

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

Country Report 2008

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

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
AZT	Azidothymidine
BNDA	Bahamas National Drug Agency
BNN+	Bahamas National Network for Positive Living
CHART	Caribbean HIV/AIDS Regional Training
DOT	Directly Observed Therapy
HIV	Human Immunodeficiency Virus
iPHIS	Integrated Public Health Information System
KAPB	Knowledge Attitudes Practices and Beliefs
M&E	Monitoring and Evaluation
MOHSD	Ministry of Health and Social Development, The Bahamas
MSM	Men who have sex with men
NASP	National HIV/AIDS Strategic Plan
NGO	Non-governmental Organizations
NHIRU	National Health Information Research Unit
PEP	Post-exposure Prophylaxis
PLWHA	Persons Living with HIV or AIDS
PMH	Princess Margaret Hospital
PMTCT	Prevention of Mother-to-Child Transmission
RMH	Rand Memorial Hospital
SCAN	Suspected Child Abuse and Neglect Unit
STI	Sexually Transmitted Infection
TB	Tuberculosis
VCT	Voluntary Counselling and Testing

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

1.2 Status of the epidemic

As of December 31, 2006, The Bahamas had a cumulative total of 10,841 reported HIV infections. Of the 7,036 living individuals, 1,693 are living with an AIDS diagnosis, while 5,343 have HIV infection that has not progressed to AIDS.

AIDS has been the leading cause of death in the 15-49 year age group in The Bahamas since 1994. Based on antenatal surveillance, it is estimated that approximately 3% of persons in The Bahamas are infected with HIV. The large majority of persons reported are in the productive years of early adulthood between the ages of 20-39 years of age. The disease occurs primarily among heterosexuals (approximately 87 percent), although under-reporting by men who have sex with men (MSM) remains a challenge.

Intravenous drug use is not a common practice in The Bahamas and therefore this is not considered to be a mode of transmission.

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

1.3 Update on policy and programmatic responses

1.3.1 National AIDS Strategic Plan

In 2007, the National AIDS Programme drafted an updated *National AIDS Strategic Plan for 2007-2015*.

While the new strategic plan has not yet been finalized and formally adopted, the draft plan is currently

being used to guide strategic planning and programme activities. The National AIDS Programme is working to finalize the plan in the first quarter of 2008.

1.3.2 De-centralization of HIV and AIDS comprehensive care

The 2005 UNGASS Report highlighted plans for the de-centralization of HIV and AIDS care into community clinics as a key strategy toward universal access of comprehensive HIV and AIDS care in The Bahamas. The process of planning for de-centralization has highlighted the need for overall strengthening of primary care delivery, in particular the need for increased physician staffing and training, and improved adherence to standardized protocols. As such, plans for de-centralization of HIV and AIDS care have now been included within a broader re-structuring of the delivery of primary health care services, with a particular emphasis on wellness and prevention. These plans include piloting a health team approach with a physician team leader and greater participation of allied health professionals in managing care, the development of a Primary Care Training Centre, partnering with the Family Medicine Programme at Princess Margaret Hospital, and a strategy to recruit physicians with an interest and training in a public health approach to primary care.

1.3.3 Information systems

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

1.3.4 Prevention and outreach

The HIV/AIDS Centre has made significant progress in the past year in establishing a relationship with the historically difficult to reach men-who-have-sex-with-men (MSM) community in The Bahamas. Through partnerships with SASH Bahamas and the Rainbow Alliance, the Centre has increased its outreach activities, including health fairs for the MSM community that offered healthy weight screening and information, glucose and cholesterol screenings and HIV testing. As well, with support of these organizations and the BNN+ and their volunteers, the Centre completed its first MSM knowledge and behaviour survey, the results of which are included in this report.

1.4 UNGASS indicators at a glance

UNGASS Indicators – Generalized Epidemic		2005 Result	2006 Result	Notes/Comments	Document Reference
National Commitment and Action					
1	Domestic and international AIDS spending by categories and financing sources.	N/A	N/A	No data available. Process of data collection for Indicator 1 is currently underway.	Section 3.1.1
2	National Composite Policy Index	See Appendix 2			Appendix 2
National Programmes					
3	Percentage of donated blood units screened for HIV in a quality assured manner.	100%	100%	All blood products have been subject to screening since 1985.	Section 3.2.3
4	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	N/A	48.43%	Numerators do not include those lost to follow-up, or those who did not start medications prior to the reporting period. Denominators were calculated for adults by modelling using Spectrum. The paediatric denominator is an actual number from the National HIV/AIDS Centre database, due to the accuracy of tracking all paediatric exposures, as well as cases.	Section 3.6.9
5	Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	71%	88.79%	Discrepancies between those receiving medication and total eligible could be due to a) those still early in pregnancy b) those who are members of immigrant and migrant populations who are difficult to find if they default on treatment, or who have been deported, as well as c) Bahamian citizens concerned about stigmatization. And d) drug users who do not access care or default on treatment. The denominators are actual numbers given the almost 100% testing rate among pregnant women.	Section 3.2.2
6	Percentage of estimated HIV-positive incident TB case that received treatment for TB and HIV	N/A	81.25%	Data were cross-referenced between the TB patient registers and HIV and AIDS ARV patient registers. In 2006 10 of the people died; they are included in the numerator and denominator.	Section 3.6.5
7	Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results.	N/A	N/A	National KAPB survey is underway in the first quarter of 2008 and results are expected by May 2008.	N/A
8	Percentage of men who has sex with men (MSM) that have received an HIV test in the last 12 months and who know their results	N/A	60.47% (2007)	Family Health International methodology used with additional questions to support intervention planning.	Section 3.2.1

UNGASS Indicators – Generalized Epidemic		2005 Result	2006 Result	Notes/Comments	Document Reference
9	Percentage of MSM reached with HIV prevention programmes	N/A	47.7% (2007)	Family Health International methodology used with additional questions to support intervention planning.	Section 3.2.6
	- Percentage receiving condoms through outreach, clinic, etc.	N/A	53.51%		
	- Percentage that know where to go to get an HIV test	N/A	87.64%		
10	Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child	N/A	N/A	No data available	N/A
11	Percentage of schools that provided life skills-based HIV education in the last academic year.	N/A	72.22%	The data were collected by both school surveys (on New Providence island) and by educational programme reviews (Family Islands). The life skills educational program is knowledge based, and not participatory. Less than 5% of schools had participatory exercises.	Section 3.4
Knowledge and Behaviour					
12	Current school attendance among orphans and among non-orphans aged 10-14	N/A	N/A	No data available	N/A
13	Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	N/A	N/A	National KAPB survey is underway in the first quarter of 2008 and results are expected by May 2008.	N/A
14	Percentage of MSM who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.	N/A	44.94% (2007)	Family Health International methodology used with additional questions to support intervention planning.	Section 3.5
15	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15.	N/A	N/A	National KAPB survey is underway in the first quarter of 2008 and results are expected by May 2008.	N/A
16	Percentage of women and men aged 15-49 who have had sexual with more than one partner in the last 12 months.	N/A	N/A	National KAPB survey is underway in the first quarter of 2008 and results are expected by May 2008.	N/A
17	Percentage of women and men aged 15-49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse	N/A	N/A	National KAPB survey is underway in the first quarter of 2008 and results are expected by May 2008.	N/A

UNGASS Indicators – Generalized Epidemic		2005 Result	2006 Result	Notes/Comments	Document Reference
18	Percentage of female and male sex workers reporting the use of a condom with their most recent client	N/A	Not reported	Questions to support this indicator were included in the MSM KAPB survey. However, the answers to the question yielded small numbers which brings the reliability into question. The definition used here is having received money, etc., for anal sex. However, there is no indication of how common the practice is of receiving money, etc., for sex for the 14 respondents. Therefore, it is not clear whether it is done on a regular basis or just randomly which makes the interpretation rather subjective. Additionally, the time frame of the question suggesting commercial sex work is 6 months as opposed to 12 months, as required for the UNGASS report. For these reasons, this indicator is not reported.	N/A
19	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	N/A	68.97% (2007)	Family Health International methodology used with additional questions to support intervention planning.	Section 3.5
20	Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	N/A	N/A	Not applicable to The Bahamian epidemic	N/A
21	Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	N/A	N/A	Not applicable to The Bahamian epidemic.	N/A

