

The Commonwealth of The Bahamas
Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS)

Country Report

April 5, 2006

Final



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Abbreviations

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

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1 Status at a Glance

UNGASS Indicators – Generalized Epidemic		2003 Result	2005 Result	Notes/Comments	Document Reference
National Commitment and Action					
Expenditure					
1	Amount of national funds disbursed by governments in low- and middle-income countries	2003 to 2005 US\$23 million		Includes US\$1.8 million from international and national donors.	Section 3.1
Policy Development and Implementation Status					
2	Percentage of schools with teachers who have been trained in life-skills-based HIV education and who taught it during the last academic year	N/A	N/A	Teachers in 15 schools have been trained in the Focus on Youth HIV life-skills training initiative. Target is to include life-skills-based HIV education in the curriculum for teacher training at the College of The Bahamas by 2008.	Section 3.3
	Percentage of primary and secondary schools where life-skills-based HIV education is taught	N/A	N/A	Focus on Youth Initiative is currently being piloted in with 15 schools in New Providence. Target is to include the Focus on Youth programme in the grade six curriculum in all schools by 2008.	Section 3.3
	Percentage of large enterprises/companies that have HIV/AIDS workplace policies and programmes	N/A	N/A		N/A
	Percentage of women and men with sexually transmitted infections at health-care facilities who are appropriately diagnosed, treated and counselled	N/A	N/A	STI diagnosis, treatment and care are centralized at a single clinic in New Providence for referrals and walk-ins. VCT is available to all STI clients and HIV-infected clients are referred to the HIV Clinic.	Section 3.4.6
	Percentage of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission	83%	71%	All antenatal women have access to VCT, and 100% of HIV-infected antenatal clients are eligible to receive antiretroviral prophylaxis. Percentage of clients <i>not</i> receiving treatment fluctuates by year and is due to: a) treatment refusal, b) not seeking antenatal care, or c) delivery/miscarriage/intrauterine death before delivery.	Section 3.2.2
	Percentage of people with advanced HIV infection receiving antiretroviral combination therapy	N/A	N/A	At the end of 2005, 1,880 individuals were receiving ART, including antenatal mothers and newborns (see above) and 100% of paediatric HIV clients received antiretroviral therapy. The HIV/AIDS Centre estimates that roughly 60% of eligible adults are currently receiving ART.	Section 3.4.9

UNGASS Indicators – Generalized Epidemic		2003 Result	2005 Result	Notes/Comments	Document Reference
	Percentage of health facilities with the capacity to deliver appropriate care to people living with HIV and AIDS	N/A	N/A	Currently all HIV care delivered through centralized clinics in New Providence and Grand Bahamas. An initiative to de-centralize and integrate HIV/AIDS services into the primary level of care is currently in progress.	Section 3.4.10
	Percentage of orphaned and vulnerable children whose households received free basic external support in caring for the child.	N/A	N/A		N/A
	Percentage of transfused blood units screened for HIV	100%	100%	All blood products have been subject to screening since 1985.	Section 3.2.3
Knowledge and Behaviour¹					
	Percentage of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	N/A	N/A		N/A
	Percentage of young women and men who have had sex before the age of 15	N/A	N/A		N/A
	Percentage of young women and men aged 15–24 who have had sex with a non-marital, non-cohabitating partner in the last 12 months	N/A	N/A		N/A
	Percentage of young people aged 15–24 reporting the use of a condom during sexual intercourse with a non-regular sex partner	N/A	N/A		N/A
	Ratio of current school attendance among orphans to that among non-orphans aged 10–14	N/A	N/A		N/A
	Percentage of children aged less than 15 years who are orphans	N/A	N/A		N/A
	Percentage of young people aged 15–24 who are HIV infected	N/A	N/A		Section 2.1
	Percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral therapy	N/A	N/A		N/A

¹ A Knowledge-Attitude-Behaviour Study is currently underway in partnership with the College of The Bahamas.

UNGASS Indicators – Generalized Epidemic		2003 Result	2005 Result	Notes/Comments	Document Reference
	Percentage of infants born to HIV infected mothers who are infected	0% (receiving treatment)	0% (receiving treatment)	In 2003, 2004 and 2005 there has been no vertical transmission of HIV from mothers to newborns among mothers that received ARV therapy.	Section 2.1
	Percentage of [most-at-risk population(s)] who received HIV testing in the last 12 months and who know the results	N/A	N/A		N/A
	Percentage of [most-at-risk population(s)] reached with HIV-prevention programmes	N/A	N/A		N/A
	Percentage of [most-at-risk population(s)] who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	N/A	N/A		N/A
	Percentage of female and male sex workers reporting the use of a condom with their most recent client	N/A	N/A		N/A
	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	N/A	N/A		N/A
	Percentage of injecting drug users who have adopted behaviours that reduce transmission of HIV, i.e., who both avoided using non-sterile injecting equipment and used condoms in the last month	N/A	N/A		N/A
	Percentage of [most-at-risk population(s)] who are HIV-infected	N/A	N/A	Sentinel surveillance in antenatal women has shown a drop in prevalence from 4.3 percent to 2.9 percent between 1993 and 2004. Among patients receiving care for STIs, the percent testing positive for HIV has decreased from 9.2 percent to 4.1 percent between 1993 and 2004. Infection rates among persons admitted to the prison has decreased from 3.4 percent to 2.5 percent from 2002 to 2004. Surveillance of blood donors shows a steady prevalence of about 0.4% since 1993 which dipped to 0.2% in 2003 and 2004.	Section 2.1

2 Overview of the AIDS Epidemic

2.1 Impact Indicators

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

As of December 31, 2005, The Bahamas had a cumulative total of 10,479 reported cases of HIV/AIDS. Of the 6853 living individuals, 1631 are living with an AIDS diagnosis, while 5222 have HIV infection that has not yet progressed to AIDS.

