

**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**



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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



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Acronyms and Abbreviations

ADHO	Assistant District Health Officer
AIDS	Acquired Immunodeficiency Syndrome
APCOM	Asia Pacific Coalition on Male Sexual Health
APN+	Asia Pacific Network of People Living with HIV
BHU	Basic Health Unit
DHO	District Health Officer
GFATM	Global Fund for AIDS, TB, and Malaria
HCP	Health Care Providers
HISC	Health Information Services Center
HIV	Human Immunodeficiency Virus
INGO	International Non-Governmental Organization
IDI	In-Depth Interview
KII	Key Informant Interview
MoH	Ministry of Health
MSM	Men who have Sex with Men
NACP	National AIDS Control Programme
NGO	Non-Governmental Organization
PLHIV	People Living with HIV
PWID	People Who Inject Drugs
REBH	Research Ethics Board of Health
SAMAN	South Asia MSM and AIDS Network
STI	Sexually Transmitted Infections
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
WHO	World Health Organization

Executive Summary

Background

Bhutan has maintained an HIV prevalence below 0.01 percent with 297 reported cases as of November 2012. However, increased incidence of sexually transmitted infections in the country remains a major concern for the National AIDS Control Programme. In addition, various surveys on sexual behaviour among sexually active men and women revealed that a significant proportion of male respondents reported same-sex sexual behaviour. The National Strategic Plan-II in Bhutan emphasizes prevention interventions that target MSM, transgender people, and other key affected populations. While the HIV prevalence for MSM and transgender people in Bhutan is still unknown, there is evidence suggesting that there is a high level of HIV-risk behaviours for MSM and transgender people, with no specific services (prevention, care & support, and treatment) being provided to reduce these HIV and STI-risk behaviours. A review on legal environments, human rights and HIV responses among men who have sex with men and transgender people in Asia and the Pacific revealed that male-to-male sex is criminalized in 19 out of 48 countries of the Asia Pacific region, including Bhutan. It is expected that MSM and transgender people in Bhutan are facing some degree of social discrimination that may increase their HIV-risk behaviours and limit their access to health services. In this context, the National AIDS Control was interested in conducting a formative assessment to assess the barriers for MSM and transgender people to access services, particularly the level of stigma and discrimination perceived by MSM and transgender people and in health care settings. The UNDP Regional Centre and UNDP Bhutan provided technical assistance to the NACP to design and conduct this formative assessment that was implemented from January to April 2013.

Methods

- **Objectives and populations:** this formative assessment was aimed at identifying recommendations to develop interventions to reduce social discrimination against MSM and transgender people in Bhutan, and to increase the use of prevention, care and support, and treatment services for these populations. The specific objectives of this formative assessment were: i) to identify level of stigma and discrimination towards MSM, transgender people, and people living with HIV among health care providers in the health care system in Bhutan; ii) to assess strengths, limitations, and needs of health services in dealing with and managing sexual health for MSM and transgender people; iii) to describe social networks of MSM and transgender people; iv) to identify key barriers for accessing health services for MSM and transgender people; v) to describe level of stigma and discrimination experienced by MSM and transgender people in their daily life and when accessing services support and care, and treatment services, particularly for HIV testing and STI screening; and vi) to identify recommendations to reduce stigma and discrimination and implement interventions reaching MSM and transgender people, including youth.
- **Design:** a cross sectional design with mixed methods (qualitative and quantitative) was used for this formative assessment. The data were collected between January and April 2013 among four distinct populations: health care providers in six selected districts (Thimphu, Sarpang, Samdrupjongkhar, Wangdue, Chukha, and Bumthang), MSM and transgender people in two cities (Thimphu and Phuntsholing), and national stakeholders.
- **Data collection procedures and sample size:** a structured questionnaire, which included closed-ended and ordered scale questions, was used for health care providers. All in-depth interviews with MSM, transgender people, and health care providers, and key informant interviews with district health officers, were conducted using topics guide. Qualitative interviews were semi-structured using open-ended probing questions and anecdotes to enhance the collection of the qualitative data. Topics discussed during the consultation with stakeholders included the presentation and discussion of the preliminary findings of the formative assessment and the priority interventions for men who have sex with men and transgender people to improve access to relevant services.

- *In-depth interviews with MSM and transgender people:* given the social context in Bhutan, it was expected that the number of MSM and transgender people who would be willing to participate to this formative assessment would be limited. It was planned to recruit 10 MSM and 10 transgender people in two selected cities of Thimphu and Phuntsholing (total of 20 MSM and 20 transgender people) to participate to IDIs.
- Self-administered and structured questionnaire: all doctors, nurses, health assistants, laboratory technicians, and HIV counsellors from selected districts were targeted for this component of the formative assessment. Based on most recent human resources data, 887 health staffs in the 6 selected districts were enumerated and expected to complete the questionnaire (take all approach).
- *In-depth interviews with health care providers:* in Bhutan, the majority of the HIV care and support and treatment services and centralized in Thimphu. Health care providers working directly on HIV care and support, and treatment were targeted for IDIs. Up to 15 health care providers (doctors, nurses, health assistants, laboratory technicians, and HIV counsellors) were contacted for IDIs.
- *Key informant interviews with district health officers:* District health officer in each selected district (6 districts) were asked to participate to key informant interviews. A total of 6 district health officers were contacted for the interview.
- *Consultation with stakeholders:* about 30 stakeholders including NACP, UN family programme manager (focal point on HIV/AIDS), INGOs and NGOs working on HIV, District Health Officers, and lawyers/policy makers were invited to participate to the consultation
- **Data analysis:**
 - *Structured questionnaire:* the team identified two major biases during data management: the unit non-response and item non-response. For the former bias, weights inversely proportional to the probability of response were calculated and then standardized for a weighted analysis. For the latter bias, multiple imputations ($m = 10$) using imputation by chained equations to compensate for missing values, was performed. Frequency for binary and categorical variables, and measures of central tendency for continuous variables were used for the descriptive analysis. Relationships between binary and or categorical variables related either to socio-demographic or professional characteristics were examined by computing the Pearson's chi-squared test with a 2-sided level of significance of $\alpha = 0.05$. After reversing code, each item of the Likert-scales was analyzed by computing the proportion of each score and the measures of central tendency including mode and quartiles. The Cronbach's alpha coefficient was computed to assess the reliability of each Likert-scale. Factor analysis (principal factor) was used for assessing the validity of the scales and for identifying underlying factors. To explore factors associated to "misconceptions about homosexuality" and "homophobia", multivariable quantile regression models for the lower (25th percentile) and upper quantile (75th percentile) were fitted.
 - *In-depth and key informant interviews:* qualitative data from were manually analyzed using thematic analysis methods. All in-depth interviews and few of the key informant interviews were conducted in native language (*Dzongkha*). Following the transcription, the recurring themes were grouped under the predefined topics described in the respective topic guides. After grouping, a summarized theme was developed. Themes were then listed, compared and contrasted by using the method of constant comparison.
- **Ethical considerations:** the protocol, including tools and consent forms, was reviewed and approved by the Research Ethics Board of Health of Ministry of Health in Bhutan (REBH Approval 2012/033). Informed consent was obtained from all the participants of the formative assessment, except for the stakeholders participating to the consultation. The interviews were anonymous and no name or any other identifiers were collected. The interviews took place in the location where privacy was respected.

Key Findings

- **Key characteristics of participants:**

- *In-depth interviews with MSM and transgender people:* in total, 6 MSM and 9 transgender people were recruited for the study using both the chain referral and opportunity sampling techniques in the two pre-identified cities of Phuntsholing and Thimphu. The age of the participants ranged from 20-32 years old for MSM, and from 20-26 years old for transgender people. All transgender participants were single, and 2 out of 6 MSM reported being in a long-term relationship with a male partner.
- *In depth interviews with health care providers:* twenty health care providers currently providing STI/HIV care and treatment were interviewed along with one assistant district health officer (ADHO) and four district officers (DHO). Of the total 20 HCPs, almost one third (seven) were medical doctors and thirteen were health assistants (HA) and assistant clinical officers (ACO). The age of the HCP ranged from 22 to 57 years old and for DHOs/ADHOs from 44 to 55 years old.
- *Structured questionnaire with health care providers:* a total of 317 out of 887 health care providers responded to the questionnaire. The overall response rate was 38 percent ranging from 25 percent in Thimphu to 83 percent in Bumthang district. The response rate ranged from 7 percent among nurse assistant to 65 percent among health assistant. In addition, among those who sent back the questionnaire, other category of health staff (4 percent) such as ward staff and x-ray technician completed the questionnaire and were classified in the category "other"; and some of the respondents (2 percent) did not mention their function. Using non-adjusted data, the mean age of the participants was 32.4 years olds (versus 31.5 years old with adjusted data) with a minimum and maximum of 20 and 54, respectively. About half of them (45.5 percent) were between 20 and 29 years old. Half of the respondents (50.7 percent) were male (versus 46.4 percent with adjusted data).

- **Social and sexual networks of MSM and transgender people**

Although MSM and transgender people respondents admitted connections with other MSM and transgender people peers, it seemed that they are not organized in networks, but rather in small groups and not really connected to each other. The respondents also revealed locations where MSM and transgender people could discreetly find sexual partners. These locations, as per their description, were not exclusive for these populations. Private parties seemed to be the most common opportunity where MSM socialized with their peers. Virtual interactions, facilitated by international social media (dating websites for "gay"), were also reported by MSM in Bhutan. MSM reported that they were more involved in bisexual behaviours and same-sex sexual behaviour tended to be diffused into the general population, whereas transgender people reported having exclusively male partners. A few MSM respondents mentioned traveling to cities in the region (e.g. Bangkok) for various purposes including meeting with sexual partners as well. Only one MSM and none of transgender people interviewed mentioned commercial male partners (either selling or buying sex services). Their sexual networks seem to include casual and regular male partners only. However, few anecdotes were collected during the design of the formative assessment, bringing to the attention of the team that male sex workers are also operating in Bhutan and mainly serving tourists.

- **Stigma and discrimination towards MSM and transgender people**

Transgender people, unlike MSM, were more likely to be open about their sexuality with their relatives and close friends and appeared to be less isolated. MSM reported strategies for coping with stigma and discrimination from their family and close friends. These strategies included bisexual behaviour, although they reported only being sexually attracted by same sex, to show off they were fitting to the norms of society. Additionally, they tended avoiding social contact with other MSM in public and did not disclose their sexual orientation to health care providers even when they had concerns about their sexual health. These findings suggest a certain level of internalized homophobia (self-stigma) among these populations in Bhutan, particularly for MSM.

They also expressed the pressure of the law criminalizing same-sex sexual behaviours in Bhutan. Although nobody has been prosecuted under this law, MSM perceived it as a sword of Damocles, impacting their

relationships with their relatives and close friends, and their health seeking behaviours (e.g., going abroad to access health services), as they still fear to be reported to local authorities and prosecuted. It is noteworthy that transgender respondents were not aware of this law.

- **Access to health services for MSM and transgender people**

While access to health services was not perceived as an issue either for MSM or transgender people, the access to proper health services (i.e. good quality of care and treatment) was described as a critical problem. MSM, as a coping strategy, did not disclose their sexual orientation to their health care providers. For transgender people, even if their gender identity could be more obvious, health care providers did not ask questions about their sexual orientation and behaviours, and transgender people do not talk about it as well. Both MSM and transgender people realized that the lack of disclosure to health care providers could affect the provision of appropriate services. A significant proportion of health care providers also revealed their level of discomfort in discussing sexuality with their clients suggesting that their communication with their client is impaired, particularly with MSM and transgender people. In addition, MSM and transgender people revealed a lack of trust in the health system in Bhutan, particularly the respect of the confidentiality and the privacy of the clients when consulting with health care providers.

- **Attitudes of health care providers towards MSM and transgender people**

Although the majority of health care providers were in agreement or strong agreement that MSM and transgender people should receive the same level of attention and care, the formative assessment identified a significant level of homophobia, misconceptions about homosexuality, and value-driven stigma that may impact the quality of care provided to these groups. Notably, the level of stigma towards PLHIV was found to be lower and not correlated with value-driven stigma, suggesting that health care providers were more judgmental towards key populations with HIV. The analysis also identified a significant and positive correlation between homophobia and misconceptions about homosexuality. Age of respondents was also found negatively correlated with homophobia and stigma towards PLHIV, and sex of respondents (men vs. women) was positively correlated with misconceptions about homosexuality. In addition, sex of respondents was found as a critical factor for misconceptions about homosexuality in the quantile regression for the lower quantile and persisting for the upper quantile. These findings suggest that male health care providers were more likely to have misconceptions about homosexuality compared to female. However, this association was found neither in our model for homophobia nor when exploring the correlation between these two variables. Similar patterns were found for acquaintance with MSM and transgender people. While this latter factor was found significant in the model for misconceptions about homosexuality, it was not for the model for homophobia. Respondents who reported acquaintance with MSM and transgender people were found with a lower index score in the lower and upper quantile for misconceptions about homosexuality suggesting that the acquaintance with MSM and transgender people had a significant impact in reducing misconceptions about homosexuality.

Health care providers who self-reported having a good level of understanding MSM and transgender health issues were found with a lower index score in all our models either for misconceptions about homosexuality or for homophobia in the lower quantile and persisting in the upper quantile. These findings validate that health care providers with a good understanding of these issues have fewer misconceptions and may be less likely homophobic. It also suggests that if the knowledge and skills of health care providers were increased, the level of homophobia and misconceptions about homosexuality among health care providers would likely decrease.

- **Limitations of the formative assessment**

There were critical limitations for this formative assessment. The first limitation was the small number of MSM and transgender people recruited for in-depth interviews. This occurred due to the difficulty in reaching and convincing enough MSM and transgender people to participate and reach the point of data saturation. While we found that some findings were consistent with the literature, we found some difficulties in interpreting other findings such as the social and sexual networks MSM and transgender people. In addition, the low response rate from health care providers (38 percent), despite multiple efforts for increasing the response rate during the follow-up, posed another critical limitation for the analysis of the study. The low response rate was also combined with item non-response (missing values) in the returned questionnaires. Both issues i.e., unit and item non-response resulted in a complex analysis to minimize these biases: weighted analysis on

imputed data. Therefore, it is not possible to generalize the findings of this formative research to the entire populations surveyed. The last limitations were related to the Likert-scales used in the questionnaire for health care providers. Although the different scales were pre-tested for the understanding of the items/questions, the team, due to time constraint did not assess the internal consistency of each scale prior to the data collection. While the scales on homosexuality and stigma towards PLHIV were found with a good and acceptable Cronbach's alpha coefficient (0.86 and 0.71, respectively), the scale related to attitude towards HIV-related health practices was found with a mediocre coefficient (0.62). Despite an item-test and factor analysis, it was not possible to improve the coefficient for internal consistency. Therefore, only a descriptive analysis was conducted for this scale. In addition, due to the lack of understanding and confusion between the terms "MSM" and "transgender people" identified among potential participants during the design of the formative assessment and the absence of these translated terms in Dzongkha, the team used in the questionnaire, which was self-administered, a more generic terminology related to behaviour rather than gender identity. For example, in the self-administered questionnaire, it has been decided to assess "homophobia" encompassing attitude towards MSM and transgender people, rather to assess "homophobia" and "transphobia" respectively. Therefore, it was not possible to assess the difference between the level of homophobia and transphobia that may be different.

Conclusions and Recommendations

The formative assessment highlighted the barriers faced by MSM and transgender people to access appropriate services responding to their sexual health needs. We found that transgender people and particularly MSM did not disclose their sexual orientation either to their in-group or out-group circles, including health care providers, due to their fears of stigma and discrimination. Despite the fact that the existing law criminalizing same-sex sexual behaviour has never been used in Bhutan, MSM, who were more aware of this law compared to transgender people, revealed concerns and fears of being reported to local authorities and prosecuted if they disclose their sexual orientation. They do not trust the health system or health care providers to maintain the confidentiality of their clients. The findings also underlined the feelings of isolation amongst MSM and the non-existence of MSM and transgender organizations or networks. The absence of targeted prevention services and lack of availability of commodities (e.g. condoms and water-based lubricants) also pose a problem for these populations. The formative assessment also found a significant level of homophobia, misconceptions about homosexuality, and value-driven stigma amongst health care providers—in contrast to lower levels of stigma towards PLHIV in general. Health care providers also lack experience and skills in dealing with and managing MSM and transgender clients. They also reported few opportunities to build their capacity either on HIV and AIDS or on male sexual health and to be involved in planning and designing interventions targeted to reduce HIV new infections in Bhutan. Because of the invisibility and also the denial of MSM and transgender people in their country, health care providers do not consider MSM and transgender people as a public health priority.

The following recommendations, which include strategies and key activities, were identified during the consultation with stakeholders and revised based on the final findings of the formative assessment.

Recommendations for the National AIDS Control Programme:

- 1. Create an enabling environment for key populations by developing a long-term strategy to reduce stigma and discrimination, to support and sustain the implementation of targeted interventions, and ultimately increase access to prevention, STI, VCT, care and treatment, and legal services for key populations**
 - *Review existing laws and corresponding policies to create a supportive environment for social change and safer behaviours. Policies regarding same-sex sexual behaviour must be addressed directly and comprehensively to promote non-discriminatory attitudes towards key populations, removing potential legal sanctions*
 - *Review policies to support positive attitudes and professional ethics of health care providers towards key populations and encourage compliance with ethical guidelines and standards of care and the protection of the rights of clients to increase access to services (prevention, STI, VCT, and care, support and treatment services) for these populations*

- *Review strategies and mechanisms for policy makers, health care providers, ethics committee members and researchers to develop guidelines for obtaining waivers for parental consent to provide care and to research underage (< 18 years old) key populations*
 - *Develop an awareness raising campaign amongst policy makers and parliamentarians on key populations issues in the country, and advocate for the implementation of supportive laws and policies to protect the rights of these populations to access health, legal, and social services. For the latter activity, establish strategic links with global, regional, and sub-regional MSM and transgender networks for possible technical assistance on advocacy and policy*
 - *Develop modules and implement workshops to sensitize health care providers, counsellors, researchers, ethics committee members, journalists, and key media agencies on key populations issues and their professional responsibilities regarding these populations*
 - *Develop interactive campaigns using above the line communication reaching broadly community to address stigma and discrimination towards key populations, and encourage dialogue and community solutions*
- 2. Increase safer sexual and health seeking behaviours among MSM and transgender populations**
- *Establish a sub-technical working group for MSM and transgender people that includes key stakeholders but as well MSM and transgender representatives, and establish linkages with global, regional, and sub-regional MSM and transgender networks for possible technical assistance on programme development*
 - *Mainstream sexuality and prevention of high-risk sexual practices such as unprotected anal sex practice into any existing prevention programme reaching key populations, including youth and male populations such as taxi-drivers, truck-drivers and uniformed services*
 - *Mobilize existing individuals and groups of MSM and transgender people to set-up peer-support groups in each targeted district. The formation of these support-groups is a first step before the establishment of networks and CBOs for these populations. Given the current situation, it may take time before the concretization of these networks or CBOs, but these groups could be initially established under the umbrella of existing NGOs (mother-NGOs) that are already working on HIV prevention and willing to support these groups*
 - *Train selected MSM and transgender peers in organizing peer-support group and providing peer-education (including prevention, condoms and water-based lube and distribution, and referral to services) to their respective peers.*
 - *Develop the capacity of selected health care providers and counsellors on male sexual health issues (including sexuality) and clinical management by developing training courses (existing modules and guidelines could be adapted to Bhutan), and guidelines. In addition, explore the opportunity to initiate after the training field clinical practices, for selected health care providers, in neighboring countries (internship rather than study tour) where specific male sexual health clinics are already established and willing to receive interns for a short period.*
 - *Sensitize support-staff of health facilities (including STI, CST, and HISC) on MSM and transgender issues.*
 - *Develop a directory of MSM and transgender friendly services and establish linkages between these services and mother-NGOs hosting MSM and transgender peer-support groups, and within the health system delivery to provide effective treatment and care to MSM and transgender people*
 - *Review and adapt current national STI guidelines and SoPs to address MSM and transgender people issues, and SoPs for counsellors as well*
 - *Ensure that STI clinics have appropriate equipment and materials for the diagnosis of rectal STI or any other rectal issues*

- *Improve the procurement and distribution of condoms and water-based lubricant between the NACP and the health system and civil society organizations, particularly those working with key populations*
 - *Establish strategic outlets for condoms and water-based distribution (free distribution through traditional outlets and social marketing in strategic entertainment establishments or shops), and promote the existence of these outlets through a demand generation campaign*
 - *Develop a targeted campaign for MSM and transgender people using below the line communication to increase self-esteem and access to services for these populations, and particularly to promote the existence of peer-support groups and a community dialogue. The development of a blog or forum online, which could be managed by the peer-support groups, could be envisaged for MSM.*
- 3. Strengthen the national strategic information framework by including key information on prevalence of same-sex sexual behaviours, high-risk behaviours, and HIV and STI, and knowledge about this population**
- *Review and standardize programme indicators for MSM and transgender people including reached through peer-outreach, access to commodities, and access to services such as VCT, STI and treatment. The data should be disaggregated by sub-populations i.e., MSM and transgender people, and also by key age groups at health services and at prevention programme level*
 - *Explore the possibility to implement a more accurate size estimation for MSM and transgender people by using the scale-up network method*
 - *Include systematic questions related to same-sex sexual behaviour and anal sex practice in any behavioural survey or integrated behavioural and biological survey among male populations (could be combined with the recommended scale-up network method for size estimation) in Bhutan, to estimate the prevalence of these key indicators and the trends over time. Although, it will be more relevant to conduct these surveys directly amongst MSM and transgender people, the absence of established and significant MSM and transgender people networks and the unmarked and diffused same-sex behaviors in Bhutan challenge the implementation of a random sampling approach that is required for these surveys. However, the implementation of these surveys may be considered at later stage.*
 - *Establish strategic linkages with universities in the region to support the development of social science research for building evidence base for HIV prevention programme among MSM and transgender people in Bhutan such as exploration of social and sexual networks, norms, value structures, social and sexual modes of engagement, and understanding of sexuality and sexual health among MSM and transgender people, including youth.*

1. Background and Rationale

HIV prevalence and incidence among men who have sex with men (MSM) and transgender people is increasing in most countries worldwide [1,2]. The levels of HIV prevalence in these countries are substantially higher compared to estimates of the general adult population [1]. In Asia, where HIV counselling and testing uptake among these populations together with the use of HIV care, support and treatment services is already low [3], the level of HIV counseling and testing uptake is much lower in the countries where male-to-male sex is criminalized [4].

