NATIONAL HIV/STI & VIRAL HEPATITIS STRATEGIC PLAN: COMMONWEALTH OF DOMINICA

2020-2025
BUILDING RESILIENCE IN THE RESPONSE TO HIV AND AIDS

Foreword

The HIV and AIDS epidemic remains a concern to health authorities, as it greatly impacts the population and health resources of any country. The Ministry of Health and Social Services in Dominica, understands the importance of a strategic program which responds to needs identified so as to respond to this epidemic in the country, and by extension the region. The recent disasters have necessitated a shift towards a resilient approach to programming for implementation of interventions for health issues to include communicable, non-communicable diseases, HIV and AIDS.

This 2020-2025 National Strategic Plan reflects the necessary actions required to achieve the UNAIDS 2020 goal of 90/90/90, and subsequently ending AIDS related deaths by 2030. The ministry has recognized the importance of this plan, being aligned to the current Climate Resilient Ministry of Health Strategic Plan and the Caribbean Strategic Framework. The Ministry of Health and Social Services will continue to lend its support at the highest level to fulfil the goals of this plan, which seeks to meet the needs of all stake holders and key populations to end this epidemic.

I would like to express profound gratitude to the Pan American Health Organization for its funding and guidance on the development of this document as well as the numerous individuals and organizations who have also contributed time and resources. The Global Fund recurrent grant over the past decade has been integral in supporting the funding needs of the OECS countries and OECS HIV Project Unit for continued guidance to National AIDS programs.

Additionally, I encourage the citizens of the country to remain vigilant. More particularly, I encourage health care workers to remain unwavering in the continued efforts to develop programs which mitigate the negative impacts of HIV and AIDS in Dominica and the region. The Government of Dominica remains committed to providing the necessary mechanisms towards the achievement of the outlined goals and objectives of this plan.

Electronic Signature

Honourable Kenneth Darroux MD

Minister of Health and Social Services

Acknowledgements

The National HIV and AIDS Response Programme (NHARP), Ministry of Health and Social Services would like to thank the stakeholders from both private and public sectors, regional and international organization for your commitment in the review process and completion of the 2020-2025 National HIV and AIDS Strategic Plan. Your participation and contribution to this process made the completion a reality.

Special mention is made of the following individuals: Dr Cleona Peters, Ms Allison Samuel, Dr. Renne West, Mrs Julie Frampton, Mr Lester Guye and staff of the National HIV and AIDS Response programs as well as Dr Shalauddin Ahmed and staff of the Health Information Unit (HIU).

Pan American Health Organization and office of the Eastern Caribbean States Commission for providing technical and financial support.

List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti Retro Viral
BCC	Behaviour Change Communication
CIA	Central Intelligence Agency
CSO	Civil Society Organization
EMTCT	Elimination of Mother to Child Transmission
GDP	Gross Domestic Product
HIU	Health Information Unit
HIV	Human Immuno-deficiency Virus
IEC	Information Education Communication
IS4H	Information Systems for Health
M&E	Monitoring and Evaluation
MSM	Men who have Sex with men
NCD	Non-Communicable Disease
NGO	Non-Governmental Organization
NHA	National Health Accounts
NHARP	National HIV and AIDS Response Programme
NSP	National Strategic Plan
OECS	Organization of Eastern Caribbean States
OI	Opportunistic Infection
PAHO	Pan American Health Organization
PEP	Post Exposure Prophylaxis
PLHIV	Persons Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre-Exposure Prophylaxis
STI	Sexually Transmitted Infection
SW	Sex Workers
TB	Tuberculosis
UNAIDS	The Joint United Nations Progamme on HIV/AIDS
VCT	Voluntary Counselling and Testing

Table of Contents

List of Tables and Figures

Executive Summary

The 2020-2025 National Strategic Plan for Dominica is the framework within which the implementation of activities in response to HIV and AIDS will be conducted. This is in keeping with the continued efforts to stem the negative effects of HIV and AIDS on the population. This plan was developed through extensive consultation with key stake holders, who provided valuable contributions to inform the themes for the strategic priorities.

The challenges identified during the consultative process examined the inconsistencies in the findings of some key programmatic areas namely: testing and counselling, treatment care and support, and behaviour change. Regarding testing and counselling, it was observed that the proportion of individuals tested versus those who were positive, indicated a very low number. This may be indicatory of necessary improvement in targeted interventions. The National Response therefore must include targeted interventions tailored to reach the key populations.

A second area of concern for stakeholders was the gap existing between those diagnosed with HIV and those who are actually enrolled in treatment (care and support) as well as their retention in care. Along the "continuum of care" individuals enrolled in care appear absent to follow-up after they have been diagnosed. At the end of 2018, there were 112 clients enrolled in care (68 males and 44 females) of these, eighty nine (89) are receiving antiretroviral therapy: 51 males and 38 females, 41 of these eighty-nine have viral loads (VL) of <1000 copies/ml (NHARP Report 2018). Retention in care supports the achievement of viral suppression, which is critical to the achievement of the UNAIDS 90/90/90 targets.

The data further suggested that despite the fact that knowledge on modes of transmission of HIV was at 95%, this did not reflect behavior change in regards to condom use. Only 75% of those persons who were interviewed indicated condoms use. It is evident therefore that behavioral change Interventions are to be sustained and continuous. (BSS 2010)

Despite these challenges, The NHARP has managed to keep the prevention of vertical transmission of HIV and congenital syphilis at 100% for the past 15 years. Therefore, efforts towards elimination of vertical transmission of HIV and congenital syphilis need to be strengthened and sustained. Validation is within reach and this plan outlines the key actions to reach this milestone.

The Strategic priorities with supporting objectives and key actions developed by stakeholders to address the challenges and sustain the gains, were along the following themes: strengthening and updating high impact prevention interventions; early diagnosis; strengthening and expanding comprehensive quality treatment care; and support services for PLHIV and their families. The importance of strengthening systems to generate strategic information, and the exploration of new sources of funding from national and external donors to sustain the HIV and STI response was also a concern as these would provide a baseline for future planning and policy.

Although the guiding principles from the previous plan were maintained, however the goals were changed to meet the 90/90/90 UNAIDS targets.

The goal of the NSP 2020-2025 is:

- To reduce the incidence of HIV infection in Dominica in accordance with the 90-90-90 targets.

In order to achieve the goal of the NSP 2020-2025 the following, 90-90-90 targets, set for 2020, should also be achieved:

- ✓ 90% of all people living with HIV know their HIV status
- ✓ 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy
- ✓ 90% of all people receiving antiretroviral therapy will have viral suppression

Pivotal to achieving these goals is the mobilization of adequate financial and human resources. This necessitates the need for analytic thinking and planning in light of dwindling donor funding in order to meet the required financial resource needed to sustain the provision of a high quality HIV Response Program. Introduction of the National Health Insurance Scheme, user fees at point of care as well as private/public partnerships, are likely alternatives to support the implementation of the Plan. Moreover, the use of high quality data through effective surveillance systems is required to monitor the progress of indicators and future review and planning. The review and update of legislation to support anti-discrimination policies is a critical element that requires continued advocacy.

The gains the country has made over the past 15 years in PMTCT, in creating a national awareness of HIV cannot go understated, yet there is an urgency for much more to be done and for a sustained momentum as Dominica aims to achieve the required behaviour change and the realization of the UNAIDS 90/90/90 targets.

This plan clearly defines the issues identified above and provides a detailed road map for implementation. The M&E Framework supports the collection of the data required to review and update planning. The overall oversight of the implementation will be supported by the Country Coordinating Mechanism (CCM) as well the administration of the Ministry of Health.

This plan, therefore, responds to and provides the platform upon which HIV and AIDS as well as other STIs will be managed in Dominica.

1. Introduction

This document sets out the guiding principles, goals and objectives for the way forward in response to HIV and STI issues in Dominica. It outlines the strategic approach to the implementation of activities as influenced by local, regional and international trends and standards. The National Strategic Plan (NSP) for HIV (2010-2014) remained in draft form due to funding and administrative challenges. However, this draft was used to guide the National AIDS response during this period. The new planning cycle began with a consultation of key stakeholders in July 2014. The Ministry of Health in collaboration with United States Agency for International Development, President's Emergency Plan for AIDS Relief, Strengthening Health Outcomes through the Private Sector and Health Financing & Governance provided the support for the process to begin the development of the new NSP. Abt Associates provided the necessary data for projections which was taken from the National Health Accounts (NHA) and HIV Sub Accounts conducted in 2013 (National HIV and AIDS Response Programme, 2015). See Section 3 for further details.

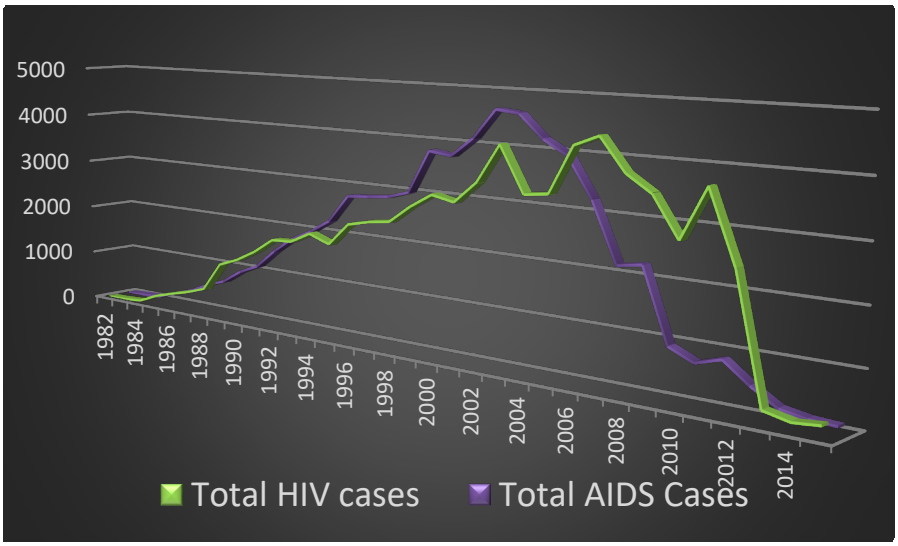
Due to various human and financial challenges, the completion of the new NSP was postponed until late 2017 when a new consultant, was contracted by the Pan American Health Organization (PAHO), Eastern Caribbean Countries office, to complete. Tragically due to Hurricane Maria, which struck Dominica on 18th September 2017, finalisation of the NSP had to be further postponed. The process continued in February 2019 when a local consultant was contracted to review the draft and complete the development of the plan. One additional consultation was conducted with key stakeholders including the NHARP staff to finalize the thematic areas of the strategic priorities.

