The Commonwealth of The Bahamas

Monitoring the Declaration of Commitment on HIV and AIDS (UNGASS)

Country Report 2010

March 31, 2010

Prepared by The National HIV/AIDS Centre, Ministry of Health and Social Development

Table of Contents

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
AZT	Azidothymidine
BNDA	Bahamas National Drug Agency
BNN+	Bahamas National Network for Positive Living
CHART	Caribbean HIV/AIDS Regional Training
DOT	Directly Observed Therapy
HIV	Human Immunodeficiency Virus
iPHIS	Integrated Public Health Information System
KAPB	Knowledge Attitudes Practices and Beliefs
M&E	Monitoring and Evaluation
MOHSD	Ministry of Health and Social Development, The Bahamas
MSM	Men who have sex with men
NASP	National HIV/AIDS Strategic Plan

NGO	Non-governmental Organizations
NHIRU	National Health Information Research Unit
PEP	Post-exposure Prophylaxis
PLWHA	Persons Living with HIV or AIDS
PMH	Princess Margaret Hospital
PMTCT	Prevention of Mother-to-Child Transmission
RMH	Rand Memorial Hospital
SCAN	Suspected Child Abuse and Neglect Unit
STI	Sexually Transmitted Infection
TB	Tuberculosis
VCT	Voluntary Counselling and Testing

Table of Figures

1 Status at a glance

1.1 Stakeholder participation in preparation of report

This report was prepared by the staff of the HIV/AIDS Centre and both the Planning Unit and the National Health Information Unit of The Ministry of Health and Social Development, with financial and technical support from UNAIDS Office for The Bahamas and The Clinton Foundation. A draft version of the report was reviewed by the UNGASS Preparation Committee, an advisory body to the National AIDS Programme with multisectoral representation from the HIV/AIDS Centre, the Ministry of Education, and the Ministry of Health and Social Development. Feedback from the UNGASS Preparation Committee was included in the final draft, and the Committee formally endorsed the report.

1.2 Status of the epidemic

As of December 31, 2008, The Bahamas had a cumulative total of 11,507 reported HIV infections. Of the 7,465 living individuals, 2,078 are living with an AIDS diagnosis, while 5,387 have HIV infection that has not progressed to AIDS.

AIDS remains the leading cause of death in the 15-49 year age group in The Bahamas. Like most Caribbean countries, the general population statistics for The Bahamas are non-existent and using modelling and based on antenatal surveillance, it is estimated that approximately 3% of persons in The Bahamas are infected with HIV. This estimates postulates that the large majority of persons reported are in the productive years of early adulthood between the ages of 20-39 years of age. The disease occurs primarily among heterosexuals (approximately 87 percent), although

accurate data due to reporting challenegse with men who have sex with men (MSM) remains a challenge Although there is no evidence to determine intravenous drug use, historically intravenous drug use is not a common practice in The Bahamas and therefore is not considered to contribute significantly to HIV transmission.

Since 1994, there has been a decreasing trend in the HIV incidence rate, with the greatest change noted in the 20 - 49 year old group. The number of newly reported HIV infections peaked in 1994, while AIDS cases peaked in 1997 with subsequent declines in both categories. A slight increase in the number of newly reported HIV infections was noted in 2005 and 2006 which was attributed to the increased testing during the "Know Your Status" campaign launched by the HIV/AIDS Centre, but subsequently, numbers are on the decline again in 2007 and 2008..

1.3 Update on policy and programmatic responses

1.3.1 National AIDS Strategic Plan

In 2007, the National AIDS Programme drafted an updated *National AIDS Strategic Plan for 2007-2015*. This plan is currently being revised, however it is being used to support strategic planning and programme activities. It is expected that revision and finalization of this plan will be completed in 2010.

1.3.2 De-centralization of HIV and AIDS comprehensive care

The 2005 UNGASS Report highlighted plans for the de-centralization of HIV and AIDS care into community clinics as a key strategy toward universal access of comprehensive HIV and AIDS care in The Bahamas. As of March 3rd 2010 a multi pronged approach to the de-centralization process began. Primary health care physicians have begun rotating

through the HIV/AIDS clinic, taking part in a four week mentorship program; which familiarizes them with standardized protocols. Decentralization coordinators have been named and trained in HIV rapid testing and Provider Initiated Testing and Counselling.

These coordinators will work along with other staff to facilitate the smooth transition of the patients from the centralized clinic.

1.3.3 Information systems

The capacity to effectively monitor and evaluate the provision of treatment and care remains a challenge. Monitoring and evaluation is critical to the success of any programme in this case, the de-centralization of HIV and AIDS care into primary health care settings. The Department of Public Health has been working for the past several years on the implementation of a public health information system (iPHIS) which will capture data of client encounters across the health care system. This data when analyzed will be used in strategic planning, programme planning and policy making. It is expected that iPHIS will play an important role in the implementation the electronic medical record. As of March 2010, The Bahamas are in the final stages of completing consulting arrangements and service contracts to address the completion of an integrated report-generating electronic medical records information system. It is expected that this system along with targeted training at present users of the data in the HIV program will result in a better characterized epidemic and a more responsive strategic plan

1.3.4 Prevention and outreach

Prevention and outreach efforts continue to be a major thrust of the National HIV/AIDS Centre. One area in which mentionable progress has been made is with the men who have sex with men (MSM) population.

Through partnership arrangements with the SASH Bahamas, the National HIV/AIDS centre and the Ministry of Health, activities including a Men's Sexual Health Expo was held. The target was men who have sex with men, and those who attended the event were offered, at no cost to them, weight screening, glucose and cholesterol screenings, HIV testing, health information and an assortment of condoms. These expos also served as a venue for data collection for this most-at-risk group, the results of which are included in this report

UNGASS indicators at a glance

UNGASS Indicators – Generalized Epidemic		2006 Result	2008Result	Notes/Comments	Document Reference
National Commitment and Action					
1	Domestic and international AIDS spending by categories and financing sources.	N/A	N/A	No data available. Process of data collection for Indicator 1 is currently underway.	Section 3.1.1
2	National Composite Policy Index	See Appendix 2			Appendix 2
National Programmes					
3	Percentage of donated blood units screened for HIV in a quality assured manner.	100%	100%	All blood products have been subject to screening since 1985.	Section 3.2.3

UNGASS Indicators – Generalized Epidemic		2006 Result	2008Result	Notes/Comments	Document Reference
4	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	48.43%	72.23%	Numerators do not include those lost to follow-up, or those who did not start medications prior to the reporting period. Denominators were calculated for adults by modelling using Spectrum. The paediatric denominator is an actual number from the National HIV/AIDS Centre database, due to the accuracy of tracking all paediatric exposures, as well as cases.	Section 3.6.9

UNGASS Indicators – Generalized Epidemic		2006 Result	2008Result	Notes/Comments	Document Reference
5	Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	88.79%	89.89%	Discrepancies between those receiving medication and total eligible could be due to a) those still early in pregnancy b) those who are members of immigrant and migrant populations who are difficult to find if they default on treatment, or who have been deported, as well as c) Bahamian citizens concerned about stigmatization. And d) drug users who do not access care or default on treatment. The denominators are actual numbers given the almost 100% testing rate among pregnant women.	Section 3.2.2
6	Percentage of estimated HIV-positive incident TB case that received treatment for TB and HIV	81.25%	100.00% (2009)	Data were cross-referenced between the TB patient registers and HIV and AIDS ARV patient registers. In 2006 10 of the people died; they are included in the numerator and denominator.	Section 3.6.5

UNGASS Indicators – Generalized Epidemic		2006 Result	2008Result	Notes/Comments	Document Reference
7	Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results.	N/A	2.35%	National KAPB survey is underway in the first quarter of 2008 and results are expected by May 2008.	
8	Percentage of men who has sex with men (MSM) that have received an HIV test in the last 12 months and who know their results	60.47% (2007)	62.81% (2009)	Family Health International methodology used with additional questions to support intervention planning.	Section 3.2.1
9	Percentage of MSM reached with HIV prevention programmes *- Percentage receiving condoms through outreach, clinic, etc.*	47.7% (2007) 53.51%	71.07% (2009) 76.86%	Family Health International methodology used with additional questions to support intervention planning.	Section 3.2.6

UNGASS Indicators – Generalized Epidemic		2006 Result	2008Result	Notes/Comments	Document Reference
	- Percentage that know were to go to get an HIV test	87.64%	84.32%		
10	Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child	N/A	N/A	No data available	N/A
11	Percentage of schools that provided life skills-based HIV education in the last academic year.	72.22%	77.63%	The data were collected by both school surveys (on New Providence island) and by educational programme reviews (Family Islands). The life skills educational program is knowledge based, and not participatory. Less than 5% of schools had participatory exercises.	Section 3.4
Knowledge and Behaviour					

UNGASS Indicators – Generalized Epidemic		2006 Result	2008Result	Notes/Comments	Document Reference
12	Current school attendance among orphans and among non-orphans aged 10-14	N/A	100%		
13	Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	N/A	N/A	National KAPB survey is underway in the first quarter of 2008 and results are expected by May 2008.	
14	Percentage of MSM who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.	44.94% (2007)	36.36% (2009)	Family Health International methodology used with additional questions to support intervention planning.	Section 3.5

UNGASS Indicators – Generalized Epidemic		2006 Result	2008Result	Notes/Comments	Document Reference
15	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15.	N/A	57.87%	National KAPB survey is underway in the first quarter of 2008 and results are expected by May 2008.	
16	Percentage of women and men aged 15-49 who have had sexual with more than one partner in the last 12 months.	N/A	N/A	National KAPB survey is underway in the first quarter of 2008 and results are expected by May 2008.	N/A
17	Percentage of women and men aged 15-49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse	N/A	N/A	National KAPB survey is underway in the first quarter of 2008 and results are expected by May 2008.	N/A

UNGASS Indicators – Generalized Epidemic		2006 Result	2008Result	Notes/Comments	Document Reference
18	Percentage of female and male sex workers reporting the use of a condom with their most recent client	Not reported	Not reported	Questions to support this indicator were included in the MSM KAPB survey. However, the answers to the question yielded small numbers which brings the reliability into question. The definition used here is having received money, etc., for anal sex. However, there is no indication of how common the practice is of receiving money, etc., for sex for the 14 respondents. Therefore, it is not clear whether it is done on a regular basis or just randomly which makes the interpretation rather subjective. Additionally, the time frame of the question suggesting commercial sex work is 6 months as opposed to 12 months, as required for the UNGASS report. For these reasons, this indicator is not reported.	N/A

UNGASS Indicators – Generalized Epidemic		2006 Result	2008Result	Notes/Comments	Document Reference
19	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	68.97% (2007)	68.82% (2009)	Family Health International methodology used with additional questions to support intervention planning.	Section 3.5
20	Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	N/A	N/A	Not applicable to The Bahamian epidemic	N/A
21	Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	N/A	N/A	Not applicable to The Bahamian epidemic.	N/A

UNGASS Indicators – Generalized Epidemic	2006 Result	2008 Result	Notes/Comments	Document Reference
Impact				