UNGASS Indicators – Generalized Epidemic	2005 Result	2006 Result	Notes/Comments	Document Reference	
Impact					
22	Percentage of young women aged 15-24 who are HIV infected		1.26% (2006)	<p>Indicator includes young women only from surveillance of antenatal attendees. While the numerator includes data collected from both the public and private sectors, the denominator is based solely on antenatal women attending community health clinics in the public sector. A mechanism is not yet in place between the public and private sectors to collect data on antenatal clinic attendees, however, this will be pursued for the next UNGASS reporting period. In total, 1 client tested positive for HIV in the private sector in 2006.</p> <p>Denominator is derived from government antenatal attendees who account for approximately 90% of all antenatal care within the country. There were approximately 2 patients that opted out of testing.</p>	Section 2
23	Percentage of MSM who are HIV infected	N/A	8.18% (2007)	Preliminary results from a limited sero-prevalence study in a targeted MSM population.	N/A
24	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	N/A	69.66%	Pharmacy records were used to compile data for this indicator. Excluded were ANC patients who did not require ART for themselves, persons lost to follow-up, defaulters or who died during the reporting periods. Of note, no paediatric patients defaulted during this reporting period.	Section 3.6.9
25	Percentage of infants born to HIV-infected mothers who are infected	0% - of those receiving treatment	1.32% overall, however 0% - of those receiving treatment	<p>Countries are not required to submit data for this indicator as it will be modelled at UNAIDS Headquarter.</p> <p>The Bahamas has reported mother-to-child-transmission in this report based on actual numbers tracked as part of its PMTCT programme.</p>	Section 2

2 Overview of the AIDS epidemic

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

As of December 31, 2006, The Bahamas had a cumulative total of 10,841 reported HIV infections (Figure 1). Of the 7,036 living individuals, 1,693 are living with an AIDS diagnosis, while 5,343 have HIV infection that has not progressed to AIDS.

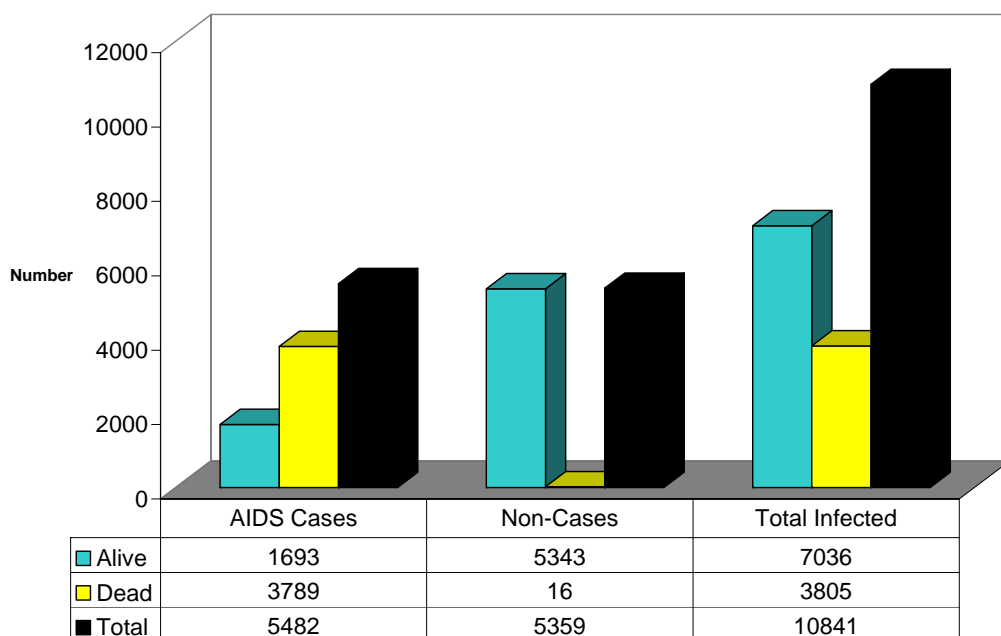


Figure 1 - Cumulative Number of Reported HIV Infections with Current Status as of December 31st, 2006

AIDS has been the leading cause of death in the 15-49 year age group in The Bahamas since 1994. Based on antenatal surveillance, it is estimated that approximately 3% of persons in The Bahamas are infected with HIV. The large majority of persons reported are in the productive years of early adulthood between the ages of 20-39 years of age. The disease occurs primarily among heterosexuals (approximately 87 percent), although under-reporting by men who have sex with men (MSM) remains a challenge. Transmission through intravenous drug use is nonexistent.

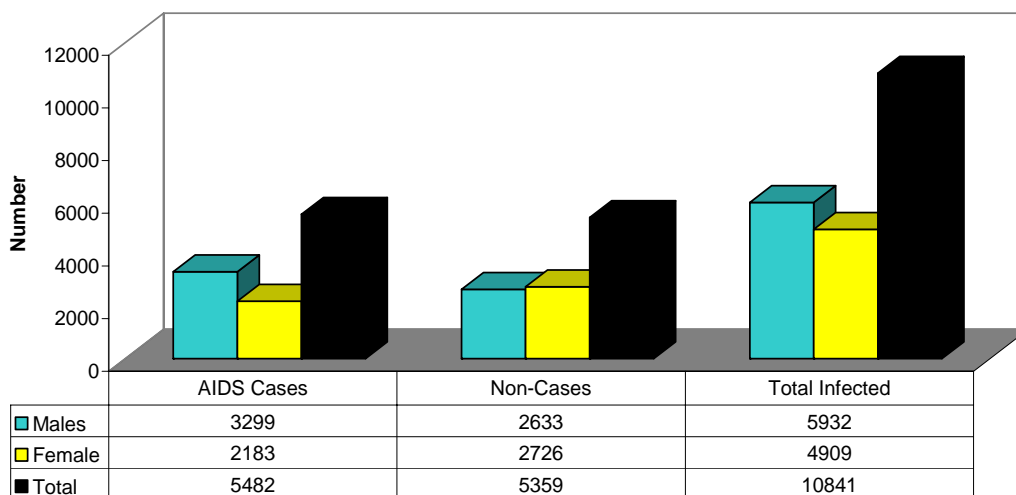


Figure 2 - Cumulative Number of Reported HIV Infections by Sex as of December 31st, 2006

Overall, the female to male ratio is 0.83 to 1 (Figure 2). However, in the 15 to 19 year old age group, the female to male ratio is 2.6 to 1, and in the 20 to 24 year old age group the female to male ratio is 1.5 to 1 (Figure 3 below). The younger age at which females contract HIV may be due to their earlier sexual activity, a higher male-to-female transmission efficiency or the preference of older men for younger women. In cooperation with the Ministry of Education and its Focus on Youth Programme, the National AIDS Programme includes a strong education and prevention focus on younger women as a strategy to address this disparity, including education on condom use for prevention, encouraging the delay of sexual activity and awareness of the risks of relationships with older men.