2. Background and Health Situational Analysis

2.1. Caribbean Overview

HIV has been reported in the Caribbean Region since 1982, peaking in 2007 with 4,383 cases followed by a sudden drop from 2011 onwards. (State of Public Health in the Caribbean Region 2014 - 2016). This sudden decline must be viewed cautiously since after 2008, reporting for the region began to rapidly decline.(Allen & West, 2017).

Figure 1 - Reported HIV and AIDS cases in the Caribbean, 1982-2015

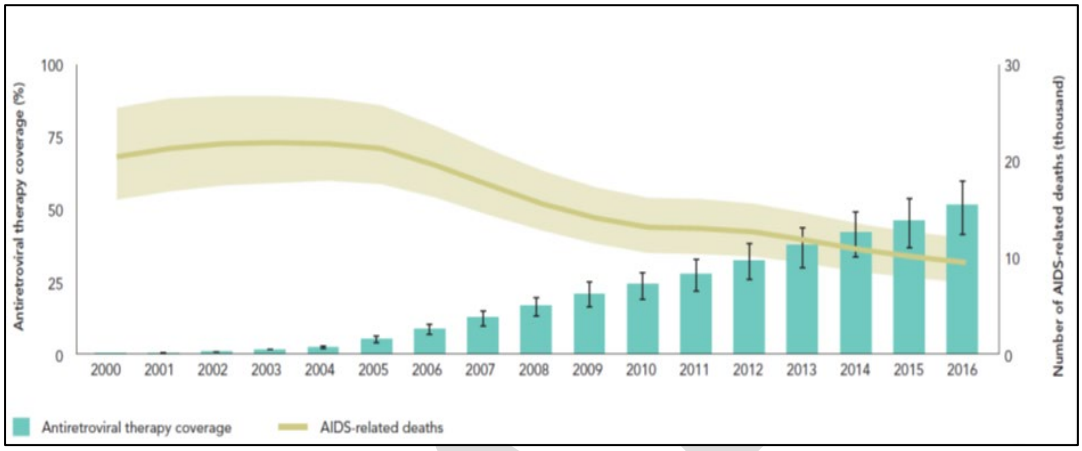


Source: Caribbean Public Health Agency, 2017

Over the period 1982 to 2015, more than 69,000 cases of HIV and less than 62,000 cases of AIDS has been reported to Caribbean Epidemiology Centre/Caribbean Public Health Authority (Allen & West, 2017).

The number of people accessing antiretroviral (ARV) therapy from 2011 to 2016, has more than doubled, assisting in reducing the number of AIDS-related deaths from an estimated 21,000 in 2000 to 9,400 in 2016 (see Figure 2) (UNAIDS, 2017).

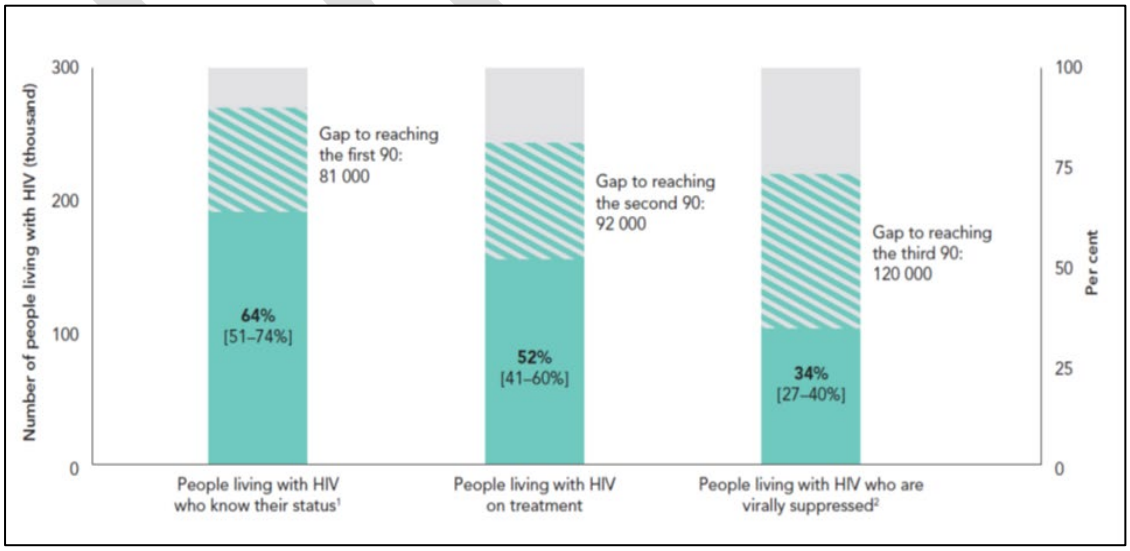
Figure 2 - AIDS-related deaths in the Caribbean, 2000-2016



Source: 2017 Global AIDS Monitoring estimates

In order to achieve UNAIDS 90-90-90 targets, knowledge of HIV testing and treatment is important. Continuum-of-case cascade indicators include % of PLHIV that have been tested and know their status; % of PLHIV on ARV treatment; and % of PLHIV on ARV with suppressed viral load (PAHO, 2014). 2016 estimates indicate that 64% of Persons Living with HIV (PLHIV) in the Caribbean know their status; 52% are on ARV therapy and 34% on ARV therapy are virally suppressed (see Figure 3) (UNAIDS, 2017).

Figure 3 - HIV testing and treatment cascade in the Caribbean, 2016



Source: UNAIDS, special analysis, 2017

2.2. Country Overview

Dominica, or officially, the Commonwealth of Dominica, is the northernmost and the largest island of the Windward Islands in the Caribbean archipelago. It is situated between the French territories, with Martinique to the south and Guadeloupe to the north (see Figure 4) and has a total land mass of 751sq km with a largely rugged mountainous terrain of volcanic origin. Having such a rugged terrain makes the country vulnerable to flash floods and destructive hurricanes which can occur throughout the latter half of the year particularly into the late summer months (CIA, 2017). In 2015, Tropical Storm Erika caused severe damage to infrastructure across the island as well as landslides and flooding. 28,000 people were affected with 14 dead and 16 missing; 574 lost their homes and 1,034 were evacuated from their homes. Availability of clean water and severe damage to food and health systems created serious health risks to the people of Dominica. Damage to the country was estimated at over 90% Gross Domestic Product (GDP) (PAHO, 2017). In addition to the effects of Tropical Storm Erika, the eye of category 5 Hurricane Maria passed over Dominica on 18th September 2017. There was total devastation with immediate loss of life, housing, agricultural crops and all communications.

Figure 4 - Map of Dominica within the Caribbean

Source: worldatlas.com

With an estimated GDP per capita of US$11, 000, which has remained stable over the last few years (estimated for 2014: US$11,500, 2015: US$11,300, 2016: US$11,300), the World Bank has classified Dominica as a upper-middle income country (CIA, 2017; Strengthening Health Outcomes through the Private Sector and Health Systems 20/20, 2012). Dominica's economy is primarily dependant on agriculture but more recently the government is seeking to promote Dominica as an ecotourism destination. In order to further diversify the country's economy, the government is seeking to encourage a financial offshore industry and develop geothermal energy resources. In 2003 the government conducted a comprehensive restructuring of the economy including privatisation of the of the state banana company and tax increases to stimulate economic growth. In 2009 and 2013, due to the global recession, the economy contracted. Public debt levels continue to exceed pre-recession levels even though the debt burden has decreased from 78% GDP in 2011 to 70% in 2012 (CIA, 2017).

Poverty and unemployment are pervasive. In 2010 household poverty was estimated at 19% and population poverty at 26%. 3.1% of the population was deemed to be indigent. 75% of the poor households live in rural areas with the remaining 25% in the larger towns of Roseau and Portsmouth (Kairi Consultants Limited, 2010). The World Bank has estimated that only 2% of the population live

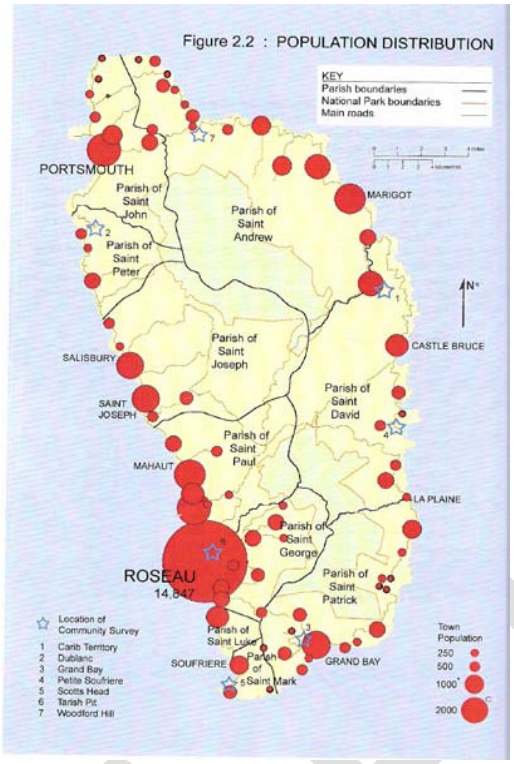
on less than US$1/day, which is low compared to other countries in the Caribbean. Unemployment has been identified as a serious problem at over 25%. Young people are disproportionately affected by unemployment with 75% being out of work and representing 25% of the total rate (Ministry of Health, 2010). The Kalinago community bear a greater proportion of the poverty; 49% are deemed to be poor compared to the national average of 28.8%. While they make up for only 4% of the total population they account for 7.8% of the country's poor (PAHO, 2017).