UNGASS Indicators – Generalized Epidemic		2006 Result	2008 Result	Notes/Comments	Document Reference
22	Percentage of young women aged 15-24 who are HIV infected	1.26% (2006)	0.80% (2009)	Indicator includes young women only from surveillance of antenatal attendees. While the numerator includes data collected from both the public and private sectors, the denominator is based solely on antenatal women attending community health clinics in the public sector. A mechanism is not yet in place between the public and private sectors to collect data on antenatal clinic attendees, however, this will be pursued for the next UNGASS reporting period. In total, 1 client tested positive for HIV in the private sector in 2006. Denominator is derived from government antenatal attendees who account for approximately 90%	Section 2

UNGASS Indicators – Generalized Epidemic		2006 Result	2008 Result	Notes/Comments	Document Reference
23	Percentage of MSM who are HIV infected	8.18% (2007)	25.64%(2009)	Preliminary results from a limited sero-prevalence study in a targeted MSM population.	
24	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	69.66%	69.66%	Pharmacy records were used to compile data for this indicator. Excluded were ANC patients who did not require ART for themselves, persons lost to follow-up, defaulters or who died during the reporting periods. Of note, no paediatric patients defaulted during this reporting period.	Section 3.6.9

UNGASS Indicators – Generalized Epidemic		2006 Result	2008 Result	Notes/Comments	Document Reference
25	Percentage of infants born to HIV-infected mothers who are infected	1.32% overall, however 0% - of those receiving treatment	4.32%	Countries are not required to submit data for this indicator as it will be modelled at UNAIDS Headquarter. The Bahamas has reported mother-to-child-transmission in this report based on actual numbers tracked as part of its PMTCT programme.	Section 2

2 Overview of the AIDS epidemic

The National AIDS Programme has been monitoring the epidemic since 1983, when the first clinical case of AIDS was identified. Surveillance for HIV and AIDS began in 1985 with the advent of the ELISA test. Legislation was amended in 1989 to make HIV infection a notifiable disease reported to the Department of Public Health.

As of December 31, 2008, The Bahamas had a cumulative total of 11,507 reported HIV infections (Figure 1). Of the 7,465 living individuals, 2,078 are living with an AIDS diagnosis, while 5,387 have HIV infection that has not progressed to AIDS.

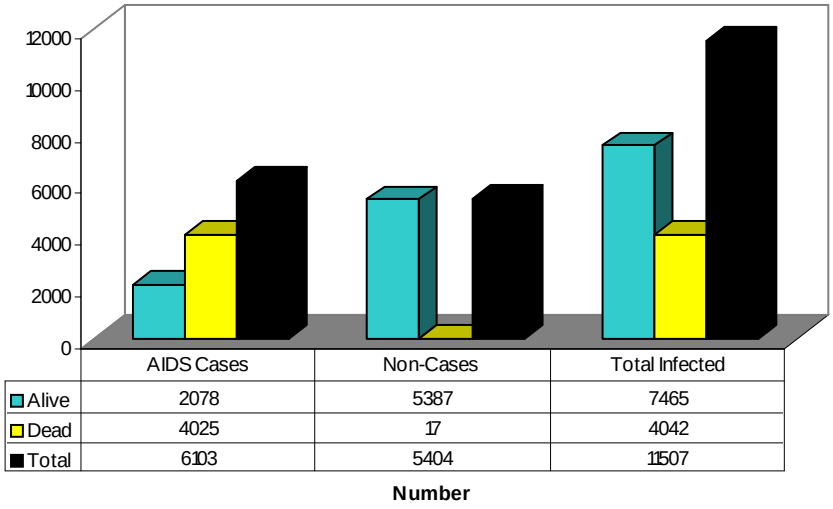
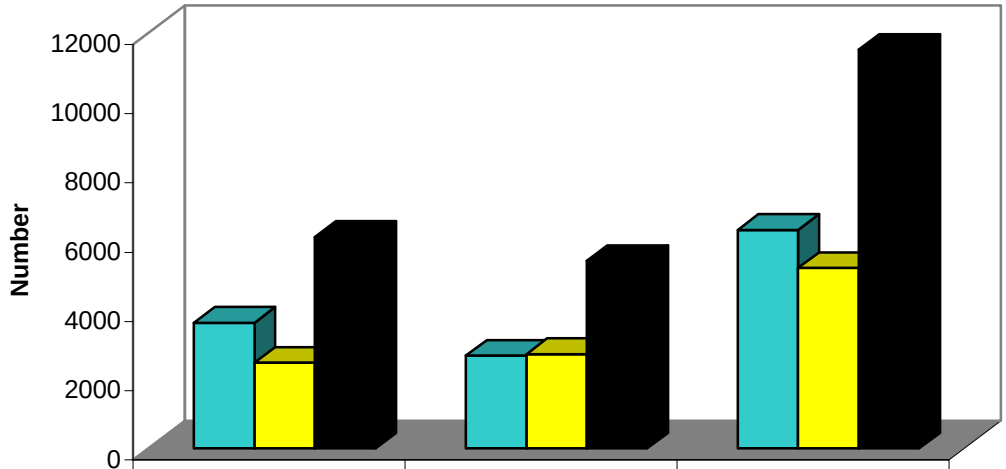


Figure 1 - Cumulative Number of Reported HIV Infections with Current Status as of December 31st, 2008

AIDS remains the leading cause of death in the 15-49 year age group in The Bahamas since 1994. As is common in the Caribbean, general population statistics are not available, and thus using population modelling based on antenatal surveillance, it is estimated that approximately 3% of persons in The Bahamas are infected with HIV.

This further postulate that the large majority of persons reported are in the productive years of early adulthood between the ages of 20-39 years of age. The disease occurs primarily among heterosexuals (approximately 87 percent), although under-reporting by men who have sex with men (MSM) remains a challenge. Transmission through intravenous drug use is nonexistent.

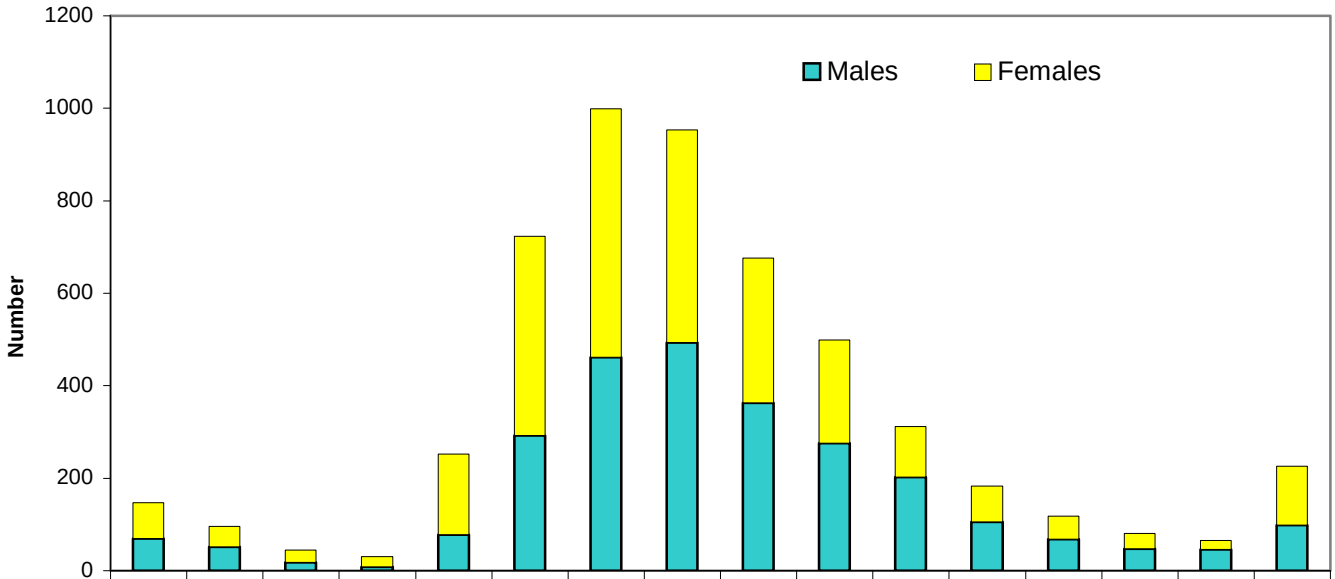


	AIDS Cases	Non-Cases	Total Infected
Males	3626	2678	6304
Females	2477	2726	5203
Total	6103	5404	11507

Figure 2 - Cumulative Number of Reported HIV Infections by Sex as of December 31st, 2008

Overall, the female to male ratio is 0.83 to 1 (Figure 2). However, in the 20 to 24 year old age group, the female to male ratio is 2.0 to 1, and in the 20 to 24 year old age group the female to male ratio is 1.6 to 1 (Figure 3 below). The younger age at which females contract HIV may be due to their earlier sexual activity, a higher male-to-female transmission efficiency or the preference of older men for younger women. In cooperation with the Ministry of Education and its Focus on Youth Programme, the National AIDS Programme includes a strong education and prevention focus on younger women as a strategy to address this disparity, including education on condom

use for prevention, encouraging the delay of sexual activity and increasing the awareness of the risks of sexual relationships with older men.

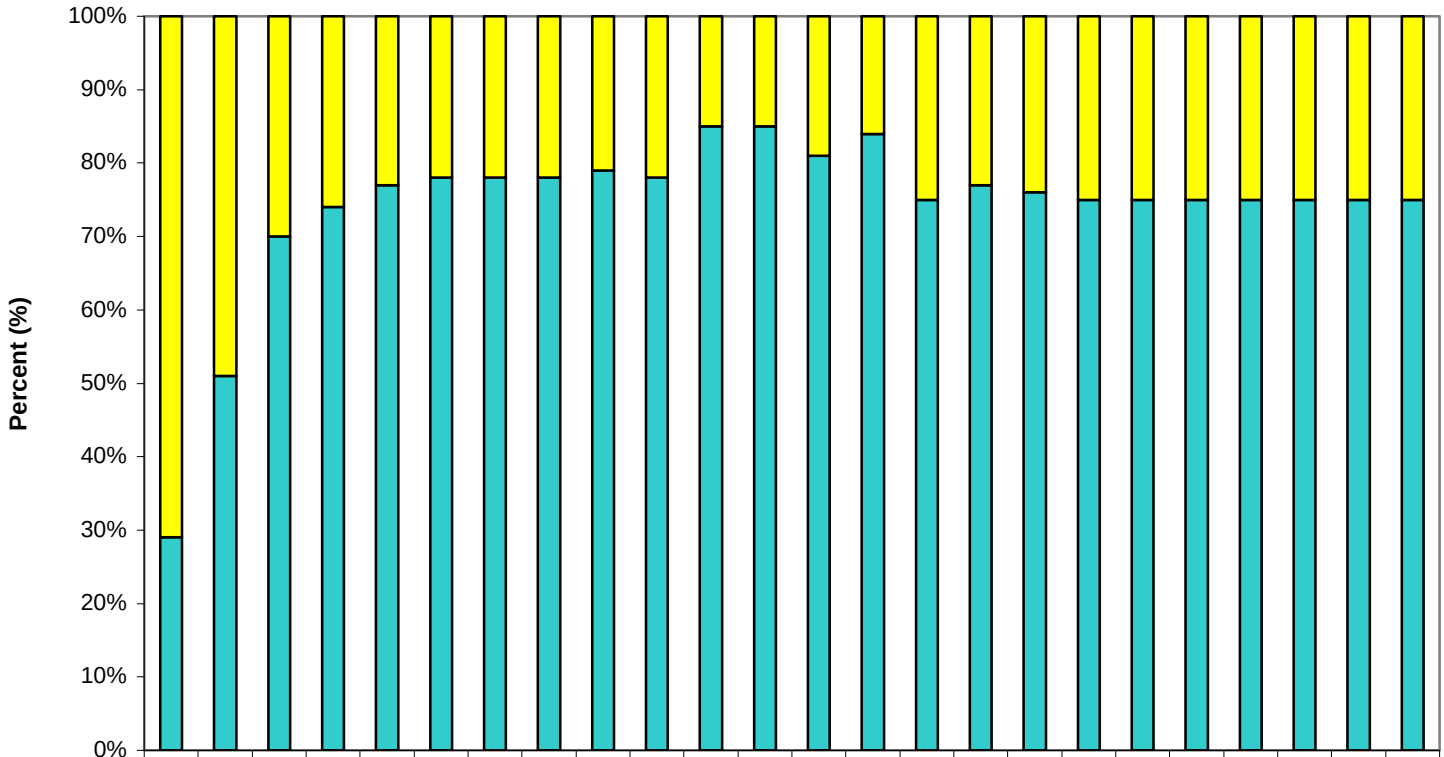


	<01	1-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+	UNK
Females	78	45	27	21	174	431	538	460	313	223	109	78	50	33	19	127
Males	69	51	18	9	78	292	461	493	363	276	203	105	68	47	46	99

