LEGAL ENVIRONMENT ASSESSMENT of HIV in Bhutan

Report
2016
CONTENTS

Glossary

Executive Summary

Recommendations (at-a-glance)

1. INTRODUCTION
1.1 The Role of Law in relation to HIV
1.2 An Overview of the Legal System in Bhutan
1.3 An Overview of HIV in Bhutan
1.4 HIV Legal Environment Assessment and Costed Action Plan for the Kingdom of Bhutan
1.5 Methodology & Modalities

2. PEOPLE LIVING WITH HIV
2.1 Context

2.2 Discrimination
2.2.1 Laws & Policies
2.2.2 Recommendations

2.3 Informed Consent
2.3.1 Laws & Policies
2.3.2 Recommendations

2.4 Confidentiality & Disclosure of Information
2.4.1 Laws & Policies
2.4.2 Recommendations

2.5 Criminalisation of HIV Transmission
2.5.1 Laws & Policies
2.5.2 Recommendations

3. TRANSGENDER PEOPLE
3.1 Issues
3.2 Context
3.3 Laws & Policies
3.4 Recommendations

4. MEN WHO HAVE SEX WITH MEN
4.1 Issues
4.2 Context
4.3 Laws & Policies
4.4 Recommendations
5. PEOPLE WHO USE DRUGS
5.1 Issues
5.2 Context
5.3 Laws & Policies
5.4 Recommendations

6. SEX WORKERS
6.1 Issues
6.2 Context
6.3 Laws & Policies
6.4 Recommendations

7. WOMEN
7.1 Issues
7.2 Context
7.3 Laws & Policies
7.4 Recommendations

8. CHILDREN & YOUNG PEOPLE
8.1 Issues
8.2 Context
8.3 Laws & Policies
8.4 Recommendations

9. CROSS-CUTTING THEMES: ACCESS TO TREATMENT
9.1 Issues
9.2 Context
9.3 Laws & Policies
9.4 Recommendations

10. CROSS-CUTTING THEMES: ACCESS TO JUSTICE
10.1 Context
10.2 Issues, Laws & Policies
10.3 Recommendations

11. CROSS-CUTTING THEMES: ACCESS TO INFORMATION
11.1 Context
11.2 Issues, Laws & Policies
11.3 Recommendations

12. CONCLUSION

References

Annexures (Costed Action Plan submitted as separate Excel Sheet document)
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Anti-natal clinic</td>
</tr>
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<td>APN+</td>
<td>Asia Pacific Network of People Living with HIV</td>
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<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>ARV</td>
<td>Anti-retrovirals</td>
</tr>
<tr>
<td>BICMA</td>
<td>Bhutan InfoComm and Media Authority</td>
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<tr>
<td>BNCA</td>
<td>Bhutan Narcotics Control Authority</td>
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<td>BNL</td>
<td>Bhutan National Legal Institute</td>
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<tr>
<td>CAP</td>
<td>Costed Action Plan</td>
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<tr>
<td>CEDAW</td>
<td>UN Convention on Elimination of all forms of Discrimination against Women</td>
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<td>CRC</td>
<td>UN Convention on the Rights of the Child</td>
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<tr>
<td>DIC</td>
<td>Drop-in Centres</td>
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<td>DVPA</td>
<td>Domestic Violence Prevention Act</td>
</tr>
<tr>
<td>GNH</td>
<td>Gross National Happiness</td>
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<tr>
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<td>Health Information Service Centres</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>IP</td>
<td>Intellectual Property</td>
</tr>
<tr>
<td>HTC</td>
<td>HIV Testing &amp; Counselling</td>
</tr>
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<td>LDC</td>
<td>Least Developed Country</td>
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<td>LEA</td>
<td>Legal Environment Assessment</td>
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<tr>
<td>LGBTQ</td>
<td>Lesbian, Gay, Bisexual, Transgender, Queer</td>
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</tr>
<tr>
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<td>National HIV/AIDS &amp; STIs Control Programme</td>
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<td>National Commission for Women and Children</td>
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<td>Narcotic Drugs, Psychotropic Substances and Substance Abuse Act 2015</td>
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<td>Non-governmental Organisation</td>
</tr>
<tr>
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<td>National HIV/AIDS Commission</td>
</tr>
<tr>
<td>NSP</td>
<td>National Strategic Plan for the Prevention and Control of STIs and HIV/AIDS</td>
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<td>NSP2</td>
<td>2nd National Strategic Plan for the Prevention and Control of STIs &amp; HIV/AIDS</td>
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<td>NTT</td>
<td>National Task Team</td>
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<td>PCR</td>
<td>Polymerase Chain Reaction</td>
</tr>
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<td>PITC</td>
<td>Provider Initiated Testing and Counselling</td>
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<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission</td>
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<tr>
<td>PEP</td>
<td>Post Exposure Prophylaxis</td>
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<td>RBP</td>
<td>Royal Bhutan Police</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>WTO Agreement on Trade-Related Aspects of Intellectual Property Rights</td>
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<tr>
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<td>United Nations Economic and Social Commission for Asia and the Pacific</td>
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<td>Voluntary Counselling and Testing</td>
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<td>World Trade Organisation</td>
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<td>YDF</td>
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Executive Summary
(To be read with Recommendations-at-a-glance)

1. INTRODUCTION
The law can play a vital role in driving positive and inclusive social change and attitudes, by reflecting evidence- and rights-based principles. It is now well understood that this inclusive approach is the only way in which to effectively deal with HIV.

The Royal Government of Bhutan is a relatively new constitutional monarchy. The Constitution contains judicially enforceable fundamental rights and provides for Principles of State Policy. The Bhutanese legal system is based on a combination of Buddhist principles, human rights enshrined in the Constitution and English common law. The Supreme Court is the apex court. Bhutan has acceded to the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). It is signatory to the UN Declaration of Commitment on HIV/AIDS 2001, the 2011 and 2016 Political Declarations on HIV/AIDS, the Millennium Development Goals and the Sustainable Development Goals (SDGs).

Bhutan has low HIV prevalence of less than 0.1% among adults (15-49 years) and is presently implementing the 2nd National Strategic Plan for the Prevention and Control of STIs and HIV/AIDS 2012-16 (NSP2), which finds its basis in the Royal Decree on HIV/AIDS issued by His Majesty the Fourth King in 2004. The multi-sectoral National HIV/AIDS Commission (NHAC) is in charge of coordinating HIV-related activities while the National HIV/AIDS & STI Control Programme (NACP) is the department within the Ministry of Health tasked with implementing the HIV programme. Civil society and non-governmental organizations are also engaged in implementation of STI and HIV programmes.

In 2016, NACP in collaboration with the United Nations Development Programme (UNDP) undertook a Legal Environment Assessment (LEA) for the Kingdom of Bhutan to examine relevant laws and policies, and their implementation as they pertain to HIV. The LEA’s recommendations are supported by a Costed Action Plan (CAP) for their implementation. The methodology was based on UNDP’s Legal Environment Assessment for HIV modified as required by time and other constraints; this included a literature review, interviews with key local experts/stakeholders, establishment of a National Task Team with periodic reporting, an analysis of laws and policies, a National Stakeholder Consultation, a Consultation on the CAP and the development of the final LEA Report and CAP.

2. PEOPLE LIVING WITH HIV
Less than 1000 people are estimated to be living with HIV in Bhutan of whom 30 are children below the age of 15 years. The HIV epidemic in Bhutan is concentrated among young people. The majority of PLHIV are located in Thimphu and in three districts bordering India. The first network of people living with HIV in Bhutan, Lhak-Sam was registered in 2010.

Discrimination
In practice, although there appears to be little or no experience of explicit discrimination based on HIV in Bhutan, people living with HIV have shared occasional experiences of subtler forms of discrimination in the workplace and in schools. His Majesty the Fourth Kings’ Royal
Decree explicitly calls for non-discrimination of people living with HIV. Moreover, Bhutan’s Constitution spells out the right to equality in Article 7(15), which protects the individual against violations by the State and the private sector. The Labour & Employment Act, 2007 also stipulates provisions to prevent discrimination and provides for occupational health and safety.

Informed Consent
The right to life and liberty enshrined in the Bhutan Constitution forms the basis of the fundamental principles of autonomy and bodily integrity from which the requirement of informed consent flows. Informed consent in medical settings is governed by the detailed provisions of the Medical and Health Council Regulations 2005 issued under the Medical Council Act 2002. NSP2 specifies voluntary counseling and testing (VCT) with pre- and post-test counseling as the primary government approach to HIV testing with Provider Initiated Testing and Counselling (PITC) adopted only at certain clinical sites (ante natal clinics for pregnant women and for those who have TB or STIs). However, a May 2016 Executive Order appears to extend PITC to all patients visiting health centres, raising concerns over the ability of the programme to ensure that such testing remains voluntary and confidential. Access to HIV testing and counselling for children and young persons is another area of concern; in this regard the extent of the implementation of the 2009 National Standards and Implementation Guide for Youth Friendly Health Services is unclear. The National Guidelines for the Management of HIV/AIDS are also silent on the process and requirement of informed consent for HIV treatment.

Confidentiality & Disclosure of Information
Confidentiality emanates from the fundamental right to privacy, and finds strong recognition in Article 7(19) of Bhutan’s Constitution. The one legal requirement related to confidentiality in Bhutan’s laws pertains to “Duties to Society” in the Medical and Health Council Regulations which is of concern as it provides very broad circumstances in which patient confidentiality can be breached, without providing specific exceptional circumstances and protocols for disclosure. For individuals whose conduct is criminalized this would be a great disincentive to access health services. The confusion around the precise legal duty of confidentiality is furthered through the National Guidelines for the Management of HIV/AIDS, which require “HIV counseling and testing services are kept confidential” on the one hand, while prescribing “partner notification if positive” for post-test counseling, on the other. Bhutanese law does not stipulate partner notification protocols and policy guidance is unclear. Confidentiality for minors who access HIV services is an additional concern. Recent MOH Executive Orders and NHAC recommendations, while recognizing the need for confidentiality, link HIV status to aspects such as contact tracing, and citizenship identity documents, without suggested frameworks for robust data protection measures. In relation to disclosure of information/privacy, Bhutan’s media is governed by the Code of Ethics for Journalists issued under the Bhutan Information, Communications and Media Act, 2006 (BICM Act), which requires “Respect for Privacy and Human Dignity.” Therefore, unless there is a foreseeable and imminent risk of danger to the public, the media’s violation of a person’s privacy by revelation of their HIV status is prohibited by the law.

Criminalization of HIV Transmission
Section 410 of Bhutan’s Penal Code makes knowing or intentional transmission of disease dangerous to life punishable. This offence is considered to be a fourth degree felony where the dangerous disease has a high likelihood of causing death. The current law in Bhutan gives rise to two issues. The first is whether a separate law criminalising the transmission of HIV is required. There is consensus among international agencies and human rights experts that countries should not enact HIV-specific criminal laws. The second issue is how to ensure that the law applies only to cases of actual, intentional transmission of HIV and how prosecutions under this provision should proceed; the current Bhutan law is broad and the phrase "endangers the safety or health" could imply that actual harm is not required unlike the international guidance that transmission should actually take place for a prosecution to proceed. To address these concerns, one approach that can be considered is that of the UK where detailed prosecutorial guidance has been issued.

3. TRANSGENDER PEOPLE
Both transgender men and transgender women are part of Bhutanese society, albeit invisible in social discourse. Two areas of law potentially impact transgender people, their marginalisation and vulnerability to HIV. First, is the issue of discrimination; since transgender people are not recognised as either male, female or as an alternative gender identity, they are not extended the fundamental rights available to all people under the Constitution, including the right to equality under Article 7(15). Second, the law criminalizes transgender people through Section 213 of the Penal Code, which proscribes “unnatural sex.” Though unused, the provision casts a pall on the lives of transgender people and deters them from approaching police or health workers due to concerns that the latter would be obliged to report their health condition to the former. Such an obligation arises under regulation 4.4 of the Medical and Health Council Regulations, which requires health workers to report crimes to the police if they come to know of the same while treating a patient.

4. MEN WHO HAVE SEX WITH MEN
Men who have sex with men are a largely invisible community in Bhutan. Similar to transgender people, two areas of law potentially impact men who have sex with men, and their marginalisation and vulnerability to HIV. First, men who have sex with men can be discriminated against in various spheres of life, particularly in employment, or while seeking health services where they are denied opportunities when their sexual orientation becomes known and is the basis of differential treatment. Second, the law criminalizes men who have sex with men through Section 213 of the Penal Code, which punishes “unnatural sex”, “sodomy”, and “any other sexual conduct that is against the order of nature.” Although unused, the very existence of this provision looms as a threat against men who have sex with men. Approaching health facilities with anal STIs would reveal their involvement in the proscribed sexual conduct, and the health worker is then obliged to report them to the police under regulation 4.4 of the Medical and Health Council Regulations. This pushes men who have sex with men away from crucial health services and treatment.

5. PEOPLE WHO USE DRUGS
Drug use in Bhutan is a matter of some concern to the government. Injecting drug use does not appear to be common in Bhutan and 1% of HIV infections may be attributable to injecting drug use. Injecting drug use and sharing of needles has been reported at a small scale. For both injecting and non-injecting people who use drugs, a comprehensive harm reduction
package is a critical intervention, particularly where the epidemic in Bhutan is in its early stages. Drug use and possession is criminalized under the Penal Code and the Narcotic Drugs, Psychotropic Substances and Substance Abuse Act of Bhutan 2015. Narcotics laws are significant in the HIV context — stringent criminal law governing the personal use of drugs can be problematic from a public health perspective as it can prevent users from accessing prevention, harm reduction, and treatment information and services, particularly if they are concerned that healthcare workers may report them to law enforcement. Additionally, the criminalisation of people who use drugs accentuates the stigma and discrimination suffered by them, hindering their ability to re-enter the mainstream by availing education and employment opportunities.

6. SEX WORKERS
Although sex work is not a visible or organised phenomenon in Bhutan, anecdotal data points to its existence, especially closer to the border areas with India. Drayangs are considered proxy sites where HIV and health information is shared with "high risk women". Where crucial health interventions are happening with already marginalised and hard-to-reach communities, criminal law used against people who make choices to engage in transactional sex, and those who pay for such sex, can lead to problematic consequences, including such activities being scattered further, pushed 'underground', into more furtive and dangerous contexts. Bhutan's approach to sex work is reflected in the Constitution which requires that the State endeavor to eliminate prostitution which is considered a form of exploitation. This approach is also reflected in Bhutan's international and regional obligations. Prostitution and related activities are crimes under the Penal Code.

7. WOMEN
The status of women in Bhutan has been assessed as relatively empowered compared to the rest of South Asia. On the other hand, data suggests that the extent of violence against women is high as is its acceptance level among women. Bhutan is signatory to CEDAW. The Constitution prohibits discrimination on the grounds of sex, and national legislations protecting women have recently been passed including the Domestic Violence Prevention Act. Legal provisions related to sexual assault in the Penal Code are comprehensive covering rape, child molestation, child abuse, gang rape, paedophilia, statutory rape, marital rape, and incest and treat these crimes as gender neutral. They also recognize that consensual sex between children of sixteen years and above is not rape. Along with an equitable inheritance system, women also have equitable child custody rights. However, the Marriage Act, 1980 provides for "[c]ompelling reasons by which a mother can be deprived of custody include: neglect,...affliction with communicable illness, and any other ground that the court determines." Another aspect related to women, which needs further understanding in the HIV context, is the illegality of abortion with data suggesting that women are forced to opt for unhygienic, dangerous methods settings; women living with HIV undergoing unsafe abortions are a higher risk for complications than other women.

8. CHILDREN AND YOUNG PEOPLE
Of the 403 people living with HIV in Bhutan, 30 are children below the age of 15 years. The age at detection for women is younger compared to males. Ten children below the age of 15 are on anti-retroviral therapy (ART). Young people in Bhutan appear to be sexually active from an early age with reports also suggesting that some youth are engaged in same sex
sexual activity. Anecdotal information suggests that children affected by HIV are facing stigma and discrimination and need social protection. In terms of access to HIV testing and counselling, the implementation of a Youth Friendly Health Services programme is low; data suggests that healthcare providers do not distribute condoms or contraceptives to adolescents. Bhutan’s life skills programme in schools includes comprehensive sex education. A significant number of young people, primarily those using drugs, come in contact with the criminal justice system of Bhutan. Bhutan is a signatory to the CRC. The Constitution recognises the duties of the State and of individuals towards children. The 2011 Child Care and Protection Act, is an important legislation in terms of HIV as it incorporates a community-based and "de-criminalisation" approach to young people in conflict with the law. Children, youth and adolescents are a primary focus of NSP2.

9. CROSS-CUTTING THEMES: ACCESS TO TREATMENT
Of the approximately 1000 people living with HIV, 167 are currently on ART, which is procured from India; 80% of the cost of treatment is borne through domestic funding. ART is provided free of cost and while most people living with HIV on treatment in Bhutan are on 1st line treatment, a few are on 2nd line treatment. Access to medicines is considered integral to the right to the highest attainable standard of health; in the case of HIV, ARVs make the difference between health and illness. The legal environment in a country and how it implements intellectual property laws can have a direct impact on whether, how and if access to affordable medicines is possible in a country. Bhutan’s Industrial Property Act 2001 (implemented since 2012) requires the grant of patents on medicines with provisions similar to those required by the World Trade Organisation’s (WTO) Agreement on Trade Related Aspects of Intellectual Property Rights even though Bhutan is not a WTO member. The law does not include the full range of health safeguards necessary to ensure access to affordable generic medicines nor are pharmaceuticals exempt from patents, a right enjoyed by “least developed countries” in the WTO until 2033.

10. CROSS-CUTTING THEMES: ACCESS TO JUSTICE
Access to justice includes the ability of a person to approach the courts or dispute redress mechanisms through representation, fora which are easily accessible, a system of justice that is affordable (including free legal aid) and prompt, continuous and ongoing training on relevant issues (in this case HIV, law and rights) for various actors involved in the justice system –prosecutors, lawyers, all levels of the judiciary, local authorities who dispense justice through alternative resolution mechanisms, and legal literacy for the general public (and in the HIV context, people living with and affected by HIV). Legal representation and legal aid for litigants remain a challenge in Bhutan. The Jabmi Act, 2003, prescribed functions of the Jabmi Tshogdey to include organizing free legal aid for indigent people. The Constitution requires that the State endeavor to provide legal aid. In the context of people living with HIV and related stigmatized contexts such as sex work, drug use or for transgender people or men who have sex men, many potential litigants avoid approaching courts as their identity could be revealed through the court proceedings.

11. CROSS-CUTTING THEMES: ACCESS TO INFORMATION
The Constitution of Bhutan guarantees the right to information, which forms the basis for critical HIV-related education, information and communication to be disseminated that is outside the pale of obscenity law. In relation to computer pornography, the Penal Code proscribes the publication and distribution of “an obscene photograph or picture on the computer or over the internet”. Obscenity law has not and should not be used as a justification to restrict the communication of vital sexual health and HIV information. In the context of access to information, as mentioned earlier, Bhutan’s media is governed by the Code of Ethics provision for Journalists under the BICM Act on “Respect for Privacy and Human Dignity” prohibits a journalist from violating the privacy of any person including the person’s health unless “it can clearly and objectively be demonstrated that there was an overriding public interest” in breaching privacy, a right protected under the Constitution.

12. CONCLUSION
HIV has exposed weaknesses in health systems, and rights-based HIV responses should ideally attempt to address these infirmities by strengthening laws, and investing human and financial resources in more strategic, effective ways that strengthen the HIV response as well as the broader health system. In line with this approach of using the HIV response as an opportunity, the Legal Environment Assessment process and report should prompt a process of broader review of health-related laws, and anti-discrimination legal measures for the marginalized. Apart from the recommendations contained in this assessment, these could include opportunities that inform the proposed National Health Bill, review of the Medical Council Act and related Regulations, discussions in the legislature on law reform in relation to sexual orientation and gender identity, and the National Law Review Task Force being chaired by the Office of the Attorney General. The new Jigme Singye Wangchuk School of Law provides an opportunity to offer studies in health law and policy, which are informed by the evolution of legal responses to the HIV epidemic globally. Finally, as part of the family of nations, Bhutan’s commitment to human rights and the advancement of all its people can only be enhanced by its ratification of the key human rights treaties that form the bedrock of the world’s commitment to human rights – the International Covenant on Civil and Political Rights and the International Covenant on Economic Social and Cultural Rights. It particularly befits a society that has set an example to the world of a more humane way of measuring national, community and human development.
Recommendations [at-a-glance]

1. PEOPLE LIVING WITH HIV – Recommendations

1.1 Discrimination
a. Although law reform is not required in relation to non-discrimination, clear-cut policy directive can provide interpretative guidance and clarity in the law by explaining that “other status” in Article 7(15) of the Constitution includes HIV status. Alternatively, anti-discrimination law that explicitly prohibits discrimination due to various grounds, including health (HIV) status can be introduced.

b. Similar policy articulation clarifying that Article 7(15) covers overt and subtle discrimination would also provide required clarity.

c. The International Labour Organisation has provided guidance for a workplace policy on HIV/AIDS, which is a basis for putting in place a comprehensive workplace programme that combines prevention, care and the protection of rights, including non-discrimination. This approach can further strengthen efforts to prevent and address discrimination in the workplace.

d. Regular reviews should be undertaken to ensure that occupational health and safety of health workers is addressed, including unfettered access to universal precautions, and post-exposure prophylaxis.

1.2 Informed Consent
a. Informed consent with pre- and post-test counseling should continue to form the backbone of the HIV programme. Informed consent for testing is based not only on human rights principles but also on public health beneficence. The expansion of PITC to all health centres in Bhutan should be reconsidered as it is contrary to international guidance and particularly given the criminalized status of key populations in Bhutan, runs the risk of alienating people from the healthcare system. Informed consent for HIV related treatment and research should also be included in the relevant policies and guidelines.

b. Law reform to facilitate the ability of those below the age of 18 to access HIV testing, treatment and other health services based on a mature minor assessment should be considered.

c. Laws protecting healthcare providers from legal or disciplinary actions who act in good faith to provide healthcare services to minors should be considered.

1.3 Confidentiality & Disclosure of Information
a. Law reform is required to amend regulation 4.4 (“Duties to Society”) of the Medical and Health Council Regulations to specify circumstances when and how confidentiality may be breached – as per globally accepted standards of shared confidentiality, under orders of a court, or in cases of partner notification after following strict protocols, as summarized above.
b. Policy should be articulated on maintenance of privacy and confidentiality by persons in context other than healthcare who come across information relating to a person’s HIV status, including the media, NGOs, and employers.

c. Rigorous legal provisions should be formulated that prescribe data protection measures while keeping HIV, medical and other information records. This includes robust guidance on contact tracing that is designed to empower and encourage individuals to undertake HIV testing, with full guarantee of confidentiality, and removing liabilities on healthcare workers who are unable to trace contacts. In this context the suggestion of the NHAC to link HIV status to citizenship identity cards should be reconsidered given the dangers such linking could pose to revelation of private information, including HIV status.

d. Suppression of identity orders should be issued by courts in the context of HIV and related cases, including in prosecutions related to HIV transmission.

1.4 **Criminalization of HIV Transmission**

a. Section 410 of the Penal Code is sufficient to address cases of intentional transmission of HIV and a specific provision or penalty should not be introduced.

b. The use of Section 410 should be restricted only to cases of actual, intentional transmission of HIV. In this regard, the government and law enforcement agencies in consultation with people living with HIV, should adopt prosecutorial and investigative guidance to ensure that any complaints of the intentional transmission of HIV are pursued with great care and based on a high standard of evidence and proof. Guidance should stipulate media reporting of such cases, and be linked with Media Guidelines on HIV that are recommended to be developed.

c. Service providers and other stakeholders (government and non-government) should receive training and capacity building to understand the role and limitations of criminal law in dealing with HIV transmission and in maintaining confidentiality of a person’s HIV-related status as well as in strictly following disclosure protocols.

d. Greater institutional collaboration and guidance is required to provide support for people living with HIV who may be destitute or in difficult circumstances.

e. Public education and awareness programmes on best practices and best public health approaches based on evidence and human rights in addressing the HIV epidemic should be introduced.

2. **TRANSGENDER PEOPLE – Recommendations**

a. Law reform should be undertaken to repeal S. 213 of Bhutan’s Penal Code. (Presently, there is discussion on this provision, its validity and its impact on the lives of those who may be lesbian, gay, bisexual, transgender or those who may not identify as such but manifest sexual behaviours that are implicated by the section. Opportunities to
repeal the law exist through forthcoming discussions within parliament’s Human Rights Committee.)

b. Law review efforts should consider and discuss recent best practice developments in legislating gender identity.

c. Understandings of sexual orientation and gender identity should be promoted through appropriate sexuality education efforts, and public messaging so that society at large and young persons receive affirmative, non-stigmatizing information about sexuality, sexual orientation and gender identity, and the use of condoms as a measure to ensure safe sexual intercourse.

d. Although law reform is not required in relation to non-discrimination, clear-cut policy directive can provide interpretative guidance and clarity in the law by explaining that “other status” in Article 7(15) of the Constitution includes gender identity would provide clarity on the law. Alternatively, anti-discrimination law that explicitly prohibits discrimination due to various grounds, including gender identity, can be introduced.

3. MEN WHO HAVE SEX WITH MEN – Recommendations
a. Law reform should be undertaken to repeal S. 213 of Bhutan’s Penal Code. (Presently, there is discussion on this provision, its validity and its impact on the lives of those who may be lesbian, gay, bisexual, transgender or those who may not identify as such but manifest sexual behaviours that are implicated by the section. Opportunities to repeal the law exist through forthcoming discussions within parliament’s Human Rights Committee.)

b. Understandings of sexual orientation should be promoted through appropriate sexuality education efforts, and public messaging so that society at large and young persons receive affirmative, non-stigmatizing information about sexuality, and sexual orientation, and the use of condoms as a measure to ensure safe sexual intercourse.

c. Although law reform is not required in relation to non-discrimination, clear-cut policy directive can provide interpretative guidance and clarity in the law by explaining that “other status” in Article 7(15) of the Constitution includes sexual orientation would provide clarity on the law. Alternatively, anti-discrimination law that explicitly prohibits discrimination due to various grounds, including sexual orientation can be introduced.

4. PEOPLE WHO USE DRUGS – Recommendations
a. Public awareness and education of HIV-related harm reduction as well as health services for people who use drugs should be introduced. Based on community consultations, positive public messaging and outreach for people who use drugs should be designed and implemented, specifically related to safer sexual practices and increasing uptake and use of condoms and the availability of voluntary and confidential health services. The capacity and infrastructure for rehabilitation should also be increased.
b. Reform and review of the narcotics laws in Bhutan should be considered based on a detailed study of impact of NDPSS 2015 and a review of global good practices including on whether criminal law should be the primary response to drug use, de-criminalisation of personal drug use and small quantity specifications, harm reduction and community-based rehabilitation.

c. Greater co-ordination at the institutional level is required to provide support and opportunities for re-integration (including in terms of employment or educational opportunities) for people who use drugs released from rehabilitation or from prison. In particular psychosocial support for people who use drugs including young people to address issues of self-stigma and shame should be reviewed and re-designed based on community consultation.

d. Laws protecting healthcare providers from legal or disciplinary actions who act in good faith to provide healthcare services to people who use drugs in relation to HIV, overdose, other medical issues should be considered and introduced. The legal requirement for healthcare workers to report people who use drugs to the police should reformed and amended as discussed in the Confidentiality section.

5. **SEX WORKERS – Recommendations**
   a. Along with an assessment of the scale of sex work in Bhutan, a review should be undertaken that examines various successful rights-based models of prostitution law and policy reform, including decriminalization and its effects, to empowerment efforts to promote and protect the health and civil rights of people involved in sex work.

   b. At the same time, data on the harmful impacts of using anti-trafficking measures to criminalize those involved in prostitution should be shared with various stakeholders, particularly law and policy-makers, so that a balanced understanding of effective and strategic ways to address both trafficking for sexual exploitation, empowerment of those in prostitution, and public health priorities can be charted.

   c. Based on the above, a review of laws to reconsider key sections in Chapter 26 of the Penal Code should be undertaken.