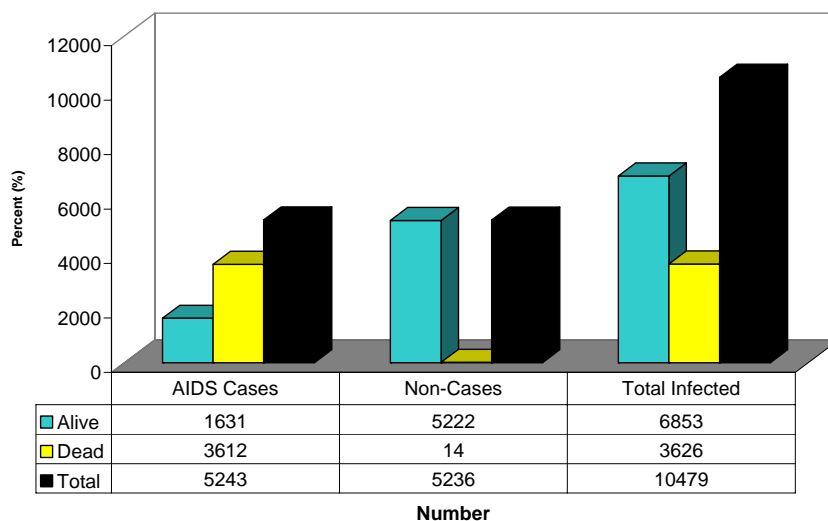


Figure 1 - Cumulative Number of Reported HIV Infections with Current Status as of December 31st, 2005

AIDS has been the leading cause of death in The Bahamas since 1994. Overall, 3 percent of persons living in The Bahamas are estimated to be infected with HIV. The large majority of these persons are in the productive years of early adulthood between the ages of 20-39 years of age. The disease occurs primarily among heterosexuals (approximately 87%), although under-reporting by men who have sex with men (MSM) remains a challenge. Transmission through intravenous drug use is considered to be insignificant.

The overall female to male ratio is approximately 0.8 to 1. However, in the younger age groups, there is higher female to male ratio. Among the 15 to 24 year old age group, the female to male ratio for non-AIDS HIV infections is 1.66 to 1. In the 25 to 29 year old age group, the female to male ration is 1.2 to 1, and in the 30 to 34 year old age group the female to male ration is 0.9 to 1. The younger age at which females contract HIV may be due to their earlier sexual activity, a higher male-to-female transmission efficiency or the preference of older men for younger women.

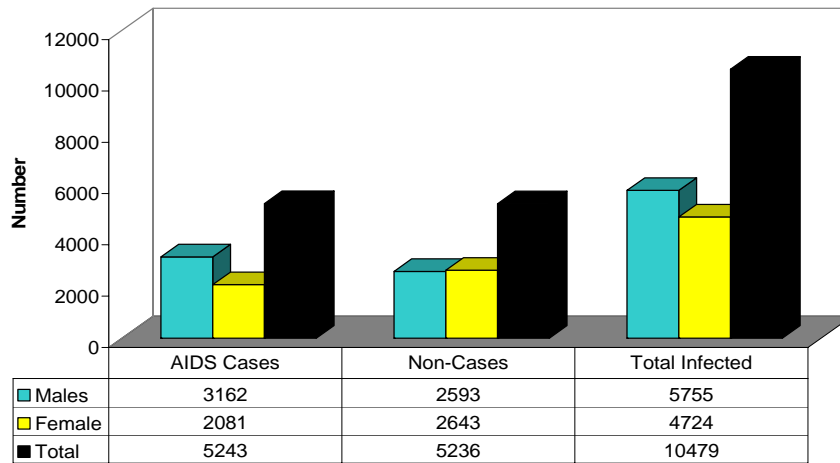


Figure 2 - Cumulative Number of Reported HIV Infections by Sex as of December 31st, 2005

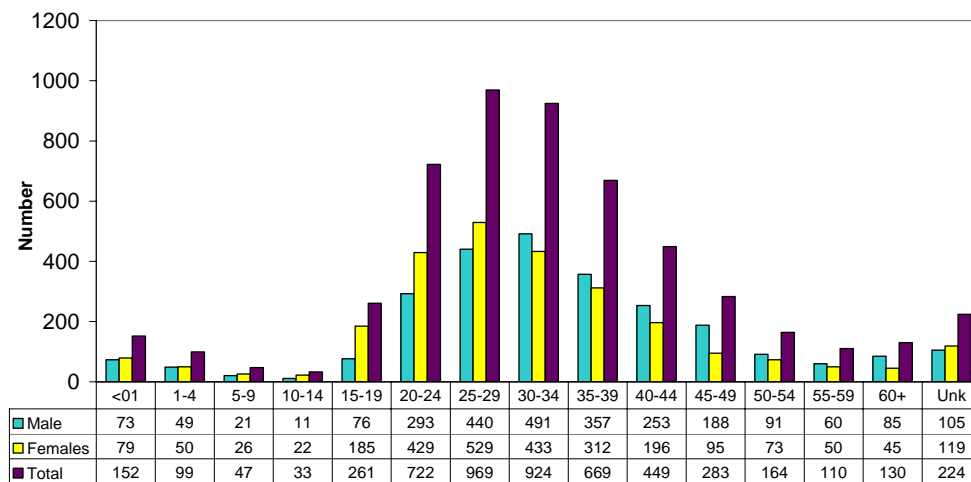


Figure 3 - Current Cumulative Number of Non-AIDS HIV Infections, By Age Group and Sex as of December 31st, 2005

The HIV/AIDS epidemic is concentrated among Bahamian citizens living on a few large islands. Approximately 82 percent of individuals with HIV disease and 86.5 percent with AIDS live on New Providence, 7 percent with HIV disease and 8 percent with AIDS live on Grand Bahama, and Abaco and Eleuthera together account for 7.5 percent and 3 percent of HIV disease and AIDS cases, respectively. All other islands combined have the remaining 3.5 percent of HIV disease and 2.5 percent of AIDS cases. In 2005, Bahamian citizens make up 75 percent of persons with HIV/AIDS. Persons of Haitian descent make up the majority of the remaining cases.

