The Commonwealth of The Bahamas

GLOBAL AIDS RESPONSE PROGRESS REPORTING

Monitoring the 2011 Political Declaration on HIV/AIDS

Country Report 2014

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Prepared by Ministry of Health/PEPFAR (Bahamas) Office

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Abbreviations

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

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

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1 Status at a glance

1.1 Stakeholder participation in preparation of report

This report was prepared by the staff of the Ministry of Health/President's Emergency Fund for AIDS Relief (PEPFAR) office with assistance from the HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) Centre, the Maternal/Child Health Programme, the STI (Sexually Transmitted Infections) Unit and the National Health Information Research Unit (HIRU) of The Ministry of Health.

Stakeholders from across the National AIDS Programme and civil society assisted in the provision of data, completion of National Commitment and Policy Instrument (NCPI) surveys, participation in a verification meeting in support of the NCPI and review of the indicators. A draft version of the report was reviewed by representatives of the Ministry of Health (MOH), the HIV Technical Advisory Group (TAG), as well as by members of the HIV Resource Committee, an advisory body to the National AIDS Programme with multisectoral representation from Governmental agencies including the Ministry of Health and the HIV/AIDS Centre; the Ministry of Education; and Non-governmental organizations. Feedback from MOH, the HIV TAG and the HIV Resource Committee was included in the final draft, and the HIV TAG formally endorsed the report.

1.2 Status of the epidemic

As of December 31, 2012, The Bahamas had a cumulative total of 12,712 reported HIV infections According to surveillance data, 8,186 persons were living with HIV or AIDS by the end of 2012. A 40% decrease in reported AIDS deaths is believed to be due to universal access to free antiretrovirals, and has contributed to a growing number of persons living with HIV. HIV/AIDS surveillance data indicate a population prevalence of 2%. However, using population modelling based on surveillance data, it is estimated that approximately 3% of persons in The Bahamas are infected with HIV. (Ministry of Health, 2013) HIV surveillance data is obtained from specific surveillance activities such as targeted testing events, in addition to testing antenatal clinic attendees, sexually transmitted infections clinic attendees, blood donors, persons accused upon remand to prison, and those entering treatment programmes for substance abuse.

In 2012, 293 persons tested positive for HIV for the first time, 78 (27%) were diagnosed with AIDS in the same year as their HIV diagnosis (including 20% at their initial HIV diagnosis). Surveillance data indicate a general reduction in newly reported diagnoses of HIV/AIDS since 2006 (Figure 1), with the exception of youth aged 15-24, who experienced a 30% increase in newly diagnosed HIV infections (35 in 2006 compared

to 50 in 2012). Late testing remains a concern for The Bahamas. The majority (65%) of late testers in 2012 were male. (Ministry of Health, 2013)

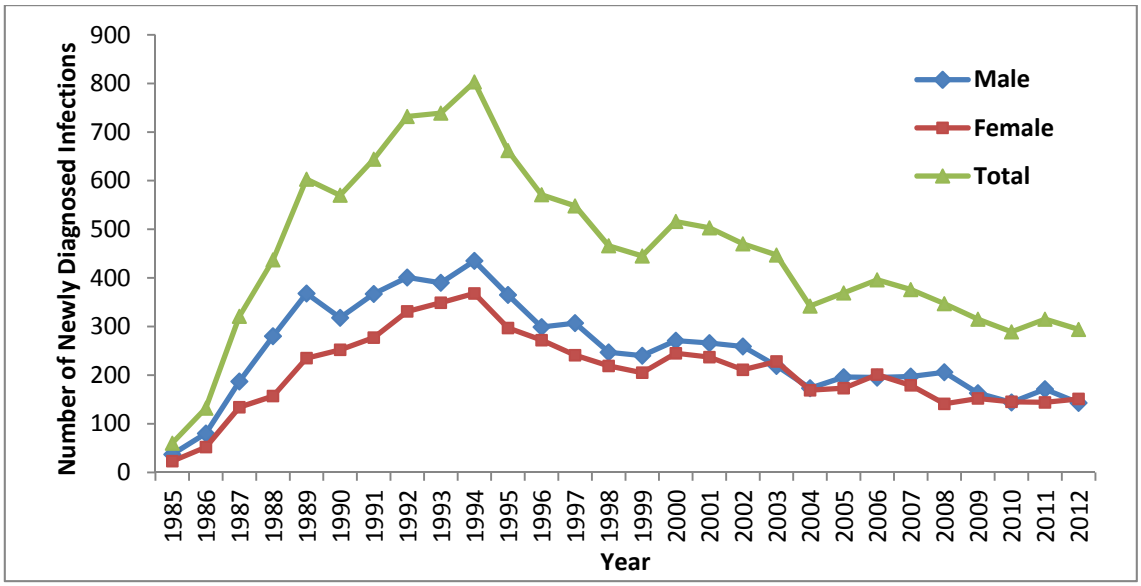

Figure 1: ***Newly diagnosed HIV infections by Gender and Year of Diagnosis, The Bahamas (1985 – 2012).***

According to 2012 HIV surveillance data, the number of new HIV infections decreased by 34% from 349 in 2003 to 293 in 2012. Also, the number of reported AIDS deaths decreased by 40% between 2003 (175 reported deaths) and 2012 (105 reported deaths). Government and NGO efforts continue to form the backbone of the response to HIV/AIDS in the Bahamas and include blood screening, surveillance, partner notification, behaviour change communications and public awareness campaigns. (Ministry of Health, 2013)

1.3 Update on policy and programmatic responses

The Ministry of Health has a long history of health system response to HIV and AIDS. The Bahamas' National AIDS Programme (NAP) is a mature programme that has been overseeing education, prevention, treatment, care and support for persons affected and infected with HIV since the mid-1980's. The Bahamas has learned many lessons throughout its history with HIV and AIDS; and has used these lessons to enhance HIV-related policies and programmes. Recently, these initiatives have been aimed at improving the access to services for those infected with HIV, enhancing data collection to accurately identify persons at risk for acquiring HIV, and increasing and developing local technical expertise and capacity to sustain the national response to HIV/AIDS in the face of shrinking financial and health care worker resources.

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

The Ministry of Health embarked on the development of a new strategic plan for the National Health Services in 2009. This culminated in the approval of the National Health Services Strategic Plan (NHSSP) 2010-2020 aimed at improving the health of the residents of the nation; focussing on seven strategic components. (Ministry of Health (2), 2013) The components reflect the interactions that occur between integral components of health care organizations that utilize a systems thinking approach:

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

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

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

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

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

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

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

After receiving input from various stakeholders, as well as the general public, The NHSSP 2010 – 2020 was presented to and approved by the Cabinet in 2013.

1.3.2 National AIDS Strategic Plan

The National AIDS Programme is reaching the end of the current Draft National AIDS Strategic Plan (NASP) 2007-2015. (Ministry of Health (3), 2007) Although never formally adopted, the NASP has been used to drive strategic initiatives and programme activities supported by the Ministry of Health and more recently, the United States of America's President's Emergency Plan for AIDS Relief (PEPFAR). The key priority areas remain aligned with the NHSSP 2010-2020:

- Strategic Planning and Management that focuses on evidence-based decision making and accountability that is reliant on strategic information and research;
- Prevention that focuses on maintaining healthy lifestyles;

- Infrastructure and Human Resources that focus on sustainable services with a high quality of care and human resources that can support these services; and
- Care, Treatment and Support Services that are patient-centred and integrated into primary care services for increased access.

In 2012, the Director of the National AIDS Programme became the Minister of Health. In 2013, the search for a new Programme Director was concluded and the Director assumed her post in November 2013. Plans are underway to review the achievements of the current draft NASP and begin the planning phase for the next NASP 2015-2020.

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

Since 2010, the Ministry of Health has been in a partnership with PEPFAR through a cooperative agreement (CoAg) with the Centers for Disease Control and Prevention Caribbean Regional Office (CDC CRO). Completing its third year, the CoAg has provided funding and technical support to the NAP in the areas of Prevention, Care and Treatment, Strategic Information, and Health Systems Strengthening. The CoAg, among its accomplishments, has provided necessary assistance to increase capacity in data management in the National HIV Centre and by extension, the NAP, as well as the MOH which contributed to improved programmatic response for patient management.

PEPFAR seeks to improve the health of women, infants and children through strengthening national programs and improving the sustainability of the provision of quality health care. In 2013, the CoAg provided financial and technical support to the National HIV Reference Laboratory in achieving accreditation by the College of American Pathologists (CAP). As a more seasoned programme, The Bahamas continues to benefit from initiatives that improve sustainability and expand access to services across the health sector, supported by increased community and private sector involvement.

1.3.4 De-centralization of HIV and AIDS comprehensive care

Decentralization of HIV services into the primary health care clinics continues to progress slowly. The expansion of counselling and testing services has continued with training of health care workers in Provider-Initiated Testing and Counselling and Rapid HIV Testing methodology across the archipelago. The initial decentralization training conducted between 2010 and 2011 for health care workers, primarily nurses and physicians resulted in small, but increasing numbers of clients receiving treatment, care and support for their HIV infection in primary care clinics. Historically, most HIV and/or AIDS patients sought care through the government facilities unbeknownst to clinic health care providers. Recently, these persons are allowing disclosure of their HIV status and are accessing HIV management at their home clinics. In

New Providence during 2013, ten primary care clinics followed clients and/or prescribed ART for them, permitting clients the choice between primary health clinics close to their home or the centralized HIV clinic. It is anticipated that with patients seeking decentralized care, there will be greater harmony in the coordination of care of the entire patient with his complete list of health concerns, while decreasing the burden of visits for the individual patient.

The number of sites providing the HIV Rapid Test methodology also continues to increase slowly. This provides access to HIV care and testing at strategic locations throughout The Bahamas, including health fairs and community outreach events in non-traditional settings. During 2013, the NAP continued to identify community outreach locations that increased access to HIV prevention activities, including prevention messaging and HIV testing for persons who do not usually seek health care.

1.3.5 Information systems

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

The development of the NHSSP 2010 – 2020 highlighted the need for an integrated data management system that allows data sharing across all public sectors including the Public Hospitals Authority (PHA) and DPH. Information and Communication Technology (ICT) for Health has identified the desired strategic direction and has completed its request for proposals for health information systems that will fulfill both the broader health information system and an electronic medical record that will be seamless throughout the public health sector. Proposals are currently being evaluated toward the eventual selection of a single product. Once this has been determined it will allow for the completion of the decentralization process with the capacity to capture information to monitor and evaluate HIV prevention, care and support services across the health sector.

At the National HIV Centre, digitized recordkeeping has continued to move forward. A number of discrete individual programmatic databases continue to be managed throughout the National HIV Centre which contributes to monitoring service provision for the NAP. The Strategic Information (SI) Unit has completed

the development of the Case-Based HIV Surveillance (CBS) database and preliminary training. The introduction of the CBS is anticipated for mid-year 2014.

