service package to the key population.

**Respect Human Rights**

The services provided to the key population should be non-discriminatory and respect the autonomy of the key population. It is derived from article 7 of the constitution of Bhutan, which enshrines non-discriminatory and autonomy as fundamental rights of the citizen.

**Gender equity and equality**

Inequality and inequity based on sex, sexual orientation, gender and gender identity and expression cause major vulnerability to HIV infection and increase the negative impact to people living with HIV/AIDS. The services should reach to the key population in equitable manner leaving “*no one behind*” particularly the marginalized and key population. Health and community systems should respond to the gender-specific needs of individuals[[3]](#endnote-3).

**Informed consent and confidentiality**

Following the principles of right based approach and autonomy, the services to the key population should be provided after seeking informed consent and service providers should maintain confidentiality of the information. This guidance document elaborates on respecting privacy, confidentiality of information, data storage and maintaining anonymity.

**Honesty and Integrity**

Honesty is about being straightforward with clients, which is an absolute necessity to build rapport and maintain their trust. Being frank and open with clients is essential to build good rapport and talk freely about their situation and personal issues.8 Integrity is about being honorable and decent at all times.

**Appropriateness**

All the information on HIV/AIDS and STIs including sexual and reproductive health should be based on the needs of the individual key population.

**Responsibility and accountability**

While providing service to the key population, the ORW, HISC Counselor and staff involved should adhere to the signed terms of reference and be accountability to the key population.

**Meaningful involvement of infected and affected population**

Development of policies, decision and strategies needs involvement and engagement of key population, so that that it suffices the needs of and is conducive towards the key population.

**Multi-sectoral partnership.**

The community-based HIV prevention needs to be holistic and multi-dimensional through the participation of the key and vulnerable populations, relevant CBO/NGOs and other relevant stakeholders.

# OPERATIONAL DEFINITION OF KEY AND VULNERABLE POPULATION

This guidance document has adopted following key definitions:

**Key populations:** These are defined groups, who due to specific higher-risk behaviours, are at increased risk of getting HIV infection. For the purpose of this guidance document, the key population are MSM, Transgender, Sex Workers, Female Sex Worker, People in prison and closed setting, Injecting Drug Users (IDUs).

**Vulnerable population:** These are groups of people who are particularly vulnerable to HIV infection in certain situations and contexts. This includes key population and high-risk women. Sex workers include female, male and transgender adults who receive money or goods in exchange for sexual services, either regularly or occasionally, People who work in entertainments and have high risk of having multiple sexual partners and others.

**Female Sex Workers (FSWs):** FSWs are those females who provides sexual services in exchange of money or goods. It always involves a sex worker and a client and it frequently also involves a third party.

**Men who have Sex with Men (MSM):** Refers to all men who engage in sexuality and/or romantic relations with other men. They may identify as gay, homosexual, bisexual, pansexual, or heterosexual.

**Transgender (TG):** Is an umbrella term used to describe the full range of people whose gender identity and/or gender role do not conform to what is typically associated with their sex assigned at birth. This includes transsexual, transgender and otherwise gender non-conforming. TG people may self-identify as transgender, female, male, transwomen or transman, trans-sexual.

**Pansexuality:**  is sexual, romantic, or emotional attraction towards people regardless of their sex or gender identity. Pansexual people may refer to themselves as gender-blind, asserting that gender and sex are not determining factors in their romantic or sexual attraction to others.

**People who use Drugs (PWUD):** Are those populations who inject a drug into the bloodstream via a hollow hypodermic needle and a syringe, which is pierced through the skin into the body.

**People in close setting:** People in prison and other closed settings refers to all places of detention in the country.

**Outreach services by HISC:** The targeted intervention to key and vulnerable populations through the Health Information and Service Center (HISC) on HIV/AIDS education, condom distribution, HIV/STIs Testing and other services as defined time to time by the MOH.

**Outreach services by CBO:** is a targeted intervention carried out by the members of the key populations based on the national standards and procedures without the direct participation of the trained HISC counsellors or health workers as a part of the community-led HIV/AIDS and STIs prevention strategy. For example, trained community ORWs from MSM will reach his MSM network with the comprehensive HIV and STIs prevention services and link them to HISC for an appropriate service. Same applies to TG, FSWs and IDUs.

**Peer**: Is a friend who has a similar background such as profession (or linked to the profession), age and language, live in the same geographical area, has similar social status or is a member of the same KP network or CSW. For example, Peer is recruited from MSM, TG, FSWs and IDUs to work as Outreach Workers (ORWs) to reach their communities with the comprehensive package of HIV prevention services.

**Peer education:** Is a process of carrying out informal or organized educational activities with individuals or small groups of peers, over a period. Peer education occurs in a variety of settings and includes many different activities in the areas of prevention and control of HIV, AIDs and STIs.

**Outreach Worker (ORW)**: A person who has agreed to work for the key population community as per the defined roles and responsibilities which could be imparting knowledge to bring positive behavior change(s) related to HIV/AIDS and STD and also assist in conducting HIV Counseling and Testing.

# INTRODUCTION TO HIV/AIDS

**What is HIV?**

* HIV stands for human immunodeficiency virus. As the name suggests, it only causes disease in humans by attacking and destroying the white blood cells of our immune system. The white blood cells in our body are also referred to as T-cells (T-Lymphocytes) and CD4 cells.
* The main function of the white blood cells (RBC) is to help our body fight the infection by attacking any bacteria, virus and germs that invade our body. Therefore, the loss of white blood cells makes our immune system weaker and unable to defend from the infections. If left untreated, it may take up to 10 or 15 years for the immune system to be severely damaged and can no longer defend from infections and diseases. This is an indication of advancing to AIDS. However, the duration of HIV advancing to AIDS depends upon person’s age and overall health condition.

**What is AIDS?**

* AIDS stands for acquired immunodeficiency syndrome and is not a virus but a set of symptoms caused by HIV virus. We called person has developed AIDS when his/her immune system becomes too weak to fight against any infections thus showing some symptoms of illnesses. This is the last stage of HIV infection in our body and if left untreated will ultimately lead to death.

**How is HIV transmitted?**

1. HIV can be transmitted from person to person if infected body fluids such as (blood, semen, vaginal or anal secretions and breast milk) come in contact with our blood in the body. There are four main ways where these fluids can come in contact with each other:
2. Having unprotected sex (vaginal, oral and anal) without using condoms with an HIV infected person. Anal sex possesses much higher risk of HIV transmission than vaginal sex.
3. Transfusion of HIV infected blood or blood products including organ transplants.
4. Sharing of HIV infected needles, syringes, blades and piercing instruments.
5. HIV infected pregnant mother to her child (during pregnancy, or at the time of delivery or during breast feeding).
6. HIV can transmit from person to person only if infected body fluids such as (Blood, semen, vaginal or anal secretions and breast milk).

**How HIV is not transmitted?**

You will not get HIV by....

1. Hugging, shaking and holding hands with a person with HIV
2. Living, sitting, eating and swimming together with HIV infected person.
3. Sharing of utensils, towels and cloths with HIV infected person.
4. Coughing and sneezing because HIV cannot survive in the air.
5. Insect bites such as mosquito because it only sucks your blood but does not inject the blood of the last person it bit.

**Main ways of preventing the HIV and Sexually Transmitted Infections (STIs).**

ABCD is the commonly use terminology to remember HIV prevention….

* A: Abstinence from unsafe sex
* B: Being faithful to your spouse or the regular partner
* C: Correct and consistent use of condom
* D: Do not use drugs

**Common symptoms of HIV/AIDS**

Within 2 to 4 weeks after a person becomes infected with HIV, they may have flu-like symptoms, such as fever, chills, or rash. The symptoms may last for a few weeks after they become infected.

* After this earliest stage of HIV infection, HIV continues to multiply but at very low levels. More severe symptoms of HIV infection, such as signs of opportunistic infections, generally don’t appear for many years. (An opportunistic **infection** is an **infection** caused by any pathogens such as bacteria, viruses, germs and fungi etc. that take advantage of an **opportunity** not normally available, such as a host with a weakened immune system). Without treatment with HIV ART medicines, HIV infection usually advances to AIDS in 10 years or longer, though it may take less time for some people.
* An opportunistic **infection** is an **infection** caused by pathogens (bacteria, viruses, fungi, or protozoa) that take advantage of an **opportunity** not normally available, such as a host with a weakened immune system.