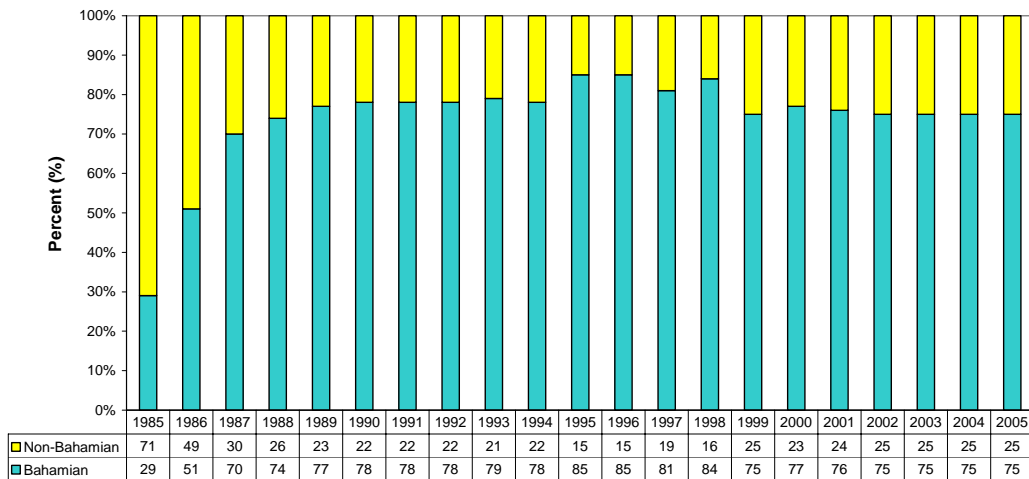


Figure 4 - Percent Distribution of HIV Infections (AIDS Cases and Non-Cases) Reported Annually, By Bahamian Status, 1985 to 2005

Between 1994 and 2005, there was a decrease in the HIV incidence rate, with the greatest change noted in the 20 - 49 year old group. The number of newly reported HIV infections peaked in 1994, while AIDS cases peaked in 1997 with subsequent declines in both categories.

At the outset of the HIV/AIDS epidemic, two other epidemics contributed to the high prevalence of HIV disease: widespread use of crack cocaine and increased incidence of genital ulcer disease. In the early years of the HIV/AIDS epidemic, approximately 30 percent of HIV-infected persons were also users of crack cocaine. Widespread crack use in the mid-1980's led to persons engaging in high-risk behaviours, including having sex with multiple partners for drugs. The marked increase in genital ulcer disease was followed by a four-fold increase in HIV infection from 1985 to 1994.

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

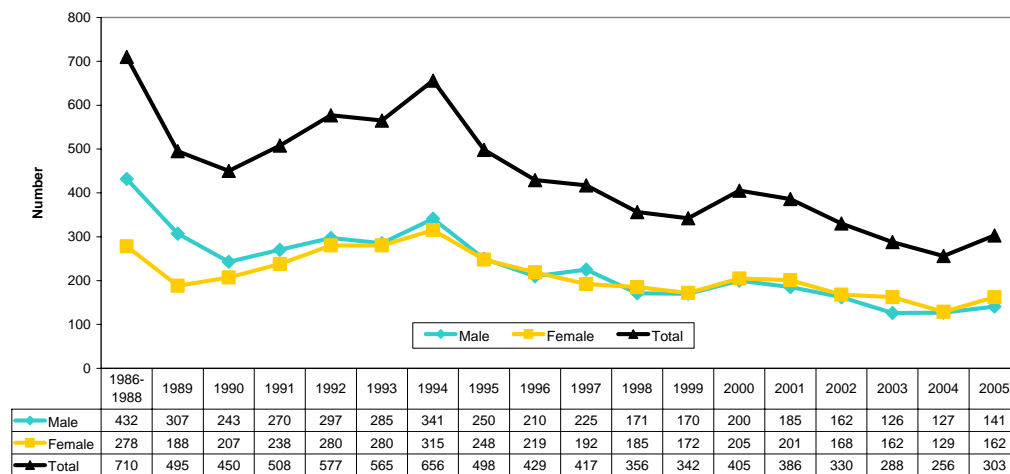


Figure 5 – New Non-AIDS HIV Infections By Sex and Reported Year, 1986-2005

The frequency of HIV is monitored through sero-prevalence surveys in sub-population groups of persons attending antenatal clinics, the sexual transmitted infection clinic (STI), blood donors and during prison intake. The number of HIV infections among women of childbearing age is diminishing. Surveillance if

HIV in antenatal women has shown a drop in prevalence from 4.3 percent to 2.9 percent between 1993 and 2004. Among patients receiving care for STIs, the percent testing positive for HIV has decreased from 9.2 percent to 4.1 percent between 1993 and 2004. Infection rates among persons admitted to the prison has decreased from 3.4 percent to 2.5 percent from 2002 to 2004. Sentinel surveillance activities continue among these target populations, and among those in treatment for substance abuse.

