SK PA·2

COMMUNITY LED MONITORING IN BHUTAN:

Pilot Project Technical Brief

January 2024

HEALTH EQUITY MATTERS

The Sustainability of HIV Services for Key Populations in South-East Asia (SKPA-2) is a three-year program (1 July 2022 and 30 June 2025), aimed at improving the sustainability of evidence-informed, prioritized HIV services for key populations in Bhutan, Mongolia, the Philippines and Sri Lanka. The objectives of SKPA-2 are to: accelerate financial sustainability; improve strategic information availability and use; promote programmatic sustainability; and remove human rights- and gender-related barriers to services.

INTRODUCTION

HIV prevention and treatment programs for communities most affected by HIV can achieve greater improvements in HIV-related outcomes when delivered through community-led models.[1] Adapted from the Global Fund's definition, SKPA-2 defines community-led monitoring (CLM) as, *"an ongoing process in which service users or local communities gather, analyze and use information to support quality improvement of HIV services and advocacy efforts to increase uptake of and retention in HIV and related health services and, ultimately, to improve health outcomes for key populations"*.[2] The SKPA-2 CLM is one of the first monitoring approaches focused on assessing the quality of key population HIV prevention and treatment services in Asia using the Availability, Accessibility, Acceptability and Quality Conceptual Framework[3] (**Figure 1**). The framework uses data collected from individuals belonging to one or more key population groups who have used HIV services recently.

In Bhutan, CLM built on learnings from the community based monitoring initiative that was piloted from 2020-2021 in SKPA-1. This report covers the SKPA-2 CLM pilot project that ran from October 2022 to June 2023 and was led by Save the Children Bhutan with technical support from Health Equity Matters and APCOM. SKPA-2 supported four key population organizations, namely, Lhak-Sam, Pride Bhutan (including Red Purse Network), Chithuen Phendey Association, and Queer Voice of Bhutan to ensure strong support from community members.

Figure 1. Adapted AAAQ framework for the CLM toolkit

[1] Ayala, George, et al. "Peer-and community-led responses to HIV: a scoping review." *PLoS One* 16.12 (2021): e0260555. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0260555
[2] https://healthequitymatters.org.au/wp-content/uploads/2022/08/SKPA2-CLM-Toolkit-2022.pdf
[3] https://www.ohchr.org/sites/default/files/Documents/Issues/ESCR/Health/RightToHealthWHOFS2.pdf

METHODOLOGY

The above organizations were trained using the CLM toolkit, *Sustainable Community-Led Monitoring of HIV Services: A Toolkit for Key Populations*, June 2022[4].