# INTRODUCTION TO OTHER STIS

Sexually transmitted infections (STI), also referred to as sexually transmitted diseases (STD) are infections that are commonly spread by sex, especially vaginal intercourse, anal sex or oral sex. In short, the route of transmission is same like that of HIV. HIV itself is one form of STIs.

|  |  |
| --- | --- |
| **Most common form of STIs in Bhutan** | **Common Signs and Symptoms** |
| Chlamydia | * *Burning sensation during urination and an abnormal vaginal/penis discharge;* * *Abdominal or pelvic pain is sometimes present for female.* * *Blood in* the urine, urinary urgency (feeling an urgent need to urinate), and increased urinary frequency can occur if the urethra is infected. * Inflammation, tenderness and pain in and around the testicles. |
| Gonorrhoea | * greater frequency or [urgency of urination](https://www.healthline.com/symptom/urinary-urgency) * A pus-like discharge (or drip) from the penis (white, yellow, beige, or greenish) in male. * [Discharge](https://www.healthline.com/health/womens-health/what-is-discharge) from the vagina (watery, creamy, or slightly green) in female. * swelling or redness at the opening of the penis (Male) * [swelling](https://www.healthline.com/symptom/swelling-of-scrotum) or [pain](https://www.healthline.com/symptom/pain-in-testicle) in the testicles (Male) * A persistent sore throat (Male & Female) * Burning sensation while urinating (Male and Female) * [Pain](https://www.healthline.com/symptom/pain-with-intercourse) upon engaging in sexual intercourse (Female) * sharp pain in the lower [abdomen](https://www.healthline.com/symptom/abdominal-pain) * [Fever](https://www.healthline.com/symptom/fever) (Female) * [Heavier periods](https://www.healthline.com/symptom/menstrual-irregularity) or [spotting](https://www.healthline.com/health/vaginal-bleeding-between-periods) (Female) |
| Syphilis | * Sore throat * Fever * Swollen lymph glands * Headaches * Fatigue * Muscle aches * Wart-like patches around skin folds or genitals * Loss of appetite * Joint pain * Enlarged lymph nodes |
| Trichomoniasis | * Irritation and itching in the genital area * [Thin or frothy discharge](http://www.medicinenet.com/vaginal_discharge/symptoms.htm) with an unusual foul odour that can be clear, white, yellowish, or greenish * Discomfort during sex and when urinating |
| Viral Hepatitis B | * Abdominal pain. * Dark urine. * Fever. * Joint pain. * Loss of appetite. * Nausea and vomiting. * Weakness and fatigue. * Yellowing of your skin and the whites of your eyes (jaundice) |
| Herpes simplex | * Blistering sores (in the mouth or on the genitals) * [pain during urination](https://www.healthline.com/symptom/painful-urination) (genital herpes) * [itching](https://www.healthline.com/health/itching) |
| Human papillomavirus (HPV) | * Genital warts: The small cauliflower flat lesions and in women it usually occurs on the vulva, near the anus and on the cervix or in the vagina. While in men it appears on the penis and scrotum or around the anus. The Genital warts rarely cause discomfort or pain, though they may itch. * Common warts: Appear on the hands, fingers and elbows. It looks unpleasant and it’s painful or susceptible to injury or bleeding. * Plantar warts: They are hard and usually appear on the heels or balls of your feet. Causes discomfort. * Flat warts: It looks little darker than your skin and appear anywhere. However, in children usually appears on face and men tend to get them in beard area while women get it on the legs. |

# COMPREHENSIVE HIV/AIDS SERVICE STANDARD

A combination of interventions is required to respond effectively to HIV prevention and control among key populations. WHO recommends the health sector interventions which include components such as behaviour change communication, condom and lubricants, peer outreach, facility and community based self-testing, as effective interventions for the prevention and control of HIV/AIDS and STIs. In addition, care, support, and treatment for HIV and STIs, sexual and reproductive health is also identified as effective care and treatment programs for those key population and people living with HIV and STIs.[[4]](#endnote-4)

Bhutan has specified in three distinct part which is well linked with the national target of 95-100-95 derived from UNAIDS global target 95-95-95 to end the AIDS epidemic by 2030. General HIV/AIDS and STIs prevention packages to enhance the comprehensive HIV transmission and prevention as part of the first 95% target. Differentiated HIV Testing Services to diagnose 95% of the estimated PLHIV in Bhutan by 2025. Linkage to Care, Support and Treatment to ensure 100% of the diagnosed PLHIV on treatment and 95% of PLHIV on treatment to achieve viral suppression by 2025. The summary and approaches of the comprehensive HIV preventions, diagnosis and treatment for the key population are summarized in Table 1. These services are based on the KP service package, however, to make it more comprehensive this guidance documents have highlighted additional platforms that has potential for providing services.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Table 1. Summary and approaches of comprehensive HIV prevention, diagnosis and treatment services for the key population in Bhutan | | | | |
| General HIV/AIDS and STIs prevention packages | | | | |
| Interventions | Target population | Materials | Point of delivery | Who will deliver |
| HIV/AIDS and STIs awareness and education. | MSM/TG/MSW/FSWs/Clients of Sex Workers, HRW, PWID, Prisoners, PLHIV, uniform personnel, religious personnel, adolescents, migrants, transport workers. | BCC materials in Dzongkha and English (electronic, and paper-based) | Health Centres, HISC, DICs, Mobile testing sites, CBS/NGOs, and at the community level, Youth Centres, AFHS | Clinicians, VCT/HISC Counsellors, MSTF, outreach workers, CBSS, HIV related CBO/NGOs, Outreach Workers and Youths etc. |
| Male condoms | MSM/TG/MSW/FSWs/Clients of Sex Workers, PWID, Prisoners, PLHIV, adolescents, migrants and transport workers. | Male condoms | Health Centres, HISC, DICs, Mobile testing sites, CBS/NGOs. Condom vending machines, hotels, entertainment centres., Pharmacy retailers, Youth Centres. | Health workers, community outreach workers, outreach workers, HIV related CBO/NGOs, Outreach Workers and Youths groups etc |
| Lubricants | MSM/TG/MSWs/FSWs & PLHIV. | Water-based lubricants. |
| Harm Reduction-Needle and Syringe program | People who inject drugs | Needles and syringes\* | HISCs and DICs, | HISC Counsellors and DIC outreach workers. |
| Harm Reduction-Opioid substitution therapy. | People who inject drugs | Buprenorphine and Tramadol. | Regional Referral Hospitals | Clinical staff |
| Pre-Exposure Prophylaxis (PrEP) | MSM, MSW, TG people, FSWs and negative partner of PLHIV who are at substantial risk of HIV. | ART | Hospitals | Clinical staff (As per National Treatment Guidelines, 2020) |
| Post-Exposure Prophylaxis (PEP) | HIV-negative people exposed to the risk of HIV infection. | ART | HISC, Hospitals | Clinical staff (As per National Treatment Guidelines, 2020) |
| Sexually Transmitted Infection (STI) Management | Men who have sex with men, male sex workers, transgender people, female sex workers, clients | As per the treatment guidelines | Hospitals and HISCs | Clinical staff or VCT/HISC Counselors. |
| Differentiated HIV Testing Services for 95% diagnosis of the estimated PLHIV | | | | |
| Interventions | Target population | Materials | Point of delivery | Who will deliver |
| Provider initiated HIV-Counselling and Testing (HCT). | Pregnant mothers, STIs patients, TB patients, other patients undergoing an invasive surgical procedure and those attending OPDs, Walk-in clients. | Rapid test kits. | Hospitals (VCT centre, OPD/IPD and then HISCs. | HISC/VCT counsellors or Lab Tech. |
| Stand-alone HCT services. | Defined key and vulnerable populations of this document. | Rapid whole blood finger prick test kits and oral HIVST. | HISC | HISC Counsellor |
| Community based mobile HCT. | Vulnerable populations | Rapid whole blood finger prick test kits. | HISC | HISC staff supported by community ORWs. |
| HIV –Self Testing | Key and vulnerable population | Oral HIVST kits | HISC, CBO, NGO, Pharmacy retailers\*\*, Youth Centres\*\* | Key and vulnerable population |
| Index Testing. | Sexual and injecting partners of individuals living with HIV, their biological children, and the biological parents of HIV-positive children | Rapid test kits | HISC and Health centres | HISC/VCT Counsellors and PLHIV Network Organization. |
| Linkage to care, support and **100%** treatment for 95% viral suppression | | | | |
| Referral, linkages and follow up | Diagnosed PLHIV | ART drugs | HISCs, Health Centres and community-based testing centres. | Health workers/community home-based care teams including outreach workers. |
| Viral Load Testing including Early Infant Diagnosis | Diagnosed PLHIV on ART | GeneXpert machines and cartridges | -Identified Viral load testing labs.  -Viral load sample collection sites | Laboratory and clinical staff including HISC/VCT counsellors. |
| CD4 testing | Diagnosed PLHIV and those lost to follow up clients re-entering into continuum of care. | CD4 machine and cartridges | -Identified CD4 testing labs.  -CD4 sample collection sites | Laboratory and clinical staff including HISC/VCT counsellors. |

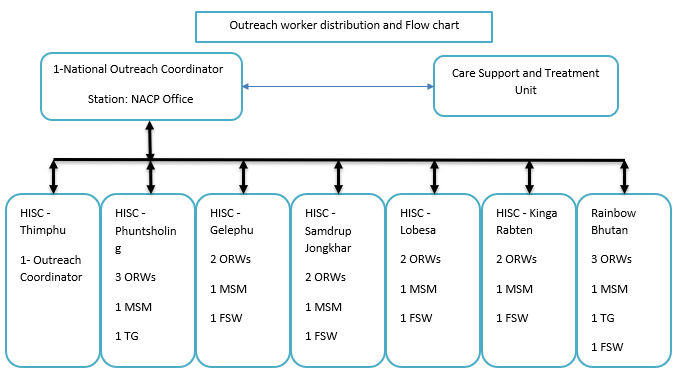
*\*This service may be implemented after obtaining policy clearance as there is no policy on this currently in Bhutan. \*\* The HIVST distribution through retail pharmacy, youth centers and any new outlets may require prior discussions, training and guidelines.*

# MANAGING TARGETED PEER OUTREACH WORKERS

Reaching the services to the key population, has been the challenge in many countries. The challenge is compounded by presence of stigma and discrimination, legal barriers, hidden population and other factors. Therefore, involving the Outreach Workers (ORWs) has become a necessary medium to reach to the key population. Investment to the peer outreach workers has shown to yield good dividends and has proven to be vital for providing HIV/AIDS services to reach to the key population including linking to care and support systems and retention with referral and cases management systems. The services provided by the peer outreach workers can be either outreach services and in-reach services.