Bhutan has maintained an HIV prevalence below 0.01 percent with total reported cases of 297 as of November 2012 [5]. However, increased incidence of sexually transmitted infections in the country remains a major concern for the National AIDS Control Programme (NACP). The Bhutan Annual Health Bulletin (2012) described a significant increase of STI incidence from 19 per 10,000 people in 2008 to 26 $\frac{\text{‰}}{\text{‰‰}}$ in 2009 [6]. Various surveys, which were conducted to study sexual behaviour among sexually active men and women, identified a significant proportion of male also reporting same-sex sexual behaviour. For instance, the General Population Survey in 2006 showed that 1.7 percent of all men in urban areas (2.3 percent of married men in urban areas) reported same-sex sexual behaviour in the past year [7]. The rapid assessment of Sexual Behaviour Network in Thimphu between October 2009 and January 2010 found that 2 percent of men reported that their first sexual partner was of the same sex [8]. Another study in 2009, the National Baseline Assessment among drug users, showed that 3 percent of male drug users reported “ever had sex’ with a male partner [9].

It calls for a review of Article 213 of the Penal Code of Bhutan and the use of new guiding principles, many of which promote enabling environments for MSM. The imperative of ensuring universal access and equity in health service delivery were echoed in the remarks of Nima Wangdi, the Honorable Secretary for the Ministry of Health, at the Bhutan National Stakeholders Meeting on Advocacy and HIV Prevention Among MSM and Transgender People in May 2012 [10]. While the HIV prevalence for MSM and transgender people in Bhutan is still not known, there are evidences suggesting that there are high level of HIV-risk behaviours for MSM and transgender people, with no specific services (prevention, care and support, and treatment) being provided to reduce these HIV and STI-risk behaviours [10]. A review on legal environments, human rights and HIV responses among men who have sex with men and transgender people in Asia and the Pacific revealed that male-to-male sex is criminalized in 19 out of 48 countries of the Asia Pacific region, including Bhutan. These repressive legal environments marginalize MSM and transgender people and contribute to low access to services [4]. Given the current absence of organized MSM and transgender people groups/networks or community response in Bhutan, as compared to neighboring countries such as Bangladesh, Nepal, and India [11], and consequently the challenges in reaching these populations, it is reasonable to expect that MSM and transgender people in Bhutan are facing some degree of social discrimination that may increase their HIV-risk behaviours and limit their access to relevant health services. Published reviews demonstrated that internalized homophobia, perceived stigma and discrimination have a significant negative impact on both mental and physical health [12–15]. In addition, several studies have shown that MSM who experience higher levels of social discrimination are also more likely to engage in risky sexual behaviour, resulting in increased vulnerability to HIV [16–18].

In this context, the National AIDS Control was interested in conducting a formative assessment to assess the barriers for MSM and transgender people to access services, particularly the level of stigma and discrimination perceived by MSM and transgender people and in health care settings. The UNDP Regional Centre and UNDP Bhutan provided technical assistance to the NACP to design and conduct this formative assessment that was implemented from January to April 2013.

2. Goal and Specific Objectives

This formative assessment was aimed at identifying recommendations to develop interventions to reduce social discrimination against MSM and transgender people in Bhutan, and to increase the use of prevention, care and support, and treatment services for these populations. The specific objectives of this formative assessment were:

- To identify level of stigma and discrimination towards MSM, transgender people, and people living with HIV among health care providers in the health care system in Bhutan
- To assess strengths, limitations, and needs of health services in dealing with and managing sexual health for MSM and transgender people
- To describe social networks of MSM and transgender people
- To identify key barriers for accessing health services for MSM and transgender people
- To describe level of stigma and discrimination experienced by MSM and transgender people in their daily life and when accessing services support & care, and treatment services, particularly for HIV testing and STI screening
- To identify recommendations to reduce stigma and discrimination and implement interventions reaching MSM and transgender people, including youth

3. Methods

3.1. Study design

A cross sectional design with mixed methods (qualitative and quantitative) was used for this formative assessment. The data were collected between January and April 2013

3.2. Study population and eligibility criteria

This formative assessment research involved four distinct populations: health care providers, men who have sex with men, transgender people, and stakeholders

3.2.1. Health care providers

Male and female health care providers from six selected districts (Thimphu, Sarpang, Samdrupjongkhar, Wangdue, Chukha, and Bumthang) were interviewed either through quantitative or qualitative methods. These districts were selected based on their population size and the number of reported HIV cases. In addition, the recent MSM and transgender people size estimation and mapping were also conducted in these districts.

- Quantitative:
 - Doctors, nurses, health assistants, laboratory technicians, and HIV counsellors currently working in the health system in 6 districts in Bhutan and who were more likely to be in contact with MSM and transgender patients/clients, were contacted to complete a structured questionnaire
- Qualitative:
 - Health care providers working directly with HIV and STIs in these selected districts were recruited to participate in-depth interview
 - The District Health Officer in each selected district was recruited to participate in key informant interviews

3.2.2. Men who have sex with men

Bhutanese men self-reporting anal or oral sex with another man in the past year, aged 18 years old or more*, and living in the selected districts for at least one year were recruited for in-depth interviews. MSM were recruited in Thimphu and Phuntsholing cities where the estimated number of MSM was estimated higher. MSM reporting age less than 18 years old were excluded from the formative assessment.

3.2.3. Transgender people

Bhutanese biological males self-identifying as a “transgender” or “woman”, self-reporting anal or oral sex with a man in the past year, aged 18 years old or more†, and living in the selected cities for at least one year were recruited for in-depth interviews. Transgender participants were also recruited in Thimphu and Phuntsholing cities. Transgender people reporting age less than 18 years old were excluded from the formative assessment. No transgender men participated in this study.

* Due to the constraints of the ethical guidelines of the REBH i.e., asking parental or guardian consent to interview underage participants, the team decided to recruit participants aged 18 years old or above. However, during the design of the formative assessment and the consultation with stakeholders it has been brought to the attention of the team the existence of underage MSM and transgender people in Bhutan

† *Ibid.*

3.2.4. Stakeholders

Stakeholders including NACP, UN family programme manager (focal point on HIV/AIDS), INGOs and NGOs working on HIV, District Health Officers, and lawyers/policy makers were invited to participate to the consultation.

3.3. Operational definitions

The following operational definitions were used during the formative assessment

- **Fear of HIV transmission** through casual contact with people living with HIV (i.e., contact that would not lead to transmission) and through common health care related practices, resulting avoidance of contact with them
- **Value-driven stigma:** assumptions and judgments made about how people living with HIV had contracted HIV, which are manifested in stigmatizing attitudes
- **Homophobia:** irrational fear, hatred, discrimination against people who are same-sex attracted, or who are perceived to be same-sex attracted. Through informal discussions with health care providers, MSM, and transgender people in Bhutan held during the design of the formative assessment, the team identified a lack of understanding and confusion between the terms MSM and transgender, and the absence of these terms in *Dzongkha* language. Therefore, in the self-administered questionnaire, it has been decided to assess “homophobia” encompassing attitude towards MSM and transgender people, rather to assess “homophobia” and “transphobia” respectively.
- **Internalized homophobia:** refers to negative attitudes and feelings that MSM and transgender people have towards themselves because of their sexuality. Internalized homophobia is also termed as self-stigma.
- **Enacted stigma:** experiences of discrimination related to being MSM or transgender people such as being discriminated in health settings or at workplace, not willing to access services due to fears of being discriminated, being physically harassed and verbally abused, and being excluded from social gathering

3.4. Data collection procedures

Different methods and instruments were developed according to the objectives and populations surveyed as indicated in table 1.

3.4.1. Questionnaire with health care providers

A structured questionnaire including closed-ended questions and ordered scale (Likert Scale) was used for health care providers. This questionnaire was self-administered and included seven sections 1) socio-demographic and economic characteristics; 2) professional experience with MSM and transgender people; 3) sexual orientation and MSM and transgender people in their social circle; 4) basic knowledge on HIV [19] and fears of contagion [20]; 5) attitude towards people living with HIV; 6) attitude towards health care related practices and HIV; and 7) attitude towards MSM and transgender people i.e., “homophobia”. Likert scale related to attitude towards people living with HIV and attitude towards health care related practices (sections 5 & 6 of the questionnaire) were adapted from a research on HIV Stigma index in India. The internal consistency reliability for this index was 0.74 (Cronbach’s alpha coefficient) [21]. The scale related on attitude towards homosexual was adapted from a study which showed a high level of internal consistency (Cronbach’s alpha coefficient = 0.93), but also a good test-retest reliability ($r = 0.71$) [22]. These scales were slightly adapted for Bhutan and field-tested to assess the level of understanding of the items. All the items were rated on a 5-point Likert scale from 1 to 5: “strongly agree”, “agree”, “no opinion”, “disagree”, and “strongly disagree”. The highest score represented a high level of the attribute being measured.

‡ As mentioned earlier, the self-administered questionnaire included only a scale on “homophobia” encompassing attitude towards MSM and transgender people, rather to assess “homophobia” and “transphobia” respectively.

Table 1: Objectives, study populations, and data collection procedures

Specific Objectives	Populations	Procedures
Identify level of stigma and discrimination towards MSM and transgender people among health care providers in the health care system in Bhutan	Health care providers in the health system in Bhutan	Self-administered structured questionnaire In-depth interviews
Assess strengths, limitations, and needs of health services in dealing with and managing sexual health for MSM and transgender people	District Health Officers	Key informant interviews
Describe social networks of MSM and transgender people Identify key barriers for accessing health services for MSM and transgender people Describe level of stigma and discrimination experienced by MSM and transgender people in their daily life and when accessing services support & care, and treatment services, particularly for HIV testing and STI screening	MSM and transgender people	In-Depth Interviews
Identify recommendations to reduce stigma and discrimination and implement interventions reaching MSM and transgender people, including youth	Stakeholders	Consultation

3.4.2. Topics guide for in-depth and key informant interviews

All in-depth and key informant interviews were conducted using topics guide, and recorded. Interviews were semi-structured using open-ended probing questions and anecdotes to enhance the collection of the qualitative data:

- Topics guide for IDIs among MSM and transgender people included the following topics: key socio-demographic characteristics, sexual orientation, MSM and transgender people networks, internalized and external homophobia, enacted stigma, and barriers to access health services. In the absence of a specific theory to understand the social support available to MSM and transgender people, the study adapted a more general social support theory, which addresses various types of support affecting an individual's psychological and environmental well-being [23], and examined emotional and tangible support for the MSM and transgender people participants.
- Topics guide for IDIs among health care providers working directly with HIV services, included the following topics: key socio-demographic characteristics, communication with MSM and transgender people as patients/clients, stigma and discrimination against MSM and transgender people, and contribution on the National Strategic Plan for HIV/AIDS (2012-2016) in Bhutan.
- Topics guide for key informant interview with district health officers included the following topics: key socio-demographic characteristics, awareness of the National Strategic Plan for HIV/AIDS in Bhutan, stigma and discrimination against MSM and transgender people, and contribution on the National Strategic Plan for HIV/AIDS in Bhutan.

3.4.3. Topics for the consultation with stakeholders

Topics discussed during the consultation with stakeholders included the presentation and discussion of the preliminary findings of the formative assessment; the identification of key barriers for accessing HIV (prevention, care & support, and treatment) and legal services for MSM and transgender people; priority interventions to improve access to relevant services for MSM and transgender people; potential funding for priority interventions. Inputs from stakeholders during the working groups were summarized and organized by key topics.

3.5. Sample size

3.5.1. Health care providers and authority

- **Self-administered and structured questionnaire (quantitative):** all doctors, nurses, health assistants, laboratory technicians, and HIV counsellors from selected districts were targeted for this component of the formative assessment. Based on most recent human resources data (table 2), **887 health staff** in the 6 selected districts were enumerated and expected to complete the questionnaire (take all approach).

Table 2: Enumeration of health care settings and health care providers in selected districts in Bhutan[§]

		Bumthang	Chhukha	S/jongkhar	Sarpang	Thimphu	Wangdue	Total
Health Facilities	Hospital	1	3	2	2	4	1	13
	BHU*-I	0	1	2	0	1	1	5
	BHU*-II	4	8	6	10	0	9	37
Health Care Providers	Medical Doctors	1	14	2	15	65	4	101
	Nurses	7	52	18	60	281	19	437
	Health Assistants	12	36	18	35	42	27	170
	Lab Tech.	4	18	12	25	115	5	179
	Total	24	120	50	135	503	55	887

*BHU = Basic Health Unit[¶]

- **In-depth interviews**

In Bhutan, the majority of the HIV care and support and treatment services are centralized in Thimphu. Health care providers working directly on HIV care and support, and treatment were targeted for IDIs. Up to **15 health care providers** (doctors, nurses, health assistants, laboratory technicians, and HIV counsellors) were contacted for IDIs. This sample size was expected to be enough to identify meta-themes and obtain data saturation [24–26].

- **Key informant interviews**

The District health officer in each selected district (6 districts) was asked to partake in key informant interviews. A total of **6 district health officers** were contacted for the interview.

3.5.2. MSM and Transgender people

Given the social context in Bhutan, it was expected that the number of MSM and transgender people, who will be willing to participate to this formative assessment, would be limited. This was confirmed during field visits for the preparation of the formative assessment. It also explains why the investigators did not plan to conduct a quantitative survey with random sampling for these populations. However, it was planned to recruit 10 MSM and 10 transgender people in two selected cities of Thimphu and Phuntsholing (**total of 20 MSM and 20 transgender people**) to participate to IDIs. These cities were selected based on the preliminary findings of the size estimation exercise that was implemented by another team during the preparation of this formative assessment. This sample size for each concerned population will be enough to identify meta-themes and obtain data saturation [24–26].

[§] Communication with Human Resources Department at Ministry of Health, Thimphu, Bhutan, on the 2nd of November 2012

[¶] BHU I is considered as a small hospital (below the district hospital in the referral system) staffed with medical doctors and including in-patient service, whereas BHU II is only staffed with health assistants and provides basic health services, including prevention (assimilated to health center).

3.5.3. Stakeholders

Up to **30 stakeholders** including NACP, UN family programme manager (focal point on HIV/AIDS), INGOs and NGOs working on HIV, District Health Officers, and lawyers/policy makers were invited to participate to the consultation.

3.6. Recruitment of participants

3.6.1. Health care providers for the self-administrated questionnaire

In each selected district, the District Health Officers were contacted by the NACP through a formal letter issued by the MoH, and a follow-up telecommunication to explain the purpose and the objectives of the formative assessment and obtain their collaboration for the distribution and collection of the questionnaires. During the implementation of the formative assessment, the recruitment strategy was modified to accommodate the poor response rate from the districts due to limited human resource and time constraints as reported by the DHOs. In Thimphu district, the HISC focal person was selected to distribute to and collect the questionnaires from health facilities. One team member of the formative assessment from Thimphu HISC was sent out to collect the questionnaires from the rest of the selected districts. In each district the DHO was contacted to identify health facilities where the questionnaires were not distributed and collected. The focal person then obtained permission from the health facility management for distributing and collecting the questionnaires. The completed questionnaires were collected in the sealed envelopes that were later opened and compiled according to district code. The new recruitment strategy assured greater response rate and timely collection.

3.6.2. Health care providers (IDIs) and district health officers (KIIs)

Health care providers were identified by the DHO in consultation with the HISC focal person in each district. After identifying the health care providers for IDIs, the respective DHO provided formal instructions to the respective health facility for conducting the interviews.

3.6.3. MSM and transgender people

Because of the social context for MSM and transgender people and the challenges to identify and contact them, MSM and transgender people were recruited through a mix of chain-referral (snowball) and opportunistic sampling techniques [26]. The formative team was divided into two groups with one member from the community in each group. The team then followed the chain-referral sampling technique. MSM and transgender people enrolled in the size estimation and mapping exercise were contacted and recruited as “seeds”. These “seeds” were interviewed and provided with the telephone number of the interviewer to set up an appointment with the referred peer. If the referred peers did not contact the interviewers, the “seeds” were then re-contacted to refer new peers.

With regard to the opportunity sampling technique, the formative assessment team used the preliminary data of the mapping exercise to identify locations where MSM and transgender people gather in the two selected districts. “Gay websites” were also used to identify and recruit potential participants. In these identified physical and virtual locations, the team approached MSM and transgender people to assess the possibility to involve them in the formative assessment. The “recruiter” from the transgender community worked with the interviewers to identify potential participants and build the relationship before starting the interview. Once agreed, the “recruiter” made the necessary arrangements for the interview.

3.7. Data management and analysis

3.7.1. Structured questionnaire

Two different data clerks using Microsoft Access performed double data entry. Dataset comparison for the validation of data entry was done with EpiData.** After correcting discrepancies and solving inconsistencies, the final dataset was exported to STATA 11†† for data management and analysis.

The team identified two major biases during data management: the unit non-response (respondents who did not answer to the questionnaire), and item non-response (respondents who did not answer to one or more questions i.e., missing value). For minimizing these biases, the following procedures were applied before the analysis:

- The unit non-response: handled by calculating and applying a weight unit inversely proportional to the probability of response. Standardized weights were then calculated for a weighted analysis.
- The item non-response: multiple imputation [27] using imputation by chained equations [28,29] to compensate for missing values, was performed. Prior to conduct the multiple imputation, the patterns of missing values were explored among the variables related to socio-demographic and professional characteristics of the respondents, and then the variables (or items) of the Likert scales: 4 percent of the respondents had no missing values, 88 percent had missing values for 1-10 variables, and 8 percent for more than 10 variables out of 74 variables. To explore the types of missing data, the correlation between missingness on key variables with other variables were assessed. Overall, the majority of the correlations between these variables (correlation matrix) were found from small to moderate suggesting a most at random (MAR) type of missing data. As the fraction of missing information was moderate, 10 imputations ($m = 10$) were performed. Variables, including dependent and independent variables, were used for the imputation, except the variable on “reported sexual orientation” and “MSM or transgender acquaintances”. For the latter, the missing values were re-coded as no-answer, leaving the variables with no need for imputation.

Frequency for binary and categorical variables, and measures of central tendency for continuous variables were used for the descriptive analysis. Relationships between binary and or categorical variables related to socio-demographic and professional characteristics were examined by computing the Pearson’s chi-squared test with a 2-sided level of significance of $\alpha = 0.05$.

Likert-scales: after reversing code, each item of the Likert-scale was analyzed by computing the proportion of each score and the measures of central tendency including mode and quartiles. The Cronbach’s alpha coefficient was computed to assess the reliability of each Likert- scale.

Factor analysis (principal factor) was used for assessing the validity of the scales and for identifying underlying factors. Prior to conduct the factor analysis, the determinant of the matrix of correlation was assessed with the Bartlett’s test for sphericity and the sampling adequacy with the Kaiser-Meyer Olkin (KMO) measure [30,31]. These measures allowed the appropriate usage of the factor analysis by assessing whether there were sufficient correlations within the correlation matrix for proceeding with the factor analysis. To determine the number of meaningful factors, the Kaiser and scree test (graphical method) were used [32]. Therefore, factor with eigenvalue of 1.0 or greater were kept for the factor analysis. Different rotation options (orthogonal: varimax, and oblique: promax) were performed and compared to find optimal solution and increase the interpretability of the underlying factors [32]. The Cronbach’s alpha coefficient was then examined for each factor to determine whether they can be used as effective measures. For each factor, indexes were predicted using the post-estimation command of the factor analysis.