6. **WOMEN – Recommendations**
   a. There is a need to review the Marriage Act, to ensure that HIV status is removed as a ground for taking away custody of a mother, especially given the chronic nature of living with HIV where anti-retroviral is made readily available.

   b. There is a need to cost and appropriately allocate budgets for effective implementation of laws such as the Domestic Violence Prevention Act.

   c. Research should be undertaken to better understand the impact of Bhutan’s abortion law on the health and safety of women.
7. CHILDREN AND YOUNG PEOPLE – Recommendations

(Note: Recommendations on laws and policies related to discrimination, consent and confidentiality are described above and should be read to apply to children and young people.)

a. Legal Protections for children and young persons in the context of HIV should be operationalised including:

i. The approach of the Child Protection & Protection Act of decriminalization for children in conflict with the law requires operationalization particularly for young people who use drugs.

ii. Separate incarceration facilities for detention and imprisonment for young people are required.

iii. Through community consultation, the manner in which the Child Care and Protection Act can support children living with HIV should be examined and implemented.

iv. Greater institutional support and coordination between child protection mechanisms and law enforcement should be considered, particularly to ensure protection for children in conflict with the law.

b. HIV related health services and programmes should be designed and implemented with a view to ensure access to children and young people including:

i. Child friendly health and HIV services that go beyond life skills, HIV awareness and sex education should be implemented to ensure access to health services including voluntary and confidential testing and treatment for children and young persons.

ii. Laws protecting healthcare providers from legal or disciplinary actions who act in good faith to provide healthcare services to children and young persons, particularly in relation to HIV services and for children and young persons from key affected populations should be considered and introduced.

iii. HIV and health services aimed at young people who are part of key populations (men who have sex with men, transgender people, people who use drugs) should be introduced and greater consideration should be given to the teaching of the life skills module as it relates to LGBTQ youth.

8. CROSS-CUTTING THEMES: ACCESS TO TREATMENT – Recommendations

a. Law reform and review of the industrial protection law, particularly as it relates to patents should be considered from the perspective of making full use of the rights of Bhutan as a country outside the WTO and as a least developed country to tailor its intellectual property regime to suit its socio-economic and industrial policy needs. This could include having no patent protection in the pharmaceutical and other sensitive sectors and having intellectual property protection that is far below what is required by TRIPS. Even least developed countries who are WTO members have till 2021 to implement TRIPS in terms of all forms of intellectual property protection and
are not required to grant or enforce pharmaceutical patents and data protection till 2033.

b. A review of the patent law should incorporate the full range of public health safeguards/TRIPS flexibilities. The experience of developing countries has shown that these safeguards and their effective use evolve over time with State practice and least developed countries should examine and benefit from the experience of developing countries.

c. In reviewing its patent laws and policies, Bhutan should seek pro-development and pro-public health technical assistance that is specifically tailored to its socio-economic needs, that prioritizes public health and access to medicines and is in public interest.

d. Apart from incorporating public health safeguards in the IP law, it is important to ensure that these safeguards are fully implemented and used. Experience shows that full and consistent use of all the flexibilities by governments and public interest groups may be key to ensuring that local production, imports and access to medicines are not impeded by compliance with the TRIPS Agreement. Incorporating health safeguards in patent laws will only be the first step for Bhutan and the administrative set up relating to intellectual property should consider the use of the public health safeguards as integral to the functioning of the intellectual property regime and institutional, financial, human and technical resources should be accordingly allocated.

e. TRIPS-plus requirements in WTO accession or free trade agreement negotiations should not be accepted. Least developed countries negotiating to get into the WTO in the past have had to concede to intellectual property obligations far in excess of the TRIPS Agreement. Bhutan should ensure that they enjoy the same rights to the transition period and resist any requirements for early compliance with the TRIPS Agreement or to undertake TRIPS-plus obligations either at the WTO or in any future free trade agreement negotiations.

9. CROSS-CUTTING THEMES: ACCESS TO JUSTICE – Recommendations

a. In order to ensure delivery of justice, particularly to indigent persons, a robust legal aid mechanism should be created, which will also serve the needs of those seeking judicial redress in the HIV context. An opportunity to do so for the future is available through lawyers graduating from the Jigme Singye Wangchuk School of Law.

b. Training on HIV and the vast array of legal issues that arise in its context can be made part of the training efforts of the BNLI, including for the judiciary, and for defense lawyers to competently serve the criminal justice system.

c. Judicial & legislative capacity-building on HIV and the law can be undertaken through the participation of experts including judicial peers.
d. Suppression of Identity orders, which facilitate access to justice should be issued by the courts in HIV-related cases before them. Legislating such special procedures may be worth considering in the context of health issues generally, in relation to the proposed National Health Bill.

e. Ongoing community legal literacy efforts can include legal and know-your-rights issues related to health generally, and HIV specifically, and also in conjunction with HIV-related awareness raising.

10. **CROSS-CUTTING THEMES: ACCESS TO INFORMATION – Recommendations**

   a. Media Guidelines have been developed in relation to reporting on women and children. Similar guidelines should be developed to report on HIV and related issues of sexuality, sexual health and marginalization, which should include the requirement to be non-stigmatizing, gender-sensitive, evidence-based and non-prejudicial, and protection of privacy.

   b. The right to information should be actualized through sensitization and capacity-building of the multiple stakeholders who are involved in the HIV response on HIV and related issues of sexuality, sexual health and marginalization. These include the police, health workers, and the media.
1. INTRODUCTION

1.1 The Role of Law in relation to HIV

“The law alone cannot stop AIDS. Nor can the law alone be blamed when HIV responses are inadequate. But the legal environment can play a powerful role in the wellbeing of people living with HIV and those vulnerable to HIV. Good laws, fully resourced and rigorously enforced, can widen access to prevention and health care services, improve the quality of treatment, enhance social support for people affected by the epidemic, protect human rights that are vital to survival and save the public money.”

- From “Risks, Rights and Health”, the report of the Global Commission on HIV and the Law

Although HIV is a medical condition, what it has revealed in the last 35 years is that a biomedical response – focused on providing people with the commodities and medicines to prevent or treat the virus – is inadequate in dealing with the epidemic. An effective response to control HIV, we have learnt, requires understanding and recognition that structural factors – such as social and economic marginalization – contribute to HIV vulnerability; and that societies need to develop abilities and demonstrate the political will to mitigate the impact of these factors if the epidemic is to be effectively controlled. HIV is often found to reside in parts of society that are the most marginalized or have been traditionally shunned – disempowered women and men, people who use drugs, sex workers, transgender people, and men who have sex with men. Much of this marginalization has been cemented in the social fabric over several generations.

The law often contributes to instilling this marginalization, by criminalizing those who are already social outcasts and pushing them further to the margins, or denying equal rights to subjects that it views through a moral lens, which often reflects majoritarian or colonial, uninformed prejudice. Yet, the law can also play a vital role in driving positive and inclusive social change and attitudes, by reflecting evidence- and rights-based principles. Its imprimatur can also have a salient affirmative impact in protecting the rights of the marginalized and ensuring that they have equal access to social resources, protections and opportunities, including to health, education, employment, housing, and freedom from violence. Such a rights-based, enabling approach, which rejects punishment and supports empowerment can contribute to social transformation by de-marginalizing the traditionally dispossessed, and giving them an array of tools through access to information, services, and justice that allow them to protect themselves and others from vulnerability to HIV.¹ A punitive legal environment in relation to HIV only exacerbates marginalization, by making targets of the law fearful of accessing the vital services required to mitigate the ill effects of the epidemic. As has been pointed out by a leading expert, the most important public health lesson emerging from the HIV epidemic is that, “the protection of the human rights of persons at risk is the most effective way of arresting or slowing the spread of the virus.”²

¹ The most recent authoritative iteration of the rights-based approach to HIV can be found in “Risks, Rights & Health”, the report of the Global Commission on HIV and the Law: http://hivlawcommission.org/index.php/report
² Law Discrimination and Human Rights - Facing up to the AIDS Paradox, The Hon Justice Michael Kirby AC CMG, Third International Conference on AIDS in Asia and the Pacific, 1995:
It is through experiences with rights-based as against punitive approaches, and with the advocacy of people living with and affected by HIV, and the understandings of health systems and governments that the family of nations has approached the HIV epidemic – through an integrationist view, which aims to foster enabling environments supported by rights-based laws and policies that encourage people to access health and HIV information and services, and reduce stigma and discrimination against them. It is now well understood that this inclusive approach is the only way in which to deal with HIV, and this is reflected in the international policy framework that governs the global HIV response through the United Nations (UN) – the Declaration of Commitment on HIV/AIDS 2001, and the succeeding 2011 and 2016 Political Declarations on HIV/AIDS, which commit nations to plan and implement robust rights-based prevention, care and treatment responses for HIV. Within the new development agenda, Bhutan as part of the family of nations has committed to achieving the Sustainable Development Goals (SDG), which comprise the goal of ensuring healthy lives and promoting wellbeing for all people, including ending AIDS by 2030.³

Bhutan has demonstrated prescience in recognizing compassion and inclusiveness as essential to a nation’s fabric. It has done so through its unique notion of Gross National Happiness (GNH), an aspiration of sustainability informed by, inter alia, good governance – for all, supported by an able infrastructure to enable efficiency and transparency – and cultural resilience – the ability to overcome challenges and difficulties from other norms. The domains in which GNH is to be infused are health, community vitality, education, and psychological wellbeing. In Bhutan’s 11th five-year-plan a National Key Result Area is the “Needs of the Vulnerable Populations addressed”. And “Bhutan 2020: A Vision for Peace, Prosperity and Happiness” notes that improving HIV programming is key to long-term progress. This bouquet of far-sighted policy planning is fertile ground within which a rights-based HIV environment can be nurtured, which sees the law and its implementation as one of the many tools to be used to empower those living with or most vulnerable to HIV as part of the overall goal of effectively controlling the epidemic.

1.2 An overview of the Legal System in Bhutan

The Royal Government of Bhutan is a relatively new constitutional monarchy where modern democratic reforms, institutions and values began to be introduced by the Fourth King Jigme Singye Wangchuk in 1981 first through structures of decentralization, such as the Dzongkhag Yargay Tshogdu (District Development Assembly). Thereafter, as Head of State the King handed over the running of government to the Prime Minister and a cabinet of ministers in 1998, culminating in the drafting and signing of the Constitution of Bhutan in 2008, and the first national elections.

The Constitution contains judicially enforceable fundamental rights in Article 7, and provides for the legal authority, structure and functioning of the organs of government – the executive, legislature and judiciary. Article 7 provides several fundamental rights that are

³Details of the Sustainable Development Goals are at http://www.un.org/sustainabledevelopment/health/
relevant in the context of HIV. Subject to reasonable restrictions, they include the rights to life, liberty and security of person, information, equality, privacy, legal representation, to own property, and the freedoms of speech, opinion and expression, of the press and media to disseminate information, of movement and residence, of association and assembly, and protection from arbitrary arrest or detention.

The Constitution also provides for Principles of State Policy in Article 9, which provide a value framework based on which the drafters envisaged the Bhutanese state to function. These principles include promotion of conditions to enable pursuit of G

 achieves; creation of a civil society free of oppression, discrimination and violence, based on the rule of law, protection of human rights and dignity; provision of fair, transparent and speedy justice; provision of legal aid irrespective of economic or other disabilities; encouragement of private sector development through fair market competition and prevention of commercial monopolies; protection of women and children from exploitation; provision of free access to basic public health services in both modern and traditional medicines; and provision of social security for the disadvantaged.

Bhutan saw the first codification of laws in the 17th century. In 1959, a comprehensive code – the Thrimzhung Chhenmo – was drafted to cover civil and criminal matters under guidance of the Third King Jigme Dorji Wangchuk. This code has undergone amendments or been replaced by subsequent legislation, yet, it forms the bedrock of the contemporary Bhutanese legal system, which is based on a combination of Buddhist principles, human rights enshrined in the Constitution and English common law.

Judicial authority in Bhutan is vested in the Royal Courts of Justice, which includes the Supreme Court, High Court, Dzongkhag (district) Court, Dungkhag (sub-district) Court and other courts and tribunals that may be established from time to time by the King on the recommendation of the National Judicial Commission. The Supreme Court is the apex court, with final authority on the interpretation of the Constitution; it has appellate, and advisory jurisdiction and the power to review official acts in contravention of the Constitution.

As a member state of the UN, Bhutan has acceded to two key international conventions that have a bearing on the nation’s response to HIV: the Convention on the Rights of the Child (CRC), and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). Further, it is signatory to the aforementioned UN Declaration of Commitment on HIV 2001, and the succeeding 2011 and 2016 Political Declarations on HIV/AIDS, the Millennium Declaration (Millennium Development Goals) and the succeeding 2030 Agenda for Sustainable Development, all of which have specific targets and indicators on HIV/AIDS. At the regional level, as a member of the UN Economic & Social Commission for Asia and the Pacific (ESCAP), Bhutan has agreed to adopt rights-based measures in its HIV control efforts, including “identifying and removing policy and legal barriers to universal access and promoting dialogue between health and other sectors, including justice, law and order and

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5 [http://www.nyulawglobal.org/globalex/Bhutan1.html](http://www.nyulawglobal.org/globalex/Bhutan1.html)

6 Article 21, Constitution of Bhutan, 2008

drug control. Regionally, and relevant to HIV, Bhutan is also signatory to the South Asian Association for Regional Cooperation (SAARC) Conventions on Combating and Prevention of Trafficking in Women and Children for Prostitution, on Promotion of Welfare of Children, and on Narcotic Drugs and Psychotropic Substances. These commitments are the basis on which member states, including Bhutan, commit to planning and implementing robust rights-based prevention, care and treatment responses to effectively deal with HIV/AIDS.

Bhutan’s HIV response finds its basis in the Royal Decree on HIV/AIDS issued by the His Majesty the Fourth King in May 2004. The Royal Decree articulates compassionate and far-sighted guiding principles for Bhutan’s HIV response: that it must be based on non-discrimination and support for people living with HIV/AIDS, and participation by all citizens in the response.

1.3 An overview of HIV in Bhutan

Bhutan has an estimated population of 733,643, of which 65.5% resides in rural areas, 61% is in the economically active 15-64 years age group, with life expectancy at birth being 66.2 years. Bhutan has low HIV prevalence of less than 0.1% among adults (15-49 years), with fewer than 1,000 people estimated to be living with HIV. Since the first case was detected in 1993, a total of 403 people have tested positive for HIV, evenly proportioned between males (204) and females (199). Of this number, 30 are children below the age of 15 years or 7.4% of the total numbers. With an estimated 175 new infections in 2014, Bhutan is considered to have a low-level, diffused epidemic that is most likely still in its early stages. The increase in the reporting of cases (more than 50% in the last ten years) have been attributed to the scaling up of HIV testing services and mass awareness programmes by the Ministry of Health (MOH) and partners. Geographically, more than half the reported cases have been in urbanized areas, with border towns also reporting relatively higher numbers of cases. Heterosexual transmission accounts for over 90% of reported cases, vertical transmission for 7% and intravenous drug use and blood transfusion are considered to account for 2% of cases. The implementation of a national Prevention of Mother-to-Child Transmission (PMTCT) programme has been successful in reducing vertical transmission in recent years.

Bhutan is currently in the latter phase of implementing the 2nd National Strategic Plan for the Prevention and Control of Sexually Transmitted Infections (STIs) and HIV/AIDS 2012-16 (NSP2), which builds on the previous NSP and finds its basis in the Royal Decree on HIV/AIDS mentioned above. Building on the Royal Decree, the NSP2 states that,

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8 UNESCAP Resolution 66/10, Regional call for action to achieve universal access to HIV prevention, treatment, care & support in Asia & Pacific: [http://www.unescap.org/sites/default/files/ESCAP-Resolution-66-10-on-HIV.pdf](http://www.unescap.org/sites/default/files/ESCAP-Resolution-66-10-on-HIV.pdf)
9 See [http://saarc-sec.org/SAARC-Conventions/63/](http://saarc-sec.org/SAARC-Conventions/63/)
10 The demographic and epidemiological information in this contextual portion has been obtained from the Country Progress Report on the HIV Response in Bhutan, 2015, National AIDS Control Programme, Department of Public Health Ministry of Health, submitted to UNAIDS pursuant to the 2011 UN Political Declaration on HIV/AIDS
“The protection of human rights, both of those vulnerable to infection & those already infected, is not only right, but also produces positive public health results against STI and HIV. In particular, it has also become increasingly clear that:

- National and local responses will not work without the full engagement and participation of those affected by HIV, particularly people living with HIV.

- The human rights of at risk and vulnerable populations must also be respected and fulfilled for the response to STI and HIV to be effective.”

The national HIV response is thus embedded within principles of universal access, human rights, and multi-sectoral collaboration to combat HIV. It follows the unique values and strong principles of equality and rights for all human beings, promoted by the Royal Decree, by Bhutan 2020: Vision for Peace, Prosperity and Happiness and by its Five-Year Plans of pursuing GNH as a development philosophy, which contains within it strong principles of equality and rights for all human beings.

The five priority strategies proposed by NSP2 are: (1) STI& HIV Prevention for the general population with particular focus on those most at risk, those people at increased risk including youth, and those at increased vulnerability including elimination of vertical HIV transmission; (2) Treatment and care for people living with/affected by HIV; (3) Institutional strengthening; (4) Strategic information, monitoring and evaluation, research; and (5) Partnerships, coordination and institutional arrangements. The challenges identified by NSP2 in implementing these strategies include social and legal barriers that prevent key populations from accessing HIV and STI prevention and treatment services. These barriers include laws that criminalize these individuals or groups, and social dynamics that create inequality.

Bhutan’s National Health Policy issued in 2012 aims to reduce the prevalence of HIV/AIDS, tuberculosis (TB) and malaria, “at least to a level at which it no longer constitutes a public health problem through multi-sectoral and multi-disciplinary approach.” This approach has characterized Bhutan’s HIV response from the beginning with a multi-sectoral body chaired by the Minister of Health – the National HIV/AIDS Commission (NHAC) in charge of coordinating HIV-related activities. The NHAC is the apex decision-making body for any HIV-related policies and programmes. It is structured on participatory principles and comprises high level representatives from the MOH, line ministries, local government, municipality authorities, faith based organizations, media foundations and the private sector. At the district level HIV prevention programmes are coordinated through Dzongkhag Multi-Sectoral Task Force (MSTF), a concept propounded by Her Majesty the Queen Mother (Gyalyum) Sangay Choden Wangchuk in 2011.

Within the MOH, the National HIV/AIDS &STIs Control Programme (NACP) is tasked with implementing the HIV programme in Bhutan. The NACP prioritizes work for and among those most at risk of STI ad HIV exposure, while continuing to provide prevention education and services to the general population. Apart from the NSP2, the MOH and NACP issue guidelines from time to time relating to the country’s HIV programme, such as the National Guidelines for the Management of HIV/AIDS in 2015. Civil society and non-governmental
organizations are also engaged in implementation of STI and HIV programmes, and are closely linked to the national programme.

1.4 HIV Legal Environment Assessment and Costed Action Plan for the Kingdom of Bhutan

In 2016, the NACP in collaboration with the United Nations Development Programme (UNDP) undertook a Legal Environment Assessment (LEA) for the Kingdom of Bhutan. The purpose of the LEA is to contribute to Bhutan’s aim of reducing vulnerability to HIV among key groups, and facilitating an enabling, non-discriminatory legal and policy environment for people living with and affected by HIV to access appropriate prevention, care, support and treatment services.

The scope of the LEA is to examine relevant laws and policies, and their implementation as they pertain to HIV. The review of laws included the following:

- Constitutional laws that establish fundamental rights and their protection;
- Current legal and policy frameworks as they pertain to HIV informed by historical and cultural perspectives (including extant traditional sources of law);
- General health laws relevant to HIV and related services (including prevention, care, support and treatment) provided through government and non-governmental mechanisms;
- Laws covering and affecting key groups vulnerable to HIV, including people who use drugs, transgender people, men who have sex with men, and sex workers (including criminal and civil laws);
- Laws covering and affecting people living with HIV (including criminal and civil laws);
- Laws related to non-discrimination, informed consent and confidentiality affecting key groups and people living with HIV;
- Laws related to women that affect their vulnerability to HIV, including laws related to inheritance, and violence;
- Laws related to children, and young people that affect their vulnerability to HIV; and
- Laws related to affordable and accessible HIV treatment, including intellectual property laws

The LEA also examined the national legal framework in the context of Bhutan’s obligations under international and regional treaties and commitments, and normative guidance provided by expert multilateral organisations, including UN agencies.

The LEA also reviewed the implementation of laws from the following perspectives:

- The extent to which key affected people are able to access justice and enforce rights;
- The extent to which key affected people know their rights;
- The capacity available through organisations, institutions and service providers for key affected people to avail of legal literacy, legal aid and advise services; and
- The capacity of law enforcement agencies in protecting key affected people, upholding and enforcing the law as it pertains to HIV
Strengths and weaknesses in the current legal and policy environment were assessed based on the framework of the recommendations in “Risks, Rights & Health” the report of the Global Commission on HIV and the Law (www.hivlawcommission.org).

These recommendations were further supported by a Costed Action Plan (CAP) for reform/amendment of laws, policies and implementation aspects of the legal environment. In particular, the CAP includes proposals for dealing with HIV and human rights, including appropriate legislative and institutional approaches. The LEA and the CAP have been developed through consultative processes of robust engagement with key stakeholders as described in the following section.

1.5 Methodology & Modalities

The methodology followed for the assignment was based on UNDP’s Legal Environment Assessment for HIV: An Operational Guide to conducting National Legal, Regulatory and Policy Assessments for HIV (http://hivlawcommission.org/index.php/legal-environment-assessments) with localised modifications as required by time and other constraints. The methodology included the following key elements:

a. Literature review and research on HIV and health epidemiology in Bhutan, and laws, policies and their enforcement vis-à-vis HIV broadly and key populations specifically, to obtain a foundational understanding and overview of the relevant legal and policy environment. Further, research was undertaken on the legal and justice system in Bhutan to understand how it is suited or can be tailored to respond to the legal and rights needs of key populations and HIV contexts. This literature review and research took place throughout the period of the LEA.

b. Interviews with key local experts and stakeholders were undertaken between 24 May and 6 June 2016, to gather information particularly where gaps existed, or if clarifications on data obtained or supplemental information was required from local experts. This was done through individual meetings organised through the lead agencies – UNDP Bhutan and the NACP, Ministry of Health. (Annexure A provides a full list of experts and stakeholders with whom meetings were held).

c. Establishment of the National Task Team and periodic reporting to it: At the commencement of the LEA, a National Task Team (NTT) was convened to provide expert guidance and support to the LEA process. The NTT was constituted and convened by the NACP(See Annexure B for a list of the members of the NTT). The NTT’s tasks included advisory and follow-up responsibilities (after completion of the process). The NTT met on two occasions during the process. The 1st meeting took place at the outset, prior to individual meetings with experts and key stakeholders. The NTT was briefed on the Inception Plan at the first meeting, including clarifying the purpose and scope of the assignment, ways forward in the process, including the various stages envisaged therein, and the expected outcomes. (The agenda for the 1st meeting is provided as Annexure C.) A second meeting of the NTT was convened at midpoint in the process (after analysis of
laws was undertaken and information garnered based on interviews with experts and stakeholders was obtained) to give relevant updates, and present draft findings.

d. An analysis of the laws and policies that pointed to strengths and weaknesses was undertaken using the recommendations of the Global Commission on HIV and the Law, the extant relevant international legal and policy architecture and the analytical framework contained in UNDP’s Legal Environment Assessment for HIV: An Operational Guide to conducting National Legal, Regulatory and Policy Assessments for HIV. This analysis was informed by the literature review and research and the interviews with experts and key stakeholders.

e. A National Stakeholder Consultation on the LEA was held on 9-10 June 2016, where the draft findings and recommendations emerging from the analysis and interviews were presented to participants for their feedback. Stakeholders included representatives of key populations, health system administrators, key justice system actors, key personnel from the law enforcement machinery, UN agencies, human rights lawyers, community leaders, law makers, and key ministries – health, home/interior, justice/law, welfare/social services, women, labour etc. The report of the meeting along with the list of participants is at Annexure D.

f. Consultation on the Costed Action Plan was held on 13-15 June 2016, for drafting a CAP to implement the recommendations of the LEA.

g. Development of Final LEA Report and CAP took place after the national stakeholder consultations. A draft LEA report which included an overview of the extant legal and policy environment related to HIV in Bhutan, the aforementioned analysis of the same, including strengths and weaknesses, key findings and recommendations for reform was submitted to the NTT for their feedback and comments. A final CAP was developed and is appended to this report as Annexure E.
2. PEOPLE LIVING WITH HIV

2.1 Context
Although the first case of a person living with HIV in Bhutan came to light in 1993, it was since 2000 that a gradual increase in the number of people testing HIV-positive was noticed. At present, less than 1000 people are estimated to be living with HIV in Bhutan of whom 30 are children below the age of 15 years. The HIV epidemic in Bhutan is concentrated among young people below 40 and almost 6% are children below the age of five. While the recorded number of incidents of parent-to-child transmission appears to be decreasing with 7 cases recorded between 2012-2014, there is some uncertainty of the precise picture due to the lack of polymerase chain reaction (PCR)-based testing for early infant diagnosis. While people have tested positive for HIV in 18 of Bhutan’s 20 districts, the majority (62%) are located in Thimphu, and in three districts bordering India with frequent movement of populations – Chukkha, Sarpang and Samdrupjongkhar.

It is of note that young women in Bhutan appear to be at greater risk of HIV infection. Below the age of 24, the ratio of male to female people living with HIV is 1:2.4 (29 males, 69 females) indicating an increased level of vulnerability for young women in Bhutan.

The first network of people living with HIV in Bhutan, Lhak-Sam began its work in 2009 and was registered with the Civil Society Organization Authority of Bhutan in November 2010. Lhak-Sam which means “altruism” is also referred to as the Bhutan Network of People living with HIV and AIDS (BNP+) and “aims to be a premier organization in Bhutan committed to providing and promoting leadership, education and capacity building to all PLHIV and their families, empowering them to improve their quality of life, by reducing stigma and discrimination and through access to appropriate prevention, care and support services.” As of 2014, Lhak-Sam had 151 registered HIV-positive members in 17 of the 20 districts of Bhutan; 16 members of Lhak-Sam are children with the youngest being three years old. At the regional level, Lhak-Sam is a member of the Asia Pacific Network of People Living with HIV (APN+).

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14 Ibid.
15 Ibid.
16 Ibid.
18 Ibid.
19 Ibid.
BOX 1: HIV-related legal and ethical debates in Bhutan – A Case Study

Debates around legal and ethical issues relating to HIV in Bhutan have coalesced around a recent, highly complicated case that has played out on social and national media. According to one news report, an association wrote to the “Royal Bhutan Police seeking their intervention in dealing with a beneficiary. The beneficiary, a woman in her late twenties is fighting a losing battle against alcoholism. Worse, she is alleged to be infected with HIV and picked up by men as she roams the streets of Thimphu under the influence of alcohol. The association guesstimates the woman to have slept with at least 50 men as they highlight the risk the woman could pose to the society.”(1) It appears that information about the woman was revealed on social media. Although her name was withheld, it seems that the information revealed was sufficient to identify her. According to another news report, “the news of a HIV positive woman in her late twenties who was alleged to have been picked up by random men went viral, creating panic and fear among the people. The woman, reported to be mentally unsound and alcoholic, is under medical supervision.”(2) These news reports expressed much sympathy and understanding for the person living with HIV and her situation, while also portraying her as a “risk to others.”

