The Commonwealth of The Bahamas

GLOBAL AIDS RESPONSE PROGRESS REPORTING

Monitoring the 2011 Political Declaration on HIV/AIDS

Country Report 2012

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Prepared by Ministry of Health/PEPFAR Office

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
AZT	Azidothymidine
CAREC	Caribbean Regional Epidemiology Centre
CARICOM	Caribbean Community
CBO	Community-based Organization
CCAC	Community Counselling and Assessment Centre
CDC	Centers for Disease Control and Prevention
CDC CRO	Caribbean Regional Office of the Centers for Disease Control and Prevention
CHART	Caribbean HIV/AIDS Regional Training
CImPACT	Caribbean Informed Parents and Children Together
CoAg	Cooperative Agreement
DEBI	Diffusion of Effective Behavioural Interventions
DNA	Deoxyribonucleic Acid
DOT	Directly Observed Therapy
DPH	Department of Public Health
ELISA	Enzyme Linked Immunosorbent Assay
FBO	Faith-based Organizaiton
FOY	Focus on Youth
FOYC	Focus on Youth in the Caribbean
GBHS	Grand Bahama Health Services
HFLE	Health and Family Life Education
HIRU	Health Information Research Unit
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
ICT	Information and Communication Technology
ImPACT	Informed Parents and Children Together
iPHIS	Integrated Public Health Information System
KAPB	Knowledge Attitudes Practices and Beliefs
M&E	Monitoring and Evaluation
MARP	Most-at-risk populations
MOH	Ministry of Health, The Bahamas

MSM	Men who have sex with men
NAP	National AIDS Programme
NASP	National HIV/AIDS Strategic Plan
NGO	Non-governmental Organizations
NHSSP	National Health Systems Strategic Plan
NIH	National Institutes of Health
NTP	National Tuberculosis Programme
PAHO	Pan-American Health Organization
PCR	Polymerase Chain Reaction
PEP	Post-exposure Prophylaxis
PEPFAR	Presidentôs Emergency Fund for AIDS Relief
PHA	Public Hospitals Authority
PITC	Provider Initiated Testing and Counselling
PLWHA	Persons Living with HIV or AIDS
PMH	Princess Margaret Hospital
PMTCT	Prevention of Mother-to-Child Transmission
RMH	Rand Memorial Hospital
SASH	Society against STI and HIV
SCAN	Suspected Child Abuse and Neglect Unit
SI	Strategic Information
SODA	**S**top to think ï Consider your **o**ptions ï Make a **d**ecision ï Take **A**ction
STI	Sexually Transmitted Infection
TAG	Technical Advisory Group
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
US	United States
USAID	US Agency for International Development
VCT	Voluntary Counselling and Testing
YAPL	Youth Ambassadors for Positive Living

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1 Status at a glance

1.1 Stakeholder participation in preparation of report

This report was prepared by the staff of the Ministry of Health/President's Emergency Fund for AIDS Relief (PEPFAR) office with assistance from the Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) Centre and the National Health Information Research Unit (HIRU) of The Ministry of Health, with technical support from Joint United Nations Programme on HIV/AIDS (UNAIDS) Office for The Bahamas and Caribbean Region Office of the Centers for Disease Control and Prevention (CDC CRO) Bahamas Representative. A draft version of the report was reviewed by representatives of the Ministry of Health (MOH), the HIV Technical Advisory Group (TAG), as well as by members of the HIV Resource Committee, an advisory body to the National AIDS Programme with multisectoral representation from Governmental agencies including the HIV/AIDS Centre; the Ministry of Education; and the Ministry of Health; and Non-governmental organizations. Feedback from MOH, the HIV TAG and the HIV Resource Committee was included in the final draft, and the HIV TAG formally endorsed the report.

1.2 Status of the epidemic

As of December 31, 2010, The Bahamas had a cumulative total of 12,096 reported HIV infections. Of the 7,816 persons believed to be living with HIV/AIDS as of that date, 2,075 (27%) had received an AIDS diagnosis. While surveillance data indicate that 2% of the general Bahamian population is infected with HIV, data modelling suggests that the actual prevalence of HIV/AIDS is 3% (UNAIDS, 2010). Between 2001 and 2010, the Bahamas experienced a 39% decrease in the annual number of newly reported HIV (non-AIDS) and AIDS cases (from 553 to 337), including a 67% decrease in the number of newly reported AIDS diagnoses. The number of AIDS-related deaths has also dropped dramatically to 116 in 2010. However, despite the decline in reported AIDS deaths over the past decade, AIDS remains one of the leading cause of death in the 15-49 year age group (Dahl-Regis, 2010). HIV in The Bahamas is believed to be transmitted primarily via heterosexual intercourse (approximately 87%). Discussions to determine the impact of HIV transmission based on men-who-have-sex-with-men (MSM) activity has been difficult due to gaps in the traditional methods of capturing data from this group. Perinatal transmissions have been reduced dramatically to levels consistent with prevention of mother to child transmission (PMTCT) elimination objectives with the introduction of robust PMTCT interventions. Injection drug use has not been documented as a risk factor in The Bahamas among HIV/AIDS cases to date.

1.3 Update on policy and programmatic responses

The Ministry of Health has a long history of health system response to HIV and AIDS. The Bahamas' National AIDS Programme (NAP) is a mature programme that has been overseeing prevention, treatment, care and support for persons affected and infected with HIV since the mid-1980's. The Bahamas has learnt many lessons throughout its history with HIV and AIDS; and have used these lessons to gradually enhance its policies and programmes in this area. This gradual building has meant that the NAP did not have to accommodate major adjustments within short time intervals. Rather, it has been able to fine-tune activities that are aligned with responses shown to have been successful. Recently, these initiatives have been aimed at improving the access to services for those infected with HIV, enhancing data collection to accurately identify persons at risk for acquiring HIV, and increasing and developing local technical expertise and capacity to sustain the national response to HIV/AIDS in the face of shrinking financial and health care worker resources.

1.3.1 The National Health Systems Strategic Plan (NHSSP) 2010- 2020

The Ministry of Health, in 2009, began the development of a new National Health Systems Strategic Plan for the period 2010-2020. This plan is based on seven strategic components aimed at improving the health of the residents of the nation:

1) Public and private sector working with civil society and communities to improve health and well-being;

2) Integrated, people-centred health care services and programmes that are delivered across every stage of life that focuses on health prevention;

3) improved health outcomes and operational efficiency that is driven by the management of strategic information and evidence-based decisions;

4) Health human resource governance, planning and management that allows the delivery of quality care and services;

5) Optimized planning and management of health facilities, infrastructure, technologies and supplies for sustainable delivery of quality health care and services;

6) Effective and accountable leadership, management and oversight that is focused on improving efficiency and quality; and

7) Sustainable health system that provides equitable and affordable access to care and services.

The NHSSP accounts for the interactions that occur between the integral components of health care organizations by utilizing a systems thinking approach that addresses the complexity of today's health care system (WHO, 2007).

After receiving input from many stakeholder groupings inclusive of the general public, The NHSSP 2010 – 2020 is in its final iterative and is awaiting approval from Cabinet, a legislative body. (MOH, 2010).

1.3.2 National AIDS Strategic Plan

In 2007, the National AIDS Programme drafted a *National AIDS Strategic Plan (NASP) 2007-2015*. While not formally adopted, this strategic plan continues to drive programmatic planning and is used to guide the development of annual work plans and drive strategic initiatives and programme activities, with support from PEPFAR. Although drafted in 2006, most of the key priority areas align with the seven strategic components of the NHSSP 2010-2020 as stated above: Strategic Planning and Management that focuses on evidence-based decision making and accountability that is reliant on strategic information and research; Prevention that focuses on maintaining healthy lifestyles; Infrastructure and Human Resources that focus on sustainable services with a high quality of care and human resources that can support these services; and Care, Treatment and Support Services that are patient-centred and integrated into primary care services for increased access. This NASP continues to provide direction for the programme and serves as a blueprint for annual planning and implementation of services and activities.

1.3.3 President's Emergency Plan for AIDS Relief (PEPFAR)

The Ministry of Health, in 2010, entered into a partnership with the United States of America's President's Emergency Fund for AIDS Relief (PEPFAR) through a cooperative agreement (CoAg) with the CDC CRO. This CoAg has been instrumental in providing funding and technical support in the areas of Prevention, Care and Treatment, Strategic Information, and Health Systems Strengthening. . It has also been influential in expanding capacity within both the Ministry of Health and the NAP in areas of data management, as well as an improved and more efficient programmatic response, patient and data management.

PEPFAR is the largest component of the U.S. President's Global Health Initiative that is aimed at improving the health of women, infants and children. PEPFAR seeks to support countries in strengthening national programmes to address HIV and AIDS while improving national health systems' capacities to sustain the provision of quality health care. As a more seasoned programme, The Bahamas is benefitting through these latter initiatives through improved sustainability and expansion of access to services across the health sector, supported by increased community and private sector involvement.

1.3.4 De-centralization of HIV and AIDS comprehensive care

Decentralization of HIV services continues to focus on expanding HIV coverage. Through the expansion of counselling and testing services; prevention interventions and introduction of HIV rapid testing protocols in the primary health care clinics throughout the archipelago, decentralization efforts are gaining momentum. Training health care workers remains a pillar of the decentralization initiative. A decentralization training programme was conducted between 2010 and 2011 for health care workers, mainly nurses and physicians, that focused on the decentralization of the provision of support, treatment and care for both HIV infected adults and children, and clinical instruction in the management of some of the more common co-infections. This included a classroom session followed by a three-month preceptorship. Provider initiated testing and counselling training continues and includes components on stigma and discrimination, testing and counselling techniques and requirements, and injection safety methods for obtaining blood specimens.

The introduction of HIV rapid testing at strategic locations throughout The Bahamas (designated primary health care clinics, various health fairs, and selected community events) has served to strengthen the decentralization initiative, by increasing the number of sites where persons can access HIV care and testing. The second phase of decentralization will address treatment, placing HIV-infected individuals in health care services that are in close proximity and convenient to their residences. The premise for the latter is based on the belief that linking HIV clients to local health care service providers will decrease the stigma and discrimination that is marked by centralized HIV care.