To explore factors associated to “*misconceptions about homosexuality*” and “*homophobia*”, a multivariable quantile regression for the lower (25th percentile) and upper quantile (75th percentile), reflecting for these underlying

** Lauritsen JM. (Ed.) *EpiData Data Entry, Data Management and basic Statistical Analysis System*. Odense Denmark, EpiData Association, 2000-2008 www.epidata.dk

†† StataCorp. 2009. *Stata Statistical Software: Release 11*. College Station, TX: StataCorp LP.

factors the lowest and highest indexes, was performed for each of these factors. This analysis did not include the exploration of factors associated with other underlying factors extracted through the factor analysis ("*stigma towards PLHIV*" and "*value-driven stigma*") as it is assumed that existing explanatory variables may be too limited to give a meaningful interpretation. Before fitting the model, categorical variables with small cells were dichotomized, such as education, function of healthcare providers, basic HIV knowledge, fears of HIV infection through occupational exposure, comfort in discussing sexuality, and level of understanding MSM and transgender health issues. Continuous variables were transformed by 10 years for "age" and by 5 years for "number of years working as health care provider", but kept as continuous variable. Binary variables with small cells such as religion were not explored. Variables related to the index of the other underlying factors ("*stigma towards PLHIV*" and "*value-driven stigma*") were kept without any transformation. A first selection of the explanatory variables (or independent variables) was done through bivariate analysis using quantile regression for each selected quantile (lower and upper quantiles). Variables with a p-value < 0.350 were then entered into a multivariable quantile regression using backward stepwise model selection procedure for each selected quantile. The goodness of fit of each model was assessed through the calculation of R-squared and a visual method with a graph of observed values and predicted responses.

3.7.2. In-depth and key informant interviews

Qualitative data from the in-depth interviews and key informant interviews were manually analyzed using thematic analysis methods. All in-depth interviews and few of the key informant interviews were conducted in native language. Both in-depth interviews and key informant interviews were tape recorded with the consent of the interviewee. The recordings were then transcribed verbatim from the native language (Dzongkha) and translated into English. During transcription, all personal identifiers were removed and an interview code was assigned to protect confidentiality of the respondent. The research coordinators checked the accuracy of the transcription by randomly choosing about 20 percent of the transcripts and comparing them with the respective audiotapes.

Following the transcription, the recurring themes were grouped under the predefined topics. After grouping, a summarized theme, which retained original illustrative quotes to minimize translator biases, was developed. Themes were then listed, compared and contrasted by using the method of constant comparison. Constant comparison is a process through which each piece of data is compared and contrasted with other data to build a conceptual understanding of the categories within the phenomenon of interest. Finally the resulted summarized themes and all representative quotes were drawn from the interviews for the report.

3.7.3. Consultation

After data collection and preliminary analysis a consultation with key stakeholders (NACP, UN family focal points on HIV/AIDS, INGOs and NGOs working on HIV, District Health Officers, and lawyers/policy makers) was organized. During this consultation, the preliminary findings of the formative assessment were presented and discussed. Participants were split-up in small groups to discuss the findings and provide inputs and recommendations. These inputs and recommendations were then organized by theme.

3.8. Ethical considerations

The protocol, including tools and consent forms, was reviewed and approved by the Research Ethics Board of Health of Ministry of Health in Bhutan (REBH Approval 2012/033). Informed consent was obtained through face-to-face contact between the interviewer and the participants partaking in-depth and key informant interviews, and self-administered (included in the questionnaire) for health care providers involved in the quantitative survey. Informed consents were not obtained from stakeholders participating to the consultation since they were asked to provide inputs only on the key findings and recommendations. The interviews were anonymous and no name or any other identifiers were collected. The interviews took place in a location where privacy was respected.

4. Results

4.1. In-depth interviews with MSM and Transgender people

4.1.1. Demographic Information

In total, 6 MSM and 9 transgender people were recruited for the study using both the chain referral and opportunity sampling techniques in the two pre-identified cities of Phuntsholing and Thimphu. The age of the participant ranged from 20-32 years old for MSM, and from 20-26 years old for transgender people. All transgender participants were currently single, and 2 out of 6 MSM reported being in a long-term relationship with a male partner. The study found a difference in level of education and monthly income between the two sub-populations. Almost all the MSM interviewed were employed, and all had an undergraduate degree, except for one who had recently completed the 12th grade and was waiting for college admission. The monthly income for MSM ranged from Nu 10,000 to Nu 20,000 (~185 to 470 USD), whereas for transgender participants it ranged from Nu 4,000 to Nu 10,000 (~74 to 185 USD). As opposed to MSM participants, the majority of transgender people were unemployed with no regular source of income.

Table 3: Key socio-demographics of MSM and transgender people interviewed through IDIs

	MSM	Transgender people
Total (15)	6 (3 in each cities)	9 (8 Thimphu and 1 in Chukkha)
Marital Status	4 single and 2 in relationship with man	All single
Age range	20-32 years old	20-26 years old
Monthly Income	Nu 10,000 – Nu 20,000	Nu 4,000 – Nu 10,000
Education	5 Undergraduate and 1 completed 12 grade	5 illiterate and 3 completed grade 6, 8 and 12
Work	1 student, 1 civil servant, 3 corporation, and 1 self-employed	5 unemployed, 2 famer, 1 server, and 1 beautician

4.1.2. Disclosure of sexual orientation

Majority of the MSM participants were uncomfortable identifying themselves as MSM or “Gay”. A 29-year-old MSM in Thimphu clearly echoed the view of other MSM:

“I identify myself as gay within the four walls of my room, but to the outside world I am a “man.” What can I say? It is hard for Bhutanese to understand and I am not going to be the first one to explain”

- a 29-year-old MSM in Thimphu

Unlike MSM participants, the study observed relatively high level of self-confidence amongst transgender people while discussing sexual orientation. All the transgender people participants were “open” about their sexual orientation.

“I am transgender people and there is nothing I can do to change it... I am what I am”

- a 27-year-old transgender people in Thimphu

In addition, few of the transgender participants have even revealed their sexual orientation to co-workers and till date it has not created any personal or professional issues.

“One day, I showed up in “kira” (national dress for women) and a [male] co-worker asked me why I was coming in “kira”. I explained that I am a transgender. After looking around, he told me that if I am happy and it does not affect the work, he has no problem. That was the only discussion we had and since then we have never had any further discussion on my sexual orientation”

- a 26-year-old transgender person in Thimphu

None of the MSM participants have ever had discussed their sexual orientation with family and friends. As mentioned by the participants, the barriers for not disclosing their sexual orientation are socially and culturally enrooted in the Bhutanese society such as: the current cultural and traditional values that define the gender roles and taboos associated in discussing sexuality including same-sex sexual behaviour. They also perceived that the legal environment emphasizes these barriers, as same-sex relationships are still illegal in Bhutan.

4.1.3. Social support

The study found different levels of social support for MSM and transgender participants. The majority of MSM to date has not revealed their sexual orientation or intimate life experiences to anyone in their inner circle such as their family and close friends. Therefore, emotional support for MSM is largely non-existent. On the other hand, the majority of transgender respondents reported having a good base for social support from family and friends, as reverberated by a transgender people.

“I am happy as I can share my problems with my other transgender people friends and they are always here for me. With family I still find difficult to discuss boyfriend related issues. If I have any financial problem then I go and talk to my family otherwise I hang around with my transgender friends and we look for a solution to my problem”

- a 25-year-old transgender person in Thimphu

All transgender participants revealed that although the process of coming out to family has been perceived as a substantial challenge and a difficult experience, they are now reaping the benefits in terms of communicating openly with their family and friends, and receiving tangible support when needed. Transgender participants generally expressed a high level of acceptance from their close social circle, whereas MSM participants expressed strong fears of stigma and discrimination from family, friends, and the general population at large.

Although transgender people expressed enjoying the support from their family and friends, most of them admitted that during the period of coming out, they experienced a difficult phase of psychological stress mainly due to the rejection by family and friends with, sometimes, violence as reported by a transgender.

“Initially it was very difficult for my parents to accept and understand me. Very often, my father abused me physically due to my feminine behaviour, and he condemned on many occasions. I was warned that if I continued to be myself, they would disown me”

- a 25-year-old transgender person in Thimphu

As opposed to transgender people, MSM participants indicated a significant lack of understanding and support from family and friends.

“Every parent has an expectation that one day their son will marry a good girl and start a family... I don't think any parent wishes to see a son bringing home a man and defy the law of nature”

- a 27-year-old MSM in Phuntsholing

4.1.4. Social Networks

From the interviews with the MSM respondents, it appeared there were not really formal social MSM networks, but rather some individual or group connections amongst MSM. MSM respondents confessed that they hardly know other MSM (who know each other and they can contact when needed). They also expressed reservation and concerns with regard to going out or to be seen together in a group with other MSM peers.

“When we go for parties, we always make sure that there are girls in our group”

- a 29-year-old MSM in Thimphu

MSM reported to get together in private parties and by organizing out of town excursions. It is noteworthy that these gatherings were never MSM exclusive, but also involved straight guys (straight men and women)

“I don’t recollect ever going to any gathering with only “gays” in Bhutan. We [his partner and himself] have been a couple of times to these exclusive parties, but abroad. In Bhutan, we always have a “mixed bag” [i.e., with straight men and women] and sometimes it is difficult to be ourselves within that group”

- a 31-year-old MSM in Thimphu

As opposed to MSM, the majority of the transgender participants had either heard from or had the phone numbers of transgender peers in the same location. They also expressed no reservation in going out together to party or gather in a public place with other transgender people.

“We always party together and most of the time we like going to “Drayang” (dance bar) to sing and dance... We are all very good dancers and some of them are working there, so we have a great time together”

- a 20-year-old transgender person in Thimphu

4.1.5. Sexual Networks

With regard to sexual partners, the study found that sexual partners of MSM are not solely male partners. While MSM respondents declared to be attracted to same gender only, most of them confessed that they had and still have sexual relationships with female partners. Two MSM participants, who also reported being in a relationship with another man, also revealed a concurrent relationship with a woman. When asked about the nature of this relationship with the women, the respondents positioned it mainly as a strategy to cope with the stigma.

“We become visible as “gay” if we don’t have a girlfriend... So to prevent many unnecessary explanations, we have a girlfriend to show off to the “society”. It seems to keep everyone from asking too many questions”

- a 22-year-old MSM in Phuntsholing

All transgender participants however mentioned that they are currently looking for male sexual partners, only. A few transgender participants revealed that they had girlfriends in the past, but once they came out about their sexual orientation, they have had male sexual partners, only.

“Today, I cannot imagine myself with a girl. When I look at them I see them as my sister or friend, but not as my sexual partners. Even if she is the prettiest girl in the world, I do not get sexually attracted with women... and I can’t say the same with man”

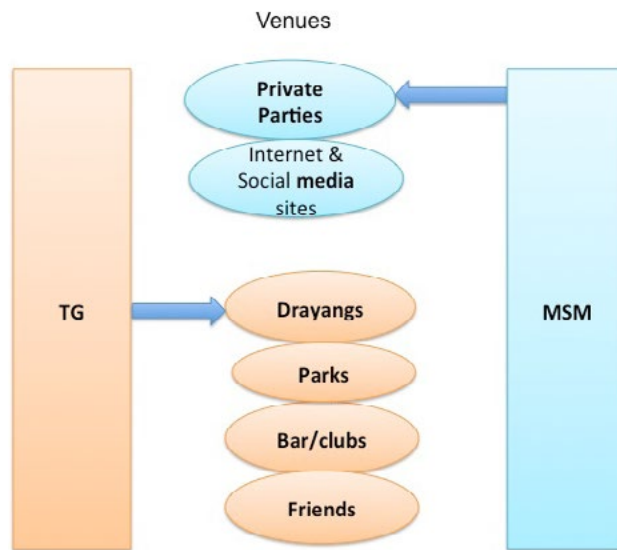
- a 26-year-old transgender person in Thimphu

The recruitment of sexual partners for MSM is mainly done during private parties and through social media websites (figure 1), and to a lesser extent through referral from their MSM peers. On the other hand, transgender participants reported finding sexual partners mainly in bars, clubs, and “drayang”, and also through referral from their transgender people peers. Social media and dating websites (international gay websites) were commonly used by MSM respondents to recruit sexual partners, whereas transgender people reported using cell phones to initially contact with their sexual partners. Most MSM respondents also reported that as a part of their education or job, they have had traveled abroad (India and USA) where they also had the opportunity to find causal male sexual partners.

“I have to confess that it is easier to find mates outside Bhutan, where we are all so uptight and live in a small society; it makes it harder to have fun”

- a 32-year-old MSM in Thimphu

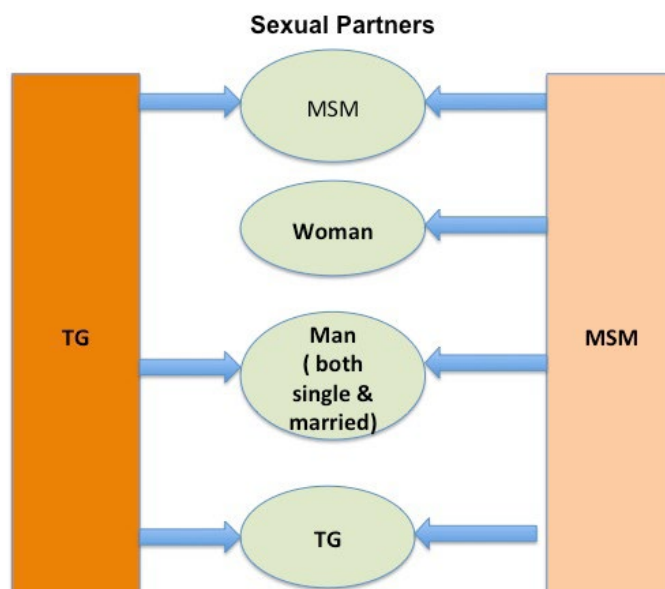
Figure 1: Types of venue for recruitment of male sexual partners of MSM and transgender people respondents



Except for two MSM respondents, none of the other MSM and transgender participants reported having a regular sexual partner. Interestingly, only one MSM revealed commercial male partners (buying sex services when traveling abroad). The majority of the study participants mentioned casual sex partners only.

After probing further on their type of sexual partners, the majority of the MSM mentioned having casual sex with women, married and single men, and transgender people. Transgender respondents confirmed MSM as casual sex partners, included married MSM, and other transgender people (figure 2).

Figure 2: Sexual partners of MSM and transgender people respondents



4.1.6. Stigma and discrimination

The majority of MSM and transgender people believed that there is a high level of stigma of MSM and transgender people in Bhutan's society. The participants recognized that the general population uses stigmatizing labels, particularly for transgender people and those with a feminine expression.

"We are always labeled as "chuckas" (stigmatizing label for transgender people) or "molem" (Dzongkha label for transgender people) and there are always many jokes and laughs about us. I am sure there is no intension to harm, but these attitudes and name- calling make us feel like second class citizens"

- a 23-year-old transgender person in Thimphu

"Some of my friends make fun of gay, and label our feminine friends as "chuckas" and advise them to be more manly"

- a 20-year-old MSM in Chukkha

In relation to education, transgender respondents reported issues of discrimination at school when they were younger, thus explaining their current educational and professional status.

"When I was 16 [years old], I could not stand myself to wear the "gho" (national dress for men) and badly wanted to wear the "kira" like the other girls at school. So, I approached the headmaster and asked if I could come to school wearing the "kira". He rejected my proposal... I was uncomfortable in "gho", so I had to skip classes and that resulted in poor academic performance"

- a 29-year-old transgender person in Thimphu

Furthermore, when asked of formal sector employment, the majority of the transgender participants raised the issues of national identity card that includes the biological sex, and the policy requirement to wear the national dress accordingly.

"I never go to "Dzongs" (District administration center) or apply for jobs in the government or corporations because we have to show our ID card where I am listed as a male with a male name, so I am sure I will never be selected due to the mismatch"

- a 21-year-old transgender person in Thimphu

To understand and shed light on the reservation and challenges of disclosing sexual orientation, the study probed discussion on the legal barriers such as the sodomy law under the penal code section. As per the penal code of Bhutan, 2004 section 213 " 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". The grading of the crime shall be a petty misdemeanor. The majority of the transgender participants were not aware of the sodomy law and any provision under the law. When explained, most of them could not believe the existence of this law.

"I thought there are only the cultural and traditional values that condemns same sex"

- a 20-year-old transgender person in Thimphu

As opposed to transgender people respondents, all MSM were aware of this law. Although till date no one has been prosecuted under the sodomy law in Bhutan, they expressed fears of prosecution. They also identified this law as one of the major deterrent factors for disclosing their sexuality to their social circles.

"When it is there in black and white, it is hard to ignore and turn a blind eye towards. I don't believe that there will be a proactive head hunt for MSM, but if some underlying issues arise then it may be used very conveniently "

- a 31-year-old MSM in Thimphu

Some participants also expressed fear of being reported to police by the health care providers while accessing HIV and STI services.

“I once had sex with a male sex worker in Bangkok and when returning home I had some rashes, which were quite serious, in my anal area. Knowing that I did not use condom, I wanted to get checked and get tested for HIV. Upon consultation with a friend, he asked me to go across the border to get my HIV and STI tested. During that period, beside the social and cultural values the sodomy law was also very much in my mind”

- a 29-year-old MSM in Thimphu

Although none of the study participants directly expressed feelings of shame or self-hate due to their sexual orientation (i.e., internalized homophobia), participants, particularly MSM, shared feelings and situations illustrating self-stigma or internalized homophobia. They shared feelings of isolation that is not corresponding to the Bhutanese society’s norms. Given that MSM were much more “hidden” compared to transgender people, their level of fear of being “recognized” as MSM and consequently the feeling of isolation was relatively higher amongst MSM respondents.

“You cannot comprehend how it is to live two lives and constantly be worried about your own identity and the fear that people will judge you because of your behaviour. Someday I hope that we will be able to come out and live our life to the fullest”

- a 32-year-old MSM in Thimphu

“My parents are uneducated and are very traditional. So, for them it will be near impossible to understand my feelings. Even my so-called well-educated friends have a difficult time accepting gays in our culture. They joke and make fun about it casually, not realizing that I too am one of them”

- a 31-year-old MSM in Thimphu

Some MSM admitted to guarding their emotions and feminine expression when at home, not only to conceal their sexuality but also in an attempt to not to bring any shame to their family members.

A few of the MSM interviewed also expressed guilt for not disclosing their sexuality to their family and friend, especially parents.

“I am very close to my parents and they have been supportive of my every decision. Sometime I feel that I should disclose my sexuality to my parents, but my greatest fear is losing the respect and love of my parents. I think my mom senses something because she tried to initiate discussion couple of times, but I don’t have the courage to face her or my dad as well”

- a 24-year-old MSM in Thimphu

Transgender people also expressed difficulty to develop a relationship with a man. The confusion on when is the appropriate time to disclose their real gender to their boyfriend and the concerns that they will never be able to have a family of an open companionship posed serious concerns and challenges for them.

“People assume that due to the mismatch of expression and orientation, we are “recognizable”, but you will be surprised by how many are clueless, and at the end we often get rejected due to our sexuality”

- a 23-year-old transgender person in Chukkha

“I was approached by a good and handsome man and he was genuinely interested in taking the relationship forward. He told me how much he loved me and looked forward to sharing a life together. I also loved him and due to the fear that I may lose him, I purposely did not have sex with him or introduce him to any of my friends. He was under the impression that I wanted a commitment from him, whereas I was worried about disclosing my real gender. So when I finally decided to tell him, he accused me of misleading him and left me standing”

- a 26-year-old transgender person in Thimphu

4.1.7. Barriers to access health services and commodities

This study looked at the barriers to access health services in the country and examined the level of comfort in communicating with the health care providers. Everyone was in agreement that they never have been barred or denied access to health services and admitted that for those who did not disclose their sexual orientation or appear feminine, it might not be an issue. However, all of them reported that they have never been asked or disclosed their sexual orientation and behaviours when visiting the hospitals or clinics, even for those who sought treatment for a STI problem. When asking about the conditions for them to disclose their sexuality to health care providers, the majority of participants said that it would depend to the attitude and interpersonal skills of the health care provider

“If the health care provider is nice and caring, then I may be willing to share my sexuality with them otherwise it is unnecessary expose ourselves”

- a 27-year-old MSM in Chukkha

Some of the participants highlighted the lack of privacy and issues of confidentiality in the health care setting.

“There are many people queued up and some patients even push the door slightly open to entry as quickly as possible. Therefore, in this environment it is very difficult to discuss personal matters with health care providers. If the word gets out somehow, in our small society it will become gossip in no time”

- a 31-year-old MSM in Thimphu

Some of the participants indicated strong concerns about the lack of interest from health care providers to discuss sexuality and the fear of being inappropriately diagnosed and treated for the health problem they consulted for.

“I am assuming that they are not interested to understand our problems because they don't even try asking questions or showing any interest in our personal life. I am not sure whether it is due to lack of time or there is something else underlying this attitude. After all, if you look at me, I am a transgender person and it is very visible... I have a manly voice with my body in a skirt”

- a 23-year-old transgender person in Chukkha

They also believed that there is a lack of awareness among health care providers on MSM/transgender health issues that may affect the quality of services provided. There was a general consensus on the need to institutionalize confidentiality and to make the health delivery system more transgender/MSM-friendly. Almost all the participants expressed the need to desensitize and build the capacity of health care providers for managing MSM/transgender people health issues.

“I don't blame our caregivers. After all there is very little awareness on our issues everywhere and if the government can help the process, we will be very much obliged”

- a 22-year-old MSM in Thimphu

In terms of access to information on HIV and STI prevention the study found a slight difference in channels for the two groups. For the MSM group the sources of information are mostly through the Internet, newspapers and magazines. On the other hand, TV/ Radios and health information service centers were identified as major sources of information for the transgender participants.