Figure 3 - Cumulative Number of Non-AIDS HIV Infections, By Age Group and Sex as of December 31st, 2008

In a reflection the population distribution among the 29 inhabited islands, data from 2206 confirmed that the HIV and AIDS epidemic is concentrated among Bahamian citizens living on a few large islands,. Approximately 84 percent of individuals infected with HIV (non-AIDS and AIDS cases) live on New Providence, 7 percent live on Grand Bahama, and Abaco and Eleuthera together account for 6 percent of HIV infections (Figure 4 below).

All other islands combined have account for the remaining 3 percent of persons with HIV infection.



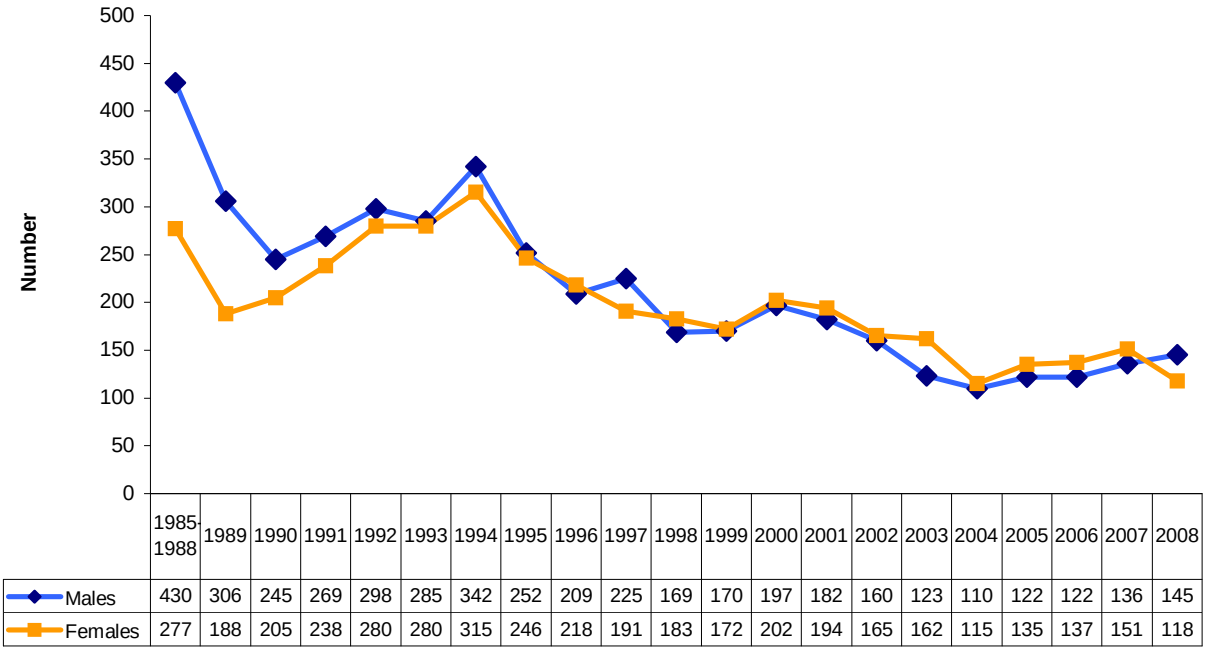
	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Non-Bahamian	71	49	30	26	23	22	22	22	21	22	15	15	19	16	25	23	24	25	25	25	25	25	25	25
Bahamian	29	51	70	74	77	78	78	78	79	78	85	85	81	84	75	77	76	75	75	75	75	75	75	75

Figure 4 - Percent Distribution of HIV Infections (AIDS Cases and Non-Cases) Reported Annually, By Bahamian Citizenship Status, 1985 to 2008

Since 1994, there has been an overall decreasing trend in the HIV incidence rate (Figure 6), with the greatest change noted in the 20 - 49 year old group. The number of newly reported HIV infections peaked in 1994, while AIDS cases peaked in 1997 with subsequent declines in both categories.

The decline in new HIV infections can be attributed to the strategies taken by the Government of The Bahamas beginning early in the epidemic, and

that continue to form the backbone of the response to HIV and AIDS, including blood screening, surveillance and partner notification, and behaviour change communication and public awareness campaigns. A small increase in newly reported HIV infections in 2005 and 2006 may be accounted for by the successful “Know Your Status” public awareness campaign which continues to encourage people to get an HIV test.



	1985-1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Males	430	306	245	269	298	285	342	252	209	225	169	170	197	182	160	123	110	122	122	136	145
Females	277	188	205	238	280	280	315	246	218	191	183	172	202	194	165	162	115	135	137	151	118

Figure 5 – New Non-AIDS HIV Infections By Sex and Reported Year, 1995-2008

Sero-prevelence surveys in sub-population groups of persons attending antenatal clinics, the sexual transmitted infection clinic (STI), blood donors and during prison intake provide frequency data for HIV. Sentinel surveillance activities continue among these target populations, and among those in treatment for substance abuse.

Surveillance of HIV in antenatal women shows drop in prevalence from 4.3 percent in 1993 to about 3 percent, beginning in 1998. The prevalence rate has remained constant since that period until the present, reflecting the fact that repeat pregnancies account for approximately 50% of all HIV-infected pregnant women. It is interesting to note that the rate is significantly lower for younger women. Of women under the age of 25 visiting antenatal clinics in 2008, 0.8 percent tested positive for HIV infection, and of women under the age of 20, only 0.4 percent tested positive (Figure 8).

	Numerator	Denominator	Value
	Number of antenatal attendees (aged 15-24) tested whose HIV results are positive	*Number of antenatal attendees (aged 15-24) tested for their HIV infection status*	*Percentage of young women aged 15-24 who are HIV infected.*
All aged 15-24	17	2173	78%
Age 15-19	14	733	41%
Age 20-24	3	1440	97%

Includes young women only from surveillance of antenatal attendees. While the numerator includes data collected from both the public and private sectors, the denominator is based solely on antenatal women attending community health clinics in the public sector. A mechanism is not yet in place between the public and private sectors to collect data on antenatal clinic attendees, however, this will be pursued for the next UNGASS reporting period. In total, 1 client tested positive for HIV in the private sector in 2006.Denominator is derived from government antenatal attendees who account for approximately 90% of all antenatal care within the country. There were approximately 2 patients that opted out of testing.

Figure 6 - UNGASS Indicator 22 - Reduction in HIV Prevalence: Antenatal Attendees 2009

The most dramatic impact of outreach and preventive interventions can be seen in the marked reduction of perinatal HIV transmission from HIV-infected pregnant women to their infants. A vertical transmission study conducted in 1992 revealed that 30 percent of infants born to HIV-infected mothers in The Bahamas were also HIV-infected. The Ministry of Health and Social Development subsequently implemented a programme of

voluntary counselling and testing for all women receiving antenatal care in the public health clinics. Following the results of ACTG 076, AZT was administered by protocol to all pregnant women and their infants. This protocol was changed to triple ARV combination therapy in 2001.

In 2008, 80 HIV infected pregnant women received antenatal care through the public health system. There were 89 births in the 2008 reporting year to HIV infected women, and 5 cases of perinatal transmission from 9 mothers who did not receive ART. Since 2003, there have been no cases of mother-to-child transmission for women receiving ART.

Enhanced diagnostic capability, an improved adherence program and better recognition and thus earlier treatment of opportunistic infections, coupled with and the increased affordability and availability of antiretroviral therapy (ART), The Bahamas has experienced a decrease in AIDS mortality. The death rate among AIDS patients decreased from 43% in 2006 to 40% in 2008.

Similarly, the number of new persons diagnosed with AIDS decreased from 329 in 2006 to 185 in 2008 and likely the result of an effective HIV awareness effort through the 'Know Your Status' campaign, and the increased number of private physicians accessing the free antiretroviral therapy program for their patients.

3 National response to HIV and AIDS in The Bahamas

3.1 Leadership and coordination

The organization of the AIDS response in The Bahamas adheres very closely to the UNAIDS principles of "The Three Ones", and as such The Bahamas has been effective in its planning, programming and use of funds. The section below describes the Three Ones principles in action within The Bahamian context, and highlights key challenges that remain.

3.1.1 One AIDS action framework – The National HIV/AIDS Programme

The National AIDS Programme remains the action framework for the response to AIDS epidemic in The Bahamas since the detection of the disease in the country in the early 1980s. With the Ministry of Health as its backbone, the National AIDS Programme embraces many of the best practices embodied in the Three Ones principles.

The Programme continues to be multisectoral, multidisciplinary and collaborative. Planning, delivery and monitoring of the Programme relies on strong partnerships among government agencies and with community and faith-based organizations, the private sector and national and international non-governmental organizations such as the Samaritan Ministries, the AIDS Foundation, the Clinton Foundation, PAHO and UNAIDS.

The table below lists the core principles and values that guide the strategic planning process and that are used to implement the plan.

Principles and values
• *Respect* for human rights and individual dignity

Principles and values
• *Accessibility and availability* – appropriate care provided at the local level. • *Equity* – care provided to all persons living with HIV and AIDS regardless of gender, age, race, ethnicity, sexual identity, income, place of residence, or immigration status. • *Coordination and integration* across the continuum of providers and levels of care. • *Community participation* – meaningful involvement in decision-making of affected individuals and families, alliances, partnerships, and mobilization of private and public sectors. • *Empowerment* – meaningful involvement of clients in the clinical management process; encouragement of individual responsibility for self-management and adherence. • *Evidence-based* – interventions based on explicit, proven guidelines and qualitative and quantitative information resources. • *Quality care* – satisfied clients receive care provided in an efficient and effective manner. • *Information* – best practices and knowledge documented, disseminated, and shared.