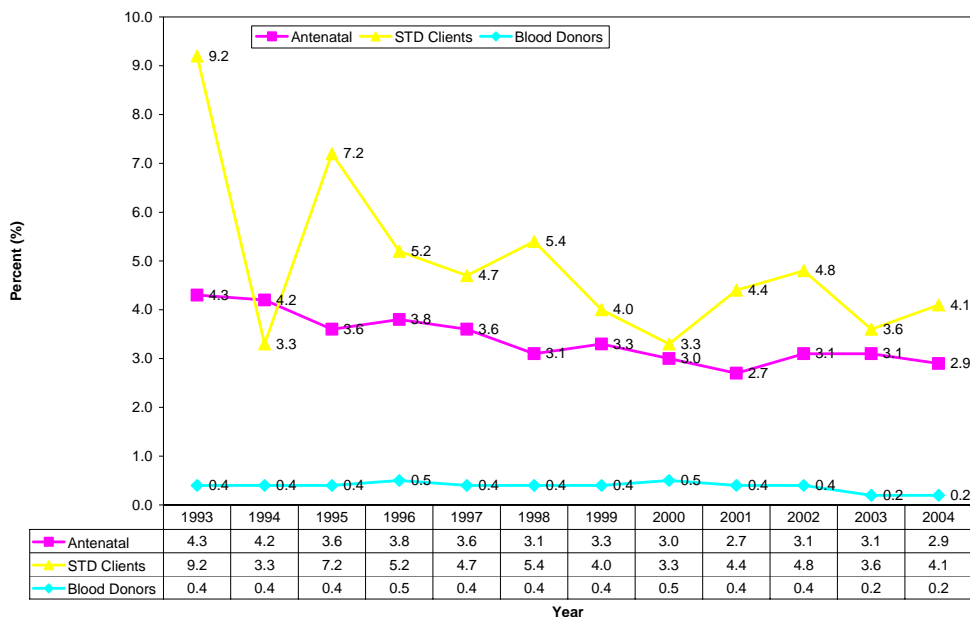


Figure 6 - Prevalence of HIV in Antenatal Women, STI Clients and Blood Donors, 1993-2004

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

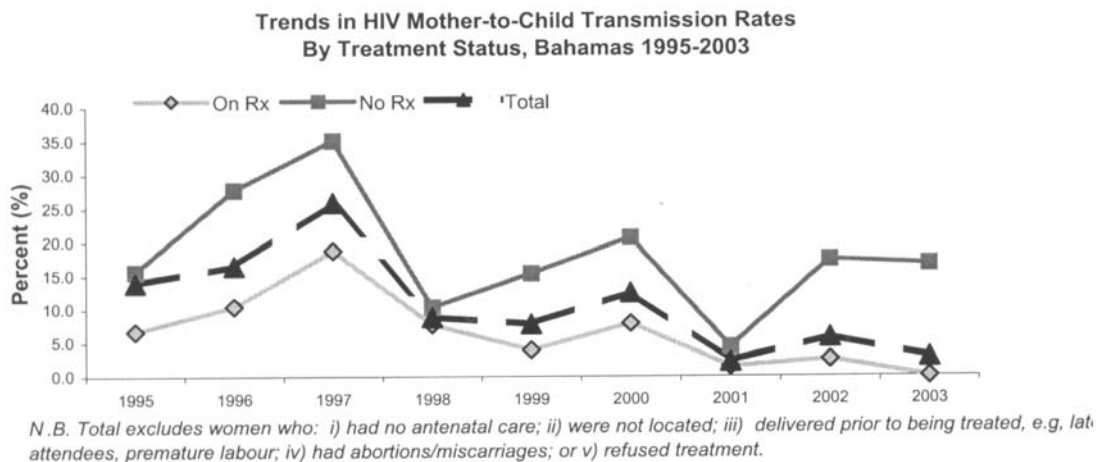


Figure 7 - Trends in HIV Mother-to-Child Transmission Rates by Treatment Status, 1995 - 2003

A decrease in AIDS mortality has occurred, with the percent of registered deaths due to AIDS dropping from 18.4 percent to 11.8 percent between 1996 and 2003. This drop is concurrent with improved ability to enter individuals in care, to diagnose and treat opportunistic infections, and the increased affordability and availability of antiretroviral therapy (ART). In 2002, the government of The Bahamas committed to providing ART to all those who are eligible – a programme made more affordable in recent years by availability of lower cost antiretroviral medications, due in large part to lobbying efforts by the Clinton Foundation.

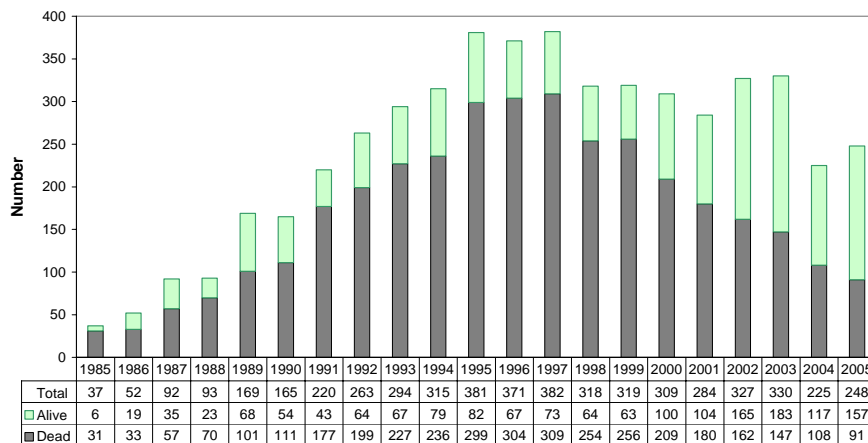


Figure 8 - Current Status of Reported AIDS Cases as of December 31st, 2005

Approximately 60% of eligible HIV-infected persons are receiving ART, including nearly all antenatal and paediatric clients. Insufficient human resources and infrastructure to adequately provide care and follow-up, fear of stigma and discrimination, and lack of knowledge among HIV-infected people on the need for treatment are the greatest barriers to universal access to ART.

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

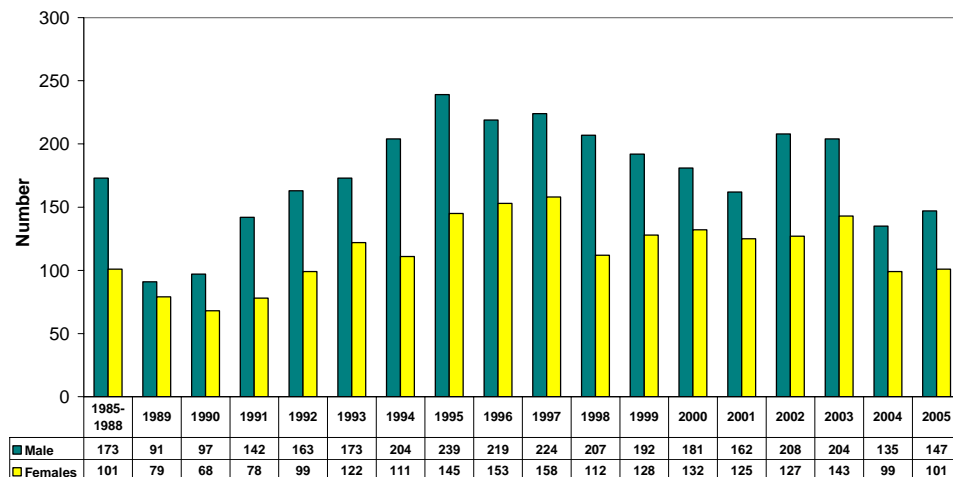


Figure 9 - New Cases of AIDS, By Sex and Year, August 1985 to December 31st, 2005