It is important to note that in general the respondents reported a low rate of condom and water-based lubricant use during anal sex, mainly due to lack of knowledge related to HIV transmission and prevention (e.g, there are strong assumptions that the probability of HIV and STI transmission is low during anal sex). The participants reported the lack of water-based lubricant in the market and health facilities, and revealed the use of saliva, petroleum jelly, and mustard oil as personal lubricant. Most of them also reported rectal issues such as tears and warts as major health concerns that would require medical attention. The awareness of availability of HIV testing facilities was high

among both MSM or transgender people. However, only one MSM — as opposed to the majority of transgender participants — reported ever had an HIV test.

4.2. In-depth interviews with HCP and key informant interviews with DHO

4.2.1. Demographic Information

As per the protocol of this formative assessment, 20 health care providers currently providing STI/HIV care and treatment were interviewed along with one assistant district health officer (ADHO) and four district officers (DHO). Of the total 20 HCPs, almost one third (seven) were medical doctors and thirteen were health assistants (HA) and assistant clinical officers (ACO).^{##} Of the seven medical doctors, two were single and five were married with children. All the HA/ACOs were married except one female HA who was single. DHOs and ADHOs were all married with children. The age of the HCP ranged from 22 to 57 years old and for DHOs/ADHOs from 44 to 55 years old. Monthly income for the participant ranged from Nu. 11,000 – Nu. 29,000. Unlike other HCP, all the medical doctors have spent time abroad during their studies, ranging from 5 to 7 years in total.

4.2.2. Experience and communication with MSM and Transgender people

Under this section, the study assessed the general level of awareness, past experiences with the community, and key barriers to discuss sexuality with MSM and transgender people.

4.2.2.1. General awareness and experience with MSM and Transgender people

Due to their extended stay outside the country, all the medical doctors were aware of MSM and transgender people, but few had specific training on sexual health. Although the general level of awareness was high among doctors, very few had interactions with MSM and transgender people. During the past three years, three doctors saw a total of eight cases, two of which were clinical case discussions with medical colleagues from other districts. On the other hand, the majority of the HAs/ACOs were not aware of MSM /transgender people. A few became more familiar during the size estimation exercise that was implemented prior to this formative assessment. Out of the thirteen HAs/ACOs, six have already had interactions with transgender people/MSM patients during OPD consultations. Within the networks of friends and family, none of the HCP was aware of MSM/transgender people. Amongst HAs/ACOs, there was a strong assumption that it does not exist in Bhutan and that it is a “western” style of living, particularly for MSM.

“Now with globalization there are many new ideas and style of living that defer from our traditional values...and I guess this is one of those modern concept which is difficult for our generation to understand”

- HA in Sarpang

As opposed to HAs/ACOs, medical doctors were more open to the possibility of having MSM/transgender people in Bhutan, but some indicated that it may be a psychological problem that can be treated with proper counselling.

“There is a possibility that it could be due to childhood abuse or absence of male role model given that it more common amongst the younger generation which could be due to the exploration and experimentation behaviour”

- a 35-year-old Doctor in Phuntsholing

4.2.2.2. Barriers to discuss sexuality with MSM and Transgender people

During the interviews, the majority of the HAs/ACOs highlighted that they are in fact challenged by the limited knowledge and understanding about MSM/transgender people sexual health issues in Bhutan.

^{##} Assistant Clinical Officers are Health Assistants with clinical skills and based for the majority in hospital or BHU I, whereas Health Assistants are mainly based at BHU II

“We honestly have no idea what are the health issues of the MSM/transgender people and what are the risks associated with same sex behaviour. In my 18 years of services I have never read or attended any training/ workshop on MSM/transgender health issues”

- a 46-year-old HA, Thimphu

When asking about their interpersonal skills on discussing sexuality with patients, there was a general assumption that sexual intercourse always happens between two people of different genders.

“We always assume that sexual intercourse happens between individuals of the opposite sex. We don’t have the knowledge or skills to ask questions on same-sex sexual behaviour, and I am sure that patients may not feel comfortable as well. It is a very sensitive matter”

- a 49-year-old HA in Sarpang

Beside the knowledge and skills limitations, the majority of the HCPs also expressed cultural barriers.

“Same-sex sexual behaviour is somewhat of a taboo in our context, so we never ask”

- a 35-year-old Doctor in Chukkha

Limited time available during medical consultations with patients was also indicated as a barrier to discuss and explore MSM and transgender people health issues.

“Most of the time we have a long line of patients waiting for us. Even if we would like to discuss, the time does not permit it... So it will be good if we can have designated STI clinic and health care providers [to manage these specific health issues]”

- a 35-year old Doctor in Thimphu

4.2.3 Social Belief and Stigma

The study found that the majority of HCPs acknowledged a high level of stigma against MSM and transgender people among general population due to the so-called “unnatural” nature of the same-sex sexual behaviour. Some HCPs described the presence of strong believe in “*lodar*” (bad luck) that could happen from interactions or close acquaintance with a MSM or transgender people.

“During my assignment with the MSM and transgender people size estimation exercise, I was working with transgender people and MSM, and most of my friends and colleagues told me to be careful and perform purification ceremony at the end of project to remove the so called bad luck”

- a 33-year-old HA in Thimphu

In addition, most of them mentioned that name-calling and labeling of MSM and transgender people with no strong intention to harm, is very common in the Bhutanese context. They also believed that compared to general population, the stigma towards MSM and transgender people may be relatively lower in the health care setting. None of the HCPs interviewed reported that they have heard or observed any discrimination against MSM and transgender people in health facilities in Bhutan. They all shared a strong believe that given the compassion of Bhutanese society, it will not happen. One of the doctors shared the experience of Lhaksam (The national network of PLHIV in Bhutan) as an example

“When they came out in public, there was an undercurrent that they will be alienated by the society, but look at what happened, instead they were all welcomed by family friends and public”

- a 39-year-old Doctor in Thimphu

4.2.4 Awareness on National HIV/AIDS Strategy

The majority of HCP respondents were not aware about the National HIV/AIDS Strategy. In addition, most of the HCP raised the issue of focusing on MSM and transgender people population as a public health priority.

“It is hard for me to understand why we are focusing on these “invisible” issues. Instead we should be focusing on other visible health concerns such as cancer, infant mortality etc.”

- a 47-year-old Doctor in Thimphu

Amongst the district health officers and ADHOs, none of them were aware of the national strategy. However, they expressed the need in the future to disseminate it widely, and to involve health care providers during the design, implementation and evaluation of the strategy. As for other HCP interviewed, DHOs and ADHOs thought that MSM/transgender health is not a public health priority in Bhutan considering other emerging non-communicable diseases such as hypertension, cancer, and diabetes.

4.3. Quantitative survey among HCP

4.3.1. Descriptive Analysis

4.3.1.1. Respondent-rate by district and health care provider category

A total of 317 out of 887 health care providers responded to the questionnaire. The overall response rate was 38 percent ranging from 25 percent in Thimphu to 83 percent in Bumthang district. The table 4 shows the number of respondents by district and category of health care providers. The response rate among health care providers ranged from 7 percent among nurse assistant to 65 percent among health assistant. A total of 4 out of 5 HIV counsellors working in Health Information Service Center (HISC) in Thimphu and Chhukha districts responded to the questionnaire. In addition, among those who sent back the questionnaire, other health staff (4 percent) such as ward staff and x-ray technicians completed the questionnaire and were classified in the category “other.” Some of the respondents (2 percent) did not mention their function.

Table 4: Respondents by district and category of health care providers

	Thimphu	Chhukha	Sarpang	S/Jongkhar	Bumthang	Wangdue	Total
Medical Doctor	3	2	7	1	0	0	13
Health Assistant	25	27	22	12	14	10	110
Nurse	57	19	20	9	3	2	110
Nurse Assistant	4	1	3	0	0	3	11
HIV Counsellor	2	2	0	0	0	0	4
Lab. Technician	27	11	10	0	2	0	50
Other	6	3	4	0	0	0	13
Unknown	2	1	0	1	1	1	6
Total	126	66	66	23	20	16	317

4.3.1.2. Level of comfort in completing the questionnaire

Because of the sensitivity of some of the questions in the questionnaire, a question exploring their level of comfort in completing the questionnaire was asked at the end of the questionnaire in order to identify response bias for these sensitive questions. More than three fourth of the respondents revealed either feeling comfortable (59.3 percent) or very comfortable (18.9 percent) to complete the questionnaire, whereas about one fifth reported a certain level of discomfort: 3.7 percent were not comfortable at all and 18.1 percent were more or less comfortable. When comparing this level of comfort by gender, no statistically significant difference was found: 80.4 percent of male versus 75.5 percent of female respondents felt either comfortable or very comfortable to complete the questionnaire ($p=0.292$). There was no significant relationship between this latter indicator and the respondents with a record of “no answer” (i.e., missing value): 78.7 percent of those who had no missing value versus 73.3 percent of those who had missing values felt either comfortable or very comfortable to complete the questionnaire ($p=0.423$).

4.3.1.3. Socio-demographic and professional characteristics of respondents

The table 5 shows the key socio-demographics characteristics of the respondents through no weighted and no imputed data analysis (unadjusted data) and weighted and imputed analysis to compensate for unit and item non-response (adjusted data). Using the unadjusted data, the mean age of the participants was 32.4 years olds (versus 31.5 years old for adjusted data) with a minimum and maximum of 20 and 54, respectively. About half of them (45.5 percent) were between 20 and 29 years old. Half of the respondents (50.7 percent) were male (versus 46.4 percent with adjusted data).

Table 5: Socio-demographic characteristics of the respondents

Socio-Demographic Characteristics	Not Weighted & Imputed			Weighted* & Imputed N** = 317		
	N	n	%	n**	%	
Sex		316				
	Female		159	50.3	160	53.6
	Male		157	50.7	147	46.4
Age	303	Mean: 32.4 SD: 8.2 Min: 20 – Max: 54		Mean: 31.5 SD: 8.0 Min: 20 – Max: 54		
Age category		303				
	20-29 years old ≥ 30 years old		138 165	45.5 54.5	160 157	50.6 49.4
Citizenship		316				
	Bhutanese		309	97.8	308	97.3
	Other		7	2.2	9	2.7
Ethnicity		311				
	Scharchop		137	44.1	139	44.0
	Lhotsampa Other		65 109	20.9 35.0	67 111	21.0 35.0
Ever Married		304				
	No Yes		65 239	21.4 78.6	82 235	26.0 74.0
Have Children		247				
	No Yes		46 201	18.6 81.4	119 198	37.5 62.5
Buddhist		317				
	No Yes		60 257	18.9 81.1	59 258	18.7 81.3

Continued

Highest Level of Education	316				
<i>Secondary High</i>		48	15.2	44	13.8
<i>Diploma- Certificate</i>		226	71.5	225	71.0
<i>Bachelor or higher degree</i>		42	13.3	48	15.2
Level of Monthly Income	299				
< NU. 15,000		162	54.2	181	57.1
NU. 15-20,000		97	32.4	97	30.5
> NU. 20,000		40	13.4	39	12.4
Ever Lived Abroad (> 12 months)	309				
No		253	81.9	253	80.0
Yes		56	18.1	64	20.0

* Standardized weight

** Weighted count

All the respondents, but 9 out of 317 (2.2 percent) were Bhutanese. Among alien health care providers, 5 reported to have an Indian and 2 a Tibetan nationality. The dominant ethnicity was *Scharchop* (44.1 percent) followed by *Lhotsampa* (20.9 percent), and the majority (81.1 percent) reported to be Buddhist. A small proportion (21.4 percent) reported to be single, and less than one fifth (18.6 percent) had no children. Out of 316 respondents, 13.3 percent reported a bachelor or higher degree as their highest level of education, and a similar proportion (13.4 percent) out of 299 respondents reported a monthly income superior to NU. 20,000 (\approx USD 367). About one fifth (18.1 percent) reported to have had ever lived abroad more than 12 consecutive months (versus 20 percent with adjusted data).

The table 6 displays the key professional characteristics of the respondents. Out of 311 respondents, two third comprised of health assistants (35.4 percent) and registered nurses (35.4 percent), and few of them i.e., 13 out of 311 (4.2 percent) were medical doctors. The mean number of years of the obtention of their degree was 8.9 years (minimum 1 and maximum 40 years) and the mean number of years working as health care provider was 9.4 (minimum 1- maximum 40). The majority of them (75.7 percent) were working in hospital whereas the other were either based in Basic Health Unit I and II or in HISC (4 counsellors).

Table 6: Professional characteristics of the respondents

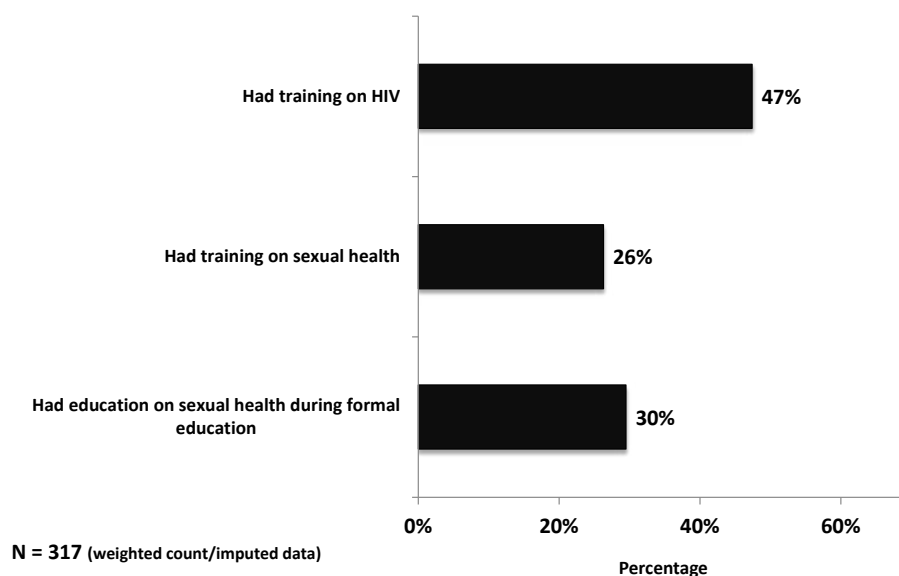
Professional Characteristics	Not Weighted & Imputed			Weighted* & Imputed N** = 317	
	N	n	%	n**	%
Function	311				
<i>Medical Doctor</i>		13	4.2	11	3.6
<i>Health Assistant</i>		110	35.4	98	30.9
<i>Nurse</i>		110	35.4	123	38.7
<i>Lab. Technician</i>		49	15.8	53	16.7
<i>Other</i>		29	9.3	32	10.1
Number Years Obtained Degree	302	Mean: 8.9 SD: 8.1 Min: 1– Max: 40		Mean: 8.1 SD: 7.7 Min: 1– Max: 40	
Number Years working as HCP	305	Mean: 9.4 SD: 7.9 Min: 1– Max: 34		Mean: 8.5 : 7.7 Min: 1– Max: 34	
Type of Health Facility (Currently working)	296				
<i>Hospital</i>		224	75.7	257	81.1
<i>Other</i>		72	24.3	60	18.9

* Standardized weight

** Weighted count

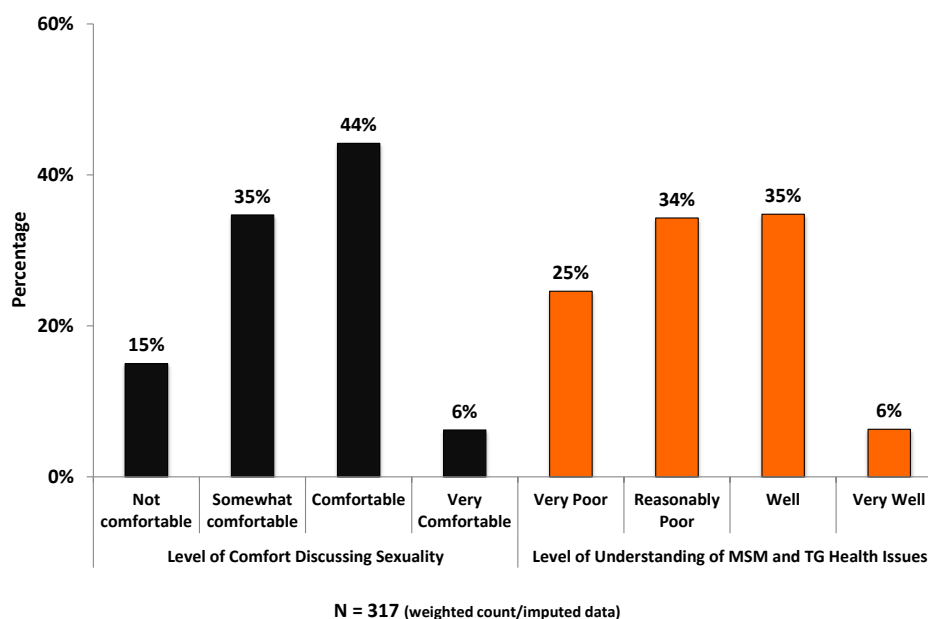
About one third (30 percent) of the respondents reported having received an education on sexual health, including sexual health for MSM and transgender people, during their formal education, and 26 percent reported having attended a training course on this same topic during extra-curricular activities (figure 3). Among the latter respondents, 30.2 percent reported having attended this training in the past 12 months. Almost half (47 percent) of the health care providers reported having attended training on HIV/AIDS, and 23.8 percent of them attended this training in the last past 12 months. Among those who reported having had attended any HIV/AIDS training course, 39 percent revealed that the training included a topic on HIV/AIDS related to MSM and transgender people.

Figure 3: HIV/AIDS and male sexual health training exposure



Health care providers were asked to report their level of comfort in discussing sexuality with their clients and their level of understanding of MSM and transgender people health issues (figure 4). Half of the respondents (50 percent) revealed to feel very comfortable or comfortable when discussing sexuality with their clients. However, out of the total sample less than half (41 percent) of the respondents reported a very good or good level of understanding of MSM and transgender health issues.

Figure 4: Self-reported level of comfort discussing sexuality with clients and understanding of MSM and transgender health issues

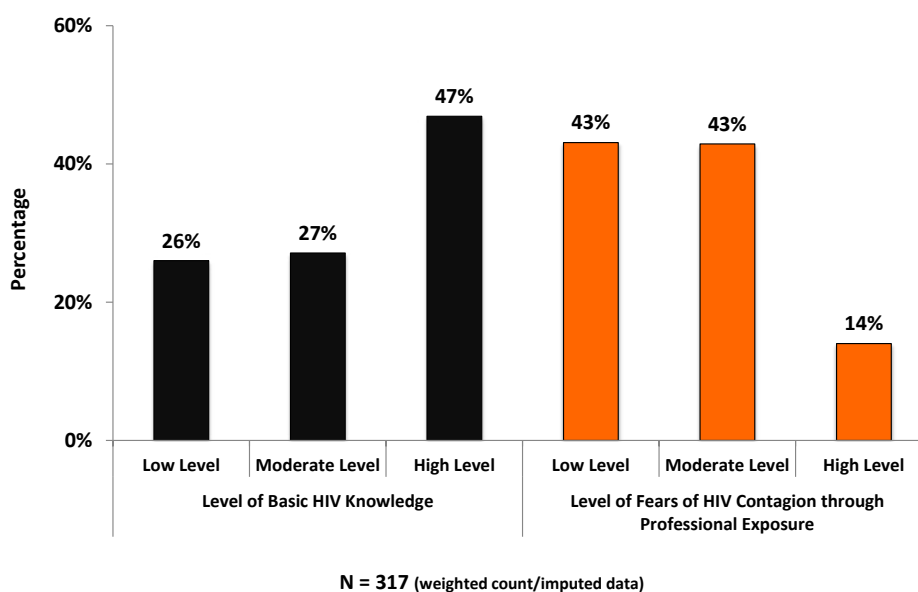


The proportion of respondents who self-reported a 'good' or 'very good' level of understanding of MSM and transgender people health issues was higher among those who had received an education on sexual health during formal education compared to those who did not: 59.6 percent vs. 33.4 percent ($p=0.020$). Similar patterns were found among those who attended a training course on sexual health during extra-curricular activities (57.6 percent vs. 35.2 percent; $p = 0.001$), and those who attended a HIV training course (47.1 percent vs. 35.8 percent; $p = 0.049$).

Likewise, the proportion of respondents who self-reported a 'comfortable' or 'very comfortable' level of comfort in discussing sexuality with patient was higher among those who had received an education on sexual health during formal education compared to those who did not (64.1 percent vs. 44.6 percent; $p=0.014$), and those who attended a training course on sexual health during extra-curricular activities (66.4 percent vs. 44.7 percent; $p=0.012$). However, there were no statistically significant difference between those who attended a HIV training and those who did not (55.1 percent vs. 46.2 percent ; $p = 0.086$).

The figure 5 depicts the level of HIV knowledge (basic knowledge on HIV transmission and prevention) and the level of fears of HIV infection through professional exposure. With regard to HIV knowledge, almost half (47 percent) of health care providers had a high level of knowledge, whereas for 57 percent reported a moderate or high level of fear of HIV infection through occupational exposure. Respondents who attended an HIV training course, compared to those who did not, had a higher level of HIV basic knowledge: 51.8 percent versus 42.6 percent ($p<0.05$). However, for those who did not attend an HIV training course the level of fears of HIV infection was lower compared to those who did attend a training: 50.9 percent versus 62.3 percent ($p<0.01$).