There have been three primary responses to this case. The first was a demand for law enforcement action and calls for criminalisation of HIV transmission. Discussions around this response raised several other issues. These included the responsibility of sexual partners to use condoms; the need for better sex education programmes; the issue of consent in sexual relations, if as some information suggested, the woman had informed the men involved of her status; and, specific legal issues around whether this was an appropriate case for police involvement and the evidence required to prosecute such cases, particularly since actual HIV transmission was not reported. The Head of the Women Division, National Commission for Women and Children called for a holistic approach noting that stricter laws may not work without changes in terms of "acceptability and non-discrimination towards people living with HIV." According to the Director General of the Department of Medical Services, "if society looks down and discriminates people suffering from such diseases, they are bound to be frustrated and behave in irrational manner," and "the only way to handle such situation is to treat people with HIV with compassion and empathy."(2)

A second response related to the revelation of the woman’s identity. Accordingly, one report rejected the notion of criminal action but asked if, "perhaps it is time we relook into the issue of confidentiality and transparency as we discuss HIV/AIDS as a health issue," stating that, "maintaining confidentiality has not helped either in our fight against the spread of the disease."(1) Countering this view, UNAIDS highlighted the fact that breaching confidentiality serving as a distraction from approaches that work including the best public health approach of beneficial disclosure of HIV status which "emphasizes that individuals must have control over if, how and when to tell others about their HIV-positive status," public education about protecting oneself from HIV and adoption of privacy and confidentiality laws, "because prejudice and discrimination constitute the greatest barriers to dealing effectively with the HIV epidemic." In terms of protection of the community, the best public health approach "encourages consistent use of condoms; especially in high-risk situations such as ‘picking up strangers in the street’ and ‘being under the influence of alcohol.""(3)

Finally, as noted in commentaries on the news reports, there are concerns that the case actually appeared to be a situation of a woman who was being subjected to sexual violence by multiple men rather than someone who was intentionally spreading HIV. The case, therefore, highlighted need for social protection from government and NGOs agencies and better co-ordination among them to ensure that support was provided to persons living with HIV who were destitute or in difficult circumstances.

Media reports and anecdotal evidence indicate that the definitive facts in this case remain difficult to ascertain, not just in terms of the person living with HIV but also with regard to the actions and responses of various agencies and stakeholders. For the purposes of the LEA, the facts do raise pertinent legal and ethical issues including: (a) In what circumstances can the transmission of HIV be considered criminal? (b) What approach should law enforcement take in cases of alleged intentional transmission of HIV? (c) Is there a duty on service providers, the media and others who may become aware of a person’s HIV status to maintain confidentiality? And (d) what sort of psycho-social and other forms of support are and should be available for people living with HIV in difficult circumstances and how can various stakeholders coordinate their responses to provide such support? Some of these issues are dealt with in the following sections of this report.

2.2 DISCRIMINATION
As has been documented in many parts of the world since the start of the HIV epidemic, those who have it often also suffer from an epidemic of stigma and discrimination due to their HIV-positive status. HIV’s association with sex and sexuality has caused this environment of prejudice. In terms of law, discrimination is one of the key legal issues that people living with HIV encounter in their life, including within educational settings, in employment, and in healthcare institutions. Legal frameworks address discrimination by guaranteeing equality, often as a fundamental right within constitutions. The right to equality protects individuals from discriminatory treatment if such treatment occurs due to various reasons, including their sex, class, religion, race, etc.

In practice, although there appears to be little or no experience of explicit discrimination against people living with HIV in Bhutan, people living with HIV have shared occasional experiences of subtler forms of discrimination in the workplace. And, in a few instances children who are HIV-positive or have parents who are known to be HIV-positive have faced stigma and discrimination in schools. In the latter situations Lhak-Sam has entered into discussions with school administrators to undertake sensitization with teachers and the student body. The situation for people living with HIV in a report of Lhak-Sam published in 2011 showed that 20% of people living with HIV had experienced some form of stigma and discrimination due to their status. In that report discrimination manifest itself in different forms – difference in treatment from healthcare workers on becoming aware of the patient’s HIV-positive status, required resignation from the armed forces or restrictions from entry into the kitchen, deregistration from the central monastic body, banishment from the village, and denial of property rights and use of common toilet within the home.20

2.2.1 Laws and Policies
Bhutan’s HIV response is rooted in the values enshrined in the Fourth Kings’ Royal Decree, which explicitly calls for non-discrimination of people living with HIV/AIDS.

Moreover, Bhutan’s Constitution spells out equality in Article 7(15): “All persons are equal before the law and are entitled to equal and effective protection of the law and shall not be discriminated against on the grounds of race, sex, language, religion, politics or other status”. The phrase “other status” is intended to provide space for interpretation in cases where unanticipated grounds need to be covered. HIV status (and sexual orientation and gender identity as discussed later) can be covered as basis for non-discrimination in the event of such cases being brought before the courts. Unlike some constitutions, wherein fundamental rights curb the actions of ‘the State’, Bhutan’s right to equality protects the individual against violations by the State and the private sector. Further, the guarantee of equality includes protection from all forms of discrimination – explicit (for instance, outright denial of promotion in employment due to HIV status) or ambiguous (for instance, subtle ways of differential treatment like prejudicial comments or behaviour).21

20 Needs Assessment Report: Baseline Survey and Need Assessment to understand the circumstances and growing needs of Bhutanese living with HIV/AIDS, Lhak-Sam, 2011
21 Article 7(15), Constitution of the Kingdom of Bhutan, 2008
The Labour & Employment Act, 2007 also stipulates provisions to prevent discrimination in the workplace, which can be read favourably to support otherwise qualified and able people living with HIV from discriminatory practices. (A similar interpretation can be given to these clauses in relation to non-discrimination of transgender people and men who have sex with men, on the grounds of gender identity and sexual orientation respectively, as discussed later.)

In order to prevent discrimination in the health sector, the Labour & Employment Act also provides for occupational health and safety, foisting a duty on the employer to provide necessary precautions and safety to workers. This includes the health sector. Such an obligation, when met, ensures that health workers are fully protected from infection in the course of their work, through provision of universal precautions, and post-exposure prophylaxis, thereby having no reason to refuse to treat people living with HIV or those suspected to have HIV, since their occupational health and safety concerns are catered to.

Non-discrimination principles are echoed in much of Bhutan's legal framework, including the Civil Service Rules & Regulations, wherein recruitment, selection and appointment to the regular civil service requires provision of equal opportunity to all eligible citizens “without discrimination on the grounds of race, sex, language, religion, and other status.”

2.2.2 Recommendations

a. Although law reform is not required in relation to non-discrimination, clear-cut policy directive can provide interpretative guidance and clarity in the law by explaining that “other status” in Article 7(15) of the Constitution includes HIV status.

b. Alternatively, anti-discrimination law that explicitly prohibits discrimination due to various grounds, including health (HIV) status can be introduced.

c. Similar policy articulation clarifying that Article 7(15) covers overt and subtle discrimination would also provide required clarity.

d. The International Labour Organisation has provided guidance for a workplace policy on HIV/AIDS, which is a basis for putting in place a comprehensive workplace programme that combines prevention, care and the protection of rights, including non-discrimination. This approach can further strengthen efforts to prevent and address discrimination in the workplace.

e. Regular reviews should be undertaken to ensure that occupational health and safety of health workers is addressed, including unfettered access to universal precautions, and post-exposure prophylaxis.

22 Sections 11 to 15, Labour & Employment Act, 2007
2.3 INFORMED CONSENT

“Informed consent is not mere acceptance of a medical intervention, but a voluntary and sufficiently informed decision, protecting the right of the patient to be involved in medical decision-making, and assigning associated duties and obligations to healthcare providers. Its ethical and legal normative justifications stem from its promotion of patient autonomy, self-determination, bodily integrity and well-being.”

- UN Special Rapporteur on the Right to Health, 2009

From a legal and human rights perspective, informed consent for a medical procedure is based on the principle of autonomy and bodily integrity and flows from human rights guarantees of life and personal liberty. Informed consent is required before any medical procedure including testing and treatment with an explanation of risks, benefits and alternatives. In relationships between healthcare providers and patients, the principle of consent is identified as a key factor contributing to balancing the relationship between the two parties. The healthcare provider is armed with knowledge and training, and is reposed with the trust of the patient. Informed consent about a test or treatment provides patients with sufficient knowledge to make an autonomous decision of whether to undergo a test, treatment or medical procedure or, crucially, whether to refuse it. Ensuring that consent is informed is the duty of the healthcare provider. Consent must be given voluntarily i.e. without coercion, undue influence or misrepresentation. A person’s ability to consent to a medical procedure is dependent on their legal capacity. For adults of sound mind, legal capacity is presumed while proxy consent from a guardian or next friend or a healthcare provider is required for persons living with mental illness or in cases of emergency. Proxy consent from a guardian is also required in most countries in the case of children and young persons, though some jurisdictions also allow children and young persons to consent where they are sufficiently mature to make such a decision. The paramount consideration is the welfare of the child and the child’s best interest. Medical procedures without the consent of a person can only be allowed if permitted by a court order and not through policy. Even in such exceptional cases mandatory testing is permitted under special circumstances and not as a rule.

Since the development of the first test for HIV, human rights concerns have been central to approaches to HIV testing and counseling. While mandatory HIV testing featured prominently in early responses to the epidemic, it has been rejected both as violative of human rights and as detrimental to public health; the importance of voluntary and confidential testing was thus highlighted in the UN Declaration of Commitment on HIV/AIDS,

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26 For instance courts have held that even persons who may not have “legal capacity” but are able to understand the nature of a proposed treatment and the consequences of their decision, cannot be subjected to treatment without their consent. Re C (adult: refusal of medical treatment), [1994] 1 All ER 819; and E (Mrs.) v Eve, (1986) 2SCR 388 (Canadian Supreme Court)

According to the World Health Organisation (WHO), the only form of mandatory testing it supports today is in relation to screening in the case of blood transfusion, manufacture of whole blood products and of donors for transfer of bodily fluids and body parts.\(^{29}\) Still mandatory HIV testing continues to be imposed in some countries for pregnant women, for prisoners and detainees, for foreign workers before work permits are issued and renewed and in the case of pre-marital mandatory HIV testing. Where mandatory HIV testing has been imposed it has resulted in an increase in stigma and discrimination while pushing people away from healthcare settings. According to UNAIDS and WHO, “people being tested for HIV must give informed consent to be tested. They must be informed of the process for HTC, the services that will be available depending on the results, and their right to refuse testing. Mandatory or compulsory (coerced) testing is never appropriate, regardless of where that coercion comes from: health-care providers, partners, family members, employers, or others.”\(^{30}\)

Approaches to HIV testing have evolved considerably in the past two decades and continue to do so. Initially voluntary counseling and testing (VCT) was recommended on an “opt-in” basis i.e. where a person seeks HIV testing to determine their status. Informed consent for HIV testing was predicated on detailed pre and post-test counseling. Given the devastating impact that an HIV-positive test result could have on an individual, this approach was favoured for many years. In 2007, WHO and UNAIDS recommended that countries introduce Provider Initiated Testing and Counselling (PITC) and “opt-out” approaches to HIV testing i.e. healthcare workers should routinely offer HIV testing while maintaining a right of refusal for patients would did not want an HIV test.\(^{31}\) According to the WHO, in high prevalence settings, PITC should be offered to all persons receiving medical care while in other epidemic settings it should be offered at clinical sites.\(^{32}\) The guidance on PITC also recommended the pre-test process could take the form of individual or group sessions to provide information. These recommendations were not without controversy and led to considerable debate among human rights experts who highlighted concerns that the routine offer of such tests could legitimate human rights violations associated with HIV testing.\(^{33}\) The UNAIDS Reference Group on HIV and human rights recommended that PITC be implemented as an opt-in model rather than an opt-out model.\(^{34}\) The UN Special Rapporteur on the Right to Health noted that the PITC guidelines which did not make testing conditional on the availability of treatment, “undermine the testing-treatment continuum and long-term prevention,” highlighted the concern that those tested through PITC, particularly from vulnerable groups often felt compelled to accept the test and was particularly critical of the “simplified pre-test information” which revoked “one of the most important HIV/AIDS-related interventions — comprehensive, individualized pre-test counselling and information — thereby forgoing an important opportunity for prevention information and services for those

29 WHO & UNAIDS, Statement on HIV testing and counseling: WHO, UNAIDS re-affirm opposition to mandatory HIV testing, 28 November 2012: [http://www.who.int/hiv/events/2012/world_aids_day/hiv_testing_counselling/en/](http://www.who.int/hiv/events/2012/world_aids_day/hiv_testing_counselling/en/)
30 Ibid.
32 Clinical sites include sexual health and tuberculosis (TB) and drug treatment clinics, antenatal, childbirth, postpartum services and sites offering services to key at risk and vulnerable populations. Ibid.
34 Ibid.
who test negative.” 35 Despite clear recommendations from WHO that human rights protections are central to the implementation of PITC, reviews of its rollout have highlighted concerns around testing of pregnant women, of vulnerable populations, the vagueness of PITC policies and the lack of explicit human rights focus and the lack of infrastructure and linkage to treatment and other services.36

HIV testing has always been considered the gateway to treatment, care and support. With the advent and scale up of effective HIV treatment and findings of its effectiveness in prevention as well, it is now considered particularly urgent for more people to be tested for HIV and to know their status. Newer approaches to testing including community based testing, couples testing and testing offered by non-medical professionals are now being considered or implemented while the availability of rapid HIV tests and more recently of home testing kits have made HIV testing easier and faster. But for many, the HIV test and a positive result is also the gateway to discrimination, stigma and criminalization. Accordingly, amidst calls for the rapid scale up of HIV testing, the UNAIDS Reference Group on HIV and Human Rights has noted that public health and human rights approaches are not mutually exclusive and recommends that the successful scale up of HIV testing requires, among other things, the creation of an enabling non-discriminatory environment, the removal of laws that criminalise key populations and access to justice.37 The WHO has also reiterated that whatever form HIV testing and counseling may take, it must comply with the 5 “Cs” (see Box 2) while the UN Special Rapporteur on Health has highlighted the importance of community involvement in testing and counseling and for special attention to the rights of women, sex workers, people who use drugs, vulnerable groups, persons deprived of liberty, ethnic minorities including refugees and migrants, indigenous populations and children in implementing HIV testing and counseling programmes.38

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Box 2: The “5 Cs”

“WHO has defined five key components—the “5 Cs”—that must be respected and adhered to by all HTC services. These components are:

1. Consent
2. Confidentiality
3. Counselling
4. Correct test results

The five Cs, and the key principles they entail, apply to all models of HTC services:

1. People being tested for HIV must give informed consent to be tested. They must be informed of the process for HTC, the services that will be available depending on the results, and their right to refuse testing. Mandatory or compulsory (coerced) testing is never appropriate, regardless of where that coercion comes from: health-care providers, partners, family members, employers, or others.
2. Testing services must be confidential, meaning that the content of discussions between the person tested and the health-care worker, testing provider, or counsellor, as well as the test results, will not be disclosed to anyone else without the consent of the person tested.
3. Testing services must be accompanied by appropriate and high-quality pre-test information or pre-test counselling, and post-test counselling.
4. Provision of correct test results. Testing must be performed and quality assurance measures followed according to internationally-recognized testing strategies, norms, and standards based on the type of epidemic. Results must be communicated to the person tested unless that person refuses the results.
5. Connections to HIV prevention, treatment and care and support services should be supported through concrete and well-resourced patient referral, support, and/or tracking systems.

The UNAIDS World AIDS Day Report 2012 provides evidence that adhering to these principles and practices for HTC and linking those tested to HIV prevention, treatment, care, and support can enable countries to reduce the incidence of new HIV infections and reduce HIV-related morbidity and mortality. These gains are further enhanced when countries take steps to increase access to: voluntary HTC, including for key at-risk and vulnerable populations; prevention of mother-to-child transmission of HIV (PMTCT); and ARV treatment to all those who need it.”

- WHO and UNAIDS, Statement on HIV testing and counselling: WHO, UNAIDS re-affirm opposition to mandatory HIV testing, 28 November 2012

While debates surrounding informed consent in the HIV context have focused primarily on testing, informed consent is also required for HIV treatment and research. HIV treatment has changed HIV to a chronic condition with dramatic, positive effects on the lives and health of patients. It is also life-long, may have toxicity and side effects and patients may need to switch treatments particularly if resistance develops and people living with HIV and consent for commencing HIV treatment requires that patients are well informed of these benefits and risks and the “appropriate provision of information in obtaining consent for voluntary HIV/AIDS treatment extends to supportive counselling to facilitate understanding the importance of adherence to long-term treatment.”

Informed consent is also mandated for HIV-related research, whether biomedical or social science related (particularly in the case of surveillance or behavioural research). In the case of research, clinical trial subjects or

research participants must be “adequately informed of the aims, methods, anticipated benefits and potential risks of the research. Consent may be withdrawn at any time, so the informed consent process must be continuous, inclusive of new adverse developments.”

Informed consent is required for HIV testing in Bhutan and testing is characterized as voluntary and confidential. It is encouraging that even HIV testing campaigns in the police and the armed forces are also based on VCT; thus while the Royal Bhutan Police (RBP) is undertaking a survey and has a quota specified to get a certain number of staff tested for HIV, this will reportedly be only on the basis of voluntary and confidential testing. VCT services are not formally linked to Lhak-Sam though in some situations informal links exist. Any person testing HIV-positive is given information about Lhak-Sam in case of any support they may require. Peer counseling (i.e. people living with HIV who act as counsellors for those testing HIV-positive) is currently being provided by Lhak-Sam regional coordinators.

It may be noted that the Bhutan Country Progress Report for 2015 records that voluntary and confidential testing accounts for only 18% of those testing positive and the majority of cases come through medical screening, construction site screening and contact tracing. It remains unclear what protocols are followed in such screening processes and the extent to which testing is voluntary and confidential. It is of note that in Lhak-Sam’s 2011 Needs Assessment Review, of the 74 PLHIV interviewed from 12 districts in Bhutan, only 53.4% reported receiving pre-test counselling while 95% reported receiving post-test counselling after testing positive. In addition, recently there have been some calls for the introduction of routine HIV testing for all persons coming in contact with the health system, including discussions in this regard at the NHAC.

An issue of importance in this context relates to consent for testing for people below the age of 18. This is particularly so, given that young people in Bhutan appear to be sexually active from an early age. Young people coming forward for an HIV test are unlikely to inform their parents or return for testing if the programme requires the consent of their parents for the test. With the majority of people testing HIV-positive in Bhutan being in the age range of 18-24, the likelihood of those below this age range being vulnerable to exposure and needing HIV testing, treatment and other services is high. As noted above, some countries allow children and young persons below a certain age or based on their level of understanding or maturity to consent for HIV testing (see Box 3).

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40 Ibid.
41 Country Progress Report on the HIV Response in Bhutan, 2015, National AIDS Control Programme, Department of Public Health Ministry of Health
42 Needs Assessment Report: Baseline Survey and Need Assessment to understand the circumstances and growing needs of Bhutanese living with HIV/AIDS, Lhak-Sam, 2011
Box 3: Good Practice: Kenya HIV and AIDS Prevention and Control Act 14 of 2006

"Section 14. Consent to HIV testing (1) Subject to subsection 2, no person shall undertake an HIV test in respect of another person except-(a) with the informed consent of that other person; (b) if that person is a child, with the written consent of a parent or legal guardian of the child Provided that any child who is pregnant, married, a parent or is engaged in behaviour which puts him or her at risk of contracting HIV may, in writing, directly consent to an HIV test;"

2.3.1 Laws and Policies
The Right to life and liberty is enshrined in the Constitution of Bhutan, which states that, "All persons shall have the right to life, liberty and security of person and shall not be deprived of such rights except in accordance with the due process of law." As noted above, this right forms the basis of the fundamental principles of autonomy and bodily integrity from which the requirement of informed consent flows.

Informed consent in medical settings is governed by the Medical and Health Council Regulations 2005 issued by the Medical and Health Council Secretariat of Bhutan under the Medical Council Act 2002. The Regulations have the force of law. Under the Regulations, “consent” is defined as means voluntary agreement, compliance or permission for examination, investigation and treatment of a patient in medical and health practices. Under the “Duties to patients” specified in the Regulations as part of the “Code of Ethics,” every medical or health professional is required to, “obtain from patient the consent for examination and treatment,” to “exercise due sensitivity and subtleness while disclosing critical or grave condition or death of the patient to the patient or the relatives as the case may be,” to “explain the side effects and risks of potential hazardous drugs when it is being used,” and to “explain to the patient regarding the techniques used, pathological investigations required and also document the same clearly, precisely and accurately.”

Although the Regulations make some reference to paediatrics and conditions affecting children, in terms of the Code of Ethics, the Regulations only require the healthcare provider to, “show due respects and recognize the rights of the child as enshrined in the rights of the child charter.” However, the “Supplementaries” to the Regulations provide that “in cases of minor consent should obtained from parents or guardian.”

The “Supplementaries” further detail the nature of consent including its validity only if “freely given, without any compulsion, and where necessary in writing” and that the patient decides whether or not to accept the advice of the practitioner. Consent may be implied (when a patient enters hospital out-patient department seeking treatment) or express (given in gesture, verbally or in writing.) Consent should be informed i.e. “wherein the patient is explained with reasonable thoroughness about his medical problem, procedures to undergo, advantages and disadvantages and alternatives.”

44Article 7(1), Constitution of the Kingdom of Bhutan
45Regulations, Medical and Health Council, Royal Government of Bhutan
46Supplementaries (Annexures), Regulations, Medical and Health Council, Royal Government of Bhutan
47Ibid.
48Ibid.
Exceptions to consent are specified in emergencies to save life, where patient or guardian refuses treatment when it is essential to save life. In such cases, an appropriate record should be made, and if possible attested by the guardian or parents. Consent is not required where there is a court order, quarantine or for mandatory mass vaccination.  

Under NSP2, VCT appears to be the primary government approach to HIV testing. This is further reflected in the National Guidelines for Voluntary Counselling and Testing, 2008, which states, "VCT provides a safe environment and easy access to right information so that people can discuss and develop specific behaviour change strategies that reduce the risk of HIV transmission. The counsellor plays key role of helping individuals make difficult decisions on behaviour specifically sexual behaviour and prepare individuals who test positive cope with the problem. Apart from clearing myths and misconceptions about HIV, VCT services will help to mitigate HIV related stigma and discrimination and normalise HIV/AIDS like any other infections diseases." An Executive Order dated 2 January 2016 from the Ministry of Health further instructs all medical and health professionals in Bhutan that, "pre-test and post-test counseling should be mandatory for all those who undergo HIV test."  

According to the anti-retroviral therapy (ART) guidelines, the 5Cs prescribed by the WHO are followed in HIV testing offered in Bhutan and PITC has been adopted at certain clinical sites such as ante-natal clinics (ANCs) for pregnant women and for those who have TB or STIs. However, an Executive Order dated 18 May 2016 appears to extend PITC to all patients visiting health centres. According to this Executive Order, all health centres in the country are required to provide HIV, STI and hepatitis screening as part of routine medical screening with an opt-out model. As noted above, the WHO recommends such a method only for high prevalence settings. Moreover, it is unclear how principles of informed consent will be adhered to in the implementation of this order. The expansion of routine testing may adversely impact health-seeking decisions, particularly of key populations who are criminalized in Bhutan.

The issue of access to health services including HIV tests for young persons is addressed in the 2009 National Standards and Implementation Guide for Youth Friendly Health Services. This guide recognizes that adolescents may be vulnerable to HIV and require access to testing and treatment services and provides for HIV related referrals as part of the package of services that health facilities should provide for adolescents and young people. Thus, "adolescents who are sexually active are to be imparted pre-test counselling for getting a voluntary test. A VCTC site is to facilitate access to ART if required." However, it appears that in practice such referrals are not taking place and healthcare workers are unclear on their obligations to provide HIV-related services to young people. In addition, while the ART guidelines provide a detailed process for disclosure to a child of their HIV-positive status, informed consent either for testing or treatment from a person below the age of 18 years is not provided for.

49 S. 41, Regulations, Medical and Health Council, Royal Government of Bhutan  
In terms of HIV treatment, the ART guidelines are silent on the process and requirement of informed consent from people living with HIV before they initiate treatment.

2.3.2 Recommendations

a. Informed consent with pre- and post-test counseling should continue to form the backbone of the HIV programme. Informed consent for testing is based not only on human rights principles but also on public health beneficence. The expansion of PITC to all health centres in Bhutan should be reconsidered as it is contrary to international guidance and particularly given the criminalized status of key populations in Bhutan, runs the risk of alienating people from the healthcare system. Informed consent for HIV related treatment and research should also be included in the relevant policies and guidelines.

b. Law reform to facilitate the ability of those below the age of 18 to access HIV testing, treatment and other health services based on a mature minor assessment should be considered.

c. Laws protecting healthcare providers from legal or disciplinary actions who act in good faith to provide healthcare services to minors should be considered.
2.4 CONFIDENTIALITY & DISCLOSURE OF INFORMATION

A key human rights issue related to an effective HIV response is that of confidentiality of HIV status of those who have been tested, including those who may have tested sero-positive. Why is such a right important? What purpose does it serve? Does it have limitations? Confidentiality of information arises in fiduciary relationships i.e. relationships of trust, which are inherently unequal and imbalanced, where one person is privy to information that s/he would not know of but for the particular skill that s/he has, for example doctors in relation to patients, or lawyers in relation to clients.

In the HIV context confidentiality has been understood to serve not just the individual interest of the HIV-positive person, but also the public interest of ensuring that society at large maintains its belief in the health system, and therefore is encouraged to access health seeking information and services, instead of shying away from them. The public interest is not served if a person knows that his/ her HIV-positive status will be revealed if s/he accesses the health system. Such a system will scare people away from it, and fuel the disappearance of HIV ‘underground’, where effective interventions to control it become even more challenging. The issue of confidentiality of HIV status is closely linked to the issue of partner notification – what are the circumstances in which a needle-sharing or sexual partner can be notified of a patient’s HIV status?

Confidentiality is a concern in the context of people living with HIV accessing healthcare services in Bhutan largely because there is lack of clarity of the manner and circumstances in which the treating health worker or physician is duty bound to maintain it, and the exceptional cases in which the HIV-positive status of a person can be revealed or shared. Unclear guidelines also lead to careless practice, where HIV status of a patient is sometimes indiscreetly discussed in healthcare settings. Sometimes confusion arises for health workers who discover that patients may be in conflict with the law for being involved in illegal activities such as sex work or anal sex. In such situations, questions of the duty to inform the police arise as against the confidentiality of the patient. On the other hand some counselors are well trained in their ethical duties to maintain confidentiality of people who use drugs accessing their services. Health Information Service Centres (HISC) in Bhutan follow partner notifications protocols after gaining the trust of the HIV-positive person, including encouraging them to bring long-term sexual partners in for testing in a 2-week timeframe. In the vast majority of cases clients do share their status with the long-term sexual partners, and in a few cases the HISC has revealed their status to the partner leading to mutually agreed separation in some instances but no documentation of violence.

Confidentiality and privacy also become concerns for people living with HIV in the workplace or when they interact with non-governmental organisations (NGOs), and when their status is known to the employer or shared with an NGO worker. Further, there is an onus on the media in all its forms to protect the privacy of people. In a recently discussed and widely reported case a woman who was living with HIV was publicly revealed as such by many who encountered or covered her situation, including allegedly NGOs who knew of her, and the media which reported on her. (See Box 1)Such reportage has the potential to stir up unnecessary and misinformed panic in society at large, and set back efforts to destigmatize HIV and encourage people to come forward to test themselves.
2.4.1 Laws and Policies

“In the long run, preservation of confidentiality is the only way of securing public health; otherwise doctors will be discredited as a source of education, for future individual patients ‘will not come forward if doctors are going to squeal on them’.”

Confidentiality emanates from the fundamental right to privacy, and finds strong recognition in Bhutan’s Constitution, which states that “A person shall not be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence nor to unlawful attacks on the person’s honour and reputation.”