3 National Response to HIV/AIDS in The Bahamas

3.1 Leadership and coordination

In September 2003 at the 13th International Conference on AIDS and STI's in Africa, a working group approved a set of guiding principles for optimizing the use of resources and improving the country-level response to AIDS. Known as the "Three Ones," these principles are aimed at improving the effectiveness of available funding, and reducing parallel financing, planning, programming and monitoring efforts.

These principles are:

- One agreed AIDS action framework that provides the basis for coordinating the work of all partners;
- One national AIDS coordinating authority, with a broad-based multisectoral mandate;
- One agreed country-level monitoring and evaluation system.

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

3.1.1 One AIDS Action Framework – The National HIV/AIDS Programme

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

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

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

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

The National HIV/ AIDS Programme is guided by the National HIV/ AIDS Strategic Plan (NASP) initially developed in 2000 and integrated into the National Health Service Strategic Plan. The NASP was updated in 2002 as *The Strategic Plan for Scaling Up HIV/AIDS Care and Treatment in The Bahamas 2003-2005* with support from the Clinton Foundation and other international partners. The NASP provides specific strategies and targets that were developed in consultation with multisectoral and multilateral partners. These strategies and targets have been translated into work plans which guide the activities of the various partners involved in the delivering the National HIV/ AIDS Programme.

The NASP also provides a single national budget for the National HIV/ AIDS Programme that addresses medications, outpatient primary and specialty medical care, inpatient care, laboratory services, prevention and education, training and technical assistance and programme support. The Bahamas Government committed to supporting 75 percent of the 3-year programme cost of \$23 million. The Clinton Foundation has also stimulated the support of the Bahamian business community, such as the Kerzner International, and donors in the United States, for an additional \$1.8 million commitment to the initiative.

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

Figure 10 - Bahamas National HIV/AIDS Strategic Plan Costs

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

The AIDS Foundation, a national AIDS organization in The Bahamas, raises money among the private sector and citizens to fund specific programs such as outreach and support groups, and a residential facility for orphans.

3.1.1.1 Challenges

The timeframe of the current NASP expired at the end of 2005. The Government of The Bahamas views the development of the *Roadmap to Scaling Up Towards Universal Access to HIV Prevention, Treatment, Care and Support Services* (February 2006) as a catalyst for the renewal and update of the strategic plan to 2010, and has included an updated NASP as a key action toward universal access.

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

Sustainable funding remains as key challenge, as the funding timeframe for the 2003 to 2005 scaling-up initiative has now ended. While Bahamas Government is maintaining its current commitments to the National HIV/AIDS programme, and new private sector and non-governmental donors are in the process of committing new funds, the strategy for achieving the goals and objectives of the NASP will require additional funds sustained over the longer term.

3.1.2 One Coordinating Authority – The National HIV/AIDS Centre

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

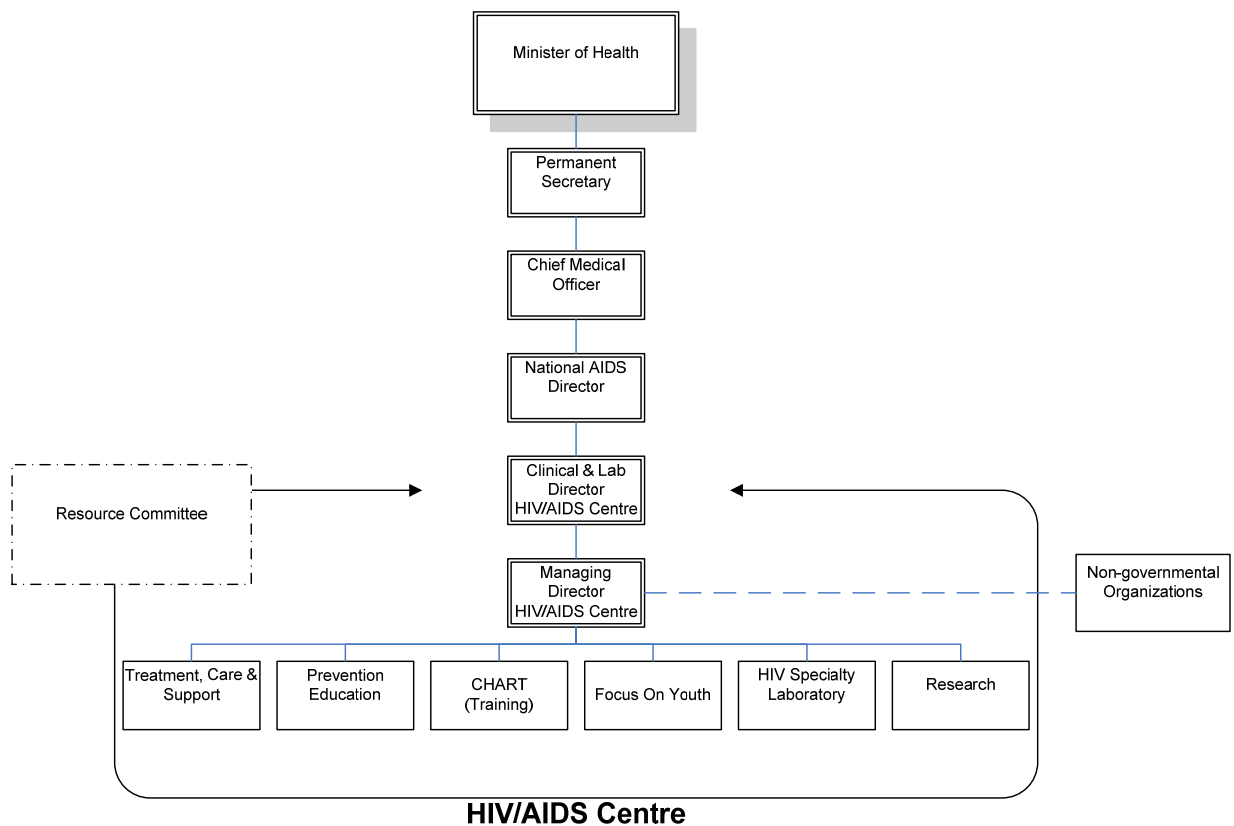
The HIV/AIDS Centre has direct line accountability to the Minister of Health. Funds from the national budget, international donors and national donors is coordinated through the Centre and prioritized within the framework set by the National HIV/AIDS Strategic Plan.