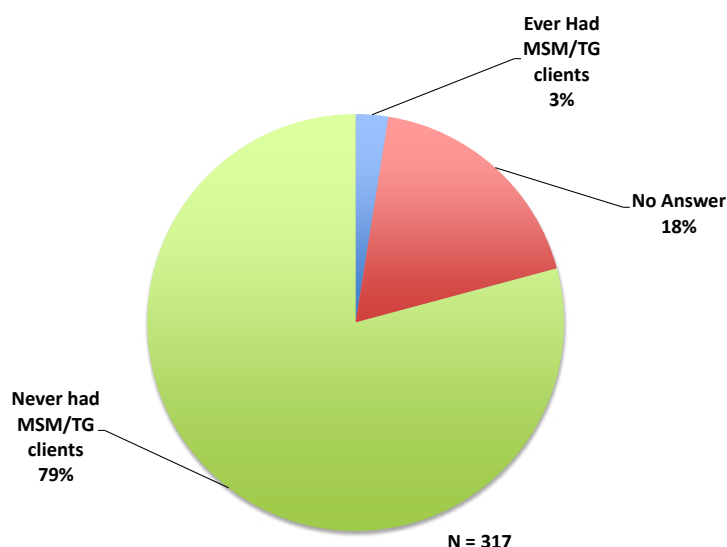
Figure 5: Level of HIV knowledge and fears of HIV infection through professional exposure



4.3.1.4. Professional experience with MSM and Transgender people

In terms of professional experience with MSM and transgender people, 10 (3 percent) health care providers reported ever had MSM or transgender people patient. Among these health care providers, five indicated that they have had seen MSM or transgender people in past 12 months prior to the interview, three reported that it was more than 12 months prior to the interview, and two did not answer to the question. The health care providers who reported professional experience with MSM or transgender people in past 12 months, were from Chhukha ($n = 2$) and Sarpang ($n = 3$), and medical doctors ($n = 2$), health assistant ($n = 1$), registered nurse ($n = 1$), and laboratory technician ($n = 1$). Curiously, no HIV counsellors from HISC reported professional experience with MSM or transgender people in the past 12 months prior to the formative assessment.

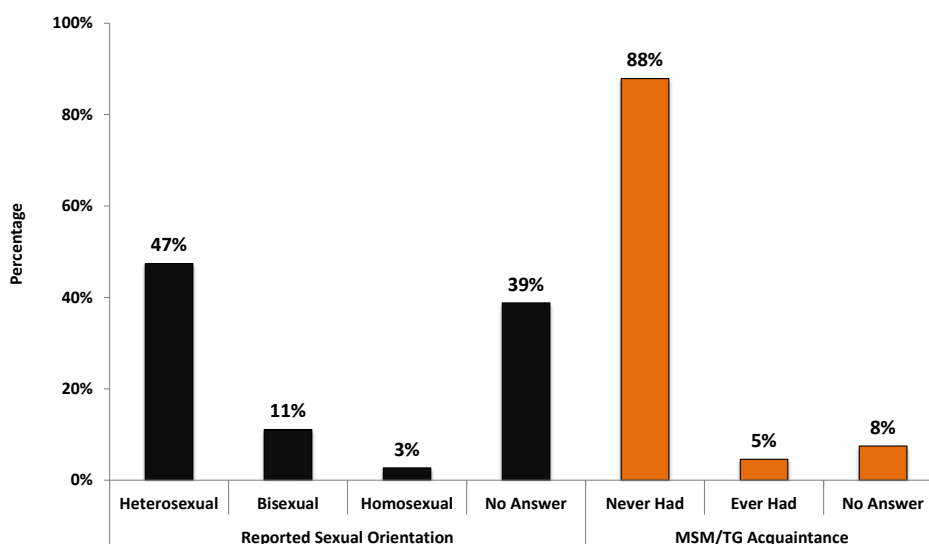
Figure 6: Professional experience with MSM and transgender people



4.3.1.5. Reported sexual orientation and acquaintance with MSM and Transgender people

The questionnaire for HCPs included 2 questions to explore the respondents' sexual orientation (current) and acquaintance with any MSM and transgender people. These variables were not imputed keeping the non-response (i.e., missing value) recorded as "no answer" as depicted in the figure 7. The non-response proportion for these 2 indicators was 38.8 percent and 7.5 percent respectively. Interestingly, 2.7 percent of respondents revealed a current homosexual behaviour, 11.0 percent a bisexual behaviour, and 47.4 percent reported exclusively sex with opposite gender i.e., a heterosexual behaviour. The majority of respondents (87.9 percent) declared that they have never had a MSM or transgender person as a friend, relative, co-worker or neighbor.

Figure 7: Reported sexual orientation and acquaintance with MSM and transgender people

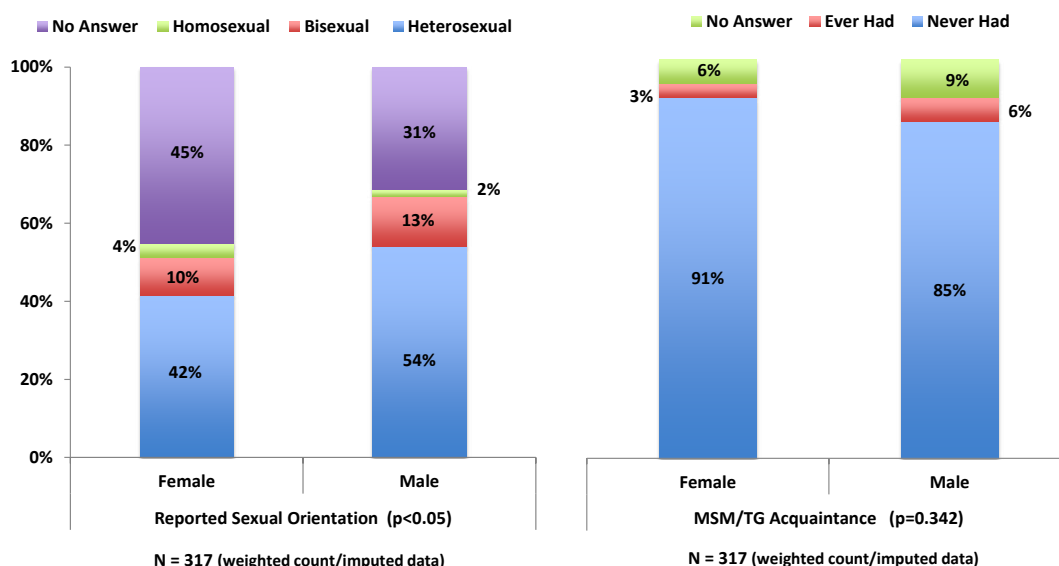


N = 317 (weighted count/imputed data)

A statistically significant difference was found ($p < 0.05$) when exploring the respondent's sexual orientation by gender. Among male respondents and female respondents respectively, 54.1 percent vs. 41.6 percent reported heterosexual behaviour, 12.7 percent vs. 9.6 percent reported bi-sexual behaviour, and 1.8 percent vs. 3.6 percent

reported homosexual behaviour. The proportion of respondents who did not answer to the question was higher among female respondents (figure 8). With regard to acquaintance with MSM and transgender people, the difference was not significant ($p= 0.342$).

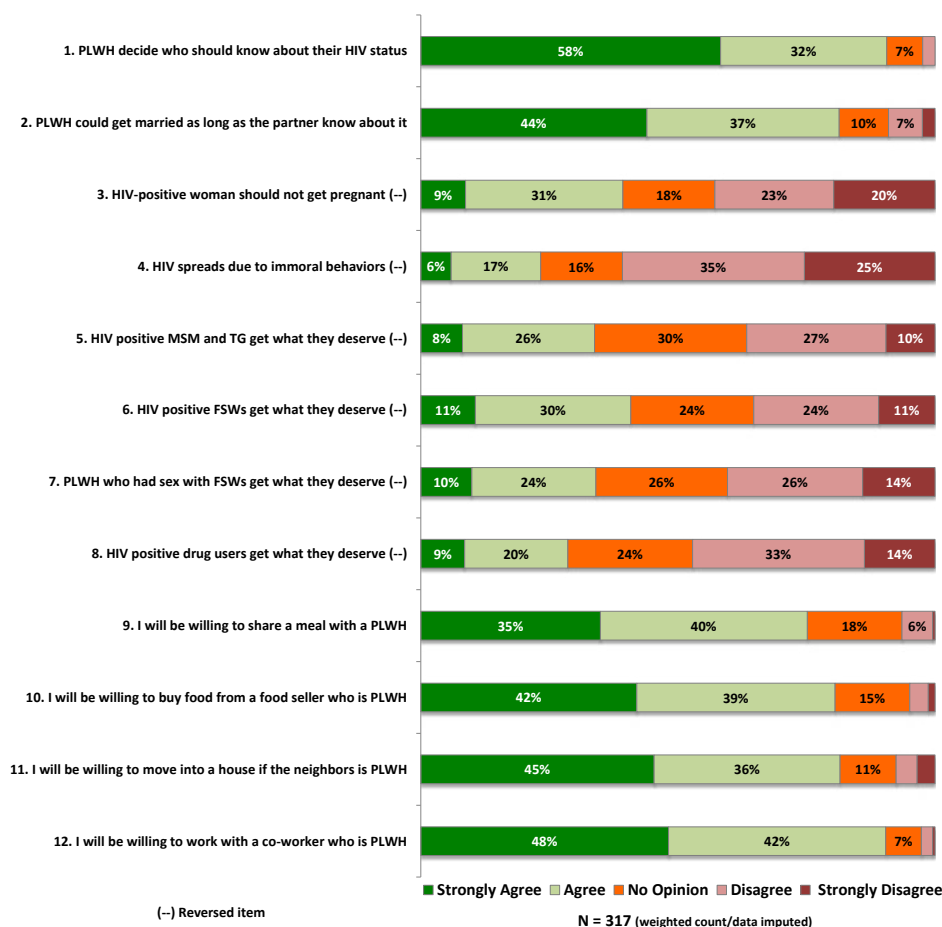
Figure 8: Reported sexual orientation and acquaintance with MSM and transgender people, by gender



4.3.1.6. Attitude towards PLHIV

The first 5-point Likert scale on attitude towards PLHIV (Cronbach's α : 0.71) describes two distinct patterns of attitude with the 12 items of the scale (figure 9). The first pattern was found with the items 1, 2, and 9-12 (6 out of 12 items) reflecting an agreement or strong agreement with these items and indicating a relatively high level of positive and respectful attitude towards PLHIV. Only a few respondents (ranging from 1 percent to 7 percent) stated disagreement or strong disagreement for these items, underlying a more stigmatizing attitude towards PLHIV. The proportion of respondents who were undecided or avoided extreme response categories ranged from 7 percent to 18 percent for these items. The second pattern was observed with the items 3-8^{§§} (6 items) and reflects more judgmental attitude towards key populations who are HIV positive (value-driven stigma), except for the item # 3, which was related to HIV positive pregnant women. For the items 4-8, the proportion of respondents, who recorded a disagreement or strong disagreement, ranged from 35 percent to 60 percent, reflecting a significant level of value-driven stigma. With regard to the respondents who expressed a non-judgmental attitude (i.e., with agreement or strong agreement) the proportions ranged from 23 percent to 41 percent, respectively. Compared to the previous pattern, a higher proportion of respondents were undecided or avoided extreme response categories (16 percent-30 percent).

§§ The scores of these items were reversed, meaning that for these items those who responded strongly agree and agree in the questionnaire were recoded into strongly disagree and disagree, and vice-versa

Figure 9: Scale “Attitude towards PLHIV”: distribution of responses¹¹

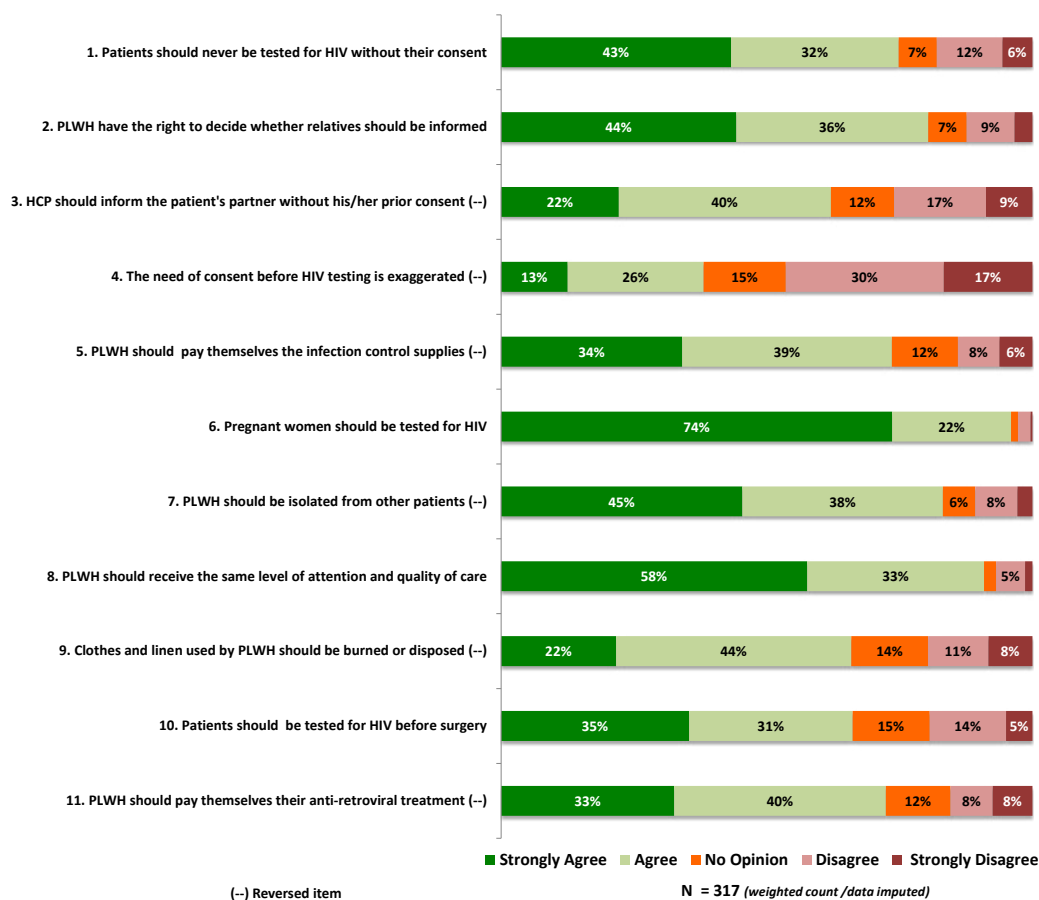
4.3.1.7. HIV-related health practices

The 5-point Likert scale on HIV-related practices (Cronbach's α : 0.62) depicts a clear pattern on HIV-related health practices with 8 out of 11 items of the scale (items 1-3, 5, 7-9, and 11) reflecting an agreement or strong agreement for these items and suggesting a high level of non-discriminatory practices (figure 10). For these items, the proportion of respondents with an agreement or strong agreement ranged from 62 percent to 89 percent, whereas the proportion of respondents with a disagreement or strong disagreement ranged from 6 percent to 26 percent. Between 2 percent to 15 percent of the respondents were undecided or avoided extreme response categories ranged from for these items.

With regard to items #6 and #10, the interpretation of the level of agreement/disagreement is done in taking in consideration the scores of the item #1 that is describing a high level of agreement and strong agreement on the “necessity to obtain consent before HIV testing”. Therefore, the majority of respondents were in agreement and strong agreement to propose an HIV test to all pregnant women and patients undergoing a surgery, after obtaining their consent. Due to a lack of clarity in the formulation of the item #4, the interpretation of the scores poses a problem since these scores given by the respondents to this item were not consistent with the score of item #1.

¹¹ For the sake of clarity, proportions < 5 percent are not displayed in the graph

Figure 10: Scale “Attitude towards HIV-related health practices”: distribution of responses***



4.3.1.8. Homophobia

This 5-point Likert scale on homophobia (Cronbach’s α : 0.86) shows a higher proportion of respondents was undecided or avoided extreme response categories compared to the two previous scales: ranging from 8 percent to 51 percent (figure 11). However, for 8 out of 21 items (2, 4, 10, 13, 14, 17, 19, and 21) there was a high level of agreement and strong agreement indicating a positive attitude towards MSM and transgender people. The highest level of agreement (40 percent) and strong agreement (44 percent) were on the item # 21 related to attitude towards MSM and transgender people in health care settings. Interestingly, for the items related to acceptance of MSM and transgender people in the family of as a teacher of their children (items # 6 and # 20), the proportion of disagreement and strong disagreement among the respondents was relatively high (42 percent to 52 percent respectively), compared to the items previously mentioned. Other items (5, 7, 9, 12, and 14), which are more related to understanding of homosexuality, had a significant level of disagreement and strong disagreement (ranging from 31 percent to 43 percent) and suggesting misconceptions about homosexuality.

*** For the sake of clarity, proportions < 5 percent are not displayed in the graph

Figure 11: Scale “Homophobia”: distribution of responses^{†††}

4.3.2. Factor Analysis

4.3.2.1. Factor analysis

Prior conducting the factor analysis and for each scale, the determinant of the matrix of correlation was assessed with the Bartlett's test for sphericity and the sampling adequacy with the Kaiser-Meyer Olkin (KMO) measure (table 7). These measures supported a factor analysis for the scale on “attitude towards PLHIV” and “homophobia”, but the KMO for the scale of health practice was low (mediocre) as well as the Cronbach's α coefficient. Despite these results for the latter scale, we proceeded to a factor analysis with different rotations, but no meaningful underlying factors were identified. Therefore, the results of the factor analysis for the scale on health practice are not presented in this report.

^{†††} For the sake of clarity, proportions < 5 percent are not displayed in the graph

Table 7: Cronbach's alpha, Bartlett's test of sphericity, and Kaiser-Meyer Olkin index

Scales (N* = 317)			
	Attitude Tw. PLHIV	Health Practice	Homophobia
Number of items	12	11	21
Cronbach's α coefficient	0.72	0.62	0.86
Bartlett's test of sphericity	<i>Chi-square</i> <i>p-value</i>	1699.10 <0.001	458.93 <0.001
		1941.94 <0.001	
Kaiser-Meyer Olkin index	0.80	0.66	0.86

* Weighted count/Data imputed

A factor analysis (principal factor) was performed on weighted and imputed data, for the scale on "attitude towards PLHIV" and "homophobia".

For the scale on "attitude towards PLHIV", the analysis yielded a two-factor solution. The table 8 shows the results of a varimax rotation of a solution for two underlying factors. Factor loadings < 0.4 are not displayed for the clarity of the table. The first factor accounted for 52 percent of the variance and included 4 items (# 5- 8) loaded onto this factor. The uniqueness of these items, which is the percentage of the common variance of the variable not shared with the factor, ranged from 29 percent to 42 percent. These items were related to "value-driven stigma" towards HIV positive key populations, as already described in figure 9. The second factor accounted for 49 percent of the variance and also included 4 distinct items (# 9-12). The uniqueness of these items ranged from 33 percent to 47 percent. These items were more related to "stigma toward PLHIV" (figure 9).

For the scale on homophobia, the analysis also yielded a two-factor solution. The table 9 shows the results of a varimax rotation of a solution for two underlying factors. The first factor accounted for 44 percent of the variance and included 9 items loaded onto this factor. The uniqueness of these items was high and ranged from 61 percent-79 percent. These items were related to "homophobia" i.e., attitude towards a person who engages in same sex behaviour (figure 11). The second factor accounted for 43 percent of the variance and also included 9 items. The uniqueness of these items ranged from 51 percent to 79 percent. These items were more related to the level of "misconceptions about homosexuality" (figure 11).