The National HIV/AIDS Programme is guided by the National HIV/AIDS Strategic Plan (NASP) initially developed in 2000 and integrated into the National Health Service Strategic Plan. The NASP was updated in 2002 as *The Strategic Plan for Scaling Up HIV/AIDS Care and Treatment in The Bahamas 2003-2005* with support from the Clinton Foundation and other international partners, and is currently being updated for the period 2007-2015 with financial support of UNAIDS Office for The Bahamas.

The NASP provides specific strategies and targets that were developed in consultation with multisectoral and multilateral partners. These strategies and targets have been translated into work plans which guide the activities of the various partners involved in the delivering the National HIV/AIDS Programme. While the new strategic plan for 2007-2015 has not yet been finalized and formally adopted, the draft plan is currently being used to guide strategic planning and programme activities. The National AIDS Programme is working to finalize the plan in the first quarter of 2008.

The budget for national HIV and AIDS initiatives comes largely from the government of The Bahamas, with some support for specific initiatives from international agencies such as PAHO and UNAIDS, as well as from private sources such as the AIDS Foundation. The government budget for HIV and AIDS care is integrated into other line items within the overall Ministry of Health and Social Development's budget as well as that of the Public Hospitals Authority. As such, it is difficult to fully identify the total HIV and AIDS spending by the categories required by UNAIDS for completion of Indicator 1 of the UNGASS Report.

The Government of The Bahamas consistently contributes approximately $3 million annually on provisions for HIV and AIDS care through the National HIV/AIDS Centre budgetary allocations. This does not include monies that are spent through the Department of Public Health, or the Public Hospitals Authority for provisions of care for persons with HIV and AIDS. The full scale of HIV spending by the government for 2006/2007 is likely to be more than what was spent in the 2003-2005 period. At that time the government committed 75 percent of the projected 3-year programme cost of $23 million (Figure 10).

Local, regional and international partners such as NIH (via Wayne State University), UNAIDS, PAHO/CAREC, CHART, the Clinton Foundation, the US Embassy, and the Exuma Foundation Bahamas, Ltd, also play a key role in meeting funding requirements.

See Indicator 25

While The Bahamas Government is maintaining its current commitments to the National HIV/AIDS programme, and new private sector and non-governmental donors are in the process of committing new funds, the strategy for achieving the goals and objectives of the NASP will require additional funds sustained over the longer term. Funding that is sustainable remains a challenge across the health sector, and the HIV/AIDS program is no exception. Strategies are presently being explored to assist in the funding of the functions and services supported by the HIV/AIDS program , and it is hoped that in a near future, a better model of financial sustainability becomes apparent.

3.1.2 One coordinating authority – The National HIV/AIDS Centre

The National AIDS Secretariat was established in 1988 to advise the Ministry of Health and Social Development on policy issues and to mobilize different sectors of society in the fight against HIV and AIDS. In 2002, the mandate of the AIDS Secretariat was enhanced and was re-named the National HIV/AIDS Centre – charged with being the national oversight, planning, training, coordination and evaluation body for The Bahamas' response to HIV and AIDS.

The HIV/AIDS Centre has direct line accountability to the Minister of Health. Funds from the national budget, international donors and national donors is coordinated through the Centre and prioritized within the framework set by the National HIV/AIDS Strategic Plan.

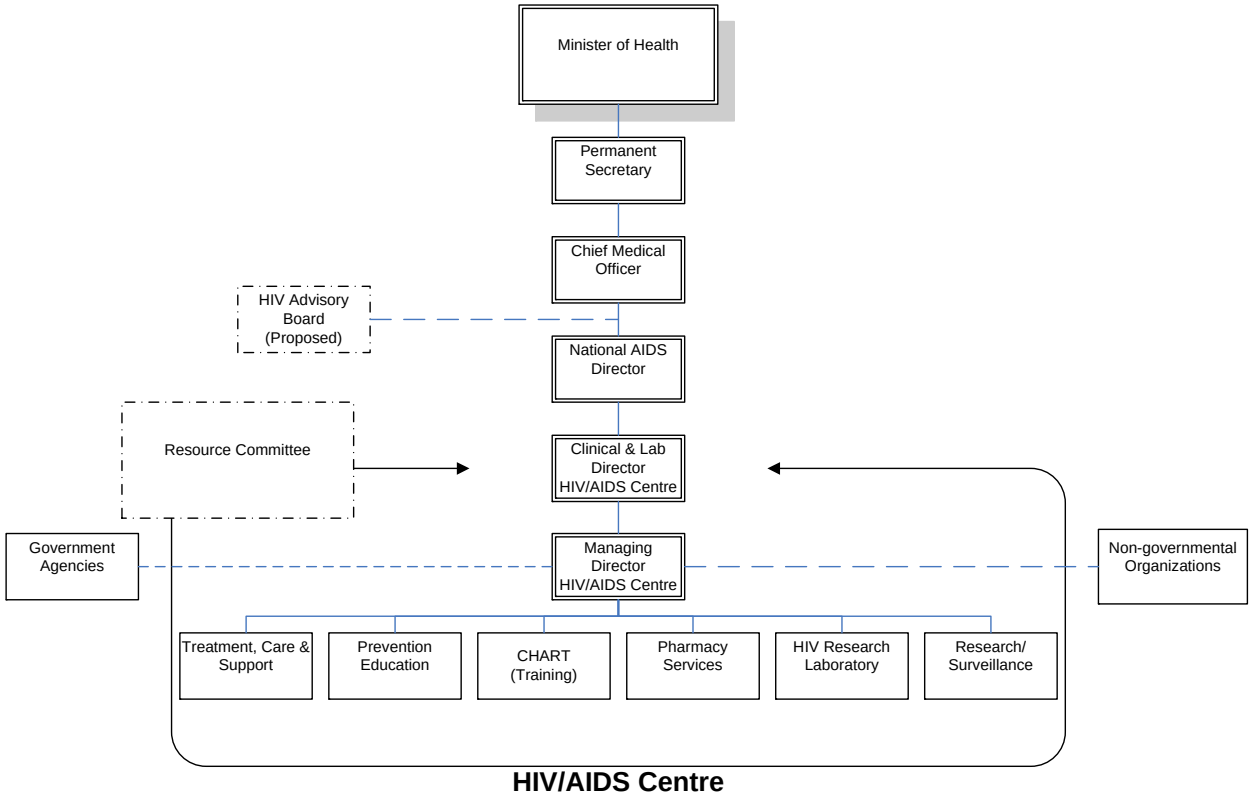
The HIV/AIDS Centre has six units, each with its own coordinator and staff that report to the Managing Director.

3.1.2.1Multisectoral mandate

The HIV/AIDS Centres enjoys broad multisectoral support from other government agencies, PLWHA, community and faith-based organizations and the private sector within The Bahamas, and is recognized among all stakeholders as the coordinating authority.

The Centre collaborates with these stakeholders through the Resource Committee, a multi-stakeholder advisory body that meets monthly to review strategic plans, programme activities and outcomes and to collaborate on joint initiatives. As well, coordinators from the Samaritan Ministries, the

AIDS Foundation and other community and faith-based organizations are actively involved in the delivery of programmes and support services, and work closely with the Managing Director and unit coordinators.



HIV/AIDS Centre

The HIV/AIDS Centre continues to be the recognized authority for the planning, management and delivery of the National HIV/AIDS Programme. Human resource management and manpower acquisition remains a challenge to the Programme.

The Centre challenges with infrastructure limitations are in the process of being addressed with increase of office locations.

The challenges of communication will likely be addressed more directly in the upcoming fiscal budget year as plans are underway to use available funds to improve on the administrative support of the HIV/AIDS program

3.1.3 One Monitoring and Evaluation (M&E) Framework:

All HIV/AIDS monitoring and evaluation activities are coordinated through the HIV/AIDS Centre in cooperation with the National Health Information and Research Unit, and the Surveillance Unit of the Department of Public Health. The Centre, in collaboration with the Surveillance Unit, undertakes a number of monitoring and evaluation activities such as serological and behavioural surveillance, program monitoring and evaluation, and research to support evidence-based clinical practices. The HIV/AIDS Centre and Health Information and Research Unit maintain a data store of indicators of the HIV/AIDS disease and the impact of the response within the country, collected largely through surveillance and surveys. These indicators are the basis of an evidence-based approach to developing strategies and planning programmes. Monitoring and evaluation activities are coordinated among the various units of the Centre and are supported by epidemiological and statistical expertise and resources from the National Health Information and Research Unit.

The Government of The Bahamas recognizes the importance of a robust M&E system, and the National AIDS Programme, with the support of UNAIDS Office for The Bahamas, is actively working to strengthen M&E capacity through identifying and designating a staff member for this area, capacity building and training of staff, as well as conducting wider

stakeholder training on M&E, and the use of the CRIS as a database for HIV and AIDS specific data.

3.1.3.2 Challenges

While the M&E Framework within the National HIV/AIDS Centre is still under-development, assessments by partner agencies like PAHO and UNAIDS have identified specific gaps which are proposed to be addressed by the end of 2010. These manpower issues will be strategically placed to enact the M&E plan and to ensure sustainability of the program, key persons in the Program will be exposed to focussed training in M&E procedures.

Prevention

Since the inception of the National HIV/AIDS programme, the focus has been on the prevention of transmission of HIV, and the comprehensive care of the individual infected with HIV. "There is no prevention without care" has become a motto within the HIV/AIDS Centre, and highlights the integrated approach of prevention, treatment, care and support adopted within The Bahamas. Even before the advent of antiretroviral treatments, this comprehensive approach to caring for the individual contributed to reduced mortality and increased quality of life for HIV-infected individuals.

3.1.4 Voluntary counselling and testing (VCT)

Individuals who request an HIV test, or who are considered by providers to be engaging in behaviours placing them at risk for HIV, receive a voluntary, confidential HIV test and pre/post test counselling (VCT) in the system of

community health clinics. There are no stand-alone VCT centers in The Bahamas. All patients with a confirmed positive test for HIV are referred to either the PMH or RMH for evaluation of their HIV disease. The CHART programme for health care providers, social service workers and volunteers has trained over 251 individuals on VCT.

A recently completed knowledge and behaviour survey (December 2009) with men who has sex with men (MSM) shows that 50.4% of those surveyed had an HIV test in the last 12 months and know their status (Figure 11). However, disaggregation of the results by age shows a significant difference in behaviour between those under and over the age of 25. For men over the age of 25, 54 percent responded they had had an HIV test in the last 12 months and knew their status, while only 48 percent of those under 25 responded the same. This discrepancy could be accounted for by stronger knowledge of the risks and causes of HIV for men over 25 years of age (see Figure 16 below), or because older men may be more comfortable with their sexuality and less fearful of the stigma associated with seeking an HIV test, especially given that 82 percent of MSM under 25 responded that they knew where to get an HIV test (see Figure 14 below).

	Numerator	**Denominator**	**Value**
	Number of MSM who had an HIV test in the past 12 months and know their	*Number of MSM included in sample.*	*MSM who had an HIV test in the past 12 months and know their results.*

	results.		
All	61	121	50.41%
<25	36	75	48.00%
25+	25	46	54.35%

Figure 7 - UNGASS Indicator 8: HIV Testing - Men who have Sex with Men (MSM)

3.1.5 Prevention of Mother-To-Child Transmission (PMTCT)

All HIV-infected pregnant women are referred to the PMH or RMH clinics for monitoring and care (see Outpatient Clinics section below). Defaulters are traced and provided additional counselling and support to improve adherence. Triple ARV therapy is recommended to all positive women beginning at the end of the first trimester or as soon as possible thereafter.