Dominica has a 2017 estimated population of 73, 897 (CIA, 2017). Over the past four decades the population has remained relatively stable (73,795 in 1980 to 71,242 in 2000 and now 73,897 in 2017) (CIA, 2017; Ministry of Health, 2010). The birth rate has been decreasing from 25 births/1,000 population in 1991 to 18 births/1,000 in 2001 to an estimated 15.1 births/1,000 in 2017 whereas the death rate has remained relatively stable around 8 deaths/1,000 (CIA, 2017; Ministry of Health, 2010). This decrease in birth rate, with a relatively stable death rate and overall population, can be explained by high level of emigration; the CIA Factbook has estimated a net negative migration rate of -5.4% migrants/1000 population for 20117 (CIA, 2017).

Approximately 80% of the total population is of African descent with a further 9% of mixed race. An additional 4% is Kalinago, the only concentration of indigenous people in the Antilles, and they live in the north-eastern part of the island in an area called the Kalinago Territory (Ministry of Health, 2010).

Dominica is made up of ten parishes (St Andrew, St David, St George, St John, St Joseph, St Luke, St Mark, St Patrick, St Paul and St Peter). Most of the population live on the coastal areas with the majority living in Roseau (approximately 15,000). There has been significant population growth in the area surrounding Roseau (in the rest of the parish of St George) and in the parishes of St John (which has the second largest town of Portsmouth) and St Paul (the parish located to the north of Roseau) (see Figure 5) (CIA, 2017; Ministry of Health, 2010).

Figure 5 - Population Distribution in Dominica

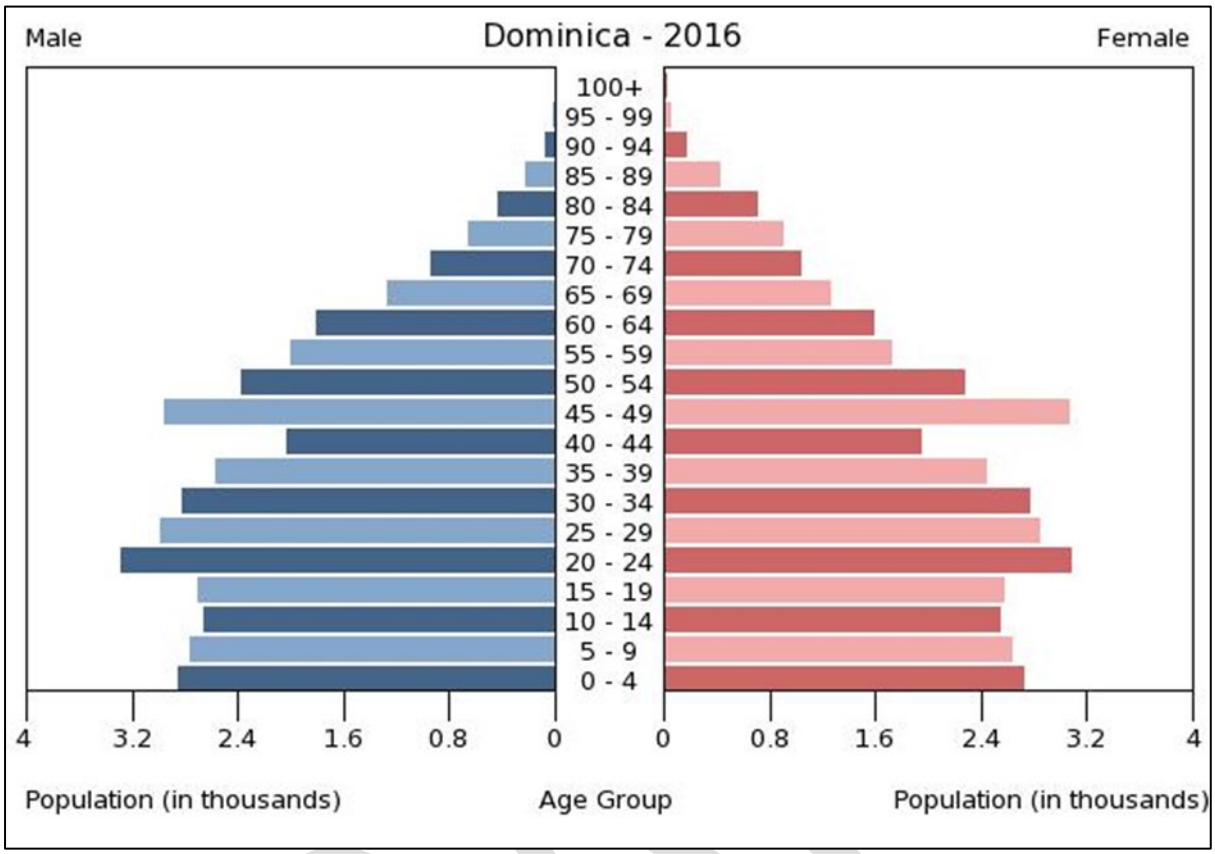


A Survey of Living Conditions report indicates that 55% of Dominican households have at least one close family member living abroad; over 30% of households have lost family members to migration; approximately 40% of migrants live in North America, a further 40% live in the Caribbean and the remainder live in the United Kingdom; and approximately 75% of migrants are adults (20-34 years old) working overseas with just over 50% of the remainder in higher education. Migration has been a fixture of the Caribbean society for over the last half century and has usually been as a result of poverty and lack of employment (Ministry of Health, 2010). As a result of the formation of the Caribbean Community Single Market Economy and the general increase in people mobility there has been an increase in migrant labour in the region. This population mobility is likely to increase the incidence of HIV and the burden of HIV and AIDS prevention, treatment and care on the host country. It is already evident in Dominica; four of the nine public facilities offering testing and counselling services have reported providing testing and counselling services to residents of other countries. In 2005 no antiretroviral (ARV) therapy patients were reported to be from outside Dominica but in 2008 there were four patients. Migrants are often reluctant to access treatment and others indicate that they plan to return to their country of origin (National HIV and AIDS Response Programme, 2015). Effective mechanisms to track the movement of PLHIV around the region need to be put in place.

2.3. Overall Health Situation and Health Systems

In 2016 life expectancy was estimated to be 77 years old (male: 74 years old; female 80.1 years old) with a median age of 33 years old (male: 32.5 years old; female 33.5 years old). The population pyramid (see Figure 6) for Dominica indicates that 42% of the population is within the 25-54 year old age group. It also demonstrates a 65+ year old age group of 11.14% (CIA, 2017). A 2011 census reported that 14.7% of the total population was over 60 years old compared to 13.5% in 2001. At the end of 2015 there were 22 centenarians in Dominica – 3 males and 19 females (PAHO, 2017).

Figure 6 - Population Pyramid, 2016



Source: CIA Factbook

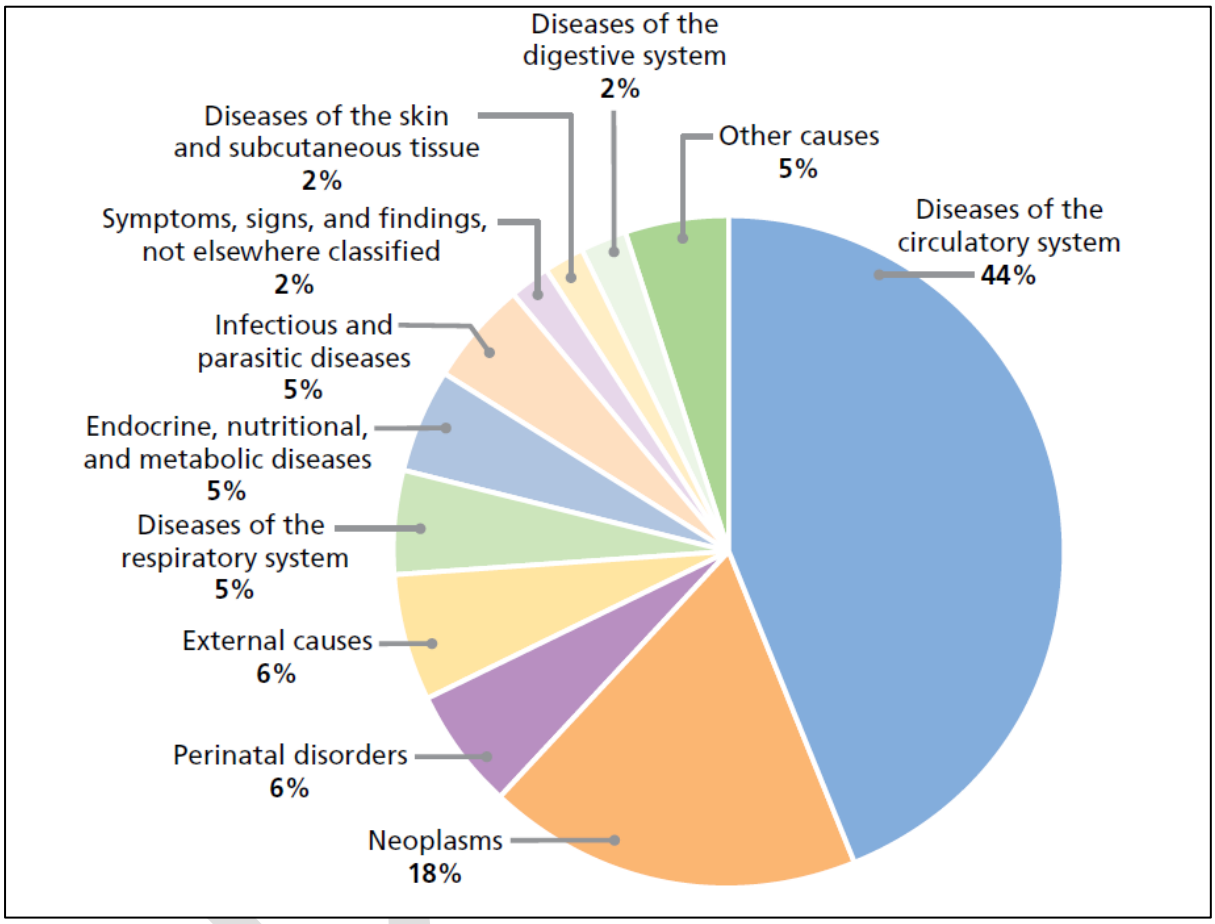
The Dominican health system is characterised by a mix of public and private actors but is dominated by public provision of services. Health services are divided into primary and secondary care, with tertiary care only available off-island. There are seven health districts, grouped into two administrative regions under the supervision of a regional manager who reports to the Director of Primary Health Care. Primary health care services include 49 health centres distributed among the towns and villages and divided into the seven Health districts throughout the country. There is a cottage Hospital in the Portsmouth Health District which provides some level of secondary care. The main Secondary care services are provided at Princess Margaret Hospital in Roseau and this is managed by a tripartite team consisting of the Hospital Services Coordinator, Medical Director and the Matron. Private services are limited to outpatient care provided by private practitioners; most of these services are based in the capital, Roseau and to a lesser extent the second town of Portsmouth There is one private hospital, approximately 12–15 private physician practices, four medical laboratories, one government and three private, nine private dentists, two private radiology centres and two private nurse practices on the island (Ministry of Health, 2010). Of importance to note is that Dominica is moving towards smart health centres. One has already been established. (MoH 2019)