**Structure of the HISC and Outreach Worker’s Team**

The NACP in collaboration with Lhak-Sam, Rainbow Bhutan and other key population networks will ensure the overall functioning of peer out-reach workers in Bhutan (Figure 1). There will be a national outreach ccoordinator stationed at the NACP and then District ORW Coordinator at each HISCs. The national outreach coordinator can either be from the key population or a social worker but preferably have a minimum of educational qualification of bachelor degree in social science or relevant field. Likewise, at the district level there will be a district outreach coordinator who will be the trained counsellors responsible for the overall management and coordination of the outreach activities. In Thimphu, Rainbow Bhutan will have three ORWs each for MSM, TG and FSWs. However, for the rest of the districts where there are no community-based office, outreach workers from each community (MSM, TG & FSWs) will be stationed at the HISCs.



Regarding the management of the diagnosed PLHIV the Care, Support and Treatment (CST) Unit at the JDWNRH under the Ministry of Health will be responsible for all the clinical based care and treatment. The Lhak-Sam and other related NGOS/CBOs will be partnering with the NACP and HISC Centres across the country in linking the diagnosed PLHIV for clinical care and treatment including assisting in carrying out the contact tracing/partner notification and providing social, family and economic support to the PLHIV. Lhak-Sam and relevant NGOs/CBOs will also provide necessary social support to those economically challenged PLHIV based on their guidelines and standards. One regional Coordinator of Lhak-Sam will be stationed at HISC to work in close coordination with district outreach coordinator at HISC for the smooth implementation of the annual outreach plan.

MANDATES OF HISC, DIC, HIV RELATED CBOS AND NGOS.

## Mandates of the HISC

**General HIV/AIDS and STIs prevention packages**

* Coordinate the conduct of outreach and in-reached activities for the key and vulnerable population to deliver the following the prevention services;
* HIV/AIDS and STIs awareness and education
* Condom and lubricant promotion
* Awareness and education on PrEP and PEP
* Management of overall condom and lubricant promotion in coordination with the relevant stakeholders.
* Coordinate and monitor the condom and lubricant distribution through the ORWs, CBOs and NGOs for key populations.

**HIV Testing and Counselling**

* Conduct Voluntary Counseling and Testing (VCT) for those walk-in clients.
* Carry out provider-initiated HIV Counseling and Testing for key and vulnerable populations.
* Carry out the community-based HIV Counseling and Testing in coordination with the Outreach Workers and other KP networks.
* Provide technical assistance in terms of counselling and testing for the OWRs in carrying out the community-led testing (Finger prick and HIVST).
* Coordinate and manage the overall index testing for partner notification among all the diagnosed PLHIV.
* Coordinate and provide community-based testing, community-led testing and self-testing based on the CBT and national testing guidelines.

**Care, Support and Treatment**

* Initiate HIV treatment in coordination with the Care, Support and Treatment Unit, of the respective hospital as per the national treatment guidelines.
* Management of opportunities infections of PLHIV in coordination with the CST Unit of the respective hospital.
* Management of the lost to follow of the PLHIV on treatment.
* Referral for treatment and management of PLHIV, VL and other care and supports

**Logistics management**

* Ensure a consistent supply of rapid HIV testing kits, other laboratory consumables and equipment as per the National HIV Testing and Counseling guidelines needed to discharge the above mandates efficiently and effectively.

**Monitoring and supervision**

* Train, provide supportive supervision and monitoring of the peer outreach workers as per the agreed monitoring and evaluation framework.
* To monitor the overall outreach and in-reached activities carried out by the ORWs and other KPs as a part of the national response towards prevention and control of HIV, AIDS and STIs.

## Mandates of Rainbow Bhutan

* At present Rainbow Bhutan (https://rainbowbhutan.org/what-we-do/) is the lead organization for the key population (MSM/TG and FSWs) community in Bhutan.

**Roles and Responsibilities are follows:**

* To implement the community-based HIV prevention services through advocacy and awareness among the key and vulnerable populations in Bhutan.
* To implement community based-HIV testing services in coordination with the HISCs as per the CBT and national HCT guidelines.
* To carry out networking of the key community members and update the list and share it with the NACP for planning and resource allocation as per the signed annual performance framework.
* To maintain proper recording and reporting of the HIV Counseling and Testing services and other prevention services as per the national standards and guideless and report on timely basis.
* To implement the community-based monitoring and report to the NACP for appropriate actions to ensure accessibility of quality HIV prevention and other health services for the defined KPs.
* Assist the HISC & CST under NACP to link the diagnosed KPs for care, support and treatment.
* Assist the HISC and CST under NACP to carry out index testing for partner notification or contact tracing of the defined KPs.

## Mandates of the Lhak-Sam

Lhak-Sam ( <https://www.lhaksam.org.bt/>) as the lead organization for the network of people living with HIV and has following mandates:

* To implement the community-based HIV prevention services through advocacy and awareness among the identified key and vulnerable populations.
* To implement community based-HIV testing services in coordination with the NACP and HISCs as per the CBT and national HCT guidelines to the identified population.
* To carry out networking of the PLHIV members and update the list and share it with NACP as a part of signed annual performance framework.
* To maintain proper recording and reporting of the HIV Testing and Counseling and other prevention services as per the national guidelines and report to NACP as per the signed annual performance framework.
* To implement the community-based monitoring and report to the NACP for appropriate actions to ensure accessibility of quality HIV prevention and other health services for the defined KPs.
* Facilitate and extend social support to economically disadvantage PLHIV.
* Assist the HISC & CST under NACP to link the diagnosed PLHIV for care, support and treatment.
* Assist the HISC and CST under NACP to carry out index testing for partner notification or contact tracing of the defined KPs.

## Mandates of the Drop in Centers

Drop-in Centers (https://bnca.gov.bt/divisions/demand-reduction-division/) is an initiative of the Bhutan Narcotics Control Agency as part of the demand reduction. The active participation of the DICS and their support in the implementation of community-based HIV prevention services is crucial to meet the national targets. Therefore, the following responsibilities can be carried out by DIC.

* Implement the harm reduction prevention services like NSP as a part of the community-led HIV prevention services in coordination with the respective HISCs and other relevant VCT centres for the DUs and IDUs.
* Assist the linkage of DUs and IDUs for the OST to relevant health centres as a part of the community-based HIV prevention services.
* Support the NACP in carrying out the outreach activities for the DUs/IDUs and other vulnerable populations through awareness education and HIV and other STIs testing services.
* Support the national program in the linkage of DUs and IDUs for HIV testing, care, support and treatment.
* Extend social support to those infected and affected communities as per the mandates of their organization.

## Roles and responsibilities of HISC Counselors

* Coordinate and conduct HIV and AIDS advocacy and awareness in close coordination with the relevant CBOs and NGOs in their respective jurisdiction.
* Develop the annual work plan, in collaboration with focal points in Rainbow Bhutan and Lhak-Sam, of the targeted interventions through outreach and in-reached activities and submit to the Outreach Coordinator, NACP.
* Develop the annual condom and lubricant distribution plan, in collaboration with focal points in Rainbow Bhutan and Lhak-Sam, for the estimated key and vulnerable populations within their jurisdictions and submit to the Outreach Coordinator, NACP.
* Develop the detailed plan of action and strategies to carry out contact tracing of the new index cases and submit the Outreach Coordinator, NACP.
* Coordinate the condom distribution through condoms vending machines, ORWs, PORWs and HIV related CBO and NGOs.
* Ensure condoms vending machines are maintained and refilled on a timely basis.
* Provide HIV Counselling and Testing for walk-in clients.
* Coordinate and conduct community-based outreach activities in coordination with focal persons in Rainbow Bhutan, Lhak-Sam and DICs and with the support of ORWs.
* Monitor and supervise the community-led HIV counselling and testing and coordinate with the focal persons in Rainbow Bhutan, Lhak-Sam, DICs and the ORWs for follow up on the result.
* Monitor the implementation of MoH funded outreach activities by the KP related CBOs and NGOs within their jurisdiction.
* Initiate tracing of the loss to follow up of HIV cases in coordination with the other HISCs and VCT centres of the hospital.
* Prepare the quarterly report of the planned activities in coordination with the designated focal persons and then submit to the Outreach Coordinator, NACP.
* Maintain the HIV testing and counselling records by updating it in the DHIS-2 system in timely basis.
* Support NACP to facilitate in-country HIV/AIDS-related training and workshop.
* Provide technical support in the area of HIV and AIDS including sexual orientation and gender identity (SOGIE) to all the relevant stakeholders (example; MSTF/CBSS/ other non-HIV related organization).