AZT is administered to the mother during delivery and to the infant post delivery for six weeks. Mother and infant are visited at home by the postnatal home service team. Babies are followed-up in the HIV/AIDS Paediatric Clinic for evaluation and testing for HIV status. HIV-infected mothers are also counselled regarding the dangers of breastfeeding, and provided with a supply of artificial milk. In combination, these measures have decreased the rate of HIV-infected infants born to HIV-infected mothers. Since 2003, no children were born infected with HIV to HIV-infected mothers who received PMTCT ARV treatment.

	Numerator	**Denominator**	**Value**
	Number of HIV-infected	*Number of HIV-infected*	*Percentage of HIV-infected*

	women who received ARVs during last 12 months to reduce mother-to-child transmission	*pregnant women in the last 12 months.*	*pregnant women who received ARVs to reduce the risk of mother-to-child transmission*
All	80	88	89.89%

This is an actual rather than an estimated denominator. The quality of coverage for antenatal care in The Bahamas is exceptionally high with approximately 90% of all antenatal clients receiving care. As a result there is near universal screening of antenatal clients. This denominator captures patient in both the private sector and those attending government clinics.

Figure 8 - UNGASS Indicator 5 - Prevention of Mother-to-Child Transmission 2008

3.1.6 Blood product screening

All blood products have been subject to quality assured routine screening in The Bahamas since the availability of HIV antibody testing in 1985.

	Numerator	**Denominator**	**Value**
	Number of donated blood units screened for HIV in blood centres/screening labs that have both 1) documented standard operating procedures and 2) participated in	*Total number of blood units donated.*	*Percentage of donated blood units screened for HIV in a quality assured manner.*

	an external quality assurance scheme.		
All	3628	3628	100%

Includes data from all three blood banks within The Bahamas, including two public blood banks at Rand Memorial Hospital and Princess Margaret Hospital, the a private blood bank at Doctors Hospital.

Figure 9 - UNGASS Indicator 3 - Blood Safety 2009

3.1.7 Post-exposure prophylaxis

All victims of sexual assault are provided post-exposure prophylaxis (PEP), and a PEP protocol is in place for occupational injuries.

3.1.8 Contact tracing and partner notification

The Bahamas was one of a few countries that treated HIV as a sexually transmitted infection in the early days of the epidemic, including subsequent contact tracing and follow-up for persons potentially exposed to the infection.

A major factor in reporting accurate HIV and AIDS statistics is the outstanding communications skills of the public health nurses and other trained staff in counseling, contact tracing, and maintaining client confidentiality. The compassionate professionalism of the medical staff in the HIV/AIDS clinics earns confidence and trust, one patient at a time. In this environment, all HIV-infected patients are encouraged to bring their sexual contacts in for education, STI screening and testing for HIV. The patient's privacy is given the highest priority. All HIV-infected clients, unwilling or unable to communicate with past or current partners, are assured by the surveillance counseling team that their identity will

not be divulged. Only after informed consent is given voluntarily are patients' contacts invited to come in for counseling.

3.1.9 Condom distribution and outreach

The HIV/AIDS Centre actively distributes condoms at public health clinics and public events along with educational material on HIV. While specific outreach to the MSM community is a recent achievement, the MSM survey (Figure 14) shows that 77 percent of survey participants had received a condom through an outreach program or clinic, and 83 percent know where to get an HIV test.

	Numerator	**Denominator**	**Value**
	Number who responded "Yes" to question "In the last twelve months, have you been given condoms? (e.g. through an outreach service, drop-in centre or sexual health clinic)	*Total number of respondents surveyed*	*Percentage who responded "Yes" to question "In the last twelve months, have you been given condoms? (e.g. through an outreach service, drop-in centre or sexual health clinic)*
All	93	121	76.86%
<25	58	75	77.33%
25+	35	46	76.09%

	Number who responded "Yes" to question "Do you know where you can go if you wish to receive an HIV test"	*Total number of respondents surveyed*	*Percentage who responded "Yes" to question "Do you know where you can go if you wish to receive an HIV test"*
All	102	121	84.30%
<25	64	75	85.33%
25+	38	46	82.61%

Figure 10 - UNGASS Indicator 9: Prevention Programmes - Men who have Sex with Men (MSM)

3.2 Knowledge and behaviour change

Since its inception, the National HIV/AIDS Programme has focused efforts on HIV and AIDS information, education and communication to prevent HIV-infections and reduce stigma and discrimination. As the epidemic progressed, the HIV/AIDS Programme was instrumental in changing risky behaviour through behaviour change communication and public awareness campaigns. The focus for HIV prevention is now centred on teenagers and young adults as this is the population which has the highest incidence of new cases. Since the mid-1980's the Ministry of Health and Social Development has involved other government ministries including Education, Tourism, and Youth, Sports, and Culture.

Efforts aimed at educating the population through prevention education related activities were coordinated initially by the AIDS Secretariat, and now by the National HIV/AIDS Centre. HIV and AIDS educational programmes draw on the expertise of volunteers and persons in non-governmental organizations, and have been successful in making the public aware of the threat of HIV and AIDS.

3.3 Focus on Youth

Initiated in 1998, the Focus on Youth HIV/AIDS education comprehensive life skills programme within the Ministry of Education's Health and Family Life Education (HFLE) curriculum is aimed at developing or increasing skills which help students protect themselves against HIV infection, and includes a parent education and participation component. The HFLE curriculum is age appropriate and includes topics on growth & development, human sexuality, disease prevention & control, substance abuse prevention and human relationships.

The Focus on Youth programme is designed to improve the knowledge of adolescents regarding HIV and AIDS and other STIs including modes of transmission and prevention, and to educate them on the proper use of a condom as well as techniques to abstain or put off their first sexual encounter. The programme offers practice in decision making, communication, assertive refusal, advocacy skills and condom use. It allows students to clarify personal values, resist pressures, and be skilled in communication and negotiating around risk behaviours. Research conducted after the initiation of this programme demonstrated a significant increase in condom usage among sexually active females.

Through home visits, and meetings in schools and libraries, the programme also includes a strong parental education component that emphasizes effective communications between parent and child, and provides parents skills to help monitor the behaviours of their children.

The majority of schools within New Providence provide HFLE at the primary level (Figure 15). However, 20 percent of schools do not include grade levels one to three in the delivery of life skills-based HIV education. In the Family Islands, 40 percent of schools do not provide HFLE to the low Primary School or only expose students to less than 20 hours of HFLE.

One of the greatest challenges to delivery of life-skills based HIV education through HFLE is the lack of priority given the curriculum by some schools, particularly at the primary level. This low priority can be attributed to the fact HFLE curriculum is not measured through end-of-term exams or national exams.

	Numerator	**Denominator**	**Value**
	Number of schools that provided life skills-based HIV education in the last academic year.	*Number of schools surveyed*	Percentage *of schools that provided life skills-based HIV education in the last academic year.*
All Schools	177	228	77.63%
Primary	80	90	88.89%

Secondary	97	138	70.29%

Data were collected by both school surveys (New Providence) and education programme reviews (Family Islands). The life-skills education program is knowledge-based and not participatory. Less than 5% of the schools had participatory exercises.

Figure 11 - UNGASS Indicator 11: Life-based HIV Education in Schools

The HIV/AIDS Centre has actively promoted HIV education and prevention activities through the use of mass media (radio, television, and press) as well as billboards and flyers. Health education and HIV and AIDS prevention education aimed at tourists and tourism workers is an ongoing activity through the Ministry of Tourism in cooperation with major hotels and their staff.

The HIV/AIDS Centre also works closely with leaders within the faith community to deliver information and education on prevention, availability of treatment and care programs and the reduction of stigma and discrimination.

The Youth Ambassadors for Positive Living (YAPL) CARICOM initiative is based on young people speaking to their peers on HIV and AIDS, drugs, child abuse, and teenage pregnancy. Their projects are geared toward sensitizing young people on sexuality and positive living. YAPL carry out their work in high schools and colleges, churches and community youth groups. YAPL assist in peer counselling youth training and discussion forums allowing them to educate while supporting their peers.

Since the last UNGASS reporting period, YAPL has become part of the HIV/AIDS Centre. Under the direction of the Centre, the YAPL together with volunteers from the Resource Committee, have accelerated their efforts, spending approximately one week in each school in New Providence. The YAPL has begun to extend its outreach to collages, and the American Embassy is funding a programme to allow YAPL to work with schools in the Family Islands.

3.4 Most-at-risk populations

Programmes and information targeted specifically at hard-to-reach groups such as commercial sex workers and men who have sex with men (MSM) have been limited by the difficulty in reaching these groups. Some programming and information for Creole-speakers has been developed and delivered through Creole-speaking staff and faith-community leaders. Public health nurses and volunteers routinely distribute condoms and informational materials at public events throughout The Bahamas.

However, the HIV/AIDS Centre has made significant progress in the past year in establishing a relationship with the historically difficult to reach MSM community in The Bahamas. Through partnerships with SASH Bahamas and the Rainbow Alliance, the Centre has increased its outreach activities, including health fairs for the MSM community that offered healthy weight screening and information, glucose and cholesterol screenings, and HIV testing.

As well, with support of these organizations, and the BNN+ and their volunteers, the Centre completed its first MSM knowledge, attitude, practices and behaviour survey, the results of which were used to complete UNGASS indicators 8, 9, 14 and 19 in this report.

Among other questions, the survey asked five questions about knowledge of the prevention of the sexual transmission of HIV, and probed on major misconceptions about HIV transmission. Overall, 36 percent of respondents answered all five questions correctly (Figure 16). Of men over the age of 25, 48 percent answered all five questions directly, as compared

with 29 percent of men under 25. The results show the need to target prevention education to younger MSM.

	Numerator	Denominator	Value
	Number of respondents who gave the correct answers to all questions.	*Number of respondents who gave answers, including "don't know", to all questions.*	*Percent of respondents who gave the correct answers to all questions.*
All	44	121	36.36%
<25	22	75	29.33%
25+	22	46	47.83%

- *Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners? (YES)*
- *Can a person reduce the risk of getting HIV by using a condom every time they have sex? (YES)*
- *Can a healthy-looking person have HIV? (YES)*
- *Can a person get HIV from mosquito bites? (NO)*
- *Can a person get HIV by sharing meal with someone who is infected? (NO)*

Figure 12 - UNGASS Indicator 14: Knowledge about HIV Prevention - Men who have Sex with Men (MSM)

This tendency among MSM over the age of 25 years to have stronger knowledge than those respondents under the age of 25 is NOT reflected in their health-seeking behaviours with regard to condom use. Overall, 69 percent of those who responded indicated they had used a condom the last time they had anal sex with a male partner (Figure 17). However,

disaggregation of the responses by age shows that 62.9 percent of MSM respondents over the age of 25 reported they had used a condom, while 72 percent of those under 25 reported the same.