1.3.6 Prevention and outreach

The HIV/AIDS Centre and the NAP remain strongly committed to prevention efforts. Improving access to prevention activities and community outreach programmes for hard-to-reach and marginalized populations continue to be a priority for the next biennium. The Ministry of Health through its NAP has demonstrated its commitment to this priority through the employment of a Community Outreach Coordinator whose responsibility is to identify and coordinate HIV/Sexually Transmitted Infection (STI) prevention activities throughout the country among these targeted populations by identifying formal and informal leaders and building relationships that encourage partnerships and introducing outreach activities. The HIV/AIDS Centre's Prevention Unit has been assisted by the Community Outreach Unit in the PEPFAR (Bahamas) Office during 2012-2013. Prevention messages were developed, tested, and deployed using a variety of mediums including murals, magnets, testing coupons and a Junkanoo parade float to name a few. Outreach activities have targeted hard-to-reach and marginalized populations, primarily in New Providence, bringing prevention messaging and HIV counselling and testing to community events, improving access using non-traditional testing venues.

PEPFAR has continued to provide financial support to community based organizations (CBO) that focus on bringing prevention interventions and increased access to counselling and testing to hard-to-reach populations in New Providence.

Through partnerships with organizations such as the Society Against Sexually Transmitted Infections and HIV (SASH) Bahamas, the Centre has increased its outreach activities to the MSM communities in The Bahamas; primarily among persons between the ages of 20 and 35. These activities include health fairs for the MSM community that have offered health information, weight screening and glucose and cholesterol screenings, STI screening and HIV testing.

Partnerships with community based organizations (CBO) such as the Urban Renewal Centres and The Bahamas Urban Youth Development Centre have focused on bringing HIV prevention interventions and increased access to counselling and testing to sex workers, another hard to reach population in community settings in New Providence.

Partnerships with the Faith-based Organization (FBO) such as Real Men Haitian Chapter from Bahamas Faith Ministries provide outreach to the Creole-speaking communities. The Samaritan Ministries continues to provide counselling and support to persons living with or affected by HIV and AIDS.

1.4 UNGASS indicators at a glance

UNAIDS Indicators		2012 Result	2014 Result	Notes/Comments	Section
Target 1: Reduce sexual transmission of HIV by 50% by 2015 (*General population)*					
1.1	Percentage of young women and men aged 15-24 who correctly ID ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV	Not Available	Not Available		--
1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	Not Available	Not Available		--
1.3	Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	Not Available	Not Available		--
1.4	Percentage of adults aged 15 - 49 who have had sexual intercourse with more than one partner in the past 12 months and who report the use of a condom during their last intercourse	Not Available	Not Available		--
1.5	Percentage of adults aged 15 - 49 who received an HIV test in the past 12 months and know their results	Not Available	Not Available		--
1.6	Percentage of young people aged 15 - 24 who are living with HIV	0.9%	0.9%	2013 Antenatal screening (15-24 year age group) in Primary Health Care Clinics	3.2.2
Target 1: Reduce sexual transmission of HIV by 50% by 2015 (*Sex Workers)*					

UNAIDS Indicators		2012 Result	2014 Result	Notes/Comments	Section
1.7	Percentage of sex workers reached with HIV prevention programmes	Not Available	Not Available	To date, no formal studies have been conducted on commercial sex workers in the Bahamas which inform the indicators of this report. There are legal barriers in place that pose problems in reaching this population.	--
1.8	Percentage of sex workers reporting the use of a condom with their most recent client	Not Available	Not Available		--
1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results	Not Available	Not Available		--
1.10	Percentage of sex workers who are living with HIV	Not Available	Not Available		--
Target 1: Reduce sexual transmission of HIV by 50% by 2015 (*Men who have sex with men)*					
1.11	Percentage of men who have sex with men reached with HIV prevention programmes	79%	Not Available	Note for 2012 Results: Data from PEPFAR-funded MSM targeted HIV testing party 2012 was used to determine results (n = 42).	--
1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	88%	Not Available		--
1.13	Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	55%	Not Available		--
1.14	Percentage of men who have sex with men who are living with HIV	14%	Not Available		--
Target 2: Reduce the transmission of HIV among people who inject drugs by 50% by 2015					
2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	Not Applicable	Not Applicable		--

UNAIDS Indicators		2012 Result	2014 Result	Notes/Comments	Section
2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	Not Applicable	Not Applicable	Current surveillance data from NGOs and national drug treatment centers indicate that injection drug use in The Bahamas remains negligible	--
2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	Not Applicable	Not Applicable		--
2.4	Percentage of people who inject drugs that have received an HIV test in the past 12 months and who know their results	Not Applicable	Not Applicable		--
2.5	Percentage of people who inject drugs who are living with HIV	Not Applicable	Not Applicable		--
Target 3: Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths					
3.1	Percentage of HIV positive pregnant women who receive ARVs to reduce the risk of mother to child transmission	88%	91%	Data derived from ARV and PMTCT records from the National AIDS Centre	3.1.1
3.1a	Percentage of women living with HIV receiving antiretroviral medicines for themselves or their infants during breastfeeding	Not relevant	Not Relevant	100% Replacement feeds are provided to all HIV+ mothers	--
3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	100%	96%	Data derived from PMTCT records from the National AIDS Centre	3.1.1
3.3	(Estimated) Percentage of child HIV infections from HIV-positive women delivering in the past 12 months	0%	2.9%	This is not an estimate. Programme data is used to inform this indicator.	3.1.1

UNAIDS Indicators		2012 Result	2014 Result	Notes/Comments	Section
Target 4: Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015					
4.1	Percentage of adults and children currently receiving ARV therapy	51%	29.9%*	Data derived from National AIDS Centre Pharmacy records and ***reflects change in calculation from previous reporting cycles**.	3.1.7.10
4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ARV	71%	50.8%	Data derived from National AIDS Centre Pharmacy records	3.1.7.10
Target 5: Reduce tuberculosis deaths in people living with HIV by 50% by 2015					
5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	92%	50%	Data derived from National Tuberculosis Programme records and ARV Register	3.1.7.7
Target 6: close the global AIDS resource gap by 2015 and reach annual global investment of US$22-24 billion in low- and middle-income countries					
6.1	Domestic and international AIDS spending by categories and financing sources	Not available	Not available		--
Target 7: Eliminating gender inequalities					
7.1	Proportion of ever-married or partnered women aged 15 - 49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	Not Available	Not Available		--
Target 8: Eliminating stigma and discrimination					
8.1	Discriminatory attitudes towards people living with HIV		Not Available		--

UNAIDS Indicators		2012 Result	2014 Result	Notes/Comments	Section
Target 9: Eliminate travel restrictions					
	Travel restriction data is collected directly by the Human Rights and Law Division at UNAIDS HQ, no reporting needed		Reported by UNAIDS		--
Target 10: Strengthening HIV integration					
10.1	Current school attendance among orphans and non-orphans aged 10-14	Not Available	Not Available		--
10.2	Proportion of the poorest households who received external economic support in the last 3 months	Not Available	Not Available		--
Policy Questions					
	National Commitments and Policy Instruments (NCPI)	Yes	Yes	Annex 2	Annex 2

2 Overview of the AIDS epidemic

The NAP has been monitoring the epidemic since 1983, when the first clinical case of AIDS was identified. Surveillance for HIV and AIDS began in 1985 with the advent of the Enzyme-linked Immunosorbent Assay (ELISA) test. Legislation was amended in 1989 to make AIDS a notifiable disease reported to the Department of Public Health. HIV surveillance data is obtained from specific surveillance activities such as targeted testing events, as well as testing antenatal clinic attendees, sexually transmitted infections clinic attendees, blood donors, persons accused upon remand to prison, and those entering treatment programmes for substance abuse.

"As of December 31, 2012, The Bahamas had a cumulative total of 12,712 reported HIV infections. Of the cases reported to the MOH between 1985 and 2012, 6,693 (53%) were known to have progressed to AIDS, while 6,109 (47%) remained HIV (non-AIDS) cases. This proportion is also consistent in the 8,186 cases currently believed to be alive at the end of 2012; however death data is known to be incomplete for HIV/AIDS cases and therefore the number of persons living with HIV and/or AIDS in The Bahamas is believed to be lower than reported. Thirty-six (36) percent (n=4,526) of persons were known to be deceased at the end of 2012.

In 2012, 383 persons were diagnosed with HIV and/or AIDS. Of these persons, 293 were newly reported HIV infections, including persons newly diagnosed with AIDS at the time of HIV diagnosis or within the same year as the HIV diagnosis. This represented a 7% decrease from 2011 (n=315), and a decrease of 35% from the previous ten years (n=447 in 2003). Over half of new infections reported in 2012 were among males. Persons aged 15-24 accounted for 17% of newly reported infections while persons aged 25-44 years made up 50% of cases. Seventy-three percent of cases reported The Bahamas as their country of origin, while cases of Haitian origin comprised 24% of newly reported infections in 2012. Ninety-one percent of persons diagnosed in 2012 resided in New Providence (n=267), followed by 5% in Grand Bahama (n=16) and 1% in Eleuthera (n=4). Forty-nine percent of newly diagnosed infections in 2012 were among males, while females accounted for 51% of cases.

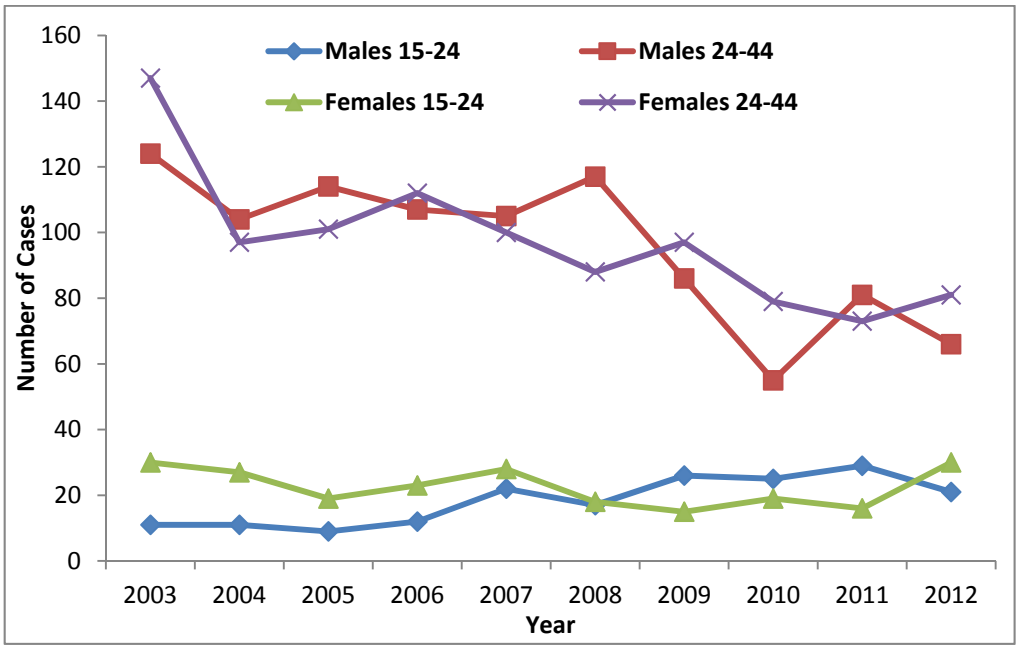

Figure 2: Newly diagnosed HIV infection by Gender and Age Group at Diagnosis, The Bahamas (2012)

Fifty percent of newly reported infections in 2012 were between the ages of 25 and 44, while 15-24 year olds made up 17% of newly reported infections in 2012. Males between the ages of 45-49 accounted for 14% of male cases (n=20) and females 25-29 accounted for 18% of female cases (n=27). Between 2003 and 2012, reported cases among 25-44 year olds decreased by 46% (45% for females and 47% for males). In contrast to other age groups where there was a decrease in newly reported cases, persons 15-24 years old showed an increase overall by 24% (90% for males and 10% for females). The overall median age at diagnosis (of HIV infection) was 36 in 2012.