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

3.1.2.1 *Multisectoral Mandate*

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

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



3.1.2.2 Challenges

While the HIV/ AIDS Centre is the recognized authority for the planning, management and delivery of the National HIV/ AIDS Programme, the Centre does not currently have the status of an agency or department within the Ministry of Health. This indeterminate status is particularly challenging with regard to human resource management, as the Centre does not have the authority to conduct its own human resource hiring or planning. Government-wide hiring freezes have made it extremely difficult for the Centre to fill identified roles with qualified and motivated personnel.

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

3.2 Prevention

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

3.2.1 Volunteer Counselling and Testing (VCT)

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

The CHART programme for health care providers, social service workers and volunteers has trained over 80 individuals on VCT, including training individuals to provide VCT training in order to more effectively expand capacity.

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

All HIV-infected pregnant women are referred to the PMH or RMH clinics for monitoring and care (see *Outpatient Clinics* section below). Defaulters are traced and provided additional counselling and support to improve adherence. AZT is administered to the mother during delivery and to the infant post delivery for six weeks. Mother and infant are visited at home by the postnatal home service team. Babies are followed-up in the HIV/AIDS Paediatric Clinic for evaluation and testing for HIV status. HIV-infected mothers are also counselled regarding the dangers of breastfeeding, and provided with a supply of artificial milk. In combination, these measures have decreased the rate of HIV-infected infants born to HIV-infected mothers. In 2003 and 2004, no children were born infected with HIV to HIV-infected mothers who accessed antenatal care.

Client Status	2001	2002	2003	2004	2005*
Total antenatal clients testing HIV positive	94	104	106	105	104
HIV-infected antenatal clients receiving PMTCT ART	71	81	88	83	74
Total HIV-infected antenatal clients not treated	23	23	18	22	30
Antenatal HIV result negative – Positive postpartum	0	0	1	2	N/A
No antenatal care	0	7	6	9	2
Not located (antenatally)/Not referred	12	8	2	4	N/A
Refused	3	3	1	2	N/A
Delivered prior to treatment	4	5	4	3	N/A
Miscarried/Aborted/Intrauterine death prior to treatment	4	0	4	2	N/A

* Full analysis for 2005 not yet completed. Source: HIV/AIDS Centre

Figure 11 - Summary of Antenatal Clients Accessing PMTCT Care

3.2.3 Blood Product Screening

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

3.2.4 Post-Exposure Prophylaxis

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

3.2.5 Contact Tracing and Partner Notification

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

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

current partners, are assured by the surveillance counseling team that their identity will not be divulged. Only after informed consent is given voluntarily are patients' contacts invited to come in for counseling.

3.3 Knowledge and behaviour change

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

Efforts aimed at educating the population through prevention education related activities were coordinated initially by the AIDS Secretariat, and now by the National HIV/AIDS Centre. HIV/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/AIDS.

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

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

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 tourist and tourism workers is an ongoing activity through the Ministry of Tourism in cooperation with major hotels and their staff.

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

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

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

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

For those that work within the National HIV/AIDS Programme, the term “care” is all-encompassing and is used to mean clinical care, psychological and emotional care, social care, and perhaps most importantly, “tender loving care” in which individuals infected with HIV are treated with dignity and respect in a non-discriminatory and non-judgemental environment. As The Bahamas moves toward decentralising and integrating HIV/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/AIDS prevention, treatment, care and support services is currently centralized at The National HIV/AIDS Centre in Nassau, and delivered through clinics in the Princess Margaret Hospital (PHM) in New Providence and at the Rand Memorial Hospital (RMH) in Grand Bahama. There are multiple entry-points to HIV/AIDS services, most commonly through voluntary counseling and testing provided at most public health clinics and many private clinics.

3.4.1 Princess Margaret Hospital Outpatient Clinics

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

3.4.1.1 *PMH Adult Clinic*

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

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

3.4.1.2 *PMH Antenatal Clinic*

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

3.4.1.3 *PMH Paediatric Clinic*

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

HIV-infected adolescent patients are also followed at one-month intervals in the paediatric or adult clinic, with consideration of age and preference. An adolescent health center in Nassau also provides a range of health services and targeted HIV prevention interventions to teenagers. Adolescents or children who acquire HIV infection outside of the perinatal period are referred to the Suspected Child Abuse and Neglect (SCAN) Unit if sexual molestation is suspected. An HIV test is part of the standard evaluation in these cases.

3.4.2 Princess Margaret Hospital Inpatient Infectious Diseases Services

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

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

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

3.4.3 Rand Memorial Hospital Outpatient and Inpatient Care

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

3.4.4 HIV/AIDS Care in the Prison System

There is one incarceration facility in The Bahamas with an inmate population of approximately 1,500. All new inmates are provided with VCT as part of the intake medical evaluation. Ten percent of the prison population is infected with HIV but there are very few with symptomatic disease. 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/AIDS are seen by a specialist visiting the Prison Clinic. The capability to draw labs and transport them to the PMH and the HIV Research Laboratories coupled with training support provided by the PMH Infectious Diseases specialist to prison staff allows most of the care needed by inmates to be provided on site at the prison. Prisoners requiring specialized HIV/AIDS evaluation and care are taken to the PMH clinic.