	Numerator	Denominator	Value
	Number of men reporting the use of a condom the last time they had anal sex with a male partner	*Number of respondents who reported having had anal sex with a male partner in the last six months*	*Percentage of men reporting the use of a condom the last time they had anal sex with a male partner*
All	64	93	68.82%
<25	42	58	72.41%
25+	22	35	62.86%

The UNGASS Guide states that if MSM are likely to have partners of both sexes, this indicator should be reported separately for sex with females. Results show this to be a practice among some MSM in the survey, therefore condom use with female partners was excluded from this indicator.

Figure 13 - UNGASS Indicator 19: Condom Use - Men who have Sex with Men (MSM)

3.5 Improving quality of life: Care, treatment and protection of human rights

For those that work within the National HIV/AIDS Programme, the term "care" is all-encompassing and is used to mean clinical care, psychological and emotional care, social care, and perhaps most importantly, "tender

loving care" in which individuals infected with HIV are treated with dignity and respect in a non-discriminatory and non-judgemental environment. As The Bahamas moves toward decentralising and integrating HIV and AIDS prevention, treatment, care and support services into the primary level of care, maintaining this all-encompassing approach to care will be a significant challenge.

The delivery of HIV and AIDS prevention, treatment, care and support services is currently centralized at The National HIV/AIDS Centre in Nassau, and delivered through clinics in the Princess Margaret Hospital (PHM) in New Providence and at the Rand Memorial Hospital (RMH) in Grand Bahama. There are multiple entry-points to HIV and AIDS services, most commonly through voluntary counselling and testing provided at most public health clinics and many private clinics.

3.5.1 Princess Margaret Hospital outpatient clinics

The adult, antenatal, and paediatric infectious diseases follow-up clinics at the Princess Margaret Hospital (PMH) run concurrently in the outpatient department each Wednesday, permitting a full range of medical, nursing, ancillary, and support services to be concentrated to meet patient needs. The clinics are staffed by an infectious diseases specialist, paediatrician, medical house officers, public health nurses, social worker, visiting nutritionist and community volunteers from the Samaritan Ministries.

3.5.1.1PMH Adult Clinic

This full day clinic serves 50 - 70 patients per clinic session, including new referrals, patients seen regularly for follow-up, and walk-in patients presenting with symptomatic complaint. Volunteers from the Samaritan Ministries are also present to provide additional support and counselling to new patients as needed.

Patients are given a return appointment when the results of initial laboratory tests are known and a plan for ongoing care determined. Adult patients not receiving ARV therapies receive routine follow-up visits for evaluation and management of their HIV disease in the absence of other clinical problems. Persons on ARV therapies are seen at regularly scheduled intervals for clinical and laboratory monitoring based on the drug regimen and patient response. Meticulous attention is given to maximizing adherence to treatment, with nurses spending considerable time with patients in supportive counselling and problem solving. Care extends from the clinic into the community, as clinic nurses and community health workers follow through with visits to the home as needed.

3.5.1.2PMH Antenatal Clinic

Approximately 20 to 30 patients are seen each week in the antenatal infectious diseases follow-up clinic. Roughly 130 out of the 5,000 annual deliveries in The Bahamas are to an HIV-infected woman. All pregnant women with an HIV-positive test are referred to the PMH clinic for evaluation and follow-up of their HIV infections throughout their pregnancy and delivery. Both mother and baby continue to be followed together after the birth of their infants. As in the adult clinic, intensive support services and adherence counselling are often critical to assisting patients self manage their care and adhere to treatment. Where required, home-based Directly Observed Therapy (DOT) is provided by public health nurses, social workers and volunteers.

3.5.1.3PMH Paediatric Clinic

The paediatric clinic shares space with the antenatal clinic. Approximately 15 to 20 children are seen each clinic day, of whom 8 to 10 are newborn follow-ups. The large majority of newborns seen in clinic are followed for evaluation of their HIV status and for their exposure to ARV therapies during gestation.

HIV-infected adolescent patients are also followed at one-month intervals in the paediatric or adult clinic, with consideration of age and preference. The Adolescent Health Center in Nassau also provides a range of health services and targeted HIV prevention interventions to teenagers. A monthly support group has been established for positive adolescents to build community and help them address the challenges associated with being an HIV positive teenager.

Through support from the AIDS Foundation, a residential home has been purchased for short-term stays for children at risk to help them learn to more effectively manage their disease, and improve adherence to treatment.

Adolescents or children who acquire HIV infection outside of the perinatal period are referred to the Suspected Child Abuse and Neglect (SCAN) Unit if sexual molestation is suspected. An HIV test and counselling is part of the standard evaluation in these cases.

3.5.1.4 Princess Margaret Hospital inpatient infectious diseases services

There are two inpatient infectious diseases wards at the PMH serving adult men and women with bed capacities of 20 and 13, respectively. Patients

admitted to the units are followed by the infectious diseases service under the direction of the Director of Infectious Diseases who also directs the outpatient clinics.

In recent years, improvements in early diagnosis and treatment of HIV with ARV's, diagnosis and treatment of opportunistic infections, appropriate prophylaxis, and aggressive efforts by the TB Control Programme have all contributed to a decrease in utilization of inpatient beds by patients with HIV and AIDS.

Inpatient care for children with HIV and AIDS is provided on the general paediatrics unit at PMH. Prior to the implementation of AZT to prevent perinatal transmission of HIV, a separate unit for children with HIV and AIDS was needed to accommodate the larger number of hospitalized children. The number of inpatient hospitalizations for HIV-related conditions among children has decreased dramatically, with only an occasional child admitted for management of drug regimens or an older child developing a first opportunistic infection before their HIV status is recognized. Today, care for children with HIV is almost entirely provided through the outpatient clinic setting.

3.5.2 Rand Memorial Hospital outpatient and inpatient care

An HIV clinic for antenatal, paediatric and adult clients is held every two weeks at the Rand Memorial Hospital (RMH) by visiting specialists and local house medical staff. Patients requiring inpatient care may be admitted to a unit at RMH or transferred to PMH if ongoing specialist care is required.

3.5.3 HIV and AIDS care in the prison system

There is one incarceration facility in The Bahamas with an inmate population of approximately 1,500. All new inmates are provided with VCT as part of the intake medical evaluation. In the initial seroprevalence survey of prison inmates conducted in 1992, 10 percent of the prison population was found to be infected with HIV but there were very few with symptomatic disease. Current screening on all intake prisoners reveals a prevalence of approximately 2 percent. Routine care for common illnesses and complaints is handled in the prison sick bay, which has full time physicians and nurses. Inmates needing care for HIV and AIDS are seen by a specialist visiting the Prison Clinic, including provisions for ART when indicated. The capability to draw labs and transport them to the PMH and the HIV Research Laboratories coupled with training support provided by the PMH Infectious Diseases specialist to prison staff allows most of the care needed by inmates to be provided on site at the prison. Prisoners requiring specialized HIV and AIDS evaluation and care are taken to the PMH clinic. Over the past two years there has been a further strengthening of the HIV clinic, with a particular emphasis on counselling.

3.5.4 National Tuberculosis Control Programme

The National HIV/AIDS Programme works closely with the National Tuberculosis (TB) Control Programme because of the overlapping vulnerabilities among people with these conditions. The prevalence of TB in The Bahamas increased modestly in the years 1997 to 2000 before dropping in 2005. Approximately 38% of individuals infected with TB also are HIV-infected.

	Numerator	Denominator	Value
	Number of adults with advanced HIV infection who are currently receiving ART in accordance with the nationally approved treatment protocol and who were started on TB treatment (in accordance with national TB programme guidelines) within the reporting year.	*Number of incident TB cases in people living with HIV*	*Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV*
All	15	15	100%
Males	10	10	100%
Females	5	5	83.33%

Data were cross-referenced from the TB patient registers with the HIV and AIDS ARV patient registers. In 2006, 10 of the people died; they are included in the numerator and denominator. This denominator is an actual rather than an estimated number. Due to the health seeking behaviours of the population, persons with ill health seek medical attention. In addition, persons with HIV and TB who do not seek

medical attention are more likely to succumb to their illness and would be captured in this manner.

Figure 14 - UNGASS Indicator 6: Co-Management of TB and HIV Treatment 2008

The activities of the TB Control Programme include investigations of reported cases, screening of potential contacts, oversight of care and treatment of confirmed and suspected patients at PMH, and coordination of follow-up care in the community including directly observed treatment service. All patients newly diagnosed with HIV infection are screened for TB. It is the standard of care to administer combination antiretroviral therapy to all persons co-infected with HIV and TB (Figure 18).

All suspected cases of active TB are hospitalized on the infectious diseases ward at PMH for additional laboratory investigation and treatment. Clients on both TB and ARV medications receive DOT for the duration of the TB treatment to ensure compliance with both classes of medication.

3.5.5 Sexually transmitted infections clinic

There is one sexually transmitted infections (STI) clinic located in Nassau which serves as a referral centre for individuals with suspected STIs and as a walk-in clinic for individuals presenting with complaints. Roughly 130 patients per week are seen in the clinic. Patients are given a physical exam, and associated diagnostic laboratory tests including an HIV test with consent. Treatment is provided and patients are given a follow-up clinic appointment to return for their HIV test result. All persons with positive HIV test results are referred to the appropriate PMH infectious diseases clinic

for follow-up and evaluation. Every effort is made to trace the contacts of infected clients and encourage them to get tested.

The STI clinics also provides information to students for research and terms papers, and STI physicians give lectures in the community as part of overall HIV outreach efforts.

3.5.6 Substance abuse and mental health services

There are two main providers of drug treatment and mental health services for The Bahamas. The Sandilands Rehabilitation Center provides inpatient and community mental health services. The Community Counselling and Assessment Center (CCAC) also offers individual and group services. More limited mental health counselling services are available on the other larger islands. There has been an increasing utilization of drug treatment services at the CCAC, with the largest numbers seen for marijuana, alcohol, and poly drug use. There has also been a pattern of rising cocaine use since 1996. Injection drug use is uncommon in The Bahamas. Persons receiving HIV and AIDS care through the PMH Infectious Diseases Follow-up Clinic are referred out to these two mental health facilities for care as needed. More limited counselling support services are provided within the clinic setting by the social worker and community volunteer from the Samaritan Ministries.

3.5.7 Hospice services

The All Saints Camp is a hospice facility with the capacity to provide shelter and basic services to 70 persons. Individuals with HIV, those in recovery for substance abuse or mental illness, and those in a transitional crisis can be cared for at the camp. Persons traveling in from the Family Islands for

clinic visits who do not have a place to stay can sometimes be accommodated at the camp. A private physician volunteers as back-up medical support once a week. The camp is eligible to receive a per diem payment from the National Insurance Board for indigent persons who are boarding at the camp for health reasons. The camp is managed by volunteers and financed primarily by the private sector.

3.5.8 Antiretroviral therapy (ART)

The Government of Bahamas has committed to providing antiretroviral therapy (ART) to all eligible HIV-infected persons in the country, regardless of immigration status. Universal access to ART is due, in large part, to increased availability and affordability of ARV medications. The Clinton Foundation has been instrumental in negotiating lower prices and a secure supply of required medications, and has also facilitated funding for ARV medications. The Bahamas has adopted regional guidelines and protocols for ART for antenatal, paediatric and adult clients, including protocols for TB co-infections. The Bahamas also serves as a resource centre for other Caribbean countries, including Turks and Caicos, Antigua, St. Kitts and Belize, providing expertise and assistance with medication acquisition, when required.