Of the 293 persons who tested positive for HIV in 2012, 78 (27%) were diagnosed with AIDS within a year (including 20% at their initial HIV diagnosis). The number of late testers reported to the MOH decreased among all demographic groups between 2003 and 2012; however Bahamian male cases increased from 28 diagnosed in 2011 to 40 in 2012 (a 43% increase). Similarly, an increase in reported late testers was observed among Haitian females from 2011 (n=3) to 2012 (n=10). " (Ministry of Health, 2013)

3 National Response to HIV and AIDS in The Bahamas

Leadership and coordination

The Government of The Bahamas made a strong political commitment in the response to HIV and AIDS in The Bahamas from the beginning of the epidemic. The largest share of resources, both financial and human, for HIV services comes from the Government. While there are still gaps in the response that have been identified, the Government is committed to providing high quality, accessible services to improve the health and well-being of persons infected with and affected by HIV. The organization of the HIV/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. (UNAIDS, 2005) The section below describes "The Three Ones" principles in action within the Bahamian context, and highlights key challenges that remain.

One AIDS action framework – The National HIV/AIDS Programme

The NAP remains the action framework for the response to the AIDS epidemic in the Bahamas. With the Ministry of Health as its backbone, the NAP still embraces many of the best practices embodied in the Three Ones principles. The Programme continues to be multisectoral, multidisciplinary and collaborative. Planning, delivery and monitoring of the Programme includes involvement of faith-based organizations, the private sector and national and international non-governmental organizations. The NGO's include, but are not limited to the Samaritan Ministries, the Bahamas AIDS Foundation, Pan American Health Organization (PAHO) and UNAIDS. In 2011, the Ministry of Health created the National HIV/AIDS Advisory Committee which was charged with coordinating and overseeing all requests from external agencies for HIV/AIDS research and the provision of services and financial grants for HIV/AIDS within The Bahamas. Composed of persons from the Ministry of Health, the NAP, the AIDS Foundation, and representatives from two international agencies, the Committee meets as necessary to review applications and provide approval or guidance on these matters as necessary.

The NAP continues to be guided by the National HIV/AIDS Strategic Plan (NASP) 2007-2015. The NASP provides specific strategies and targets that were developed in consultation with multisectoral and multilateral partners. These strategies and targets have guided the development of work plans which direct the activities of the various partners involved in delivering activities and services for the National HIV/AIDS Programme. While the strategic plan for 2007-2015 remains in draft format it continues to steer strategic planning and programme activities. The National AIDS Programme is now seeking to update and expand the plan to coincide with the NHSSP 2010 – 2020.

Funding for national HIV/ AIDS initiatives comes primarily from the Government of The Bahamas, with some support for specific initiatives from a variety of local, regional and international partners such as the AIDS Foundation of the Bahamas, the National Institutes of Health (NIH) (Focus on Youth Programme via Wayne State University), UNAIDS, Caribbean Regional Public Health Agency (CARPHA), PEPFAR (through the CDC CoAg) and United States Agency for International Development (USAID), as well as the United State's (US) Embassy and the US Department of Defence

The Government's budget for HIV and AIDS care is integrated into line items within the overall Ministry of Health's budget as well as that of the Public Hospitals Authority.

At present it is not possible to fully identify the total HIV/ AIDS spending by the categories required by UNAIDS for completion of Indicator 6 of the UNAIDS Report.

The current commitment of the Bahamian Government, along with the contributions of new private sector and non-governmental donors has greatly aided the advancement of the NAP. Funding that is sustainable remains a challenge across the health sector, and the HIV/AIDS program is no exception.

One coordinating authority – The National HIV/AIDS Centre

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

The HIV/AIDS Centre has direct line accountability to the Minister of Health. Funds from the national budget, international donors and national donors are coordinated through the Ministry of Health with advisement from the National HIV/AIDS Advisory Committee 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 who report to the Director.

The HIV/AIDS Centre has broad multisectoral support from other government agencies, people living with HIV/AIDS (PLWHA), community and faith-based organizations and the private sector within The Bahamas, and is recognized among all stakeholders as the coordinating authority. These organizations are actively involved in the delivery of programmes and support services, and work closely with the Director and unit coordinators. The Centre also collaborates with these stakeholders through the Resource Committee, a multi-stakeholder advisory body that meets monthly to review strategic plans, programme activities and outcomes and to collaborate on joint initiatives.

The HIV/AIDS Centre 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 which has responsibility for Programme management throughout the archipelago.

One Monitoring and Evaluation (M&E) Framework:

All HIV/AIDS monitoring and evaluation (M&E) activities are coordinated through the HIV/AIDS Centre in cooperation with HIRU, the DPH and the STI Programme. The Centre undertakes a number of monitoring and evaluation activities such as serological and behavioural surveillance, program monitoring and evaluation, and research to support evidence-based clinical practices. The HIV/AIDS Centre and HIRU maintain a data store of indicators of the HIV 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-supported approach to developing strategies and planning programmes. M&E activities are coordinated among the various units of the Centre and are supported by epidemiological and statistical expertise and resources from the Epidemiologist and the M&E Specialist in the Strategic Information Unit at the PEPFAR (Bahamas) Office and the HIRU.

The Strategic Information (SI) Unit also provides capacity building to the agencies that support the HIV/AIDS response throughout the country and coordinates the gathering, analysis and dissemination of data, information and reports to further inform evidence-based decision-making.

Challenges

The development of the M&E Framework within the National HIV/AIDS Centre has placed increased demands on all staff within the Programme, as they seek to inform national and international reports, while working to maintain services within the Centre.

3.1 Prevention, Care, Treatment and Support

Since the inception of the original National HIV/AIDS Secretariat, the primary focus has been on the prevention of the transmission of HIV, with an integrated approach to prevention, care, treatment and support. This comprehensive, integrated approach to caring for the individual contributed to reduced mortality and increased quality of life for HIV-infected individuals, even before the advent of antiretroviral treatments. When antiretroviral (ARV) therapy became more widely available, the Government of The Bahamas was one of the first countries in the Caribbean to offer ARVs to all eligible persons free-of-charge in 2002. With the added advantage of early entry into care and the provision of free ARV treatment to all persons medically in need, the National HIV/AIDS Centre continues its tradition of prevention-based programmatic planning.

Prevention

3.1.1 Voluntary counselling and testing (VCT)

Voluntary Counselling and Testing (VCT) has now transitioned to a programme of provider initiated testing and counselling (PITC). HIV testing and counselling (HTC) continues to be provided to all individuals who request an HIV test and to persons throughout the system of community health clinics and hospitals for whom providers feel testing should be considered, as well as to persons in whom there is no suspicion of infection in an opt-out testing format. While there are no stand-alone VCT/PITC centers in The Bahamas, access to HIV testing has increased with the introduction of Rapid HIV testing, especially in non-traditional settings, such as mobile testing in the Mobile Health Clinic and community outreach events. All individuals with a confirmed positive test for HIV are referred to either the PMH or RMH or a private physician of their choice for evaluation of their HIV disease. The HIV Centre provides training in PITC and Rapid HIV Testing in the Primary Health Care clinics and supports all community outreach testing venues, assisted by funding through the PEPFAR initiative.

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

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

MTCT decreased from 10 cases in 2000 to 2 cases in 2013. This is the result of HIV screening for all pregnant women as part of their antenatal care and the administration of appropriate treatment. Of the known 68 HIV positive women who delivered infants in 2013, 62 (91%) received ARVs during pregnancy. Twenty-seven (40%) were on ARVs to maintain or improve maternal health, including 19 who initiated therapy during pregnancy, while 30 (44%) initiated ARV treatment to prevent mother-to-child transmission (Table 1). A total of nine (9) women received no antenatal care. Of these women, five (5) were documented as having received intravenous AZT during labour and delivery. The remaining 6 women (9%) did not receive ART during pregnancy nor did they have documentation to support the receipt of intravenous AZT during delivery.

	Newly Initiated on ART during current pregnancy	Already on ART before the current pregnancy	Maternal triple ARV prophylaxis	Maternal AZT (prophylaxis component during pregnancy and delivery of WHO Option A)	Total
HIV Positive Pregnant Women on Treatment	19	8	30	5	62
HIV positive pregnant Women who gave birth in 2013	68	68	68	68	68
Percentage of total HIV+ pregnant women who gave birth in 2013	27.9%	11.8%	44.1%	7.4%	91.2%

Table 1: Percentage of HIV positive pregnant women who received ARTs to reduce the risk of mother-to-child-transmission, 2013 (Indicator 3.1)

The proportion of women receiving treatment remains consistent with the 2012 UN GARPR (88% coverage reported during 2010). (Ministry of Health, 2012) All HIV-infected pregnant women were referred to the PMH or RMH clinics for monitoring and care. Defaulters were 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. Intravenous zidovudine (AZT) is given to all HIV infected mothers during labour and delivery in hospital. All HIV-exposed infants are given a six week course of oral AZT as part of the PMTCT programme. All HIV infected pregnant women are counselled about the risks of breastfeeding and are provided, as needed, with replacement feeds for their infants. At each clinic visit the mothers are asked about their feeding practise and reminded about not breastfeeding. The mothers receive ART adherence counselling at each clinic visit and home visit. Defaulters in the PMTCT programme have decreased substantially in the previous five years (from 30 down to 10 or less between 2005 and 2013). When possible, defaulters are contacted by members of the National HIV/AIDS Centre to reinforce the importance of the programme and to bring them back to participatory status. There are still challenges with women presenting to the hospital in labour with no ANC. These women are given intravenous AZT and tested for HIV at that time and their babies are followed as potentially "at risk" for HIV.