## Roles and responsibilities of the national OR Coordinator at NACP

* Maintain a calendar of outreach activities, including community events, workshops, and other communications with HISCs and HIV related CBO/NGOs and monitor on a timely basis.
* Coordinate and manage outreach activities of all the HISCs and then report to the NACP on a timely basis for interventions.
* Coordinate with HISC, for the preparation of the annual work plan.
* Coordinate with HISC for the quarterly reporting of the progress updates as per the signed performance agreement between the HISCs, CBO/NGOs and NACP.
* Initiate the recruitment of new ORWs and coordinate the transfer of the ORWs in coordination with the NACP.
* Coordinate the World AIDS Day and the national testing week with the HISCs and CBO/NGOs.
* Coordinate the training and workshop activities for the HISC Counselors and PORWs.
* Schedule regular meetings, prepare minutes and reports as per the requirement of the NACP.
* Roles and responsibilities of the Focal Person LGBTIQ Focal Person
* To assist the District ORW Coordinator to develop an overall outreach implementation plan on day-to-day basis.
* To coordinate and assist the ORW to implement the community-based HIV prevention and testing services in coordination with the HISCs in the field.
* To supervise the ORW and report any shortfalls to the district ORW coordinator for appropriate actions.
* Coordinate the weekly outreach review meeting at the HISCs and respective CBO/NGO to discuss issues related to outreach activities.
* To coordinate between the KP CBOs, HISC and NACP for smooth implementation of the outreach activities.
* To assist the district ORW coordinator to prepare a monthly report for onwards submission to the national ORW coordinator at NACP.
* To represent the voice of the other ORWs to the NACP and other HIV, AIDS-related forums.

## Roles and responsibilities of the ORWs

* Facilitating community mobilization and the process of individual and community empowerment through networking and mapping of the hotspots linking to information and services.
* Educating peers (FSWs, MSM, TGs and IDUs including the vulnerable population) on STIs and HIV in one-on-one and small group sessions under the technical guidance of the HISC counsellors.
* Conducting/administering/ assisting HIVST or community led testing for the community members
* Assisting peers to access condoms and referring for voluntary counselling and testing (VCT) services to the HISCs.
* Distributing condoms/lubricants and demonstrate correct condom use to their peers.
* Participating in HIV outreach and in-reach services as per the approaches mentioned in this guidance document.
* Distributing educational materials to the peers on prevention and transmission of HIV and STIs including the information on the sex, sexuality and gender.
* Teaching peers to negotiate safer sex (Hetero sex, anal sex and oral sex) through appropriate condom negotiation skills.
* Facilitating and catalyzing the development of positive self-image and self-esteem within the key populations.
* Maintaining recording and reporting of day-to-day outreach and in-research activities and report to the HISC for onwards submission to Outreach Coordinator at the NACP.
* Perform any other tasks related to HIV, AIDS and STIs prevention under the stewardship of instruction and guidance of HISCs and outreach coordinator.

# CORE COMPONENTS OF THE HIV/AIDS AND STIs OUTREACH SERVICES

Outreach is a highly effective means of delivering HIV prevention interventions such as NSPs, condom programmes and targeted communication, as well as a useful access point for referral to OST and ART. Hence, outreach is an essential component of all HIV-related programmes[[5]](#endnote-5), [[6]](#endnote-6). The main objectives of the community-based outreach services are as follows;

* To strengthen HIV and STIs prevention services through advocacy and awareness for the key and vulnerable populations.
* To implement the community-based HIV testing and counselling services for key and vulnerable populations.
* To support People Living with HIV/AIDS and STIs to link for appropriate care, support and treatment for quality life and ensure those without HIV remain negative by providing timely prevention measures.

**The outreach services can be grouped into following main areas:**

## HIV awareness, education, counselling and referral

* HIV awareness and prevention education are one of the very important parts of outreach activities. The Outreach activities should provide correct information on the transmission and prevention of HIV, AIDS and STIs including the importance of testing and treatment to their peers and the larger communities.
* Such information will help them to make an informed decision of their behaviour to decide whether or not to take an HIV test.[[7]](#endnote-7)
* The effective awareness education will also reduce the existing myths and misconceptions, about HIV transmission and death thus reducing the fear of becoming infected; of living with HIV; and of accessing HIV treatment. This will ultimately decrease the self and social stigma associated with the people living with HIV and AIDS.[[8]](#endnote-8)
* Awareness should include reducing stigma and discrimination towards key population and PLHIV by general public and service providers
* At the individual level, one-on-one counselling may focus on awareness of personal risk and risk reduction strategies; for example, counsellors or community workers may discuss risk behaviours, relate a participant’s activities directly to HIV risk, and consider strategies to reduce this risk.
* At the community level or group, sessions can focus more on awareness of overall risk at the community level and can seek group support for finding workable risk-reduction strategies.

|  |  |  |  |
| --- | --- | --- | --- |
| Beneficiaries | Commodities | Service delivery points | Responsible people |
| MSM, TG, FSWs and PLHIV. | IEC materials  Tools for recording and reporting including referral forms | Outreach and in reach | HISC Counsellors, Outreach Workers or peer outreach workers of HSIC and HIV related CBO/NGOs. |

## Condom and Lubricant Promotion

Increasing the availability, accessibility, affordability and use of male and female condoms and condom-compatible lubricants among general population and particularly to key populations will be done through targeted distribution programmes. In addition, consistent and correct use of male condoms reduces sexual transmission of HIV and other STIs in both vaginal and anal sex by up to 94%. Use of water- or silicone-based lubricants (as opposed to petroleum-based) helps to prevent condoms from breaking and slipping.[[9]](#endnote-9),[[10]](#endnote-10),[[11]](#endnote-11) Effective condom programming is particularly important for key populations. Unprotected sex and other high-risk behaviours such as substance use, alcohol consumption often coincide for key populations, in particular adolescents.[[12]](#endnote-12),[[13]](#endnote-13)

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| WHO recommendation: The correct and consistent use of condoms with condom-compatible lubricants is recommended for all key population to prevent sexual transmission of HIV and STIs |

* The outreach should disseminate information about benefits of condoms and lubricant in the prevention and control of HIV/AIDS and STIs including the unwanted pregnancies and generate demand from the key populations.
* Wherever condoms are distributed, water-based lubricants should also be made available according to the preferences of key populations. The lubricant should not only be part of the service for MSM but it should be made available for female sex workers and transgender women, people who inject drugs, and prisoner also. [[14]](#endnote-14)
* The behaviour change communication should focus to address a variety of personal barriers to condom use, including:[[15]](#endnote-15)
  + Information on choosing safe, effective lubricants and avoiding unsafe lubricants.
  + Training in safer sex negotiation skills, including how to negotiate condom use and strategies for reducing risk when no condom is available.
  + Addressing misconceptions around condom use, such as double condom use.
  + Information on how to protect oneself when providing a broad range of sexual services, such as the fulfilment of sexual fantasies, and non-penetrative sexual services.
  + Specific discussions of the condom and lubricant needs of male-to-male anal sex, male-to-female anal sex, vaginal sex and/or male-to-transgender anal sex.
  + Providing risk-reduction education around common reproductive health misconceptions, including douching, washing after sex and preventing unintended pregnancies.