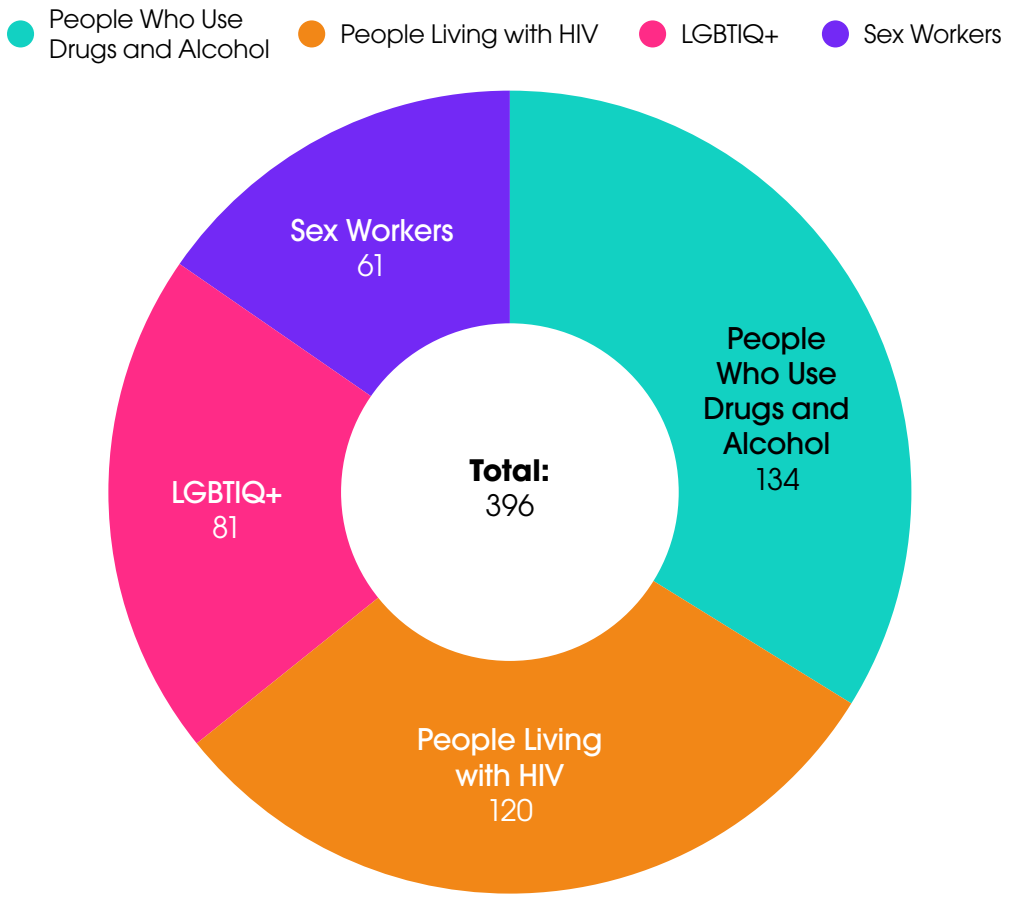
Following the training, data were collected in 15 districts. The districts selected had higher concentrations of key populations, and CLM was conducted using a computer-assisted personal interviewing tool. A total of 396 key population community members participated in the pilot. The selected indicators are listed under **Table 1** and more detailed information can be found in the SKPA-2 CLM toolkit[5].

RESULTS

A1: CLM participation in the pilot reach a total; of 396 as follows: 81 LGBTIQ+ persons; 61 female sex workers; 120 people living with HIV; and 134 people who use drugs and alcohol as shown in **Figure 2**. The participants visited various facilities including the National Referral Hospital (18.6%), Regional Referral Hospitals (9.5%), District-level Hospitals (33.7%) and Primary Health Centers (12.8%). The results of all CLM indicators are presented in **Table 1**.

Most of the services sought were reported to be available (91%), accessible (72.7%), acceptable (90.6%), and of good quality (84.8%). These observations applied across all key population groups and are quite promising. Services were ranked lower for accessibility compared to the other indicators as there were some issues around affordability of health services for some populations and for transgender women, some gay men, and female sex workers. Many from these communities faced difficulties in funding travel and reaching health facilities for services. Serious incidents recorded were low at 2.6% and most cases were related to stigma and discrimination faced mainly by LGBTIQ+ community in general and, in particular, transgender women.

Figure 2. Bhutan CLM Pilot Participation - May – June 2023



Source: CLM Bhutan Pilot – June 2023.

[4] https://healthequitymatters.org.au/wp-content/uploads/2022/08/SKPA2-CLM-Toolkit-2022.pdf
[5] https://healthequitymatters.org.au/wp-content/uploads/2022/08/SKPA2-CLM-Toolkit-2022.pdf