The Bahamas has seen an historical reduction in maternal deaths with the introduction of the policy that promoted delivery of all infants in a health care institution under the supervision of a trained health care

professional. This policy, when combined with the national policy to provide lifesaving drugs to all HIV-infected persons eligible for ART has decreased the number of HIV-associated maternal deaths to sporadic cases (Table 2).

Year	# of HIV-Maternal Deaths Among HIV-Positive Women
2007	0
2008	0
2009	2
2010	0
2011	0
2012	0

Table 2: HIV-Maternal Deaths, The Bahamas 2007-2013

After discharge from hospital, mothers and infants are visited at home by the postnatal home service team. HIV-exposed infants are followed-up in the HIV/AIDS Paediatric Clinic for evaluation and testing for HIV status. Follow-up testing within 2 months of birth with HIV DNA PCR was carried on 96% of the live births to HIV positive women in 2013 (65/68).

Infants receiving DNA-PCR Tests	65
Women giving birth	68
Result	96%

Table 3: Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth, 2013 (Indicator 3.2)

Between 2003 and 2013, no children were born infected with HIV when the HIV infected mothers received and adhered to appropriate PMTCT ARV treatment. In 2013, one HIV-positive pregnant woman who received ARV therapy for the prescribed period delivered an HIV-infected infant. It is theorized that due to an extremely high viral load at the beginning of pregnancy the fetus was infected *in utero*.

Although the majority of pregnant women in the Bahamas receive PMTCT interventions, some mother-to-child transmission was observed over the past decade, primarily among women who were not enrolled in the PMTCT programme or did not access antenatal care. Between 2000 and 2013, 35 perinatal transmissions occurred among infants whose mothers were not on treatment (an average of 2.6 per year), while 8 occurred among infants whose mothers accessed treatment, with the most recent occurring as previously reported.

No perinatal transmission was documented by the National AIDS Centre in 2010, although 2 cases have occurred in each of the 3 succeeding years.

MTCT HIV infections (Programme data)	2
HIV positive mothers giving birth, 2013	68
HIV Mother-to-Child Transmission Rate	2.9%

Table 4: Percentage of child HIV infections from HIV-positive women delivering in the past 12 months, 2013 (Indicator 3.3)

All ART is provided free of charge to all persons in The Bahamas. This type of strong PMTCT programme contributes to a decreased rate of transmission, as evidenced by the MTCT data (Figure 3).

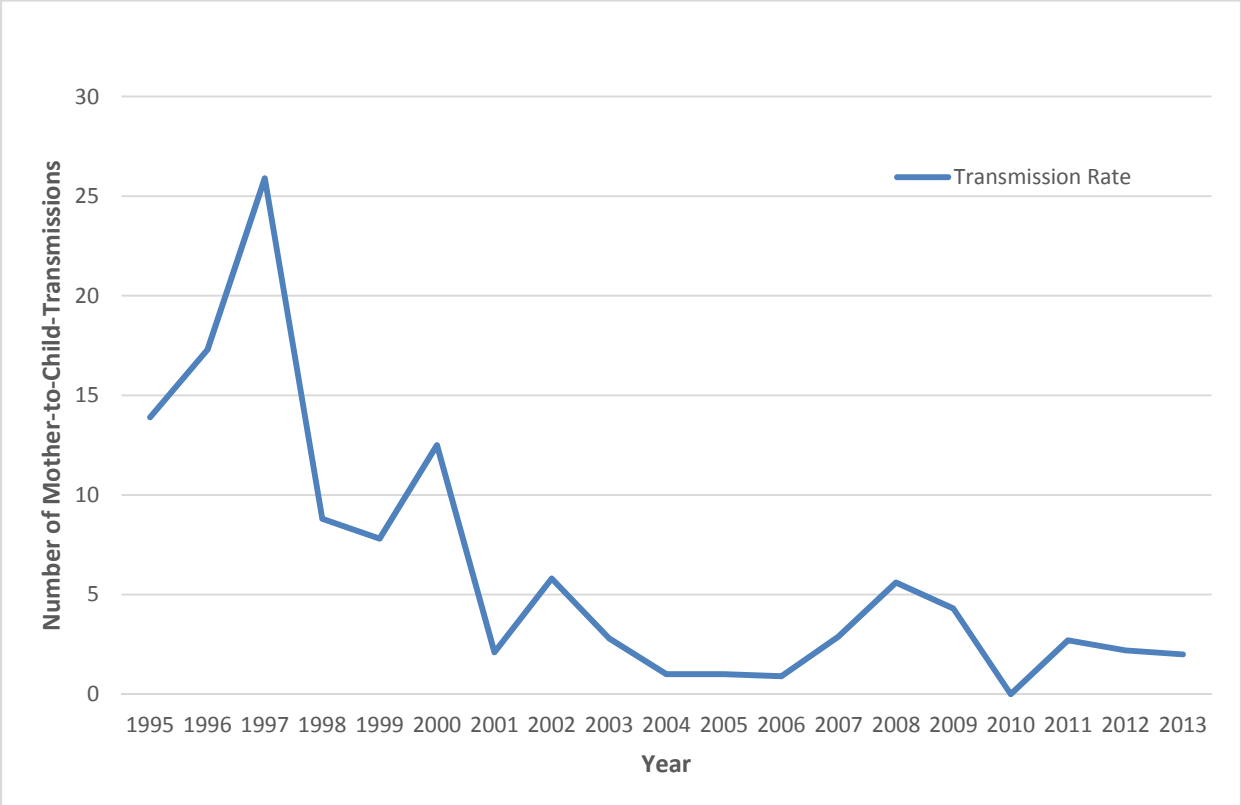

Figure 3: HIV Mother-to-Child Transmission Rates, 1995-2013, The Bahamas

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

3.1.2 Blood product screening

In the Bahamas, all blood products have been routinely screened, using quality assured techniques, since the availability of HIV antibody testing in 1985. This continues today as a standard of care in all three blood banks in The Bahamas (Princess Margaret Hospital (PMH), Rand Memorial, and Doctors' Hospital). PMH processes the largest volume of donated blood. In 2013, PMH Blood Bank screened 3,872 units of blood with 0.2% testing positive for HIV infection.

3.1.3 Post-exposure prophylaxis

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

3.1.4 Contact tracing and partner notification

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

A major factor in the capacity of the NAP to perform contact tracing is the outstanding work 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 NAP and the STI Programme earn the confidence and trust of clients. In this environment, all HIV-infected patients are encouraged to bring their sexual contacts in for education, STI screening and testing for HIV. The patient's privacy is given the highest priority. All HIV-infected clients, unwilling or unable to communicate with past or current partners, are assured by the surveillance counseling team that their identity will not be divulged. Only after informed consent is given are patients' contacts invited to come in for counseling.

3.1.5 Condom distribution and outreach

The HIV/AIDS Centre actively promotes the use of condoms through a condom social marketing and distribution programme at public health clinics, health fairs and community outreach events throughout The Bahamas. This social marketing programme is done in combination with the distribution of

educational materials on HIV. During the first three quarters of 2013, the Centre distributed 4,246 female condoms and 49,423 male condoms in clinics, schools, businesses and festivals and events throughout the year. This was augmented by distribution through the Community Outreach Coordinator at PEPFAR-sponsored events throughout the year, at which 18,850 condom packets which contained a male and female condom and a packet of lubricant were distributed.

Care, Treatment and Support

For 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". 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 still mainly centralized at The National HIV/AIDS Centre in Nassau, and delivered through clinics in the Princess Margaret Hospital (PHM) in New Providence and at the Rand Memorial Hospital (RMH) in Grand Bahama and through a small network of private physicians; however, the number of primary care clinics providing HIV services is gradually increasing. There are multiple entry-points to HIV and AIDS services, most commonly through voluntary counselling and testing provided at most public health facilities and many private clinics.

3.1.7 Princess Margaret Hospital outpatient clinics

The HIV 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. These clinics followed 770 women, 611 men and 63 children (<14 years) during 2013. The clinics are staffed by consultants (an infectious diseases specialist and a paediatrician), medical house officers, public health nurses, a social worker, visiting nutritionist and community volunteers from the Samaritan Ministries.

3.1.7.1 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 complaints. Volunteers from the Samaritan Ministries are present to provide additional support and counselling to patients as needed.

Patients are given a return appointment to review the results of initial laboratory tests and to develop a plan for ongoing care. Adult patients not receiving ARV therapies are given routine follow-up visits for evaluation and management of their HIV infection 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 providing supportive counselling and problem solving. Care extends from the clinic into the community, as clinic nurses and community health workers follow through with visits to the home as needed.

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

3.1.7.2 PMH Antenatal Clinic

Approximately 20 to 30 patients are seen each week in the antenatal infectious diseases follow-up clinic. From 2003 to 2013, an average of 91 (range 74-105) out of the approximately 5,000 (range 4,745-5854) annual deliveries in The Bahamas were to an HIV-infected woman. All pregnant women are tested in both the first trimester and for those who are negative, again in the third trimester. All pregnant women with a positive HIV test are referred to the PMH clinic for evaluation and follow-up of their HIV infection throughout their pregnancy and delivery. Triple ARV therapy is recommended for all pregnant women, either as treatment or as prevention of HIV transmission to the baby. An initiative is currently underway that introduces rapid HIV testing in Labour and Delivery to identify HIV infection in women who have not received antenatal care in order to improve access to PMTCT interventions that were not implemented prior to onset of labour. After delivery, both mother and baby continue to be followed up together. As in the adult clinic, intensive support services and adherence counselling are often critical to assisting patients to self manage their care and adhere to treatment; and where required, home-based Directly Observed Therapy (DOT) is provided by public health nurses, social workers and volunteers.

3.1.7.3 PMH Paediatric Clinic

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

In 2013, 63 HIV-infected children under the age of 15 were known to be living in The Bahamas. Approximately 43 HIV-infected children are enrolled in care with the NAP. HIV-infected adolescent patients 15 years and older are 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 through the AIDS Foundation for positive adolescents and their siblings to build community and help them address the challenges associated with being an HIV positive teenager, to help them learn to effectively manage their disease, and to improve adherence to treatment.

The Suspected Child Abuse and Neglect (SCAN) Unit, under the Department of Public Health sees all adolescents or children in whom sexual molestation is suspected. HIV testing and counselling is part of the standard evaluation in these cases.

3.1.7.4 Princess Margaret Hospital inpatient infectious diseases services

The Princess Margaret Hospital has two inpatient Infectious Diseases wards serving adult men and women with HIV and other infectious diseases, with bed capacities of 20 and 13, respectively.

Inpatient care for children with HIV and AIDS is provided on the general paediatrics unit at PMH. The number of inpatient hospitalizations for HIV-related conditions among children has decreased dramatically, with admission for management of drug regimens or development of an opportunistic infection or disease. Today, care for children with HIV is almost entirely provided through the outpatient clinic setting.