1.3.5 Information systems

Information systems and data management continue to be a challenge for the Ministry of Health, including the NAP. The capacity to effectively monitor and evaluate the provision of treatment and care is critical to the success of the de-centralization of HIV and AIDS care into community clinics. The Department of Public Health (DPH) worked for 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 could also be used to monitor the standards of care, as well as provide information for planning and decision-making. This system will soon be obsolete and the selection of a system that will meet the needs of both the acute care and primary health care system is currently underway. The deployment of a cross-cutting compatible system will be crucial in using evidence to make management decisions.

The development of the NHSSP 2010 – 2020 highlighted the need for an integrated data management system that allows data sharing across all public sectors including the Public Hospitals Authority (PHA)

and DPH. Information and Communication Technology (ICT) for Health was included in the development phase of the NHSSP 2010-2020; the decommissioning of the iPHIS data management programme was recommended along with the adaptation of the current hospital based information system or the identification of an alternative system for the primary health care system that could be integrated with the hospital-based system for continuity of care across the health care continuum. Discussions on the final system remain ongoing.

At the National HIV Centre, digitized recordkeeping presents a challenge on several fronts; however, the introduction has continued to move forward slowly. The development of a digital computer forecasting programme for the procurement of ARV medications has formed the basis of an electronic patient pharmacy record. Also, a number of discrete individual programmatic databases are being managed throughout the NAP. The Strategic Information (SI) Unit which was introduced in September 2011 will begin the consolidation of these databases which when completed will increase he efficiency of programme monitoring thus allowing for evaluation of services in a timelier manner.

1.3.6 Prevention and outreach

The HIV/AIDS Centre continues to make significant progress in establishing relationships with the historically hard to reach most-at-risk-populations (MARP). Through partnerships with organizations such as the Society Against Sexually Transmitted Infections and HIV (SASH) Bahamas, the Centre has increased its outreach activities to the MSM communities in The Bahamas; primarily among persons between the ages of 20 and 35. These activities include health fairs for the MSM community that have offered health information, weight screening and glucose and cholesterol screenings, STI screening and HIV testing. New partnerships have been established with community based organizations (CBO) such as the Urban Renewal Centres and The Bahamas Urban Youth Development Centre. These organizations focus on bringing HIV prevention interventions and increased access to counselling and testing to sex workers, another hard to reach population in community settings in New Providence. Partnerships have also been established with the Faith-based Organization (FBO) Real Men Haitian Chapter from Bahamas Faith Ministries who are working within the Creole-speaking communities. These organizations have been provided with financial assistance from the PEPFAR grant to assist with these initiatives.

Improving access to prevention activities and community outreach programmes for hard-to-reach and marginalized populations continue to be a priority for the next biennium. The Ministry of Health through its NAP has demonstrated its commitment to this priority through the identification and employment of a Community Outreach Coordinator whose responsibility will be to identify and coordinate HIV/Sexually Transmitted Infection (STI) prevention activities throughout the country among

these targeted populations by identifying formal and informal leaders and building relationships that encourage partnerships and introducing outreach activities.

1.4 UNGASS indicators at a glance

UNAIDS Indicators		2008 Result	2010 Result	Notes/Comments	Section
Target 1. Reduce sexual transmission of HIV by 50 per cent by 2015					
1.1	Percentage of young women and men aged 15-24 who correctly ID ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV	N/A	17%	Results based on the Youth KABP survey conducted in 2009. Results were published in the 2010 UNGASS report, but not disaggregated.	3.3.1.1
1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	58%	28%		3.3.1.1
1.3	Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	N/A	21%		3.3.1.1
1.4	Percentage of adults aged 15 - 49 who have had sexual intercourse with more than one partner in the past 12 months and who report the use of a condom during their last intercourse	N/A	79%		3.3.1.1
1.5	Percentage of adults aged 15 - 49 who received an HIV test in the past 12 months and know their results	2%	5%		3.3.1.1
1.6	Percentage of young people aged 15 - 24 who are living with HIV	0.8% (2009 data)	0.9%		3.3.1.1
1.7	Percentage of sex workers reached with HIV prevention programmes	Not Required	Not Available	To date, no formal studies have been conducted on commercial sex workers in the Bahamas which	
1.8	Percentage of sex workers reporting the	Not Required	Not Available		

UNAIDS Indicators		2008 Result	2010 Result	Notes/Comments	Section
	use of a condom with their most recent client			inform the indicators of this report.	
1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results	Not Available	Not Available		
1.10	Percentage of sex workers who are living with HIV	Not Required	Not Available		
1.11	Percentage of men who have sex with men reached with HIV prevention programmes	71%	79%	Data from PEPFAR-funded MSM targeted HIV testing party 2012 was used to determine results.	3.5.2
1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	69%	88%		3.5.2
1.13	Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	63%	55%		3.5.2
1.14	Percentage of men who have sex with men who are living with HIV	26% (2009 data)	14%		3.5.2
Target 2. Reduce Transmission of HIV among people who inject drugs by 50 per cent by 2015					
2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	Not required	N/A	Current surveillance data from NGOs and national drug treatment centers indicate that injection drug use in The Bahamas remains negligible	
2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	N/A	N/A		
2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	N/A	N/A		

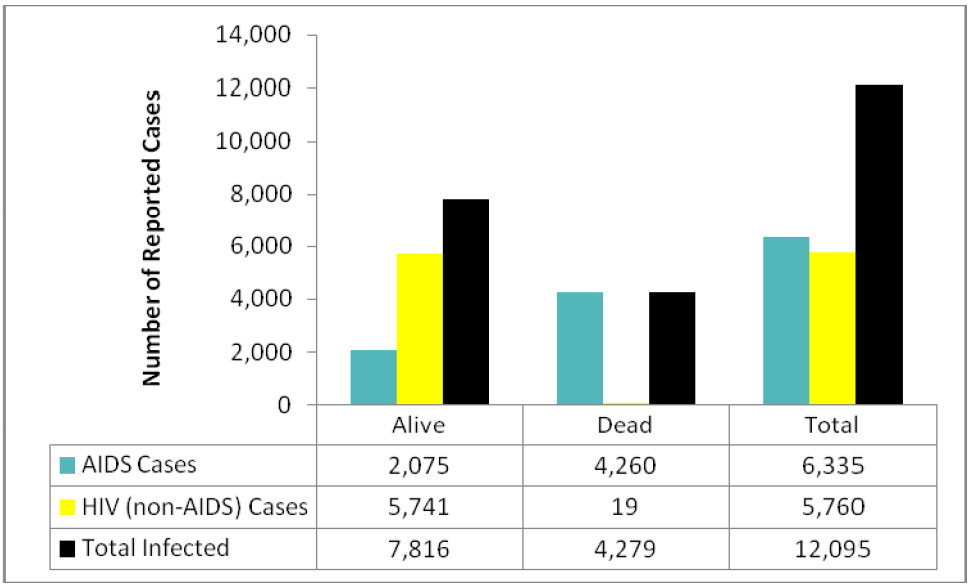
UNAIDS Indicators		2008 Result	2010 Result	Notes/Comments	Section
2.4	Percentage of people who inject drugs that have received an HIV test in the past 12 months and who know their results	Not required	N/A		
2.5	Percentage of people who inject drugs who are living with HIV	Not required	N/A		
Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths					
3.1	Percentage of HIV positive pregnant women who receive ARVs to reduce the risk of mother to child transmission	90 %	88%		3.2.2.1
3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	Not required	100%		3.2.2.1
3.3	Mother-to-child transmission	Not required	35%	Numerator based on Spectrum data only, which may inflate estimates for countries with small populations.	3.2.2.1
Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015					
4.1	Percentage of eligible adults and children currently receiving ARV therapy	72%	39%		3.6.8.1
4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ARV	70%	71%		3.6.8.1
Target 5. Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015					
5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	100 %	67%		3.6.4.1

UNAIDS Indicators		2008 Result	2010 Result	Notes/Comments	Section
Target 6. Reach a significant level of annual global expenditure (US$22-24 billion) in low- and middle-income countries					
6.1	Domestic and international AIDS spending by categories and financing sources	Not available	Not available		
Target 7. Critical Enablers and Synergies with Development Sectors					
7.1	National commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation				Annex 2
7.2	Proportion of ever-married or partnered women aged 15 - 49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	Not required	Not Available		
7.3	Current school attendance among orphans and non-orphans aged 10-14	100%	Not Available		
7.4	Proportion of the poorest households who received external economic support in the last 3 months	Not required	Not Available		

2 Overview of the AIDS epidemic

The NAP 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 Enzyme-linked immunosorbent Assay (ELISA) test. Legislation was amended in 1989 to make AIDS a notifiable disease reported to the Department of Public Health.

As of December 31, 2010, The Bahamas had a cumulative total of 12,095 reported HIV infections (Figure 1). Of the 7,816 people living with HIV, 2,075 had been diagnosed with AIDS, while 5,741 were living with HIV (non-AIDS). AIDS remains a leading cause of death in the 15-49 year age group in The Bahamas. HIV/AIDS surveillance data indicate a population prevalence of 2%. However, as is common in the Caribbean, general population statistics are not complete. Therefore, using population modelling based on antenatal surveillance, it is estimated that approximately 3% of persons in The Bahamas are infected with HIV.