In 2008, 72 percent of all persons with advanced HIV infection were receiving ART (Figure 19). Of the children less than 15 years of age 75 percent of children received ART, which reflects the strong paediatric HIV/AIDS programme in The Bahamas. The largest gap is among adult HIV-infected persons, many of whom do not regularly access care because

of stigma and fears of discrimination, or because they are generally healthy and do not seek diagnosis or treatment.

	Numerator	Denominator	Value
	Number of adult and children with advanced HIV infection who are currently receiving ART in accordance with nationally approved treatment protocols.	*Estimated number of adults and children with advanced HIV infection*	*Percentage of adult and children with advanced HIV infection who are currently receiving ART in accordance with nationally approved treatment protocols.*
All Adults and Children	1506	2085	72.23%
Males	608	1154	52.69%
Females	898	931	96.46%
15+	55	73	75.34%
<15	1451	2012	72.12%

Advanced HIV infection for the numerator was defined as CD4 <350. Numerators do not include those lost to follow-up or people who did not start medications prior to the reporting period. Denominators were calculated for adults by modeling using Spectrum. The paediatric denominator is an actual number from the National HIV/AIDS Centre database due to the accuracy of tracking all paediatric exposures as well as cases.

Figure 15 - UNGASS Indicator 4: HIV Treatment Antiretroviral Therapy 2008

3.5.9 Decentralisation and integration of prevention, treatment, care and support services

As of 31 December 2008, there was a cumulative total of 11507 reported cases of HIV infection since reporting began in 1985. Of the 7,465 persons alive at the end of 2008, 2,078 were living with full-blown AIDS, 5,387 were HIV positive. AIDS has been the leading cause of death in the 15-49 year age group in The Bahamas since 1994. 3% of the adult population in The Bahamas are infected with HIV. The large majority of persons reported are in the productive years of early adulthood between the ages of 20-39 years of age Between 1985-2008, 55% of cases were males , 37% were between 25-34 yrs old and there was a 61%: 39% M:F deaths ratio.

As of December 31st 2009, there were approximately 9,950 persons living with HIV/ AIDS (PLWHAs) and currently 1,506 patients are actively on anti-retroviral therapy and 2,507 are in care. Approximately 6,000 were lost to care,.

Patients are currently being seen at the weekly infectious disease clinic at Princess Margaret Hospital (PMH), which has created an ever-increasing load on the HIV/AIDS clinical and hospital staff. The goal over the next year is to decentralize ***non judgmental, non discriminatory, non-stigmatizing*** HIV/AIDS treatment and care services to four polyclinics in New Providence and eventually to Grand Bahama and the

Family Islands.

However, decentralisation and integration of services also presents a number of challenges which have been addressed in the *2007-2015 National HIV/AIDS Strategic Plan*:

- Adequate infrastructure and human resources to provide services that meet standards of care;
- Quality control and monitoring to ensure adherence to guidelines and protocols;
- Ensuring confidentiality throughout an expanded system;
- Ensuring that services are provided in non-stigmatized, non-judgemental and nondiscriminatory environment.

The process of planning for de-centralization has highlighted the need for overall strengthening of primary care delivery, in particular the need for increased physician staffing and training, and improved adherence to standardized protocols. As such, plans for de-centralization HIV and AIDS care have now been included within a broader re-structuring of the delivery of primary health care services, with a particular emphasis on wellness and prevention. These plans include piloting a health team approach with a physician team lead and greater participation of allied health professionals in managing care, the development of a Primary Care Training Centre, partnering with the Family Medicine Programme at Princess Margaret Hospital, and a strategy to recruit physicians with an interest and training in a public health approach to primary care.

Advocacy, public policy, and legal framework

3.5.9.1Advocacy

In additional to public policy advocacy conducted by The National HIV/AIDS Centre, there are a number of other community and faith-based

organizations that undertake advocacy roles, such as the Bahamas National Network for Positive Living (BNN+), a network and support group for Bahamians living with and affected by HIV and AIDS, the AIDS Foundation, and the Samaritan Ministries. Through their networks, these organizations work to increase awareness of issues of stigma and discrimination and promote access to treatment and care. However, stigma and discrimination remains a significant barrier to the participation of PLWHA in public advocacy efforts.

3.5.9.2 Public policy and legal framework

From the inception of the AIDS epidemic, The Bahamas recognized the importance of protecting individuals against discrimination through public policy, education and legislation. The AIDS Secretariat was specifically created to promote education and information on HIV and AIDS and to tackle issues of stigma and discrimination. Several key policies and pieces of legislation have been instrumental in allowing The Bahamas to successfully mount an attack against HIV and AIDS, a direct result of the support of key governmental officials and lawmakers:

The Bahamas was one of the first Caribbean nations to de-criminalize homosexuality. The Employment Act of 2001 states that employees or persons applying for employment may not be discriminated against based on their HIV status, nor can an employee or applicant be required to submit to an HIV test. The Ministry of Education has recently submitted draft policy relating to HIV and AIDS, which includes requirements for treatment, management and education of all persons affected and infected with HIV and AIDS (including students and teachers), and also includes the provision of systematic and consistent information and educational materials on HIV and AIDS to students and school personnel; work was

done with assistance of UNESCO, and technical support from the HIV/AIDs Centre to broaden the proposed school policy to include an overall workplace policy.

The revised Education Act of 1996 stated that all 5-16 year olds are entitled to free education and this included provisions for children regardless of their HIV status. Children of all ages are properly educated about the disease so they are aware of precautionary measures that should be taken. The Ministry of Education has adopted specific policies to protect HIV-infected children from discrimination. The HIV or AIDS infected student/athlete has a right to confidentiality and thus his/her medical condition in this instance need not be placed on general medical records in the school. Additionally to protect their confidentiality as it relates to play and sport. The HIV or AIDS infected student/athlete participation in sports and other recreational activity has not to date presented sufficiently clear indications that such practices expose others to the infection.

The Sexual Offences and Domestic Violence Act include a provision that makes it a criminal offence for a HIV-infected person to engage in sexual intercourse with another person without disclosing his or her status. To-date, no one has been prosecuted under this provision. While The Bahamas does have strong legislative and policy protections against discrimination in many sectors, there are still gaps, such as protections based on sexual orientation or preference. Fear of stigma, retribution and further discrimination prevent many PLWHA from pursuing redress to discriminatory actions, even when protected by law or policy.

4 Best Practices

As outlined in the previous section, The Bahamas has made significant progress in improving prevention, treatment and care, but has also experienced a number of challenges that continue to be a barrier to reaching targets. The following is a summary of some of the key lessons learned in the past several years and highlights best practices that have contributed to the achievements to-date.

4.1 Lesson: Political leadership and commitment are essential to success

The political will and commitment of The Government of The Bahamas to the scaling-up initiative has been crucial to the successes of the effort to-date. This has to continue and increase, effective leadership is required to mobilize all stakeholders in the process. However, the time and effort required to provide leadership and to coordinate and mobilize resources and partners is considerable. Senior government officials must be prepared to become engaged in building support and consensus among multisectoral

partners. And civil society.

4.2 Lesson: An integrated approach accelerates the process, but requires effective management

The multisectoral partnership approach facilitates an accelerated process, develops momentum at the national level and facilitates broad participation and the achievement of results. Early in the process, the MOH identified the need for a Task Force of international partners, headed someone with experience in programme management, coordination and execution. The Bahamas experiences shows that it is important that the person who leads this process be experienced in these areas, but does not necessarily need

to be a clinician. The decentralized structure of PAHO/WHO in the Americas, and the technical assistance directly provided by the PAHO and UNAIDS in The Bahamas has contributed to the success of the process by providing expertise and resources that were aligned with the specific needs within the context of The Bahamas.

4.3 Lesson: Tools are essential to support planning and implementation

It is important to have a conceptual methodology and framework for identifying, planning and implementing strategies, and for monitoring and evaluating outcomes and impact. The choice of methodology and framework should be sensitive to the specific capacities and resources available within the country.

Effective tools for evaluating and measuring existing resource capacity across the health system are required to identify capacity gaps which may hinder scale-up efforts. It is critical to identify gaps in the system so that these can be addressed in the scale-up strategy. More effort is required to source or develop tools for estimating the start-up and ongoing operational costs for scale-up. Accurately identifying and predicting future costs in order to plan for sustainable funding was a key challenge in the process.

4.4 Lesson: The identification of cost saving in the provision of existing services may facilitate financing

Identifying cost savings may be critical in securing funds for scale-up activities. In the case of The Bahamas, ARV therapy costs were reduced from approximately $3,000 per person per year, to US$480 per person per year through efforts of the Clinton Foundation and other international

partners. For The Bahamas, these cost savings made scale-up targets realistic and achievable. Other examples could include rationalization of services or improvement in information management or business processes that provide savings to the system that can be re-directed to scale-up activities.

4.5 Lesson: The ability to execute and sustain a strategy depends on the timely mobilization of financial and human resources

Once the costs of a response initiative have been identified, it is critical to immediately begin efforts to secure financing to address any gaps. Delays in accessing the required financial resources were one of the key barriers to meeting the identified targets in The Bahamas. In a similar vein, it is also important to consider the impact of the strategy on human resource requirements and the effort and time required to recruit, contract and train healthcare professionals and programme management staff. This process should begin as soon as possible, as delays in acquiring the required human resources will lead to delays in achieving scale-up goals.

4.6 Lesson: Additional benefits are derived for the entire healthcare system through the process of planning and developing initiatives for HIV and AIDS

In The Bahamas, the process of strengthening HIV and AIDS care occurred in tandem with a review of the healthcare system and services at the national level. The ongoing planning for de-centralization of HIV and AIDS care has been a contributing driver for the re-structuring and the delivery of

primary care. The tools, processes and methodologies used for HIV and AIDS planning, and the lessons learned can be applied to other areas of the healthcare system. As well, strengthening human resources and infrastructure for extending access to comprehensive HIV/and AIDS care can have a positive impact on parts of the health system.

5 Major challenges faced and actions need to achieve goals/targets

The table below summarizes the challenges faced by The Bahamas in its response to HIV and AIDS as defined in the 2008 report, proposed actions to address these challenges, and any updates on these challenges and actions.

6 Support from country's development partners

Sustainable funding remains as key challenge. While the Bahamas Government is striving toward maintaining its current commitments to the National HIV/AIDS programme, and new private sector and non-governmental donors are in the process of committing new funds, the strategy for achieving the goals and objectives of the NASP will require additional funds sustained over the longer term. Key national partners who continue to contribute to the NAP include the AIDS Foundation, Colina Imperial, Samaritan Ministry, The Bahamas Red Cross, Bahamas Family Planning Association, All Saints Camp, Scotia Bank and Kerzner International/Atlantis. Key international donors include PAHO, UNAIDS, the United States Embassy, the Clinton Foundation, and the Hospital for Sick Kids.

A key ongoing challenge is that The Bahamas is excluded from many international donors and funds because of its GDP and the size and

distribution of the population. The donor pool of funding is limited. For the most part, sustained commitment by these donors has been the result of long-standing relationships built by the members of the NAP as it carried out its mission within The Bahamas.