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| --- | --- | --- | --- |
| Beneficiaries | Commodities | Service delivery points | Responsible people |
| MSM, TG, FSWs and PLHIV. | Male condom and lubricants.  Lubricant: Water based | Outreach and In-reach | HISC Counsellors, Outreach Workers or Peer Outreach Workers of HISC and HIV related CBO/NGOs. |

## HIV Counselling and Testing

The HIV Counselling and Testing is the gateway to HIV prevention, care support and treatment. For those who test negative, HCT is an important opportunity to link them to primary HIV prevention services to ensure that they remain negative and to encourage later retesting.[[16]](#endnote-16)

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| WHO recommendation: Voluntary HTC should be routinely offered to all key populations both in the community and in clinical settings. Community-based HIV testing and counselling for key populations, linked to prevention, care and treatment services, is recommended, in addition to provider initiated testing and counselling. |

* The HIV Counselling and Testing at the health facilities should be carried out based on the national HIV Counselling and Testing guidelines.
* The Community based and community led HIV Counselling and Testing should be carried out based on the national CBT protocol 2021.

|  |  |  |  |
| --- | --- | --- | --- |
| Beneficiaries | Commodities | Service delivery points | Responsible people |
| MSM, TG, FSWs. IDUs and PLHIV. | Oral Swap HIVST kits and Finger prick HIV test kits.  Recording and reporting tools. | HISC, Outreach and In-reach | HISC Counsellors, Outreach Workers or Peer Outreach Workers of HISC and HIV related CBO/NGOs. |

## Providing education about pre-exposure prophylaxis (PrEP) and Postexposure prophylaxis (PEP).

Currently PEP is available only for health workers who had exposure to HIV. Both PrEP and PEP are not available at the moment but NACP plan to introduce these interventions in the coming years.

|  |
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| WHO recommendation: Oral pre-exposure prophylaxis ( PrEP) containing tenofovir disoproxil fumarate should be offered as an additional prevention choice for key population at substance risk of HIV infection as part of combination HIV prevention approaches |

|  |
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| WHO recommendation: Post –exposure prophylaxis PEP) should be available to all eligible people from key populations on a voluntary basis after possible exposure to HIV |

* Adequate awareness on the benefit of the PrEP and PEP and then accordingly link those key populations who are at “substantial risk” of HIV infection14 for PrEP and PEP. The evidence shows that awareness and knowledge about PrEP are very low among the key populations across the globe.8
* The PORWs should be able to disseminate the correct information about the benefit of the PrEP and ensure those KPs on PrEP and PEP adheres properly because good adherence to PrEP will be effective to prevent HIV as condoms.[[17]](#endnote-17)
* As per the latest National HIV Treatment Guidelines, 2020, PEP is recommended for any known HIV negative person who is exposed to HIV infection from the known HIV positive person.
* The PORW should be aware of where and how PrEP and PEP are available in case of clients contact them and should accompany clients to access it if so requested.

|  |  |  |  |
| --- | --- | --- | --- |
| Beneficiaries | Commodities | Service delivery points | Responsible people |
| MSM, TG, FSWs. PLHIV. | ART medicines | HISC and hospitals | HISC Counsellors and trained health workers. |

Linkage to harm reduction services**.**

Currently, there is no known IDU in Bhutan and there are no facilities for access to sterile injecting equipment’s through needle and syringe programs. Also, there is no Oral Substitution therapy for IDU.

**Needle and syringe program (NSP) & Opioid Substitution Therapy (OST)**

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| --- |
| WHO recommendation:  All people from key populations who inject drugs should have access to sterile injecting equipment through needle and syringe programs  All people from key populations who are dependent on opioids should be offered and have access to opioid substitution therapy.  All people from key populations who inject drugs should have access to sterile injecting equipment through needle and syringe programmes. |

* There are no recent reported cases of PWID in Bhutan
* The drug for the OST listed guidelines for treatment of opioid dependence and opioid substitution therapy is by Tramadol or Buprenorphine. Currently, it is provided only at JDWNRH, mental health department[[18]](#endnote-18)
* Bhutan may amend and adopt policies and strengthen access sterile injecting equipment through needle and syringe programs and other OST programs if situations necessitate in future

## HIV, STIs and Hepatitis B/C treatment services.

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| --- |
| WHO recommendation: Screening, diagnosis and treatment of sexually transmitted infections should be offered routinely as part of comprehensive HIV prevention and care for key populations. |

* Bhutan has adopted ART treatment for all HIV/AIDS detected cases since 2019. As a result, all people diagnosed with HIV/AIDS are initiated with ART treatment irrespective of their CD4 count.
* The national guideline for STIs and Hepatitis B/C treatment should also apply to key population. All ORW would be trained on recognizing symptoms of STI and link to the treatment and care unit.

## Screening, diagnosis and treatment

* The HIV, STIs and Hepatitis B/C treatment services available in all the hospitals across the country and for the key population one should get in contact with the HISC or VCT focal person if additional support is needed.
* HIV treatment adherence can be increased by addressing HIV stigma and discrimination, ensuring the confidentiality of key population and PLHIV clients and without stigma and discrimination at the health care setting.
* Routine HIV testing should be offered to all people with presumptive and diagnosed TB (strong recommendation, low quality of evidence).
* ART should be initiated in all individuals with HIV and active TB disease regardless of WHO clinical stage or CD4 cell count (strong recommendation, low quality of evidence).

## Non-Communicable Disease Services

* Currently all NCD services are offered at the hospitals
* No NCD services are offered from HISC or outreach and in-reach services
* Many key populations have NCD behavioral risk particular alcohol and Tobacco
* It is very important that NCD screening services are offered comprehensively to the key population along with the other HIV/AIDS services. If these services are offered together with HIV/AIDS services, it would also reduce stigma and discrimination

|  |  |  |  |
| --- | --- | --- | --- |
| Beneficiaries | Commodities | Service delivery points | Responsible people |
| All key population | BP instrument, Alcohol Screening and Brief Intervention (SBI) Audit Tools and Tobacco, 5A (e 5As (Ask, Advise, Assess, Assist, Arrange) and 5 R’s – (Relevance, Risks, Rewards, Roadblocks, and Repetition) | DIC and HISCs, Hospitals, Mobile clinics, Outreach and In-reach services | HISC Counsellors and PORWs, DIC. |

# PEER OUTREACH WORKERS RECRUITMENT

## Recruitment process and selections criteria

* The right mix of outreach workers from different backgrounds and operating in different social and sexual networks is necessary.
* The National Program Manager of the NACP, in consultation with the KP CSOs and Networks, should develop a recruitment plan that ensures a proper mix of the outreach team, including the number of outreach workers needed.
* The programmatic targets in the identified city/district of operation, and expected turnover, and the extent to which outreach efforts needed online or offline; should be taken into account while recruiting.
* It is important to know the desired age, ethnicity, level of education, sexual orientation, gender identity, areas of residence of the PORWs for effective deployment.
* Do not rely solely on people who volunteer to be outreach workers as they might not be representative of the target population and may not be able to commit consistently.
* There should be a clear term of reference or job description of the PORWs and it should be advertised during the time of job announcement for recruits or replacement of ORW.
* There should also be agreement and detailed TOR for the PORWs for efficiency and accountability purpose.

## Eligibility

The Peer Outreach Workers should be from the same community group such as MSM, TG. FSWs and PWID and must possess basic education to read, write and educate their peers and community at large. The following are the e**ssential competencies required for ORWs;**

* Communicate in different local language
* Emotional maturity to cope in difficult situations
* Honesty, integrity and ethical
* Socially networked

# CORE KNOWLEDGE AND SKILLS OF OUTREACH WORKERS

It is very important that PORW workers pose skills and knowledge discharge the responsibility efficiently. They will be provided as per the competency framework provided in annexure 1.

## Peer outreach worker’s field kit

It is essential to have well-defined PORWs kits to enable them to carry out the outreach and in-reach activities more effectively. The kit should comprise of the following items;

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| --- | --- |
| **Particulars** | **Item List** |
| Information materials | Leaflets, pamphlets, flipcharts, Reference guides, Demonstration kits such as wooden, rubber or plastic ‘dildos’ that can be used to perform condom demonstrations, torch, dog alarm |
| Prevention materials | Male and female Condoms, water-based lubricants, PrEP and PEP medicines, |
| Testing | Oral swab kits, RDT, Alcohol swap, lancet, |
| Forms | A set of Client Intake forms, Meeting notes form, Daily recording sheet, Unregistered Clients Sheet, and Weekly Report format. |
| Others | Pen, paper, Forms, seal, Name tag, torch, mobile phone |

# SUPERVISION AND MONITORING OUTREACH WORKERS

The overall monitoring and supervision of the outreach activities will be carried out by the Outreach Coordinator at the NACP and the in the field the respective District Outreach Coordinator/HISC Counselor will monitor and supervise the work of outreach focal person and peer, outreach workers, as mentioned under the mandates of the HISC. The HISCs and HIV related CBO/NGOs including the DICs will be made accountable through the signing of the contractual agreement or performance framework (which would be developed in coordination with HISC Counsellors and KP Networks and CSOs) with the NACP to measure the financial and physical progress. Therefore, for both the online and community-based physical outreach services appropriate recording and reporting should be followed.

Online outreach: The OWR will use a recording sheet as per (Annexure 3 & 4 ) to record the daily online outreach activities. For example, the online PORWs should register the social media ID via which he/she is communicating with the client, and try to back this up with at least one other way to contact the client (can be another social media ID/profile or a phone number).8 There should be some form of proof such as screenshots of chats on the different social media platforms or screenshots of the inboxes showing message received. Since this is the new approach of outreach services in Bhutan respective organization should find out a way that works well without burdening the PORWs in reporting requirements and not breaching the client’s confidentiality.

Community-based Physical outreach services. The daily recording and reporting of the onsite outreach services will be done as per the existing routine surveillance system of the NACP for the targeted interventions either through paper-based or through the DHIS-2 system.