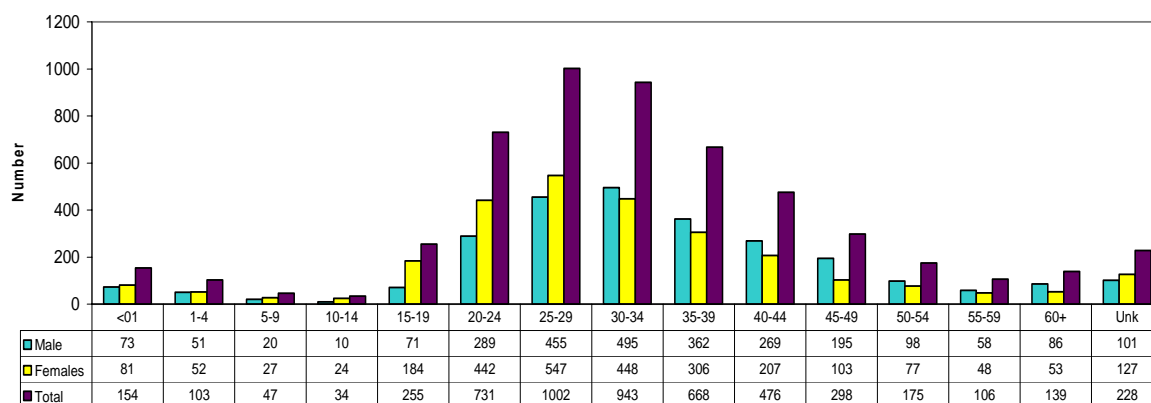


Figure 3 - Cumulative Number of Non-AIDS HIV Infections, By Age Group and Sex as of December 31st, 2006

The HIV and AIDS epidemic is concentrated among Bahamian citizens living on a few large islands, reflecting the population distribution among the 29 inhabited Islands. Approximately 84 percent of individuals infected with HIV (non-AIDS and AIDS cases) live on New Providence, 7 percent live on Grand Bahama, and Abaco and Eleuthera together account for 6 percent of HIV infections (Figure 4 below). All other islands combined have account for the remaining 3 percent of persons with HIV infection.

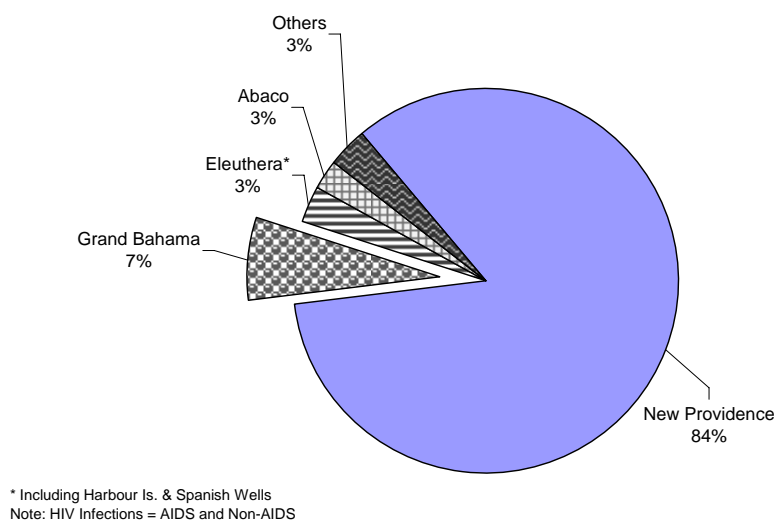


Figure 4 - Distribution of HIV Infections Reported as of December 31st, 2006, By Island of Usual Residence

Bahamian citizens make up 75 percent of persons with HIV and AIDS (Figure 5). Persons of Haitian descent make up the majority of the remaining cases. This distribution has remained relatively stable since 1999. According to the 2000 census, approximately 6.6% of the population is of Haitian descent, and while this figure likely does not fully account for illegal immigrants, it does suggest a higher prevalence in this population than among Bahamian citizens.

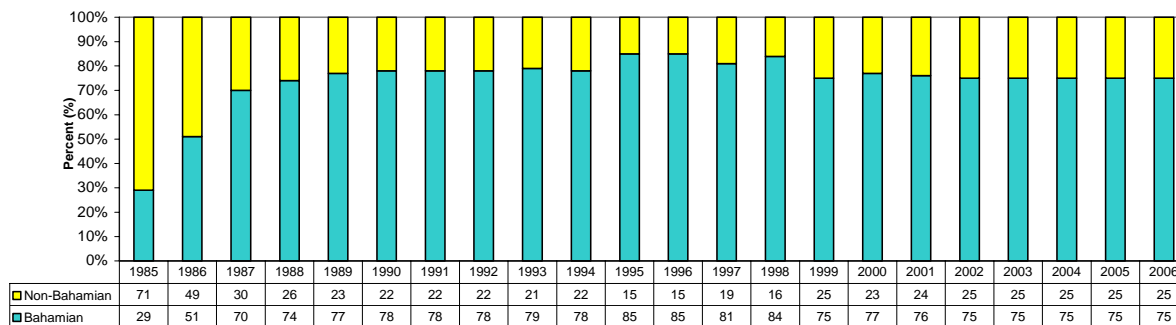


Figure 5 - Percent Distribution of HIV Infections (AIDS Cases and Non-Cases) Reported Annually, By Bahamian Citizenship Status, 1985 to 2006

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

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

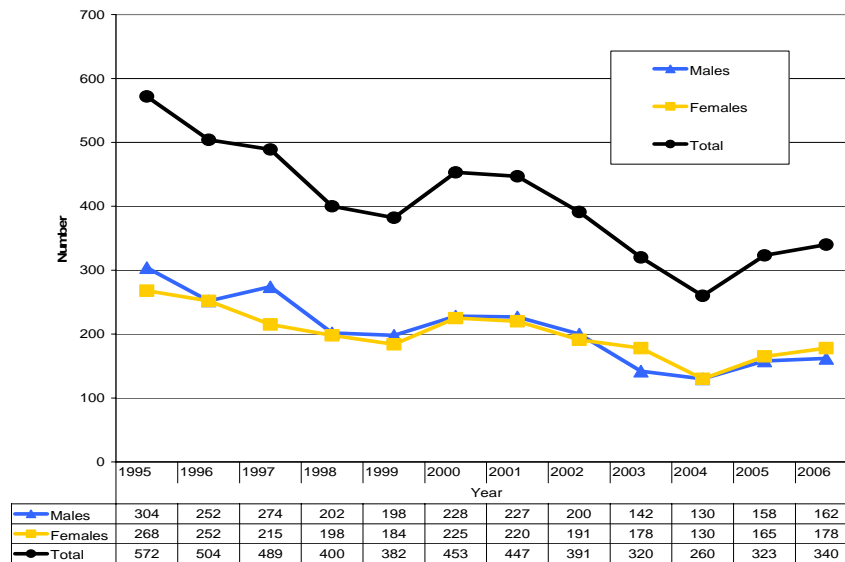


Figure 6 – New Non-AIDS HIV Infections By Sex and Reported Year, 1995-2005

The frequency of HIV is monitored through sero-prevalence surveys in sub-population groups of persons attending antenatal clinics, the sexual transmitted infection clinic (STI), blood donors and during prison intake (Figure 7). Among patients receiving care for STIs, the percent testing positive for HIV has decreased from 9.2 percent to 5.3 percent between 1993 and 2006. Sentinel surveillance activities continue among these target populations, and among those in treatment for substance abuse.

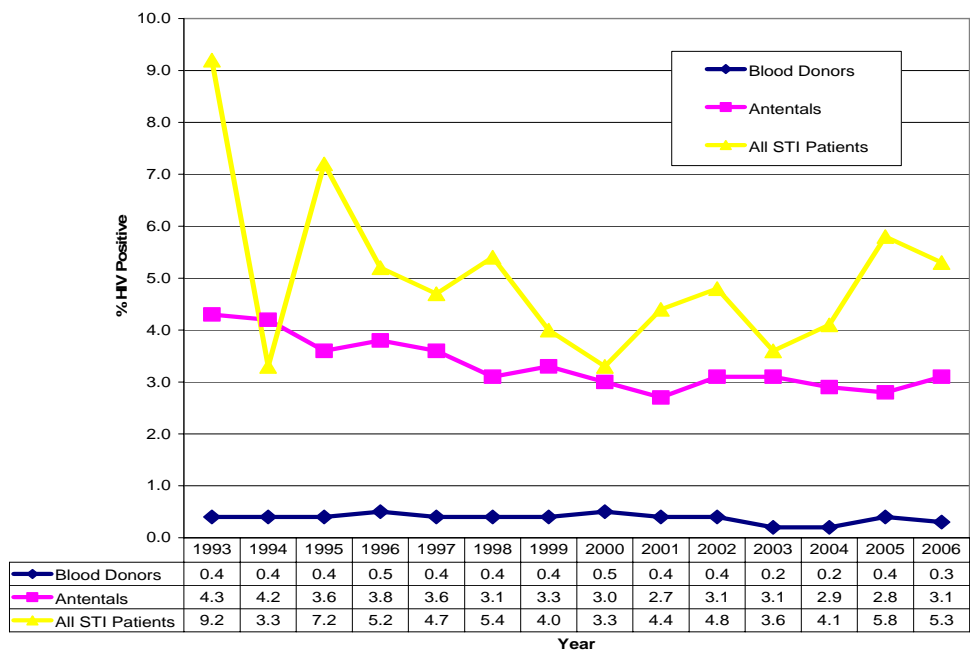


Figure 7 - Prevalence of HIV in Antenatal Women, STI Clients and Blood Donors, 1993-2006