Reproductive health services are accessible to all within both public and private sectors. This service is at no cost to consumers in the public sector. The Dominica Planned Parenthood Association is the main provider of contraceptives and other reproductive health services (pap smear screening, pregnancy tests, counselling). Maternal mortality rate has remained at 0/1,000 live births, HIU 2017.

Quality antenatal care is available to all women and all births are attended by skilled health personnel (PAHO, 2017). Overall infant mortality rate for 2018 is estimated at 8.3 deaths/1,000 live births.

Chronic Non-Communicable Diseases (NCDs) are a significant problem with heart disease, stroke, cancer, diabetes and chronic respiratory diseases ranking as the leading causes of mortality and disability. Diseases of the circulatory system (44%) and neoplasms (18%) account for almost two-thirds of the deaths (PAHO, 2017). See Figure 7 for the leading causes of mortality in Dominica, 2014.

Figure 7 - Leading Causes of Mortality in Dominica, 2014



Source: Pan American Health Organization, 2017

Vector-borne diseases continue to be a source of concern. Chikungunya was first reported in Dominica in late 2013 and up to 2016 there were 3,771 cases reported of which 173 were laboratory-confirmed. There were 723 cases of Zika virus infection reported between March and July 2016 with 65 laboratory-confirmed. Five pregnant women were diagnosed with Zika and one patient with Guillian-Barré syndrome, who was treated in Martinique. Dengue is endemic in Dominica with significant outbreaks in 2010 and 2013; 641 and 233 cases reported respectively. Over the past 5 years there has been a major leptospirosis outbreak with 41 reported cases including 4 deaths (PAHO, 2017).

The incidence of tuberculosis remains low. Of the 4 cases of tuberculosis (TB) reported in 2018; all received directly observed treatment free of charge. In 2013 there was a single case of rifampicin-

resistant TB reported (PAHO, 2017). In 2016, there was one new case of TB/HIV co-infection (National HIV and AIDS Response Programme, 2016). There have been no cases of co-infection since.

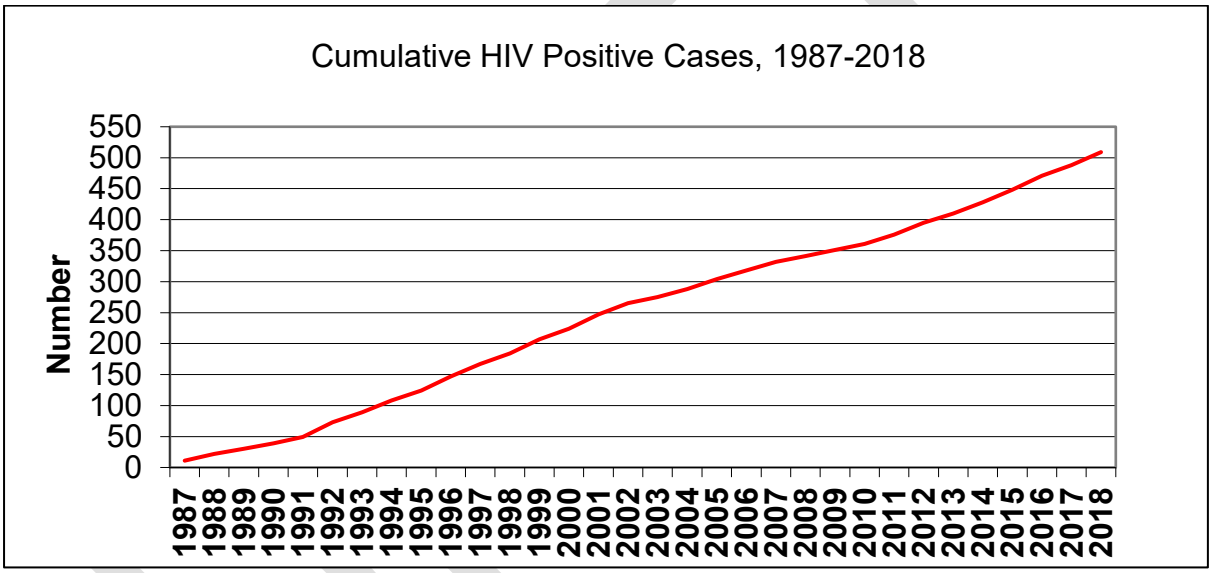
3. HIV and AIDS in Dominica

3.1. Status at a glance

The first case of HIV in Dominica was recorded in 1987 and the present HIV epidemic can be described as a generalised one. (NHARP 2018)

The incidence of HIV remains under one percent in Dominica with the cumulative number of PLHIV, since the start of the epidemic in-country at 519 (see Figure 8). The HIV epidemic continues to disproportionately affect males. (National HIV and AIDS Response Programme, 2018)

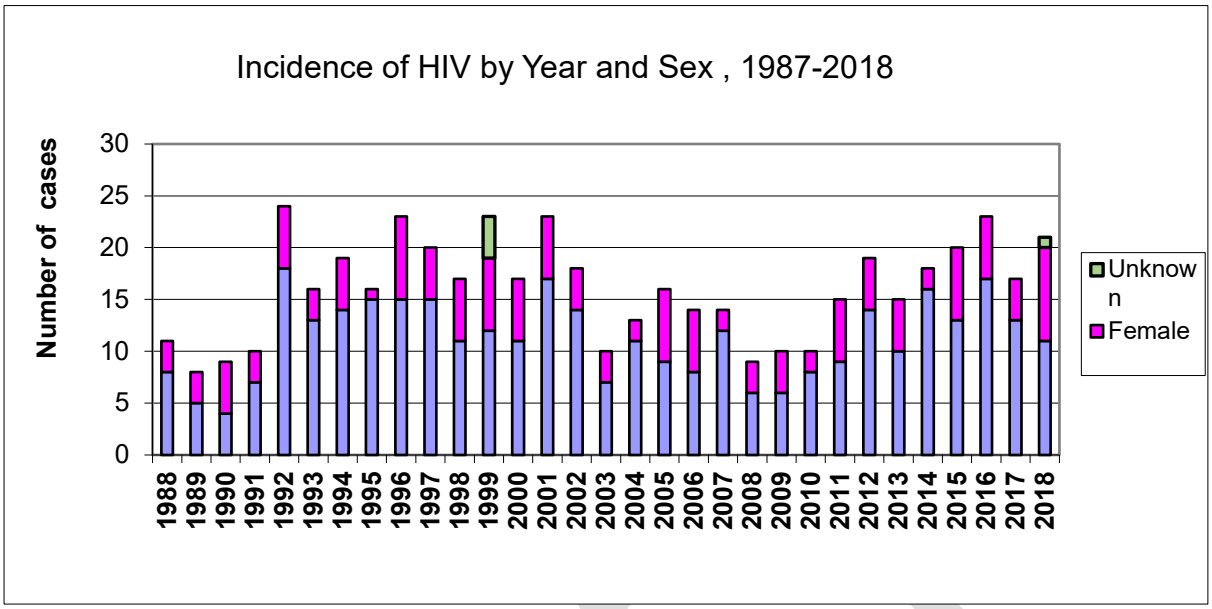
Figure 8 - Cumulative HIV Positive Cases, 1987-2018