Table 8: Varimax rotated factor loadings of "attitude towards PLHIV" scale

N* = 317	Factor 1	Factor 2
	Value-driven Stigma	Stigma towards PLHIV
Item 1	-	-
Item 2	-	-
Item 3	-	-
Item 4	-	-
Item 5	0.7608	-
Item 6	0.8124	-
Item 7	0.8664	-
Item 8	0.8411	-
Item 9	-	0.7267
Item 10	-	0.7747

Continued

Item 11	-	0.7721
Item 12	-	0.8126
<i>Number of items</i>	4	4
<i>Eigenvalue</i>	2.901	2.674
<i>% of variance accounted for</i>	52.4%	49.2%
<i>Cronbach's a coefficient</i>	0.90	0.87

(-) Loading factor < 0.4 (cut-off): not displayed *Weighted count/data imputed

Table 9: Varimax rotated factor loadings of the "homophobia" scale

N* = 317	Factor 1 Homophobia	Factor 2 Misconceptions about Homosexuality
Item 1	0.5283	-
Item 2	0.6293	-
Item 3	-	0.4388
Item 4	-	-
Item 5	-	0.5709
Item 6	-	-
Item 7	-	0.4888
Item 8	0.4445	-
Item 9	-	0.5596
Item 10	-	0.4508
Item 11	-	0.4929
Item 12	-	0.6964
Item 13	0.5449	-
Item 14	0.6758	-
Item 15	-	0.5556
Item 16	-	0.5381
Item 17	-	-
Item 18	0.4377	-
Item 19	0.5392	-
Item 20	0.5006	-
Item 21	0.4450	-
<i>Number of items</i>	9	9
<i>Eigenvalue</i>	5.19	1.34
<i>% of variance accounted for</i>	43.5%	42.8%
<i>Cronbach's a coefficient</i>	0.80	0.81

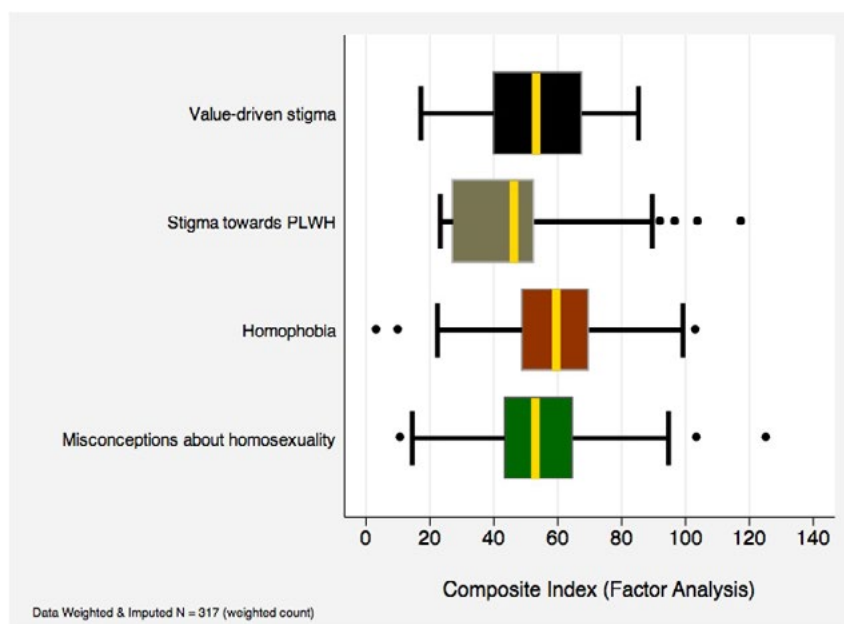
(-) Loading factor < 0.4 (cut-off): not displayed *Weighted count/data imputed

4.3.2.2. Composite index for each factor

Through the factor analysis, index scores were predicted for further analysis with the highest index score represented a high level of the attribute being measured. The figure 12 shows, except for the mean and standard deviation (SD), the key measures of the central tendency for each factor. The mean index score for the factor “*value-driven stigma*” was 52.2 (SD = 16.8) with a minimum at 17, a maximum at 85, and a median at 53 (Q1^{###}= 40; Q3^{\$\$\$}= 67.5). With regard to “*stigma towards PLHIV*” the mean index score was lower compared to “*value-driven stigma*” (43.8; SD =16.9) with a minimum at 23 and maximum at 117, and a median at 46 (Q1 = 27.3; Q3 = 52.6). As it is also depicted in the figure 12 for the latter factor, there were few outliers (4) with high index scores compared to the former factor. It explains the difference for the maximum score between these two factors. However, the median was much higher for the first factor (53) compared to the second factor (46) suggesting a higher level of “*value-driven stigma*” compared to “*stigma to PLHIV*”.

With regard to the factor “*homophobia*”, the mean index score was 59.2 (SD = 15.8) with a minimum and maximum index score at 3 and 103, respectively. There were two outliers with very low scores. The median for this factor was higher compared the median for the factor related to “*value-driven stigma*”: 60 (Q1= 49; Q3=70) and 53 respectively. The mean index score for the last factor related to “*misconceptions about homosexuality*” was 53.5 (SD = 15.8) with a median at 53 (Q1=44; Q3=65). The minimum and maximum index score was 11 and 125 (including 2 outliers), respectively.

Figure 12: Box-and-whisker plot for composite index of the factors

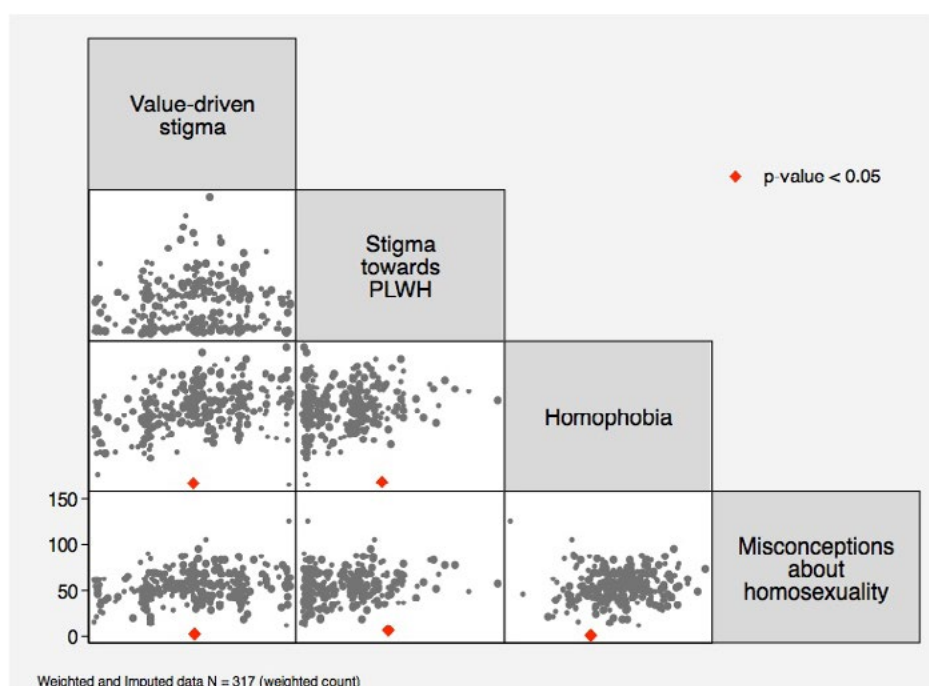


Using the Pearson’s correlation coefficient, we examined the correlation between these factors (figure 13). The strongest correlation, although moderate, was found between “*value-driven stigma*” and “*homophobia*” ($r=0.368$, $p<0.05$), and “*stigma towards PLHIV*” and “*misconceptions about homosexuality*” ($r=0.2492$, $p<0.05$). Lower levels of correlation, but still statistically significant, were also found between “*value-driven stigma*” and “*misconceptions about homosexuality*” ($r=0.1766$, $p<0.05$), “*stigma towards PLHIV*” and “*homophobia*” ($r=0.1648$, $p<0.05$), and “*homophobia*” and “*misconceptions about homosexuality*” ($r=0.1594$, $p<0.05$).

Q1: first quantile (25th percentile)

\$\$\$ Q3: third quantile (75th percentile)

Figure 13: Correlation between factors



With regards to socio-demographic characteristics, age was negatively correlated, significant but moderately correlated, with *“homophobia”* ($r = -0.178$, $p < 0.05$) and *“stigma towards PLHIV”* ($r = -0.146$, $p < 0.05$) suggesting that older respondents were less likely homophobic and with more positive attitude towards PLHIV. There was no significant correlation between age and the two other factors *“misconceptions about homosexuality”* and *“value-driven stigma”*. Sex was positively correlated with *“misconceptions about homosexuality”* ($r = 0.152$, $p < 0.05$) only, signifying that male respondents were more likely to have misconceptions than female respondents. Education was found negatively correlated with *“homophobia”* ($r = -0.117$, $p < 0.05$) and *“value-driven stigma”* ($r = -0.245$, $p < 0.05$), and positively correlated with *“stigma towards PLHIV”* ($r = 0.113$, $p < 0.05$). No significant correlations were found between category of staff and these factors.

4.3.3. Quantile regression for *“misconceptions about homosexuality”*

To explore factors associated to *“misconceptions about homosexuality”*, a multivariable quantile regression model for the lower (25th percentile) and for the upper quantile (75th percentile) were fitted. The tables 10 and 11 show the results of both quantile regressions for *“misconception about homosexuality”*.

Although the age of the respondents was not associated to this factor either for the lowest or highest scores, the gender of the respondents was found strongly associated. Males had a higher index score i.e., more likely to have more misconceptions about homosexuality, compared to female for both quantiles: +4.2 (95 percent CI +1.57/+6.77, $p=0.002$) for the lower quantile and +7.1 (95 percent CI: +3.23/+11.04, $p<0.001$) for the upper quantile. Health care providers, who reported having or having had an acquaintance either with MSM or transgender people, were found with lower index score i.e., less likely to have more misconceptions about homosexuality, compared to those who had not. The index score decreased significantly for both quantiles: -11.4 (95 percent CI: -17.92/-4.93, $p=0.001$) and -13.6 (95 percent CI -22.35/-4.88, $p=0.002$) respectively.

Table 10: Quantile regression (lower quantile) for “misconceptions about homosexuality”

Quantile 0.25 (Lowest Index Scores)	Misconceptions about Homosexuality N* = 317			
	Coefficient	95% CI**		p-value
		Lower	Upper	
Sex (Male vs. Female)	+4.18	+1.57	+6.77	0.002
Age (By 10 years)	-0.98	-5.09	+3.14	0.640
Had male sexual health training during formal education (Yes vs. No)	+6.60	+3.53	+9.67	<0.001
Had male sexual health training during extra-curricular activities (Yes vs. No)	-3.46	-6.51	-0.42	0.026
MSM or transgender acquaintance (Yes vs. No or No answer)	-11.43	-17.92	-4.93	0.001
Comfort in completing the questionnaire (Yes vs. No)	-4.08	-7.31	-0.85	0.013
Number of years working as health care provider (By 5 years)	+1.45	-0.92	+3.81	0.229
Stigma towards PLHIV (Index)	+0.15	+0.08	+0.23	<0.001
Comfort in discussing sexuality (Yes vs. No)	-2.56	-5.24	+0.11	0.060
Understanding MSM and transgender health issues (Yes vs. No)	-3.76	-6.38	-1.14	0.005
Constant	41.27	31.26	51.28	<0.001

* Weighted count/data imputed ** Confidence Interval

Surprisingly, health care providers who attended a training course on male sexual health during their formal education were found with higher index for the lower quantile (+6.60, 95 percent CI +3.53/+9.67, $p < 0.001$) and the upper quantile (+7.71, 95 CI +2.95/+12.47, $p = 0.002$), i.e., HCPs who attended this training course were more likely to have misconceptions about homosexuality. However, those who attended a training course on male sexual health during extra-curricular activities had a lower index score (-3.46, 95 percent CI -6.51/-0.42, $p = 0.026$) for the lower quantile, but this association was not retained in the upper quantile of the final model ($p > 0.300$). Health care providers who self-reported a good understanding on MSM and transgender health issues were found with a lower index score either for the lower or upper quantile: -3.76 (95 percent CI -6.36/-1.14, $p = 0.005$) and -6.19 (95 percent CI -10.34/-2.04, $p = 0.004$), respectively. Similar patterns, although the relationship particularly for the upper quantile was weaker, were also found for health care providers who reported being comfortable in discussing sexuality with their clients: -2.56 (95 percent CI -5.24/+0.11, $p = 0.060$) and -4.71 (95 percent CI -9.17/-0.26, $p = 0.038$). Attendance to HIV training was only found with a borderline relationship, for the upper quantile, but showing a decrease of the index: -3.81 (95 percent CI -7.69/+0.06, $p = 0.054$).

Table 11: Quantile regression (upper quantile) for “misconceptions about homosexuality”

Quantile 0.75 (Highest Index Scores)	Misconceptions about Homosexuality N* = 317			
	Coefficient	95% CI**		p-value
		Lower	Upper	
Sex (Male vs. Female)	+7.13	+3.23	+11.04	<0.001
Age (By 10 years)	-0.39	-6.15	+5.36	0.893
Had male sexual health training during formal education (Yes vs. No)	+7.71	+2.95	+12.47	0.002
MSM or transgender people acquaintance (Yes vs. No or No answer)	-13.61	-22.35	-4.88	0.002
Comfort in completing the questionnaire (Yes vs. No)	-8.29	-13.22	-3.37	0.001
Number of years working as health care provider (By 5 years)	+1.8	-1.14	+4.83	0.225
Stigma towards PLHIV (Index)	+0.20	+0.09	+0.32	0.001
Value-driven Stigma (Index)	+0.20	+0.09	+0.30	<0.001
Medical Doctor or Health Assistant (vs. other)	-3.80	-7.89	+0.28	0.068
Same-Sex behaviour (Yes vs. No or No answer)	-2.85	-8.02	+2.31	0.278
Comfort in discussing sexuality (Yes vs. No)	-4.71	-9.17	-0.26	0.038
Understanding MSM and transgender people health issues (Yes vs. No)	-6.19	-10.34	-2.04	0.004
Had HIV training (Yes vs. No)	-3.81	-7.69	+0.06	0.054
Constant	52.76	35.91	69.61	<0.001

* Weighted count/data imputed ** Confidence Interval

The tables 10 and 11 also show a significant increase, with a strong relationship, of the index for the factors “*stigma towards PLHIV*” and “*value-driven stigma*”. For an increase of one index in these respective factors, the predicted index for “*misconceptions on homosexuality*” will increase by 0.20 among the respondents in the upper quantile. For the respondents in the lower quantile, only “*stigma towards PLHIV*” was retained in the final model. An increase of one index in this latter factor will correspond to an increase by 0.15 for “*misconceptions on homosexuality*”.

4.3.4. Quantile regression for “*homophobia*”

Similar analysis i.e., a multivariable quantile regression for the lower (25th percentile) and upper quantile (75th percentile) for the factor “*homophobia*” was performed. The tables 12 and 13 show the results of both quantile regressions for “*homophobia*”.

Age and sex were not associated with homophobia either at the lower or upper quantile. In the lower quantile, there is a significant association between “*understanding MSM and transgender health issues*” and homophobia.

This association was still found significant in the upper quantile suggesting that respondents who reported a better understanding of these issues are less likely to be homophobic compared to those who reported no lack of understanding about these issues: -7.85 (95 percent CI -12.55/-3.15, $p = 0.001$) in lower quantile and -4.20 (95 percent CI -8.35/-0.06, $p = 0.047$) in upper quantile.

For both quantiles, there is significant increase, with a strong relationship ($p < 0.001$), of the index for the factors “value-driven stigma”. For an increase of one index in this latter factor, the predicted index for “homophobia” will increase by 0.25 among the respondents who obtained low index (lower quantile) and by 0.15 for the respondents who obtained high index (upper quantile). The factor “misconceptions about homosexuality” was also associated with homophobia, but only among respondents in the upper quantile.

Table 12: Quantile regression (lower quantile) for “homophobia”

Quantile 0.25 (Lowest Index Scores)	Homophobia N* = 317			
	Coefficient	95% CI**		p-value
		Lower	Upper	
Sex (Male vs. Female)	+3.04	-1.23	+7.30	0.162
Age (By 10 years)	+0.93	-5.26	+7.13	0.767
Had male sexual health training during formal education (Yes vs. No)	+3.95	-1.67	+9.56	0.168
Same-sex sexual behaviour (vs. not or not answer)	+3.40	-2.69	+9.50	0.273
Had male sexual health training during extra-curricular activities (Yes vs. No)	+4.35	-0.93	+9.62	0.106
Number of years working as health care provider (By 5 years)	-2.69	-5.92	+0.54	0.102
Stigma towards PLHIV (Index)	+0.11	-0.01	+0.23	0.067
Understanding MSM and transgender health issues (Yes vs. No)	-7.85	-12.54	-3.15	0.001
Value-driven stigma (Index)	+0.25	+0.12	+0.38	<0.001
Basic knowledge on HIV transmission (vs. not)	-3.41	-7.59	0.76	0.108
Constant	34.02	15.88	52.18	<0.001

* Weighted count/data imputed ** Confidence Interval

Other factors were associated with homophobia among respondents with high index. Respondents who reported same-sex sexual behaviour and those who had never been married were less likely to be homophobic in the upper quantile: -5.81 (95 percent CI -11.58/-0.04, $p = 0.049$) and -6.31 (95 percent CI -11.72/-0.90, $p = 0.022$) respectively. It is noteworthy that these factors were not associated in the lower quantile.

For respondents in the upper quantile and who reported ever had attended a training course on male sexual health during their formal education, were also found with a higher index compared to those who did not attend this type

of training during their education (+7.47, 95 percent CI +2.64/+12.31, $p=0.003$), but it was not significant for the lower quantile.

Table 13: Quantile regression (upper quantile) for “homophobia”

Quantile 0.75 (Highest Index Scores)	Homophobia N* = 317			
	Coefficient	95% CI**		p-value
		Lower	Upper	
Sex (Male vs. Female)	+3.26	-0.94	+7.45	0.125
Age (By 10 years)	+0.51	-6.87	+7.89	0.892
Had male sexual health training during schooling (Yes vs. No)	+7.47	+2.64	+12.31	0.003
Same-sex sexual behaviour (vs. not or not answer)	-5.81	-11.57	-0.04	0.049
Ever attended HIV training (Yes vs. No)	+4.04	-0.41	+8.50	0.075
Single (vs ever married)	-6.31	-11.77	-0.01	0.022
Number of years working as health care provider (By 5 years)	-2.80	-6.56	0.96	0.144
Misconceptions about homosexuality (Index)	+ 0.15	+0.01	0.29	0.041
Understanding MSM and transgender health issues (Yes vs. No)	-4.20	-8.35	-0.06	0.047
Value-driven stigma (Index)	+0.33	+0.21	+0.46	<0.001
Constant	45.48	+25.06	65.90	<0.001

* Weighted count/data imputed ** Confidence Interval

5. Discussion

The formative assessment first highlighted the difficulty of reaching MSM and to a lesser extent transgender people in the different districts targeted by this assessment. During the different phases of the implementation of the formative assessment i.e., field preparation, pre-testing tools, and data collection, the team, which also included interviewers from the transgender groups, faced challenges in connecting with and recruiting these populations. Previous surveys among sexually active male and female populations in selected districts in Bhutan revealed the existence of same-sex sexual behaviour among male or female respondents in urban [7,8] and rural areas [7]. About 2 percent of male respondents reported male-to-male sex behaviours: 2.3 percent among married males in urban and 1.5 percent in rural area (12 months prior to the interview), and 2 percent among male patronizing entertainment venues. The most recent study also indicated that about 12 percent of male respondents (vs. 9 percent of female) declared knowing at least one MSM in Bhutan [8]. All these male respondents reported sex with female partners as well. This formative assessment also identified same-sex sexual behaviour among health care providers, who self-completed the questionnaire, but with a higher level as compared to the previous mentioned studies. Although MSM and transgender respondents admitted connections with other MSM and transgender peers, it would seem that they are not organized in networks, but rather in small groups and not really connected to each other. Places where MSM and transgender people can discreetly find their sexual partners exist, but these places are not exclusive for these populations. These places are also recognized as locations where MSM and transgender people socialize with their friends, but not only with their MSM and transgender people peers. Private parties seem to be the most common opportunity where MSM meet for socializing with their peers. Virtual spaces, facilitated by international social media (dating websites for “gays”), are also used by MSM in Bhutan, but the number of active profiles in Bhutan is still limited. It is noteworthy that a significant number of the posted profiles onto these dating websites does not include picture of the person. Given the social context, one could speculate that this absence of picture is related to the fear of being recognized and because Bhutan is a small country “*where everybody knows everybody*”¹¹¹ this fear is understandable. The team also explored the possibility of contacting and recruiting MSM through these websites, but to no avail. All of them, but one during the design of the study, refused to meet physically for a discussion.

Although there is strong evidence that MSM and transgender populations exist in Bhutan, it seems that most MSM do not derive an identity from their same-sex attraction and behaviours. Most are sexually involved with women as well as with men, and aim to fulfill the expectations of mainstream society and family that they get married and establish a family. Transgender people, in contrast, tend to have exclusively male partners and are more visible. Same-sex behaviours in Bhutan are less marked and more diffuse, and are not expressions of belonging to a “gay community”. This is both caused by, and the cause of, the non-existence of specific “gay” entertainment locations aimed at facilitating sexual contacts with high numbers of different partners. From an epidemiological point of view, it may be safe to conclude that sexual networks of MSM and transgender people in Bhutan are not dense enough, and partner turnover is not rapid enough for an HIV epidemic to take hold. This is in sharp contrast to other capital cities in Asia where the number of new HIV infections among these populations is still increasing [3]. Nevertheless, some of the MSM respondents mentioned traveling to cities in the region (e.g., Bangkok) for various purposes including meeting with sexual partners as well. It is noteworthy that only one MSM mentioned commercial male partners when traveling abroad, but for the remaining respondents, their sexual networks appear to include casual and to a lesser extent regular male partners. Through informal communication during the design of the formative assessment, it has been brought to the attention of the team that there were male sex workers also operating in Bhutan and mainly serving tourists. This has not been confirmed during the data collection, as the team was not successful in penetrating these networks. However, commercial sex is not uncommon in Bhutan. One study on sexual networks in Bhutan found a significant proportion of male and female respondents patronizing entertainment establishments and public places revealed commercial sexual partners: 32.5 percent of males and 1.5 percent of females declared ever having paid for sexual services, whereas 3.5 percent of male and 8.2 percent of female reported ever had received money in exchange of services [8]. However, it was not clear in the report

¹¹¹ Communication with a MSM during the design of the formative assessment

whether the latter male respondents, who received money, engaged in sex with male or female partners. The absence of organized networks for MSM and to a lesser extent for transgender people may certainly challenge the implementation of targeted interventions or research or surveillance study e.g., integrated behavioural and biological surveillance or behavioural surveys, among these populations.