3.4.5 National Tuberculosis Control Programme

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

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

All suspected cases of active TB are hospitalized on the infectious diseases ward at PMH for additional laboratory investigation. If the case is confirmed, patients are started on a course of anti-TB medication, then have repeat chest X-ray and AFB sputum test before discharge back in the community where they are followed by community workers. Clients on both TB and ARV medications receive DOT follow-up to ensure compliance with both classes of medication.

3.4.6 Sexually Transmitted Infections Clinic

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

Year	Latent Syphilis	Primary Syphilis	Secondary Syphilis	Chlamydia	Gonorrhea	Herpes	Human Papillomavirus	Hepatitis B	Non-specific Urethritis	Lymphogranuloma a Venereum	Chancroid
2001	18	1	3	77	50	27	22	26	51	6	2
2002	21	3	-	56	50	28	21	12	43	4	2
2003	12	3	-	51	44	17	21	20	58	2	5
2004	16	-	-	82	47	13	16	25	49	4	3
2005	26	-	-	48	28	17	17	11	35	2	-

Figure 12 – Number of Cases of Sexually Transmitted Infections Diagnosed at the New Providence STI Clinic, 2001 to 2005

3.4.7 Substance Abuse and Mental Health Services

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

3.4.8 Hospice Services

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

3.4.9 Antiretroviral Therapy (ART)

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

As of December 2005 there were 1416 adults, 127 children and 337 antenatal clients receiving ART, which represents approximately 60% of estimate eligible HIV-infected persons. As nearly all eligible HIV-infected antenatal women and children are receiving treatment, the largest gap is among adult HIV-infected persons, many of whom do not regularly access care because of stigma and fears of discrimination, or because they are generally healthy and do not seek diagnosis or treatment.

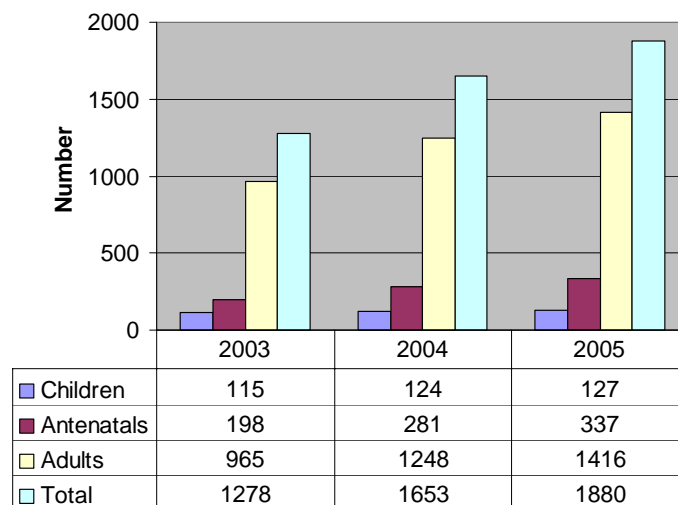


Figure 13 - Cumulative Number of HIV-Infected Clients Receiving Antiretroviral Therapy to December 31, 2005

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

In striving to expand access to comprehensive care and support for Bahamians living with HIV/AIDS, the Ministry of Health has identified a strategy to decentralise the care and treatment from the Specialty Clinics at PMH into an integrated programme involving community clinics. The decentralisation and

subsequent integration of HIV/AIDS care into the primary level of the public health clinic structure fulfils the “Healthy People” vision as laid out in the *National HIV/AIDS Strategic Plan* of 2000 as well as the 2002 strategy document *Accelerating Access to HIV/AIDS Care for Bahamians living with HIV/AIDS* and the *Strategic Plan for Scaling Up HIV/AIDS Care and Treatment in The Bahamas 2003 – 2005*.

The strategy calls for the integration of HIV/AIDS services into the primary level of care within all clinics in the Family Islands. All comprehensive treatment and care services, voluntary counseling and testing, pharmacy services and ancillary support services will be offered in four polyclinics, the Adolescent Health Clinic and the Prison Clinic, with an appropriate sub-set of services delivered through smaller Family Island clinics. Comprehensive services would be available at planned mini-hospitals in the Family Islands when fully operational.

The PMH and Rand Clinics would become specialty and tertiary care providers, accepting referrals from primary care providers for non-routine cases, such as therapy failure or complex opportunistic infections.

This integration will allow the National AIDS Programme to reduce existing barriers to universal access by:

- Overcoming resistance to accessing care caused by centralization within specialty clinics identified specifically with HIV/AIDS care;
- Increasing capacity to provide HIV/AIDS care across the primary level of care, thereby reducing barriers caused by human resource and infrastructure constraints;
- Reducing geographical barriers to accessing services by provide geographically dispersed service capacity.

However, decentralisation and integration of services also presents a number of challenges which must be addressed with the Roadmap to universal access and subsequent updates to the National HIV/AIDS Strategic Plan:

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

Decentralisation and integration of HIV/AIDS services has been a high priority initiative within the HIV/AIDS Programme since 2002, and considerable progress has been made, including:

- Creation of the HIV/AIDS Centre as the central coordinating authority for all prevention, treatment, care, and support services;

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- Increasing the human resource capacity the National HIV/AIDS Programme, in particular through additional pharmacy, laboratory, social work and counseling resources, funded in part through Clinton Foundation networks;
 - Development of draft HIV/AIDS protocols and guidelines adapted from regional guidelines and adapted for The Bahamian context;
 - Strengthening of laboratory service capacity to include viral load and CD4 testing in-country (CD4 testing available in February 2006);
 - Creation of a draft service delivery model to support the decentralisation of services;
 - Initiation of VCT, PMTCT and nutrition training to public health nurses, social workers and volunteers throughout The Bahamas, including stigma and discrimination training;
 - Training public health primary care physicians in HIV/AIDS prevention, treatment, care and support protocols and guidelines, including referral protocols.