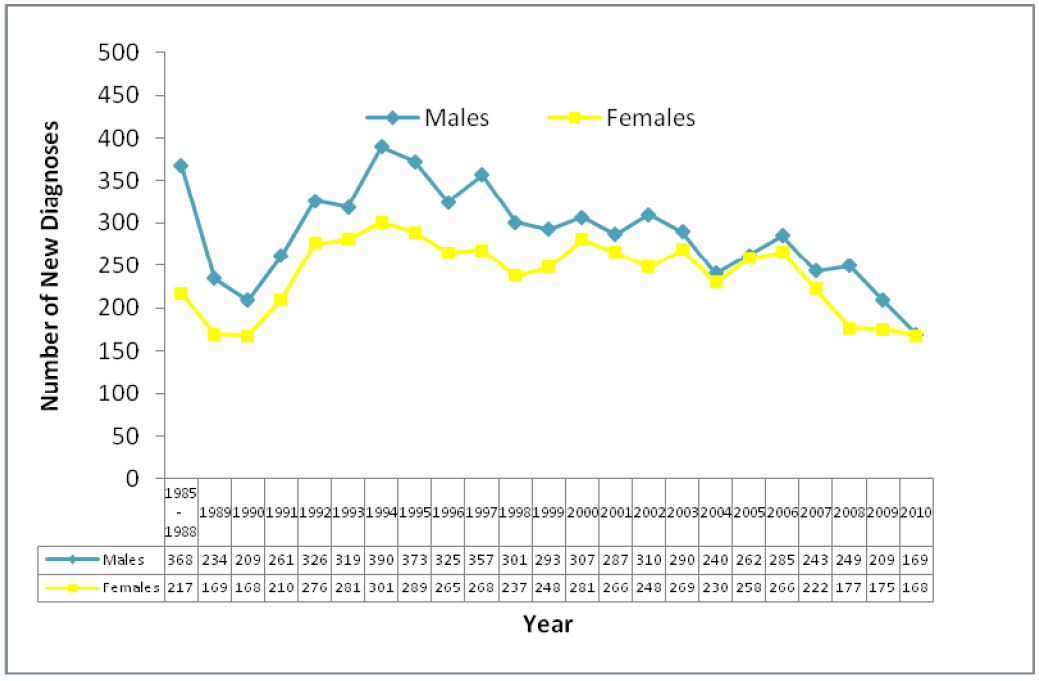
	Alive	Dead	Total
AIDS Cases	2,075	4,260	6,335
HIV (non-AIDS) Cases	5,741	19	5,760
Total Infected	7,816	4,279	12,095

Figure 1. Cumulative Number of Reported HIV/AIDS cases, The Bahamas, 1983-2010

HIV surveillance data also reveal that reported cases of HIV/AIDS occurred primarily among heterosexuals in 2010 (approximately 87%), although under-reporting of men-who-have-sex-with-men sex as a risk behaviour remains a challenge. Transmission through intravenous drug use has not been documented in the Bahamas.

Geographically, HIV/AIDS is not restricted to New Providence. Although the majority of cases (85%) were living in New Providence at the end of 2010, 7% of cases resided in Grand Bahama, 3% in Abaco, 2% in Eleuthera, and 4% in other Family Islands. This is somewhat reflective of the general population, with 70% of the nation's population living in New Providence, 15% in Grand Bahama, 5% in Abaco, 2% in Eleuthera and 6% in other islands. Also, changes in HIV/AIDS distribution is found to vary by nationality: 75% of HIV/AIDS cases reported in 2010 were among Bahamian citizens, while 25% were non-Bahamian citizens. These proportions have remained consistent since 2002.

According to 2010 HIV surveillance data, the number of new HIV (non-AIDS) and AIDS infections reported to the Ministry of Health decreased to 337 in 2010 from 553 in 2001, a decline of 39%, and from a peak of 691 cases in 1994 (a 51% decline) (Figure 2). Also, the number of reported AIDS deaths decreased by 70% between 2001 (197 reported deaths) and 2010 (116 reported deaths). The actions of the Bahamian government and other organizations early in the epidemic may have helped reduce the total number of reported cases through the strategies initiated. These strategies continue to form the backbone of the response to HIV/AIDS in the Bahamas and include blood screening, surveillance, partner notification, behaviour change communications and public awareness campaigns. Small increases in the number of reported cases during 2005 and 2006 were likely due to the 'Know Your Status' testing campaign which occurred during those years.



	1985-1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Males	368	234	209	261	326	319	390	373	325	357	301	293	307	287	310	290	240	262	285	243	249	209	169
Females	217	169	168	210	276	281	301	289	265	268	237	248	281	266	248	269	230	258	266	222	177	175	168

Figure 2: Number of HIV/AIDS cases reported to the MOH by Year and Gender, 1985-2010

HIV surveillance data is obtained from general surveillance activities, targeted testing events, antenatal clinic attendees, sexually transmitted infections clinic, blood donors, prisoners upon intake, and those in treatment for substance abuse. Sentinel surveillance activities continue among these target populations and among those in treatment for substance abuse.

3 National response to HIV and AIDS in The Bahamas

3.1 Leadership and coordination

The Government of The Bahamas made a strong political commitment in the response to HIV and AIDS in The Bahamas from the beginning of the epidemic. The largest share of resources, both financial and human, for HIV services has traditionally, and continues to come from, the Government. While there are still gaps in the response that have been identified, the Government is committed to providing high quality services which are increasingly accessible to improve the health and well-being of persons infected and affected by HIV. The organization of the AIDS response in the Bahamas adheres very closely to the UNAIDS principles of "The Three One", 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.

One AIDS action framework – The National HIV/AIDS Programme

The NAP remains the action framework for the response to the AIDS epidemic in the Bahamas since the detection of the disease in the early 1980s. This continues with minimal modifications today. With the Ministry of Health as its backbone, the NAP still 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 faith-based organizations, the private sector and national and international non-governmental organizations such as the Samaritan Ministries, the Bahamas AIDS Foundation, the Clinton Foundation, Pan American Health Organization (PAHO) and UNAIDS. In 2011, the Ministry of Health realized that a variety of external agencies were interested in coming to The Bahamas to implement HIV programmes and services or to conduct research; in response to this awareness, the Ministry of Health created the National HIV/AIDS Advisory Committee which was charged with coordinating and overseeing all requests for HIV/AIDS research and the provision of services and financial grants for HIV/AIDS within The Bahamas. Composed of persons from the Ministry of Health, the NAP, the AIDS Foundation, and representatives from two international agencies, the Committee meets as necessary to review applications and provide approval or guidance on these matters as necessary.

The NAP continues to be guided by the National HIV/AIDS Strategic Plan (NASP) 2007-2015. The NASP provides specific strategies and targets that were developed in consultation with multisectoral and multilateral partners. These strategies and targets have guided the development of work plans which direct the activities of the various partners involved in delivering activities and services for the National

HIV/AIDS Programme. While the strategic plan for 2007-2015 remains in draft format it continues to steer strategic planning and programme activities. The National AIDS Programme is now seeking to update and expand the plan to coincide with the NHSSP 2010 – 2020.

Funding 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 the Clinton Foundation, PAHO and UNAIDS, as well as from private sources such as the AIDS Foundation. The government's budget for HIV and AIDS care is integrated into other line items within the overall Ministry of Health's budget as well as that of the Public Hospitals Authority. However it consistently contributes approximately $3 million annually on provisions for HIV and AIDS care through the National HIV/AIDS Centre budgetary allocation, as well as through DPH and PHA.

The integration of the budget into the various agencies' line items make it difficult to fully identify the total HIV and AIDS spending by the categories required by UNAIDS for completion of Indicator 6 of the UNAIDS Report. Assessment of the actual expenditure for fiscal year 2010/2011 is currently underway.

Funding from local, regional and international partners such as National Institutes of Health (NIH) (via Wayne State University), UNAIDS, PAHO/Caribbean Regional Epidemiology Centre (CAREC), the Clinton Foundation, PEPFAR (through the CDC CoAg) and the United State's (US) Embassy, as well as the US Department of Defence also are also key in meeting funding requirements. United States Agency for International Development (USAID) has also been instrumental in funding local initiatives, including C. Change which builds capacity among vulnerable populations and has conducted workshops with these populations to develop behaviour change messages that are appropriate to the population, and World Learning which has provided grants to local Non-governmental Organizations (NGO) for the implementation of HIV initiatives.

The current commitment of the Bahamian Government along with the monetary contributions of new private sector and non-governmental donors has greatly aided the advancement of the NAP. Despite these investments, additional funding is critical for sustainability and achievement of the programme's goals and objectives. 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 the near future, a better model of financial sustainability becomes apparent.

One coordinating authority – The National HIV/AIDS Centre

The National AIDS Secretariat was established in 1988 to advise the Ministry of Health 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 the Secretariat was re-named the National HIV/AIDS Centre and

was 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 are coordinated through the Ministry of Health 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.

The HIV/AIDS Centres enjoys broad multisectoral support from other government agencies, people living with HIV/AIDS (PLWHA), community and faith-based organizations and the private sector within The Bahamas, and is recognized among all stakeholders as the coordinating authority. These organizations such as the Samaritan Ministries, the Bahamas AIDS Foundation, SASH and other community-based organizations (CBO) and faith-based organizations (FBO) are actively involved in the delivery of programmes and support services, and work closely with the Managing Director and unit coordinators. The Centre also 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.

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 Centres challenges with infrastructure limitations are in the process of being addressed with the increase of officespace and additional locations.

The challenges of communication are currently being addressed as improvements in telecommunications infrastructure and data and information management and support are being developed throughout the Centre. The addition of administrative and data support for the HIV/AIDS programme are scheduled to be addressed in the next fiscal year.

One Monitoring and Evaluation (M&E) Framework:

All HIV/AIDS monitoring and evaluation (M&E) activities are coordinated through the HIV/AIDS Centre in cooperation with HIRU, and the DPH Surveillance Unit. 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 HIRU 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. M&E activities are coordinated among the various units of the Centre and are supported by epidemiological and statistical expertise and resources from the HIRU.

The Government of The Bahamas recognizes the importance of a robust M&E system, and the NAP, with the support of the PEPFAR Office and the CDC CoAg in The Bahamas, actively sought to strengthen M&E capacity. In 2011, the Ministry of Health introduced a Strategic Information (SI) Unit in the PEPFAR Office and staffed it with a SI Manager, an Epidemiologist and a Monitoring and Evaluation Specialist. The goal of this Unit is to provide capacity building to the agencies that support the HIV/AIDS response throughout the country and to coordinate the gathering, analysis and dissemination of data, information and reports to further inform evidence-based decision-making.

Challenges

The development of the M&E Framework within the National HIV/AIDS Centre is in its start-up phase. The demands of this new programme have put considerable strain on all staff within the program as they seek to inform national and international reports, while working to maintain services within the Centre.