Transgender people as opposed to MSM are more likely to be open about their sexuality with their relatives and close friends. They are perceived to be less isolated compared to MSM who have developed strategies coping with stigma and discrimination from their family and close friends. These strategies include bisexual behaviour, although they reported only being sexually attracted to male, to show off they are fitting to the norms of the society, and avoidance behaviours such as avoiding social contact with other MSM peers in public, and not disclosing their sexual orientation to health care providers even when facing sexual health issues. These feelings and situations mentioned by the participants such as feeling of isolation, fears of being identified in public, social discomfort with other MSM or transgender people, and coping strategies, which as been identified as key dimensions associated with internalized homophobia in key studies [33,34], strongly suggest a certain level of internalize homophobia among these populations in Bhutan, particularly for MSM. They also expressed the pressure of the law criminalizing same-sex sexual behaviours in Bhutan. Although nobody has been prosecuted under this law, MSM perceived it as a sword of Damocles impacting their attitudes towards their relatives and close friends, and their health seeking behaviours (e.g., going abroad to access health services), as they still fear to be reported to local authorities and prosecuted. It is noteworthy that transgender people respondents were not aware of this law. Although it has not been directly explored, these findings suggest that transgender people and MSM have experienced diverse stressful life events related to stigma and discrimination that may have impacted their mental health status to different degree [12–15], and consequently may become involved in high-risk behaviours [16–18,35].

While access to health services is not perceived as an issue either for MSM or transgender people, the access to proper health services (i.e. good quality of care and treatment) poses a critical problem. As described in different studies, MSM, as a coping strategy, avoid disclosing their sexual orientation to their health care providers [36–39]. This is consistent with the findings of our formative assessment. For transgender people, even if their sexual orientation could be more obvious, health care providers do not ask questions about their sexual orientation, and transgender people do not talk about it as well. Both MSM and transgender people realized that the lack of disclosure to health care providers might affect the provision of appropriate services as clearly demonstrated in a recent research [40]. A significant proportion of health care providers also revealed their level of discomfort discussing sexuality with their clients suggesting that their communication with their client is impaired, particularly with MSM and transgender people. Several studies have clearly identified factors associated with lack of communication skills of health care providers when discussing sexuality: embarrassed feelings, complexity and sensitivity of discussing same-sex sexual behaviour with their clients, time constraints, and lack of skills and expertise [41–44]. As it was also mentioned by one of the health care providers interviewed, the assumption of assuming that all patients are heterosexual is not uncommon [42,44]. It could also explain the low proportion of health care providers (3 percent) who reported ever had a MSM or transgender people as a client. In addition, the formative assessment also identified a low level of trust towards the health system, particularly the respect of the confidentiality and the privacy of the clients when consulting health care providers.

Although the majority of health care providers (88 percent) were in agreement or strong agreement that MSM and transgender people should receive the same level of attention and care, the formative assessment identified significant levels of homophobia, misconceptions about homosexuality, and value-driven stigma that could impact the level of quality of care provided to these populations. However, stigma towards PLHIV was found lower and not correlated to value-driven stigma suggesting that health care providers have more negative attitude or are more judgmental towards HIV positive key populations such as PWID, FSWs, MSM and transgender people, and homophobic attitudes. While it may be not the case for all health care providers, as we found a significant level of the population surveyed with low index scores, this is however consistent with the perceptions of the MSM and transgender people had towards their health care providers and could also explain the difficulty for them to disclose their sexual orientation.

Interestingly, the findings of the descriptive analysis of the items of the scale on homophobia showed that health care providers reported a higher level of acceptance of MSM and transgender as friend, neighbors, or co-workers

compared to level of acceptance of having a son or daughter “homosexual” or having a “homosexual” teacher for their children. While it shows a certain level of tolerance vis-à-vis homosexuals in their social environment, it is more difficult to accept when it is happening directly to a close member of their family. These may be due to the fears of losing hopes and dreams of their children, the loss of a traditional life matching with the norms of the society [45] and reinforced by conflicting beliefs and misconceptions about homosexuality.

Age of respondents was found negatively correlated with homophobia and stigma towards PLHIV implying that older health care providers were less likely homophobic and reported more positive attitude towards PLHIV. In addition, sex of respondents (male vs. female) was only positively correlated with misconceptions about homosexuality and found as a critical factor for misconceptions about homosexuality in the quantile regression for the lower quantile and persisting for the upper quantile. These findings suggest that male health care providers were more likely to have misconceptions about homosexuality compared to female. However, the analysis did not identify any association between sex of respondent and homophobia either when exploring the correlation between these two variables or in the quantile regression model for homophobia. This latter finding is not really consistent with literature where it is found that females are less likely to be homophobic than males [46,47]. However, because these studies were done among the general population and young students, it may not be possible to compare. Similarly, patterns were found for acquaintance with MSM and transgender people. While this latter factor was found significantly associated with misconceptions about homosexuality in the quantile regression, it was not for the model for homophobia. Respondents who reported acquaintance with MSM and transgender people were found with a lower index score in the lower and upper quantile for misconceptions about homosexuality, suggesting that the health care providers who reported an acquaintance with MSM and transgender people were less likely to have misconceptions about homosexuality. This finding is consistent with the latter study mentioned [47] that clearly demonstrated that the acquaintance of MSM and transgender people was also a determinant factor to reduce level of homophobia among general population.

Health care providers who reported having a good level of understanding MSM and transgender people health issues were found with a lower index score in all our models either for misconceptions about homosexuality or for homophobia in lower quantile and persisting in the upper quantile. These findings validate that health care providers with good understanding of these issues have fewer misconceptions and may be less likely homophobic. It also suggests that if the knowledge and skills of health care providers were increased, the level of homophobia and misconceptions about homosexuality among health care providers would likely decrease. A significant number of health care providers reported attending a training course on male sexual health either during their education or extra-curricular activities. In our models, an association was found among respondents who reported male sexual health training during their education, but this association revealed that these respondents had a higher index score for misconceptions (upper and lower quantile) and homophobia (upper quantile only), suggesting that they were more likely to be homophobic and to have misconceptions about homosexuality. Unfortunately, no questions were asked about the content of their curriculum, but it is suspected that their curriculum may not correctly address the sexual needs of MSM and transgender people. Attending other training courses (i.e. HIV and AIDS training or male sexual health training during extra-curricular activities) did not identify relevant findings in our models. However, in bivariate analysis, respondents, who attended these training courses, had a higher level of understanding of MSM and transgender health issues and comfort in discussing sexuality with patients, compared to those who did not attend these training courses.

There were critical limitations for this formative assessment. The first limitation was the small number of MSM and transgender people recruited for in-depth interviews due to the impossibility to reach and convince enough MSM and transgender people to participate in the formative assessment, and to reach the point of data saturation during the analysis. While some findings were consistent with the literature, we also found some difficulties in interpreting other findings such as the social and sexual networks MSM and transgender people. Furthermore, during the design of the formative assessment it has been brought to the attention of the team the existence of underage MSM and transgender people, which was also confirmed by national stakeholders during the consultation. However due to the constraints of the ethical guidelines in Bhutan, it was decided to include only participants aged 18 years old or above. Therefore, this formative assessment may have missed some critical information describing different opinions and situations for this specific sub-segment of MSM and transgender people. In addition, the low response rate from health care providers (38 percent), despite multiple efforts for increasing the response

rate during the follow-up, posed another critical limitation for the analysis of the study. Low response rate among health care providers is not uncommon in the literature [48–50] and particularly when asking about their sexual orientation [49]. The low response rate was also combined with item non-response (missing values) in the returned questionnaires. Both issues i.e., unit and item non-response resulted in a complex analysis to minimize these biases: weighted analysis on imputed data. Therefore, it is not possible to generalize the findings of this formative research to the entire populations surveyed. The last limitations were related to the Likert-scales used in the questionnaire for health care providers. Although the different scales were pre-tested for the understanding of the items/questions, the team, due to time constraint did not assess the internal consistency of each scale prior to the data collection. While the scales on homosexuality and stigma towards PLHIV were found with a good and acceptable Cronbach's alpha coefficient (0.86 and 0.71, respectively), the scale related to attitude towards HIV-related health practices was found with a mediocre coefficient (0.62). Despite an item-test and factor analysis, it was not possible to improve the coefficient for internal consistency. Therefore, only a descriptive analysis was conducted for this scale. In addition, due to the lack of understanding and confusion between the terms "MSM" and "transgender people" identified among potential participants during the design of the formative assessment and the absence of these translated terms in Dzongkha, the team used in the questionnaire, which was self-administered, a more generic terminology related to behaviour rather than gender identity. For example, in the self-administered questionnaire, it has been decided to assess "homophobia" encompassing attitude towards MSM and transgender people, rather to assess "homophobia" and "transphobia" respectively. Therefore, it was not possible to assess the difference between the level of homophobia and transphobia that may be different.

6. Conclusions and Recommendations

The formative assessment highlighted the barriers faced by MSM and transgender people to access appropriate services responding to their sexual health needs. We found out that transgender people and particularly MSM do not disclose their sexual orientation either to their in-group or out-group circles, including health care providers, due to their fears of stigma and discrimination from both circles. Despite the fact that the existing law criminalizing same-sex sexual behaviour has never been used in Bhutan, MSM, who were aware about this law compared to transgender people, reported concerns and fears of being reported to local authorities and prosecuted if they disclose their sexual orientation. They do not trust the health system or health care providers to maintain confidentiality of their clients. The findings also underlined the feelings of isolation, particularly for MSM and the non-existence of MSM and transgender people organizations or networks. The absence of targeted prevention services and lack of availability of commodities (such as condoms and water-based lubricants) also pose a problem for these populations. The formative assessment also found a significant level of homophobia, misconceptions about homosexuality, and value-driven stigma amongst health care providers—in contrast to lower levels of stigma towards PLHIV in general. Health care providers also lack of experience and skills in dealing with and managing MSM and transgender people clients. They also reported few opportunities to build their capacity either on HIV/AIDS or on male sexual health and to be involved in planning and designing interventions targeted to reduce HIV new infections in Bhutan. Because of the invisibility and also the denial of MSM and transgender people in their country, health care providers do not consider MSM and transgender people as a public health priority.

The preliminary findings of the formative assessment were presented and discussed during a consultation meeting held in Thimphu in April 2013 with key stakeholders including four transgender people. The following strategies and key activities were identified during the consultation and revised based on the final findings of the formative assessment. Recommendations are aimed to reduce the number of new infections amongst MSM and transgender people by increasing their access to services including preventions, VCT and STI, and care & support and treatment services. These recommendations address in priority the key issues identified through the formative assessment and discussed during the consultation. The first strategy, which is related to the development of an enabling environment, targets mainly key populations such as men who have sex with men, transgender people, female sex workers, and people who inject (and take) drugs, whereas the remaining strategies are specifically recommended for addressing issues and needs of MSM and transgender people in Bhutan.

Recommendations for the National AIDS Control Programme:

1. **Create an enabling environment for key populations by developing a long-term strategy to reduce stigma and discrimination, to support and sustain the implementation of targeted interventions, and ultimately increase access to prevention, STI, VCT, care and treatment, and legal services for key populations**
 - *Review existing laws and corresponding policies to create supportive environment for social change and safer behaviours. Policies regarding same-sex sexual behaviour must be addressed directly and comprehensively to promote non-discriminatory attitudes towards key populations, removing potential legal sanctions*
 - *Review policies to support positive attitudes and professional ethics of health care providers towards key populations and encourage compliance with ethical guidelines and standards of care and the protection of the rights of clients to increase access to services (prevention, STI, VCT, and care, support and treatment services) for these populations*
 - *Review strategies and mechanisms for policy makers, health care providers, ethics committee members and researchers to develop guidelines for obtaining waivers for parental consent to provide care and to research underage (< 18 years old) key populations*
 - *Develop an awareness raising campaign amongst policy makers and parliamentarian on key populations issues in the country, and advocate for the implementation of supportive laws and policies to protect the rights of these*

populations to access health, legal, and social services. For the latter activity, establish strategic link with global, regional, and sub-regional MSM and transgender people networks for possible technical assistance for advocacy and policy

- Develop modules and implement workshops to sensitize health care providers, counsellors, researchers, ethics committee members, journalists, and key media agencies on key populations issues and their professional responsibilities regarding these populations
- Develop interactive campaign using above the line communication reaching broadly community to address stigma and discrimination towards key populations, and encourage dialogue and community solutions

2. Increase safer sexual and health seeking behaviours among MSM and transgender people populations

- Establish a sub-technical working group for MSM and transgender people that includes key stakeholders but as well MSM and transgender people representatives, and establish linkages with global, regional, and sub-regional MSM and transgender people networks for possible technical assistance on programme development
- Mainstream sexuality and prevention of high-risk sexual practices such as anal sex practice into any existing prevention programme reaching key populations, including youth and particularly male populations such as taxi-drivers, truck-drivers and uniformed services
- Mobilize existing individuals and groups of MSM and transgender people to set-up peers-support groups in each targeted district. The formation of these support-groups is a first step before the establishment of networks and CBOs for these populations. Given the current situation, it may take time before the concretization of these networks or CBOs, but these groups could be initially established under the umbrella of existing NGOs (mother-NGOs) that are already working on HIV prevention and willing to support these groups
- Train selected MSM and transgender peers in organizing peer-support group and providing peer-education (including prevention, condoms and water-based use and distribution, and referral to services) to their respective peers.
- Develop the capacity of selected health care providers and counsellors on male sexual health issues (including sexuality) and clinical management by developing training courses (existing modules and guidelines could be adapted to Bhutan), and guidelines. In addition, explore the opportunity to initiate after the training field clinical practices, for selected health care providers, in neighboring countries (internship rather than study tour) where specific male sexual health clinics are already established and willing to receive interns for a short period
- Sensitize support-staff of health facilities (including STI, CST, and HISC) on MSM and transgender people issues
- Develop a directory of MSM and transgender people friendly services and establish linkages between these services and mother-NGOs hosting MSM and transgender people peer-support groups, and within the health system delivery to provide effective treatment and care to MSM and transgender people
- Review and adapt current national STI guidelines and SoPs to address MSM and transgender people issues, and SoPs for counsellors, as well
- Ensure that STI clinics have appropriate equipment and materials for the diagnosis of rectal STI or any other rectal issues
- Improve the procurement and distribution of condoms and water-based lubricant between the NACP and the health system and civil society organizations, particularly those working with key populations
- Establish strategic outlets for condoms and water-based distribution (free distribution through traditional outlets and social marketing in strategic entertainment establishments or shops), and promote the existence of these outlets through a demand generation campaign

- *Develop a targeted campaign for MSM and transgender people using below the line communication to increase self-esteem and access to services for these populations, and particularly to promote the existence of peer-support groups and a community dialogue. The development of a blog or forum online, which could be managed by the peer-support groups, could be envisaged for MSM.*
- 3. Strengthen the national strategic information framework by including key information on prevalence of same-sex sexual behaviours, high-risk behaviours, and HI and STI, and knowledge about this population**
- *Review and standardize programme indicators for MSM and transgender people including reached through peer-outreach, access to commodities, and access to services such as VCT, STI and treatment. The data should be disaggregated by sub-populations i.e., MSM and transgender people, and also by key age groups at health services and at prevention programme level*
 - *Explore the possibility to implement a more accurate size estimation for MSM and transgender people by using the scale-up network method [51]*
 - *Include systematically questions related to same-sex sexual behaviour and anal sex practice in any behavioural survey or integrated behavioural and biological survey among male populations (could be combined with the recommended scale-up network method for size estimation) in Bhutan, to estimate the prevalence of these key indicators and the trends over time. Although, it will be more relevant to conduct these surveys directly amongst MSM and transgender people, the absence of established and significant MSM and transgender people networks and the unmarked and diffused same-sex behaviours in Bhutan challenge the implementation of a random sampling approach that is required for these surveys. However, the implementation of these surveys may be considered at later stage.*
 - *Establish strategic linkages with universities in the region to support the development of social science research for building evidence base for HIV prevention programme among MSM and transgender people in Bhutan such as exploration of social and sexual networks, norms, value structures, social and sexual modes of engagement, and understanding of sexuality and sexual health among MSM and transgender people, including youth*

7. References


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8. Appendixes

8.1. Approval from Research Ethics Board of Health



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ROYAL GOVERNMENT OF BHUTAN
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REBH/Approval/2012/033
Date: 3rd January, 2013

REBH Approval Letter

PI: Mr Namgay Tshering Institute: National HIV Aids Control Program, Ministry of Health	Study Title: 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	
REBH's Decision: Approved with conditions	Protocol Version No. 2 Dated: 20 th December, 2012	Informed Consent Version No. 2 (Verbal) Dated: 20 th December, 2012
	Mode of Review: ✓ <i>Full Board Review Meeting No. 4/2012 (13th)</i> ✓ <i>Expedited Review</i>	
Conditions for Approval <ol style="list-style-type: none"> 1. <i>This is a very sensitive topic and you are recommended to up hold full confidentiality and pay due respect for all participants.</i> 2. <i>Final report of the study both in soft and hard copy must be submitted to REBH at the end of the study before publishing.</i> 3. <i>Any changes to the proposal or to the attachments (informed consent and research tools such as forms) should be approved by REBH before implementation</i> 4. <i>The approval for this proposal is valid ONLY for ONE year from the approval date.</i> 		



(Dr. Phurb Dorji)
Chairperson-REBH

For further information please contact: mongal56@health.gov.bt; REBH Member Secretary

8.2. Topics Guide for IDI among MSM and transgender people

Topics Guide and probing questions for MSM & transgender people

- **Key socio-demographic characteristics:** *age, marital status, occupation, educational level, living in other country (specify) more than one year, living with*
- **Sexual orientation:** *are you identifying yourself as a man, a gay, a woman, a transgender, or any other? Do you have sex only with men or also with women? In past year? Do you have currently a regular (someone with who your have emotional bond and you take care) partner? Male or female or both? Have you discussed your sexual orientation with somebody from your family? Who? How did you feel about this coming out?*
- **MSM and transgender people network:** *how many people, like you i.e., MSM or transgender person, do you know and know you (know = they know your name and you know their name)? Among those people, how many of them you met in the past month? Which kind of social activities do you have together? How often? Where? Private parties? Do you go out with people who are also heterosexual? Among those people you are socializing, have you had sex with at least one of them? Where do you usually meet you sexual partner? Internet?*
- **Internalized and external homophobia:** *how do you feel being a MSM or transgender person? Are you comfortable with your sexual orientation? Do you think it is natural? Do you think that you would change your sexual orientation if it were possible? Do you feel comfortable to go out with MSM or transgender people? How would you feel if somebody sees you outside with MSM or transgender people? Do you think that people like you are treated as “inferior” or “unnatural” compared to heterosexual? Do you discuss your sexual orientation with your friends MSM or transgender people? With heterosexual friends? Do you think that many people like you are stigmatized and discriminated in Bhutan?*
- **Enacted stigma:** *have you experienced any discrimination (verbal or physical harassment, blackmail, lost of job or no promotion, isolated...) in your daily life? And when you accessed health services? Could you share with us one or two examples that affected you a lot? Do you think that they are a lot of people like you who are stigmatized or discriminated? Are you aware about a law in Bhutan that criminalizes male-to male sex? What do you think about this law? Contributing to this level of stigma and discrimination? How?*
- **Perceived HIV stigma:** *I don't want to know the results, but have you ever been tested for HIV? In the past year, have you been tested as well? What make you feeling to have or have not a test? I heard that people who are HIV positive are stigmatized by the population... have you heard this? What do you think? Is it a big deal to be HIV positive in Bhutan? Why? What about being MSM or transgender people and HIV positive?*
- **Barriers to access services:** *what are your fears when you would like to access health services? Do you have example to share? When discussing with your health care providers, do you spontaneously tell them your sexual orientation? Why? In case health care providers ask you about your sexual orientation and sexual practices (anal and oral sex), would you tell him or her? Why? How do you fee about the quality of communication between you and your health care providers? Where do you get information related to HIV and STI prevention? Are you satisfied with the information given? What is missing? What are you expecting from these kinds of interventions? Do you know in you area a MSM/transgender people-friendly service for STI, or HIV service, or general health? Private or public? Tell me more*

8.3. Topics Guide for IDI among Health Care Providers

Topics Guide and probing questions for Health Care Providers

- **Key socio-demographic characteristics:** *age, marital status, degree, educational level, living in other country (specify) more than one year, current position, how many years in this position*

- **Communication with MSM and transgender people as patients/clients:** *I am going to talk about specific populations such as men who have sex with men and transgender people (explain). Have you ever heard about these populations? In which way? In your daily work, how often do you see MSM and transgender people as patient/client? Are they telling you spontaneously that they engage in male-to-male sex or you need to probe yourself? Is it difficult for you to communicate with them when discussing about their sexuality or sexual health? Why? What are the barriers? Feeling uncomfortable discussing this topic? Don't have enough knowledge and experience related to sexual health for these populations?*
- **Stigma and discrimination against MSM and transgender people:** *It has been brought to our attention that MSM and transgender people face a certain degree of stigma and discrimination in Bhutan both in the society and in health settings. What do you think? Do you have some anecdotes to illustrate this statement?*
- **Contribution on the National Strategic Plan for HIV/AIDS in Bhutan for MSM and transgender people:** *(Read the following):*

“The NSP-II emphasizes prevention interventions that target men who have sex with men and other key affected populations. It calls for a review of Article 213 of the Penal Code of Bhutan and the use of new guiding principles, many of which promote enabling environments for MSM. The imperative of ensuring universal access and equity in health service delivery were echoed in the Honorable Secretary for the Ministry of Health, Nima Wangdi’s remarks at the Bhutan National Stakeholders Meeting on Advocacy and HIV Prevention Among MSM and Transgender People in May 2012”

Are you aware about it? What do you think about this new public health strategy? Do you think it is a public health priority? Why? Will you support this move? Why? What could we do in terms of 1) policy in health settings, 2) capacity building/ training for health staff, 3) interventions for reducing HIV and STI-risk behaviours among these populations, and 4) interventions to increase access to services? Do you have any other ideas?