Source: Health Information Unit, Ministry of Health

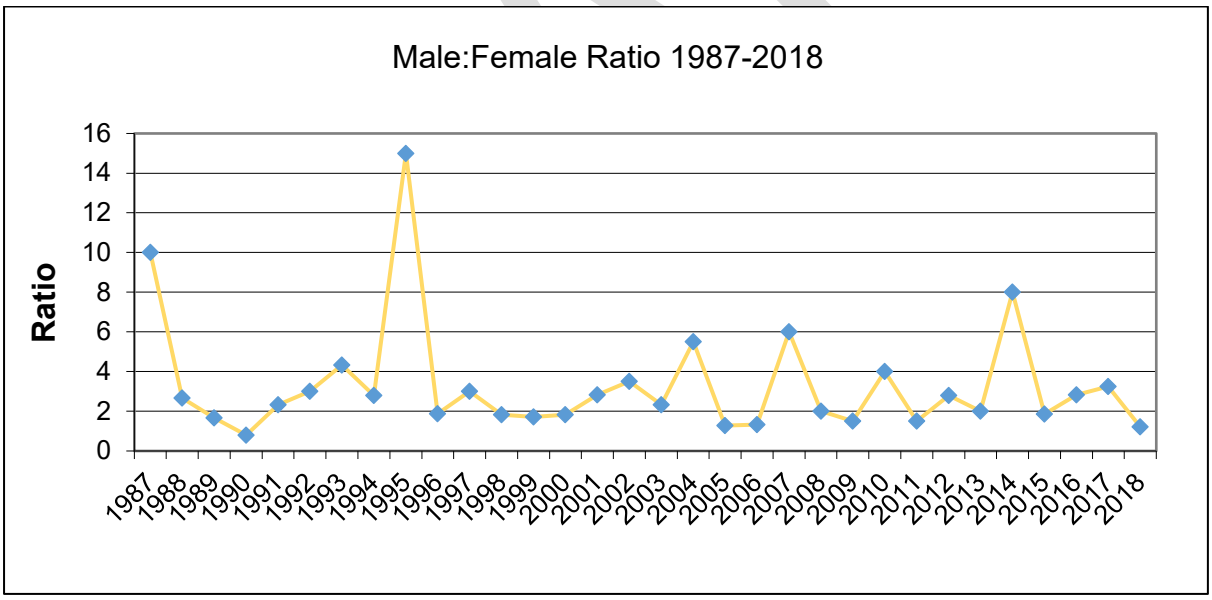
The epidemic is male dominated with approximately 75% of all cumulative cases being males (see Figure 9 and 10). This has been the trend over the last 20 years of the epidemic (National HIV and AIDS Response Programme, 2018).

Figure 9 - Incidence of HIV by year and sex, 1987-2018



Source: Health Information Unit, Ministry of Health

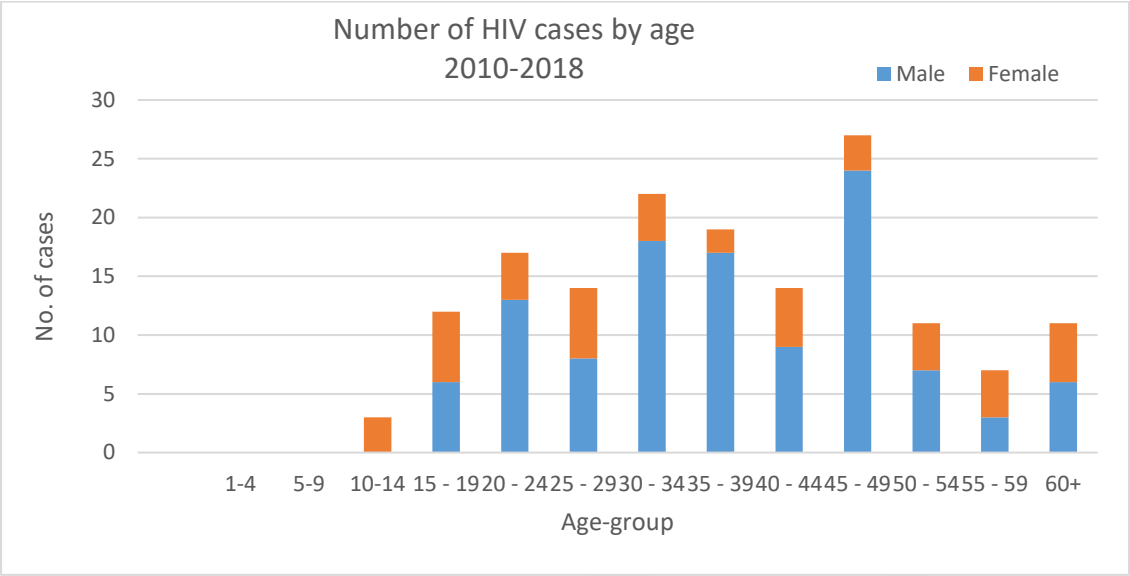
Figure 10 - Male-to-female ratio of HIV-positive cases, 1987-2015



Source: Health Information Unit, Ministry of Health

Figure 11 demonstrates the number of HIV cases by age group for the period 2010-2018. Although the 20-49 year old age group continues to be the most affected population, in particular the 45-49 year old age group, there has been an increase in the incidence of males and females, over the last few years in the over 50 year old age group. Change dates and numbers

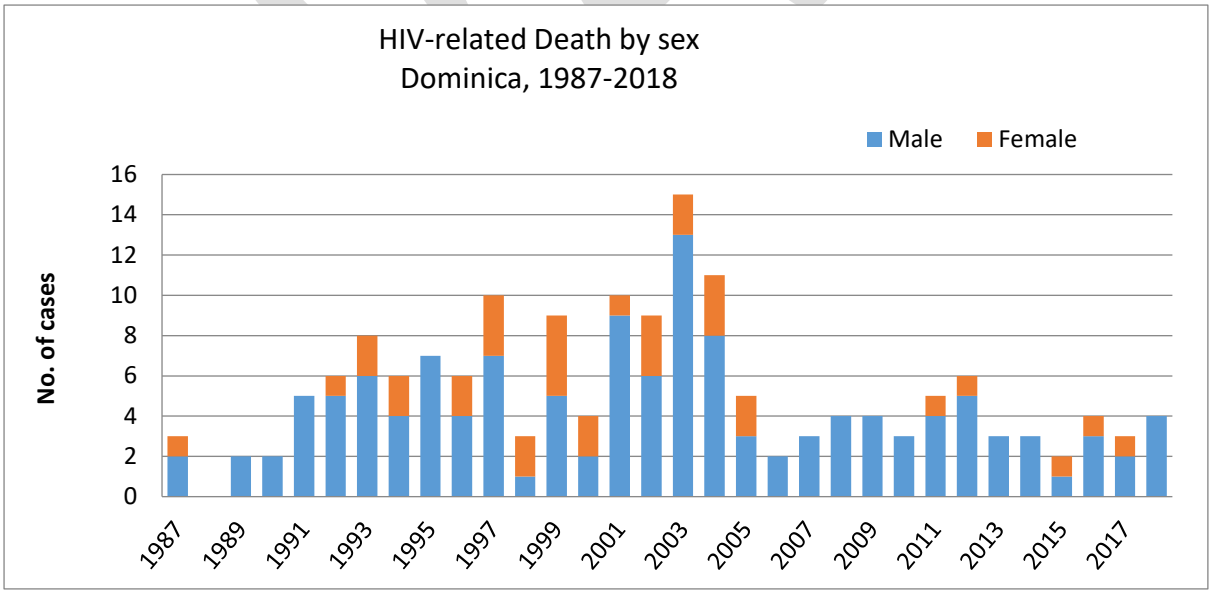
Figure 11 - Number of HIV cases by age group, 2010-2018



Source: Health Information Unit, Ministry of Health

The total number of reported AIDS-related deaths, from 1987-2016 has been 159. With the epidemic being more male oriented the cumulative number of male deaths is 127 and that of females is 32 (see Figure 12). The total number of deaths reported during 2017 was four – 2 males 2 females(National HIV and AIDS Response Programme, 2018).

Figure 12 - HIV-related deaths by sex, 1987-2018



Source: Health Information Unit, Ministry of Health

Prevention Services

Strengthened and updated high impact interventions along the continuum of care for HIV and STI prevention, diagnosis and comprehensive care and treatment and co-infections including TB and Viral Hepatitis

- Implement high impact interventions tailored to the needs of key populations (MSM, SWs, youth, migrants, indigenous populations, prisoners)
- Strengthen country wide high impact behaviour change programmes for HIV and STI prevention and early detection
- Eliminate Mother-To-Child Transmission (EMTCT) of HIV and syphilis
- Strengthen key interventions to expand EMTCT services to include testing for viral hepatitis, syphilis, partner testing and treatment, and family planning
- Build capacity among health care workers to better detect and manage HIV co-infections and TB

3.1 Pre-Exposure (PreP) and Post Exposure (PEP) Programme

According to the WHO, there is high-quality evidence which strongly supports the use of PrEP by any person at substantial risk of acquiring HIV infection. There are twelve trials of the effectiveness of oral PrEP which have been conducted among sero-discordant couples, so Commonwealth of Dominica has considered the benefits of Roling out PREP in country. A country plan has been put in place which would include a position paper and technical and financial preparation

Evaluate programme success, gaps, challenges that would need to be improved, strengthened, solved and resolved to ensure success of full implementation. Meeting with Financial stakeholders to complete forecasting for Travada needed for full implementation in June, next PPS ordering period.