# Monitoring and supervision

## Qualitative monitoring & supervision

* Team meeting among the PORWs is necessary to get the feedback of their outreach work which can be useful in re-strategizing the outreach activities and also carry out revision of the messages of their reference manuals for awareness education on HIV/AIDS and STIs.
* The HISCs should conduct the weekly coordination meeting with outreach workers and record the information with the way forward to make the outreach activities more resilient and efficient.
* The Outreach Coordinator, NACP should coordinate the quarterly meeting with the HISCs and all the focal persons and PORWs. The HISC, CBO/NGOs should present the quarterly progress, challenges and way forward based on the field experience to improve the overall outreach activities.
* The supportive supervision and monitoring should be given to the PORWs by the trained public health experts, HISC/VCT counsellors and other related to the filed through a one-on-one meeting or group discussion.
* The benefit of the one-on-one meeting is that it will solve more private/sensitive problems the outreach worker may encounter, whereas more general, work-related problems are discussed in the weekly of fortnightly team meetings to plan the coming week(s). to solve the various issues that they face in the field.8
* The overall approach of the qualitative aspect of monitoring should be towards mentoring so that PORW’s needs for further training or skills development can be determined. Refer the guide for an in-depth interview for the one-on-one meeting (Annexure 6).

## Quantitative Monitoring and supervision

* The quantitative aspect of reporting is important as it measures the coverage of the services through outreach activities and most often a visible tangible outcome of the CBOs/NGOs and PORWs.
* The appropriate and pre-defined indicators with evidence-based baseline need to be established together as the art of the contractual agreement taking into account all the circumstances and difficulty of reaching the targets for some hidden populations.
* The setting targets against each PORWs also need to consider the old and new PORWs because new will not have much network or experiences in recruiting the clients for services unlike the old.
* For outreach workers not to lose their motivation, it is a good idea to agree on lower (or even no) targets during the first two months of their contract.
* The HISCs should collect the data for the outreach and in reached through every week and compile it for the quarterly reporting to the outreach coordinator, NACP.
* The National Strategic Plan (2017-2023) has a set of defined indicators that needs to be achieved. All the indicators related to key and vulnerable that will be delivered through the outreach and in reached targeted interventions and become the part of the overall Performance Framework or contractual agreement between the ANCP and implementing partners.

## Reviewing of the quarterly Outreach Report

The scheduled reviewing of quarterly outreach report (Annexure 7) is very important to ensure that quarterly report is of high quality for onward submission to the NACP.

* Any usual reporting or missing key information should be corrected now and then by inviting the PORWs.
* If an outreach worker misses his numerical targets repeatedly, the supervisor should look carefully before assessing his performance because the low number does not necessarily mean a poor performance of the PORW. This could be that the clients refereed are from high-risk group belonging to the new network thus PORW might have taken time to get the required number.
* The reviewer should have some flexibilities and encourage the PORWs to reach as many PLHIV but not aware of their HIV status instead of reporting many negatives.

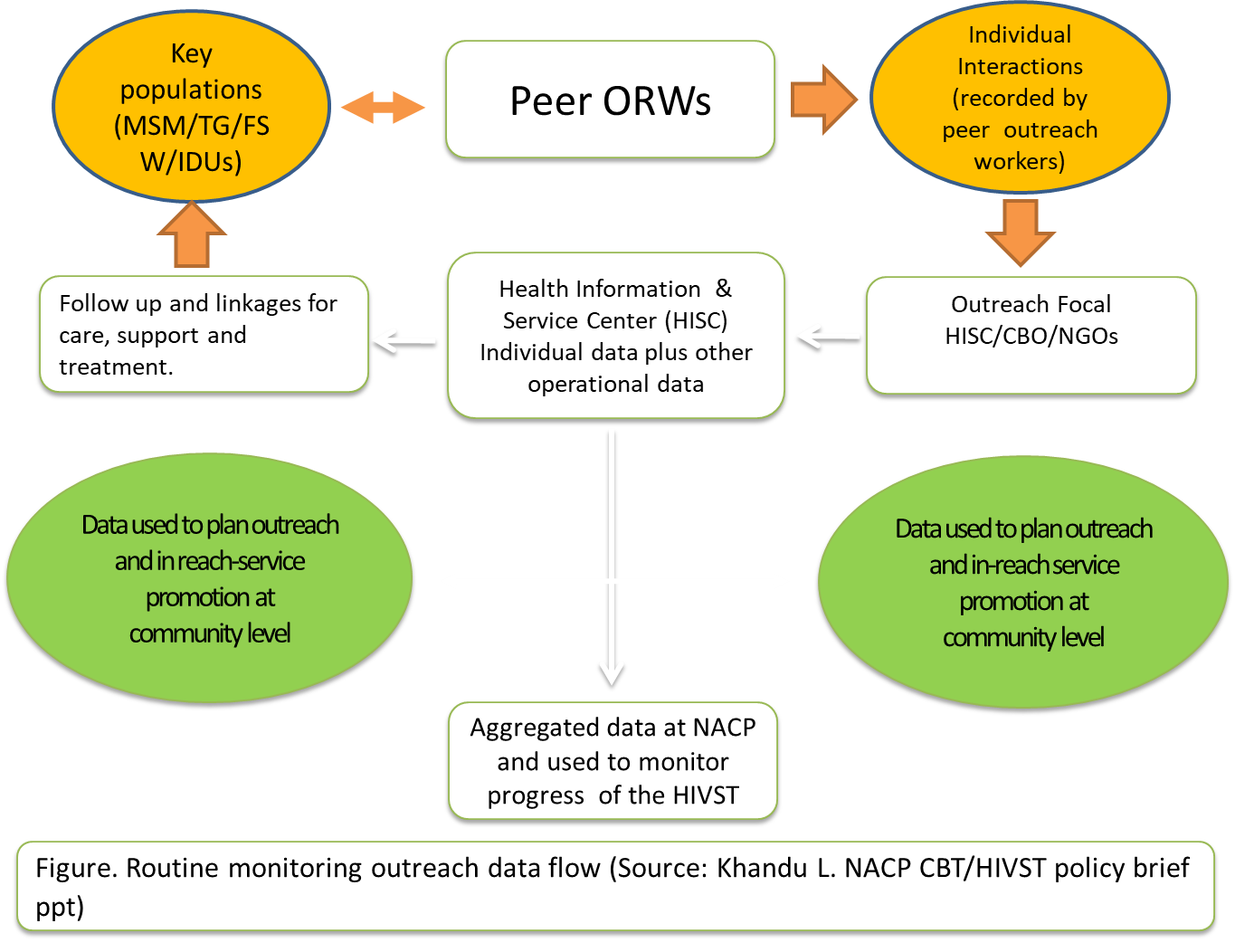


Figure 2: Flow of the routine outreach data

## Data Management

* As indicated in the Figure 2 the routine data for the outreach activities will be collected by the ORWs and relevant CBOs and NGOs and then report to the respective HISC for onward disaggregation and submission to the NACP.
* The information at HISC will be used to trace and track those diagnosed and high-risk populations through the support of the PORWs for linkage to care and treatment services. While the aggregated data at the NACP will be used to improve the overall community-based HIV prevention services.
* The information related to HIV counseling and testing including care and treatment will be recorded in a register and then will be entered into the DHIS-2 system of the Ministry of Health.
* The other information on outreach activities such as evidence of online outreach and weekly meeting minutes and activity reports will be maintained at the respective service delivery points.
* All the information related to key populations and PLHIV should be kept securely under the lock and key to protect the rights and confidentiality of the clients.

# ENSURING PERFORMANCE OF ORW

## Action on non-performing ORW

* If PORW is not able to meet his or targets then the HISC Counselor needs to carry out a joint analysis of the causes such as illness, family events etc. If that is the causative factors, then it should be considered.
* However, if targets are not met for several months then despite necessary corrective measures motivation and guidance the HISC counsellor in consultation with the NACP should issue an administrative action with the warning of termination if no improvement.
* After three two written warning two weeks’ part and no improvement then the contract of the PORW need to terminate and new recruitment should be initiated immediately.

## Action on HIV/AIDS service ethical issues

* Anyone working in implementing the community-based outreach services and found guilty of breaching the confidently of the clients and patients are subject to administrative action by the HISC and then warned for termination provided the matter is not serious legal implication.
* If the matter of breaching confidentiality is a serious issue and has legal consequences, then it has to be dealt in accordance with the law of the country.

## Stress management for the ORW.

To conduct the outreach activities are usually not easy due to many structural barriers and legal implications associated with the key population like MSM, TG, Sex Workers and PWID. Therefore, the likelihood of encountering many obstacles high from law enforcing agencies and also from the clients. Therefore, an appropriate measure needs to be instituted to ensure the safety of the ORWs and also to overcome the work-related stress.