Table 1. CLM participation

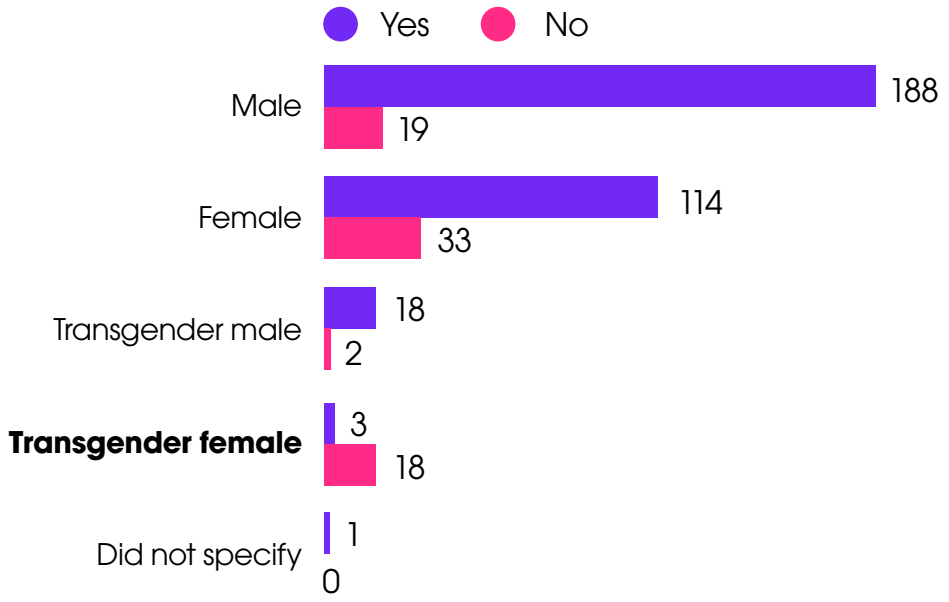
Indicator Short Name	Results
A1. CLM participation	396
A2. HIV service availability	91%
A3. HIV service accessibility	72.7%
A4. HIV service acceptability	90.6 %
A5. HIV service quality	84.8 %
A6. HIV service satisfaction	8/10
A7. Prevalence of serious incidents	4 % (16 persons)
A8. Prevalence of stigma and discrimination	3.3 % (13 persons)
B1. Serious incident follow-up attempts	12.5 % (2 clients)
B2. Successful client follow-up of serious incidents	12.5 % (2 client)
B3. Accurate reporting of serious incidents	100 % (2 out 2)
B4. Referrals to services following a serious incident	50% (1 referral)
B5. Successful and timely resolution of serious incidents	1 client

A2. HIV Service Availability was measured by taking the number and percentage of users who received all of the HIV and health services they sought. Overall, 91% of key populations found their HIV services available. This was highest among female sex workers (99%) and LGBTIQ+ persons (98%) and was 95% among people living with HIV and people who use drugs and alcohol. While the availability of most of the services that include ART refill (98%), STI diagnosis (97%), and TB services (98%) was reported to be high, 13% of people living with HIV reported that viral load testing was not available. The very high level of service availability is very encouraging. This could be because viral load testing is available only at selected higher-level facilities in Bhutan. Using the CLM data, Lhak Sam is continuing to advocate for the need to improve access to viral load testing.

A3. HIV Service Accessibility was measured using four different variables, and all needed to be in place for the service to be rated as accessible. These include, 1) convenient location; 2) safe location; 3) suitable opening hours; and 4) affordable services. Results are shown in **Figure 3**. Overall, 72.7% of key populations found the HIV services to be accessible: people who use drugs and alcohol (95%); people living with HIV (87.5%); LGBTIQ+ persons (60%); and sex workers (64%). By facility type, Drug Rehabilitation Centers (92%) and Health Information Service Centers – HISCs (81%) were reported to be highly accessible, whereas the National Referral Hospital (63.5%) and hospitals with 10-60 beds (68%) were rated lowest. Of the four components of accessibility, safety and convenience of location scored the highest at 94%, followed by suitable opening hours (91%) and affordability (82%). Service affordability had the most impact on the overall score with 85% of transgender women reporting services to be unaffordable. For the 21 transwomen, the most sought-after HIV health services includes HIV screening (43%) and confirmation tests (48%) along with condom supply (48%). It is not clear which specific service the respondents found unaffordable. Affordability may also have depended on the type of facility. Over 20% of respondents availing services from hospitals reported services to be unaffordable; compared to only 14% among those availing services from HISCs and Primary Health Centers (PHCs). Drop-In Centers were the most affordable type of facility accessed, with only one respondent (3%) finding such services unaffordable. While suitability of opening hours scored highly at 91%, this was not consistent across all groups

surveyed. A significant minority of LGBTIQ+ participants (22.2%) found the opening hours for the HIV service inconvenient. Within this group, transwomen heavily influenced the result with 11 (52%) finding the opening hours unsuitable.