Development of a tailored Communication Plan for dissemination of information on PrEP to the general and target populations, clinician and policy makers

3.2 Human Papilloma Virus (HPV)

To be developed- same as above

3.3 VIRAL Hepatitis

To be developed- same as above

3.2. Mother-to-Child Transmission Plus (HIV, Syphilis and Hepatitis B)

Prevention of Mother-To-Child Transmission (PMTCT) of HIV has been a great success in Dominica; there have been no cases of MTCT for the past fifteen (15) years. (NHARP 2018) The first reported pediatric case was in 1987. In 2001 the PMTCT programme was implemented in Dominica and became formalized in 2004. The advent of the formalization of the PMTCT programme, gave rise to early identification and treatment of HIV positive pregnant women, a supportive environment of family

strengthening, appropriate counseling and psychosocial support. Supplemental Feeding for all exposed infants is a significant aspect of the PMTCT programme. Dominica is working towards Validation of the elimination of mother to child transmission of HIV and congenital syphilis. The term validation is used to attest that a country has successfully achieved the indicators (regional and global targets established for validation) to eliminate mother-to-child transmission of HIV and syphilis at a specific point in time and demonstrate a health system strong enough to maintain the gains. It is therefore critical to continue to provide high quality ante natal care. Indicators required by PAHO / WHO for validation include:

- ✓ Impact indicators—must be reached for at least two consecutive years:
- ✓ 30 cases or fewer of new perinatal HIV infections per 100,000 live births; and
- ✓ 50 cases or fewer of congenital syphilis per 100,000 live births; and
- ✓ 2% or below rate -to- of mother child transmission of HIV.
- ✓ Process indicators—must be achieved for at least two consecutive years:
- ✓ 95% or more of all pregnant women should receive at least one antenatal care visit.
- ✓ 95% or more of pregnant women living with HIV tested for the virus.
- ✓ 95% or more of pregnant women attending prenatal care screened for syphilis.
- ✓ 95% or more of pregnant women diagnosed with HIV or syphilis receive adequate treatment.

HIV testing is not mandatory, in Dominica, yet district midwives have ensured that all pregnant women have at least one test during their pregnancy depending on their booking date. The pregnant mothers, especially those who test early are encouraged to have a second test as well as to have their partners tested (National HIV and AIDS Response Programme, 2015). In 2018 NHARP reported three HIV positive women delivering. DNA PCR was carried out for all reported highly exposed infants (HEI). These infants have tested negative for HIV. As it relates to Congenital Syphilis 2 women were diagnosed and treated and the babies have all been cleared.

Key Populations

There is limited information on size, prevalence, knowledge of status, ARV therapy coverage, condom use, and coverage of HIV programmes including testing programmes for key populations. However, it has been determined that 1.8% of the prisoners in Dominica are HIV-positive. In 2016 four prisoners tested positive for HIV, out of which two are receiving ARV therapy. There appears to be no prisoners with hepatitis C or co-infected with HIV and hepatitis C, and similarly there are no prisoners with TB or co-infected with HIV and TB (National HIV and AIDS Response Programme, 2016).

There has been some effort to establish size estimates as well as prevalence among Men who have Sex with Men (MSM). A Mapping and Size Estimation in Dominica was conducted by the Ministry of Health where methods of ethnographic mapping and capture/recapture were used to estimate the number of MSM in the population; this number was calculated from a specific formula to be 454 (Government of Dominica, n.d.). Additionally a Behavioural and HIV Seroprevalence Survey among Men Who Have Sex with Men in Dominica, conducted in 2010, found an estimated prevalence to be 26.7%. The study also identifed that 63.6% of MSM used a condom at last anal sex with regular partner and 77.1% used a condom at last anal sex with non-regular partner. Yet with female partners, MSM reported consistent condom use only 11.6% of the time (OECS, 2015b).

Identification and working alongside the Most at Risk Populations (MARPS) which consist of SW, MSM and youth still continues to be challenging, it is more so with the MSM population. A great drive with

conducting programs and workshops with these populations on safer sex practices, self-empowerment, legal advocacy, and strengthening organizational management were piloted with support from GF grant. J-FLAG provided Support for Key Population activities especially with the MSM community; self-empowerment training and capacity. (NHARP 2018)

HIV testing and Counselling.

Voluntary counselling and testing remains a vital part of the National HIV and AIDS Response Programme (NHARP). The advent of provider initiated testing and counselling (PITC) has supported the gaps in VCT. Testing sites have been established in all seven health districts with qualified testing and counselling providers. Testing is also available on the maternity unit of the Princess Margaret Hospital to capture those mothers who present for delivery without HIV test results from the antenatal clinic (National HIV and AIDS Response Programme, 2014, 2015). The 2015 WHO Consolidated Guidelines on HIV testing have been partially implemented. Dominica has also implemented strategies to link HIV testing and counselling to treatment and care, for example, streamlined interventions (enhanced linkages, disclosure and tracing), peer support and patient navigation approaches and CD4 testing at point of care) (National HIV and AIDS Response Programme, 2016). In 2018, 3,229 people accessed rapid testing sites. Due to the large numbers presenting for testing it appears that people would like to know their status, however, it is usually females accessing testing and counselling services. This female-led testing trend can be due to the aggressive testing and counselling programme within the antenatal unit (National HIV and AIDS Response Programme, 2014, 2015). The 2018 NHARP report indicated an improvement in the number of males presenting for testing at the World AIDS Day 2017 “know Your Status” campaign, a total of 366 persons were tested 211 females (57%) and 155 males (42%).

The NHARP continues to partner with local NGOs and CSOs as Testing and counselling continues to be expanded to included schools, pharmacists and other (National HIV and AIDS Response Programme, 2018).

3.3. Outreach, BCC and IEC

The behavioural change communication (BCC) and information education and communication (IEC) approach under the prevention component of the programme continues to be a vital aspect of the approach as we look to decrease the incidence of the HIV epidemic on the island.

The NHARP participates in some of the festive activities such as carnival, World Creole Music festival, carnival, health fairs. Two primary and one secondary school were provided with peer counselling sessions. The World AIDS Day walk 2018 and sensitization marathon also played a significant role in addressing the challenge of stigma and discrimination. In addition a number of radio programmes on all the radio stations during the year, were part of the continued sensitization of the public. The NHARP piloted a radio infomercial all "HIV-TIDBIT".

Behavioural Change Communication (BCC) is very important to the prevention work of the NHARP throughout the communities and workplaces. The Ministry of Education is scaling up its National Health and Family Life Education training focusing on sexuality and sexual health for its teachers across the country. In 2014, teachers across certain areas of the Kalinago Territory, LaPlaine/Delices and the Roseau Valley were provided with skills to provide HIV education from grades K to 6. It is expected that this training will be scaled up to include the other areas in the near future (National HIV and AIDS Response Programme, 2015).

Prevention education is also provided to schools, faith-based organisations, pharmacies and community groups as requested. Other NGOs and civil society organisations such as the National Youth Council, Youth Advocacy Movement and Kiwanis Club are involved in prevention activities targeting key populations (National HIV and AIDS Response Programme, 2014, 2015).

Condom use remains an important element of the BCC strategy, especially among key populations. In 2018, the NHARP office distributed 10,270 male condoms, 423 female condoms, 22 dental dams and 1,342 sachets of lubricant. During that report period there were no stock outs. (NHARP 2018)

A total of 38,100 condoms and 3602 lubricants were distributed for the year.

Table 1 - Distribution of Commodities in 2018 within the Government System

Yearly	Male Condoms	Lubricants	Female	Totals
Totals	**25741**	**5465**	**1188**	**41702**

Treatment, Care and Support

The Treatment and Care programme follows the Organization of Eastern Caribbean States (OECS) HIV/STI Treatment and Care Guidelines which were updated in 2017. The management of PLHIV has been updated to include Treatment 2.0 and Option B+ for the PMTCT programme (National HIV and AIDS Response Programme, 2018). The Clinical Care Team at the Infectious Disease Clinic, ensure that clients receive high quality clinical care, adherence counseling, positive prevention and psychosocial support. This support includes nutritional support from a government and civil society supported food bank (National HIV and AIDS Response Programme, 2015). National guidelines recommend ARV

therapy for all PLHIV with active TB, all PLHIV with viral hepatitis, and severe liver disease, for the HIV partner in serodiscordant couples, test and treat of all newly diagnosed clients. (OECS HIV/STI guidelines 2017)

At the end of 2018, there were 112 clients enrolled in care (68 males and 44 females) of these, seventy-four (89) are receiving antiretroviral therapy with 41 with VL of < 1000 copies/ml. OECS protocol indicates that clients with viral loads of <, 1000 copies/ml have achieved vial suppression. The NHARP along with HIU has not presented the Continuum of care cascade for Dominica for 2018 as result of issues experienced after hurricane Maria.(NHARP 2018.) Health personnel such as District Medical Officers, were provided with training on the revised guidelines on the management of HIV and STIs in an effort to decentralize care, treatment and support to patients at the district level (National HIV and AIDS Response Programme, 2015).

All clients enrolled in care receive comprehensive services including immunologic monitoring and psychosocial support. CD4 cell counts are conducted internally. Equipment for CD4 monitoring suffered some damage during the passage of Hurricane Maria. Viral loads are sourced externally in Barbados. The major issue experienced is a three week turnaround time for results. (NHARP 2018)

An HIV Drug Resistance study was carried out in the second half of 2018 with 31 clients. The results of the study have not been published. (NHARP 2018.)

The NHARP Report 2018 highlighted a few challenges which hinder the provision of high quality treatment, care and support along the continuum of care cascade. These include; lost to follow up, incomplete data, lack of M&E Officer and Health Educator as well as a dedicated IDC nurse.

As part of the OECS Global Fund implementation, the OECS HIV and Tuberculosis Elimination Project (HTEP) has implemented a plan to assist the OECS in meeting the goal to end TB by 2030, in support of fulfilling the one of the Sustainable Development Goals of health. The guidelines to support the management of TB, HIV and STIs were revised in 2017.

3.4. TB/HIV CO-INFECTION

(TO BE DEVELOPED)

3.5. Strategic Information

Improved national HIV and STI and TB surveillance system to deliver quality data for evidence informed programming and policy decisions

Strengthen Monitoring and Evaluation (M&E) capacity to measure impact and effectives of the HIV response.