Surveillance of HIV in antenatal women shows drop in prevalence from 4.3 percent in 1993 to about 3 percent, beginning in 1998. The prevalence rate has remained constant since that period until the present, reflecting the fact that repeat pregnancies account for approximately 50% of all HIV-infected pregnant women. It is interesting to note that the rate is significantly lower for younger women. Of women under the age of 25 visiting antenatal clinics in 2006, 1.26 percent tested positive for HIV infection, and of women under the age of 20, only 0.4 percent tested positive (Figure 8).

	Numerator	Denominator	Value
	<i>Number of antenatal attendees (aged 15-24) tested whose HIV results are positive</i>	<i>Number of antenatal attendees (aged 15-24) tested for their HIV infection status</i>	<i>Percentage of young women aged 15-24 who are HIV infected.</i>
All aged 15-24	33	2618	1.26%
Age 15-19	4	1003	0.40%
Age 20-24	29	1615	1.79%

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

Figure 8 - UNGASS Indicator 22 - Reduction in HIV Prevalence: Antenatal Attendees 2006

The most dramatic impact of outreach and preventive interventions can be seen in the marked reduction of perinatal HIV transmission from HIV-infected pregnant women to their infants. A vertical transmission study conducted in 1992 revealed that 30 percent of infants born to HIV-infected mothers in The Bahamas were also HIV-infected. The Ministry of Health and Social Development subsequently implemented a programme of voluntary counselling and testing for all women receiving antenatal care in the public health clinics. Following the results of ACTG 076, AZT was administered by protocol to all pregnant women and their infants. This protocol was changed to triple ARV combination therapy in 2001.

In 2006, 107 HIV infected pregnant women received antenatal care through the public health system. There were 76 births in the 2006 reporting year to HIV infected women, and one case of perinatal transmission from a mother who did not receive ART. Since 2003, there have been no cases of mother-to-child transmission for women receiving ART.

A decrease in AIDS mortality has occurred, with the percent of registered deaths due to AIDS dropping from 18.4 percent in 1996 to 8.8 percent in 2005. This drop is concurrent with improved ability to enter individuals in care, to diagnose and treat opportunistic infections, and the increased affordability and availability of antiretroviral therapy (ART). In 2002, the government of The Bahamas committed to providing ART to all those who are eligible – a programme made more affordable in recent years by availability of lower cost antiretroviral medications, due in large part to lobbying efforts by the Clinton Foundation.

A slight increase in the number of new and cumulative AIDS cases in 2005 and 2006 (Figure 9) is likely the result of improved diagnostic capacity to identify AIDS cases through laboratory testing with the addition of CD4 testing in 2001, and individuals with an AIDS diagnosis living longer through improved treatment of opportunistic infections and ART.

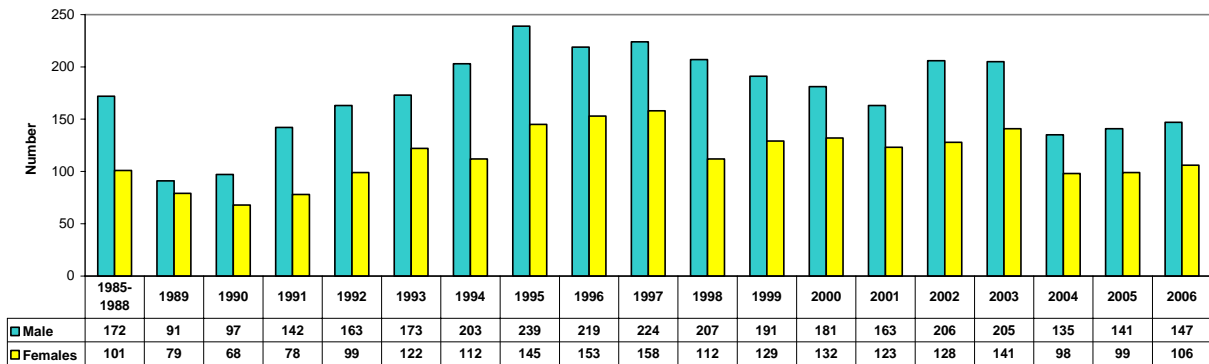


Figure 9 - New Cases of AIDS, By Sex and Year, August 1985 to December 31st, 2006

3 National response to HIV and AIDS in The Bahamas

3.1 Leadership and coordination

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

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

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

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

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

Principles and values
<ul style="list-style-type: none"> • <i>Respect</i> for human rights and individual dignity • <i>Accessibility and availability</i> – appropriate care provided at the local level. • <i>Equity</i> – care provided to all persons living with HIV and AIDS regardless of gender, age, race, ethnicity, sexual identity, income, place of residence, or immigration status. • <i>Coordination and integration</i> across the continuum of providers and levels of care. • <i>Community participation</i> – meaningful involvement in decision-making of affected individuals and families, alliances, partnerships, and mobilization of private and public sectors. • <i>Empowerment</i> – meaningful involvement of clients in the clinical management process; encouragement of individual responsibility for self-management and adherence. • <i>Evidence-based</i> – interventions based on explicit, proven guidelines and qualitative and quantitative information resources.

Principles and values

- *Quality care* – satisfied clients receive care provided in an efficient and effective manner.
- *Information* – best practices and knowledge documented, disseminated, and shared.

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

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

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

The Government of The Bahamas spends approximately \$2.5 million annually on provisions for HIV and AIDS care through the National HIV/AIDS Centre budgetary allocations. This does not include monies that are spent through the Department of Public Health, nor the Public Hospitals Authority for provisions of care for persons with HIV and AIDS. The full scale of HIV spending by the government for 2006/2007 is likely to be more than what was spent in the 2003-2005 period. At that time the government committed 75 percent of the projected 3-year programme cost of \$23 million (Figure 10).

Local, regional and international partners such as NIH (via Wayne State University), UNAIDS, PAHO/CAREC, CHART, the Clinton Foundation, the US Embassy, and the Exuma Foundation Bahamas,

Ltd, also play a key role in meeting funding requirements. Assessment of the actual expenditure for fiscal year 2006/2007 is currently underway.

Category	2003	2004	2005	Total
Medications	\$1,040,073	\$1,652,564	\$2,030,432	\$4,723,069
Outpatient primary and specialty medical care	\$1,208,105	\$1,093,585	\$1,111,585	\$3,413,275
Inpatient medical care	\$3,282,525	\$2,904,822	\$1,969,515	\$8,156,862
Laboratory services	\$1,200,170	\$1,039,250	\$1,044,120	\$3,283,540
Equipment and capital improvements	\$493,680	\$22,480	\$14,680	\$530,840
Prevention and education	\$303,000	\$200,000	\$200,000	\$703,000
Training and technical assistance	\$188,400	\$183,400	\$183,400	\$555,200
Research	\$142,800	\$142,800	\$142,800	\$428,400
Surveillance	\$55,000	\$45,000	\$45,000	\$110,000
Monitoring and evaluation	\$105,000	\$57,000	\$57,000	\$219,000
Program support	\$358,000	\$308,000	\$308,000	\$974,000
Total Expenses	\$8,231,753	\$7,551,901	\$7,009,532	\$22,793,186

Figure 10 - Bahamas National HIV/AIDS Strategic Plan Projected Costs 2003-2005

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

3.1.1.1 Challenges

While work plans and budgets are in place, milestones often cannot be achieved by target dates because of human resource, funding and infrastructure constraints.