Legal frameworks generally recognize that there are exceptions to the protection of confidential information, and these include allowing shared confidentiality between caregivers, in the best interests of the patient; if disclosure is required by order of a court to decide issues before it; and if disclosure is required to protect another person. Laws usually stipulate a strict protocol in cases of the latter reason for disclosure, and it is these protocols that are to be followed in cases of partner notification of HIV-positive status. Such protocols are to be used only in circumstances where an identifiable third party is at imminent risk.

Although Bhutanese law does not stipulate partner notification protocols, the following steps should be undertaken as per suggested precedent: a healthcare provider may disclose HIV-positive status of the patient if s/he -

a. Reasonably believes that the partner is at the significant risk of transmission of HIV from such person;

b. The HIV-positive person has been counseled to inform the partner;

c. The HIV-positive person is unwilling to inform the partner; and

d. The healthcare provider has informed the HIV-positive person of the intention to disclose their HIV status to the partner.

53 X v Y [1988] 2 All ER 648
54 Article 7(19), Constitution of the Kingdom of Bhutan
56 Public Health Act, 1991 (New South Wales, Australia)
57 Illinois AIDS Confidentiality Act, 1996 (USA), Singapore Infectious Disease Act, 1976
58 Tarasoff v Regents of the University of California 17 Cal 3d 358
59 Illinois AIDS Confidentiality Act, 1996 (USA), Singapore Infectious Disease Act, 1976
The one legal requirement related to confidentiality in Bhutan’s laws is a provision pertaining to “Duties to Society” of the Medical and Health Council Regulations. It is an overly broad and vague clause that stipulates: “All medical and health professionals shall disclose information even if it is obtained in confidence from patient when it is necessary to do so in the interest of the security of the state, the maintenance of law and order, in the court of law and infectious diseases of public health importance or communicable diseases. It is obligatory to inform police on crimes.”

The vagueness of this clause is of concern as it provides very broad circumstances in which patient confidentiality can be breached, without providing specific exceptional circumstances and protocols for disclosure. Such a requirement can act in turning people away from a health system that could be perceived as untrustworthy. For individuals whose

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60 Regulation 4.4, Medical & Health Council Regulations
conduct is criminalized under law – sodomy (Section 213 of the Penal Code) or sex work (under Section 373 of the Penal Code) – this would be a great disincentive to access health services. The confusion around the precise legal duty of confidentiality is furthered through the National Guidelines for the Management of HIV/AIDS, which require “HIV counseling and testing services are kept confidential” one the one hand, while prescribing “partner notification if positive” for post-test counseling, on the other.\textsuperscript{61}

In January 2016, the MOH issued an Executive Order that required strict compliance with maintenance of confidentiality of HIV status.\textsuperscript{62} Yet, more recently it issued another Executive Order, which contains language that has the potential to bring lack of clarity in the context of confidentiality of persons living with HIV.\textsuperscript{63}Although unclear in its intent, the order acknowledges that breach of confidentiality concerns are growing and that this is denuding the faith of the people in seeking health services. Yet, it expresses concern not because this is a potential violation of the rights of the patient, but because these breaches prevent effective contact tracing from taking place. It further foists legal liability on the health worker to ensure contact tracing takes place (and not maintenance of confidentiality), in order to avoid charges of professional negligence. It is unclear how contact tracing in Bhutan takes place while also maintaining the confidentiality of the index patient, and ensuring the informed consent of the contact is taken before testing. A coercive policy that imposes legal liability on a health worker in the manner of this order has the potential to push the health worker to compromise standards of confidentiality while zealously undertaking contact tracing.

Another concern related to confidentiality of HIV status is an unprecedented recommendation made by the NHAC in its 16\textsuperscript{th} meeting in March 2016, for “the use of Citizenship Identity Card (CID#) as part of patient/client information during the routine Voluntary Counseling and Testing (VCT). This is aimed at strengthening the patient tracking systems and aid contact tracing methods.” The NHAC also recommends, “maintaining strict confidentiality and observing compliance with the Bhutan Medical and Health Council Act” and “instructed the secretariat to liaise with BHMC to sensitize the health workers on provisions of the Act.” Yet, the Act’s main directive on confidentiality is only the aforementioned vague and problematic Regulation 4.4 under its regulations. These recommendations could well be read to allow for breaches of confidentiality without any safeguards if linked to citizenship identity information. The potential implication of this on breaches of confidentiality and data protection measures are significant – who will be privy to HIV status information, if this is linked to a government department that provides citizenship identity? What data protection measures are to be put in place to ensure that HIV status is not revealed to anyone outside the patient-health worker relationship? Given the unclear legal framework that governs confidentiality in Bhutan, these regulations, recommendations and orders create enough leeway for breaches to take place that can have gravely deleterious human rights and public health consequences.

\textsuperscript{61} National Guidelines for the Management of HIV/AIDS, 2015, Chapter 1
\textsuperscript{62} Royal Government of Bhutan, Ministry of Health, Executive Order, MoH/Sec/33/2014-15, Dated: 2 January 2016
\textsuperscript{63} Royal Government of Bhutan, Ministry of Health, Executive Order, MoH/Sec/33/2014-15, Dated: 18 May 2016
In relation to disclosure of information/privacy, Bhutan’s media is governed by the Code of Ethics for Journalists issued under the Bhutan Information, Communications and Media Act, 2006 (BICM Act). Clause 6.7 of the code on “Respect for Privacy and Human Dignity” provides that a journalist shall “not invade the privacy of any person without his consent and shall respect his private and family life, home, health and correspondence, except in circumstances where it can clearly and objectively be demonstrated that there was an overriding public interest in the invasion of his privacy. The onus of demonstrating the overriding public interest shall be on the journalist.” Therefore, unless there is a foreseeable and imminent risk of danger to the public, the media’s violation of a person’s privacy by revelation of their HIV status is prohibited by the law.

Another area of concern in the context of HIV is the confidentiality for minors who access HIV services, which is discussed later. Some questions it throws up are: What is the obligation of the healthcare provider to inform a parent or guardian? Will such an obligation turn sexually active young people away from health services? And if so, should not the law recognize the legal category of “mature minors” in order to allow such young people to access crucial health information and services?

2.4.2 Recommendations
a. Law reform is required to amend regulation 4.4 (“Duties to Society”) of the Medical and Health Council Regulations to specify circumstances when and how confidentiality may be breached – as per globally accepted standards of shared confidentiality, under orders of a court, or in cases of partner notification after following strict protocols, as summarized above.

b. Policy should be articulated on maintenance of privacy and confidentiality by persons in context other than healthcare who come across information relating to a person’s HIV status, including the media, NGOs, and employers.

c. Rigorous legal provisions should be formulated that prescribe data protection measures while keeping HIV, medical and other information records. This includes robust guidance on contact tracing that is designed to empower and encourage individuals to undertake HIV testing, with full guarantee of confidentiality, and removing liabilities on healthcare workers who are unable to trace contacts. In this context the suggestion of the NHAC to link HIV status to citizenship identity cards should be reconsidered given the dangers such linking could pose to revelation of private information, including HIV status.

d. Suppression of identity orders recommended later should be issued by courts in the context of HIV and related cases, including in prosecutions related to HIV transmission.

2.5 CRIMINALIZATION OF HIV TRANSMISSION

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Debates surrounding the criminalisation of transmission of HIV emerged soon after its discovery and continue to take place in many countries. While the last decade in particular has seen a spurt in countries introducing HIV-specific criminal laws, there has also been increasing consensus among legal, human rights and public health experts that not only does such legislation fail to serve its purposes, it is counter-productive to efforts at expanding the reach of HIV prevention and treatment services and decreasing stigma and discrimination associated with HIV. Moreover, the transmission of HIV, particularly between sexual partners throws up complex issues that criminal law is often ill-equipped to handle: (a) Is there a duty on both partners (given HIV awareness) to protect themselves from HIV and to use condoms; (b) What is the role of risk of violence or abandonment in decisions to inform partners of HIV status; (c) How does the law account for persons on sustained treatment who will have very low viral load and where studies in sero-discordant couples show negligible risk of HIV transmission.

There are two key reasons put forward for criminalizing HIV transmission:67

- to punish harmful conduct by imposing criminal penalties, and
- to prevent HIV transmission by deterring or changing risk behaviours.

A global study by UNAIDS in 2012 to map the laws criminalising HIV transmission examined these aspects in greater detail. It notes that the deterrence argument is not backed by evidence from countries that criminalised HIV transmission. The reasons for this included, "...that few people with HIV are actually aware of their duties under the law, and most of those who are aware already disclose and/or practice safer sex...The studies also found that sexual behaviour is difficult to change through fear of punishment or opprobrium. Despite the concern of some people with HIV in these studies that they could face criminal liability for their actions, they described the difficulty of sustaining HIV disclosure and/or practising safer sex in all sexual settings."68 In relation to the objective of punishment, the study notes that criminal

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66 Presentation of Report from Special Select Committee on the Criminal responsibility of Persons living with HIV, Dr. Leslie Ramsammy Minister of Health September 8, 2011: http://criminalisation.gnpplus.net/sites/default/files/Guyana_Minister_of_Health_Ramsammy_%20Speech%20to%20Parliament_NO_CRIMINALISATION_DECISION%2008Sep2011.pdf
67 UNAIDS and UNDP, Criminalisation of HIV Transmission, Policy Brief, 2008, p. 2
68 Criminalisation of HIV Non-Disclosure, Exposure and Transmission: Background and Current Landscape, Background Paper, UNAIDS, February 2012, Revised Version:
Prosecution requires evidence of intent to harm and an act that causes or could cause harm: "Retribution against those who had no intent to do harm and did not engage in an act that caused harm is arguably unjust." 

<table>
<thead>
<tr>
<th>Box 5: Adverse Impact of Criminalisation on HIV Transmission</th>
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<tbody>
<tr>
<td>&quot;There are no data demonstrating that the threat of criminal sanctions significantly changes or deters the complex sexual and drug-using behaviours which may result in HIV transmission. Available data show no difference in behaviour between places where laws criminalizing HIV transmission exist and where they do not. Furthermore, using criminal law beyond cases of intentional:</td>
</tr>
<tr>
<td>• It could discourage HIV testing, since ignorance of one’s status might be perceived as the best defence in a criminal law suit. This would obstruct efforts to increase the number of people accessing testing and being referred to HIV treatment, care and support. HIV testing and treatment are vital for HIV prevention because people who receive a positive diagnosis usually change their behaviour to avoid transmitting HIV and because taking antiretroviral therapy reduces infectiousness and the likelihood of onward HIV transmission.</td>
</tr>
<tr>
<td>• It places legal responsibility for HIV prevention exclusively on those already living with HIV and dilutes the public health message of shared responsibility for sexual health between sexual partners. People may (wrongly) assume their partners are HIV negative because they have not disclosed, and thus not use protective measures.</td>
</tr>
<tr>
<td>• It could create distrust in relationships with health- service professionals and researchers and impede the provision of quality care and research, as people may fear information regarding their HIV status will be used against them in a criminal case.&quot;</td>
</tr>
</tbody>
</table>

- UNAIDS and UNDP, Criminalisation of HIV Transmission, Policy Brief, 2008

While evidence of the intended consequences of criminalising HIV transmission is scarce, its unintended consequences are well documented. The Global Commission on HIV and the Law found that, "the criminal justice system fights the health care system," as fear of prosecution keeps people living with HIV away from health services, discourages testing and treatment as well as disclosure to partners. Criminalisation is also likely to discourage people living with HIV from contacting or alerting partners to take post-exposure prophylaxis (PEP) in cases where there may have been exposure to HIV. The commission also highlights the often prejudiced or selective application of the criminal law to certain persons. It notes, for instance, that "in Denmark, Estonia, Finland, Sweden and the United Kingdom, migrants and asylum seekers have been disproportionately represented among those prosecuted for HIV transmission and exposure," and that "anti-transmission and exposure laws are often arbitrarily and disproportionately applied to those who are already considered inherently criminal." Similarly, UNAIDS and UNDP note that sex workers, men who have sex with men and people who use drugs are disproportionately prosecuted as they are "blamed" for


70 Global Commission on HIV and the Law, HIV and the Law: Risks, Rights and Health, UNDP 2012, p. 20


"transmitting HIV, despite insufficient access to HIV prevention information, services or commodities, or the ability to negotiate safer behaviours with their partners due to their marginalized status."\(^{73}\)

A 2015 WHO report concludes that that the broad application of criminal law to HIV transmission achieves neither criminal justice nor public health goals, and only fuels stigma, and fear, "... discouraging people from being tested to find out their HIV status, and undermining public health interventions to address the epidemic. Thus, such laws may actually increase rather decrease HIV transmission." \(^{74}\) Crucially, this report highlights the disproportionate and deleterious impacts such laws have on women, as they are more likely to be tested for HIV before their partners:"Furthermore, for many women it is either difficult or impossible to negotiate safer sex or to disclose their status to a partner for fear of violence, abandonment or other negative consequences, and they may therefore face prosecution as a result of their failure to disclose their status. Criminal laws have also been used against women who transmit HIV to their infants if they have not taken the necessary steps to prevent transmission. Such use of criminal law has been strongly condemned by human rights bodies."\(^{75}\)

UNDP and UNAIDS similarly caution against such actions against pregnant women noting that in the extremely rare cases where pregnant women refuse treatment, it is usually out of fear that their HIV status may be disclosed and they will face violence or abandonment.\(^{76}\)

Prosecuting women reluctant to take treatment for fear of disclosure is also likely to push women away from ANCs and harm both the woman and the child if she is imprisoned.

Additionally, the 2015 International Association of Providers of AIDS Care (IAPAC) Guidelines for Optimizing the HIV Care Continuum for Adults and Adolescents note that laws criminalising HIV transmission have not kept pace with the changing science of HIV treatment and prevention, act as a barrier in optimizing HIV care, and should be repealed. Based on perceived exposure to HIV without evidence of intent to do harm, the guidelines note that these laws criminalise behaviours that pose a low or negligible risk, that no differences in behaviour are noted in countries with and without these laws and most importantly they do not account for the use of condoms or the preventive benefits of ART. Thus, they note, "most PLHIV who know their status take steps to prevent transmitting HIV to others. HIV-specific laws thus primarily exacerbate HIV-related stigma and decrease HIV service uptake."\(^{77}\)

There is considerable variance in laws criminalising HIV transmission. While some countries have adopted HIV-specific laws, others use general criminal law provisions. Criminal actions range from actual, intentional HIV transmission to mere exposure or non-disclosure of HIV status with no actual transmission (and as noted above, in some extreme cases, also include pregnant women over their choice to undergo treatment or not). In not keeping pace with

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\(^{73}\) UNAIDS and UNDP, Criminalisation of HIV Transmission, Policy Brief, 2008, p.3
\(^{74}\) WHO, Sexual Health, human rights and the law, 2015: [http://apps.who.int/iris/bitstream/10665/175556/1/9789241564984_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/175556/1/9789241564984_eng.pdf?ua=1)
\(^{75}\) Ibid
\(^{76}\) UNAIDS and UNDP, Criminalisation of HIV Transmission, Policy Brief, 2008, p.6
the science, laws also allow for prosecutions for spitting, biting, urinating or spreading fecal matter although it is well known that the risk of HIV transmission from such actions is negligible. That cases of actual, intentional HIV transmission are few in reality is reflected in the kinds of prosecutions and convictions that have taken place. For instance, of the 124 arrests and prosecutions between January 2008 and May 2011 in the United States (US), the majority involved cases of adults having sex, without disclosing known HIV-positive status and without intent to harm, or acts that posed no significant risk of HIV transmission such as spitting or biting. In Canada, 57 of the 96 cases prosecuted till 2010 resulted in convictions, of which only 23% involved an allegation that HIV was actually transmitted.\(^7\)

Bearing in mind the global experience with the criminalization of HIV transmission, there is expert consensus that governments should limit criminalization to cases of intentional transmission of HIV i.e. "where a person knows his or her HIV positive status, acts with the intention to transmit HIV, and does in fact transmit it."\(^7\) Although international agencies are expressing growing alarm at the number of countries that appear to have adopted far broader criminal laws than what is being advised, the reasons for this are notable. For instance, Africa has seen wide adoption of such laws due to a model law proposed by US Agency for International Development. Such laws exist in many US states due to a federal law requirement in order to access HIV funding.\(^8\)

Notably, most countries in South Asia and many in South-East Asia do not have HIV-specific laws criminalising transmission. Law reform proposals in several countries are moving towards limiting the role of criminal law to cases of intentional HIV transmission. In 2011, Denmark's Minister of Justice suspended Article 252 of the Danish Criminal Code, which was an HIV-specific criminal statute. He did this on being made aware of the impact of ART in improving life expectancy and reducing infectiousness.\(^8\) Lawmakers are increasingly aware of the concerns around overly broad criminalization of HIV. In 2007, the 1st Global Parliamentary Meeting on HIV/AIDS acknowledged the adverse impact of criminalising HIV transmission (see Box6). In 2011, the National Assembly of Guyana determined that an HIV-specific criminal law was not required and that intentional transmission cases could be addressed under the general criminal law.\(^9\) Where broad HIV-specific criminal laws have been passed, courts are stepping in to narrow the scope of the law and to ensure that the law keeps up with the science. Thus In 2015, in a landmark decision, the High Court of Kenya


\(^8\) UNAIDS and UNDP, Criminalisation of HIV Transmission, Policy Brief, 2008, p.1


\(^8\) Global Commission on HIV and the Law, HIV and the Law: Risks, Rights and Health, UNDP 2012

struck down Section 24 of the HIV and AIDS Prevention and Control Act, 2006, which criminalised HIV transmission finding that the provision was vague and uncertain.83

Box 6: Excerpts from the conclusions of the 1st GLOBAL PARLIAMENTARY MEETING ON HIV/AIDS
Manila, Phillipines, December 2007*

14. Some countries have enacted HIV-specific criminal legislation making it a crime to transmit or expose another person to HIV, and there are public calls for such legislation in other countries where it does not yet exist.

15. We have asked whether criminal laws and prosecutions represent sound policy responses to conduct that carries the risk of HIV transmission. On the one hand, it is obviously reprehensible for a person knowingly to infect another with HIV or any other life-endangering health condition. On the other hand, using criminal sanctions for conduct other than clearly intentional transmission may well infringe upon human rights and undermine important public policy objectives.

16. We accept that the use of criminal law may be warranted in some circumstances, such as in cases of intentional transmission of HIV or as an aggravating factor in cases of rape and defilement. Individual parliaments will determine the specific circumstances, depending on their local context.

17. Before rushing to legislate, however, we should give careful consideration to the fact that passing HIV-specific criminal legislation can: further stigmatize persons living with HIV; provide a disincentive to HIV testing; create a false sense of security among people who are HIV-negative; and, rather than assisting women by protecting them against HIV infection, impose on them an additional burden and risk of violence or discrimination.

18. In addition, there is no evidence that criminal laws specific to HIV transmission will make any significant impact on the spread of HIV or on halting the epidemic. Therefore, priority must be given to increasing access to comprehensive and evidence-informed prevention methods in the fight against HIV/AIDS.

* Approximately 160 parliamentarians from all parts of the world attended this meeting and adopted these final conclusions on the last day

- UNAIDS and UNDP, Criminalisation of HIV Transmission, Policy Brief, 2008

Even the application of the general criminal law requires prudence as these laws can be broad. Thus, it is recommended that governments, "issue guidelines to limit police and prosecutorial discretion in application of criminal law (e.g. by clearly and narrowly defining ‘intentional’ transmission, by stipulating that an accused person’s responsibility for HIV transmission be clearly established beyond a reasonable doubt, and by clearly indicating those considerations and circumstances that should mitigate against criminal prosecution).”84 In this regard, the United Kingdom (UK) is noteworthy in issuing detailed guidance to prosecutors for such cases. The guidance covers several issues such as the definition of recklessness (including consent, use of a condom, level of infection, number of sexual contacts), and the requirement of evidence.85 In tandem, the National AIDS Trust issued guidance for people living with HIV to explain police investigation processes in this regard.

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83 AIDS Law Project v Attorney General & 3 others, Petition Number 97 Of 2010, High Court of Kenya (Date Of Decision: 18 March 2015)
84 UNAIDS and UNDP, Criminalisation of HIV Transmission, Policy Brief, 2008, p.1
including the need for legal representation (see Box 7). Even where laws are limited to the actual, intention transmission of HIV, it should be noted that prosecutions are complicated, often requiring scientific evidence to show proof of transmission, for instance. Phylogenetic testing, for instance, apart from being costly and unavailable in many countries, only determines the degree of relatedness of two samples of HIV and cannot establish beyond a reasonable doubt the source, route or timing of infection.

### Box 7: Good Practice: Prosecution Guidance in the UK

<table>
<thead>
<tr>
<th>Intentional or Reckless Sexual Transmission of Infection</th>
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<tbody>
<tr>
<td><strong>Snapshot of Issues addressed in Prosecutorial and Investigation Guidance</strong></td>
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<tr>
<td><strong>Guidance for People living with HIV</strong></td>
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<tr>
<td><strong>Introduction</strong></td>
</tr>
<tr>
<td><strong>Central Issues</strong></td>
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<tr>
<td><strong>Scientific and Medical Evidence</strong></td>
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<tr>
<td><strong>Non-cooperation by the Suspect</strong></td>
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<tr>
<td><strong>Sexual History</strong></td>
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<tr>
<td><strong>Recklessness</strong></td>
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<tr>
<td><strong>Safeguards against Transmitting Infection</strong></td>
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<tr>
<td><strong>Attempt to Commit, Section 20 Grievous Bodily Harm</strong></td>
</tr>
<tr>
<td><strong>Intentional Transmission, Section 18 Offences Against the Person Act 1861</strong></td>
</tr>
<tr>
<td><strong>Rape</strong></td>
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<tr>
<td><strong>Sexual Transmission of an Infection as an Aggravating Feature of Another Sexual Offence</strong></td>
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<tr>
<td><strong>Public Interest Issues</strong></td>
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<tr>
<td><strong>Compromising and Witness Care Issues</strong></td>
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<tr>
<td><strong>Auxiliary Orders</strong></td>
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<tr>
<td><strong>ACPO Guidance</strong></td>
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</table>

International guidance also warns against reactions to "sensationalized" cases leading to unwarranted changes in criminal laws. The Global Commission on HIV and Law documents the case of "Sarah Jane Porter, a forty-three-year-old British single mother and hair salon receptionist, was convicted in 2006 and sentenced to thirty months for grievous bodily harm in transmitting HIV to her former boyfriend. The press portrayed her as a wildly promiscuous “AIDS avenger” on a rampage against black men like her son’s father, from whom she had contracted HIV. The police, claiming she had dozens of potential victims, put out a nationwide call for accusers and three of the four they contacted tested negative for HIV. While describing Porter as “callous” and “manipulative”, the prosecution praised her accusers as “very articulate”.
professional decent men who were trying to do their best in life”. Porter’s friends and neighbours, meanwhile, described a quiet, overworked mother whose boyfriend had asked for unprotected sex and whose only “crime” was her denial of her own HIV status—the reason she did not disclose it to others.”88

This case probably finds some resonance in Bhutan, where it appears that the issue of criminalisation of HIV transmission has arisen in a particular case of a woman living with HIV, who was alleged in social and national media to have placed sexual partners at risk of HIV transmission. (See Box 1)

2.5.1 Laws and Policies
Section 410 of Bhutan’s Penal Code makes knowing or intentional transmission of disease dangerous to life punishable. Thus the Penal Code defines criminal nuisance to be when a person, “knowingly or recklessly creates or maintains a condition including spreading of dangerous diseases that causes injury or endangers the safety or health of an individual or the public.” The offence under this provision is considered to be a misdemeanor, and a fourth degree felony where the dangerous disease has a high likelihood of causing death.

The current law in Bhutan gives rise to two issues. The first, which is currently the subject of considerable debate within government is whether a separate law criminalising the transmission of HIV is required. A discussion on criminalization of HIV transmission is reflected in the 2016 Meeting Resolutions of the NHAC:

"As the National Programme is increasingly noticing some difficult to deal cases (extreme cases), the secretariat proposed to the Commission to execute the use of legal provisions under Bhutan Penal Code (Amendment) Act, 2011. Section 410 of the Penal Code states … The Commission directed the secretariat to explore the application of similar laws in other countries."

It further recorded:

"Aimed at improving adherence and compliance for some of the HIV/AIDS cases, the Hon’ble Chairperson directed the Policy and Planning Division (PPD) under Ministry of Health and the Secretariat to look into provision for incorporating the legal provisions under National Health Bill (NHB), for legal amendment of the penalty for intentional spreading of any infectious diseases including HIV/AIDS, that has huge potential to cause death to individual."

As noted above there is consensus among international agencies and human rights experts that countries should not enact HIV-specific criminal laws. The Global Commission on HIV and the Law recommended that, "Countries must not enact laws that explicitly criminalise HIV transmission, HIV exposure or failure to disclose HIV status. Where such laws exist, they are counterproductive and must be repealed. The provisions of model codes that have been

advanced to support the enactment of such laws should be withdrawn and amended to conform to these recommendations.\textsuperscript{89}

The second issue relating to the current law as it stands is the extent to which it is applicable to cases of actual, intentional transmission of HIV and how prosecutions under this provision can proceed. As noted above, one approach is that of the UK where detailed prosecutorial guidance has been provided. Even with the advice that general criminal law should be applied only in cases of intentional HIV transmission, the current Bhutan law is broad and the phrase "endangers the safety or health" could imply that actual harm is not required unlike the international guidance that transmission should actually take place for a prosecution to proceed.

\begin{table}[h]
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\begin{tabular}{|l|l|}
\hline
\textbf{Box 8: When is HIV Transmission Criminal?} & \\
\hline
\textbf{When is HIV transmission criminal} & \textbf{When is HIV transmission not criminal} \\
\hline
\begin{itemize}
\item KNOWING that he or she is HIV positive,
\item UNDERSTANDS the implications of an HIV+ result
\item UNDERSTANDS how HIV is transmitted
\item ACTS with the INTENT to transmit HIV, and
\item ACTUALLY does transmit HIV,
\end{itemize} & \begin{itemize}
\item did not know that s/he was HIV positive;
\item did not understand how HIV is transmitted;
\item disclosed his or her HIV-positive status to the person at risk (or honestly believed the other person was aware of his/her status through some other means);
\item did not disclose his or her HIV-positive status because of fear of violence or other serious negative consequences;
\item took reasonable measures to reduce risk of transmission, such as practising safer sex through using a condom or other precautions to avoid higher risk acts; or
\item previously agreed on a level of mutually acceptable risk with the other person.
\end{itemize} \\
\hline
\end{tabular}
\caption{When is HIV Transmission Criminal?}
\end{table}

\begin{itemize}
\item \textsuperscript{89} Ibid at p. 25
\end{itemize}

\textbf{2.5.2 Recommendations}

a. Section 410 of the Penal Code is sufficient to address cases of intentional transmission of HIV and a specific provision or penalty should not be introduced.

b. The use of Section 410 should be restricted only to cases of actual, intentional transmission of HIV. In this regard, the government and law enforcement agencies in consultation with people living with HIV, should adopt prosecutorial and investigative guidance to ensure that any complaints of the intentional transmission of HIV are pursued with great care and based on a high standard of evidence and proof. Guidance should stipulate media reporting of such cases, and be linked with Media Guidelines on HIV that are recommended to be developed.
c. Service providers and other stakeholders (government and non-government) should receive training and capacity building to understand the role and limitations of criminal law in dealing with HIV transmission and in maintaining confidentiality of a person's HIV-related status as well as in strictly following disclosure protocols.

d. Greater institutional collaboration and guidance is required to provide support for people living with HIV who may be destitute or in difficult circumstances.

e. Public education and awareness programmes on best practices and best public health approaches based on evidence and human rights in addressing the HIV epidemic should be introduced.
3. TRANSGENDER PEOPLE

3.1 Context
Although there is no disaggregated demographic data on transgender people in Bhutan, transgender people – both transgender men and transgender women – are part of Bhutanese society, albeit invisible in social discourse. Gender identity as a notion is not widely understood in society and rarely discussed. Yet, transgender women have their social networks and communities. They have a safe space to meet and discuss their issues within Lhak-Sam. Often, hostile legal and social environments inhibit them from speaking about the stigma and violence that they encounter, which therefore remains undocumented. Lack of understanding of transgender people’s issues leads to non-recognition of gender identity issues within sexuality education efforts, and health sector sensitization. Yet, there are also few positive examples of transgender people receiving understanding and support from conventionally unexpected quarters. For instance, in a case of a transgender woman being arrested on one occasion, the police demonstrated sensitivity in placing her in the section designated for female prisoners.