Build capacity of surveillance personnel in line with international standards

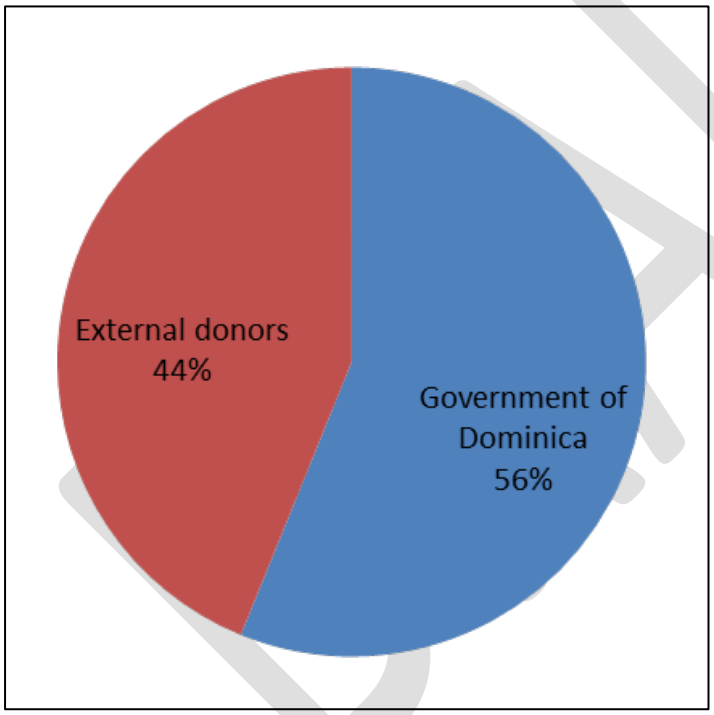
Complete or finalize outstanding manuals i.e. pandemic influenza preparedness plan ;
Communicable Disease Manual

3.6. Funding for HIV and AIDS Programmes

Financing of HIV/AIDS services, from the mobilisation of resources and risk pooling to allocating funds to cover the health needs of the population, is a critical element to ensuring access to a quality HIV and AIDS response. In 2010-2011, the Ministry of Health conducted a study to determine the

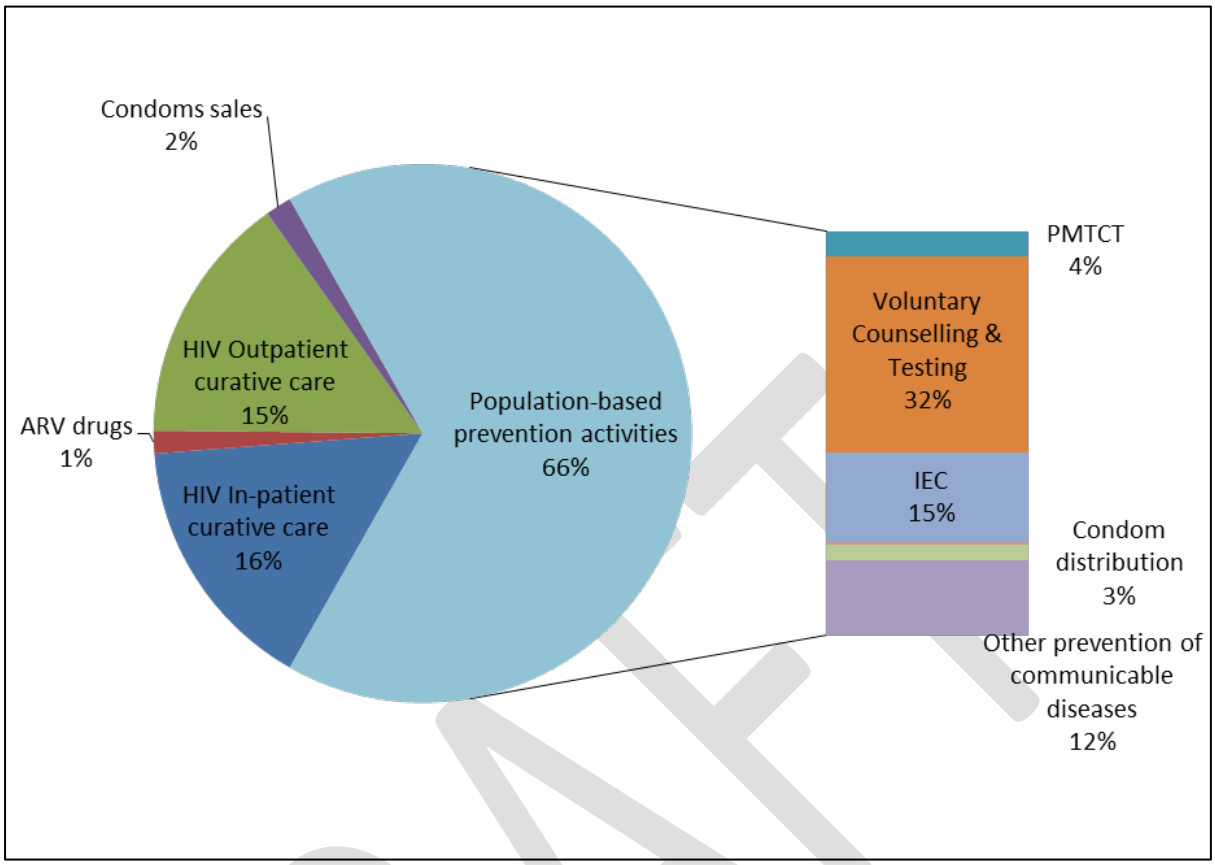
magnitude and components of the health expenditure in Dominica. Health spending represents 15.5% of total government spending (which exceeds the regional average of 12%), and 6 .1% of GDP (equal to the regional average). The HIV subaccount findings indicated that 2% (US$719,000) of the total health expenditure was for the national HIV response. Of this 2%, the government provided 56% of funding for the national AIDS response (see Figure 14). The majority of the funds (59%) are directed at population-based prevention services; 66% towards HIV testing and counselling and 15% towards information, education and communication (see Figure 15) (Ministry of Health, 2013; National HIV and AIDS Response Programme, 2014). Dominica was also supported by a Centers for Disease Control and Prevention Cooperative Agreement (US$200,000) (National HIV and AIDS Response Programme, 2014). This grant was used to scale testing. The OECS has been awarded the recipient of funds from Global Fund Grant to Fight AIDS Tuberculosis and Malaria. The first 2005-2010 focused on HIV (US$8,000,000) alone whereas the second 2016-2019 focusses on both HIV and TB (US$5,000,000). (OECS, 2015a)

Figure 13 - Sources of HIV funding



Source: Ministry of Health & Social Services, Dominica

Figure 14 - Flow of funds to providers of HIV services



Source: Ministry of Health, Dominica

In 2014, with assistance from USAID -funded Health Finance and Governance and Strengthening Health Outcomes through the Private Sector projects an analysis and projection of costs for future prevention and treatment interventions was conducted. Three scenarios were given, their impacts on the national HIV epidemic and the projected financial resources needed (see Table 2) (Abt Associates, 2014).

Table 2 - Financial resources needed for HIV and AIDS programming, 2015-2020

	SCENARIO 1 - MAINTENANCE	SCENARIO 2 – NATIONAL STRATEGIC PLAN 2015-2019	SCENARIO 3 – 90-90-90 2015-2020
Description of scenario	Funding for prevention programmes and ARV therapy to remain at current levels	Scale-up of prevention and treatment programmmes to include targets set in NSP, for example 80% of population covered by condom promotion and 80% coverage of ARV therapy for adults and children	Reflects 90-90-90 targets. For example, 80% of population covered by condom promotion and 90% coverage of ARV therapy for adults and children
No of infections averted	Not available	63	70

No of AIDS-related deaths averted	Not available	75	83
Cost	ECD$10.8 million	ECD$17.8 million	ECD$18.2 million

This costing exercise was conducted when the new NSP was developed to be implemented from 2015-2019. This has not been the case but the calculations give an estimate of funding needed for the desired outputs. There is not a significant difference between the scenario 2 and 3. The major difference is a faster increase in scale-up of treatment coverage in the 90/90/90 scenario as compared to the scale-up in the NSP. The majority of costs are for prevention, followed by care and treatment, and policy and programme support. Costs for treatment scale-up are offset by reduced costs for treatment of opportunistic infections. (Abt Associates, 2014)

4. Development of the National Strategic Plan

The Development of the plan commenced with two consultation workshops on July 8th and 9th 2014 with stakeholders involved in the national HIV/AIDS response, including members of civil society, private sector, and the Ministries of Health, Education and Finance. This process aimed to review the current progress and challenges to date and identify strategic priorities, objectives and key actions for the 2015-2019. Additionally, as a result of the delay due to Hurricane Maria in 2018, the new strategic plan would run from 2020-2025. To support these dates, two follow-up consultations were conducted during the first half of 2019. During these consultations, stakeholders maintained the challenges however, fine-tuned the strategic priorities.

Following a review and discussion of the situational analysis and financial landscape, stakeholders identified key challenges and themes for consideration when defining the strategic priorities for the new NSP. In the analysis of challenges, some of the recurring themes included identifying those with HIV and ensuring that they receive clinical care and retained in care as well as support services. In addition, strengthening and expanding programmes for highly vulnerable populations, such as MSMs and SWs, requires continued follow up and interventions. Other important challenges for analysis are summarised in Box 1.

Box 1: Challenges identified during consultation workshop July 2017 and maintained in 2019

Challenges

- Proportion of numbers being tested and those who are positive. Is prevalence really low or are we not testing the right people?
- A gap exists between those who are diagnosed with HIV and those actually in treatment and care.
- How do we reach and retain PLHIV in care?-Along the continuum
- Male dominated epidemic calls for tailored interventions.
- Higher MSM prevalence.
- Increased knowledge about HIV and AIDS does not necessarily translate to behavior change (95% aware of male condom but 75% condom use).
- Need to strengthen and integrate STI, HIV and TB management and services at primary care level.
- Maintain EMTCT achievements.