Sustainable funding remains as key challenge. While The Bahamas Government is maintaining its current commitments to the National HIV/AIDS programme, and new private sector and non-governmental donors are in the process of committing new funds, the strategy for achieving the goals and objectives of the NASP will require additional funds sustained over the longer term.

3.1.2 One coordinating authority – The National HIV/AIDS Centre

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

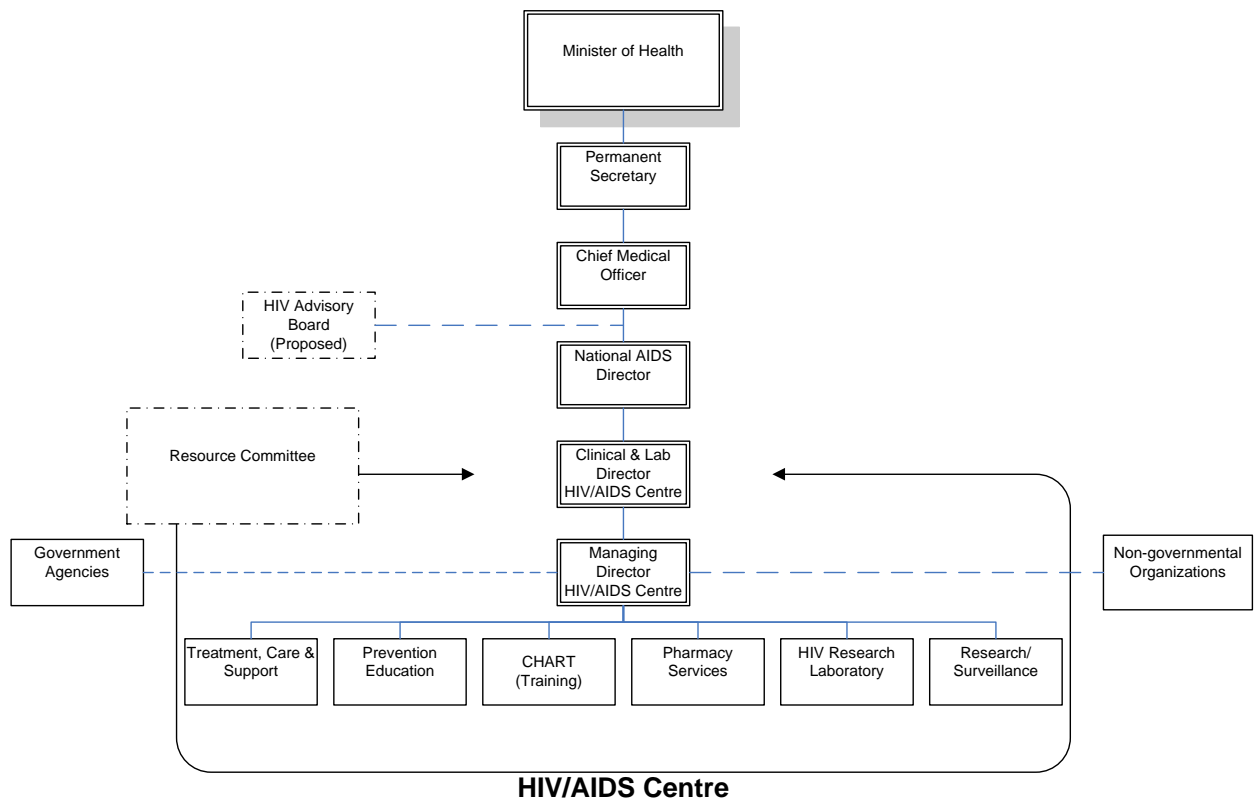
The HIV/AIDS Centre has direct line accountability to the Minister of Health and Social Development. Funds from the national budget, international donors and national donors is coordinated through the Centre and prioritized within the framework set by the National HIV/AIDS Strategic Plan.

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

3.1.2.1 Multisectoral mandate

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

The Centre collaborates with these stakeholders through the Resource Committee, a multi-stakeholder advisory body that meets monthly to review strategic plans, programme activities and outcomes and to collaborate on joint initiatives. As well, coordinators from the Samaritan Ministries, the AIDS Foundation and other community and faith-based organizations are actively involved in the delivery of programmes and support services, and work closely with the Managing Director and unit coordinators.



3.1.2.2 Challenges

The HIV/AIDS Centre is 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. In particular the Centre is in need of a financial, administrative, information management and data entry support.

The Centre is further challenged by infrastructure limitations. The Centre's physical space is strained beyond capacity while it awaits the renovation of a building that will house the new HIV laboratory and office space. Programme and service delivery is hampered by lack of transportation and communication resources, and Centre staff often work long hours to meet the demands of service delivery, planning and administration. Lastly, sustainable financing, both national and international remains a constant challenge to the Programme.

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

All HIV/AIDS monitoring and evaluation activities are coordinated through the HIV/AIDS Centre in cooperation with the National Health Information and Research Unit, and the Surveillance Unit of the Department of Public Health. The Centre, in collaboration with the Surveillance Unit, undertakes a number of monitoring and evaluation activities such as serological and behavioural surveillance,

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

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

3.1.3.2 Challenges

The development of the M&E Framework within the National HIV/AIDS Centre is still in its infancy. The start-up demands of a new programme put considerable strain on all staff within the program as they seek to collect the data necessary for national and international reporting, monitoring and evaluation requirements, while working to support the development of a more comprehensive system.

3.2 Prevention

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

3.2.1 Voluntary counselling and testing (VCT)

Individuals who request an HIV test, or who are considered by providers to be engaging in behaviours placing them at risk for HIV, receive a voluntary, confidential HIV test and pre/post test counselling (VCT) in the system of community health clinics. There are no stand-alone VCT centers in The Bahamas. All patients with a confirmed positive test for HIV are referred to either the PMH or RMH for evaluation of their HIV disease. The CHART programme for health care providers, social service workers and volunteers has trained over 251 individuals on VCT.

A recently completed knowledge and behaviour survey (December 2007) with men who has sex with men (MSM) shows that 60.5% of those surveyed had an HIV test in the last 12 months and know their status (Figure 11). However, disaggregation of the results by age shows a significant difference in behaviour between those under and over the age of 25. For men over the age of 25, 76 percent responded they had had an HIV test in the last 12 months and knew their status, while only 49 percent of those under 25 responded the same. This discrepancy could be accounted for by stronger knowledge of the risks and causes of HIV for men over 25 years of age (see Figure 16 below), or because older men may be more comfortable with their sexuality and less fearful of the stigma associated with seeking an HIV test, especially given that 82 percent of MSM under 25 responded that they knew where to get an HIV test (see Figure 14 below).

	Numerator	Denominator	Value
	<i>Number of MSM who had an HIV test in the past 12 months and know their results.</i>	<i>Number of MSM included in sample.</i>	<i>MSM who had an HIV test in the past 12 months and know their results.</i>
All	52	86	60.47%
<25	24	49	48.98%
25+	28	37	75.68%

Figure 11 - UNGASS Indicator 8: HIV Testing - Men who have Sex with Men (MSM)

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

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

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

	Numerator	Denominator	Value
	<i>Number of HIV-infected women who received ARVs during last 12 months to reduce mother-to-child transmission</i>	<i>Number of HIV-infected pregnant women in the last 12 months.</i>	<i>Percentage of HIV-infected pregnant women who received ARVs to reduce the risk of mother-to-child transmission</i>
All	95	107	88.79%

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

Figure 12 - UNGASS Indicator 5 - Prevention of Mother-to-Child Transmission 2006

3.2.3 Blood product screening

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

	Numerator	Denominator	Value
	<i>Number of donated blood units screened for HIV in blood centres/screening labs that have both 1) documented standard operating procedures and 2) participated in an external quality assurance scheme.</i>	<i>Total number of blood units donated.</i>	<i>Percentage of donated blood units screened for HIV in a quality assured manner.</i>
All	4951	4951	100%

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

Figure 13 - UNGASS Indicator 3 - Blood Safety 2006

3.2.4 Post-exposure prophylaxis

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

3.2.5 Contact tracing and partner notification

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

A major factor in reporting accurate HIV and AIDS statistics is the outstanding communications skills of the public health nurses and other trained staff in counseling, contact tracing, and maintaining client confidentiality. The compassionate professionalism of the medical staff in the HIV/AIDS clinics earns

confidence and trust, one patient at a time. In this environment, all HIV-infected patients are encouraged to bring their sexual contacts in for education, STI screening and testing for HIV. The patient's privacy is given the highest priority. All HIV-infected clients, unwilling or unable to communicate with past or current partners, are assured by the surveillance counseling team that their identity will not be divulged. Only after informed consent is given voluntarily are patients' contacts invited to come in for counseling.