3.2 Issues
Two areas of law potentially impact transgender people, their marginalisation and vulnerability to HIV. First, is the issue of discrimination; since transgender people are not recognised as either male, female or as an alternative gender identity, they are not extended the fundamental rights available to all people under the Constitution, including the right to equality and concomitant non-discrimination under Article 7(15).

Second, is the issue of criminalisation and its effect in stigmatising their behaviour and identity and casting them as criminals for their sexual conduct, thereby pushing them to the margins of social engagement, and away from vital health messages, information and services. Experiences of transgender women suggest that when they are subject to sexual violence they are reluctant to complain to the police, and when they suffer from STIs they are similarly reluctant to approach health facilities due to the criminality that surrounds them.

3.3 Laws and Policies
The law criminalizes transgender people through Section 213 of Bhutan’s Penal Code: “Unnatural sex: A defendant shall be guilty of the offence of unnatural sex, if the defendant engages in sodomy or any other sexual conduct that is against the order of nature.” In practice, this section appears not to have been used. Yet, it casts a pall on the lives of transgender people who are aware of their criminality, and deters them from approaching police or health workers as mentioned earlier. Crucial health services and treatment become unavailable in such an environment, due to concerns that physicians and other healthcare workers would be obliged to report their health condition to the police due to evidence of criminal conduct. Indeed, the law facilitates such disclosure – the aforementioned regulation 4.4 of the Medical and Health Council Regulations stipulate “Duties to Society”, which require health workers and physicians to report crimes to the police if they come to know of the same while treating a patient.90

90 Regulation 4.4, Medical & Health Council Regulations
As pointed out earlier, Bhutan’s Constitution spells out equality in Article 7(15): “All persons are equal before the law and are entitled to equal and effective protection of the law and shall not be discriminated against on the grounds of race, sex, language, religion, politics or other status”. The phrase “other status” is intended to provide space for interpretation in cases where unanticipated grounds need to be covered. Gender identity can be covered as basis for non-discrimination in the event of such cases being brought before the courts, thereby protecting transgender people from discrimination.

3.4 Recommendations
a. Law reform should be undertaken to repeal S. 213 of Bhutan’s Penal Code. (Presently, there is discussion on this provision, its validity and its impact on the lives of those who may be lesbian, gay, bisexual, transgender or those who may not identify as such but manifest sexual behaviours that are implicated by the section. Opportunities to repeal the law exist through forthcoming discussions within parliament’s Human Rights Committee.)

b. Law review efforts should consider and discuss recent best practice developments in legislating gender identity such as Argentina, Malta etc.\(^1\)

c. Understandings of sexual orientation and gender identity should be promoted through appropriate sexuality education efforts, and public messaging so that society at large and young persons receive affirmative, non-stigmatising information about sexuality, sexual orientation and gender identity, and the use of condoms as a measure to ensure safe sexual intercourse.

d. Although law reform is not required in relation to non-discrimination, clear-cut policy directive can provide interpretative guidance and clarity in the law by explaining that “other status” in Article 7(15) of the Constitution includes gender identity would provide clarity on the law. Alternatively, anti-discrimination law that explicitly prohibits discrimination due to various grounds, including gender identity, can be introduced.

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4. MEN WHO HAVE SEX WITH MEN

4.1 Context
Men who have sex with men are a largely invisible community in Bhutan, although with efforts around HIV prevention gaining momentum attempts have been made to estimate same-sex behaviour in Bhutan, and the impact of stigma and discrimination on men who have sex with men, transgender people and their vulnerability to HIV.\(^{92}\) Nationwide surveys are currently underway to map key populations affected by HIV, including men who have sex with men. The burgeoning of social networking through the internet has also begun to bring men who have sex with men together. And, media coverage has fostered better understandings of sexual orientation issues in Bhutanese society. Yet, these understandings are still rudimentary for the most part. In relation to the health sector, Bhutan has taken encouraging steps to include issues of sexual orientation and gender identity within postgraduate training in medicine, and also to a limited degree through life skills and sexuality education efforts – a guidebook developed in collaboration with UN Population Fund (UNFPA) provides a session on sexual orientation, although it is not easily explained or discussed since teachers are not well-versed on the issue, and understandings of homosexuality have only recently begun to be understood. Although these understandings are not enhanced with other key stakeholders involved in the HIV response such as policymakers, police, and lawmakers, Bhutan’s Tertiary Education Policy explicitly describes the criteria to establish a university to include “a policy that ensures equality of opportunity such that admission to any office or appointment in the university and the admission of students to the university shall be on merit and irrespective of religion, origin, sex, sexual orientation, or race.”\(^{93}\)

4.2 Issues
Similar to transgender people, two areas of law potentially impact men who have sex with men, and their marginalisation and vulnerability to HIV. Firstly, men who have sex with men can be discriminated against in various spheres of life, particularly in employment contexts, or while seeking health services where they are denied opportunities when their sexual orientation becomes known and is the basis of differential treatment.

Secondly, men who have sex with men are subject to criminal law for their sexual conduct i.e. ‘sodomy’. Criminalisation has negative impacts on the ability of health services to be accessible and accessed for and by men who have sex with men, thereby marginalising them from vital health messages, information and services. Experiences of men who have sex with men suggest that when they do suffer from STIs the knowledge of their criminalisation inhibits them from approaching health facilities due to the fear of being reported for a crime.

\(^{92}\) NACP, UNDP (2015), Formative Assessment on Stigma and Discrimination Impacting Universal Access to HIV and Health Services for Men who have Sex with Men and Transgender People in Bhutan. Bangkok, UNDP; UNDP (2016), Breaking new ground: A municipal review of HIV and rights programmes and services for men who have sex with men and transgender people in Thimphu, Bhutan; UNDP (2013), Bhutan Advocacy Framework: HIV, Human Rights and Sexual Orientation and Gender Identity, Bangkok, UNDP.

The Global Commission on HIV and the Law, in its report, “Risks, Rights & Health” pointed out that where laws criminalize men who have sex with men in some African and Caribbean countries, HIV prevalence among them is worrisomely higher than places that do not have criminal law:

4.3 Laws and Policies
The law criminalizes men who have sex with men through the abovementioned Section 213 of Bhutan’s Penal Code, which punishes “unnatural sex”, “sodomy”, and “any other sexual conduct that is against the order of nature.” Although this section appears not to have been
used, its very existence looms as a threat against men who have sex with men. Approaching health facilities with anal STIs would reveal their involvement in the proscribed sexual conduct, making it obligatory for the healthcare worker to report their condition to the police due to evidence of criminal conduct. This pushes men who have sex with men away from crucial health services and treatment. Indeed, as pointed out earlier, the law facilitates such disclosure – regulation 4.4 of the Medical and Health Council Regulations stipulate "Duties to Society", which require health workers and physicians to report crimes to the police if they come to know of the same while treating a patient.\footnote{Regulation 4.4, Medical & Health Council Regulations}

With regard to discrimination, as aforementioned, Bhutan’s Constitution spells out equality in Article 7(15): “\textit{All persons are equal before the law and are entitled to equal and effective protection of the law and shall not be discriminated against on the grounds of race, sex, language, religion, politics or other status}”. The phrase “other status” is intended to provide space for interpretation in cases where unanticipated grounds need to be covered. Sexual orientation can be covered as basis for non-discrimination in the event of such cases being brought before the courts, thereby protecting men who have sex with men (and indeed, women who have sex with women too) from discrimination.

4.4 Recommendations

a. Law reform should be undertaken to repeal S. 213 of Bhutan’s Penal Code. (Presently, there is discussion on this provision, its validity and its impact on the lives of those who may be lesbian, gay, bisexual, transgender or those who may not identify as such but manifest sexual behaviours that are implicated by the section. Opportunities to repeal the law exist through forthcoming discussions within parliament’s Human Rights Committee.)

b. Understandings of sexual orientation should be promoted through appropriate sexuality education efforts, and public messaging so that society at large and young persons receive affirmative, non-stigmatizing information about sexuality, and sexual orientation, and the use of condoms as a measure to ensure safe sexual intercourse.

c. Although law reform is not required in relation to non-discrimination, clear-cut policy directive can provide interpretative guidance and clarity in the law by explaining that “other status” in Article 7(15) of the Constitution includes sexual orientation would provide clarity on the law. Alternatively, anti-discrimination law that explicitly prohibits discrimination due to various grounds, including sexual orientation can be introduced.
5. PEOPLE WHO USE DRUGS

5.1 Context
The use of drugs in Bhutan is a matter of some concern to the government. Injecting drug use does not appear to be common in Bhutan and 1% of HIV infections may be attributed to injecting drug use. Most people who use drugs in Bhutan reportedly use cannabis or tablets, usually painkillers like dicyclomine and nitrazepam. However, a recent seizure of brown sugar was considered highly unusual for Bhutan. Drugs appear to be accessed by users and dealers primarily from India. In the border town of Phuentsholing, detentions and arrests are based primarily on prior information or at times through random checks. In Thimphu arrests usually take place during an incident or disturbance and drug use detected through urine tests.

State supported services for people who use drugs take the form of the Drop-In Centres (DICs) and the Rehabilitation Centre run by the Youth Development Fund (YDF). The Chithuen Phendhey Association which started as a self-help support group for drugs and alcohol dependent individuals provides treatment, aftercare, education and social integration programs to substance users. Lhak-Sam’s outreach workers also provide services to people who use drugs. Overall, services for users are hampered by limited financial and human resources. DICs counsel and refer users for HIV testing. However, data on the number who have presented themselves for testing or have tested HIV-positive is not available in keeping with confidentiality norms, and to assure users coming to the DICs that they would not be identified as being HIV-positive.

Criminal laws penalizing the use and possession of drugs in Bhutan appear to be impacting health-seeking behaviour of users. Fear of being reported to the police is a reason that many users who overdose do not reach hospitals, as friends or fellow users attempt to handle the problem themselves. The use of condoms among people who use drugs is reported to be low while STI rates are high. Self-stigma among users also exists, and is reinforced in part by public messaging.

It is unclear if legal aid is available for those arrested on use and possession charges; some cases can take as few as 20 days between arrest and sentencing. Appeals are difficult and expensive to pursue and usually unsuccessful. Reports on counseling and support for users who had come out of rehabilitation or prison to get back into the mainstream through school or jobs were contradictory. While one view suggested that former users could get any job as long as they had the skills, and were able to return to school, another perspective described considerable stigma attached to former users and proactive support to get jobs or education being absent in current programmes.

5.2 Issues
Among the greatest risks of drug use is heightened exposure to HIV infection. This risk is particularly elevated for the approximately 16 million people worldwide who inject drugs - about 3 million already have HIV, and about one in ten new HIV infections is related to

95 Country Progress Report on the HIV Response in Bhutan, 2015, National AIDS Control Programme, Department of Public Health Ministry of Health
injecting drug use.\textsuperscript{96} While injecting drug use may not be a major concern for Bhutan at present, it is worth noting that injecting drug use and sharing of needles has been reported at a small scale.

The Commission on AIDS in Asia pointed out that HIV can spread rapidly among people who inject drugs: "Several countries and areas in Asia have seen HIV infection levels soar from zero to 40 per cent or higher in only a few years. In the Nepalese capital, Kathmandu, HIV prevalence was 68 per cent among injecting drug users in 2003, while in Viet Nam’s northern port city of HaiPhong, 66 per cent tested HIV positive in 2006. In Lashio, close to Myanmar's border with China, 60 per cent of drug injectors were found to be infected in 2004. In Karachi (Pakistan), HIV prevalence among injecting drug users rose from under 1 per cent in early 2004 to 26 per cent in March 2005."\textsuperscript{97} Noting that once HIV prevalence peaks, it can take 7-10 years to bring infection rates down again, the commission recommends early rights-based interventions in places that still can curb an upsurge, citing the example of Hong Kong which "opted for this route, and its harm-reduction programme has helped keep HIV prevalence among drug injectors low for many years."\textsuperscript{98}

NSP2 notes that harm reduction is a new concept for Bhutan and recommends training and study tours to understand how these programmes work in neighbouring countries. "Harm reduction" refers to policies, programmes and practices aimed at reducing the harms associated with the use of illegal drugs—but not prevention or cessation of drug use itself. Harm reduction focuses on people who, for whatever reason, continue to use drugs, helping them protect their health and that of their drug-using companions, sex partners or children.\textsuperscript{99} There are several successful examples of harm reduction programmes from across the world, including New Zealand, Australia, Germany, Switzerland, Iran and India.\textsuperscript{100} According to WHO, UNAIDS and the UN Office on Drugs and Crimes (UNODC), a comprehensive harm reduction package has the following components, several of which can be applied in non-injecting contexts:\textsuperscript{101}

- Needle and syringe programmes
- Opioid substitution therapy and other drug dependence treatment
- HIV testing and counseling
- Antiretroviral therapy
- Prevention and treatment of STIs
- Condom programmes for people who inject drugs and their sexual partners
- Targeted information and education for people who inject drugs and their sexual partners
- Vaccination, diagnosis and treatment of viral hepatitis
- Prevention, diagnosis and treatment of TB

\textsuperscript{96} Mathers B.M. et al. \textit{Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review.} The Lancet (online edition), September 24\textsuperscript{th}, 2008
\textsuperscript{97} REDEFINING AIDS IN ASIA Crafting an Effective Response Report of the Commission on AIDS in Asia, 2008, p. 42
\textsuperscript{98} Ibid at p. 43
\textsuperscript{99} Global Commission on HIV and the Law, HIV and the Law: Risks, Rights and Health, UNDP 2012
\textsuperscript{100} Ibid.
NSP2 also notes high rates of STIs and low condom use reported by people who use drugs. Additionally, it has been pointed out that apart from HIV people who use drugs have to often contend with other challenges, such as the inability to access HIV and health services due to criminal laws that keep them away from the same.\textsuperscript{102} For injecting and non-injecting users, criminalisation of drug use can adversely impact their health and inhibit their inclination to access services; and crime reporting requirements on healthcare workers can act as disincentives to health-seeking behaviour. To ensure the provision of health services to people who use drugs and protect healthcare workers from any adverse action for providing these services, some countries are considering laws to protect the provision of health and harm reduction services. (See Box 9)

\begin{boxedidge}
\textbf{BOX 9: Provision from HIV/AIDS Bill, 2014 (India)}

\textbf{CHAPTER IX}

\textbf{PROMOTION OF STRATEGIES FOR REDUCTION OF RISK}

22. Notwithstanding anything contained in any other law for the time being in force any strategy or mechanism or technique adopted or implemented for reducing the risk of HIV transmission, or any act pursuant thereto, as carried out by persons, establishments or organizations in the manner as may be specified in the guidelines issued by the Central Government shall not be restricted or prohibited in any manner, and shall not amount to a criminal offence or attract civil liability.

Explanation.—For the purpose of this section, strategies for reducing risk of HIV transmission means promoting actions or practices that minimise a person’s risk of exposure to HIV or mitigate the adverse impacts related to HIV or AIDS including—

(i) the provisions of information, education and counselling services relating to prevention of HIV and safe practices;
(ii) the provision and use of safer sex tools, including condoms, and safe intravenous drug use practices; and
(iii) drug substitution, drug maintenance, needle and syringe exchange programmes.

Illustrations

(a) A supplies condoms to B who is a sex worker or to C, who is a client of B. Neither A nor B nor C can be held criminally or civilly liable for such actions or be prohibited, impeded, restricted or prevented from implementing or using the strategy.

(b) M carries on an intervention project on HIV or AIDS and sexual health information, education and counselling for men, who have sex with men, provides safer sex information, material and condoms to N, who has sex with other men. Neither M nor N can be held criminally or civilly liable for such actions or be prohibited, impeded, restricted or prevented from implementing or using the intervention.

(c) X, who undertakes an intervention providing registered needle exchange programme services to injecting drug users, supplies a clean needle to Y, an injecting drug user who exchanges the same for a used needle. Neither X nor Y can be held criminally or civilly liable for such actions or be prohibited, impeded, restricted or prevented from implementing or using the intervention.

(d) D, who carries on an intervention programme providing Opioid Substitution Treatment (OST), administers OST to E, an injecting drug user. Neither D nor E can be held criminally or civilly liable for such actions or be prohibited, impeded, restricted or prevented from implementing or using the intervention.


There is also now, an increasing recognition of alternate, non-punitive legal approaches to drug use. Portugal has moved away from a criminal law regime resulting not only in a

\textsuperscript{102} Global Commission on HIV and the Law, HIV and the Law: Risks, Rights and Health, UNDP 2012, p. 29
significant drop in drug use but also a dramatic improvement in health outcomes. (See Box 10) Alternatives approaches to incarceration in the form of community-based treatment is also being considered across the South-East Asia region.\textsuperscript{103} Community based treatment approaches can create long term support systems for people who use drugs. In Cambodia, for instance, UNODC’s Community-Based Drug-Treatment programme was launched in 2011 as an alternative to the Compulsory Centres for Drug Users. It provides users with “voluntary, cost-effective and sustainable drug treatment, rehabilitation and reintegration services. Community stakeholders include public hospitals, health centres, HIV/STI services, non-government organizations, families, community leaders and the police. At any stage of their drug use and dependence, drug-users can freely and continuously access services that include counseling, self-help and harm-minimization education.”\textsuperscript{104}

\begin{center}
\textbf{Box 10: Good Practice: Less Punishment, less Drug Use}
\end{center}

\begin{center}
\textbf{Portugal’s Success}
\end{center}

"On July 1, 2001, a Portuguese law came into effect that decriminalised the possession and use of illicit drugs in small enough amounts to suggest personal use. Drug trafficking continues to be a criminal offence, and drug possession and use are still illegal, but these latter infractions incur only administrative penalties, just as a parking ticket would. Rather than prison or other criminal penalties, as earlier laws mandated, people found to be in possession of or using drugs go before a panel consisting of a psychologist, a social worker and a legal adviser. The panel may impose any of a range of sanctions, including fines, community service and suspension of professional licences. For those who are dependent on drugs, the panel may forego a sanction and instead order the person to attend an educational programme or receive treatment.

The number of people on methadone and buprenorphine for drug dependency rose to 14,877 from 6,040 after decriminalisation—treatment funded with the money Portugal saves on police and prisons.

Portugal now reports one of the lowest rates of lifetime marijuana use (that is, at least one use in a lifetime) in the EU: 8.2%, compared with 25% in the EU generally. Data also shows a drop in drug use by teens; lifetime heroin use in 16- to 18-year-olds dropped from 2.5% to 1.8%. New HIV infections among people who use drugs fell by 17% from 1999 to 2003, while fewer people died from causes related to drug use.”

- \textit{Global Commission on HIV and the Law, HIV and the Law: Risks, Rights and Health, UNDP 2012}

\section*{5.3 Laws and Policies}

Drug use and possession is criminalized in Bhutan under the Penal Code and the Narcotic Drugs, Psychotropic Substances and Substance Abuse Act of Bhutan 2015 (NDPSS). The NDPSS 2015 replaces the 2005 law that specifies quantities to determine whether drugs found in the possession of a person indicate personal use or dealing. It also provides for treatment and rehabilitation of drug dependent persons. Persons who present themselves voluntarily for treatment are not prosecuted for drug use. The Bhutan Narcotics Control Authority (BNCA) was established in 2006 following the enactment of the 2005 law. It functions as the secretariat to the Narcotic Control Board and is the nodal government agency for all matters related to narcotics drugs, psychotropic substances and substance abuse.

\textsuperscript{103} New roadmap to voluntary community-based services for people who use drugs in Asia, Press Release, UNAIDS and UNODC, 23 September 2015

\textsuperscript{104} Innovative community based drug treatment pilot makes inroads in Cambodia, Press Release, UNODC, 8 February 2012
Public concern over increasing cases of drug use, and too much discretionary judicial power in sentencing were reasons cited for the replacement of the 2005 law with the stricter NDPSS 2015. Quantities to distinguish personal use from dealing were determined by policy-makers and medical community representatives based on the amount usually prescribed as painkillers; it appears that former users or organisations working with users were not consulted in this process.

The impact of NDPSS 2015 is uncertain given its recent introduction. Yet, incidents of smuggling, sale and use appear to have been unaffected by the harsher law, and its effect is largely felt by users and not dealers, although this role often overlaps. Users are often caught with more than the prescribed quantity, since they may purchase in bulk for multiple uses, or their intake needs exceed the current quantity limits. Stricter law has increased the risk of selling and dealing, thereby increasing the cost of drugs. This has created concern that petty crimes may increase to ensure greater finances needed by users to sustain their habit. In addition, there is concern that the operation of regulation 4.4 of the Medical and Health Council Regulations relating to “Duties to Society”, which requires health workers and physicians to report crimes to the police if they come to know of the same while treating a patient is likely preventing people who use drugs from accessing health services. 105

Several young people appear to have been detained or arrested for drug use or trafficking. While first-time offenders are sent for rehabilitation, the monthly cost of Nu 3000 (and Nu 1000 as deposit) is a significant financial challenge for persons from poorer contexts who wish to access this service. The rehabilitation centre that exists can only cater to small numbers of clients at a time. An additional rehabilitation centre is reportedly opening in the near future. For many users, withdrawal occurs in detention or jail where there is a lack of withdrawal management. Prisoners rely on each other for assistance and seldom report the need for medical assistance to jail authorities. Those that do report are taken to nearby hospitals according to the RBP. Recidivism is also frequent.

As mentioned earlier, narcotics laws such as the NDPSS 2015 are significant in the HIV/AIDS context - a stringent criminal legal regime governing the personal use of drugs can be problematic from a public health perspective as it can prevent people who use drugs from accessing prevention, harm reduction and treatment information and services, particularly if they are concerned that healthcare workers may report their habit to law enforcement. 106 Additionally, the criminalisation of people who use drugs accentuates the stigma and discrimination suffered by them, hindering their ability to re-enter the mainstream by availing education and employment opportunities and keeps them away from health services for fear of being reported to law enforcement. As the Global Commission on HIV and Law recommended: “Countries must reform their approach towards drug use. Rather than punishing people who use drugs who do no harm to others, they must offer them access to effective HIV and health services, including harm reduction and voluntary, evidence-based treatment for drug dependence. Countries must …[d]ecriminalise the possession of drugs for

105 Regulation 4.4, Medical & Health Council Regulations
106 Regulation 4.4 of the Medical and Health Council Regulations (“Duties to Society”), which require health workers and physicians to report crimes to the police if they come to know of the same while treating a patient has been discussed earlier.
personal use, in recognition that the net impact of such sanctions is often harmful for society.”

5.4 Recommendations

a. Public awareness and education of HIV-related harm reduction as well as health services for people who use drugs should be introduced. Based on community consultations, positive public messaging and outreach for people who use drugs should be designed and implemented, specifically related to safer sexual practices and increasing uptake and use of condoms and the availability of voluntary and confidential health services. The capacity and infrastructure for rehabilitation should also be increased.

b. Reform and review of the narcotics laws in Bhutan should be considered based on a detailed study of impact of NDPSS 2015 and a review of global good practices including on whether criminal law should be the primary response to drug use, de-criminalisation of personal drug use and small quantity specifications, harm reduction and community-based rehabilitation.

c. Greater co-ordination at the institutional level is required to provide support and opportunities for reintegration (including in terms of employment or educational opportunities) for people who use drugs released from rehabilitation or from prison. In particular psychosocial support for people who use drugs including young people to address issues of self-stigma and shame should be reviewed and re-designed based on community consultation.

d. Laws protecting healthcare providers from legal or disciplinary actions who act in good faith to provide healthcare services to people who use drugs in relation to HIV, overdose, other medical issues should be considered and introduced. The legal requirement for healthcare workers to report people who use drugs to the police should reformed and amended as discussed in the Confidentiality section.

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6. SEX WORKERS

6.1 Context
Although sex work is not a visible or organised phenomenon in Bhutan, anecdotal data points to its existence at a small scale, especially closer to the border areas with India, such as the town of Phuntsholing, and in larger cities such as Thimphu. Often, sex work is done as a part-time activity by women who wish to augment their income. Bhutan does not have designated areas, such as brothels, where sex work occurs. Since there is no established industry, the ability to support sex workers with HIV and sexual health interventions is a challenge. This scenario is exacerbated by criminal law.

Drayangs are commonplace, particularly in the border towns. They are venues where women provide dance entertainment to male clients, and are licensed as entertainment businesses by the Bhutan InfoComm and Media Authority (BICMA). Drayang owners are required to ensure that prostitution-related offences are not committed on the premises, and BICMA is tasked with conducting site inspections in collaboration with the RBP and the Regional Trade and Industry Office to ensure the prevention or cessation of illegal activities, if any. Although concerns have been expressed that drayangs could be sites for sex work, evidence pointing towards this is inconclusive. Efforts to steer women away from working in drayangs, through vocational skills development such as tailoring, have not borne fruit, since employment at a drayang is far more profitable.

6.2 Issues
Drayangs are considered proxy sites where HIV and health information is shared with “high risk women”. Efforts to work with sex workers on HIV and sexual health have occurred in Bhutan, including sero-surveillance in Phuntsholing in early 2000, based on which counseling and testing services and condoms were provided by the HIS. This work built into a steady collaboration over time, but police raids of hotels and lodges disrupted these efforts. This led to sensitization of the RBP by the HIS staff. Over time, police became partners in the HIV and health efforts of the MOH and the HIS, and this cooperation has ensures that the criminal law is not used to disrupt these efforts, although in cases where complaints are made police use the criminal law to intervene and prevent sex work.

In such a scenario where crucial health interventions are happening with already marginalised and hard-to-reach communities, criminal law used against people who make choices to engage in transactional sex, and those who pay for such sex, can lead to problematic consequences, including such activities being scattered further, pushed ‘underground’, into more furtive and dangerous contexts. Such an environment can distance people from vital health information and services. In India where sex work is effectively criminalized under overarching anti-trafficking legislation, rights-based efforts to empower sex workers despite the looming threat of criminal law has borne great fruit. In Kolkata an STI/HIV/AIDS intervention project was introduced in the brothel of Sonagachi in 1992, which included provision of STI treatment, information and education on sexual health and HIV, and condom promotion through a strategic participatory, peer-oriented & rights-based approach. Very encouraging results have been witnessed over time through the efforts of the
sex worker collective, Durbar Mahila Samanway Committee (DMSC) and its associated Usha Cooperative. Condom use showed sharp increases, along with significant reductions in HIV. Self-regulatory boards that were set up reduced minors in sex work from 25% to 2%, while the median age of women in sex work increased from 22 to 28 years.

Addressing structural and systemic causes (including poverty, and lack of access to education and gainful employment) that influence people to make the choice of earning income through transactional sex becomes necessary to address the roots of exploitation that may occur within sex work. Simultaneously, criminal justice system resources are best spent in addressing cases of trafficking that take place in the context of prostitution – against those people who use force and coercion for purposes of sexual exploitation of others.

6.3 Laws and Policies

Bhutan’s approach to sex work is reflected in the Constitution, which lays down the Principle of State Policy thus: "The State shall endeavour to take appropriate measures to eliminate all forms of discrimination and exploitation against women including trafficking, prostitution, abuse, violence, harassment and intimidation at work in both public and private spheres."