Figure 3. A3: Service Accessibility and Affordability by Gender, Bhutan.

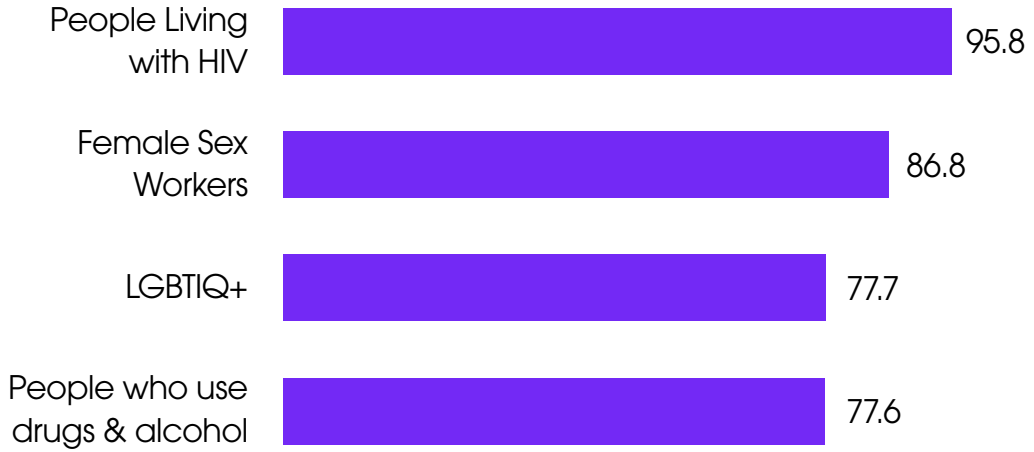


Source: CLM Bhutan Pilot – June 2023.

A4. HIV Service Acceptability was measured through three different variables and all three had to be in place to be rated as acceptable: 1) client treated respectfully; 2) consent sought; 3) privacy and confidentiality met. Overall acceptability scored 91% and the scores were high across all key populations, gender, and age groups with 95% treated respectfully, 94% had their consent given, and 98% having their privacy and confidentiality respected. Overall, these indicate that key populations are finding HIV services acceptable especially at lower-level health facilities. When assessed by facility type, most of the disrespectful treatment occurred at the National Referral Hospital and District-Level hospital (five persons in each location). Similarly, most respondents who did not have their consent taken also attended the National Referral Hospital (15 participants).

A5. HIV Service Quality was high at 84%, with people living with HIV (95.8%), and sex worker (86.8%) communities reporting the service to be of good quality. Results are shown in **Figure 4**. This was slightly lower for people who use drugs and alcohol (77.6%) and LGBTIQ+ persons (77.7%) with most instances occurring at the referral and district-level hospitals. The mean waiting time was around 60 minutes although this still resulted in high levels of service satisfaction scores with a mean of eight out of a possible 10.

Figure 4. A5: HIV Service Quality by Key Population, Bhutan.