3.1.7.5 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 medical house staff. Patients requiring inpatient care may be admitted to RMH or transferred to PMH if ongoing specialist care is required. As in PMH, adult patients not receiving ARV therapies receive routine follow-up visits for evaluation and management of their HIV infection in the absence of other clinical problems. Persons on ARV therapies are seen at regularly scheduled intervals for clinical and laboratory monitoring based on the drug regimen and patient response.

3.1.7.6 HIV and AIDS care in the prison system

There is one incarceration facility in The Bahamas with an inmate population of approximately 1,500. All new inmates are provided with PITC as part of the intake medical evaluation. In the initial seroprevalence survey of prison inmates conducted in 1992, 10 percent of the prison population were found to be infected with HIV but there were very few with symptomatic disease. (Dahl-Regis, 2010) Current screening on all intake prisoners reveals a prevalence of approximately 2 percent. Routine care for common illnesses and complaints is handled in the prison sick bay, which has full time physicians and nurses. Inmates needing care for HIV and AIDS are seen by a specialist visiting the Prison Clinic, who initiates ARV treatments when indicated. In 2013 routine HIV Rapid Test methodology was initiated and currently all persons on remand are tested for HIV with informed consent which has resulted in the timely identification of persons with HIV infection and subsequent entry into care. Blood specimens are transported to the HIV Reference Laboratories for additional testing if necessary (DNA PCR testing) and for evaluation laboratory testing (CD4 and viral load). Most of the HIV care needed by inmates is now provided on site at the prison. Prisoners requiring inpatient HIV and AIDS care are taken to the PMH hospital for clinical management.

3.1.7.7 National Tuberculosis Control Programme

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

The National HIV/AIDS Programme works closely with the National Tuberculosis Programme (NTP). The prevalence of TB in The Bahamas increased modestly in the years 1997 to 2000 before dropping in 2005. In 2013, the percentage of individuals newly diagnosed with TB who are co-infected with HIV remain at just less than 50%, but it is important to note that this number is small at just 10 individuals.

The activities of the NTP include investigation 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 provision of directly observed therapy (DOT) . All patients newly diagnosed with HIV infection are screened for TB and vice versa. It is the standard of care to administer combination antiretroviral therapy to all persons co-infected with HIV and TB. All suspected cases of active TB are hospitalized on the Infectious Diseases ward at PMH or the Rand Memorial Hospital for additional laboratory investigation and treatment. Clients on both TB and ARV medications receive DOT for the duration of the TB treatment to ensure compliance with both classes of medication.

In 2013, 10 TB patients were found to be co-infected with HIV. Among co-infected cases, 2 patients diagnosed with TB and HIV expired, one patient was diagnosed with TB and HIV disease and departed the country immediately after diagnosis and one patient absconded from the hospital and could not be located. Of the remaining patients diagnosed with TB, 5 (50%) received TB treatment and ARV therapy

during that year (Table 5). The number of TB/HIV co-infected cases has declined since 2006, when 32 co-infected cases were reported. However, the percentage of co-infected cases has remained relatively constant.

	HIV/TB Cases on Treatment	All HIV/TB Cases	%
Male	2	4	50%
Female	3	6	50%
Under 15	0	0	--
15 and older	5	10	50%
Total	5	10	50%

Data were cross-referenced from the TB patient registers with the HIV and AIDS ARV patient registers. This denominator is an actual rather than an estimated number. Due to the health seeking behaviours of the population, persons with ill health seek medical attention. In addition, persons with HIV and TB who do not seek medical attention are more likely to succumb to their illness and would be identified and captured in this manner. One patient who did not receive ARVs was diagnosed with HIV while hospitalized for TB infection and departed the country immediately after HIV diagnosis.

Table 5: Percentage of HIV-positive incident TB cases that received treatment for both TB and HIV, 2013 (Indicator 5.1)

The NTP continues to be challenged by migrants who travel to their country of birth during the course of their treatment which may result in interruption of therapy for TB as well as for HIV and by illegal migrants who are diagnosed and repatriated at the beginning of their course of treatment. The NTP continues to explore mechanisms to improve transfer of patients between the two countries which will result in more favourable outcomes.

The need to prevent TB disease in persons with HIV in the first instance is crucial to decreasing deaths from TB-HIV co-infection. The NAP and the TB Control Programme are working together to increase the number of persons screened for TB infection, and the number with TB infection who complete a course of preventive therapy to prevent subsequent TB disease.

3.1.7.8 Sexually Transmitted Infections Unit

There is one Sexually Transmitted Infections (STI) Unit located in Nassau. The STI clinic serves as a referral centre for individuals with known or suspected STIs and as a walk-in clinic for individuals presenting with complaints. On average, 80 patients per week are seen in the STI clinic. Patients are given a physical exam, and associated diagnostic laboratory tests including an HIV test, with consent. Treatment is provided and patients are given a follow-up clinic appointment to return for their HIV test result. All persons with positive HIV test results are referred to the appropriate PMH Infectious Diseases Clinic for follow-up and evaluation. Every effort is made to trace the contacts of infected clients and encourage them to get tested.

The STI Unit also participates in prevention education activities and community outreach events. Physicians give lectures in the community as part of overall HIV outreach efforts.

3.1.7.9 Substance abuse and mental health services

The Public Hospitals Authority is the main provider 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) offers outpatient individual and group services. The inpatient Dyah Ward at the Rand Memorial Hospital provides mental health services in Grand Bahama. More limited mental health counselling services are available on the other larger islands through the Primary Health Clinics of the Department of Public Health. Utilization of drug treatment services at the CCAC has been on the increase, with the largest numbers seen for marijuana, alcohol, and poly drug use. There has also been a pattern of increasing cocaine use since 1996. Injection drug use has not been reported in The Bahamas.

Persons receiving HIV and AIDS care through the PMH Infectious Diseases Follow-up Clinic are referred to these two mental health facilities for additional drug treatment services as needed. More limited counselling support services are provided within the Infectious Diseases Follow-up Clinic by the social worker and community volunteer from the Samaritan Ministries.

3.1.7.10 Hospice services

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

3.1.7.10 Antiretroviral therapy

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

To increase longevity and quality of life among HIV patients, the NAP and the National HIV Centre placed access to ARV therapy as a major priority beginning in 2002. The Government of Bahamas committed to providing antiretroviral therapy (ART) to all eligible HIV-infected persons in the country, regardless of immigration status, at no cost to the clients. This includes patients in both the public and private sectors. Universal access to ART is due, in large part, to increased availability and affordability of ARV medications. The Clinton Foundation was instrumental in negotiating lower prices and a secure supply of required medications. The Bahamas also serves as a resource centre for other Caribbean countries, including

Antigua, Belize, St. Kitts and Nevis, and the Turks and Caicos Islands, providing expertise and assistance with medication acquisition, when required.

The Bahamas has adopted regional guidelines and protocols for the prescribing of ART for antenatal, paediatric and adult clients, including protocols for TB co-infections. At this time, The Bahamas recommends ARV therapy for persons with CD4 counts less than 350, as well as for all HIV-infected children less than 12 months of age. By the end of this reporting period in 2013, approximately 60% percent of all persons estimated to be medically eligible for ARVs were documented to be on treatment (Table 6). The 2014 UNAIDS GARPR saw a change in the method to calculate the percentage of persons receiving ARVs, which is now based on the total number of persons living with HIV, as opposed to previous years when it was based on the number of persons estimated to be eligible for therapy. For this reason, the new calculation cannot be compared to previous years. At the end of the reporting period in 2013, approximately 30% of all persons infected with HIV were on antiretroviral therapy (Table 6). There were 49 children <15 years of age living with HIV in the Bahamas in 2013. Among these children, 5 had defaulted, 3 commenced treatment in 2013, and 39 had already begun treatment prior to 2013.

	Cases on ARVs*	Estimated number of persons eligible for ARVs[ŧ]	% eligible persons on ARVs	Estimated number of adults and children living with HIV[ŧ]	% HIV infected on ARVs overall
Male	1047	1877	55.8%	3984	26.3%
Female	1160	1834	63.2%	3568	32.5%
Unknown Gender	48				
Under 15	49	88	55.7%	103	47.5%
15 and older	1941	3623	53.6%	7449	26.0%
Unknown Age	265				
Total	2255	3711	60.7%	7552	29.9%

Source: *National HIV Centre Pharmacy Data, 2013

[ŧ]Spectrum Estimate

Table 6: Percentage of eligible adults and children currently receiving ARV therapy at the end of 2013 (Indicator4.1)

Overall, the majority (51%) of persons initiating treatment in 2012 were still considered to be on treatment a year after starting (Table 7). However, challenges in data collection for private physicians may cause the true number of people maintaining consistent drug pickups from the NAC pharmacy to be underestimated.

The use of a digital data management system instituted in 2011 and refined in 2012 to document ART dispensing and drug management has improved the capacity of the Progamme to monitor the dispensing of ARVs and adherence data.

	Number on Treatment after 12 months	Number Initiating Treatment	Result
Male	16	31	51.6%
Female	17	30	56.7%
Under 15	2	2	100%
15 and older	30	56	53.6%
Total	33	65	50.8%

Two persons started on ARV, one of whom continued on ARV, of unknown gender.

Source: National HIV Centre Pharmacy Data, 2012 and 2013

Table 7: Percentage of adults and children with HIV starting treatment in 2012 and completing at least 12 months of ARV therapy (Indicator 4.2)

The challenges to providing universal access to ART include insufficient human resources and infrastructure to adequately provide care and follow-up, fear of stigma and discrimination, lack of knowledge among HIV-infected people on the need for consistent treatment, and the difficulty in tracing members of immigrant and migrating populations who default on treatment.

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

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

The decentralization strategy also calls for the integration of HIV and AIDS services into the primary level of care within clinics throughout the country. HIV rapid testing, pharmacy services and ancillary support services are scheduled to be included in services offered in four polyclinics, the Adolescent Health Clinic and the Prison Clinic, with an appropriate sub-set of services delivered through smaller Family Island clinics. Comprehensive services are anticipated to be available at planned mini-hospitals in the Family Islands when fully operational. Currently, voluntary counselling and testing is available in every main and polyclinic countrywide and ongoing care and treatment are available at a growing number of clinics and HIV clients chose to attend clinic services at facilities closer to their residence.