Chapter 26 of Bhutan’s Penal Code clearly stipulates the offence of prostitution and related crimes. Sections 373 and 374 criminalize the prostitute as guilty of a misdemeanor, Sections 375 and 376 punish “promotion of prostitution” i.e. anyone who contacts a person for the purpose of prostitution, or encourages, induces or otherwise causes another to become or remain a prostitute, is guilty – covering pimps, madams and brothel/ business owners - in varying degrees (from a misdemeanor to a third degree felony), and Sections 377 and 378 criminalize a client (in similar varying degrees of punishment). Sections 379 and 380 punish the trafficking of persons for prostitution. As the NACP’s Country Progress Report on the HIV Response in Bhutan 2015 points out, “there is no documentation to date of anyone being prosecuted under these provisions of the Penal Code, but their very existence is likely to contribute to fear, prejudice and exclusion.”

Bhutan has committed to "...take all appropriate measures, including legislation, to suppress all forms of traffic in women and exploitation of prostitution of women"as per its international obligations contained in the CEDAW. Further, as signatory to the CRC, Bhutan has committed to ensuring that children are protected from sexual exploitation, including prostitution. Similar commitments have been made by Bhutan at the regional level through the SAARC Convention on Preventing and Combating Trafficking in Women and Children.

109 [http://ushacoop.org/about.php](http://ushacoop.org/about.php)
112 Article 9 (17), Constitution of the Kingdom of Bhutan, 2008
114 Article 6, CEDAW
115 Article 34, CRC
As party to the SDGs, Bhutan also aims to achieve gender equality by eliminating “all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation” as per SDG 5.

6.4 Recommendations
a. Along with an assessment of the scale of sex work in Bhutan, a review should be undertaken that examines various successful rights-based models of prostitution law reform, including decriminalization and its effects in New Zealand, to empower efforts to promote and protect the health and civil rights of people involved in sex work, such as those in India.

b. At the same time, data on the harmful impacts of using anti-trafficking measures to criminalize those involved in prostitution should be shared with various stakeholders, particularly law and policy-makers, so that a balanced understanding of effective and strategic ways to address both trafficking for sexual exploitation, empowerment of those in prostitution, and public health priorities can be charted.

c. Based on the above, a review of laws to reconsider key sections in Chapter 26 of the Penal Code should be undertaken.

7. WOMEN

7.1 Context
The status of women in Bhutan has been assessed as relatively empowered compared to the rest of South Asia. Women find themselves with equal rights in relation to inheritance of property. A recent report notes the preponderance of matrilineal inheritance practices in large parts of Bhutan;\footnote{World Bank Group, Bhutan Gender Policy Note, 2013: \url{http://documents.worldbank.org/curated/en/960591468017989867/pdf/ACS45510PNT0P10Box0379884B00PUBLIC0.pdf}} about 60% of rural women and about 45% of urban women have land and property titles registered in their name. Although this has bolstered the economic empowerment of women due to the cultural importance of land, it has also entrenched social roles, since the rationale behind Bhutan’s traditional inheritance practices appears to be linked to the care of aging parents.

The National Commission for Women and Children (NCWC) as the nodal agency on protection and promotion of the rights of women plays an important role to advance gender equality and empower women.

On the other hand, violence against women has been a phenomenon that began to be unearthed and understood in the last decade, led by the Queen Mother whose interaction with Bhutanese women as UNFPA’s Goodwill Ambassador revealed the health issues that women were facing including teenage pregnancies, lack of health support for pregnant women, and violence within domestic contexts, which was not discussed until then. Data suggests that the extent of violence against women is high and the acceptance level among women is also high. An NCWC study found that almost a quarter of females between 15-49 years had experienced some form of violence from their husbands or partners.\footnote{National Commission for Women & Children, Situation of Violence against Women in Bhutan, 2013: \url{http://www.ncwc.gov.bt/en/files/publication/Study%20on%20Situation%20of%20Violence%20against%20Women%20in%20Bhutan.pdf}}

7.2 Issues
Bhutan has had a robust response to address the issue of gender based violence, including efforts to establish a comprehensive and sustainable protection system for survivors, led by NCWC in partnership with other organizations such as Renew, a civil society organization that supports women experiencing discrimination and violence. Among other methods, Renew uses a community-based support system, which is a volunteer network in all districts, and is often the first point of contact for survivors of violence. Until recently, the crime of battery under the Penal Code was used to punish offenders. Now, with a domestic violence law and awareness campaigns such as “Yeshi Dawa” in newspapers, on radio and TV the issue is being addressed in a sustained manner. In attempts to ensure multi-sectoral involvement, anti-domestic violence work has also included police, and health officials in trainings that are conducted.

Women living with HIV are also supported by organizations like Renew. However, there are only a few cases where family support is not forthcoming. It is in such instances that HIV-positive women approach Renew for support.
Anecdotal data also suggests that many women seek abortion services, but struggle to obtain them since abortion is illegal in Bhutan. This forces them to opt for unhygienic and dangerous methods to abort fetuses, often by crossing the border to India where spurious entities provide services. Although there is no direct co-relation between abortion and HIV vulnerability, women who find themselves in unsanitary health environments can potentially expose themselves to infections due to contaminated medical equipment. And women living with HIV undergoing unsafe abortions are a higher risk for complications than other women.\(^{121}\)

### 7.3 Laws and Policies

Bhutan is signatory to the CEDAW, which requires ratifying member states to ensure the equality and dignity of women through protection from discrimination and violence against them in all their forms. Bhutanese laws reflect this respect for gender equality. At the highest level, the Constitution prohibits discrimination on the grounds of sex, and national legislations that protect women have been passed more recently.\(^{122}\) For instance, Bhutan has the robust Domestic Violence Prevention Act (DVPA), which came into force in 2013. It covers various forms of violence – “any act, omission or behavior towards a person which results in physical, sexual, emotional or economic abuse.” It covers a wide range of relationships: spousal, familial, intimate, or shared household relationship. The DVPA provides for necessary health services, including facilities and trained personnel to cater to victims, and crises centres to provide required medical treatment. It requires that the law be given wide publicity through various, and that periodic sensitization and awareness training be conducted with key stakeholders. It prescribes personnel for effective implementation, including protection officers and service providers. Standard Operating Procedures for the “Referral and Management of cases related to Children and Women in Difficult circumstances” have been developed, and are aimed at ensuring the effective implementation of the DVPA. They prescribe roles and responsibilities of different stakeholders in implementing the law. Yet, challenges do exist in implementation of the law, particularly in relation to allocating sufficient resources to support its infrastructure including trained personnel, crisis centres, protection officers etc.

Legal provisions related to sexual assault contained in Chapter XIV of the Penal Code are also comprehensive. They cover rape, child molestation, child abuse, gang rape, paedophilia, statutory rape, marital rape, and incest. This set of provisions particularly distinguish themselves from many other countries in their treating such crimes as gender neutral, and their clear recognition of marital rape as a crime, while also recognizing that minors can and do indulge in sexual intercourse, thereby deeming consensual sex between children of sixteen years and above not to be rape.\(^{123}\)

Apart from an equitable inheritance system mentioned earlier, women also have equitable custody rights over children under the age of nine, in cases of divorce, and the father is obliged to pay child support until the child reaches the age of 18. Yet, the Marriage Act, 1980

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\(^{121}\) WHO/UNFPA 2006: [http://www.who.int/hiv/pub/guidelines/sexualreproductivehealth.pdf](http://www.who.int/hiv/pub/guidelines/sexualreproductivehealth.pdf)

\(^{122}\) Article 7(15), Constitution of the Kingdom of Bhutan

\(^{123}\) Section 183, Penal Code
provides for “[c]ompelling reasons by which a mother can be deprived of custody include: neglect, ..., affliction with communicable illness, and any other ground that the court determines.”

An aspect that is related to women, which needs further understanding in terms of its impact on the HIV epidemic, is the illegality of abortion.

### 7.4 Recommendations

a. There is a need to review the Marriage Act, to ensure that HIV status is removed as a ground for taking away custody of a mother, especially given the chronic nature of living with HIV where anti-retroviral is made readily available.

b. There is a need to cost and appropriately allocate budgets for effective implementation of laws such as the Domestic Violence Prevention Act.

c. Research should be undertaken to better understand the impact of Bhutan’s abortion law on the health and safety of women.

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124 Section 7.2, Marriage Act
8. CHILDREN AND YOUNG PEOPLE

8.1 Context

Of the 403 people living with HIV in Bhutan, 30 are children below the age of 15 years. This represents 7.4% of people living with HIV. As noted previously, the age at detection for women is younger compared to males, and of the 11 cases in the age group of 15-19 years, ten are female. Ten children below the age of 15 are on anti-retroviral therapy.125

Young people in Bhutan appear to be sexually active from an early age. A 2009 'Knowledge, Attitude, Practice and Behaviour Study on HIV/AIDS/STI Among Uniformed Personnel, In School and Out of School youth in Bhutan' found that four out of five out-of-school youth had sex in the past 12 months, of whom 38.1 percent reported multiple sexual partners; one-sixth reported sex with sex workers and of these 12 percent did not use condoms. Numbers of in-school youth engaging in sexual activity in the past 12 months were lower at two out of five; of these 51.3% reported multiple sexual partners. Six percent of out-of-school youth and two percent of in-school youth reported ever having sex with male partners.126 These findings underscore the need for the HIV programme to be designed with a view to address the issues and concerns of young people.

For children living with or affected by HIV, Renew and Lhak-Sam provide financial and other support. 16 children living with HIV are members of Lhak-Sam; the oldest being nineteen and the youngest is three years of age. Educational support for children affected by HIV is provided through Lhak-Sam. Between 2011 and 2014, Lhak-Sam provided educational support to 16 disadvantaged children living with HIV who had lost either one or both parents, educational support to 8 affected children whose parents are HIV-positive and stationary support to 23 children living with or affected by HIV.127 At the institutional level, the mission of the NCWC includes the protection and promotion of the "rights of children through child-responsive interventions."128

8.2 Issues

The Committee on the Rights of the Child in its General Comment 3 on HIV/AIDS and the Rights of the Child (General Comment 3) notes that the issue of children and HIV/AIDS is perceived as mainly a medical or health problem, although in reality it involves a much wider range of issues; "all children can be rendered vulnerable by the particular circumstances of their lives being mainly a) children who are themselves HIV-infected b) children who are affected by the epidemic because the loss of parental care giver or teacher and/or because their families or communities are severely strained by its consequences and c) children who are most vulnerable to be infected or affected."129 Although NSP2 states that the impact of HIV on

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125 Country Progress Report on the HIV Response in Bhutan, 2015, National AIDS Control Programme, Department of Public Health Ministry of Health
128 Mission, National Commission for Women and Children
children and young people needs to be further researched, some of the consequences of the HIV epidemic are being experienced by children and youth in Bhutan.

**Discrimination**

For children and young people affected by HIV, stigma and discrimination can have devastating impacts. In the Bhutanese context anecdotal information suggests that children affected by HIV are facing stigma and discrimination (See Box 11). Their situation also reveals the need for social protection for families affected by HIV – in some cases grandparents or other family members look after children living with or affected by HIV whose parents have passed away; these guardians find it difficult, particularly with advancing age, to properly care for these young people. According to Lhak-Sam, examples of extended families raising or fostering HIV-positive orphan children are few. “This is made difficult because of perceived risk of accidental transmission to their own children and family members, fear of stigma and discrimination from others and scorn of neighbors.” Lhak-Sam proposes to build a Community Based Care Centre to provide shelter and support to children affected by HIV. “The centre will aim at providing food, shelter, education and skills to earn an income for our orphaned children and for those who are abandoned because of their HIV and economic status.” More research in this area will provide better insight on the nature of social protection that needs to be provided in these contexts.

**Box 11: Stigma and Discrimination faced by children affected by HIV and AIDS**

"Even very recently at his son’s school, Namgay’s son was standing in a queue for a routine blood test. The wife of the same medical officer from Namgay’s office, who had detected the virus in Namgay and his wife, was teaching in the school. When Namgay’s son’s turn came, she said there is no need to test this boy. His parents are positive and he has to be positive’. Namgay has four children and all are HIV negative. "That one sentence changed my son’s life. Three times we have changed his school. Now I have sent him to a school in the eastern region where no one is aware about our status.”


**Access to health services: Consent and Confidentiality**

One of the basic principles underlying the CRC is the right of children to express their views freely in all matters affecting them, these views being given due weight in accordance with their age and maturity. The CRC further recognizes the right of children to access health services. According to General Comment 3, “in the context of HIV/AIDS and taking into account the evolving capacities of the child, States parties are encouraged to ensure that health services employ trained personnel who fully respect the rights of children to privacy (article 16) and non-discrimination in offering them access to HIV related information, voluntary counseling and testing, knowledge of their HIV status, confidential sexual and reproductive health services, free or low cost contraception, condoms and services, as well as HIV-related care and treatment if and when needed, including for the prevention and treatment of health problems related to HIV/AIDS e.g. tuberculosis and opportunistic infections.” Noting that the evolving capacities of the child would determine whether the child or their guardian

131 Article 12, CRC
132 Article 24, CRC
consents to testing, the child’s right to receive information under Articles 13 and 17 of the CRC requires that the risks and benefits of testing are conveyed to the child. Several countries have laws or guidelines recognising the capacity of minors to consent for testing and treatment, depending on their age and ability to understand the nature of the diagnosis or treatment.\textsuperscript{133} Also known as the "mature minor rule," laws also protect healthcare workers who provide services to minors. (See Box 12)

In Bhutan, although a Youth Friendly Health Services programme has been initiated, its implementation is low. According to the 2010/11 Adolescent Sexual and Reproductive Health Review several healthcare providers do not distribute condoms or contraceptives to adolescents and are largely unaware that adolescents are more vulnerable to STIs and "don't seek care as adults do."\textsuperscript{134}

<table>
<thead>
<tr>
<th>Box 12: Example of Protective Laws for Healthcare Workers providing services to minors</th>
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<td>&quot;An Act To Require Reporting on Medical Services or Treatment Provided to Minors without Parental Consent Be it enacted by the People of the State of Maine as follows:</td>
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</table>

§ 1504. Good faith reliance on consent A health care practitioner or health care provider who takes reasonable steps to ascertain that a minor is authorized to consent to health treatment as authorized in section 1503 and who subsequently renders treatment in reliance on that consent is not liable for failing to have secured consent of the minor’s parent or guardian prior to providing health care services to the minor.

A health care practitioner or health care provider who provides health care services or health treatment to a minor without the consent of that minor's parent or guardian shall file the following information in a report to the Department of Health and Human Services:

1. Age. Age of minor;

2. Date of services or treatment provided. Date of services or treatment provided;

3. Type of services or treatment rendered. Type of services or treatment rendered such as substance abuse counseling, mental health services, general medical treatment, emergency services, family planning, cosmetic services, dental services or other specified services;

4. Methods to attempt to obtain consent. Methods used to attempt to obtain the consent of the parent or guardian;

5. Date of attempt to obtain consent. Dates attempts were made to obtain the consent of the parent or guardian; and

6. Number of times patient treated. Number of times the patient was treated previously at the facility.

SUMMARY This bill requires a health care practitioner or health care provider who provides health care services or health treatment to a minor without the consent of that minor's parent or guardian to file a report containing specified information with the Department of Health and Human Services."  

\textsuperscript{133} See General Medical Council Guidelines (England); Paragraphs 23 and 24, General Medical Council: Seeking Patient’s Consent: The Ethical Considerations (London: General Medical Council, 1998); Gillick v West Norfolk and Wisbech Area Health Authority & Anr. [1984] 1 Q.B. 581; and National VCT Guidelines, 2001 (Kenya)

\textsuperscript{134} Bhutan National Strategic Plan for the Prevention and Control of STIs and HIV/AIDS 2012 – 2016, National STIs and HIV/AIDS Control Programme, Department of Health, Ministry of Health, Royal Government of Bhutan
Sexuality Education
The Global Commission on HIV and the Law points out that “age-appropriate comprehensive sex education, including information on HIV prevention, serves the health of young people. Studies show that such programmes result in more frequent condom use, fewer sexual partners and significantly reduced sexual risk-taking. No studies find that sex education leads to earlier, riskier or more prolific sexual activity.” 135

Several national policies address the needs and requirements of children and young persons in Bhutan including the National Youth Policy and various education policies. School enrolment is high in Bhutan and a life skills programme that includes sex education and information about HIV has been in place for over a decade. Bhutan has had a long-term commitment to life skills education in educational institutions led by Her Majesty, the Queen Mother. The aim of the programme is to provide life skills education and information on HIV, gender-based violence, and teenage pregnancy. Importantly the HIV-related education and information is also extended to monasteries and nunneries and the Dratshang Lhentshog is also involved in disseminating and educating on HIV, safety, prevention and compassion.

Children and Young People in Conflict with the Law
A significant number of young people, primarily those using drugs, come in contact with the criminal justice system of Bhutan. According to NSP2, there are 35 juvenile convicts in Bhutan’s prisons; their access to HIV/STI information and services is unclear. YDF runs a rehabilitation centre and another is being opened for young people who use drugs. However, it appears that that young people are often detained in jails with adult prisoners. As pointed out earlier, after release or rehabilitation, their access to schools, to psychosocial support (to deal with, inter alia, high levels of self-stigma among young people who use drugs), or to employment opportunities is severely limited.

8.3 Laws and Policies
(Note: Laws and Policies related to discrimination, consent and confidentiality are described in the section on people living with HIV above; legal issues related to drug use are also described above and this section should be read in conjunction with these sections in the context of children and young people.)

Bhutan is a signatory to the CRC. 136 The CRC recognises the right of every child to family, education, health services, participation in decision making, freedom of expression, freedom of association and the right against exploitation, trafficking and torture. General Comment 3 interprets and applies the CRC in the context of HIV, noting that “HIV/AIDS impacts so heavily on the lives of all children that it affects all their rights – civil, political, economic, social and cultural.” 137

136 Other important documents include The Paris Declaration on Women and Children and the Acquired Immunodeficiency Syndrome (AIDS), November 1989; The Agenda item 19 of the Forty-Third World Health Assembly, Vienna, May 1990; UNGASS Declaration of Commitment and International Guidelines on HIV/AIDS and Human Rights.
The Constitution of Bhutan recognises the duties of the State and of individuals towards children. Under Article 9(16), "the State shall provide free education to all children of school going age up to tenth standard and ensure that technical and professional education is made generally available and that higher education is equally accessible to all on the basis of merit." Further, "the State shall endeavour to take appropriate measures to ensure that children are protected against all forms of discrimination and exploitation including trafficking, prostitution, abuse, violence, degrading treatment and economic exploitation." Read together, these Constitutional provisions form the basis of the obligation of the State to provide appropriate HIV-related health- and sexuality-related information and services to children in Bhutan.

Bhutan has a number of child related legislations and legal provisions. Of these, the 2011 Child Care and Protection Act, is among the most important in terms of HIV. The Act aims to "to consolidate and provide care, protection, guidance, counselling, treatment, development, rehabilitation, adjudication and disposition of matters relating to children in conflict with law in the most favourable manner and in the best interest of the child." The Act enshrines various rights of children (those below 18 years) including privacy, care and protection from the State. The Act incorporates a community-based and "de-criminalisation" approach to young people in conflict with the law, adopting the principle of diverting the child from the criminal justice system and for separate detention facilities. This is particularly apposite in the context of minors who use drugs. Specific to HIV, the Act requires that authorities arrange for counseling on health, substance abuse, HIV/AIDS, life skills and behavioral education, and other related topics. The extent to which these provisions of the law are being implemented is unclear.

The Penal Code specifies the age of 18 as the age of consent for sex though consensual sex between the ages of 16 and 18 is not considered to be rape. Interestingly, the issue of the age of consent for sex has been raised in the National Youth Policy, which includes in its priority interventions, to "review the laws in regard to statutory rape for young people under the age of 18 when sex is consensual," and "establish an age for sexual consent."

Children, youth and adolescents are a primary focus of NSP2. According to NSP2, a "Children Affected By AIDS Technical Coordination Committee" was formed to develop the Bhutan Children Affected By AIDS Programme Framework, based on the SAARC Regional Strategic Framework for the Protection, Care and Support for Children Affected by AIDS. NSP2 also recognises the need to adopt a universal approach to ensure that children affected by AIDS have access to the same public and social support systems available to other children, rather than being separated or singled out, and to assess and develop practical support mechanisms for the psychological needs of children living with HIV and their families. NSP2 proposes to conduct a mapping exercise to collect data on age, socio-economic status, location and access to schools and social protection services of children affected by AIDS.

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138 Article 8 includes in Fundamental Duties that, "A person shall not tolerate or participate in acts of injury, torture or killing of another person, terrorism, abuse of women, children or any other person and shall take necessary steps to prevent such acts."
Bhutan’s life skills programme in schools which includes comprehensive sex education is a positive and progressive approach, particularly in the South Asian context. According to NSP2, there are some gaps in the implementation of this programme. Thus, "parents and teachers hold the wrong notion that SRH information encourages youth sexual behaviour; judgmental attitudes on youth sexuality; inadequate teaching abilities and self-confidence; misunderstanding of basic concepts of life skills education; school-based life skills education is not delivered through a compulsory channel (‘stand alone subject). The life skills ‘Guide book for teachers’ (MOR-MOH 2006) is not widely used; no M&E to keep track of the quality/frequency of life skills education/SRH life skills education; no strategy and few interventions to reach out-of-school youth (DYS, 2010); no SRH education role for the private sector: pharmacies, pool halls, bars frequented by out-of-school youth (CGPH, 2010); scarce involvement of in-/out-of-school youth in planning, and implementing interventions intended for them."

Aware of these shortcomings, stakeholders are making attempts to improve the training and capacities of teachers to deliver the programme. Although the curriculum does have a section relating to the Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) community, this is seldom addressed or taught. This gains greater significance given the findings of a Study quoted in the NSP that reveal same sex sexual activity among the youth. Given the approach to the programme, it is likely that young LGBTQ people have inadequate access to accurate and appropriate sex education and information.

8.4 Recommendations
(Note: Recommendations on laws and policies related to discrimination, consent and confidentiality are described above and should be read to apply to children and young people.)

a. Legal Protections for children and young persons in the context of HIV should be operationalised including:
   i. The approach of the Child Protection & Protection Act of decriminalization for children in conflict with the law requires operationalization particularly for young people who use drugs going.
   ii. Separate incarceration facilities for detention and imprisonment for young people are required.
   iii. Through community consultation, the manner in which the Child Care and Protection Act can support children living with HIV should be examined and implemented.
   iv. Greater institutional support and coordination between child protection mechanisms and law enforcement should be considered, particularly to ensure protection for children in conflict with the law.

b. HIV related health services and programmes should be designed and implemented with a view to ensure access to children and young people including:
   i. Child friendly health and HIV services that go beyond life skills, HIV awareness and sex education should be implemented to ensure access to health
services including voluntary and confidential testing and treatment for children and young persons.

ii. Laws protecting healthcare providers from legal or disciplinary actions who act in good faith to provide healthcare services to children and young persons, particularly in relation to HIV services and for children and young persons from key affected populations should be considered and introduced.

iii. HIV and health services aimed at young people who are part of key populations (men who have sex with men, transgender people, people who use drugs) should be introduced and greater consideration should be given to the teaching of the life skills module as it relates to LGBTQ youth.
9. CROSS-CUTTING THEMES: ACCESS TO TREATMENT

9.1 Context
Of the approximately 1000 people living with HIV in Bhutan, 167 are currently on antiretroviral (ARV) treatment. 139 Bhutan procures generic ARVs for the national programme from India and 80% of the cost of treatment is borne through domestic funding (through the Bhutan Health Trust Fund). ART is provided free of cost and while most people living with HIV on treatment in Bhutan are on 1st line treatment, a few are also on 2nd line regimens. Bhutan will start distributing three-in-one fixed dose combination ARVs for 1st line treatment in 2016. ART is available and dispensed at the local level through Basic Health Units. For co-infections, although the government provides treatment free of cost, these can be delayed by a few weeks and at times people living with HIV have had to procure them at their own cost.

9.2 Issues
Access to medicines is considered integral to the right to the highest attainable standard of health. 140 In the case of HIV, as the Global Commission on HIV and the Law reports, "antiretroviral drugs and other medicines to counteract the effects of HIV and its co-infections make the difference between health and illness, productive life and early death." 141 However, when ART was first introduced its prohibitive pricing kept it out of the reach of the developing world; at the best discount of USD 10,439 per person per year, few governments could afford to provide ART to their citizens. 142 Today nearly 17 million people living with HIV across the world are on treatment; this was made possible by, among other things, the dramatic price reductions in costs of ART treatment brought about by generic competition. Generic companies in Brazil, Thailand and India were able to manufacture these medicines at a fraction of the prices available in developed countries because there were no product patents on medicines in these countries at the time.

Today, however, generic competition has become increasingly restricted. First line ART has been successfully scaled up across the globe. Yet, 2nd and 3rd line treatment for HIV and for co-infections like hepatitis C and drug resistant TB, remains out of reach in many developing countries. This has happened, in large part, as a result of the implementation of the World Trade Organisation’s (WTO) Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) in the developing world. The TRIPS Agreement requires WTO to members to grant 20-year product and process patents in all areas of technology including pharmaceuticals. With these exclusive rights, patents holders can prevent or severely restrict the production, supply and import of affordable generic medicines. For WTO members who are developing countries, sustaining access to ART and other treatment after 2005 (which was their deadline for complying with TRIPS), has been dependent on the use of public health safeguards. Also referred to as TRIPS ‘flexibilities’, the right of all countries

139 Country Progress Report on the HIV Response in Bhutan, 2015, National AIDS Control Programme, Department of Public Health Ministry of Health
to use these safeguards was reiterated in the *Doha Declaration on TRIPS and Public Health* (Doha Declaration) in 2001 which stated that “the (TRIPS) Agreement can and should be interpreted and implemented in a manner supportive of WTO Members’ right to protect public health and, in particular, to promote access to medicines for all.”143

The importance of the use of these provisions has also been underscored in the SDGs, which explicitly recognize the link between treatment access and the use of TRIPS flexibilities: “...[s]upport the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all.”144

Accordingly Malaysia, Indonesia, Thailand, Brazil and India have issued compulsory licenses on medicines while India, Argentina and the Philippines have adopted strict patent criteria that restrict the grant of patents on new forms and new uses of existing medicines.145 Thus, the legal environment in a country and how it implements intellectual property (IP) laws can have a direct impact on whether, how and if access to affordable medicines is possible either through local production or imports. For developing and least developed countries (LDC), UN agencies working on development and health as well as other international agencies and experts are unanimous in their recommendations that these countries preserve and use to the maximum, policy space within international commitments to ensure access to affordable generic medicines and ensure that patents do not create barriers in this regard.146

LDCs enjoy the maximum policy space within the WTO and TRIPS framework.147 At present, LDCs in the WTO enjoy two transition periods i.e. till 2021 to comply with TRIPS and till 2033 to grant or enforce pharmaceutical patents and data protection requirements. In 2007, the United Nations Conference on Trade and Development’s annual LDC Report which focused on knowledge, technological learning and innovation for development found that LDCs in the WTO agreed to align “their IP legislation with the legislation of the major industrial economies in the hope that greater intellectual property protection would lead to

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144 See SDG 3.b, United Nations General Assembly. 25 September 2015. Transforming our world: the 2030 Agenda for Sustainable Development. A/RES/70/1
more innovation and increased technology transfer. However, the expectation that this would yield higher rates of technology transfer, FDI and innovation has not been met. Accordingly at their stage of development, the report recommends that LDCs pursue open source rather than proprietary IP-based models of knowledge governance and make full use of the policy space within TRIPS including parallel imports, compulsory licenses, exceptions and limitations.

LDCs can lose this policy space by taking on restrictions on their use of public health safeguards, which can come through WTO accession negotiations or through free trade agreements negotiated outside the WTO. Developing countries are advised not to take on TRIPS-plus measures that limit their ability to make full use of TRIPS flexibilities. Cambodia’s accession to the WTO was marked by outrage from public health groups over questions regarding whether the country had been pressured into committing to full TRIPS compliance by 2007, thereby foregoing the transition period and undertaking TRIPS-plus obligations on data protection. Although the WTO Deputy Director-General clarified that Cambodia’s "terms of this accession do not preclude access to the benefits under the Doha Declaration on the TRIPS Agreement and Public Health to Cambodia as a (least-developed country)," LDC accessions since then continue to feature restrictions on transition periods, TRIPS-plus obligations as well as no roll-back commitments. This is contrary to their rights within the WTO and detrimental to their ability to take actions to protect public health from the impact of patents on medicines.