3.4.11 Advocacy, Public Policy, and Legal Framework

3.4.11.1 Advocacy

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

3.4.11.2 Public Policy and Legal Framework

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

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

- The Bahamas was one of the first Caribbean nations to de-criminalize homosexuality;
- The Employment Act of 2001 states that employees or persons applying for employment may not be discriminated against based on their HIV status, nor can an employee or applicant be required to submit to an HIV test;
- The Ministry of Education has recently submitted draft legislation relating to HIV/AIDS, which includes requirements for treatment, management and education of all persons affected and infected with HIV/AIDS (including students and teachers), and also includes the provision of systematic and consistent information and educational materials on HIV/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/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/AIDS infected student/athlete has a right to confidentiality and thus his/her medical condition in this instance need not be placed on general medical records in the school.

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

While The Bahamas does have strong legislative and policy protections against discrimination in many sectors, there are still gaps, such as protections based on sexual orientation or preference. Fear of stigma, retribution and further discrimination prevent many PLWHA from pursuing redress to discriminatory actions, even when protected by law or policy.

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

The table below summarizes the challenges currently faced by The Bahamas in meeting Commitment on HIV/AIDS and provides recommended solutions².

Challenges	Actions
Societal stigma and fear of discrimination of HIV/AIDS prevents people at risk of infection and those already infected from seeking services.	<ul style="list-style-type: none"> • Provide services throughout the primary care level in settings that are not specifically associated with HIV/AIDS care; • Target behavioural change communications and public awareness campaigns to change attitudes among service providers and the general population that reduce stigma and discrimination; • Ensure appropriate anti-discriminations policies and laws are in place, and ensure existing policies and laws are enforced; • Conduct education and public awareness campaigns to encourage people to know their status, and on the importance of seeking treatment if HIV-infected; • Empower PLWHA to advocate for change on their own behalf, and provide legal and other services to help them seek redress for discriminatory actions.
The outpatient clinics at PMH and RMH lack capacity to provide all required services to all HIV-infected individuals.	<ul style="list-style-type: none"> • Decentralise comprehensive HIV/AIDS prevention, treatment, care and support services to the primary care level to distribute demand across the system; • Increase HIV/AIDS prevention, treatment and care capacity through training providers at the primary care level; • Reduce HIV transmission through prevention programs such as PMTCT and behavioural change communications

² Specific actions and milestone are addressed in further detail in *The Bahamas Roadmap to Scaling Up Towards Universal Access to HIV Prevention, Treatment Care and Support Services – 2006 to 2010*, February 2006.

Challenges	Actions
<p>There is shortage trained professionals with expertise in HIV/AIDS prevention, treatment care and support services to meet the needs of the expanding number of patients accessing services which is exacerbated by the ineffective deployment of existing human resources.</p>	<ul style="list-style-type: none"> • Provide HIV/AIDS training to health care providers and other service providers throughout the primary care level • Implement a comprehensive human resources management plan that appropriately targets resources to identified needs and gaps, and includes strategies for recruitment and retention. • Liaise with National programs aimed at developing human resource capacity to ensure that the appropriate competencies required for HIV/AIDS prevention, treatment, care and support services, including planning and management capacity, are addressed.
<p>The level of social support interventions, nutrition services, mental health services, and oral health care is compromised due to inadequate numbers of personnel to provide these services in the clinic setting and through home visits in the community.</p>	<ul style="list-style-type: none"> • Implement a comprehensive human resources management plan that appropriately targets resources to identified needs and gaps, and includes strategies for recruitment and retention. • Increase HIV/AIDS support capacity through partnerships with volunteer community and faith-based organizations, and through international support for technical assistance.
<p>Community clinics are at physical capacity for all patient categories, even without treating HIV patients.</p>	<ul style="list-style-type: none"> • Identify infrastructure requirements and develop a plan and budget to upgrade facilities, including communication and transportation systems.
<p>Medical records are not yet computerized in The Bahamas, and there is no common patient identification system in place linking community clinics, hospital settings, and ancillary services. This makes it difficult to monitor quality of care, especially in a decentralised model. Information required to support prevention, treatment and care services is not readily available, and manual processes and duplication of tasks consume valuable human resources.</p>	<ul style="list-style-type: none"> • Implement a Public Health Information System, including a unique client identifier with appropriate protections for confidentiality.
<p>There is no integrated information system to permit central monitoring and tracking, distribution, and consumption of ARVs across all pharmacy/dispensary sites.</p>	<ul style="list-style-type: none"> • Implement a Pharmacy Information System.
<p>The existing hospital laboratory system, which serves both hospital-based services and community polyclinics, lacks a computerized lab information system that is linked with patient records. All data entry into charts is manual, delaying receipt of patient results.</p>	<ul style="list-style-type: none"> • Implement a Laboratory Information System integrated with the Public Health Information System.

Challenges	Actions
<p>There is inadequate funding available to fully scale-up human resource capacity and infrastructure to support universal access to comprehensive HIV/AIDS care as required.</p> <p>The Bahamas is generally excluded from international donor and funds because of its GDP.</p> <p>Sustained funding to support the current capacity of service delivery is not guaranteed.</p>	<ul style="list-style-type: none"> • Develop roles and expertise to focus on accessing both domestic and international sources of funding; • Work with government officials and international donors to remove barriers to funding; • Work with private sector and international organizations to secure access to low-cost technologies, such as laboratory equipment and supplies.

5 Support required from country's development partners

Sustainable funding remains as key challenge, as the funding timeframe for the 2003 to 2005 scaling-up initiative has now ended. While Bahamas Government is striving maintaining its current commitments to the National HIV/AIDS programme, and new private sector and non-governmental donors are in the process of committing new funds, the strategy for achieving the goals and objectives of the NASP will require additional funds sustained over the longer term. A key ongoing challenge is that The Bahamas is excluded from international donors and funds because of its GDP.

6 Monitoring and evaluation environment

6.1 The National M&E framework

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

6.2 Challenges of one national M&E system

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

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

Annex 1: Bibliography

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