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

3.2 Knowledge and behaviour change

3.2.1 Target 1: Halve sexual transmission of HIV by 2015

Since its inception, the NAP has focused efforts on HIV and AIDS information, education and communication to prevent HIV-infections and reduce stigma and discrimination. As the epidemic progressed, the HIV/AIDS Programme focussed on addressing risky behaviour through behaviour change communication and public awareness campaigns. More recently the HIV prevention programme has targeted at-risk populations, particularly teenagers and young adults, as this population has the highest incidence of new cases. (Ministry of Health, 2013) Also targeted in the at-risk population are men-who-have-sex-with-men, sex workers, and Haitian immigrants. Efforts aimed at educating the population through prevention education related activities are coordinated by the National HIV/AIDS Centre Prevention Education Unit. HIV and AIDS educational programmes draw on the expertise of volunteers and persons in non-governmental organizations, and have been successful in making the public aware of the threat of HIV and AIDS. The Community Outreach Coordinator assists in aligning programme goals and targets with appropriate outreach activities. Increased access and utilization of non-traditional testing locations are expected to result in greater referrals to treatment, care and support for persons newly identified with HIV infection. Media events and social marketing have expanded the mediums in which prevention messages are being distributed, including the use of murals painted on buildings with high visibility that provide HIV prevention messages.

3.2.2 General Population

The Bahamas continues to work to reach the target of reducing new HIV infections by fifty percent through activities described previously in this report. Between 2003 and 2012, the number of newly reported HIV cases in the Bahamas decreased by 34% from 447 cases in 2003 to 293 cases in 2012; however, the number of newly diagnosed infections among 15-24 year olds increased by 30% between 2006 and 2012. Many of these public health activities include targeting persons whose behaviours put them at risk for infection; particularly youth aged 15-24. To ensure efficacy in this area, the Ministry of Health continues to seek ways

to understand trends in sexual behaviour as well as knowledge, perceptions and attitudes about HIV/AIDS among young people.

The Bahamas remained challenged in conducting population-based Knowledge, Attitudes, Practices and Belief surveys due to the economic and human resource constraints that have existed, particularly since 2008. The Ministry of Health is currently exploring alternative methods with which to conduct surveys, beyond the traditional face-to-face methods of the past. Currently, some information regarding knowledge and attitudes is collected via the Focus on Youth Programme; however it is only applicable to students aged 15-17 years. The Programme is expanding to capture some data from out-of-school youth as well.

Persons between 15 and 24 are estimated to constitute around 17% of persons reported to be living with HIV/AIDS in the Bahamas. However, overall population rates for this age group may be difficult to accurately quantify. Since HIV transmission is largely heterosexual in the Bahamas, antenatal clinic data from both Grand Bahama and New Providence have been used to approximate the percentage of young persons living with HIV, as approximately 85% of the population resides in these two urban centres. Based on these data, approximately 0.9% of young persons who were living in the Bahamas in 2013 were HIV positive (Table 8). This estimate may be biased due to lack of testing and/or reporting by remote clinics; however, 99% of clients come to New Providence or Grand Bahama for delivery and are tested at delivery if no information is available regarding HIV status at the time of presentation. This may contributes to the accuracy of this proxy in estimating the percentage of 15-24 year olds infected with HIV in The Bahamas.

HIV positive ANC females	16
Total ANC females screened	1,789
Result	0.9%

Data are based on public health clinics From Grand Bahama and New Providence reporting 2013 data only.

Table 8: Percentage of antenatal clinic attendees 15-24 years old testing positive for HIV, 2013 (Indicator 1.6)

3.2.3 Focus on Youth

The Focus on Youth (FOY) HIV and AIDS education comprehensive life skills programme within the Ministry of Education's Health and Family Life Education (HFLE) curriculum was implemented in 1998. Focus on Youth is a collaborative project between researchers from the United States (US) and the Ministries of Health and of Education in The Bahamas. It involves the development, adaptation and evaluation of interventions targeting youth to prevent and reduce HIV risk behaviours. Focus on Youth was based on the US adolescent HIV prevention programs, "Focus on Kids" and a parental monitoring

program "Informed Parents and Children Together" (ImPACT), which had been effective in reducing adolescent risk behaviour. Focus on Kids and ImPACT are currently part of the Centers for Disease Control and Prevention's "Diffusion of Effective Behavioural Interventions (DEBI)" Portfolio.

The goal of the Bahamian FOY programme was to reach youth before the onset of sexual risk behaviour. Early research estimated that 30% of youths 13-15 years of age were sexually experienced and this rate increased to 57% for youth 16 years and older (National Institutes of Health, 2008). This resulted in the adaptation of FOY and ImPACT for pre-adolescents in the sixth grade (average age 10 years). The US-Bahamian research team recommended that the curriculum be administered at the sixth grade level because this would reach the majority of Bahamian youth *before* involvement in sexual activity. The US-Bahamian research team evaluated the Bahamian adaptations of Focus on Kids which was a 10-session adolescent HIV prevention program entitled "Focus on Youth in The Caribbean" (FOYC) and the 1-hour adapted parental monitoring intervention entitled "Caribbean Informed Parents and Children Together". (CImPACT). These adapted programs were evaluated through a randomized, controlled trial involving 1,360 six grade youth and 1,175 of their parents.

Description of Focus on Youth and Development of FOYC

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

FOYC youth showed significant improvements in most of the categories of knowledge, condom-use skills, perceptions and intentions regarding condoms and condom use behaviour compared to youth receiving the control condition. Although condom use behaviour only reached statistical significance at the 36 month follow-up, the trend was present earlier even though the rates of sexual activity were low.

Thirty-six month evaluation of 81% of the original participants demonstrated strong self-efficacy in the use of condoms in youth who had participated in FOYC, particularly when their parents had participated in CImPACT also. Children from the FOYC program had higher condom use rates (44.9%) as compared to the control group 31.5%. The authors noted that these results are important because they support the

theory that interventions introduced prior to sexual initiation can result in consistent increases in condom use (Chen, et al., 2010).

An adapted version of FOYC and CImPACT was delivered and evaluated through a randomized controlled trial to approximately 2,500 high school students from eight government high schools in New Providence. A subset of this current cohort (598) was previously enrolled in the grade six evaluation of FOYC. Analyses from this subset demonstrate sustained intervention effects on knowledge, condom-use skills and self efficacy four years later. Further analyses 60 months post the initial intervention in grade 6 and 12 month post the intervention in grade 10 showed that youth who received both interventions had the greatest increase in condom-use skills. Youth who received FOYC in grade 6 only had the greater score in knowledge and intention. The results suggest that youth received the most protection with early and repeated exposure to HIV risk reduction interventions (Dinaj-Koci, 2013).

One of the greatest challenges to FOYC is the sustainability of this life-skill-based intervention despite the success of the student and parent components. Concerned that the intervention was not sustained following the research, the Bahamian and US researchers once again partnered in 2011/12 to explore the fidelity of implementation of FOYC and CImPACT. This study assessed the environment in which FOYC was to be sustained (i.e., initial workshop or training atmosphere for teachers, support from school administrators, perceived value of the intervention by teachers, actual implementation of FOYC etc.) This research that is in its 3rd year, included 163 grade 6 teachers and 78 school administrators through the islands of the Bahamas. Approximately 3,000 students completed the baseline and 6-month follow-up. The strongest predictor of implementation fidelity was teacher comfort level with the FOYC curriculum. Teachers who did not perceive the FOYC intervention to be important for their students or who had attended only part of a FOYC training workshop were more likely to change the curriculum. Increased duration of experience as a teacher (>10 years) was negatively associated with fidelity of implementation. Teacher's perception of the importance of the FOYC intervention and implementation fidelity had direct positive effects on students' HIV/AIDS knowledge, reproductive health skills, protective intentions and self-efficacy. Youth did not appear to benefit from FOYC if two or fewer sessions were delivered. (Wang B, 2012) 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/AIDS prevention education aimed at tourists and tourism workers is an ongoing activity through the Ministry of Tourism in cooperation with major hotels and their staff. Plans were approved in 2011 to develop in-house capacity to produce digital mass media productions for both radio and television to increase prevention messaging capacity and scale-up mass media campaigns. This initiative is scheduled to commence in mid-2012.

3.2.4 Youth Ambassadors for Positive Living

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

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

3.2.5 Most-at-risk populations

Programmes and information targeting specifically hard-to-reach groups have been limited by the difficulty in reaching these groups. Some programming and information for Creole-speaking persons has been developed and delivered through Creole-speaking staff and faith-based community leaders. Public health nurses and volunteers routinely distribute condoms and informational materials at public events throughout The Bahamas. Sex Workers have been targeted for increased prevention education activities through a partnership with the Urban Renewal Programme in at-risk neighbourhoods.

3.2.5.1 Sex Workers

Data collected on commercial sex work in the Bahamas are very sparse, and do not answer the indicators required by this report. However, inroads have been made in the SW (sex worker) community by a formalized programme for HIV prevention for sex workers which has been established by Bahamas Urban Youth Development Centre, in cooperation with the National HIV/AIDS Centre. In partnership with World Learning though a grant funded by PEPFAR/USAID, BUYDC has implemented an HIV/AIDS Prevention Education Project called "Advancement for Health" targeting female sex workers (FSW) one of the groups identified by UNAIDS as Most at Risk Population (MAPRs). Advancement for Health (A4H) will serve 180 female sex workers (ages 17-35) in New Providence and Grand Bahama over a three years period, focusing on HIV/AIDS Prevention Education and Life skills training. The program is designed to help FSWs develop condom negotiation and self efficacy skills needed to negotiate condom use during every sexual encounter. The goal of A4H is to make participants aware of the importance of consistent condom use; regular HIV testing and STI screenings; effective condom negotiation, budgeting & money management skills and job readiness skills. The Centre's role is to support testing and education of persons involved in sex work. Commercial sex work is illegal in the Bahamas, and to date, no formal studies have been conducted in this population. However, anecdotal data indicate that SW are able to access HIV testing

and prevention materials (barrier protection with both male and female condoms) through government-sponsored programmes. Also, the Bahamas PEPFAR Co Ag currently supports outreach efforts by the HIV Centre which target sex workers.

3.2.5.2 Men who have Sex with Men

The HIV/AIDS Centre continues to make progress in establishing more formalized prevention activities among MSM in The Bahamas. The Ministry of Health, with the assistance of NASTAD, under the PEPFAR CoAg is preparing to begin a biobehavioural survey among men-who-have-sex-with-men (MSM) which is expected to collect not only prevalence data regarding HIV infections among this population, but also to further define local customs that contribute to risk and the transmission of HIV in The Bahamas.

3.2.5.3 Intravenous drug users

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

There is no evidence to suggest that injection drug use in the Bahamas is a major problem. To date, injection drug use has been rarely reported among HIV cases, and the Bahamas National Drug Council has not noted injection drug use among their drug-using populations. Early programme data did suggest that non-injecting drug (crack cocaine) use did play a role in the HIV epidemic as persons were engaging in high risk behaviours which included having sex with multiple partners (Ministry of Health, 2001) In the 1980's approximately 30% of persons with AIDS used cocaine. Recent data regarding the percentage of persons with AIDS who use cocaine is not available.