Bhutan is in an unusual position as compared to most other developing countries and LDCs as it is not yet a WTO member and therefore not a signatory to the TRIPS Agreement. Bhutan is presently among 48 countries featured on the UN’s list of LDCs. In 2015, Bhutan met the eligibility criteria for LDC graduation for the first time and according to UN rules, if it does so again in 2018, it could be recommended for graduation.

As an LDC, Bhutan continues to receive international funding though there has been a noticeable decrease in such health-related funding in recent years; external financing of health has dropped from around 28% in 1996 to about 12% in 2012. Although the Global Fund for AIDS, TB and Malaria continues to support Bhutan, with national GDP increasing, this may not be the case in the near future.

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151 WTO. 11 September 2003. Day 2: Cambodia and Nepal membership sealed as ministers start negotiations. Summary: [https://www.wto.org/english/thewto_e/minist_e/min03_e/min03_11sept_e.htm](https://www.wto.org/english/thewto_e/minist_e/min03_e/min03_11sept_e.htm)
152 2015 triennial review, UN Office Of The High Representative For The Least Developed Countries, Landlocked Developing Countries And Small Island Developing States: [http://unohrlls.org/about-ldcfs/criteria-for-ldcfs/](http://unohrlls.org/about-ldcfs/criteria-for-ldcfs/)
In terms of access to ARVs, as an LDC Bhutan is included in voluntary licenses given by multinational companies to Indian generic companies for the supply of ARVs and for treatment for hepatitis C. However, as Bhutan moves to higher income categories, its access to price discounts and generic medicines through voluntary licenses is likely to be impeded. This concern extends beyond HIV and communicable diseases, with LDCs already facing significant health burdens related to such diseases, and likely to bear the brunt of non-communicable diseases including cancer whose incidence is likely "to rise 82% in 2030 in low-income countries compared to 58 percent in upper-middle and 40 percent in high-income countries."\textsuperscript{154} LDCs and developing countries already account for "over 80% of cardiovascular and diabetes deaths."\textsuperscript{155} While still grappling with infectious diseases, Bhutan is also facing a similar increase in the prevalence of non-communicable diseases, which are expensive to treat.\textsuperscript{156}

9.3 Laws and Policies
Bhutan acceded to the Paris Convention for the Protection of Intellectual Property in 2000 but is not a member of the WTO and has been in negotiations to join the WTO since 1999. As it is yet to join the WTO, Bhutan has far greater policy space than even the LDCs within the WTO framework and enjoys considerable freedom to design its IP system and even decide, as several developing countries have in the past, not to have any or have extremely limited product patent protection in the pharmaceutical sector and in other sensitive sectors. While patent protection can have the most direct impact in restricting the ability of Bhutan to produce or import generic medicines, other forms of IP can also be of concern and should be subject to safeguards, exceptions and limitations. The registration of trademarks for medicines that use non-proprietary names can create barriers for generic medicines while extensive copyright protection can impact access to knowledge including affordable educational books or scientific literature.\textsuperscript{157}

Bhutan has trade agreements with India, Bangladesh and Thailand and is party to the Agreement on South Asian Free Trade Area (SAFTA); none of these trade agreements include issues related to IP. Bhutan is also party to the ongoing Bay of Bengal Initiative for Multi-Sectoral Technical and Economic Cooperation negotiations, which also does not feature IP issues.

Bhutan introduced an Industrial Property Act in 2001, which became operational in 2012. As Bhutan is yet to join the WTO, at present its international obligations relating to IP arise from the Paris Convention. Not being a member of the WTO, however, there was no obligation on Bhutan to introduce intellectual property protection at the level required by

\textsuperscript{154} WTO. 23 February 2015. Request For An Extension Of The Transitional Period Under Article 66.1 Of The Trips Agreement For Least Developed Country Members With Respect To Pharmaceutical Products And For Waivers From The Obligation Of Articles 70.8 And 70.9 Of The Trips Agreement. Communication From Bangladesh On Behalf Of The LDC Group. IP/C/W/605


the TRIPS Agreement. The law covers all forms of IP including patents. Almost 10 years were spent in building technical expertise, developing infrastructure, and putting in place standard operating procedures and for other preparation.

Bhutan’s IP law includes provisions similar to those required by the TRIPS Agreement including patent protection of 20 years for products and processes even though it is not required to do so. The law also does not contain the full range of critical public health safeguards that are available even to WTO members and that, as advised by the UN Special Rapporteur on the Right to Health, should be fully incorporated and implemented in the patent laws of LDCs.\(^{158}\) This includes an international exhaustion regime for parallel imports that would allow Bhutan to import lower priced patented products from anywhere in the world. The law also does not feature the full extent of the flexibilities available even to WTO members in the issuance of compulsory licenses. For instance, Article 31 of the TRIPS Agreement waives the requirement for prior negotiations with a patent holder in situations of national emergency, extreme urgency and public non-commercial use. The Bhutan law, however, waives this requirement only for cases of national emergency and extreme urgency. The patent laws of other countries also list a greater number of grounds for issuing compulsory licenses including where the patented product is not affordable or available. Developing countries have also adopted strict patentability criteria and strict examination processes including allowing pre and post grant patent oppositions to ensure that only genuine inventions are granted patents. Bhutan’s patent law does not exempt pharmaceuticals from patents and data protection although this flexibility is available to those LDCs who are part of the WTO.

At the stage of economic development that Bhutan is as an LDC, overly strict IP protection that favours inventors can create barriers for the protection of public health or even for technological advancement. For instance, removal of patent barriers has been shown to support LDCs in achieving local production capacities. UNAIDS and UNDP note that “…without the requirement of providing intellectual property protections, LDCs are free to follow the historic path of copying and adaptation to develop their technological capacities, at the same time strengthening their human, administrative, financial and other capacities…”\(^{159}\)

The Bhutan patent office has already started receiving patent applications and has a total of 30 pending applications. As the patent office does not have patent examination capacity, these patent applications have been referred to the World Intellectual Property Organisation for assistance. Bhutan is also considering introducing a system of petty patents or utility model patents for local inventors. These will not be available to foreign applicants. The Bhutan patent office appears to be aware of the concerns related to patents on pharmaceuticals. At present, a proposal for amendments to include certain public health safeguards is under consideration of the cabinet.

\(^{158}\) Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (Right to health in the context of access to medicines and intellectual property rights), A/HRC/11/12, 31 March 2009, available at http://www2.ohchr.org/english/bodies/hrcouncil/docs/11session/AHRC.11.12_en.pdf

9.4 **Recommendations**

a. Law reform and review of the industrial protection law, particularly as it relates to patent should be considered from the perspective of making full use of the rights of Bhutan as a country outside the WTO and as a least developed country to tailor its intellectual property regime to suit its socio-economic and industrial policy needs. This could include having no patent protection in the pharmaceutical and other sensitive sectors and having intellectual property protection that is far below what is required by TRIPS. Even least developed countries who are WTO members have till 2021 to implement TRIPS in terms of all forms of intellectual property protection and are not required to grant or enforce pharmaceutical patents and data protection till 2033.

b. A review of the patent law should incorporate the full range of public health safeguards/TRIPS flexibilities. The experience of developing countries has shown that these safeguards and their effective use evolve over time with State practice and least developed countries should examine and benefit from the experience of developing countries.

c. In reviewing its patent laws and policies, Bhutan should seek pro-development and pro-public health technical assistance that is specifically tailored to its socio-economic needs, that prioritizes public health and access to medicines and is in public interest.

d. Apart from incorporating public health safeguards in the IP law, it is important to ensure that these safeguards are fully implemented and used. Experience shows that full and consistent use of all the flexibilities by governments and public interest groups may be key to ensuring that local production, imports and access to medicines are not impeded by compliance with the TRIPS Agreement. Incorporating health safeguards in patent laws will only be the first step for Bhutan and the administrative set up relating to intellectual property should consider the use of the public health safeguards as integral to the functioning of the intellectual property regime and institutional, financial, human and technical resources should be accordingly allocated.

e. TRIPS-plus requirements in WTO accession or free trade agreement negotiations should not be accepted. Least developed countries negotiating to get into the WTO in the past have had to concede to intellectual property obligations far in excess of the TRIPS Agreement. Bhutan should ensure that they enjoy the same rights to the transition period and resist any requirements for early compliance with the TRIPS Agreement or to undertake TRIPS-plus obligations either at the WTO or in any future free trade agreement negotiations.
10. CROSS-CUTTING THEMES: ACCESS TO JUSTICE

10.1 Context
However robust the substantive legal framework a country provides its people, the law in the books has little meaning in people’s lives unless it is backed by a system of (and resources for) enforceability when rights are violated, duties not fulfilled or if the law is transgressed. Access to justice includes a variety of aspects: the ability of a person to approach the courts, or dispute redress mechanisms through representation (legal aid), and fora which are easily accessible, a system of justice that is affordable (including free legal aid for indigent people) and prompt, and continuous and ongoing training on the relevant issues (in this case HIV, law and rights) for the various actors involved in the law and justice system – prosecutors, civil lawyers practicing at the bar, all levels of the judiciary, local authorities who dispense justice through alternative resolution mechanisms, and legal literacy for the general public (and in the HIV context, people living with and affected by HIV).

Bhutan is a non-litigious society, where settlement of disputes has traditionally taken place outside the formal court system. Mediation and conciliation have occurred over centuries through the guidance provided by village elders. Bhutan has had traditional informal systems of dispute resolution at local levels, and a legal framework has been established recently under the Alternative Dispute Resolution Act, 2013. The Bhutan National Legal Institute (BNLI) takes the lead role in training judicial personnel, and promoting access to justice by training local leaders like bangmis in mediation skills in relation to local issues.

The BNLI also conducts trainings for prosecutors to enhance their skills in drafting charge sheets, and in being familiar with rules of evidence and investigation. Further, the BNLI has also taken the initiative to disseminate knowledge of the law to people at local levels, particularly in relation to marriage, land inheritance, children, domestic violence, and adoption. School Law Clubs are encouraged to promote constitutional values, and are made to understand the principles of mediation and informal methods of dispute resolution in case they occur. A recent Assessment and Strengthening of Legal Awareness Raising Initiatives with Youth undertaken by BNLI in partnership with UNDP, suggests initiatives for BNLI to take up with Lhak-Sam, which include development of HIV & the law materials, and workshops on legal issues related to HIV.

In order to ensure speedy justice, the courts in Bhutan are not allowed to reserve judgment, and cases are not supposed to be pending for more than a year. A bench of the High Court is likely to be set up in order to ensure speedy justice in matrimonial and child-related matters.

10.2 Issues, Laws & Policies
Legal representation and legal aid for litigants remain a challenge in Bhutan. Although there are lawyers in private practice, there are very few to act as defense lawyers in criminal cases,

which is apposite to the needs of those criminalized under laws in Bhutan who are vulnerable to HIV, as discussed earlier. The Jabmi Act, 2003, which prescribed functions of the Jabmi Tshogdey to include organizing of free legal aid to indigent people.\textsuperscript{163} Presently, the Office of the Attorney General is to undertake the development of a Legal Aid Action Plan, supported by UNDP.\textsuperscript{164}

Article 9(6) of the Constitution, a Principle of State Policy provides that, “The State shall endeavour to provide legal aid to secure justice, which shall not be denied to any person by reason of economic or other disabilities.” Yet, this is a weak link in Bhutan’s legal system that can be enhanced. An opportunity to do so is now available in the form of the new Jigme Singye Wangchuk School of Law.

Further, in the context of people living with HIV and related stigmatized contexts such as sex work, drug use or for transgender people or men who have sex men, many potential litigants are deterred from approaching the courts since their identity would be revealed through the court documentation and proceedings. However, procedural innovations do exist that facilitate such persons in accessing justice. Suppression of Identity orders can be obtained from the court prior to any hearing of the case, so that all parties are anonymized in the case and court records. This has been done frequently in HIV-related cases in India such as MX v ZY,\textsuperscript{165} Mr. X v Hospital Z\textsuperscript{166} etc.

10.3 Recommendations
a. In order to ensure delivery of justice, particularly to indigent persons, a robust legal aid mechanism should be created, which will also serve the needs of those seeking judicial redress in the HIV context. An opportunity to do so for the future is available through lawyers graduating from the Jigme Singye Wangchuk School of Law.

b. Training on HIV and the vast array of legal issues that arise in its context can be made part of the training efforts of the BNLJ, including for the judiciary, and for defense lawyers to competently serve the criminal justice system.

c. Judicial & legislative capacity-building on HIV and the law can be undertaken through the participation of experts including judicial peers.\textsuperscript{167}

d. Suppression of Identity orders, which facilitate access to justice should be issued by the courts in HIV-related cases before them. Legislating such special procedures may be worth considering in the context of health issues generally, in relation to the proposed National Health Bill.

\textsuperscript{163} Section 9(g), Jabmi Act, 2003
\textsuperscript{164} UNDP’s Final Progress Report to the Austrian Development Agency, 2015
\textsuperscript{165} [1998] 8 SCC 296
\textsuperscript{166} AIR 1997 Bom 406
\textsuperscript{167} As was done in India by Lawyers Collective HIV/AIDS Unit over several years. The Hon. Michael Kirby, formerly judge of the High Court of Australia, and Justice Edwin Cameron of the Constitutional Court of South Africa, both international experts in the field of HIV and law made regular trips to India to do numerous workshops/ symposia with judges of High Courts and the Supreme Court. An example of The Hon. Michael Kirby’s speech at the first such meeting is available at http://www.michaelkirby.com.au/images/stories/speeches/1990s/vol43/1999/1552-Courts_and_Judges_in_the_Era_of_HIV-AIDS_(Introduction_to_Workshop).pdf

83
e. Ongoing community legal literacy efforts can include legal and know-your-rights issues related to health generally, and HIV specifically, and also in conjunction with raising HIV-related awareness.
11. CROSS-CUTTING THEMES: ACCESS TO INFORMATION

11.1 Context
In relation to HIV, dissemination of accurate, evidence-based, non-prejudicial, gender-sensitive information is critically important in order to empower the general public, and people living with and affected by HIV with knowledge on HIV-related prevention, care and treatment, and related information, and to encourage health-seeking behaviour. Issues on sexual health and HIV information needed for children in the context of life skills education have been described earlier. Efforts are underway to educate people with critical HIV-related information through teachers’ training colleges, and engagement with monasteries, and nunneries as influential messengers. (As mentioned earlier, Dratshang Lhentshog is also involved in disseminating information, educating people and relaying values of compassion in the context of HIV.) As stated above, in relation to human rights and law, the ongoing efforts at community legal and know-your-rights literacy can include issues related to health generally, and HIV specifically, in conjunction with HIV-related awareness raising.

11.2 Issues, Laws & Policies
The Constitution of Bhutan guarantees the Bhutanese citizen with the right to information. This is a particularly important right as it is the basis on which critical HIV-related education, information and communication can be disseminated, which is outside the pale of obscenity law. In relation to computer pornography, the Penal Code proscribes the publication and distribution of “an obscene photograph or picture on the computer or over the internet”. Obscenity law has not and should not be used as a justification to restrict the communication of vital sexual health and HIV information under reasonable restrictions provided by the Constitution.

In the context of access to information, as mentioned earlier, Bhutan’s media is governed by the Code of Ethics for Journalists under the BICM Act. Clause 6.7 of the code on “Respect for Privacy and Human Dignity” prohibits a journalist from violating the privacy of any person including the person’s health unless “it can clearly and objectively be demonstrated that there was an overriding public interest” in breaching the privacy. Privacy itself is a protected right under the Constitution.

11.3 Recommendations
a. Media Guidelines have been developed in relation to reporting on women and children. Similar guidelines should be developed to report on HIV and related issues of sexuality, sexual health and marginalization, which should include the requirement to be non-stigmatizing, gender-sensitive, evidence-based and non-prejudicial, and protection of privacy.

168 Article 7 (3), Constitution of Bhutan
169 Section 476, Penal Code
170 Article 7(22), Constitution of Bhutan
173 Article 7(19), Constitution of Bhutan
b. The right to information should be actualized through sensitization and capacity-building of the multiple stakeholders who are involved in the HIV response on HIV and related issues of sexuality, sexual health and marginalization. These include the police, health workers, and the media.
CONCLUSION

Although this Legal Environment Assessment contains recommendations, which provide a conclusion to the process that was undertaken, certain broader themes are worth noting to support Bhutan’s rights-based commitment to dealing with HIV, and also in relation to its commitments to inclusive and humane national growth and development and the aspiration toward Gross National Happiness.

HIV has caused much pain and upheaval in the lives of individuals, families, communities and societies. Yet, its presence has also created an opportunity for people, and societies to look within at the prejudices, inequalities and inequities that exist, confront many marginalizations that were hitherto hidden, and make honest attempts at alleviating these vulnerabilities and aspiring to a fairer and more compassionate social compact.

HIV has exposed weaknesses in health systems, and rights-based HIV responses should ideally attempt to address these infirmities by strengthening flaws, and investing human and financial resources in more strategic, effective ways that strengthen the HIV response as well as the broader health system.

In line with this approach of using the HIV response as an opportunity, the Legal Environment Assessment process and report should prompt a process of broader review of health-related laws, and anti-discrimination legal measures for the marginalized. Apart from the recommendations contained in this assessment, these could include opportunities that inform the proposed National Health Bill, review of the Medical Council Act and related Regulations, discussions in the legislature on law reform in relation to sexual orientation and gender identity, and the National Law Review Task Force being chaired by the Office of the Attorney General.

The new Jigme Singye Wangchuk School of Law provides an opportunity to offer studies in health law and policy, which are informed by the evolution of legal responses to the HIV epidemic globally. Finally, as part of the family of nations, Bhutan’s commitment to human rights and the advancement of all its people can only be enhanced by its ratification of the key human rights treaties that form the bedrock of the world’s commitment to human rights – the International Covenant on Civil and Political Rights and the International Covenant on Economic Social and Cultural Rights. It particularly befits a society that has set an example to the world of a more humane way of measuring national, community and human development.
References


12. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (Right to health in the context of access to medicines and intellectual property rights), A/HRC/11/12, 31 March 2009: http://www2.ohchr.org/english/bodies/hrcouncil/docs/11session/A.HRC.11.12_en.pdf


15. UNAIDS and UNDP, Criminalisation of HIV Transmission, Policy Brief, 2008


**ANNEXURE A**

List of stakeholders and experts consulted

<table>
<thead>
<tr>
<th>Sl.no.</th>
<th>Date</th>
<th>Name</th>
<th>Organisation</th>
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<tr>
<td>1</td>
<td>23rd May, 2016</td>
<td>National Task Team (NTT)</td>
<td>NTT</td>
<td>Mr. Sonam Penjore, Officiating Director</td>
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<td></td>
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<td>NCWC</td>
<td>Dasho Pelzang Wangchuk, Lyonpo Dorji Wangdi and Dasho Kinley Om (also deputy chair legislative Committee)</td>
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<td></td>
<td></td>
<td>Chair</td>
<td>Human Rights Committee NA</td>
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<td>2</td>
<td>24th May, 2016</td>
<td>Chief Justice</td>
<td>Royal Court of Justice</td>
<td>Dasho Lungten Dubgyur, Justice, Royal Court of Justice, High Court</td>
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<td>YDF</td>
<td>Ms. Tshering Cheki, Counsellor</td>
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<td>Chair</td>
<td>Women, Children &amp; Youth Committee NA</td>
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<td></td>
<td></td>
<td>Executive Director</td>
<td>Office of Attorney General</td>
<td>Namgay Dorji, Sr. Attorney, Legal Service Division</td>
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<td>3</td>
<td>25th May, 2016</td>
<td>Executive Director</td>
<td>RENEW</td>
<td>Dr. Meenakshi Rai, Director, Community Outreach Department and Ms. Gaki Yangzom, Legal Officer</td>
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<td>Wangda Dorji, Executive Director, Lhak-Sam, 17854195</td>
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<td>Executive Director</td>
<td>Lhak-Sam (NHAC member)</td>
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<td>Khesar Gyalpo University of Medical Sciences</td>
<td>Dr. Tashi Tobgay, Director, Human Resources Division, 17614894, Confirmed</td>
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<td>4</td>
<td>26th May, 2016</td>
<td>Director General</td>
<td>Bhutan Narcotics Control Agency</td>
<td>Mr. Phuntsho Wangdi, Director General</td>
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<td></td>
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<td>Mr. Dawa Penjor, Executive Director</td>
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<td></td>
<td>Director</td>
<td>Bhutan Media Foundation</td>
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<td>Mr. Tshewang Tenzin, Executive Director</td>
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<td></td>
<td>Chithuen Phendey Association</td>
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<td>Major Tsheten Norbu, Staff Officer to additional Chief of Police</td>
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<td>5</td>
<td>27th May, 2016</td>
<td>Sr. Counsellor</td>
<td>HISC, Thimphu</td>
<td>Mr. Ngawang Choida, Sr. Counsellor, HISC</td>
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<td></td>
<td>IP Officer</td>
<td>Ministry of Economic Affairs</td>
<td>Met Mr. Kencho Palden, Intellectual Property Officer</td>
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<td></td>
<td>Director</td>
<td>Bhutan National Legal Institute</td>
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<td>6</td>
<td><strong>30th May, 2016</strong></td>
<td>RBP, Phuntsholing</td>
<td>Dasho Wangchuk la Superintendent of Police, Major Nima Tshering, OC and Lieutenant T. Palden.</td>
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<td></td>
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<td>HISC, Phuntsholing</td>
<td>Ms. Karma Choden, Sr. Counsellor, HISC, Dorji Zangmo Outreach Worker and Ms. Karma Dema Outreach worker.</td>
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<td></td>
<td>DIC, BNCA, Phuntsholing</td>
<td>Ms. Pema Cheiki, Sr. Counsellor, DIC, BNCA</td>
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<td></td>
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<td>Dungkhag Court, Phuntsholing</td>
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<td>7</td>
<td><strong>1st June, 2016</strong></td>
<td>UN Women</td>
<td>Ms. Rinzin Pem, National Coordinator</td>
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<td>Dr. Ruben Del Prado, UNAIDS Country Director for Bhutan and Nepal</td>
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<td>UNFPA</td>
<td>Mr. Yeshey Dorji, Assistant Resident Representative for UNFPA</td>
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<td></td>
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<td>Dratshang Lhentshog</td>
<td>Dasho Karma Wangchuk Penjor, Secretary</td>
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<td></td>
<td>GNHC</td>
<td>Mr. Sherab Gyeltshen, Health Focal GNHC</td>
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# ANNEXURE B

## National Task Team

<table>
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<tr>
<th>Si.No</th>
<th>Name of Officials</th>
<th>Designation</th>
<th>Office</th>
<th>Contact No</th>
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ANNEXURE C

Agenda for 1st National Task Team Meeting, 23 May 2016

10.00 – 10.15 am Welcome to NTT members (by NACP), round of introductions

10.15 – 10.45 am Background of Process/ Assignment/ HIV in Bhutan (by NACP/UNDP)

10.45 – 11.00 am Role of NTT – discussion, clarifications (by NACP)

11.00 – 11.15 am Presentation on HIV and the Law (by expert consultants)

11.15 – 11.45 am Presentation of Inception Plan (by expert consultants)

11.45 am – 12.30 pm Discussion moderated (by NACP)

12.30 – 12.45 pm Explanation of Future Process (by NACP)

12.45 – 1.00 pm Wrap Up
Day 1: Thursday, June 9th, 2016
Time: 2:30 - 6:30 pm

Agenda 1: Welcome Address
Mr. Chador Wangdi, Program officer, National AIDS Control Programme (NACP), Ministry of Health (MoH) opened the workshop and welcomed the Honorable Secretary, Ministry of Health, UNDP policy advisor, implementing partners and all other national stakeholders to the national stakeholders consultation workshop. Mr. Chador, on behalf of the NACP, thanked the two international experts and UNDP country office and the UNDP Bangkok Regional Hub for their support and hard work in mobilizing the technical assistance. Mr. Chador, then informed the participants on the overall methodology of the workshop and objective of the legal environment assessment. Following objectives of the assessment were stated during the welcome address:

- To identify and examine all important legal and human rights issues affecting all people in the country in the context of HIV.
- To develop a costed action plan based on the recommendation of the assessment.

Ending the welcome address with the objective, Mr. Chador requested the participant to briefly introduce themselves with designation and organization.

Agenda 2: Keynote Address
Following a round of introduction by the participants, Dr. Dorji Wangchuk, the Honorable Secretary, Ministry of Health delivered the keynote address. Welcoming the participants from various national, international and multilateral organizations Dr. Dorji Wangchuk highlighted the importance of the workshop to inform the national program on future strategies and the need for evidence based programming. The Honorable Secretary also reiterated the need to contextualize the issue to Bhutan and encouraged the participant to discuss any issues in light of the Bhutanese cultural, social and legal frameworks. Dr. Dorji Wangchuk also, requested the participant to be open in discussing the challenges and drafting the way forward. Prior to passing the floor to the international experts for presentation on assessment, Dr. Dorji Wangchuk delivered the following key messages:

- The vital role of CSO such as Lhak-Sam in delivering care and support to the PLHIV in Bhutan must be supported.
- Building partnership with various government agencies, CSO, community, and multilateral partners to achieve the NASP goals.
- Preventing the transmission of HIV must be the primary objective of any policy or programmatic interventions.
- The critical role of LGBT community must be acknowledged in reaching the hidden population for HIV prevention amongst the MARPS.
- Services to LGBT community must be strengthened and efforts must be made to remove fears through legislative amendment to improve access to services.
Empirical evidence must be built on barrier (punitive laws, social and cultural barrier and S&D) to access health services for key population.

Programmatically, late case detection resulting in higher mortality must be reviewed.

National Program is working towards "treatment as prevention", but cost and reach of the program must be addressed prior to rolling out the interventions.

Given that the programs are currently funded by the GF the need to plan transition is an important planning for the NACP and MOH.

Agenda 3: HIV in Bhutan

Mr. Chador Wangdi, presented the epidemiological overview of the HIV/AIDS epidemic and the overall national response to the HIV epidemic in Bhutan. In his address, he highlighted the strong political leadership for HIV/AIDS prevention in the country. He informed the forum that the Royal Decree (Royal Kasho May 2004) from His Majesty the Fourth and the Fifth Druk Gyalpo forms the guiding principle for the National Response. In addition, the National Programme also acknowledged the continuous support from Her Majesty the Queen Mother in her capacity as the UNFPA Goodwill Ambassador. Mr. Chador through his presentations highlighted the following milestone of the HIV national response:

- 1988: Established STI/HIV program under the department of health, Ministry of Health & Education
- 1993: The first HIV case in Bhutan was detected
- 1999: Royal patronage for HIV
- 2001: MSTF established in all dzongkhags after successful piloting in Chukhadzongkhag
- 2002: The first case of Mother-to-Child Transmission of HIV was detected.
- 2004: Royal Decree on HIV/AIDS by HM the 4th King of Bhutan
- 2004: National AIDS Committee has been upgraded to National HIV/AIDS Commission (NHAC) during the 220th session of the coordination committee meeting of the Council of Ministers held in February 2004.
- 2004: ART therapy first introduced in Bhutan.
- 2005: CD4 cell count facility introduced
- 2005: Free standing VCT established in Thimphu & P/Ling
- 2006: First ART treatment guideline/VCT developed
- 2006: VCT introduced in all hospitals in 2006 with rapid test facilities
- 2013: HCT services integrated up to BHU

Following the national response, Mr. Chador in his statement indicated that HIV cases as well as STI transmissions have been increasing in Bhutan and it becoming a national concern. As of December 2015, 460 HIV cases have been detected (234 Male and 226 female) across 18 of the 20 districts. Of the total detected, 90% of the transmissions were through heterosexual route. But he informed the forum that the previous data collection forms do not differentiate sexual route. The presentation also included demographic and social economic distribution of the 460 PLHIV. In case of case detection Thimphu was highest at 203 followed by Chuka and S/jongkhar at 76 and 28 respectively. With regard to key population, Mr. Chador presented snapshots of current available literatures and acknowledged the current evidence limitation on high-risk population in Bhutan. In addition he also commended the efforts of NACP in reaching the key population with targeted interventions. Mr. Chador also updated the participants on the current IBBS implementation and expressed aspiration that the data will greatly add value to the design of future interventions in the country. In conclusion, he presented the public health impact of punitive laws (listed below) and thanked the two experts, UNDP and the entire participants for taking time out to attain the consultation workshop.
Stop seeking prevention and treatment services for fear of exposing themselves to prosecution
Providers may stop offering care or shift their strategies, making services more difficult to access.
Driving at-risk populations underground—undermining national and global commitments to achieving an AIDS-free future.
Stigma, discrimination and fear of violence or legal sanctions often undermine access to health care, including HIV services.
HIV criminalization undermines public health efforts, is an impediment to care for people living with HIV and puts an undue burden on resource-constrained legal systems. Such laws:
- Punish responsible behavior—getting tested—and privilege ignorance of HIV status. Yet most new infections are transmitted by people who do not know they have HIV.
- Create mistrust of and lessen cooperation for effective public health initiatives such as partner notification and alienate people living with HIV from their health care providers.
Breaking down these barriers is essential to achieving an AIDS-free generation.