3.2.6 Condom distribution and outreach

The HIV/AIDS Centre actively distributes condoms at public health clinics and public events along with educational material on HIV. While specific outreach to the MSM community is a recent achievement, the MSM survey (Figure 14) shows that 54 percent of survey participants had received a condom through an outreach program or clinic, and 88 percent know where to get an HIV test.

	Numerator	Denominator	Value
	<i>Number who responded "Yes" to question "In the last twelve months, have you been given condoms? (e.g. through an outreach service, drop-in centre or sexual health clinic)</i>	<i>Total number of respondents surveyed</i>	<i>Percentage who responded "Yes" to question "In the last twelve months, have you been given condoms? (e.g. through an outreach service, drop-in centre or sexual health clinic)</i>
All	52	97*	53.61%
<25	33	58	56.90%
25+	19	38	50.0%
	<i>Number who responded "Yes" to question "Do you know where you can go if you wish to receive an HIV test"</i>	<i>Total number of respondents surveyed</i>	<i>Percentage who responded "Yes" to question "Do you know where you can go if you wish to receive an HIV test"</i>
All	78*	89*	87.64%
<25	41	50	82.00%
25+	36	38	94.75%

*Group totals do not add up due to missing data in one of the age groups.

Figure 14 - UNGASS Indicator 9: Prevention Programmes - Men who have Sex with Men (MSM)

3.3 Knowledge and behaviour change

Since its inception, the National HIV/AIDS Programme has focused efforts on HIV and AIDS information, education and communication to prevent HIV-infections and reduce stigma and discrimination. As the epidemic progressed, the HIV/AIDS Programme was instrumental in changing

risky behaviour through behaviour change communication and public awareness campaigns. The focus for HIV prevention is now centred on teenagers and young adults as this is the population which has the highest incidence of new cases. Since the mid-1980's the Ministry of Health and Social Development has involved other government ministries including Education, Tourism, and Youth, Sports, and Culture.

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

3.4 Focus on Youth

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

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

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

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

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

	Numerator	Denominator	Value
	<i>Number of schools that provided life skills-based HIV education in the last academic year.</i>	<i>Number of schools surveyed</i>	<i>Percentage of schools that provided life skills-based HIV education in the last academic year.</i>
All Schools	104	144	72.22%
Primary	33	109	65.14%
Secondary	71	35	94.29%

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

Figure 15 - UNGASS Indicator 11: Life-based HIV Education in Schools

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

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

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

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

3.5 Most-at-risk populations

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

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

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

Among other questions, the survey asked five questions about knowledge of the prevention of the sexual transmission of HIV, and probed on major misconceptions about HIV transmission. Overall, 45 percent of respondents answered all five questions correctly (Figure 16). Of men over the age of 25, 57 percent answered all five questions directly, as compared with 36 percent of men under 25. The results show the need to target prevention education to younger MSM.

	Numerator	Denominator	Value
	<i>Number of respondents who gave the correct answers to all questions.</i>	<i>Number of respondents who gave answers, including "don't know", to all questions.</i>	<i>Percent of respondents who gave the correct answers to all questions.</i>
All	40	89*	44.94%
<25	19	53	35.85%
25+	20	35	57.14%

No age is available for one respondent, accounting for the discrepancy in the disaggregated data. Correct answers were needed to all five questions used to assess this indicator:

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

Figure 16 - UNGASS Indicator 14: Knowledge about HIV Prevention - Men who have Sex with Men (MSM)

This tendency among MSM over the age of 25 years to have stronger knowledge than those respondents under the age of 25 is also reflected in their health-seeking behaviours with regard to condom use. Overall, 69 percent of those who responded indicated they had used a condom the last time they had anal sex with a male partner (Figure 17). However, disaggregation of the responses by age shows that 87.5 percent of MSM respondents over the age of 25 reported they had used a condom, while only 62 percent of those under 25 reported the same.

	Numerator	Denominator	Value
	<i>Number of men reporting the use of a condom the last time they had anal sex with a male partner</i>	<i>Number of respondents who reported having had anal sex with a male partner in the last six months</i>	<i>Percentage of men reporting the use of a condom the last time they had anal sex with a male partner</i>
All	20	29	68.97%
<25	13	21	61.90%
25+	7	8	87.50%

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

Figure 17 - UNGASS Indicator 19: Condom Use - Men who have Sex with Men (MSM)

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. There are multiple entry-points to HIV and AIDS services, most commonly through voluntary counselling and testing provided at most public health clinics and many private clinics.

3.6.1 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 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.

3.6.1.2 *PMH Antenatal Clinic*

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

3.6.1.3 *PMH Paediatric Clinic*

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

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

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

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

3.6.1.4 *Princess Margaret Hospital inpatient infectious diseases services*

There are two inpatient infectious diseases wards at the PMH serving adult men and women with bed capacities of 20 and 13, respectively. Patients admitted to the units are followed by the infectious diseases service under the direction of the Director of Infectious Diseases who also directs the outpatient clinics.

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

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

3.6.2 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 a unit at RMH or transferred to PMH if ongoing specialist care is required.

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

3.6.4 National Tuberculosis Control Programme

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

	Numerator	Denominator	Value
	<i>Number of adults with advanced HIV infection who are currently receiving ART in accordance with the nationally approved treatment protocol and who were started on TB treatment (in accordance with national TB programme guidelines) within the reporting year.</i>	<i>Number of incident TB cases in people living with HIV</i>	<i>Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV</i>
All	26	32	81.25%
Males	16	20	80.00%
Females	10	12	83.33%

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

Figure 18 - UNGASS Indicator 6: Co-Management of TB and HIV Treatment 2006

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

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

3.6.5 Sexually transmitted infections clinic

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

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

3.6.6 Substance abuse and mental health services

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

3.6.7 Hospice services

The All Saints Camp is a hospice facility with the capacity to provide shelter and basic services to 70 persons. Individuals with HIV, those in recovery for substance abuse or mental illness, and those in a transitional crisis can be cared for at the camp. Persons traveling in from the Family Islands for clinic visits who do not have a place to stay can sometimes be accommodated at the camp. A private physician volunteers as back-up medical support once a week. The camp is eligible to receive a per diem payment from the National Insurance Board for indigent persons who are boarding at the camp for health reasons. The camp is managed by volunteers and financed primarily by the private sector.

3.6.8 Antiretroviral therapy (ART)

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

In 2006, 48 percent of all persons with advanced HIV infection were receiving ART (Figure 19). Of the children less than 15 years of age 92 percent of children received ART, which reflects the strong paediatric HIV/AIDS programme in The Bahamas. The largest gap is among adult HIV-infected persons, many of whom do not regularly access care because of stigma and fears of discrimination, or because they are generally healthy and do not seek diagnosis or treatment.

	Numerator	Denominator	Value
	<i>Number of adult and children with advanced HIV infection who are currently receiving ART in accordance with nationally approved treatment protocols.</i>	<i>Estimated number of adults and children with advanced HIV infection</i>	<i>Percentage of adult and children with advanced HIV infection who are currently receiving ART in accordance with nationally approved treatment protocols.</i>
All Adults and Children	1252	2585	48.43%
Males	573	1099	52.14%
Females	679	1486	45.69%
15+	1144	117	46.35%
<15	108	2468	92.1%

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

Figure 19 - UNGASS Indicator 4: HIV Treatment Antiretroviral Therapy 2006

Preliminary numbers for 2007 indicate that as of September 30, 60 percent of eligible HIV-infected persons are receiving ART, including nearly 89 percent of antenatal clients and nearly 92 percent of paediatric clients.