3.2 Prevention

Since the inception of the National HIV/AIDS programme, the primary focus has been on the prevention of the transmission of HIV, and the comprehensive care of the individual infected with HIV. "There is no prevention without care" became a motto within the HIV/AIDS Centre, and highlighted the integrated approach of prevention, treatment, care and support adopted within The Bahamas that continues today. This comprehensive approach to caring for the individual contributed to reduced mortality and increased quality of life for HIV-infected individuals, even before the advent of antiretroviral treatments,. With the added advantage of early entry into care and the provision of free antiretroviral (ARV) treatment to all persons medically in need, the NAP continues its tradition of prevention-based programmatic planning.

3.2.1 Voluntary counselling and testing (VCT)

Voluntary Counselling and Testing (VCT) has transitioned to a programme of provider initiated testing and counselling (PITC). HIV testing and counselling (HTC) continues to be provided to all individuals who request an HIV test or to persons throughout the system of community health clinics and hospitals for whom providers feel testing should be considered. 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 or a private physician of their choice. The Caribbean HIV/AIDS Regional Training (CHART) programme for health care providers, social service workers and volunteers had previously trained over 251 individuals on VCT. The HIV Centre continued training in PITC assisted by funding through the PEPFAR initiative.

Prevention of Mother-To-Child Transmission (PMTCT)

3.2.1.1 Target 3: Eliminate Mother-to-Child Transmission of HIV by 2015 and substantially Reduce AIDS-related Maternal Deaths

The PMTCT programme has been a success story of the Ministry of Health for several years and has been described as a regional best practice. PMTCT has decreased from 10 cases in 2000 to 0 in 2010. This can be credited to the efforts of the Ministry of Health to screen for HIV among all pregnant women receiving prenatal care and during delivery, and the administration of appropriate treatment. Of the known 103 HIV positive women who were pregnant in 2010, 86 (84%) were indicated as receiving ARVs during pregnancy. Forty-three (42%) were documented as being on ARVs to maintain or improve maternal health (Category A) including 17 who initiated therapy during pregnancy, while 37 (36%) initiated ARV treatment to prevent mother-to-child transmission (Category B)(Table 1). An additional 11 pregnant women (11%) were determined as being on ARVs, but the reason for treatment could not be determined. There were 10 women (10%) who received no ARVs during pregnancy.

	Category A	Category B	Category C	Category D	Total
Women on Treatment	43	37	0	0	91*
HIV positive pregnant Women	103	103	103	103	103
Result	42%	36%	0%	0%	88%

**Disaggregates do not include eleven women on ARV for undetermined reason, these 11 women are included in the total*

Table 1: Percentage of HIV positive pregnant women who receive ARVs to reduce the risk of mother-to-child-transmission, 2010 (Indicator 3.1)

The proportion of women accessing treatment services has decreased since the last UNGASS Report (90% coverage reported in 2009). However, all HIV-infected pregnant women are referred to the PMH or RMH clinics for monitoring and care. 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.

Azidothymidine (AZT) is administered to all HIV infected mothers during delivery. All HIV-exposed infants are given a six week course of AZT prophylaxis to protect against HIV transmission. All HIV infected pregnant women are counselled about the risks of breastfeeding and if necessary, are provided with milk substitutes for their infants. At each clinic visit the mothers are asked if they are giving their infants milk substitutes and confirming that breastfeeding is not being done as a method of feeding. The mothers receive adherence counselling at each clinic and home visit regarding the importance of their

ARV therapy and the need to continue until the doctor discontinues the medications, if possible. Defaulters to the PMTCT programme have decreased significantly in the previous five years (from 30 down to 10 between 2005 and 2010) and are contacted by members of the NAP to reinforce the importance of the programme and to bring them back to participatory status. 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. 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. Children are also followed up with virological testing: 100% of live births in 2010 to HIV positive women (77/77) received at least one HIV DNA PCR test within two months of being born.

Infants receiving DNA-PCR Tests	77
Women giving birth	77
Result	100%

Table 2: Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth, 2010 (Indicator 3.2)

Although the majority of pregnant women in the Bahamas receive some degree of PMTCT intervention, some mother-to-child transmission was observed over the past decade (primarily among women who were not enrolled in the PMTCT programme). Between 2000 and 2009, 29 perinatal transmissions occurred among infants whose mothers were not on treatment (an average of 2.6 per year), while only 7 occurred among infants whose mothers accessed treatment (all of which occurred between 2000 and 2002). No perinatal transmission was documented in 2010. Estimates from the Spectrum programme indicated that 35% of births in 2010 would result in HIV transmission to infants (Table 3). However, as noted previously, the Spectrum programme may provide overestimates for smaller population, which may possibly inflate the estimate.

Spectrum estimated MTCT HIV infections	27.5
HIV positive mothers giving birth, 2011	78
Result	35%

Table 3: Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months, 2010 (Indicator 3.3)

The Commonwealth of The Bahamas has previously voiced its concern over the use of modelling, particularly in small nations with a strong NAP that allows for accurate accounting of both cases and persons screened. It is noteworthy that with approximately 5,000 deliveries in The Bahamas annually, every woman who gives birth is attended by a health care professional and greater than 99% of deliveries

take place in a hospital or health care institution. Women who do not receive antenatal care are screened at the time of delivery and their infants are provided with AZT in the first six weeks of life and tested to determine their infection status through a series of three consecutive DNA PCR tests. Adherence counselling for mothers in the post-partum period includes the importance of antiretroviral therapy for the infant to prevent transmission. All ART is provided free of charge to all persons in The Bahamas. This type of strong PMTCT programme contributes to the inappropriate application of the Spectrum modelling for all countries, but particularly small nations such as The Bahamas.

The Bahamas is fortunate in having a small enough population of antenatal clients that clients can be monitored throughout pregnancy and in the post-delivery and post-partum periods to increase adherence to the PMTCT interventions.

3.2.2 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. This tradition continues today as a standard of care in all three blood banks in The Bahamas (Princess Margaret Hospital (PMH), Rand Memorial, and Doctors' Hospital). Traditionally, PMH processes the largest volume of donated blood. In 2010, PMH Blood Bank screened more than 5497 units of blood with 0.2% testing positive for HIV infection.

3.2.3 Post-exposure prophylaxis

Post-exposure prophylaxis (PEP) has been available in The Bahamas for occupational exposure to blood and other potentially infectious body fluids since the 1990's. Originally provided in cooperation with the Infection Control Unit at the PMH, this responsibility was later shared with the HIV Centre beginning in 2002. Current PEP protocols are available for victims of sexual assault seen at the emergency room or at a physician's office and occupational injuries. The provision of Post-exposure prophylaxis is currently coordinated through the HIV Centre for persons who are victims of rape and for occupational exposures in settings other than the PMH and incorporates the use of triple drug therapy. Persons who require PEP are followed with routine monitoring and counselling and testing for HIV infection.

3.2.4 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 are patients' contacts invited to come in for counseling.

3.2.5 Condom distribution and outreach

The HIV/AIDS Centre actively promotes the use of condoms through a condom social marketing and distribution programme at public health clinics and public events, and in conjunction with civil society partners at major events throughout The Bahamas. This social marketing programme is done in conjunction with distribution of educational materials on HIV. During 2010, the Centre distributed 4857 female condoms and 115,669 male condoms in clinics, schools, businesses and festivals and events throughout the year.

3.3 Knowledge and behaviour change

3.3.1 Target 1: Halve sexual transmission of HIV by 2015

Since its inception, the NAP 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 focussed on addressing risky behaviour through behaviour change communication and public awareness campaigns. More recently the HIV prevention programme has targeted at-risk populations, particularly teenagers and young adults, as this is the population which has the highest incidence of new cases, men-who-have-sex-with-men, sex workers, and Haitian immigrants. A newly hired Community Outreach Coordinator will oversee these new activities and help to align programme goals and targets with appropriate outreach activities. Increased access and utilization of non-traditional testing locations are expected to result in greater referrals to treatment, care and support for persons newly identified with HIV infection.

Efforts aimed at educating the population through prevention education related activities are coordinated by the National HIV/AIDS Centre Prevention Education Unit. 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.

3.3.1.1 General Population

The Bahamas has made great strides in reducing the number of new HIV infections by fifty percent through actions mentioned previously in this report. Between 2001 and 2010, the number of newly reported HIV and AIDS cases in the Bahamas decreased by 39% from 553 cases to 337 cases. Many of these actions include targeting persons whose behaviours put them at risk for infection; particularly youth aged 15-24. To ensure efficacy in this area, the Ministry of Health has sought to understand trends in sexual behaviour as well as knowledge, perceptions and attitudes about HIV/AIDS among young people.

No recent population-based studies have been conducted in the general Bahamian population to determine knowledge, attitudes, behaviours and perceptions concerning HIV transmission. However, in 2009, a Knowledge, Attitudes, Beliefs and Practices (KABP) youth study was conducted among 15 – 17 year olds in various high schools throughout the country. Of significance, participants in the nation's Focus on Youth study were not included in the Youth KAPB. Data from this study indicate that knowledge of HIV transmission needs improvement among 15 – 17 year olds. Among the 891 respondents, only 148 (17%) were able to correctly answer five questions concerning HIV risk behaviour and myths about HIV transmission. However, greater knowledge about HIV transmission was demonstrated among females than among males (Table 4). Early sexual debut among the participants was also high: 28% reported sexual activity before the age of 15. Again, rates of risky behaviour were substantially higher among males (Table 5). The percentage of adolescents who reported having more than one sexual partner in the past 12 months was another issue of concern. Twenty-one percent of all survey participants reported having multiple partners in the previous 12 months, with males, again, having a larger proportion of respondents than females (Table 6).

	All Correct	Total	% Correct
Males	50	429	12%
Females	98	462	21%
Total	148	891*	17%

*Previous study results show 894 respondents. However, age could not be verified for 3 respondents.