3.3 Improving quality of life: impact alleviation

3.3.1 Advocacy, public policy, and legal framework

3.3.1.1 Advocacy

The Bahamas has been a leader in advocacy for persons infected and affected by HIV. Public policy advocacy has been undertaken by agencies and organizations such as the National AIDS Programme, the Bahamas AIDS Foundation, and the Samaritan Ministries. Through their networks, these organizations work to increase awareness of issues of stigma and discrimination and promote access to treatment and care. However, stigma and discrimination remain significant barriers to the participation of persons living with HIV and AIDS (PLWHA) in public advocacy efforts.

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. Recent qualitative research conducted by Brown, Bailey and Tureski (2012) found that stigma and discrimination were present with respect to persons living with HIV and AIDS, as well as for persons from most-at-risk populations (MARP) such as men-who-have-sex-with-men (MSM) and sex workers (SW). (Brown A., 2012) These were evidenced by gossip, jokes about persons' HIV status, and negative comments as reported by health facility staff and social service organizations staff who participated in the study.

The Bahamas remains challenged by stigma and discrimination, particularly with MSM, as this is not socially accepted within this community. This is further fueled by a conservative religious community. Sex work (prostitution) is illegal in The Bahamas, which also increases stigma and discrimination associated with this population.

The Government has made attempts through Policy and advocacy to protect persons against HIV, specifically through the revision of the Sexual Offenses and Domestic Violence Act of 1991. The Bahamas has also taken on the sensitive issue of domestic violence, although much remains to be done. In 2008, The Bahamas enacted the Domestic violence (Protections Orders) Act which provides for a person to apply for a Protection Order against someone who has threatened domestic violence or attempted domestic violence against that person. The newly drafted National Policy for Gender Equality is expected to be completed in 2014 and provides a framework for guidelines, strategies and objectives designed to positively impact both women and men and promote social justice and equity, facilitate respect and tolerance between women and men and transform structures of inequalities.

There is currently no data available to inform the true amount of domestic violence which is occurring in The Bahamas, as much of it is not reported. Data that is available through the Royal Bahamas Police Force is limited.

3.3.1.2 Public policy and legal framework

From the inception of the AIDS epidemic, The Bahamas developed several key policies and pieces of legislation which were instrumental in allowing The Bahamas to successfully mount an effective response to the problem of HIV and AIDS. As a direct result of the support of key governmental officials and lawmakers the following were instituted:

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

The Ministry of Education has adopted specific policies to protect HIV-infected children from discrimination and to protect their confidentiality as it relates to play and sport:

- The HIV or AIDS infected student/athlete participation in sports and other recreational activity has not to date presented sufficiently clear indications that such practices expose others to the infection;
- The HIV or AIDS infected student/athlete has a right to confidentiality and thus his/her medical condition in this instance need not be placed on general medical records in the school.

The Sexual Offences and Domestic Violence Act includes a provision that makes it a criminal offence for a HIV-infected person to engage in sexual intercourse with another person without disclosing his or her status. To-date, no one has been prosecuted under this provision.

3.3.1 Travel Restrictions

The Bahamas does have a law that speaks to persons having a communicable disease in the Immigration Act in section 22E; however The Bahamas does not actively enforce this Act nor impose HIV-related travel restrictions on entry, stay or residence.

3.3.2 Strengthen integration of the AIDS response in global health and development

3.3.3.1 Current school attendance among orphans and non-orphans aged 10-14 years

The Bahamas promotes education amongst all residents and has a strong history of school attendance since the Government made school attendance mandatory for all Bahamians between the ages of 5 and 16 years in 1962. The overall attendance rate at schools has been reported in previous renditions of the United Nations Millennium Development Goals Report where it should be noted that attendance rates of greater than 90% in primary schools. While this does not reflect the difference in attendance between orphans and non-orphans, it does argue that school attendance in general is high. Discussions continue with the Ministry of Education to identify data collection methods to capture the data for further analysis and reporting.

3.3.3.2 Proportion of the poorest households who received external economic support in the last 3 months

The Bahamas does not have current data to inform the proportion of persons in the lowest quintile who are receiving some form of economic support. The Department of Statistics performs semi-annual economic and labour surveys. Discussions between the Department and the Ministry of Health have been initiated and are expected to provide a method for data capture using existing survey processes in the Department.

4 Best Practices

In The Bahamas capacity building exercises have improved knowledge and increased the ability to provide treatment, care and support. Exercises in HIV Rapid Testing training and deployment of rapid testing to appropriate sites have increased access to timely identification of new HIV cases and allowed improved referral for treatment and care. This being said, the country is not without challenges that impede progress toward reaching targets and goals.. The following summary describes key lessons learned in the past and highlights best practices that have become successes of the programme in the face of serious financial, human and infrastructural constraints.

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

The political will and commitment of The Government of The Bahamas has contributed to the success of the programme. In spite of the economic downturn of 2008 and the continued recession, the Government has continued its commitment to fund the programme through successive governments. Effective

leadership is required to mobilize all stakeholders in the process. The time and effort required providing this leadership in coordinating and mobilizing resources and partners is considerable.

Best Practices:

The Bahamas HIV/AIDS Program has shown that it can be effective in engaging and securing the support of the Government through education on the impact of HIV and AIDS.

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

Once the costs of a response initiative have been identified, it is critical to immediately begin efforts to secure financing to address any gaps. In a similar vein, it is also important to consider the impact of the strategy on human resource requirements and the effort and time required to recruit, contract and train healthcare professionals and programme management staff. This process should begin as soon as possible, as delays in acquiring the required human resources will lead to delays in achieving scale-up goals. The Ministry of Health has used the introduction of new positions initially financed through the PEPFAR CoAg that have subsequently been transitioned into more permanent positions within the Ministry for continued sustainability and capacity building through transfer of knowledge.

Best Practices:

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

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

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

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

As well, strengthening human resources and infrastructure for extending access to comprehensive HIV and AIDS care has had a positive impact on parts of the health system. This has been particularly evident in the HIV Reference Laboratory, where building capacity for PCR technology and genotyping will provide

access to this technology in other disciplines, e.g., oncology. This has also resulted in the attainment of Laboratory Certification by the College of American Pathologists in 2013, demonstrating a level of achievement in quality that will benefit the entire health system.

Best Practices:

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

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

The Bahamas has faced significant challenges in its response to HIV and AIDS. These challenges include issues of financial, human and infrastructure constraints, as well as programmatic implementation issues. The Bahamas identified key challenges and constraints during the development of its 2013 Mid-Term Report and these remain relevant at the time this report is being written.

Key challenges and constraints	**Key programmatic actions necessary**	**Policy and enabling environments necessary to stay on track with achievements**	**Recommendations to ensure the implementation of suggested changes**
Minors are unable to access care without the permission of a parent or guardian, including birth control and HIV testing	Implementation of Gilleck Competence as a standard of competence for health care decisions	Develop Health Policy for Minors that includes Gilleck Competence	Strengthen capacity of MOH to take leadership/stewardship role in implementation of changes
Systems issues, including vertical components within the health system, confinement of application of HIV testing methodology to clinicians.	Approval of Rapid HIV Testing Methodology for non-blood specimens; Improve advocacy and public service announcements	Update Health Act/Health Rules	Integration of PMTCT into primary health care system which highlights integration of ARV into ANC programme
Underreporting of domestic and sexual violence	Finalize National Policy for Gender Equity	Develop interventions for gender equity and empowerment	Approval by Cabinet & Parliament of National Policy for Gender Equity; Strengthen Focus on Youth Programme
Continued need for education and training of health professionals; Training and capacity building to include partner agencies and governmental agencies	Development of Human Resource Development (HRD) Plan with clear targets	Review of annual Work Plans linked to Annual Budget	Identification of all necessary HRD components with associated HRD Plan for Implementation
Need to align model of care between health system partners (MOH/DPH/PHA and private sector)	Identify gaps in information systems and databases Continue plans to acquire an integrated information system	Alignment of all health services & health information systems under a single umbrella	National Health Insurance Plan for sustainability

Key challenges and constraints	Key programmatic actions necessary	Policy and enabling environments necessary to stay on track with achievements	Recommendations to ensure the implementation of suggested changes
Improve M&E implementation across programmes	Finalize M&E Plan	Introduction of data for decision-making (DFDM) within all programmes	Improved M&E across programmes with clear data flow plan for collection & review by key partners & stakeholders

6 Support from country's development partners

Small island nations and developing countries will always be challenged by sustainable funding. The Government of The Bahamas recognizes the need to identify funding for all health initiatives, including the National AIDS Programme

While the Bahamas Government is striving to maintain its current commitments and new private sector, non-governmental and international donors are continuously being sought, the strategy for achieving the goals and objectives of the NASP will require additional funds sustained over the longer term. One of the most significant challenges The Bahamas faces is its designation as a high income country. As a result, The Bahamas is frequently excluded from many international donor funds because of its GDP. For the most part, sustained commitment by donors has been the result of long-standing relationships built by the members of the NAP as it carried out its mission within The Bahamas.

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

7 Monitoring and evaluation environment

7.1 The National M&E framework

HIV and AIDS monitoring and evaluation activities were traditionally coordinated through the HIV/AIDS Centre in cooperation with the National Health Information and Research Unit (NHIRU) in the Ministry of Health. While the HIV/AIDS Centre and NHIRU maintained a data store of indicators collected largely through surveillance and surveys of the HIV and AIDS disease and the impact of the response within the country, a formal framework for monitoring and evaluation had been a challenge to a system that lacked sufficient numbers of persons dedicated to an M&E programme. These indicators were used for an evidence-based approach to developing strategies and planning programmes. Monitoring and evaluation activities among the various units of the Centre were supported by epidemiological and statistical expertise and resources from the National Health Information and Research Unit.

Since 2011, through the MOH/CDC CRO CoAg, the Ministry now has an Epidemiologist and a Monitoring and Evaluation Specialist working with the National HIV/AIDS Centre to assist with surveillance, monitoring and evaluation and strategic information activities. The presence of these two professionals has increased capacity within the Ministry for characterizing the epidemic and monitoring and evaluating

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

7.2 Challenges of one national M&E system

During the past two years (2012-2013), The Bahamas has developed a draft framework for monitoring and evaluation which will be put forward for discussion, revision and approval in 2014. Data collected from various sources and methodologies have not been well-integrated into a single set of approved core indicators. The development of a single set of core indicators and minimum data sets will enhance the national capacity to monitor and evaluate the National AIDS Programme from a national perspective

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

Under the MOH/CDC CRO CoAg, the development of a comprehensive patient information system (IS) has been highlighted with project oversight being given by parties from the Ministry of Health as well as the Public Hospitals Authority. This IS will be designed to address information needs across the continuum of care (and between public sector health agencies) and provide data to address indicators for monitoring and evaluation and to characterize the HIV epidemic in a timelier manner.