8.4. Topics Guide for KII among District Health Officers

Topics Guide and probing questions for District health Officers

- **Key socio-demographic characteristics:** *age, marital status, degree, educational level, living in other country (specify) more than one year, how many years in this position*
- **Awareness of the National Strategic Plan for HIV/AIDS in Bhutan:** *are you aware about this plan? Former plan? From where? Have you already discussed this plan with health authorities in Thimphu such as the NACP or public health division? Have you received further instructions and support on this plan? Please, explain. Are you using it for your daily work as a district health officer? Give me some examples*
- **Stigma and discrimination against MSM and transgender people:** *I am going to talk about specific populations such as men who have sex with men and transgender people (explain). Have you ever heard about these populations? In which way? It has been brought to our attention that MSM and transgender people face a certain degree of stigma and discrimination in Bhutan both in the society and in health settings. What do you think? Do you have some anecdotes to illustrate this statement?*
- **Contribution on the National Strategic Plan for HIV/AIDS in Bhutan for MSM and transgender people:** *(Read the following):*
- “The NSP-II emphasizes prevention interventions that target men who have sex with men and other key affected populations. It calls for a review of Article 213 of the Penal Code of Bhutan and the use of new guiding principles, many of which promote enabling environments for MSM. The imperative of ensuring universal access and equity in health service delivery were echoed in the Honorable Secretary for the Ministry of Health,

D] District Code

|_|

Consent

We would like to invite you to participate in this assessment on ***Stigma and Discrimination Impacting Universal Access to HIV and Health Services for Men who have Sex with Men (MSM) and Transgender (transgender people) People in Bhutan***. This assessment, which is implemented by the National AIDS Control Programme (NACP) in Bhutan and sponsored by United Nations for Development Programme (UNDP), will help us to understand the level of stigma and discrimination towards men who have sex with men and transgender people, particularly in health settings, and to describe the social network of men who have sex with men and transgender people. This questionnaire includes 7 different sections including questions related to 1) your socio-demographic and economic characteristics; 2) your professional experience with MSM and transgender people; 3) your sexual orientation, and MSM and transgender people in your social circle; 4) basic knowledge on HIV and fears of contagion; 5) attitude towards people living with HIV; 6) attitude towards health care related practices and HIV; and 7) attitude towards homosexuals

There is no physical risk for taking part in this assessment. However you will be asked some very personal questions that you may find difficult to answer. However, we would like to reassure you that we would not share the information collected from you with anyone outside of this assessment team. Your name or any information that could be linked to you, such as telephone number and address, will not be written in this questionnaire, **because we will not ask you this information**. Therefore, any information you will share with us will be difficult to be associated with you. **You can refuse to answer any questions in the questionnaire. You should not feel obligated to continue the interview, and you can stop participating to the interview at anytime**. The completion of this questionnaire will take about a maximum of 30 minutes of your time. It is strongly recommended, that **you complete this questionnaire alone** in a quiet place. There is no right or wrong answer to any of the questions in this questionnaire. If you agree to complete this questionnaire, we will much appreciate your honesty, as it will help us better understand the needs of men who have sex with men and transgender people in Bhutan, and allow us to deliver better services. Once the questionnaire is completed, please return the questionnaire to your personnel relation officer in a sealed envelope (attached with the questionnaire). Participation is voluntary. If you decide that you do not want to participate, that decision will not affect your current or future position in the health care system in Bhutan. However, will we ask you to share with us few of your socio-demographic characteristics and return the questionnaire in the sealed envelop. **Please write down the date, and tick the box according to your decision:**

E] Date (dd/mm/yy) : |_|_| / |_|_| / |_|_|_|_|

- I understood this consent and I agree to complete this questionnaire: (go to next page)

- I understood the consent and I do not what to participate to this formative assessment and consequently not completing this questionnaire: Please, answer to the questions (below), insert this questionnaire in the envelop, seal it, and return it to your personnel relation officer

Age: ____ Sex: Male Female

Marital status: Single Married Divorced/separated Widower

Current function: Medical Doctor Health Assistant Nurse Nurse Assistant HIV counsellor Lab technician Other

Section I: Socio-demographic and economic characteristics

Q #	Questions	Categories	Skip
101	How old are you?	Age in year: _____ 99. No answer <input type="checkbox"/>	
102	What is your sex? <i>(One choice only)</i>	1. Male <input type="checkbox"/> 2. Female <input type="checkbox"/> 3. Other <input type="checkbox"/> Specify: _____ 99. No answer	
103	What is your nationality? <i>(One choice only)</i>	1. Bhutanese <input type="checkbox"/> 2. Other <input type="checkbox"/> Specify: _____ 98. Don't Know <input type="checkbox"/> 99. No answer <input type="checkbox"/>	
104	What is your current marital status? <i>(One choice only)</i>	1. Never Married <input type="checkbox"/> 2. Currently Married <input type="checkbox"/> 3. Divorced/separated <input type="checkbox"/> 4. Widower <input type="checkbox"/> 99. No answer	
105	How many children do you have? <i>(One choice only)</i>	Enter number of children: ____ 97. Don't remember <input type="checkbox"/> 99. No answer <input type="checkbox"/>	
106	What ethnic group do you belong to? <i>(One choice only)</i>	1. Ngalop <input type="checkbox"/> 2. Sarchop [Tshangla] <input type="checkbox"/> 3. Kurtep <input type="checkbox"/> 4. Bumthap <input type="checkbox"/> 5. Lhotsampa <input type="checkbox"/> 6. Other <input type="checkbox"/> Specify: _____ 98. Don't Know <input type="checkbox"/> 99. No answer <input type="checkbox"/>	
107	What is your religion? <i>(One choice only)</i>	1. Buddhism <input type="checkbox"/> 2. Hinduism <input type="checkbox"/> 3. Christian <input type="checkbox"/> 4. Atheist <input type="checkbox"/> 5. Other <input type="checkbox"/> Specify: _____ 98. Don't know <input type="checkbox"/> 99. No answer <input type="checkbox"/>	
108	How often do you typically attend religious ceremony? <i>(One choice only)</i>	0. Never <input type="checkbox"/> 1. Few times annually <input type="checkbox"/> 2. Once or twice per month <input type="checkbox"/> 3. Once per week <input type="checkbox"/> 4. More than once per week <input type="checkbox"/> 99. No answer <input type="checkbox"/>	

Continued

109	<p>What is your highest level of education?</p> <p><i>(One choice only)</i></p>	<p>1. Secondary High - Grade 9-12 <input type="checkbox"/></p> <p>2. Diploma/Certificate <input type="checkbox"/></p> <p>3. Bachelors <input type="checkbox"/></p> <p>4. MBBS <input type="checkbox"/></p> <p>5. Master or higher <input type="checkbox"/></p> <p>6. Other <input type="checkbox"/> Specify: _____</p> <p>97. Don't remember <input type="checkbox"/></p> <p>99. No answer <input type="checkbox"/></p>	
110	<p>Which year did you obtain the above-mentioned grade, certificate or degree?</p>	<p>Enter the year (YYYY): _____</p> <p>97. Don't remember <input type="checkbox"/></p> <p>99. No answer <input type="checkbox"/></p>	
111	<p>In total, for how long have you been working as a health care worker (doctor, nurse, nurse assistant, HIV counsellor, Lab technician...)?</p>	<p>Enter number of years: ____ ____</p> <p>(If less than 1 year, enter "1")</p> <p>97. Don't remember <input type="checkbox"/></p> <p>99. No answer <input type="checkbox"/></p>	
112	<p>What is your current and main function?</p> <p><i>(One choice only)</i></p>	<p>1. Medical Doctor <input type="checkbox"/></p> <p>2. Health Assistant <input type="checkbox"/></p> <p>3. Nurse <input type="checkbox"/></p> <p>4. Nurse Assistant <input type="checkbox"/></p> <p>5. HIV counsellor <input type="checkbox"/></p> <p>6. Lab technician <input type="checkbox"/></p> <p>7. Other <input type="checkbox"/> Specify: _____</p> <p>99. No answer <input type="checkbox"/></p>	
113	<p>For how long have you been working with this function at this health care facility?</p>	<p>Enter number of years: ____ ____</p> <p>(If less than 1 year, enter "1")</p> <p>97. Don't remember <input type="checkbox"/></p> <p>99. No answer <input type="checkbox"/></p>	
114	<p>Have you ever lived abroad for more than 12 months continuously?</p> <p><i>(One choice only)</i></p>	<p>0. Never <input type="checkbox"/></p> <p>1. Yes <input type="checkbox"/> Indicate the country _____</p> <p>97. Don't remember <input type="checkbox"/></p> <p>99. No answer <input type="checkbox"/></p>	
115	<p>What is your current level of income?</p> <p><i>(One choice only)</i></p>	<p>0. Less than Nu. 11,000</p> <p>1. Nu. 11,000-15,000 <input type="checkbox"/></p> <p>2. Nu. 15,001-20,000 <input type="checkbox"/></p> <p>3. Nu. 21,001-30,000 <input type="checkbox"/></p> <p>4. Nu. 31,001-40,000 <input type="checkbox"/></p> <p>5. Nu. 41,001-50,000 <input type="checkbox"/></p> <p>6. More than Nu. 50,000 <input type="checkbox"/></p> <p>97. Don't remember <input type="checkbox"/></p> <p>98. Don't know <input type="checkbox"/></p> <p>99. No answer <input type="checkbox"/></p>	

Section II: Professional experience with MSM and transgender people

Q #	Questions	Categories	Skip
201	Have you ever had patient/client who was a man who have sex with men or transgender person? <i>(One choice only)</i>	0. Never <input type="checkbox"/> 1. Yes <input type="checkbox"/> 97. Don't remember <input type="checkbox"/> 98. Don't know <input type="checkbox"/> 99. No answer <input type="checkbox"/>	If never, go to Q205
202	In the past 12 months, how many men who have sex with men or transgender people have you had as patients/clients? <i>(One choice only)</i>	0. Nil <input type="checkbox"/> 1. About 1- 5 patients/clients <input type="checkbox"/> 2. About 6-10 patients/clients <input type="checkbox"/> 3. More than 10 patients/clients <input type="checkbox"/> 97. Don't remember <input type="checkbox"/> 98. Don't know <input type="checkbox"/> 99. No answer <input type="checkbox"/>	
203	How many men who have sex with men or transgender people patients/clients disclosed spontaneously their sexual orientation to you? <i>(One choice only)</i>	1. None of them <input type="checkbox"/> 2. Some of them <input type="checkbox"/> 3. Most of them <input type="checkbox"/> 4. All of them <input type="checkbox"/> 97. Don't remember <input type="checkbox"/> 98. Don't know <input type="checkbox"/> 99. No answer <input type="checkbox"/>	
204	How many men who have sex with men or transgender people patients/clients you needed to ask and probe their sexual orientation because they did not spontaneously tell you? <i>(One choice only)</i>	1. None of them <input type="checkbox"/> 2. Some of them <input type="checkbox"/> 3. Most of them <input type="checkbox"/> 4. All of them <input type="checkbox"/> 97. Don't remember <input type="checkbox"/> 98. Don't know <input type="checkbox"/> 99. No answer <input type="checkbox"/>	
205	How comfortable are you to discuss sexuality, including sexual orientation and practices, with patients/clients who are men who have sex with men or transgender? <i>(One choice only)</i>	1. Not comfortable at all <input type="checkbox"/> 2. Somewhat uncomfortable <input type="checkbox"/> 3. Comfortable <input type="checkbox"/> 4. Very comfortable <input type="checkbox"/> 98. Don't know <input type="checkbox"/> 99. No answer <input type="checkbox"/>	
206	How comfortable are you to discuss sexuality, including sexual orientation and practices, with any of your patients/clients who are not men who have sex with men or transgender? <i>(One choice only)</i>	1. Not comfortable at all <input type="checkbox"/> 2. Somewhat uncomfortable <input type="checkbox"/> 3. Comfortable <input type="checkbox"/> 4. Very comfortable <input type="checkbox"/> 98. Don't know <input type="checkbox"/> 99. No answer <input type="checkbox"/>	

Continued

207	How well do you understand the health issues that men who have sex with men and transgender are facing? (One choice only)	1. Very poorly <input type="checkbox"/> 2. Reasonably poorly <input type="checkbox"/> 3. Well <input type="checkbox"/> 4. Very well <input type="checkbox"/> 98. Don't know <input type="checkbox"/> 99. No answer <input type="checkbox"/>	
208	During your schooling, have you received education or training on sexual health that included sexual health for men who have sex with men or transgender people? (One choice only)	0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/> 97. Don't remember <input type="checkbox"/> 98. Don't know <input type="checkbox"/> 99. No answer <input type="checkbox"/>	
209	Through your work experience, when was the last time you attended a course on sexual health that included sexual health for men who have sex with men or transgender people? (One choice only)	0. Never <input type="checkbox"/> 1. In the past 12 months <input type="checkbox"/> 2. More than one year ago <input type="checkbox"/> 97. Don't remember <input type="checkbox"/> 98. Don't know <input type="checkbox"/> 99. No answer <input type="checkbox"/>	
210	Through your work experience, when was the last time you attended any training course on HIV and AIDS? (One choice only)	0. Never <input type="checkbox"/> 1. In the past 12 months <input type="checkbox"/> 2. More than one year ago <input type="checkbox"/> 97. Don't remember <input type="checkbox"/> 98. Don't know <input type="checkbox"/> 99. No answer <input type="checkbox"/>	If Never go to Q301 Next page
211	Did this course include a special topic on men who have sex with men or transgender? (One choice only)	0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/> 97. Don't remember <input type="checkbox"/> 98. Don't know <input type="checkbox"/> 99. No answer <input type="checkbox"/>	

Section III: Sexual orientation, and MSM and transgender people in your social circle

Q #	Questions	Categories	Skip
301	How would you describe your current sexual orientation or affectional preference? (One choice only)	1. Exclusively heterosexual <input type="checkbox"/> 2. Bisexual <input type="checkbox"/> 3. Exclusively homosexual <input type="checkbox"/> 99. No answer <input type="checkbox"/>	
302	To your knowledge, have you had or have a close relationship (i.e., friend, coworker, family member) with a man who have sex with man or transgender person? (One choice only)	0. I never had <input type="checkbox"/> 1. I had in the past, but not currently <input type="checkbox"/> 2. I have currently <input type="checkbox"/> 99. No answer <input type="checkbox"/>	

Section IV: Basic knowledge on HIV and fears of contagion

For each statement or questions, please answer either “No” or “Yes” or “Don’t know”, or “No answer”, by ticking **only one box** for each statement/question

Q #	Questions	0 No	1 Yes	98 Don't Know	99 No Answer
401	HIV could be transmitted by sharing food with an HIV-positive person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
402	HIV could be transmitted by shaking hands with an HIV-positive person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
403	HIV could be transmitted by a mosquito	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
404	It is possible for a healthy-looking person to have HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
405	HIV could be transmitted by sharing needles (injection) with a HIV-positive person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
406	HIV could be transmitted from an HIV-positive pregnant mother to her fetus (baby)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
407	Condoms are effective means to reduce the risk of HIV infection during anal sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
408	Abstaining from sexual intercourse is an effective means to reduce the risk of HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
409	Condoms are effective means to reduce the risk of HIV infection during vaginal sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
410	Avoiding anal sex is an effective means to reduce the risk of HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
411	A medical treatment, which enable HIV-positive person to live healthy without symptoms, is available in many countries worldwide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
412	This specific medical treatment for HIV positive people is also available in Bhutan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
413	Do you or will you have fear of contagion when taking blood pressure (or any other non-invasive procedure) of a person with HIV?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
414	Do you or will you have fear of contagion when changing the bed linens of a person with HIV?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Do you have or will you have fear of contagion when changing the clothes of person with HIV?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
416	Do you have or will you fear of contagion when performing an invasive procedure (e.g., taking blood specimen) or testing blood or any other secretions from a person with HIV, even if wearing recommended protection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section V: Attitude towards people living with HIV

Please, indicate your level of agreement with each item using the scale from 1 (strongly agree) to 5 (strongly disagree). Tick only **one box** for each item

Q #	Items	1 Strongly Agree	2 Agree	3 Neutral	4 Disagree	5 Strongly Disagree
501	People living with HIV have a right to decide who should know about is HIV status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
502	People with HIV could get married as long as both partners know about it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
503	HIV-positive women should not get pregnant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
504	HIV spreads due to immoral behaviour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
505	HIV positive men who have sex with men and transgender people get what they deserve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
506	HIV positive female sex workers get what they deserve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
507	HIV positive men who had sex with female sex workers get what they deserve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
508	HIV positive drug users get what they deserve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
509	I will be willing to share a meal with an HIV-positive person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
510	I will be willing to buy food from a food seller who is HIV positive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
511	I will be willing to move into a home if the neighbor is HIV-positive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
512	I will be willing to work with a co-worker who is HIV positive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section VI: Attitude towards health care related practices and HIV

Please, indicate your level of agreement with each item using the scale from 1 (strongly agree) to 5 (strongly disagree). Tick only **one box** for each item

Q #	Items	1 Strongly Agree	2 Agree	3 Neutral	4 Disagree	5 Strongly Disagree
601	Patients' blood should never be tested for HIV without their consent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
602	Patients who test positive have the right to decide whether or not their relatives should be informed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
603	When a person tests positive, the doctor should inform the patient's partner without the consent of the person tested HIV positive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
604	The need for consent is exaggerated. HIV tests should be handled like any other blood test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Continued

605	HIV patients should pay themselves for gloves and other infection control supplies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
606	All pregnant women should be tested for HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
607	Patients with HIV should be kept at a distance from other patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
608	Patient with HIV should receive the same level of attention and quality of care than the other patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
609	Clothes and linen used by HIV patients should be disposed of or burned	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
610	Patients should be tested for HIV before surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
611	HIV patients should pay themselves their anti-retroviral treatment (specific treatment for HIV people)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section VII: Attitude towards homosexuals

The term “homosexuals” in this section encompasses men who have sex with men (MSM) and transgender people. Please, indicate your level of agreement with each item using the scale from 1 (strongly agree) to 5 (strongly disagree). Tick only **one box** for each item

Q #	Items	1 Strongly Agree	2 Agree	3 Neutral	4 Disagree	5 Strongly Disagree
701	I would not mind having a homosexual as friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
702	Finding out that my co-worker was homosexual would have no effect on my appreciation of his/her work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
703	I won't associate with known homosexuals if I can help it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
704	I would look for a new place to live if I found out my neighbor was homosexual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
705	Homosexuality is a mental illness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
706	I would not be afraid for my child to have a MSM or transgender people teacher	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
707	Homosexuals dislike members of the opposite sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
708	I do not really find the thought of homosexual acts disgusting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
709	Homosexuals are more likely to commit deviant sexual acts, such as child molestation and rape, than are heterosexuals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
710	Homosexuals should be kept separate from the rest of society (i.e., separate housing, restricted employment).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
711	Two individual of the same sex holding hands or displaying affection in public is revolting.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Continued

712	The love between two males or two females is quite different from the love between two persons of the opposite sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
713	Homosexuality, as far as I'm concerned, is not sinful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
714	I would not mind being employed by a homosexual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
715	Homosexuals should be forced to have psychological treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
716	The increasing acceptance of homosexuality in our society is aiding in the deterioration of morals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
717	I would not decline membership in an organization just because it had homosexual members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
718	I would vote for a homosexual in an election for public office	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
719	If I knew someone were gay, I would still go ahead and form a friendship with that individual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
720	If I were a parent, I could accept my son or daughter being homosexuals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
721	Homosexual should receive the same level of attention and quality of care than the other patients in any health care setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Thanks So Much for your kind cooperation in this project! Please check that you have ticked a box for each question (except for the skipped questions). Answer to the below questions, then insert the questionnaire in the envelope, seal it, and send it back to your personnel relation officer. Thanks again!

Q#	Questions	Categories
801	Which type of health facility are you currently working?	1. Hospital <input type="checkbox"/> 2. BHU I <input type="checkbox"/> 3. BHU II <input type="checkbox"/> 4. HISC <input type="checkbox"/> 99. No answer <input type="checkbox"/>
802	How did you feel when completing this questionnaire? (One choice only)	1. Not comfortable at all <input type="checkbox"/> 2. Somewhat uncomfortable <input type="checkbox"/> 3. Comfortable <input type="checkbox"/> 4. Very comfortable <input type="checkbox"/> 98. Don't know <input type="checkbox"/> 99. No answer <input type="checkbox"/>



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