Table 4: Percentage of youth answering five questions on HIV transmission correctly, by gender, KAPB Study, 2009 (Indicator 1.1)

	Sex before age 15	Total	%
Males	178	429	41%
Females	77	462	17%

Total	255	891	29%

Table 5: Percentage of youth indicating sexual activity before the age of 15, by gender, KAPB Study, 2009 (Indicator 1.2)

	Multiple partners	All Respondents	%
Males	116	429	27%
Females	71	462	15%
Total	187	891	21%

Table 6: Percentage of youth having multiple partners, KAPB Study, 2009 (Indicator 1.3)

Although the youth involved in the 2009 KABP survey demonstrated risk for HIV infection by having insufficient knowledge about HIV transmission, engaging in early sexual debut and having multiple partners, they also demonstrated conducting safe sex practices. Condom use was reported to be high among survey respondents with multiple partners, with 79% reporting that they used a condom during their last sexual intercourse (Table 7). However, more may need to be done to encourage or allow HIV testing among young people, as only 5% of the respondents reported obtaining an HIV test in the past 12 months and knowing their test results (Table 8). Of note, health policy requires parental consent for health care, including HIV testing, in persons less than 18 years of age.

Persons between 15 and 24 constitute around 12% of persons reported to be living with HIV/AIDS in the Bahamas. However, overall population rates for this age group may be difficult to quantify. Since HIV transmission is largely heterosexual in the Bahamas, antenatal clinic data has been used to approximate the percentage of young persons living with HIV. Based on these data, approximately 0.9% of young persons who were living in the Bahamas in 2010 were HIV positive (Table 9). However, this estimate may be biased due to lack of reporting among remote clinics.

	Used a Condom	All Respondents	%
Males	95	116	82%
Females	53	71	75%
Total	148	187	79%

Table 7: Percentage of youth having multiple partners who reported using a condom at last sexual intercourse, KAPB Study, 2009 (Indicator 1.4)

	Tested and Aware of Result	All Respondents	%

Males	21	429	5%
Females	24	462	5%
Total	45	891	5%

Table 8: Percentage of youth receiving an HIV test in the past 12 months, KAPB Study, 2009 (Indicator 1.5)

HIV positive ANC females	18
Total ANC females	2,045
Result	0.9%

Data are based on clinics reporting 2010 data only.

Table 9: Percentage of antenatal clinic attendees 15-24 years old testing positive for HIV, 2010 (Indicator 1.6)

3.4 Focus on Youth

The Focus on Youth (FOY) HIV and AIDS education comprehensive life skills programme within the Ministry of Education's Health and Family Life Education (HFLE) curriculum was implemented in 1998. Focus on Youth was a collaborative effort between researchers from the United States (US) and the Ministries of Health and of Education in The Bahamas in the development, adaptation and evaluation of interventions targeting youth to prevent and reduce HIV risk behaviours. Focus on Youth was based on the US adolescent HIV prevention programs, "Focus on Kids" and a parental monitoring program "Informed Parents and Children Together" (ImPACT), which had been effective in reducing adolescent risk behaviour. Focus on Kids and ImPACT are currently part of the Centers for Disease Control and Prevention's "Diffusion of Effective Behavioral Interventions (DEBI)" Portfolio.

The goal of the Bahamian team was to reach youth before the onset of sexual risk behaviour. Early research estimated that 30% of youths 13-15 years of age were sexually experienced and this rate increased to 57% for youth 16 years and older (NIH, 2008). This resulted in the adaptation of FOY and ImPACT for pre-adolescents in the sixth grade (average age 10 years). The US-Bahamian research team recommended that the curriculum be administered at the sixth grade level because this delivery approach would reach the majority of Bahamian youth *before* involvement in sexual activity. Since the majority of youth in sixth grade are ages 10 and 11, it was anticipated that most would be sexually inexperienced. The US-Bahamian research team evaluated the Bahamian adaptations of Focus on Kids which resulted in a 10-session adolescent HIV prevention program entitled "Focus on Youth in The Caribbean" (FOYC) (see Table 1 for summary) and the 1-hour adapted parental monitoring intervention entitled "Caribbean Informed Parents and Children Together". (CImPACT). These adapted programs

were evaluated through a randomized, controlled trial involving 1,360 six grade youth and 1,175 of their parents.

Description of Focus on Youth and Development of FOYC

The adapted FOYC retained most of the content of Focus on Kids. However Focus groups with local youths identified two additional sessions which were added: one emphasizing sexual abuse and healthy relationships and the other providing more basic factual material regarding substance abuse and sexual risk behaviours given the correlation between alcohol and intercourse. Each of the ten sessions addresses one or more of the constructs of Protection Motivation Theory through games, stories (from daily life), role plays and discussions, all of which are very interactive. Facts about HIV/STIs and pregnancy are presented. The "SODA" Decision-making model (**S**top to think-Consider your **O**ptions-Make a **D**ecision-Take **A**ction) is a central concept of the curriculum which is repeated throughout all ten sessions. The "Family Tree", a make-believe family is used to contextualize decision-making in everyday life.

The intervention effects across three years for knowledge, condom-use skills, perceptions and intentions regarding condoms and condom use behaviour are strong, with increases among FOYC youth showing significant improvements in most categories compared to youth receiving the control condition. Although condom use behaviour only reached statistical significance at the 36 month follow-up, the trend was present earlier even though the rates of sexual activity were low.

Thirty-six month evaluation of 81% of the original participants demonstrated positive results with strong self-efficacy towards the use of condoms in youth who had participated in FOYC, particularly when their parents had participated in CImPACT also. Children from the FOYC program had higher condom use rates (44.9%) as compared to the control group 31.5%. The authors noted that these results are important because it supports the theory that interventions that are introduced prior to sexual initiation can result in consistent increases in condom use (Chen, Stanton, Gomez, Lunn, Deveaux, Brathwaite, Li, Marshall, Cottrell, and Harris, 2010, p.7)

Currently an adapted version of FOYC and CImPACT is being delivered and evaluated through a randomized controlled trial to approximately 2,200 high school students among the eight government high schools in New Providence. A subset of this current cohort (509) was previously enrolled in the grade six evaluation of FOYC. Analyses from this subset demonstrate sustained intervention effects on knowledge, condom-use skills and self efficacy four years later.

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.

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. Plans were approved in 2011 to develop in-house capacity to produce digital mass media productions for both radio and television to increase prevention education capacity and scale-up mass media campaigns. This initiative is scheduled to commence in mid-2012.

3.4.1 Youth Ambassadors for Positive Living

The Youth Ambassadors for Positive Living (YAPL) Caribbean Community (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.

YAPL has become now been integrated into the Prevention Education Unit of the HIV/AIDS Centre. Under the direction of the Centre, the YAPL spends approximately one week in each school in New Providence.

3.5 Most-at-risk populations

Programmes and information targeted specifically at hard-to-reach groups such 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-based community leaders. Public health nurses and volunteers routinely distribute condoms and informational materials at public events throughout The Bahamas. Sex Workers have been targeted for increased prevention education activities through a partnership with the Urban Renewal Programme in at-risk neighbourhoods.

3.5.1 Sex Workers

Data collected on commercial sex work in the Bahamas are very sparse, and do not answer the indicators required by this report. However, inroads have been made in the SW (sex worker) community by a formalized programme for HIV prevention for sex workers which has been established by Bahamas Urban Youth Development Centre, in cooperation with the National HIV/AIDS Centre whose role is to support testing and education of persons involved in sex work. Commercial sex work is illegal in the

Bahamas, and to date, no formal studies have been conducted in this population. However, anecdotal data indicate that SW are able to access HIV testing and prevention materials (barrier protection with both male and female condoms) through government-sponsored programmes. Also, the Bahamas PEPFAR Co Ag currently supports outreach efforts by the HIV Centre which target sex workers.

3.5.2 Men who have Sex with Men

The HIV/AIDS Centre continues to make progress in establishing more formalized prevention activities with the MSM community in The Bahamas. The partnerships with SASH Bahamas, who has benefitted from a grant from PEPFAR under the CDC CoAg, has allowed the Centre to increase its outreach activities, including health fairs and testing parties for the MSM community that offer healthy weight screening and information, glucose and cholesterol screenings, and HIV testing. However, males who attend these functions are typically younger (the median age of attendees was 23 for all testing events held). Therefore, MSM indicators reported in this document may not reflect the overall distribution of behaviours and beliefs among MSM in the Bahamas.

The most recently performed KABP exercise successfully captured responses from 42 males who identified as MSM. Participants indicated that they had been exposed to prevention messages: 79% of those surveyed indicated that they had knowledge of where to receive an HIV test and that they had been given condoms through outreach services (Table 10). Condom use overall among survey participants was at 88%, although fewer MSM under 25 reported using condoms than those over 25 (Table 11). Over half of all respondents (55%) reported having an HIV test done within the past 12 months (Table 12). However, these results may be biased because of small sample size, and the fact that this survey was administered at an HIV testing party (which included access to testing and prevention materials). Also, persons attending the testing party may differ from the national distribution of MSM in age and likelihood of openly identifying as MSM. Therefore, the MSM data in this report may only reflect the behaviours of young MSM who are comfortable being open about their sexual orientation. At this time, it is unknown if MSM who are open about their sexual orientation differ in their risk behaviours than MSM who are not open about their sexual orientation in the Bahamas. Plans for conducting a population-based MSM survey are currently underway at the Ministry of Health.

Despite their limitations, the data indicate that MSM's have been reached with prevention programmes and are aware of HIV testing availability. However, more may need to be done concerning improvement of HIV testing frequency among MSM, as only about half of respondents indicated being tested within the 12 months.

	Number reached	All Respondents	%
Under 25	17	20	85%
25 and older	16	22	73%
All Ages	33	42	79%

Table 10: Percentage of MSM reached with HIV prevention programmes (Indicator 1.11)

	Used a condom	MSM reporting anal sex	Total
Under 25	15	19	79%
25 and older	20	21	95%
All Ages	35	40	88%

Number reflects MSM who have reported ever having anal sex with a male partner, not anal sex with a male partner in the previous six months

Table 11: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner (Indicator 1.12)

	Tested and Knew Results	All Respondents	Total
Under 25	10	20	50%
25 and older	13	22	59%
All Ages	23	42	55%

Table 12: Percentage of MSM who received an HIV test in the past 12 months and knew their results (Indicator 1.13)

Results from the most recent MSM testing party also indicate that 14% of MSM in the Bahamas may be HIV positive (Table 13). Again, this estimate is biased due to the size (n=36), youthfulness of the sample (median age = 23), and the fact that the sample was derived by convenience (attendees of a testing event). However, previous testing party data indicate similar HIV prevalence among MSM.