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 migration populations who default on treatment. Further, asymptomatic HIV infected individuals frequently do not access care because they feel and look healthy. The HIV/AIDS Centre estimates there are 5,000 HIV infected individuals who currently do not access care.

	Numerator	Denominator	Value
	<i>Number of adults and children who are still alive and on ART at 12 months after initiating treatment</i>	<i>Total number of adults and children who initiated ART during the twelve months prior to the beginning of the reporting period.</i>	<i>Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy</i>
All Adults and Children	163	234	69.66%
Males	68	100	68.00%
Females	95	134	70.90%
15+	18	214	67.76%
<15	145	20	90.00%

Pharmacy records were used to compile data for this indicator. Excluded were persons lost to follow-up, defaulters or who died during the reporting periods.

Figure 20 - UNGASS Indicator 24: HIV Treatment - Survival After 12 Months on Antiretroviral Therapy 2006

Of those beginning ART in 2006, 70 percent of those still alive remained on therapy for at least 12 months (Figure 20). Among children under the age of 15, 90 percent remained on therapy, reiterating the strength of paediatric HIV programme, and in particular, the diligence and support of clinic nursing staff and volunteers to ensure a high level of adherence. The gap in adult adherence reflects the challenges identified above, in particular follow up with migrant populations, some of whom may have been deported during the treatment period, as well the need for additional resources to increase follow-up activities.

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

The 2005 UNGASS Report highlighted plans for the de-centralization of HIV and AIDS care into community clinics as a key strategy toward universal access of comprehensive HIV and AIDS care in The Bahamas. The strategy called for the integration of HIV and AIDS services into the primary level of care within all clinics in the Family Islands. All comprehensive treatment and care services, voluntary counselling and testing, pharmacy services and ancillary support services will be 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 would be available at planned mini-hospitals in the Family Islands when fully operational.

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

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

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

3.6.10 Advocacy, public policy, and legal framework

3.6.10.1 *Advocacy*

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

3.6.10.2 *Public policy and legal framework*

From the inception of the AIDS epidemic, The Bahamas recognized the importance of protecting individuals against discrimination through public policy, education and legislation. The AIDS Secretariat was specifically created to promote education and information on HIV and AIDS and to tackle issues of stigma and discrimination.

Several key policies and pieces of legislation have been instrumental in allowing The Bahamas to successfully mount an attack against HIV and AIDS, a direct result of the support of key governmental officials and lawmakers:

- The Bahamas was one of the first Caribbean nations to de-criminalize homosexuality;
- The Employment Act of 2001 states that employees or persons applying for employment may not be discriminated against based on their HIV status, nor can an employee or applicant be required to submit to an HIV test;
- The Ministry of Education has recently submitted draft policy relating to HIV and AIDS, which includes requirements for treatment, management and education of all persons affected and infected with HIV and AIDS (including students and teachers), and also includes the provision of systematic and consistent information and educational materials on HIV and AIDS to students and school personnel; Currently additional work is being done with assistance of UNESCO , with a workshop planned for early 2008 to broaden the proposed school policy to include an overall workplace policy.
- The revised Education Act of 1996 stated that all 5-16 year olds are entitled to free education and this included provisions for children regardless of their HIV status. Children of all ages are properly educated about the disease so they are aware of precautionary measures that should be taken.

The Ministry of Education has adopted specific policies to protect HIV-infected children from discrimination 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

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

4.1 Lesson: Political leadership and commitment are essential to success

The political will and commitment of The Government of The Bahamas to the scaling-up initiative has been crucial to the successes of the effort to-date. Effective leadership is required to mobilize all stakeholders in the process. However, the time and effort required to provide leadership and to coordinate and mobilize resources and partners is considerable. Senior government officials must be prepared to spend the required time to meet with decision-makers from various sectors of government, the private sector and civil society.

Best Practices:

- Secure the support of senior government representatives through education on the impact of HIV and AIDS, the need for political commitment and leadership, and the need for multisectoral participation and support;
- Engage senior government representatives in building support and consensus among multisectoral partners.

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

The multisectoral partnership approach facilitates an accelerated process, develops momentum at the national level and facilitates broad participation and the achievement of results.

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

Best Practices

- Use a multidisciplinary team with experience in programme areas, clinical care, information management, programme management, etc. to develop and plan scale-up initiatives;
- Include international partners with specific expertise in the planning process;
- Leverage the technical expertise of international partners such UNAIDS and PAHO/WHO that understand the context, issues and needs of the country and region.

4.3 Lesson: Tools are essential to support planning and implementation

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

As well, effective tools for evaluating and measuring existing resource capacity across the health system are required to identify capacity gaps which may hinder scale-up efforts. It is critical to identify gaps in the system so that these can be addressed in the scale-up strategy.

More effort is required to source or develop tools for estimating the start-up and ongoing operational costs for scale-up. Accurately identifying and predicting future costs in order to plan for sustainable funding was a key challenge in the process.

Best Practices:

- Select a conceptual methodology (e.g., logic models) that provides a framework for planning, monitoring and evaluating scale-up strategies. The choice of model should be aligned with the knowledge and human resource capacities of the country.
- Source or develop effective tools for evaluating resource capacity and for costing start-up and ongoing costs.

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

Identifying cost savings may be critical in securing funds for scale-up activities. In the case of The Bahamas, ARV therapy costs were reduced from approximately \$3,000 per person per year, to US\$480 per person per year through efforts of the Clinton Foundation and other international partners. For The Bahamas, these cost saving made scale-up targets realistic and achievable. Other examples could include rationalization of services or improvement in information management or business processes that provide savings to the system that can be re-directed to scale-up activities.

Best practices:

- Seek to identify potential cost-savings in the delivery of existing services which can be re-directed toward the scale-up initiative.

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

Once the costs of a response initiative have been identified, it is critical to immediately begin efforts to secure financing to address any gaps. Delays in accessing the required financial resources were one of the key barriers to meeting the identified targets in The Bahamas.

In a similar vein, it is also important to consider the impact of the strategy on human resource requirements and the effort and time required to recruit, contract and train healthcare professionals and programme management staff. This process should begin as soon as possible, as delays in acquiring the required human resources will lead to delays in achieving scale-up goals.

Best Practices:

- Identify an approach and human resources for securing required financial resources when developing initial plans and strategies;
- Consider the time and effort required to recruit, contract and train human resources when developing work plans, and initiate this process as soon as possible to prevent delays.

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

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

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

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

Best Practices:

- Share knowledge, tools, processes and methodologies with other sectors of the healthcare system;
- Encourage healthcare leaders to use the HIV and AIDS initiatives as a catalyst for reviewing and improving other aspects of the healthcare sector;
- Identify and communicate the benefits that the scale-up process has had across the healthcare system, and use these benefits to stimulate additional funding or collaborative efforts.

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

The table below summarizes the challenges faced by The Bahamas in its response to HIV and AIDS as defined in the 2005 report, proposed actions to address these challenges, and any updates on these challenges and actions.

2005 Challenges	Proposed Actions	2006/2007 Update
<p>Societal stigma and fear of discrimination of HIV and AIDS prevents people at risk of infection and those already infected from seeking services.</p>	<ul style="list-style-type: none"> • Provide services throughout the primary care level in settings that are not specifically associated with HIV and AIDS care; • Target behavioural change communications and public awareness campaigns to change attitudes among service providers and the general population that reduce stigma and discrimination; • Ensure appropriate anti-discriminations policies and laws are in place, and ensure existing policies and laws are enforced; • Conduct education and public awareness campaigns to encourage people to know their status, and on the importance of seeking treatment if HIV-infected; • Empower PLWHA to advocate for change on their own behalf, and provide legal and other services to help them seek redress for discriminatory actions. 	<ul style="list-style-type: none"> • Conducted “Ouch” Programme – mass media campaign in cooperation with PAHO and with financial support from UNAIDS • Conducted “Live Up” mass media campaign in cooperation with CAREC • Conducted “Know Your Status” Poster campaign • Working with UNESCO to develop and adopt a nation workplace. • Produced wide ranging materials, posters, banners and conducted radio and TB programmes on HIV with the financial support of UNAIDS Office for the Bahamas and as part of the World AIDS Campaign 2007.