* The supervisor needs to monitor and diagnose the signs and symptoms of burnout. The Burnout ‘emerges when the demands of a job outstrip a person’s ability to cope with the stress.[[19]](#endnote-19)
* In the high burden areas sometimes, it will be too tasking for ORWs to reach and refer for testing linking the client for care and treatment for HIV/AIDS and STIs and other services while watching for his or her stress.
  + Burnout is a state of chronic stress that leads to:19
    - physical and emotional exhaustion
    - cynicism and detachment
    - feelings of ineffectiveness and lack of accomplishment

# PROMOTING MENTAL HEALTH

Key populations can experience high levels of anxiety, mental health issues and related challenges as a result of rejection, isolation and marginalization. Research suggests that key population members, especially MSM and transgender people are at increased risk for major depression, bipolar disorder, and generalized anxiety disorder likely as a result of the stigma, discrimination and homophobia they commonly experience.[[20]](#endnote-20) [[21]](#endnote-21) [[22]](#endnote-22)Sustained stress can also lead to key population members turning to drugs and alcohol to cope with their problems and even to envisage suicide, while use of drugs themselves can lead to or aggravate mental illness.

This module provides a review of common challenges being faced by KPs from a mental health perception and the factors that drive those challenges. It also provides basic guidance for how community-based model can better support their clients to care for their mental health.

## Factors Leading to Poor Mental Health Outcomes among Key Population

* PORW shall all undergo mental health first Aid course and provided mental health first aid to the community members to prevent any adverse events
* Key population demonstrate an endless devotion and commitment to the communities they belong and remain resilient despite issues of marginalization and discrimination; however, many presents with mental health challenges.
* Social discrimination is a key factor leading to poor mental health outcomes across all key population groups. This discrimination is well documented in settings all around the world, regardless of the cultural, social, political, economic, or legal environment. Discrimination manifests in many ways, including personal hardships like harassment, ridicule, rejection, or violence, and also higher-level structural factors like discriminatory policies or human rights violations.
* Criminalization Beyond violating basic rights, criminalization has made key population members more vulnerable to poor health outcomes, reduced their access to health services and created inequities in access to and affordability of essentials like housing and work. Repealing laws that criminalize sex work, drug use and same-sex behaviour is an important step towards combating prejudice against key populations. However, it must also be accompanied by work at the grassroots level to address societal attitudes. Other consequences of criminalization of sex work, drug use and same-sex sexual behaviour include:
  + - Under representation of key population members in the development and implementation of policies and programs.
    - Lowered client participation of key population members in the development and implementation of policies and programs.
    - Lack of research and resources concerning key populations.

## Strategies to focus during outreach services

Behaviour change counselling: Should clients themselves express the desire to change sexual orientation the most effective and appropriate therapeutic response that results in maximum mental health benefit is provider-initiated support, acceptance, and validation of same-sex sexual orientation. Same is true for other KPs, accepting drug use and choices of sexual orientation will help the ORWs focus on behaviour change therapies.

Coping with family rejection: Research correlates family rejection with negative health outcomes among KPs. Research studies suggest that family rejection during younger eras of KPs are eight times more likely to attempt suicide, six times more likely to report high levels of depression, three times more likely to use drugs and report unprotected sexual intercourse than peers who report no or low levels of family rejection. It is important that ORWs and counsellors are aware of these issues and probe to better understand circumstances.

In situations where a family member has difficulty accepting someone’s sexual orientation, ORWs should counsel and try meeting family members in a confidential manner and refer them to an appropriate support. If possible, connect the family member experiencing the difficulty to local resources that can help them accept their family member without feeling guilt, shame, prejudice or judgment.

Marginalization and discrimination: Social mobilisers will be responsible for ART treatment initiation in case of reactive KPs and in dealing with vulnerable risk awareness. The harassment and discrimination experienced contribute significantly to anxiety and are linked to depression and other mental health disorders.

Anxiety: It is a normal emotion and is closely related to fear. However, when anxiety becomes excessive, is difficult to control, and affects everyday life, it becomes a disorder and must be adequately managed. Some symptoms of anxiety disorders which outreach workers must acknowledge and refer for additional support are;

***Fear, uneasiness, worry, sweating, shaking, racing heart. Nausea, dizziness, shortness of breath, chills or hot flushes.***

In case of these symptoms, daily work sheet of ORWs must submit a plan of action for additional support.

Depression is far more than simply a bad mood. It is a prolonged mood disorder that can drastically affect daily life. Some symptoms of depression include:

* Feeling sad, hopeless, worthless, guilty, or bad about oneself.
* Being unable to enjoy things that would usually be pleasurable
* Feeling apathetic and lacking motivation to act
* Feeling tired and having no energy
* Feeling lonely and cut off from other people
* Difficulty in concentrating
* Sleeping badly – either sleeping too much or too little
* A change in eating habits – either eating too much or too little
* Contemplating suicide.

Approaching Drug Users: The drug and alcohol use are a difficult topic for both the outreach workers and their clients. It is therefore important for all CBOs/NGOs/HISCs/DICs staff to be sensitive to their own anxiety as well as that of their client, when discussing drug use. They should use appropriate language when asking questions about drug use. Some principles to consider are as follows;

* Begin by building rapport and confidence with the client.
* Remind clients that any information they share will be kept confidential. If information will be shared, ORWs must tell the client with whom it will be shared and under what circumstances. Clients have a right to know if what they disclose will be documented and how that information will be used.
* Remember to use a non-judgmental and non-confrontational approach when discussing drug use with clients

# INFECTION CONTROL PROTOCOLS

Performing HIV tests poses a potential health hazard to the tester. Coming in contact with human blood or blood products is potentially hazardous. Safety involves taking precautions to protect you and the client against infection. All specimens should be treated as though potentially hazardous.[[23]](#endnote-23)

**Who need to be protected from cross infection?**

* Besides tester and client, we need to protect other people from infection.
* Never leave blood spills that could infect others.
* Never leave used lancets lying around for anyone else to pick up – they could prick themselves with HIV contaminated lancets.
* Always seal contaminated waste – you don’t want to risk infecting the person who removes contaminated waste from the rapid testing site.
* In addition, it is important to protect the integrity of test products. Shield unused tests from any contamination. If a new or unused test is contaminated by a drop of blood from a previous client, the test may not yield accurate result when used on the next client.
* It is also important to protect the environment from hazardous material. Avoid transferring contaminated materials into areas outside of the testing area.

**Universal or Standard Precautions**

* Before testing, specimens shall be transported in a manner to prevent contamination of workers, patients, and environment. This includes using appropriate packing containers, and following national and international postal and transport regulations.
* During testing, follow the safety rules when performing finger-prick and actual testing of the client’s blood.
* After testing, remember to clean up working area and properly dispose of contaminated waste.
* Develop Personal Safe Work Habits. It is important that you:
  + Wash hands before and after testing each patient.
  + Wear a fresh pair of gloves with each patient.
  + Wear lab coat or apron
  + Dispose of contaminated sharps and waste immediately after testing
  + Never pipette by mouth.
  + Never eat, drink or smoke at the test site
  + Keep food out of the laboratory/testing site refrigerator
  + Remember, never let your mouth touch anything from work, such as pens, pencils, etc.
  + Maintain Clean & Orderly Work Space
  + It is important to:
  + Keep work areas uncluttered and clean
  + Disinfect work surfaces daily (“disinfect” means kill any harmful germs/pathogens)
  + Restrict or limit access when working
  + Keep supplies locked in a safe and secure area
  + Keep emergency eye wash units in working order and within expiry date.
  + The eye wash unit is used to clean one’s eyes when they are accidentally splashed with any type of specimen (for example, from patients, controls, reagents, etc.). If an eye wash unit is not available, please consult your local infection control personnel for alternate procedures to follow in the event of an accidental splash.

**Take Precautions to avoid Needle Stick Injury**

* Needle-stick injury can be dangerous because infected blood containing pathogens can be transferred to the person and cause infection.
* Needle stick injury may occur due to lack of concentration, inexperience, lack of concern for others, or improper disposal of sharps. To prevent needle stick injury, you should focus on where the needle is, as well as where your hand and your client’s hand are. Don’t let yourself be distracted. Only people who have received appropriate training should perform the finger-stick procedure.
* Always follow proper procedures to dispose of used needles and sharps. For example,
* Place used lancets in the sharp’s disposal container.
* Do not leave used needles or lancets lying around.
* Clean up after each client.
* Any needle stick injury should be reported to NACP and initiate PEP as per protocol

**Drop Used Sharps in Special Containers**

There are many makes, shapes and sizes of sharp bins. However, all sharp containers should have:

* lid
* Puncture-proof or thick walls
* large enough hole for lancets and needles
* Leakproof sides and bottom
* label or color code indicating bio-hazard material
* And should be available in Sufficient quantity at each testing site

***Note: Not all sharp containers need be purchased commercially. An empty bleach container will suffice such as seen on the right. This type container meets all previously mentioned specification. Additionally, the opening is small so that you cannot insert your hand.***

**Do’s and Don’ts-Sharps and Waste Containers**

* Do not break, bend, re-sheath or reuse lancets, syringes or needles. You could injure yourself if you try to bend needles or lancets.
* Never shake sharps containers to create space because this leads to formation of aerosols. Aerosols are tiny invisible droplets in the air that can also carry infectious agents/pathogens.
* Never Place Needles or Sharps in Office Waste Containers
* Plastic bag must be securely tied once filled. This is appropriate for disposing of contaminated waste such as used gauze. This type of container is NOT appropriate for disposal of sharps.
* Contaminated waste should be kept separate for office waste. It is the tester’s responsibility not to put any other persons at risk of infection.