Agenda 4: Introduction to Legal Environment Assessment

Mr. Vivek Divan, HIV legal expert, thanked the Chair, National Programme, and all the stakeholders for their support and guidance during the implementation phase of the assessment. He started his presentation by informing the floor on the process and the methodology adopted for the legal environment assessment. Through his presentation he provided an overarching framework for understanding the importance of legislative assessment and its implication on access to services for most at risk population. To further, strengthen the understanding of the participants, Mr. Divan, through global best practices explained the human rights approach paradox in the context of HIV/AIDS and public health. To help facilitate the discussion on the next session “Key Findings, recommendations and Initial Responses”, Mr. Divan presented the pro and cons of two varying approaches: Isolationist and Integrationist with examples and best practices.

<table>
<thead>
<tr>
<th>Isolationist</th>
<th>Integrationist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandatory testing</td>
<td>Voluntary testing</td>
</tr>
<tr>
<td>confidentiality breached</td>
<td>confidentiality maintained</td>
</tr>
<tr>
<td>discrimination if HIV-positive</td>
<td>no discrimination if HIV-positive</td>
</tr>
<tr>
<td>Criminalization of vulnerable groups</td>
<td>De-criminalization of vulnerable groups</td>
</tr>
<tr>
<td>...leading to isolation of people living with and vulnerable to HIV</td>
<td>...leading to integration of people living with and vulnerable to HIV</td>
</tr>
</tbody>
</table>

Following the right approach, Mr. Divan noted many positive aspects of the Bhutanese laws and National Strategic Plan II, which includes many human rights programmes and opportunities to strengthen the enabling environment for key population. Mr. Divan also informed the participants on the right-based international responses such as the UNGASS Declaration of Commitment on HIV (2001) and successive UN Declarations on HIV, Report of the Global Commission on HIV and the Law and the institutional mechanism within the Global Fund. With the backdrop presentation on international commitment, Mr. Divan highlighted the following unique national commitment to inclusiveness in addition to the commitment laid out in the National Strategic Plan for vulnerable populations:

**Gross National Happiness** – an aspiration of sustainability & inclusiveness informed by:
- **Good governance**: for all, supported by an able infrastructure to enable
efficiency and transparency
- **Preservation & promotion of culture**: cultural resilience, and ability to overcome challenges and difficulties from other norms
- **Domains**: Health, Community Vitality, Education, Psychological Well-being

**11th Five-year-plan** - National Key Result Area: “Needs of the Vulnerable Populations addressed”

**Bhutan 2020**: A Vision for Peace, Prosperity and Happiness - improving HIV programming

**Sustainable Development Goals**: “Leaving no one behind”
- No. 3: Ensure Healthy Lives & promote well-being for all at all ages
- Ending AIDS and Access to sexual and reproductive health services
- Strengthen prevention & treatment of substance, narcotics, alcohol abuse
- No. 4: Ensure education for all
- No. 5: Achieve gender equality
- No. 10: Reduce inequality within and among countries
- No. 16: Promote inclusive societies, institutions, and access to justice for all

Taking queue from the previous presentation, Ms. KajalBhardwaj, UNDP Consultant, further supplemented the HIV commitments through presentation on the Bhutanese legal framework. Through her presentation, she highlighted the clauses within the international and regional commitment that Bhutan is signatory to and explaining each provision within the commitments pertaining to HIV/AIDS, she emphasized the need to protect the right of vulnerable population in Bhutan. The commitments explained are presented below:

- United national Special session on HIV/AIDS – 2001
- UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)
- UN Convention on the Rights of the Child (CRC); General Comment 3 (HIV/AIDS and the rights of the child)
- United Nations Economic and Social Commission for Asia and the Pacific (ESCAP)
- SAARC Regional strategy on HIV/AIDS

After setting the context, Ms. Bhardwaj, presented a brief overview of the methodology adopted for the assessment. The approach of the assessment was based on the UNDP’s Legal Environment Assessment for HIV: An Operational Guide to conducting National Legal, Regulatory and Policy Assessments for HIV. Ms Bhardwaj informed that the assessment process included, literature review; interviews with key local experts and stakeholders; and a periodic reporting to the National Task Team (NTT). Under the literature review, the following laws were reviewed to identify gaps and opportunities:

- Constitutional laws (establish fundamental rights and their protection);
- Legal and policy frameworks as they pertain to HIV informed by historical and cultural perspectives (including extant traditional sources of law);
- General health laws relevant to HIV and related services (including prevention, care, support and treatment);
- Laws covering and affecting key groups vulnerable to HIV, including people who use drugs, transgender people, men who have sex with men, and sex workers (criminal and civil laws);
- Laws covering and affecting people living with HIV (criminal and civil laws);
- Laws related to non-discrimination, informed consent and confidentiality affecting key groups and people living with HIV;
- Laws related to women that affect their vulnerability to HIV, including laws related to inheritance, and violence;
- Laws related to children & young people;
- Laws related to affordable and accessible HIV treatment, including intellectual property laws.
In addition to the literature review, following organizations were approached and interviewed to provide insights into implementation and translation of the current laws and policies.

<table>
<thead>
<tr>
<th>Judiciary:</th>
<th>Parliament Committees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Justice, High Court, Thimphu</td>
<td>Human Rights (NA)</td>
</tr>
<tr>
<td>Dungkhag Court, Phuntsholing</td>
<td>Women, Children Youth (NA)</td>
</tr>
<tr>
<td><strong>Executive:</strong></td>
<td><strong>Civil Society</strong></td>
</tr>
<tr>
<td>Office of the Attorney General</td>
<td><strong>RENEW</strong></td>
</tr>
<tr>
<td>National Commission for Women and Children</td>
<td>Lhak-Sam</td>
</tr>
<tr>
<td>Royal Bhutan Police</td>
<td>LGBT community representative</td>
</tr>
<tr>
<td>Bhutan Narcotics Control Authority</td>
<td>Drug Users representatives</td>
</tr>
<tr>
<td>Bhutan National Legal Institute</td>
<td>Youth Development Fund</td>
</tr>
<tr>
<td>National AIDS Control Programme</td>
<td>Chithuen Phendey Association</td>
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<tr>
<td>IP Officer, Ministry of Economic Affairs</td>
<td><strong>Others</strong></td>
</tr>
<tr>
<td>Dratshang Lhentshog</td>
<td>National Task Team</td>
</tr>
<tr>
<td>GNHC</td>
<td>Khesar Gyalpo University of Medical Sciences</td>
</tr>
<tr>
<td>HIV Treatment and Care Unit</td>
<td>Bhutan Media Foundation</td>
</tr>
<tr>
<td>HISC, Thimphu</td>
<td>UN Agencies (UNFPA, UN Women, UNDP)</td>
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<tr>
<td>HISC, Phuntsholing</td>
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<tr>
<td>RBP, Phuntsholing</td>
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</table>

**Break 4:30-5pm**

**Agenda 5: Overview of Key Findings, Recommendations & Initial Responses**

The post break session was **“Key findings and recommendations”** which was presented by both the experts, starting with Mr. Divan presenting the overall scheme of the presentation. The key findings and recommendations were primarily grouped under three key issues: **Legal – ethical issues; Criminalization; and Cross Cutting Issues**. Under the **Key Legal-Ethical Issues** the findings were presented for Discrimination, Informed Consent for Testing and Treatment, and Confidentiality and Disclosure of Information. The **Criminalization** covered Criminalization of HIV Transmission, Men who have sex with men, Transgender people, Sex Work and Drug Use. Lastly the **Crosscutting issues** highlighted findings related to Women, Children and Youth, Access to Treatment and Access to Legal Aid174.

Mr. Divan expressed gratitude for the support rendered during the assessment and noted the high level of openness and political support for HIV/AIDS in Bhutan. He also added that the key findings and recommendations might change as they continue to review documents as and when it is made available to them. With that limitation, Mr. Divan presented the key finding on Legal – ethical issues. Mr. Divan, once again emphasized the high level political support through the Royal Decree and the protection of rights under the Bhutanese Constitution (Article 7(15)). Following were some key findings presented:

- The Royal Decree of His Majesty the Fourth King
- Equality of “other status” in Article 7(15) – intended to cover unanticipated grounds
- Protects against actions of the State and private sector

174 Given the time limitation – Access to Legal aid was not presented.
Equality guarantee includes protection from all forms of discrimination – explicit or ambiguous.

In practice, although little experience of explicit discrimination by people living with HIV, occasional experience of subtler discrimination (e.g. in the workplace)

Based on the key findings, two major recommendations were presented; to include HIV status, sexual orientation and gender identity in the “other status”, through an interpretation from the Supreme Court or with policy directives. The second recommendation was to review existing practices and guidelines to ensure that occupational health & safety of health workers is addressed – including unfettered access to universal precautions, and post-exposure prophylaxis.

**Discussions:** Following the presentation, the chair opened the floor for discussion. Majority of the participants agreed that the interpretation of the “other status” should be left to the implementer of laws and by defining as HIV status, sexual orientation, gender identity etc. may limit the scope of the provision in future. Alternate option recommended was to file public interest litigation by the key affected groups to the Supreme Court.

The next key findings on the “informed consent for testing and treatment” also described protection both in the constitution article 7(1) and the Medical Council Regulations. The key area of concern was for testing and treating minors for HIV, where there is a requirement to have a legal guardian / parents. Based on the above findings, the recommendation included law reforms to lower the age of consent to access health services and to consider “safe haven” laws for health care providers working with minors.

**Discussion:** There was an overall consensus that the informed consent should continue to form the backbone of HIV programme and “safe haven” laws and policy must be instituted to improve access to testing for high risk minors. The legal officer from NCWC, informed the forum that lowering the age of consent, may have other ramification on other Act such as rape, violence and child protection and it must be reconsidered in light of existing laws. Therefore, any changes to the “consent age” must be viewed through other legislative lens and not just for prevention of HIV.

The discussion was followed by Mr. Divan’s presentation on the key findings on “Disclosure of information and confidentiality”. He once again acknowledged the strong recognition of confidentiality both in the Medical Council Regulation and the Constitution Article 7(198) of Bhutan. Key areas of concerns identified through the assessment were the current practice of partner notification, intentional transmission, confidentiality of the minor and limited mechanism for shared confidentiality amongst the service providers. Based on the concerns following recommendations were presented:

- Amendment to regulations to clarify “Duties to Society” for healthcare workers and also to include safe haven laws/provision for the service providers.
- Policy on privacy and confidentiality for persons other than healthcare providers.
- Prescribe protocols for data management and protection of PLHIV.

**Discussion:** Dr. Rai, Medical specialist who has been treating PLHIV informed the forum on the need for disclosure of HIV status to other health service providers. He cited medical incidences where the patient withheld HIV status information from the care provider and they had no means of knowing the status of the patients. This was also seconded by the Chair and expressed his concern on lack of mechanism for information sharing due to the issue of confidentiality.

The chair of the National Assembly legislative Committee, Honorable member of the parliament Dasho Ritu Raj Chhetri informed the forum that the workshop was timely given that the committee is
in the process of reviewing and harmonizing the current act and policy such as rape, detention of minor and civil and criminal laws, prison, police and penal code. Honorable Dasho also reassured that for all ten NA committees, women and youth are in forefront of their discussion. Dasho also acknowledged the limitation of information on LGBT community in Bhutan and said “we are uncertain on the LGBT at this point and we are not sure how to handle this – we are not confident what legislation should be in place”. He also informed that floor that many of the amendment will be taken into consideration during the next (winter) parliament session.

Thanking the Honorable MPs, the Chair informed the forum that the current practice of partner notification has been quite successful in the context of Bhutan, but guidelines must be developed to protect the right of the vulnerable population and to further strengthen the existing approach. To which Ms. Bhardwaj shared regional incidences of abandonment particularly women in India, when they are found positive during the antenatal clinic visit. In conclusion the Chair, urged the participants to consider the following while deliberating on the finding and recommendation of the assessment:

1. When and in which situations can service provider breach confidentiality?
2. How to establish institutional linkages for sharing information and what impact would it have on testing and treatment?
3. Knowing status and not using condom - how to tackle this intentional issue?
4. Examine the medical council act in light of the finding and recommendation of the assessment – are the issues adequately addressed through the Medical Council Act?
5. How to establish clear delineation- ethical and legal framework

Dr. Rai, also raised the issue of lost to follow up and its implication on treatment compliance due to limited institutional linkages and not having proper guidelines for shared confidentiality. In addition he also raised the potential risk to health providers as patients seek services from different facilities and are not mandated to inform the providers. The WHO country representative Dr. OrnellaLincetto also commented that “to protect the right of the public, sharing of information mechanism needs to be spelled out under the current medical regulation provision”.

With the permission of the Chair, Ms. Bhardwaj presented the second section of the key issue “Criminalization”. Under the criminalization, five key findings and recommendations were presented; Criminalization of transmission, men who have sex with men, transgender person, sex work and drug use. Ms. Bhardwaj acknowledged that transmission of HIV, particularly between sexual partners throws up complex issues that criminal laws are often ill equipped to handle. In the context of Bhutan, the section 410 of the penal code makes knowing or reckless transmission of disease dangerous to life punishable, thus adequately covered. But in light of the recent incidence involving a positive woman, the report highlighted the need for adoption of policy /guidelines by the law enforcer on the management of such cases. Thus the recommendation included two areas for improvement:

1. Training and capacity building of service providers on the role and limitations of criminal law.
2. Greater institutional collaboration and guidance to provide support for PLHIV in difficult circumstances.

Ms. Bhardwaj also informed the forum on the global best practices and shared the guideline adopted by the UK police titled "police investigation of HIV transmission". The HIV focal person from the Royal Bhutan police also reminded the participants that any guideline must be aligned with the existing Police Act.

Next key issue “criminalization of MSM was presented by Mr. Divan. He informed the forum that beside consultation with the key stakeholders, they also had an opportunity to meet and interview
community members. The four major findings presented focused primarily on the limitation within the legislation and access to services for MSM.

- Section 213 of the penal code looms as a threat against MSM
- Regulation 4.4 of Medical & Health Council Regulations – as part of “duty to society” – “obligatory to inform police on crimes”
- MSM suffering from anal STIs – deterred from accessing health services – due to above obligation on healthcare workers
- MSM in prisons – not provided condoms because of Section. 213

Mr. Divan also informed the participants on the current legislative review taken up by the Human Rights Committee to repeal the law (section 213). Furthermore, Mr. Divan presented evidence of positive impact on HIV prevalence due to decriminalization of same sex sexual activity. Following the findings, recommendations on law reforms and capacity building of the health care providers to address sexuality were suggested. Mr. Chador, informed the forum that there are current collaboration with the Medical University to train health workers on sexuality under the Global Fund country grant.

For the section on Transgender (TG), Mr. Divan noted the recognition of TG women’s gender identity particularly in one case and in the prison context for incarcerated TGs. Similar to the MSM, recommendations for TG included amendment of legislation (section 213) and capacity building of service providers through sexuality education.

Ms. Bhardwaj presented next section on the criminalization of Sex work. She informed the forum that there is very little information on sex work in Bhutan, but there is a general consensus that it is there. Key findings highlighted during the presentation were:

- Limited evidence of large scale sex work in Bhutan
- Law criminalises those who engage in transactional sex (Section 373), clients (Section 377).
- Structural causes of sex work (e.g. poverty, lack of access to education & gainful employment) that influence people to make the choice of earning through transactional sex.

Following the finding Ms. Bhardwaj highlighted the recommendations for sex work that included conducting in-depth research to understand the phenomena of sex work in Bhutan and to review various right based model of prostitution law reforms. The Chair, also acknowledged the limitation of evidence for sex work and the targeted intervention currently being implemented by NACP in collaboration with RENEW and HISRC. Mr. Wangda, Executive Director from Lhaksam, added that most of the sex workers are economically and socially challenged and has no other means to make a living. He cited few incidences where rights of sex workers were grossly violated and given the criminalization law, access to protection was not availed. Taking cue from the discussion, Ms. Bhardwaj presented the following recommendations for consideration and deliberation:

- In-depth research to understand phenomenon of sex work – useful to design appropriate law, policy and programming that protects sex worker’s rights and health
- Review various rights-based models of prostitution law reform – e.g. decriminalisation and its effects in New Zealand, legalisation and its impact in the Netherlands, Germany, empowerment in India.
- Review key sections in Chapter 26 of the Penal Code – suggested by National Strategic Plan for HIV 2012-16

Following the discussion, Mr. Divan presented the last key issue under the criminalization – Drug use. He shared his experience of talking to the drug user community in Bhutan who were primarily youth and few were incarcerated under the current revised Narcotic act 2015. He informed the forum
that the current law - Narcotic Drugs, Psychotropic Substances and Substance Abuse Act of Bhutan 2015 (NDPSS) is relatively stricter than the previous law and the unintended consequences of the amendment needs to be assessed. He stated that “currently there are large number of young drug users going through the prison system and for a GNH country, it is a concern”. Mr. Divan noted the current effort put in place by Youth Development Fund for rehabilitation services and the human and financial constraints faced by the NGOs. In light of the findings, the recommendations included a two-prong strategy: improving health services through greater commitment of resources to outreach activities and evidence based legislative reforms. Due to time constraints, presentation continued with the last section of the key findings and recommendations - Cross Cutting Issues.

The section was divided into five sub groups; Women, Children and Youth, and Access to Information, Treatment and Justices. Ms. Bhardwaj noted the robust right affirming laws and political will and support in the country for protection of women’s right. She highlighted that unlike many countries in the region, women are protected and provided equal access to social and economic opportunities in Bhutan. In the context of women’s health, she raised the health implication of unsafe abortion that happens across the border due to the pro-life laws in Bhutan. In addition she also highlighted the limitation in resources for implementation of the domestic violence law. For this section, two key recommendations were suggested: to strengthen current institution such as NCWC and to build more evidence on abortion through research. In case of Children and Youth, Ms. Bhardwaj informed the forum that there is a strong recognition of child’s right and protection in Bhutan through the adoption of the international conventions, the Child Care & Protection Law, and the Child Adoption Law. Key areas of concerns identified were access to HIV and STI services for young children, key population and incarcerated youth. Ms. Bhardwaj stated that “although there are strong legislative in place for protection of children and youth, the operationalization of legal protection is still a challenge”. Thus following interventions were recommended:

- Child Protection law approach of decriminalization for children in conflict with the law requires operationalization particularly for young drug users going through prisons. The primary objective of the Act to provide alternate sentencing in lieu of the arrest, prosecution, conviction and imprisonment must be implemented where it is appropriate.
- Separate incarceration facilities for detention and prison as per the Section 76 of the Child Care and Protection Act.
- Through community consultation, examine how the Child Care and Protection law can support children living with HIV
- Greater institutional support and coordination between child protection mechanisms and law enforcement.

In the interest of time, Mr. Divan, briefly explained the sexuality education findings and recommendations. With almost an hour pass the scheduled time, the coordinators decided that recommendation would be revisited again in the next day session prior to the group work.

In conclusion, Mr. Chador once again thanked the two experts for their extensive review given time constraints, UNDP for their support, the national task team members and all the participants for their collaboration and time.

Day 2: Friday, June 10th, 2016
Time: 09:00 am – 6pm

Mr. Chador welcomed back the participant for the 2nd day workshop and thanked the participants for their continuous support to the National Programme. Following the welcome note, Mr. Chador requested Dr. Rai to Chair the workshop. The objective and the methodology adopted for the 2nd day of the workshop was delivered by Ms. Sangay Wangmo, Program Officer, UNDP – Bhutan. She
informed the forum that the overall design of the workshop would be a combination of group work and presentation of assessment recommendations with global and regional best practices. Participants were pre grouped into three groups: PLHIV, KAP and Women and youth. Key considerations on professional background, technical expertise, institutional capacity and community representations were made to achieve a representative group. Each group was asked to identify a facilitator and a presenter. Ms. Sangay then handed over the floor to Mr. Divan for the presentation on the recommendations. All the recommendations from the previous day were revisited again with global best practices and regional experiences to help participant contextualize the recommendation to Bhutan. For the group work, participants were provided with four guiding questions and instruction for completing the task:

Guiding Questions:
- Based on the recommendations, please identify 5 priorities.
- Who would be the key stakeholders and partners to effectively implement the same?
- Are there any gaps and challenges that need to be included?
- Are there law/ policy reform and review processes that should link to the implementation of the LEA?

Instructions:
- Identify a rapporteur and a presenter
- 10 minutes reporting back + 10 minutes discussion per group
- Present 2 out of the 5 priorities
- Use separate flip chart for each priority

Key recommendations and concerns from the groups are compiled below under each thematic areas (Table 1)
**Table 1: Recommendations from the Groups**

### 1. PLHIV Group

<table>
<thead>
<tr>
<th>Key Thematic Area</th>
<th>Recommendations and Concerns</th>
</tr>
</thead>
</table>
| **Discrimination** | • Discretion of the court to define the “other status” to prevent limitation of the interpretation of the law.  
• Increase awareness and advocacy on the current laws so that PLHIV and general population are aware of their rights and responsibilities.  
• Need to operationalize the universal precautions for the health worker through education and awareness program. |
| **Criminalization** | • Law reform to lower the age of consent to enhance access to health services for young population.  
• Consider safe haven laws for health care providers who provide services to minors.  
• Policy directive for sharing of information especially for service providers and health workers.  
• Law reforms and policy directives for privacy and confidentiality for health care providers  
• Adoption of policy/ guidelines to response to adherence to treatment.  
• Collaboration with CSOs to improve testing and treatment compliance. |
| **DU** | • In depth study on the DU in Bhutan (trend and patterns) to inform future interventions.  
• Strengthen collaboration with the CSOs such as YDF to implement targeted interventions. |
| **SW** | • In-depth research to understand the phenomena on sex works in Bhutan.  
• Policy directive on empowerment, support and services for SWs through CSOs and other national NGOs such as RENEW.  
• How to tackle HIV positive SWs? |
| **MSM/TG** | • Repeal section 213 based on evidence and situational l analysis  
• Continue the targeted intervention for the key population |
| **Women and Children** | • Evidence building on HIV related issues for women in general.  
• Appropriate resources and services for children in conflict with the laws. (separate detention facilities and prison for youth). |
| **Education** | • Representative of KAP group in development of programs / interventions. |

### 2. KAP Group

<table>
<thead>
<tr>
<th>Key Thematic Area</th>
<th>Recommendations and Concerns</th>
</tr>
</thead>
</table>
| **Discrimination** | • Need to specify the “other status” and must include HIV status to prevent misinterpretation in future.  
• Public awareness on discrimination against PLHIV and key population in collaboration with MOH, CSO, Media and MOE.  
• Education of health workers on sexuality.  
• Review of penal code provisions to prevent discrimination. |
<table>
<thead>
<tr>
<th>Key Thematic Area</th>
<th>Recommendations and Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminalization</td>
<td>Consultation meeting with Women, Children and Youth Committee (Penal code) to improve services to KAP to prevent discrimination.</td>
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<tr>
<td></td>
<td>Explicit interpretation of “confidentiality and duties to Society.</td>
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<td></td>
<td>Development of protocol for implementers to prevent criminalization in collaboration with MOH, Media, MOE and CSOs.</td>
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<td></td>
<td>Law reform to lower the age of consent to improve access to health services to ensure access for young people.</td>
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<td></td>
<td>Section 410 is sufficient, but need to adopt policy for police, HCP, parliamentarians and the court.</td>
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<td></td>
<td>Institutional collaboration: MOH, media, and CSO.</td>
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<td>DU</td>
<td>Improve services for DUs: outreach, Help services, public awareness, after care services and rehabilitation.</td>
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<td></td>
<td>Evidence building to inform legal reforms: research on drug use patterns.</td>
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<tr>
<td>SW</td>
<td>Evidence building through research both quantitative and qualitative to inform legislative reforms.</td>
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<td></td>
<td>Explore right-based model for law reforms.</td>
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<td></td>
<td>Community base dialogue through media (social, print and radio).</td>
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<tr>
<td>MSM/TG</td>
<td>Repeal section 213 through sensitization of judiciary and parliament members.</td>
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<td></td>
<td>Promote understanding of sexuality through health services, education center and media.</td>
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<td></td>
<td>Train health worker and other partners on sexuality – MOLHR, MOE, CSO and Prison setting.</td>
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<td></td>
<td>Promote inclusive consultation with community members.</td>
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<td>Build evidence through research for advocacy.</td>
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<td></td>
<td>Fund mobilization for the community interventions.</td>
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<tr>
<td>Women and Children</td>
<td>Legalize abortion law.</td>
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<td></td>
<td>Evidence building through research on implication and prevalence of discrimination violence.</td>
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<td>Need to cost and appropriately allocate resources for implementation of the DV Act.</td>
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<td>Capacity building of the implementers and partners on implementation of DV act.</td>
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<td></td>
<td>Operationalization of legal protection for children in conflict: training of probation officers in child psychology; institutional collaboration. (Bhutan children parliament).</td>
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<td>Awareness programs on CCPA and DV.</td>
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<td></td>
<td>Research on children living with HIV.</td>
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<td></td>
<td>Engage youth through media and other forums.</td>
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<tr>
<td>Education</td>
<td>Integration of sex education in schools.</td>
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<tr>
<td></td>
<td>Improve use of media for education.</td>
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<td></td>
<td>Build partnership with key stakeholders.</td>
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</tbody>
</table>

3. **Women and Children Group**
<table>
<thead>
<tr>
<th>Category</th>
<th>Recommendations</th>
</tr>
</thead>
</table>
| Discrimination    | • No Law reforms are required, but need to invest resources on sensitization and awareness programs of the current available legislations.  
                    • Review of Medical and Health council regulation to ensure occupational health and safety are adequately addressed. |
| Criminalization   | • Informed consent should continue with provision for “safe haven” to protect health workers working with minors.  
                    • Review and revision of the BMHC to explicitly include “confidentiality” provisions.  
                    • Section 410 of penal code is sufficient but need to develop guidelines / tools and build capacity of the implementers. |
| DU                | • Increase services for women DUs.  
                    • Design targeted intervention to help women DUs |
| SW                | • In-depth studies to inform the current practices and prevalence of sex work  
                    • High level consultation for policy clearance. |
| MSM/TG            | • Law reform: Sec 213  
                    • Training of health workers in providing sensitive services to KAP |
| Women and Children| • Dissemination of the SOP and costed Action plan for NCWC  
                    • Increase HR and capacity of the service providers |
| Education         | • Train health care providers on women and children issues. |
ANNEXURE E

Costed Action Plan *(submitted as separate Excel Sheet document)*