	Positive MSM	All MSM Tested	Total
Under 25	3	20	15%
25 and older	2	16	13%
All Ages	5	36	14%

Table 13: Percentage of MSM who are living with HIV (Indicator 1.14)

3.5.2.1 Target 2: Reduce Transmission of HIV among People who Inject Drugs by 50% by 2015

There is very little evidence to suggest that injection drug use in the Bahamas exists on a large scale. To date, injection drug use has been rarely reported among HIV cases, and the Bahamas National Drug Council has not indicated injecting drug use among their drug-using populations. Early programme data did suggest that non-injecting drug (crack cocaine) use did play a role in the HIV epidemic as persons were engaging in high risk behaviours which included having sex with multiple partners (MOH, 2001) In the 1980's approximately 30% of persons with AIDS used cocaine. More recent data (HIRU 2009) from the Sandilands Rehabilitation Hospital and the Community Counselling and Assessment Centre (CCAC) (the inpatient and outpatient arms of drug and alcohol treatment in the public sector) indicated that new cases of drug treatment (cocaine/poly drug and marijuana) saw an increase in the early 2000's with approximately 202 and 240 respectively seen. Data available through 2006 has shown a moderate decline.

3.6 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 and through a small network of private physicians. There are multiple entry-points to HIV and AIDS services, most commonly through voluntary counselling and testing provided at most public health facilities and many private clinics.

3.6.1 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 saw 1341 women, 497 men and 110 children during 2010. 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.

3.6.1.1 PMH 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.

The adherence programme plays a key role, particularly for patients that are followed in the clinic setting. Maintaining ARV schedules and the importance of regular clinic evaluations and follow-up lab work is stressed at each clinic visit and any subsequent home visits which occur.

3.6.1.2 PMH Antenatal Clinic

Approximately 20 to 30 patients are seen each week in the antenatal infectious diseases follow-up clinic. From 2005 to 2010, approximately 95 (range 71-107) out of the 5,000 (range 4,966-5854) annual deliveries in The Bahamas were to an HIV-infected woman. All pregnant women are tested in both the first trimester and for those who are negative, again in the third trimester. 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. An initiative is currently underway to introduce rapid HIV testing in Labour and Delivery to identify HIV infection in women who have not received antenatal care in order to improve access to PMTCT interventions that were not implemented prior to onset of labour. After delivery, both mother and baby continue to be followed up together. 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.

3.6.1.3 PMH Paediatric Clinic

The paediatric clinic shares space with the antenatal clinic. Approximately 15 to 20 children are seen each clinic day, 8 to 10of which 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.

Approximately 110 HIV-infected children are enrolled in care with the NAP. At this point in time, most of the children are over the age of 15, with less than 40 children under the age of 15 years. 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 and their siblings to build community and help them address the challenges associated with being an HIV positive teenager and to help them learn to more effectively manage their disease, and improve adherence to treatment.

The Suspected Child Abuse and Neglect (SCAN) Unit, under the Department of Public Health sees all adolescents or children who acquire HIV infection outside of the perinatal period if sexual molestation is suspected. An HIV test and counselling is part of the standard evaluation in these cases.

3.6.1.4 Princess Margaret Hospital inpatient infectious diseases services

The Princess Margaret Hospital has two inpatient infectious diseases wards serving adult men and women with HIV and other infectious diseases 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.

Inpatient care for children with HIV and AIDS is provided on the general paediatrics unit at PMH. 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.

3.6.2 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 RMH or transferred to PMH if ongoing specialist care is required. As in PMH, 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.

3.6.3 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 PITC 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, who initiates ARV treatments when indicated. The ability to take specimens and transport them to PMH and the HIV Research Laboratories, coupled with training support provided by the PMH Infectious Diseases specialist to prison staff allow most of the HIV care needed by inmates to be provided on site at the prison. The introduction of rapid HIV testing in 2012 is expected to improve the timely identification of persons with HIV infection and subsequent entry into care. Prisoners requiring inpatient HIV and AIDS care are currently taken to the PMH hospital for clinical management.

3.6.4 National Tuberculosis Control Programme

3.6.4.1 Indicator 5: Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015

The National HIV/AIDS Programme works closely with the National Tuberculosis Programme (NTP) 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. In 2010, approximately 47% of individuals infected with tuberculosis (TB) were also HIV-infected.

The activities of the NTP 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 therapy (DOT) 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. 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.

In 2010, 15 patients were found to be HIV positive (Table 14). Among co-infected cases, 10 (67%), received TB treatment and ARV therapy during that year. The remaining 5 cases were treated for TB, but not for HIV. The number of TB/HIV co-infected cases has declined dramatically since 2006, in which 32 co-infected cases were reported, however, the percentage of co-infected cases has remained relatively stable.

	HIV/TB Cases on Treatment	All HIV/TB Cases	%
Male	6	10	60%
Female	4	5	80%
Under 15	0	0	--
15 and older	10	15	67%
Total	10	15	67%

Data were cross-referenced from the TB patient registers with the HIV and AIDS ARV patient registers. 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 identified and captured in this manner.

Table 14: Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV, 2010 (Indicator 5.1)

The NTP is challenged in general by Haitian migrants who travel to Haiti during the course of their treatment which may result in interruption of therapy, for TB as well as for HIV when co-infection is present. The NTP is currently engaged in exploring mechanisms to improve transfer of patients between the two countries which will result in more favourable outcomes.

3.6.5 Sexually Transmitted Infections Unit

There is one Sexually Transmitted Infections (STI) Unit located in Nassau which oversees the operations of the STI clinic. The STI clinic serves as a referral centre for individuals with suspected STIs and as a walk-in clinic for individuals presenting with complaints. On average, 80 patients per week are seen in the STI 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 Unit also participates in prevention education activities and provides information to students for research and terms papers. Physicians give lectures in the community as part of overall HIV outreach efforts.

3.6.6 Substance abuse and mental health services

There Public Hospitals Authority is the 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) offer outpatient individual and group services. The inpatient Dyah Ward at the Rand Memorial Hospital provides mental health services in Grand Bahama. More limited mental health counselling services are available on the other larger islands through the Primary Health Clinics in the Department of Public Health. Utilization of drug treatment services at the CCAC has been on the increase, 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 to these two mental health facilities for additional drug treatment services as needed. More limited counselling support services are provided within the Infectious Diseases Follow-up Clinic by the social worker and community volunteer from the Samaritan Ministries.

3.6.7 Hospice services

The All Saints Camp is a hospice facility managed by volunteers and financed primarily by the private sector. It has 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 there. 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.

3.6.8 Antiretroviral therapy

3.6.8.1 Indicator 4: Have 15 million people living with HIV on antiretroviral drugs by 2015

To increase longevity and quality of life among HIV patients, the NAP and the National HIV Centre have placed access to ARV therapy as a major priority. The Government of Bahamas has committed to providing antiretroviral therapy (ART) to all eligible HIV-infected persons in the country, regardless of immigration status or ability to pay. Universal access to ART is due, in large part, to increased availability and affordability of ARV medications. The Clinton Foundation was instrumental in negotiating lower prices and a secure supply of required medications, and previously facilitated funding for ARV

medications. The Government of The Bahamas has assumed full responsibility for providing the financial mechanism for procuring ARV for all clients.

The Bahamas also serves as a resource centre for other Caribbean countries, including Antigua, Belize, St. Kitts and Nevis, and the Turks and Caicos Islands, providing expertise and assistance with medication acquisition, when required.

The Bahamas has adopted regional guidelines and protocols for the prescribing of ART for antenatal, paediatric and adult clients, including protocols for TB co-infections. By the end of this reporting period in 2011, 39% percent of all persons who were medically eligible for ARVs were determined to be on treatment (Table 15). Of the children less than 15 years of age records indicate that only 12 percent of children received ART. This figure is substantially different than that indicated in previous UNGASS reports. However, the difference may be accounted for by changes in the pharmacy programme – as more HIV patients gained access to drugs supplied from the National HIV Centre pharmacy, the increased demand outgrew the Centre's ability to effectively document consumers. In addition, the denominator has been estimated utilizing the Spectrum programme which may inflate the number estimated to be in need of ARV therapy. Yet, it is reasonable to assume that certain gaps in access to treatment may also be responsible for the disparity. There is an observed gap in access to treatment among adult HIV-infected persons, many of whom do not regularly access care including further diagnosis or treatment because of stigma and fears of discrimination, or because they are generally healthy.

	Cases on ARVs	Persons eligible for ARVs	%
Male	501	1,500	33%
Female	689	1,447	48%
Under 15	39	155	25%
15 and older	1098	2,637	42%
Total	1,149	2,947	39%

Source: National HIV Centre Pharmacy Data, 2012

Table 15: Percentage of eligible adults and children currently receiving ARV therapy at the end of 2011 (Indicator4.1)

Overall, the majority (71%) of persons initiating treatment in 2010 were still considered to be on treatment a year after starting. However, challenges in data collection and storage may cause the true number of people maintaining consistent drug pickups from the NAC pharmacy to be underestimated.

	Number on Treatment after 12 months	Number Initiating Treatment	Result
Male	20	30	67%
Female	22	29	76%
Under 15	1	3	33%
15 and older	41	56	73%
Total	42	59	71%

.One person was started on ARV, continued on ARV, but is of unknown gender.

Source: National HIV Centre Pharmacy Data, 2012

Table 16: Percentage of adults and children with HIV starting treatment in 2010 and completing at least 12 months of ARV therapy (Indicator 4.2)

The challenges to providing universal access to ART include insufficient human resources and infrastructure to adequately provide care and follow-up, fear of stigma and discrimination, lack of knowledge among HIV-infected people on the need for treatment, and the difficulty in tracing members of immigrant and migrating populations who default on treatment. The HIV/AIDS Centre estimates there are 5,000 HIV infected individuals who currently do not access care.