The Bahamas must continue to forge new relationships, while maintaining its good standing with its current partners. There is however also a need for a review and revision of donor agency requirements for access to funding.

7 Monitoring and evaluation environment

7.1 The National M&E framework

As discuss previously, all HIV and AIDS monitoring and evaluation activities are coordinated through the HIV/AIDS Centre in cooperation with the National Health Information and Research Unit (NHIRU), and the Surveillance Unit of the Department of Public Health. The Centre, in collaboration with the Surveillance Unit, undertakes a number of monitoring and evaluation activities such as serological and behavioural surveillance, programme monitoring and evaluation, and research. The HIV/AIDS Centre and NHIRU maintain a data store of indicators of the HIV and AIDS disease and the impact of the response within the country, collected largely through surveillance and surveys. These indicators are the basis of an evidence-based approach to developing strategies and planning programmes. Monitoring and evaluation activities are coordinated among the various units of the Centre and are supported by epidemiological and statistical expertise and resources from the National Health Information and

Research Unit. The establishment of a Monitoring and Evaluation Unit remains among the Centre's priorities.

UNAIDS Office for The Bahamas financially has supported capacity building through the training of staff, conducting a wider stakeholder training on monitoring and evaluation, installing the Country Response Information System (CRIS) and training stakeholders on the use of the data base for HIV and AIDS information; and assisting in the collection of data on domestic and international expenditures on AIDS through applying the National AIDS Spending Assessment (NASA) resource tracking system. UNAIDS has also committed to further technical expertise in this area as needed.

7.2 Challenges of one national M&E system

There remains an urgent need for a national monitoring and evaluation system. While the National HIV/AIDS Programme has always incorporated monitoring and evaluation as a key component and has been driven by an evidence-based approach, The Bahamas faces many challenges that are common to low- and middle-income countries. In particular, The Bahamas lacks a comprehensive monitoring and evaluation framework. Data collected from various sources and methodologies are not well-integrated into a single set of core indicators. Like many countries, The Bahamas must respond to requests from international multilateral organizations and donors using different and sometimes conflicting sets of indicators.

The HIV/AIDS Centre requires additional funding, human resources and expertise to develop a comprehensive monitoring and evaluation framework that is based on a single set of core indicators, harmonized with

international organizations and donors. A lack of information systems provides additional challenges. Most surveillance and other data is manually collected and summarized, a highly time-consuming process for already overworked staff. Raw and indicator data are maintained in multiple data stores, including spreadsheets and databases. These manual collection processes and disparate storage systems mean that data is often months or even years out of date, and information is not readily available when required for reporting or evaluation purposes.

As such, the Department of Public Health has been working for the past several years on the implementation of a public health information system (iPHIS) to provide a single client health record across all primary care delivery locations that can also be used to monitor the standards of care, as well as provide information for planning and decision-making. Since 2005, the Department of Health has implemented iPHIS in several clinics in New Providence and Grand Bahama. The full national roll-out of iPHIS continues, with the goal of implementing iPHIS is most major clinics by the end of 2008.

Annex 1: National Composite Policy Index

NCPI Summary – The Bahamas[1]

Part A

I. Strategic Plan

The Bahamas has followed a multisectoral strategy to combat AIDS for the last 22 years. Strategy planning efforts are considered above average, and there has been some improvement since 2005. The most recent strategy (2007 to 2015) lays out programme goals, clear targets and milestones, a detailed budget per programmatic area, indications of funding sources and a monitoring and evaluation framework. Target populations include men having sex with men, pregnant women, youth/students, migrant immigrant populations, and prisoners. Settings and cross-cutting issues in the strategy include the workplace, schools, prisons, HIV/AIDS and poverty, human rights protection, involvement of people living with HIV, stigma and discrimination and gender empowerment/equality. The strategy was developed via a participatory process with support from civil society and Development Partners.

II. Political Support

[1] There may be limitations where questions were comprised of rating scales. The scores applied varied sometimes according to discipline-specific perspectives, and it is sometimes difficult to incorporate all respondents' opinions into one number on a scale. Where opinions differed, these issues were further discussed for resolution.

Additionally, some of the questions do not fully allow for a full understanding of the HIV/AIDS situation in the Bahamas, as with the monitoring and evaluation section of Part A. The "yes/no" format of the questions also do not capture exactly what is in place currently, nor what is being done in the way of improvement. These types of issues can be addressed more fully in a narrative report, rather than relying solely upon the NCPI for comprehensive understanding of the impact of HIV/AIDS.

Overall there is above average political support for HIV and AIDS programmes. Since 2005, there has been an increase in government support, especially in ARV treatment and schools/education prevention work. High officials, including the Prime Minister, speak publicly and favourably about AIDS efforts in major domestic fora. The Resource Committee is a recognized national multisectoral AIDS management body which reviews and promotes policy decisions. Established in 1991, the Resource Committee is a formal organization that meets at least quarterly with comprehensive stakeholder participation. The National HIV and AIDS Centre and Ministry of Health Advisory Committee comprise the national AIDS body that implements HIV and AIDS programmes.

III. Prevention

There has been steady progress in the implementation of HIV prevention programmes since 2005. Although there have been no new policies since the end of 2005, the country has updated the guidelines (primarily in education), and are developing more focused policies to guide all groups and workplaces in prevention programming. The Bahamas has a policy/strategy that promotes information, education and communication (IEC) on HIV to the general population and vulnerable sub-populations, targeting abstinence, monogamy, safe sex, prostitution, violence against women, and stigma.

IV. Treatment, Care and Support

Treatment, care and support are improving in the Bahamas. The country has a policy/strategy to promote comprehensive HIV treatment, care and support and gives sufficient attention to barriers for vulnerable sub-populations, and all districts have been identified as in need of support. There is also a policy for developing/using generic drugs or parallel importing of drugs for HIV and the country has access to regional procurement and supply management mechanisms for antiretroviral drugs, condoms and opportunistic infection medications. There is a policy/strategy in place regarding HIV or AIDS-related needs of orphans and an operational definition and specific national action plan for other vulnerable children (OVC). Although there is no current estimate of OVC being reached by existing interventions, work is in progress to document the numbers.

V. Monitoring and Evaluation

Monitoring and Evaluation (M&E) efforts are relatively below average in the Bahamas, although an M&E report on HIV is published annually. An M&E Committee has been established, and a plan and budget are in progress. M&E training has been conducted for three individuals at the national and sub-national levels and there is also a functional Health Information System at the National-level. There is a great need for a centralized, automated data management system.

Part B

I. Human Rights

The NCPI rates the effort to enforce existing policies, laws and regulations in relation to human rights and HIV and AIDS as above average however the rate of effort to enforce such policies is ranked below average. There is an Employment Act in place which protects people living with HIV against discrimination and HIV screening is prohibited for general employment purposes. In addition, there are no legal obstacles to effective HIV prevention, treatment, care and support for vulnerable sub-populations. Although there are no non-discrimination laws or regulations which specify protection for vulnerable sub-populations, members of the judiciary have been trained/sensitized to HIV and AIDS and human rights issues. HIV policy/strategy explicitly mentions the promotion and protection of human rights but there is currently no mechanism to document discrimination experienced by PLWHAs or most-at-risk populations. The Bahamas has a policy of free services for HIV prevention, antiretroviral treatment, and HIV-related care and support interventions and a policy to ensure equal access for women and men and most at-risk populations. Legal support services for PLWHAs, and education programmes to raise awareness of their rights are also available. Furthermore media, education, spokespersons and church and union programs designed to reduce stigmatization associated with HIV and AIDS. The government has introduced some human rights M&E mechanisms.

II. Civil Society Participation

The NCPI ranks civil society's access to adequate financial and technical support as average. Efforts to increase civil society participation which were considered below average in 2005 have improved in 2007. Civil

society involved in HIV activities are very diverse, and have had strong influence in strengthening the political commitment of top leaders and national policy formulation. Civil society has also been active in the planning and budgeting process for the National Strategic Plan on AIDS. Prevention, treatment, and care and support services provided by civil society are mostly included in National Strategic plans and reports and sometimes in the national budget. The Bahamas included civil society in their 2006 National Review of the National Strategic Plan.

III. Prevention

The country's efforts in the implementation of HIV prevention have increased since 2005. Districts in need of HIV prevention programmes have been identified and the status of their need assessed.

IV. Treatment, Care and Support

The country's efforts in the implementation of HIV treatment, care and support have improved since 2005. Districts in need of HIV and AIDS treatment, care and support programmes have been identified and the status of their need assessed. Civil society is estimated to contribute between 25 and 50 percent in various HIV programmes and services. In 2007, the efforts to meet the needs of OVC have improved from below average in 2005 to average.

Annex 2: Bibliography

A list of the primary resources used to develop this document.

Accelerating Access to Care and Support for Bahamians Living with HIV/AIDS: A Strategic Initiative of The Bahamas, the United Nationals System and The Private Sector, Ministry of Health and Social Development, May 2002.

Annual Report of the Chief Medical Officer, M. Dahl-Regis 2001-2003, Ministry of Health and Social Development, April 2005.

Bahamas HIV/AIDS statistic 1985-2009 (cumulative), Ministry of Health 2009

Bahamas Roadmap to Scaling Up Towards Universal Access to HIV Prevention, Treatment, Care and Support Services, Ministry of Health and Social Development, February 2006.

Expanded Response Guide to Core Indicators for Monitoring and Reporting and HIV/AIDS Programs, USAID and the HIV/AIDS New Indicator Working Groups, November 2002.

Guidelines for Conducting HIV Sentinel Serosurveys among Pregnant Women and Other Groups, UNAIDS, December 2003

Guidelines for effective use of data from HIV surveillance systems – 2004 Country Response Information System (CRIS) Overview of the system and its plan of establishment, UNAIDS, March 2003

HIV/AIDS Programme: A Model of Success, Ministry of Health and Social Development, June 2001.

Mid-Term Report on The Commonwealth of The Bahamas National Health Service Strategic Plan 2000-2004 and Revised Commonwealth of The Bahamas National Health Services Strategic Plan 2003-2004, Ministry of Health and Social Development, 2003.

Monitoring the Declaration of Commitment on HIV/AIDS Guidelines on Construction of Core Indicators, UNAIDS, march 2009.

Regional HIV/STI Plan for the Health Sector, 2006-2015, Pan American Health Organization, November 2005.

Scaling Up – The Challenges, a presentation by Dr. M. Perry Gomez and Rose Mae Bain, The National HIV/AIDS Centre, Ministry of Health and Social Development.

Strategic Plan for Scaling UP HIV/AIDS Care and Treatment in The Bahamas 2003-2005: Proposal to the William Jefferson Clinton Presidential Foundation, Ministry of Health and Social Development, December 2002.

The "Three Ones" in Action: Where We Are and Were We Go From Here, UNAIDS, 2005.

The Commonwealth of The Bahamas Country Report: Follow-Up to The Declaration of Commitment on HIV/AIDS (UNGASS), Ministry of Health and Social Development, June 2003.

The Commonwealth of The Bahamas Draft National Health Services Strategic Plan 2007-2012, Ministry of Health 2006.

Various documents, presentations and supporting material provided

by the National HIV/AIDS Centre.