2005 Challenges	Proposed Actions	2006/2007 Update
<p>The outpatient clinics at PMH and RMH lack capacity to provide all required services to all HIV-infected individuals.</p>	<ul style="list-style-type: none"> • Decentralise comprehensive HIV and AIDS prevention, treatment, care and support services to the primary care level to distribute demand across the system; • Increase HIV and AIDS prevention, treatment and care capacity through training providers at the primary care level; • Reduce HIV transmission through prevention programs such as PMTCT and behavioural change communications 	<ul style="list-style-type: none"> • De-centralization efforts integrated into overall Department of Health re-structuring.
<p>There is shortage of trained professionals with expertise in HIV and AIDS prevention, treatment care and support services to meet the needs of the expanding number of patients accessing services which is exacerbated by the ineffective deployment of existing human resources.</p>	<ul style="list-style-type: none"> • Provide HIV and AIDS training to health care providers and other service providers 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. 	<ul style="list-style-type: none"> • Department of Public Health re-structuring includes development of Training Centre and recruitment of providers specifically trained in the public health approach to primary care

2005 Challenges	Proposed Actions	2006/2007 Update
<p>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.</p>	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Department of Public Health re-structuring includes development of Training Centre and recruitment of specifically trained public health care providers
<p>Community clinics are at physical capacity for all patient categories, even without treating HIV patients.</p>	<ul style="list-style-type: none"> • Identify infrastructure requirements and develop a plan and budget to upgrade facilities, including communication and transportation systems. 	<ul style="list-style-type: none"> •
<p>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.</p>	<ul style="list-style-type: none"> • Implement a Public Health Information System, including a unique client identifier with appropriate protections for confidentiality. 	<ul style="list-style-type: none"> • iPHIS implemented in several New Providence and Grand Bahama community clinics • Full time person within medical records added to HIV/AIDS Centre • Move to terminal digit filing system in Family Island Clinics

2005 Challenges	Proposed Actions	2006/2007 Update
<p>There is no integrated information system to permit central monitoring and tracking, distribution, and consumption of ARVs across all pharmacy/dispensary sites.</p>	<ul style="list-style-type: none"> • Implement a Pharmacy Information System. 	<ul style="list-style-type: none"> • Local pharmacy system implemented by Department of Public Health • Public Hospitals Authority in the process of Pharmacy Information System that includes direct linkage to inventory management within Bahamas National Drug Agency
<p>The existing 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.</p>	<ul style="list-style-type: none"> • Implement a Laboratory Information System integrated with the Public Health Information System. 	<ul style="list-style-type: none"> • Public Hospitals Authority has identified a laboratory information system for us in hospitals labs and community clinics. Implementation scheduled for 2008.
<p>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.</p> <p>The Bahamas is generally excluded from international donor and funds because of its GDP.</p> <p>Sustained funding to support the current capacity of service delivery is not guaranteed.</p>	<ul style="list-style-type: none"> • Develop roles and expertise to focus on accessing both domestic and international sources of funding; • Work with government officials and international donors to remove barriers to funding; • Work with private sector and international organizations to secure access to low-cost technologies, such as laboratory equipment and supplies. 	<ul style="list-style-type: none"> •
<p>Lack of in-country capacity for some HIV monitoring laboratory services</p>	<ul style="list-style-type: none"> • Extension of the HIV/AIDS laboratory services to include facility and equipment for the provision of onsite CD4, viral load and PCR testing 	<ul style="list-style-type: none"> • Project approved. Additional funding required for completing the project.

6 Support from country's development partners

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

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

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

The Centre is making great strides in establishing a Monitoring and Evaluation Unit. In 2007, a staff member was identified to anchor the Monitoring and Evaluation Unit. UNAIDS Office for The Bahamas financially supported the training for the Officer and also has supported capacity building through the training of that staff member, conducting a wider stakeholder training on monitoring and evaluation, installing the Country Response Information System (CRIS) and training stakeholders on the use of the data base for HIV and AIDS information; and assisting in the collection of data on domestic and international expenditures on AIDS through applying the National AIDS Spending Assessment (NASA) resource tracking system. UNAIDS has also committed to further technical expertise in this area as needed.

7.2 Challenges of one national M&E system

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

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

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

Annex 1: Consultation Process for Preparation of Report

Consultation/preparation process for the Country Progress Report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

1) Which institutions/entities were responsible for filling out the indicator forms?

a) NAC or equivalent	Yes	No
b) NAP	Yes	No
c) Others (please specify) Ministry of Health	Yes	No

2) With inputs from

Ministries:		
Education	Yes	No
Health	Yes	No
Labour	Yes	No
Foreign Affairs	Yes	No
Others (please specify)	Yes	No
Civil society organizations	Yes	No
People living with HIV	Yes	No
Private sector	Yes	No
United Nations organizations	Yes	No
Bilaterals	Yes	No
International NGOs	Yes	No
Others (please specify)	Yes	No

3) Was the report discussed in a large forum? **Yes** **No**

4) Are the survey results stored centrally? **Yes** **No**

5) Are data available for public consultation? **Yes** **No**

6) Who is the person responsible for submission of the report and for follow-up if there are questions on the Country Progress Report?

Name / title: Dr. Perry Gomez, National AIDS Director

Date: 29 January 2008

Signature: 

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Annex 2: National Composite Policy Index

NCPI Summary – The Bahamasⁱ

Part A

I. Strategic Plan

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

II. Political Support

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

III. Prevention

There has been steady progress in the implementation of HIV prevention programmes since 2005. Although there have been no new policies since the end of 2005, the country has updated the guidelines

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

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

(primarily in education), and are developing more focused policies to guide all groups and workplaces in prevention programming. The Bahamas has a policy/strategy that promotes information, education and communication (IEC) on HIV to the general population and vulnerable sub-populations, targeting abstinence, monogamy, safe sex, prostitution, violence against women, and stigma.

IV. Treatment, Care and Support

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

V. Monitoring and Evaluation

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

Part B

I. Human Rights

The NCPI rates the effort to enforce existing policies, laws and regulations in relation to human rights and HIV and AIDS as above average however the rate of effort to enforce such policies is ranked below average. There is an Employment Act in place which protects people living with HIV against discrimination and HIV screening is prohibited for general employment purposes. In addition, there are no legal obstacles to effective HIV prevention, treatment, care and support for vulnerable sub-populations. Although there are no non-discrimination laws or regulations which specify protection for vulnerable sub-populations, members of the judiciary have been trained/sensitized to HIV and AIDS and human rights issues. HIV policy/strategy explicitly mentions the promotion and protection of human rights but there is currently no mechanism to document discrimination experienced by PLWHAs or most-at-risk populations. The Bahamas has a policy of free services for HIV prevention, antiretroviral treatment, and HIV-related

care and support interventions and a policy to ensure equal access for women and men and most at-risk populations. Legal support services for PLWHAs, and education programmes to raise awareness of their rights are also available. Furthermore media, education, spokespersons and church and union programs designed to reduce stigmatization associated with HIV and AIDS. The government has introduced some human rights M&E mechanisms.

II. Civil Society Participation

The NCPI ranks civil society's access to adequate financial and technical support as average. Efforts to increase civil society participation which were considered below average in 2005 have improved in 2007. Civil society involved in HIV activities are very diverse, and have had strong influence in strengthening the political commitment of top leaders and national policy formulation. Civil society has also been active in the planning and budgeting process for the National Strategic Plan on AIDS. Prevention, treatment, and care and support services provided by civil society are mostly included in National Strategic plans and reports and sometimes in the national budget. The Bahamas included civil society in their 2006 National Review of the National Strategic Plan.

III. Prevention

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

IV. Treatment, Care and Support

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

Annex 3: Bibliography

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

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