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

The integration of HIV/AIDS services has been slowly occurring over the past several years. Provisions for HIV/AIDS care are integrated into Prison Health Services for all inmates newly diagnosed or known to be infected with HIV. This integration provided improved access to care for inmates and more timely response to medical issues associated with the management of a chronic disease in this at risk population.

The decentralization strategy called for the integration of HIV and AIDS services into the primary level of care within clinics throughout the country. Currently, voluntary counselling and testing is available in every main and polyclinic countrywide. HIV rapid testing, pharmacy services and ancillary support

services are scheduled to be included in services offered in four polyclinics, the Adolescent Health Clinic and the Prison Clinic, with an appropriate sub-set of services delivered through smaller Family Island clinics. Comprehensive services are anticipated to be available at planned mini-hospitals in the Family Islands when fully operational.

The decentralisation process will continue to present a number of challenges which have been provisionally addressed in the *2007-2015 NASP*, including adequate space and appropriately trained and maintained human resources to provide services that meet standards of care; quality control and monitoring through a strong M&E framework to ensure adherence to guidelines and protocols; ensuring confidentiality throughout an expanded system; and lastly ensuring that services are provided in a non-stigmatized, non-judgemental and non-discriminatory environment.

The process of planning for de-centralization brought to the forefront 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. This has emphasized the need for a broader restructuring of the delivery of primary health care services, with a particular emphasis on wellness and prevention which incorporates HIV disease as a chronic communicable disease.

3.6.10 Advocacy, public policy, and legal framework

3.6.10.1 Advocacy

The Bahamas has been a leader in advocacy for persons infected and affected by HIV. Public policy advocacy has been undertaken by agencies and organizations such as the National AIDS Programme, the Bahamas 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 persons living with HIV and AIDS (PLWHA) in public advocacy efforts.

3.6.10.2 Public policy and legal framework

From the inception of the AIDS epidemic, The Bahamas developed several key policies and pieces of legislation which were 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 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.
- 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 and 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 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.

The Sexual Offences and Domestic Violence Act includes 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

The Bahamas continues to make progress in combating HIV and AIDS. Capacity building exercises have improved knowledge and increased the ability to provide treat, care and support. Exercises in HIV Rapid Testing training and deployment of rapid testing where clients are most likely to be found have increased access to timely identification of new HIV cases and allow for improved referral for treatment and care. This being said, the country is not without its challenges that impede progress toward reaching targets and goals moving forward. The following summary describes key lessons learned in the past and highlights best practices that have become highlights of the success of the programme in the face of serious financial, human and infrastructural constraints.

4.1 Lesson: Continued political leadership and commitment are essential to success

The political will and commitment of The Government of The Bahamas is a highlight of the success of the programme. In spite of the economic downturn of 2008 and the continued recession, the Government has continued to commit funding to ensure the continuation of the programme. Effective leadership is required to mobilize all stakeholders in the process. However, the time and effort required in providing leadership and coordinating and mobilizing resources and partners is considerable. Senior government officials must be prepared to spend the required time to meet with decision-makers from various sectors of government, the private sector and civil society.

Best Practices:

The Bahamas has shown that is can be effective in engaging and securing the support of senior government representatives through education on the impact of HIV and AIDS; to sustain the needed political commitment and leadership, and involve these senior officials in the engagement of participation and support among multisectoral partners. ;

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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.

The MOH identified the need for a Task Force of international partners, led by a person 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 technical assistance directly provided by the PAHO, UNAIDS and the introduction of PEPFAR/CDC Cooperative Agreement in The Bahamas has contributed to the success of the process by providing expertise and resources that are aligned with the specific needs and context of The Bahamas.

Best Practices

The Bahamas has demonstrated the use of a multidisciplinary advisory team with experience in programme areas, clinical care, information management, programme management, etc. to develop and plan initiatives and oversee programme strategic planning; The Bahamas have been able to demonstrate that leveraging the technical expertise of international partners such as UNAIDS, PAHO/WHO, and CDC, particularly when they can understand the context, issues and needs of the country and region are beneficial to achieving targeted results.

The inclusion of international partners with specific expertise in the planning process has been shown to contribute to the success of the process;

4.3 Lesson: Tools are essential to support planning and implementation

Conceptual methodologies and frameworks for identifying, planning and implementing strategies, and for monitoring and evaluating outcomes and impact are crucial tools, but must be aligned with the available capacities and resources within the country. Implementation cannot occur if capacity gaps which may hinder efforts are not identified and addressed in a pro-active capacity building strategy.

Planning and implementation will not succeed if estimations of the start-up and ongoing operational costs for scale-up cannot be determined. Accurately identifying and predicting future costs in order to plan for sustainable funding is a key challenge in any process.

Best Practices:

The Bahamas identified the importance and worked to source or develop effective tools for evaluating resource capacity and for costing start-up and ongoing costs. The selection of a conceptual methodology (e.g., logic models) that provides a framework for planning, monitoring and evaluating scale-up strategies was essential and the choice of the model should be aligned with the knowledge and human resource capacities of the country to utilize in-country knowledge.

4.4 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. 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.

Best Practices:

The Bahamas has demonstrated the importance of considering the time and effort required to recruit, contract and train human resources, and the need to initiate the process to secure position sustainability as soon as possible to prevent loss of human capacity.

4.5 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 planning for de-centralization of HIV and AIDS care has been a continuing and contributing driver for the re-structuring and capacity building of primary care.

The tools, processes and methodologies used for HIV and AIDS planning, and the lessons learned have been applied to other areas of the healthcare system.

As well, strengthening human resources and infrastructure for extending access to comprehensive HIV and AIDS care has had a positive impact on parts of the health system.

Best Practices:

The Ministry of Health has taken the opportunity to share knowledge, tools, processes and methodologies with other sectors of the healthcare system while strengthening HIV and AIDS services and all healthcare leaders have used the HIV and AIDS initiative to review and improve other aspects of the healthcare sector.

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

The Bahamas has faced significant challenges in its response to HIV and AIDS. These challenges include issues of financial, human and infrastructure constraints, as well as programmatic implementation issues.

Challenges	Proposed Actions
Societal stigma and fear of discrimination of HIV and AIDS prevents people at risk of infection and those already infected from seeking services.	• Increase access to HIV testing and counselling through the use of rapid HIV testing through community outreach programmes and non-traditional testing sites that are not associated with HIV and AIDS care and continue to conduct education and public awareness campaigns to encourage people to know their status, and on the importance of seeking treatment if HIV-infected; • Increase access to ART and improve universal access to treatment, care and support in the most remote regions of the country • Continue to scale up services throughout the primary care level and in settings that are not specifically associated with HIV and AIDS care; • Decrease discrimination in health care workers by providing exposure of all health care providers to high quality standards of care for HIV/STI/TB through training and preceptorship programmes • Re-evaluate current anti-discriminations policies and laws, ensure existing policies and laws are enforced; propose new policies to protect marginalized populations
The outpatient clinics at PMH and RMH increasingly lack capacity to provide all required services to all HIV-infected individuals.	• Continue to decentralise comprehensive HIV and AIDS prevention, treatment, care and support services to the primary care level to distribute demand across the entire point of care health system; • Increase HIV and AIDS prevention, treatment and care capacity through training providers at the primary care level; • Further reduce HIV transmission with renewed emphasis on prevention programs aimed at most-at-risk populations and innovative behavioural change communications that target marginalized and disenfranchised populations

Challenges	Proposed Actions
The expansion of HIV and AIDS services through decentralization into the primary care clinics will require increasing the cadre of trained professionals with expertise in HIV and AIDS which is exacerbated by the ineffective deployment of existing human resources.	• Increase the provision of training in the care of HIV and AIDS to healthcare professionals throughout the primary care level • Implement a comprehensive human resources management plan that appropriately targets resources to identified needs and gaps, and includes strategies for recruitment and retention. • Liaise with National programs aimed at developing human resource capacity to ensure that the appropriate competencies required for HIV and AIDS prevention, treatment, care and support services, including planning and management capacity, are addressed. • Consider intensifying exposure to HIV clinical management during pre-service training programmes for nurses and physicians
The level of social support interventions, nutrition services, mental health services, and oral health care is compromised due to inadequate numbers of personnel to provide these services in the clinic setting and through home visits in the community.	• Develop a social support needs register to better identify and coordinate necessary services and referrals and align clients with available services • Implement a comprehensive human resources management plan that appropriately targets resources to identified needs and gaps, and includes strategies for recruitment and retention. • Increase HIV and AIDS support capacity through partnerships with volunteer community and faith-based organizations, and through international support for technical assistance. • Expand the social support network to include provisions in the Family Islands

Challenges	Proposed Actions
Medical records are not yet computerized in The Bahamas, and there is no common patient identification system in place linking community clinics, hospital settings, and ancillary services. This makes it difficult to monitor quality of care, especially in a decentralised model. Information required to support prevention, treatment and care services is not readily available, and manual processes and duplication of tasks consume valuable human resources.	• Implement a Health Information System, including a unique client identifier with appropriate protections for confidentiality that is linked to clinical support services and encompasses all government funded health care facilities. • Champion the use of such systems while communicating the benefits of same to users and consumers of data alike • Speak with one voice on the way forward in the capturing of data pertaining to health indicators in the available health information system
There is no integrated information system to permit central monitoring and tracking, distribution, and consumption of ARVs across all pharmacy/dispensary sites.	• Implement a Pharmacy Information System. • Devise protocols to review drug use and changes in procurements and prescribing practices • Consider areas of integration with lab to determine role for HIV Drug Resistance Testing
The hospital laboratory system, which serves both hospital-based services and community polyclinics, lacks a computerized lab information system that is linked with patient records. All data entry into charts is manual, delaying receipt of patient results.	• Improve the linkage between the Public Hospitals Authority Laboratory Information System and the National HIV/AIDS Laboratory and the network of government funded health facilities • Implement a fully functional Public Health Information System.