Sharp container:The sharps containers must be:

* Placed near workspace
* Closed when not in use
* Sealed when ¾ full

**HIV testing related incineration of waste**

Incineration is the burning of contaminated waste to destroy and kill micro-organisms. Contaminated waste should be burned to completion (that is, beyond re-use). It protects environment and must be supervised. Care should be taken in transporting waste from one site to another for incineration.

**Disinfect work areas with bleach**

In order to keep a clean and orderly work area, disinfect your work surface on a daily basis. It is part of the general safe practice that you need to follow. Remember, disinfection to;

* Kills germs and pathogens
* Keeps work surface clean
* Prevents cross-contamination
* Reduces risks of infection

**In case of an accident**

There are three types of accidents that may happen:

* Potential Injury, i.e., needle pricks, falls
* Environmental, i.e., splashes or spills
* Equipment damage

***Note: In case of an accident, you should report to your supervisor immediately. Assess the situation and take action accordingly. Record the accident using appropriate forms, and continue to monitor the situation. For more detail, refer to the national HIV testing and treatment guidelines for Post Exposure Prophylaxis.***

# ANNEXURES

## Annexure 1. Training Framework for ORWs

|  |  |  |  |
| --- | --- | --- | --- |
| **Topic** | **Topic to be covered** | **Mode of deliver** | **Items required** |
| Basics about peer outreach and their roles and responsibilities of  ORW. | * Concept of Peer outreach, roles and responsibilities including the qualities of ORWs. * Understanding the community, the risk and vulnerabilities and their network. * Sex, sexuality and gender identity (SOGI) | Brainstorming and group discussions, power points, videos show. | * Flip chart and marker pen * LCD and laptop |
| Knowledge about HIV/AIDS | * HIV/AIDS prevention and control * Testing methods and conducting HIVST * Linking to treatment and care | Brainstorming and group discussions, power points, videos show. | * Flip chart and marker pen * LCD and laptop |
| Basic knowledge on HIV Counseling and Testing. | * Risk assessment * Pretest counselling * Testing and result interpretation for rapid diagnostic test including HIVST. * Posttest counselling * Linkages to prevention, care, support and treatment. * Mental Health First Aid | Brainstorming and group discussions, power points, videos show, role play. | * Flip chart and marker pen * LCD and laptop |
| Peer Outreach Planning | * Spot analysis, hotspot mapping and line listing of the KPs. * Development of a simple action plan | Group discussion and presentations | * Flip chart and marker pen * LCD and laptop |
| Sexually Transmitted Infections | * Understanding Sexually Transmitted Infections * Role of PEs in Prevention and Control of STI | PowerPoint presentations | * Flip chart and marker pen * LCD and laptop |
| Condom and lubricant Promotion | * Male and Female Condoms * Condom Demand and Supply * Condom Accessibility and Availability Mapping Condom Estimation * Condom Gap Analysis * Condom negotiation skills | Brainstorming and group discussions, power points, videos show, role play. | * Flip chart and marker pen * LCD and laptop |
| Behavior Change Communication | * Dialogue-based Inter-Personal Communication * One-One Communication by PORs. | Brainstorming and group discussions, power points, videos show, role play. | * Flip chart and marker pen * LCD and laptop |
| Safety of outreach workers. | * Knows the safety protocols * Understand and develops skills in self-protection | Group discussions, power points, | * Flip chart and marker pen * LCD and laptop |
| NCD Preventions and control. | * Knows how to measure BP, BMI and its interpretation * Knows how to administer and alcohol cessation intervention using 5A and 5R method | Group discussions, power points, demonstration and case studies | * Flip chart and marker pen * LCD and laptop |
| Monitoring and documentation | * Target setting, analysis and report writing * Tools and forms related to Peer Outreach activities | Group discussions, power points | * Flip chart and marker pen * LCD and laptop |

## Annexure 2: Chat Room Activity Report Format

|  |  |
| --- | --- |
| Chat Room Activity Report Format | |
| Date |  |
| Name of ORW |  |
| Screen or profile name |  |
| Sexual orientation of client |  |
| Gender |  |
| Age |  |
| Nationality |  |
| Time spent in chat room |  |
| Referral given or not? |  |
| Recruit for testing or not? |  |
| Number of HIV/AIDS messages posted |  |
| Chat transcript in detail recorded? |  |

## Annexure 3: Chat Room Log Book

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Chat Room Log Book | | | | | | | | | |  |
| S/No | Name of the ORW | Screen or profile name of the clients | Age | Websites/Websites/another online platform visited | Target population | | | | | Referred to Testing (Y/N) |
| MSM | TGW | TGM | FSW | HRW |
|  |  |  |  |  |  |  |  |  |  |  |
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## Annexure 4: Email Activity Report Form

|  |
| --- |
| Email Activity Report Form |
| From: |
| To: |
| Date |
| Original E-mail: |
| E-mail Response: |

## Annexure 5: In depth Interviewing8

It is suggested that a more in depth probing of outreach worker skills should be done every 2-3 months as part of the one-on-one meetings, whereby open questions are asked to the outreach worker. While answering, the supervisor should take notes and provide comments, so that after the interview is finalized, he can give targeted feedback on the different aspects of the questionnaire. A list of suggested questions (not all need to be used/answered):

1. How do you feel about being an outreach worker? • Probe: What are things you like about it? What are things you don’t like about it? [Look out for signs of burnout or depression]
2. Since the last interview, three months ago, has anything changed about your work? Can you explain? • Probe: Do you like it more or less than 3 months ago, and why? What can be done to make you happier?
3. Via which channels do you reach new clients? • Probe: referral/certain locations/clan leaders/ websites/ chatrooms/ via friends or via existing clients (chain referral).
4. How do you approach an individual new client? What are some of your ‘pick-up lines’ that you find are working for you?
5. How do you make a client trust you and feel comfortable to talk to you?
6. How do you decide whether clients need to be reached out to? • Probe: Is a risk-assessment done in terms of assessing a client’s unsafe sexual behaviours and checking knowledge and attitudes towards condom use and drug use, history of STIs, Hep B and C?
7. How do you convince clients to take an HIV test? • Probe: Can you give some examples where you succeeded and where you failed, and why? What fears do you encounter among clients about HIV testing?
8. In what way do you discuss mental health problems, alcohol and drugs and their relation to HIV transmission in your outreach to clients?
9. In what way do you discuss the possibility of living a long and healthy life with HIV if one adheres to free antiretroviral treatment with clients? • Probe: Does the outreach worker reduce fears of ARTs, their costs, their side-effects and other aspects of treatment, care and support when talking to the client?
10. How, if at all, do you discuss the different risk for HIV transmission attached to different sexual behaviors, and suggest shifting from anal to oral sex/mutual masturbation as a risk reduction strategy? • Probe: Does the outreach worker use ‘Prevention 2.0’-principles? Is an assessment of HIV risk made, and are options for risk reduction offered UPDATED 9 JUNE 2019 53 to the client? Which options are discussed and which are not discussed and why?
11. Do you create the opportunity for the client to get back in touch with you after the outreach contact ends? How do you do that?
12. Do you have suggestions for how you can improve your own performance? • Probe: Training needs? How happy is he/she with the supervision he receives? Does he/she use the Reference Manual regularly?

## Annexure 6: Quarterly reporting Format for ORWs to be submitted to NACP

|  |  |  |  |
| --- | --- | --- | --- |
| Reporting Format for ORWs | | | |
| Date | | | |
| Name of ORW | | | |
| Location | | | |
| Total clients reached in past Quarter: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_of whom \_\_\_\_\_\_\_\_were   NEW clients\_\_\_\_\_\_\_ Existing clients\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Coverage Indicator Number | Standard Indicator | Numbers | |
| 1 | Number of key populations registered with Rainbow Bhutan | MSM |  |
| TGW |  |
| TGM |  |
| Others (Specify)………... |  |
| 2 | No of key population reached through out to key population through online outreach activity | MSM |  |
| TGW |  |
| TGM |  |  |
| Others (Specify)………... |  |
| 3 | Number of key populations reached with HIV service package | MSM |  |  |
| TGW |  |  |
| TGM |  |
| Others (Specify)………... |  |
| 4 | Number of key populations issued HIVST | MSM |  |  |
| TGW |  |  |
| TGM |  |
| Others (Specify)………... |  |
| 5 | Number of key populations referred to testing | MSM |  |  |
| TGW |  |
| TGM |  |  |
| Others (Specify)………... |  |

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