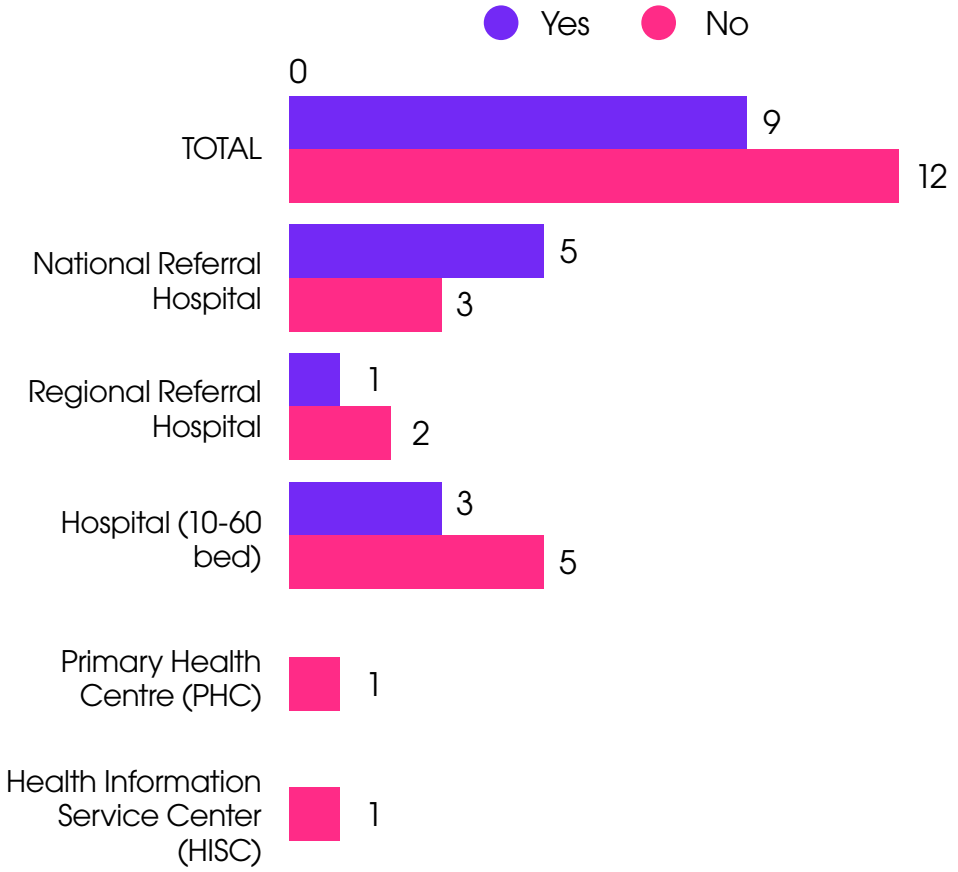


Source: CLM Bhutan Pilot – June 2023.

Serious Incidents, including Stigma and Discrimination. Overall, 3.3% of CLM clients experienced a Serious Incident; mostly reports of stigma and discrimination, specifically among transgender women, of whom 43% faced stigma and discrimination when accessing services. Results are shown in **Figure 5**. While the overall number is low, the high prevalence among this subgroup highlights the need improve health service delivery for transwomen. The data suggest the impact of patriarchal norms and attitudes on their right to stigma-free healthcare. One transwoman gave the following feedback:

"I feel stigma and discrimination is there; which as a transwoman, I face, but not from the health staffs but from the other patients. Why I am saying this is because while availing I had to wait in line where there were lots of other patients who were talking bad about me, asking question like if I am girl or boy, which made me uncomfortable."

Figure 5. A8: Experiences of Stigma and Discrimination among Transwomen, January to June 2023.



Only two serious incidents (5%) were followed up, because many persons did not consent to follow-up. Additionally, there seemed to be no adequate formal referral and redress mechanisms in place to ensure this issues were appropriately managed.

Source: CLM Bhutan Pilot – June 2023.

RECOMMENDATIONS

Based on the findings of the CLM pilot, we make the following recommendations to be incorporated into national CLM scale-up plans:

- CLM action plans are needed at both health facility level and national level to address recommendations including:
  - Make HIV and related services more accessible with operating hours of service centers more suitable to key populations.
  - Develop strategies to reduce stigma and discrimination, and waiting times should be developed, especially targeted at referral and district-level health facilities.
  - Develop strategies by the National HIV Program to make viral load testing more accessible and affordable for people living with HIV.
  - Ensure that the health system strictly adhere to and implement policies on respectful treatment of service users; and seek the consent of service users, especially key population members.
  - Train healthcare and community workers on gender, human rights, sexual and gender diversity, and the needs of key populations so that they provide sensitive and responsive services.
- Institute mechanisms to report and address serious incidents routinely.
- Design specific programs to be implemented for key populations especially for transgender women to address the high levels of stigma and discrimination from the general population and healthworkers; unaffordability of health services; and inconvenient opening times;.
- Improve programs aimed to reduce or eliminate stigma and discrimination focused nationwide and in particular on the National Referral Hospital and district-level hospitals.
- Address the high levels of unaffordable health services for key populations through strategies such as expanding virtual and key-populations led services, establishing social support systems and linking disadvantaged key populations with support services in collaboration with relevant stakeholders, including the national HIV Program.

CONCLUSION

The pilot found the overall framework and process was feasible, but the toolkit needed to be adapted to suit the local context along with ensuring that that the tools are field tested and understood by community members. While the pilot was successful in testing the data collection, analysis and report writing, partners were not very confident as to whether advocacy efforts using the CLM findings would lead to policy change and improve service quality and delivery. The need to build a stronger culture for using data for decision-making was evident through the pilot implementation, and this requires both adequate funding and capacity building. Additionally, there is a need to improve communities' understanding of how CLM findings can be used for advocacy, especially given that some key population communities expressed doubt that their input will result in service delivery improvements.

CONSIDERATIONS

- The views expressed were obtained voluntarily and represent the most recent experience of the clients stated at interviews by trained key population community representatives.
- The scores presented are in not representative of general patient care at the facilities profiled; at the individual level or overall; and are only related to the persons interviewed.
- No incentives were provided to participate.
- CLM is a non-research programmatic activity. The statistics as well as insights presented are intended for quality improvement purposes and do not, intend to reflect or measure the standard of care in the same way as a more rigorous population-based study might.
- As the first exercise with a new toolkit, there were data quality gaps, and, even with training, local adaptation and extensive review and revision of the results, there remain several unknowns around data quality. SKPA-2 technical briefs such as this build appreciation of how these data could lead to better insights for future programming.
- The conclusions are offered in the spirit of partnership between community members and health authorities towards a stronger response to HIV, human rights and gender.

ACKNOWLEDGMENTS

The CLM pilot in Bhutan process would not have been possible without the support from the lead national CLM consultant, Tshering Jamtsho along with Save the Children Bhutan staff. We would also like to thank all members of the Technical Working Group and implementors of CLM pilot in Bhutan.

The Sustainability of HIV Services for Key Populations in Asia-2 (SKPA-2) is a three-year project funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria under Agreement No. QSA-H-AFAO for the period 1 July 2022 to 30 June 2025. SKPA-2 is implemented by Health Equity Matters as the Principal Recipient, in collaboration with the following subrecipients; Action for Health Initiatives (ACHIEVE Inc.), APCOM Foundation, Family Planning Association Sri Lanka, International Community of Women Living with HIV Asia & Pacific (ICWAP), Save the Children Bhutan and Youth for Health Center.

REFERENCES

[1] Ayala, George, et al. "Peer-and community-led responses to HIV: a scoping review." *PLoS One* 16.12 (2021): e0260555. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0260555

[2] https://healthequitymatters.org.au/wp-content/uploads/2022/08/SKPA2-CLM-Toolkit-2022.pdf

[3] https://www.ohchr.org/sites/default/files/Documents/Issues/ESCR/Health/RightToHealthWHOFS2.pdf

[4] https://healthequitymatters.org.au/wp-content/uploads/2022/08/SKPA2-CLM-Toolkit-2022.pdf

[5] https://healthequitymatters.org.au/wp-content/uploads/2022/08/SKPA2-CLM-Toolkit-2022.pdf

HEALTH EQUITY MATTERS

THANK YOU

healthequitymatters.org.au

For further information,
please contact
Ms. Felicity Young
Principal Director – SKPA-2
felicity.young@healthequitymatters.org.au