7.3 Remedial Actions to address the challenges

The M&E Unit in the Strategic Planning Unit of the MOH/PEPFAR (Bahamas) Office has begun the process of developing a comprehensive M&E programme for HIV and AIDS. The M&E Specialist began the process with a desktop review of the current state of M&E activities within the NAP. One of the key gaps that was identified was the need to build capacity within the health sector in M&E and surveillance. This has resulted in the development of training programmes to address these needs in both the public sector and within civil society. The trainings programmes in both M&E and surveillance commenced in 2013 and are scheduled to be ongoing through 2015. This capacity building is expected to produce human resources capable of applying M&E knowledge and activities to their daily work schedules and to produce reports for dissemination and use in decision-making and planning.

The M&E Specialist is also charged with developing an M&E Plan for the NAP which includes both public and private, as well as civil society partners. The presentation of the framework for this plan is scheduled for 2014, at which time key partners will provide input, assist in the development of the final indicators, and provide validation of the plan prior to its submission to the National AIDS Advisory Committee for final approval and implementation. The National HIV M&E Plan is reliant upon participation from all partners in the "One M&E System" to support data sharing and programme reports top inform decision-making.

7.3 M&E technical assistance and capacity-building

The Bahamas has a relatively new M&E programme and as such, is working with key partners to obtain the technical assistance to train adequate numbers of the workforce in M&E and Surveillance techniques. Through the MOH/CDC CRO CoAg, The Bahamas is partnering with CHART to provide technical assistance in M&E training and capacity-building.

Capacity-building is expected to continue over the life of the Cooperative Agreement. During this time MOH anticipates the development of a cadre of staff capable of sustaining the M&E programme into the future by continuing the work of M&E and providing continued training and mentoring to the health sector.

Annex 1: Consultation Process for Preparation of Report

1. Describe the process used for NCPI data gathering and validation:

   The Ministry of Health, in cooperation with the National AIDS Programme, compiled the necessary documentation to inform a desk review by all participants and published the documents on a shared website. Participants were then invited to participate in the desk review prior to the application of the survey. The members of the M&E Unit in the MOH/PEPFAR (Bahamas) Office consulted and interviewed or procured completed survey instruments from national government agencies (including Ministry of Health and the Department of Public Health, the Ministry of Education, National Insurance Board, and the Attorney General's Office) and civil society representatives (such as the Bahamas AIDS Foundation and members of the AIDS Resource Committee, i.e. the Red Cross, Bahamas Urban Youth Development, SASH, HOPHAS, World Learning, Crisis Centre and BNN+), and UN organizations (PAHO/WHO) to inform this report. This information was then collated and analysed for further discussion, clarification and validation.

2. Describe the process used for resolving disagreements, if any, with respect to responses to specific questions:

   The Ministry of Health compiled the responses for the NCPI for both Part A and Part B. The Ministry then sponsored a one-day consultation and validation meeting for all participants. The participant worked in groups during the morning session, where clarification was made for some responses and when differences of opinion occurred, further consulted participants to clarify their response and discuss the issue in order to obtain consensus for the report. The afternoon was spent in discussion of the findings, comparing and contrasting the findings between the government sector and civil society and finished with a validation of the results by the participants.

3. Highlight concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):

   The survey format is extensive and obtaining agreement for participation for such an instrument is difficult in a small island nation where persons have multiple areas of responsibility and even shared leadership positions in both the public sector and civil society. The provision of an electronic format for data capture would facilitate the process and improve the subsequent data analysis phase as well. The quality of the data may be affected by the small numbers of

participants, however, it is still representative based on the consultative process which took place during the validation phase.

Annex 2: National Composite Policy Index

NCPI Summary – The Bahamas

Part A

I. Strategic Plan

The Bahamas has followed a multisectoral strategy to respond to HIV and AIDS since its introduction into this country in the early 1980's. The most current strategic plan encompasses 2007-2015 and is nearing the end of its cycle. Most participants acknowledged that they were not involved at the beginning of the cycle. The NCPI participants did note the inclusion of a wide variety of government agencies in the plan, but they could not speak to the presence of earmarked budgets. The Ministry of Education has been a collaborative partner since early in the epidemic and their representatives noted that there was no ear-marked budget during this fiscal cycle. The strategy addresses key populations and vulnerable groups, as well as cross-cutting issues such as prisons, schools and workplace. The consensus of the participants was that there was moderate to active involvement of civil society in the development of the strategy, although they acknowledged that this involvement had declined over time. Respondents were not aware of integration of HIV into development plans, and further, were not aware of the presence of the development plans themselves. The respondents noted that operational plans to support the National AIDS Strategic Plan do not include detailed costs for each programmatic area. ON the positive side, the participants do agree that a health systems strengthening strategy is in place. Overall, the NCPI rates planning efforts in the country's NAP as average with key achievements including the testing of all antenatal women for HIV, the reduction in new HIV cases, and the accreditation of the HIV Reference Laboratory, and networking within civil society. Challenges that are still to be resolved include (1) civil society alignment and communication (better communication between the public sector and civil society for planning and coordination), (2) combining/integrating HIV with other programmes (e.g. CNCD), (3) sustainable funding for both public and private sector activities, and (4) capacity building in the National Programme

II. Political Support

Overall, there is above average political support for HIV as noted by respondents. HIV and AIDS was seen as being in the forefront of Health. Participants were divided between the perceived multisectoral AIDS management body responsible for promoting the national HIV and AIDS response as either the AIDS Advisory Committee in the Ministry of Health or the AIDS Resource Committee. The AIDS Resource Committee is a longstanding multisectoral committee that coordinates activities between civil society partners and the National HIV Centre and also provides human resource assistance/volunteers to augment HIV Centre staff at many events. The AIDS Advisory Committee provides guidance to the Government

(Ministry of Health) on a more technical basis. Government officials are recognized as supporting the response by speaking publicly and favourable about national AIDS efforts in both national and international fora. The use of budgetary allocations from the National HIV budget toward civil society activities were viewed as being small, although admittedly largely unknown.

III. Human Rights

The NCPI participants agreed that while there are protections in place for certain populations, there are still gaps with respect to key populations and other vulnerable groups. Obstacles to effective HIV prevention, treatment, care and support remain for some key populations. The discord between policies relating to age of consent and age of treatment continue and participants feel these need to be addressed in order to meet the needs of the adolescent population who have been identified as a high risk population.

IV. Prevention

The NCPI rates policy efforts to support HIV prevention programmes as above average with key achievements including the "Know your status" campaign (as was identified in the previous NCPI report), expanded outreach activities under the PEPFAR Cooperative Agreement, and key messages being specifically promoted to most-at-risk populations and other vulnerable groups, but focus is needed on how to reach the key populations that have been identified. Specific needs for prevention include the conduct of behavioural surveys. Prevention components that need to be strengthened include HIV prevention in the workplace; information, education and communication on stigma and discrimination; risk reduction for intimate partners; risk reduction for men-who-have-sex-with-men; and risk reduction for sex workers. Prevention programmes for the Family Islands are limited, perceived as being due to the expense to travel to the islands to conduct prevention activities. Participants also rated efforts to implements HIV prevention programmes as above average.

V. Treatment, Care and Support

With the exception of a select few components, respondents noted the programme for treatment care and support of persons with HIV was generally present and implemented. Challenges remain in meeting the needs of orphans and vulnerable children. Policies to address issues such as social support and palliative care are necessary. Overall, the NCPI rates efforts to implement a comprehensive package of treatment care and support as above average.

VI. Monitoring and Evaluation

Monitoring and evaluation efforts continue to be seen as an incomplete component of the national HIV and AIDS strategy. While some components of a national system are identified as being in place, a number of gaps were identified by respondents. Overall, the NCPI rated efforts to implement M&E as average, with challenges remaining in areas such as the need to harmonize the M&E Plan with all the partners and to

identify a mechanism for consistent data submission to inform M&E reports (including such areas as private sector and Grand Bahama and the Family Islands). Participants reported challenges with the accuracy of the data (data gaps with validation and verification) and the sustainability of the M&E Plan. The consensus was that a Monitoring and Evaluation Working Group needs to be established and incorporate multisectoral participation, which is presently weak.

Part B

I. Civil Society Participation

The NCPI ranks civil society participation in the involvement of policy, budgeting and programme development as below average. There is consensus that services provided by civil society are included in the national HIV strategy and in the nation HIV reports; however, civil society is not felt to be included in the national HIV budget. The role of civil society in monitoring and evaluating the HIV response was rated below average and note the lack of mechanisms for collaboration between the public sector and civil society. The NCPI does rate the representation of civil society in overall HIV efforts as high, but acknowledges that access to financial support for implementation of activities has been limited while technical support for the planning of these activities is above average. The ability of civil society to execute programmes is weak, resulting in the majority of programmes being executed by government agencies. Challenges to greater involvement include provision of technical support for planning and execution, as well as sustainable funding for civil society programmes. The group perception was that information is provided but planning participation is weak so information flows one way only.

II. Political Support and Leadership

The NCPI rated the government as not involving people living with HIV, key populations and other vulnerable groups in policy design and programme development.

III. Human Rights

The NCPI rates the existence of non-discriminatory laws and regulations that afford protection for specific sub-populations and vulnerable groups as below average. Laws and regulations do exist to protect persons living with HIV and AIDS, as well as those with disabilities, from discrimination in the workplace, however protections for other vulnerable groups, such as men who have sex with men, prison inmates, sex workers and migrant populations are not specifically written. Obstacles to effective HIV prevention, treatment, care and support remain for some key populations. While non-discrimination laws are in effect for persons living with HIV, the enforcement is difficult, as persons have not brought suit in this respect due to continued stigma and discrimination associated with publicizing their HIV status. There is currently no mechanism to record, document and address cases of discrimination experienced by PLWHA, key

populations and other vulnerable groups and there is a lack of monitoring and enforcement of laws and policies that are in place. There is a lack of training for PLWHA and key populations regarding their rights with respect to their HIV disease, but also within the judiciary and law enforcement on HIV and human rights issues. While there is free legal aids, most persons are not aware of it and so do not take advantage of it. The NCPI does note strong support for persons living with HIV with respect to non-discrimination due to ability to pay for services, as The Bahamas has a policy of free services for HIV prevention, antiretroviral treatment and care support interventions.

IV. Prevention

The NCPI rates prevention programmes as average, with the presence of programmes for almost all aspects of HIV. The rate of implementation efforts was scored well above average, with key gaps identified in the areas of information, education and communication on stigma and discrimination and HIV prevention in the workplace and risk reduction programs for intimate partners of key populations, men-who-have-sex-with-men, and sex workers. The major impediments to better prevention programmes include financial and human resources to implement and sustain these efforts. This impediment also impacts the ability to reach rural areas (Family Islands) with adequate prevention programmes.

V. Treatment, Care and Support

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

Annex 3: Bibliography

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