Challenges	Proposed Actions
There is inadequate funding available to fully scale-up human resource capacity and infrastructure to support universal access to comprehensive HIV and AIDS care as required. The Bahamas is generally excluded from international donor and funds because of its GDP. Sustained funding to support the current capacity of service delivery is not guaranteed.	• Increase the efficiency of available HIV and AIDS care services through effective information management to better utilise current resources • Work with government officials and international donors to identify new funding streams and remove barriers to funding; • Work with private sector and international organizations to identify and secure access to low-cost technologies, including laboratory equipment and supplies.
Lack of in-country capacity for advanced HIV monitoring laboratory services	• Extension of the HIV/AIDS laboratory services to include facility and equipment for the provision of onsite PCR and resistance testing • Increase the capacity of the National HIV/AIDS laboratory through the addition of appropriately trained staff

6 Support from country's development partners

Sustainable funding will always remain as a key challenge. While the Bahamas Government is striving to maintain its current commitments and new private sector, non-governmental and international donors are continuously being sought, the strategy for achieving the goals and objectives of the NASP will require additional funds sustained over the longer term. One of the most significant challenges The Bahamas faces is its designation as a high income country. As a result, The Bahamas is frequently excluded from many international donors and funds because of its GDP and locally because of the size and distribution of the population of The Bahamas; 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

HIV and AIDS monitoring and evaluation activities have traditionally been coordinated through the HIV/AIDS Centre in cooperation with the National Health Information and Research Unit (NHIRU) in the Ministry of Health. While 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, a formal framework for monitoring and evaluation has been a challenge to a system that lacks sufficient numbers of persons dedicated to M&E posts. The database and compendium of indicators has been collected largely through surveillance and surveys. These indicators have formed 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.

In the fourth quarter of 2011, through the MOH/CDC CRO CoAg, the Ministry recruited an epidemiologist and a Monitoring and Evaluation Specialist. The hiring of these two professionals is expected to increase capacity within the Ministry for characterizing the epidemic and monitoring and evaluating the response. These two professionals will be instrumental in providing training in

surveillance techniques and also in monitoring and evaluation techniques throughout the health system with a goal of further improving the use of evidence-based decision-making for programmatic response.

7.2 Challenges of one national M&E system

There still remains an urgent need for a national monitoring and evaluation system. The Bahamas developed a draft framework but was challenged by the collection of data which integrates information from a multiplicity of surveillance systems. Data collected from various sources and methodologies have not been well-integrated into a single set of core indicators. The development of a single set of core indicators and minimum data sets will enhance the national capacity to monitor and evaluate the National AIDS Programme from a national perspective.

The Bahamas also faces challenges from the lack of a single integrated information system. Most surveillance and other data continue to be manually collected and summarized periodically - a highly time-consuming process which often leads to inaccurate datasets. Raw and indicator data are maintained in multiple data stores, including spreadsheets and databases that operate on different platforms. These manual collection processes and disparate storage systems mean that data is often months out of date, and information is not readily available when required for reporting or evaluation purposes.

The Department of Public Health spent 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 was found to be inadequate for reporting purposes and could not be interfaced with other health information systems within the public health sector. Under the MOH/CDC CRO CoAg, the development of a comprehensive patient information system has been highlighted for immediate action and will be designed to address information needs across the continuum of care and provide data to address indicators for monitoring and evaluation and to characterize the HIV epidemic in a timelier manner.

This same initiative has resulted in the acquisition of a Monitoring and Evaluation Specialist who will be charged with developing a comprehensive M&E Framework in collaboration with the HIV Centre, national partners and stakeholders, and in collaboration with international partners. This framework will be designed to improve the use of strategic information for evidence-based programme planning, and to improve local capacity to respond to reporting requirements and dissemination of information.

Annex 1: Consultation Process for Preparation of Report

1. Describe the process used for NCPI data gathering and validation:
   The Ministry of Health, in cooperation with the National AIDS Programme, consulted and interviewed or procured completed survey instruments from national government agencies (including Ministry of Health and the Department of Public Health, the Ministry of Education, and the Attorney General's Office) and civil society representatives (such as the Bahamas AIDS Foundation and the AIDS Resource Committee), and bi-lateral agencies and UN organizations (PAHO/WHO, UNAIDS, and the United States Embassy) to inform this report. This information was then entered into Microsoft Excel for further analysis.

2. Describe the process used for resolving disagreements, if any, with respect to responses to specific questions:
   The Ministry of Health compiled the responses for the NCPI and when differences of opinion occurred, further consulted participants to clarify their response and discuss the issue in order to obtain consensus for the report.

3. Highlight concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):
   Some of the questions do not allow for a full understanding of the dynamics of National HIV/AIDS Programme within The Bahamas. The yes/no format of some of the questions do not always capture the full extent of what is in place currently, nor what is being done in the way of improvement. The addition of a narrative report allows for a more informed response that is relevant to the national context.

Annex 2: National Composite Policy Index

NCPI Summary – The Bahamas

Part A

I. Strategic Plan

The Bahamas has followed and continues to follow a multisectoral strategy to respond to HIV and AIDS since its introduction into this country in the early 1980's. The NCPI acknowledges the inclusion of a wide variety of government agencies and civil society in the response and strategic planning process. The strategy addresses key populations and vulnerable groups, as well as cross-cutting issues such as prisons, schools and workplace. The respondents did note that while the strategy is wide-ranging, it did not extend to integration in the national general development plans. As such, no country evaluation on the impact of HIV on socioeconomic development has been carried out. The respondents noted that there has not been sufficient costing of the implementation of the National AIDS Strategic Plan and reliable estimates are only available for current needs and still requires forecasting for future needs, particularly with respect to persons requiring antiretroviral therapy. ON the positive side, the participants do agree that a health systems strengthening strategy is in place. Overall, the NCPI rates planning efforts in the country's NAP as above average with key achievements including the prevention of mother-to-child transmission in women who access PMTCT programme, the reduction in AIDS-related deaths and the improved identification of most at risk populations. Challenges that are still to be resolved include strengthening capacity for M&E, the development of a comprehensive communication plan and a better understanding of the drivers of the HIV epidemic in the country.

II. Political Support

Overall, there is above average political support for HIV as noted by respondents. The AIDS Resource Committee is viewed as the multisectoral AIDS management body responsible for promoting the national HIV and AIDS response. Government officials are recognized as supporting the response by speaking publicly and favourable about national AIDS efforts in both national and international fora.

III. Human Rights

The NCPI participants agreed that while there are protections in place for certain populations, there are still gaps with respect to other vulnerable groups. The discord between policies relating to age of consent

and age of treatment are being reviewed in order to further address the needs of the adolescent population who have been identified as a high risk population.

IV. Prevention

The NCPI rates policy efforts to support HIV prevention programmes as above average with key achievements including Life Skills Education as a part of the curriculum, the Focus on Youth programme in primary schools throughout The Bahamas and the "Know your status" campaign. Specific needs for prevention have been identified through the strategic planning process and access to prevention programmes is generally considered to be strong, with challenges still faced in workplace programmes and in the area of stigma and discrimination. Participants also rated efforts to implements HIV prevention programmes as above average.

V. Treatment, Care and Support

With the exception of a select few components, respondents noted the programme for treatment care and support of persons with HIV was generally present and implements. Challenges remain in the areas of workplace and nutritional care. Policies to address issues such as social support, the use of generic medications and procurement mechanisms and supply management for critical commodities are seen as being in place and functioning throughout the system. Overall, the NCPI rates efforts to implement a comprehensive package of treatment care and support as above average, including efforts to meet the needs of special populations such as orphans and other vulnerable children.

VI. Monitoring and Evaluation

Monitoring and evaluation efforts continue to be seen as an incomplete component of the national HIV and AIDS strategy. While some components of a national system are identified as being in place, a number of gaps were identified by respondents. Overall, the NCPI rated efforts to implement M&E as average, with challenges remaining in areas such as lack of a centralized, functional unit and training on M&E and the appropriate use of data as primary obstacles in improving M&E efforts.

Part B

I. Civil Society Participation

The NCPI ranks civil society participation in the involvement of policy, budgeting and programme development as below average. While civil society involvement was ranked below average in 2005, participants believed that efforts to improve this were well above average. Participation in the national HIV strategy was seen as active and participatory, but the budgetary process for the National AIDS

Programme does not include civil society participation. The national M&E plan has been one of the weakest components of the NAP and as such, participation opportunities by civil society have been limited. The NCPI does rate the representation of civil society in overall HIV efforts as average, but acknowledges that access to financial support for implementation of activities has been limited while technical support for the planning of these activities is average. The ability of civil society to execute programmes is weak, resulting in the majority of programmes being executed by government agencies. Challenges to greater involvement include provision of technical support for planning and execution, as well as sustainable funding for civil society programmes.

II. Political Support and Leadership

The NCPI rated the involvement of people living with HIV, key populations and other vulnerable groups in policy design and programme development as mixed and appeared to be aligned to participant association in the national HIV/AIDS response over time. Persons who were longstanding participants tended to rank the involvement higher than those who were more recently associated.

III. Human Rights

The NCPI rates the existence of non-discriminatory laws and regulations that afford protection for specific sub-populations and vulnerable groups as below average. Laws and regulations do exist to protect persons living with HIV and AIDS, as well as those with disabilities, from discrimination in the workplace, however protections for other vulnerable groups, such as men who have sex with men, prison inmates, sex workers and migrant populations are not specifically written. While non-discrimination laws are in effect for persons living with HIV, the enforcement is difficult, as persons have not brought suit in this respect due to continued stigma and discrimination associated with publicizing their HIV status. The NCPI does note strong support for persons living with HIV with respect to non-discrimination due to ability to pay for services, as The Bahamas has a policy of free services for HIV prevention, antiretroviral treatment and care support interventions.

IV. Prevention

The NCPI rates prevention programmes as above average, with the presence of programmes for almost all aspects of HIV. The rate of implementation efforts was scored well above average, with one key gap identified in the area of information, education and communication on stigma and discrimination. The

major impediments to better prevention programmes include financial and human resources to implement and sustain these efforts.

V. Treatment, Care and Support

The country's efforts with respect to treatment, care and support were uniformly acknowledged and rated above average with the exception of workplace treatment and referral programmes, which have not traditionally been seen. There is an identified gap with the identification of orphans and vulnerable children and the linkage with services to address their particular needs.

Annex 3: Bibliography

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

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