Through a participatory process, stakeholders analysed each strategic priority and key actions defined in the NSP 2010-2014 (Annex A) and suggested revisions, new sub-populations and an additional strategic area related to sustainability of the national response. This review process resulted in the strategic priority areas and objectives discussed in section 5. The 2020-2025 has been developed in accordance with the following national, regional and international policies and frameworks:

- 2016: United Nations. Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030. Resolution adopted by the General Assembly on 8 June 2016. A/RES/70/266.
- 2016: The Global Fund to Fight AIDS, Tuberculosis and Malaria. Framework agreement between The Global Fund to Fight AIDS, Tuberculosis and Malaria and the Organisation of Eastern Caribbean States. Contract No OECS/120/2015.
- 2015: United Nations. Transforming our world: the 2030 Agenda for Sustainable Development. Resolution adopted by the General Assembly on 25 September 2015 A/RES/70/1.
- 2015: Pan American Health Organization. Elimination of mother-to-child transmission of HIV and syphilis in the Americas – Update 2015.
- 2014: The Joint United Nations Programme on HIV/AIDS. 90-90-90 An ambitious treatment target to help end the AIDS epidemic. 2014
- 2014: Pan American Health Organization. HIV Continuum of Care Monitoring Framework.
- 2014: Pan Caribbean Partnership against HIV and AIDS Caribbean. Caribbean Regional Strategic Framework on HIV and AIDS 2014-2018.

4.1. Guiding Principles and Critical Elements

Stakeholders have confirmed that the guiding principles of the first NSP will be maintained. The 2020-2025 NSP also ensures the continuity of all work commenced in the previous draft NSP in the area of prevention, treatment, and care of HIV and AIDS. The broad principles of the NSP are:

- ✓ Preservation of human life and well-being- every attempt will be made to preserve the well-being of the individual regardless of his or her health status, sexual persuasion or other personal characteristics.
- ✓ Respect for human dignity- the national response will seek to foster a greater sense of self-esteem and self-respect among all Dominicans at all times.

- ✓ Sustained effort- the scope and intensity of the response will be in keeping with the dimension of the problem.

Critical elements used as a basis for this plan include:

- ✓ Ownership of the NSP by all stakeholders;
- ✓ Capacity to implement the programme;
- ✓ Clearly defined goals that are readily understood;
- ✓ Operational Plan with goal oriented activities which will move the programme forward;
- ✓ Beneficiaries, service providers, and programme managers are all engaged in programme preparation and implementation;
- ✓ Programme managers will ensure that tasks will only be implemented when ready; and
- ✓ An effective monitoring and evaluation programme will be developed that will be linked to the GF OECS 2016 and the 90-90-90 targets.

4.2. Goals

The goal of the NSP 2018-2022 is: To reduce the incidence of HIV infection in Dominica in accordance with the 90-90-90 targets and reduce the incidence of STIs and TB

Vision: Zero New Infections, Zero HIV related deaths, and Zero related stigmas and discrimination

Goal: END of AIDS and other sexually transmitted infections as a public health threat by 2030

In order to achieve the goal of the NSP 2020-2025 the following, 90-90-90 targets, set for 2020, should also be achieved:

- ✓ 90% of all people living with HIV know their HIV status
- ✓ 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy
- ✓ 90% of all people receiving antiretroviral therapy will have viral suppression
- ✓ 25% reduction of new HIV infection
- ✓ 80% of the general population tested for Hepatitis B and C
- ✓ Hepatitis B and C treatment provided to all persons diagnosed with Hepatitis B and C
- ✓ No cases of perinatal HIV, syphilis and Hepatitis B
- ✓ Hepatitis B Vaccine -Birth dose is available to all new borns

The United Nations Fast Track Strategy (2016-2021) seeks to accelerate and reduce the rate of new HIV infections and AIDS-related deaths (United Nations, 2016). In doing so it will achieve the 90-90-90 treatments targets (UNAIDS, 2014) and the Sustainable Development Goal target of ending AIDS by 2030 (United Nations, 2015). This goal is also in keeping with the Caribbean Regional Strategic Framework 2014-2018.

5. Focus on Priority Areas (see some suggestions below- can reword)

- Addressing financial barriers to access, reducing prices and cost and improving efficiencies;
- Improved selection, procurement and supply of affordable medicines, diagnostics and commodities;
- Revision of the national structure and coordinating mechanisms to ensure an effective inter-programmatic and multi-sectoral response to HIV, priority STIs, HPV, viral hepatitis B & C, as well as TB/HIV co-infection;
- Review and implement norms and guidelines to expand hepatitis B beyond immunisation, and to advance toward the timely implementation of birth dose and expand access to the at-risk population;
- Revise, update and standardise national guidelines, norms and protocols to support diagnosis and treatment of the infections within all health sectors, both public and private;
- Implementation of framework which will support the promotion of health throughout the life course, reduction of risk factors and disease prevention with the involvement of civil society organisations;
- Strengthening of a comprehensive information system for HIV and STI case reporting to monitor the continuum of prevention, care and treatment services, especially for key populations;
- Standardize forms to collect data on HIV/STI, Hepatitis (B & C) and TB/HIV from all health facilities and to report to the surveillance unit;
- Identify and develop mechanisms to capture data from private health facilities for HIV/STI, Hepatitis (B & C) and TB/HIV co-infection, forwarded to the surveillance unit to support improved strategic information and programmatic decision making.(see operational plan)

6. Strategic Priority Areas and Objectives

Strategic Priority 1: Strengthened and updated high impact interventions along the continuum of care for HIV and STI prevention and diagnosis.

Prevention interventions to reduce HIV and STI transmission among the general and key populations require a combination approach. This includes (1) ARV-based interventions that include ARV therapy Pre-Exposure Prophylaxis; (PrEP) for persons at a higher risk of HIV infection, and Post-Exposure Prophylaxis (PEP) for occupational and sexual exposure (2) comprehensive sexual and reproductive health services that include male and female condom and lubricant programmes; (3) comprehensive sexual and reproductive health information, education and communication strategies for behavioural risk reduction and management; (4) STI prevention, screening and treatment; (5) comprehensive harm reduction services for the consumption of psychoactive substances, injectable and non-injectable, as well as for alcohol dependency; (6) HIV testing services; (7) voluntary medical circumcision; and (8) promotion of 'positive prevention' intervention for people with HIV.

Key populations, MSM, SWs, migrants, indigenous populations, youth (15-24 years old) and prisoners, have been defined using one, or more of the following criteria – (1) having a higher HIV prevalence than that of the general population; (2) exhibiting behaviours that place the group at a higher risk for HIV infection, multiple partners, and low condom use; or (3) demonstrating an increased risk to HIV infection due to factors such as poverty, social exclusion. Each of these key populations requires a range of evidence-based behavioural and biological prevention programmes that are tailored to the country context and social and cultural needs of the individual group.

To ensure that high impact interventions are successful it is necessary to develop and implement guidelines and procedures that maintain the safety of blood supplies and blood components; focussing on screening for HIV, STI and viral hepatitis. With regards to MTCT there have been no cases in Dominica since monitoring began in 2001. It is necessary to continue this positive trend and eliminate vertical transmission of hepatitis B and congenital syphilis by enforcing the use of existing protocols as well providing regular training for clinicians. To maximise the prevention and early detection efforts, the role and impact of civil society, including the network of NGOs, Civil Society Organisations (CSOs) and faith-based organisations needs to be strengthened to ensure a coordinated response with the NHARP.

Objectives	**Key Actions**	**Activities**
1.1: Implement high impact interventions tailored to the needs of key populations (MSM, SWs, youth, migrants, indigenous populations, prisoners)	• Improve access to health services for key populations by implementing new evidence based interventions for HIV prevention • Strengthen communication strategies using TV, radio, social media to promote behaviour change • Update HIV testing guidelines to align to OECS / WHO recommendations	• Anti-stigma Training for Health Care Provider • Train testing providers among key population • Implement feasibility study and implementation of PrEP • Strengthen STI and hepatitis diagnosis for key population within a comprehensive package of services • Use of Community Animators • Develop BCC/IEC strategies • Conduct training on new guidelines • Strengthen HIV/STI testing at primary care level • Pilot the use of the syphilis rapid test for key population & EMTCT
Indigenous Population	• HIV prevention programmes that take into account cultural practices of the indigenous Kalinago population	• Conduct needs assessment • Develop specific substance abuse, vocational training, leader empowerment programmes

MSM	• Strategies to increase demand and generate effective distribution of safer sex commodities • Determine size estimates and risk behaviours	• Develop targeted BCC program • Develop targeted interventions • Conduct size estimate study with BSS component
Youth	• Implement youth-friendly sexual and reproductive services in the schools and communities	• Train Specialized HFLE Teachers • Develop Youth BBC programs • Establish linkages with youth community groups • Peer Counselling programs in schools
SW	• Implement strategies to increase demand and generate effective distribution of safer sex commodities • Determine knowledge and risk behaviours	• Develop targeted BBC/IEC program • Conduct knowledge, attitudes, beliefs and practices study among SWs
Prisoners	• Determine prevalence among inmates • Implement continuous Targeted interventions at DSP • Maintain care and support of HIV positive inmates	• Conduct Seroprevalence and BSS • Develop targeted BCC/IEC • Conduct follow-up of inmates testing positive after leaving prison
1.2: Strengthened country wide high impact behavioral change programmes for HIV and STI prevention and early detection.	• Increase behavior change interventions • Build capacity of Health Promotion Department and NHARP	• Develop BCC/IEC program • Reactivate Face Book page • Organized parenting sessions in schools

	• Determine National Prevalence • Safer sex commodities available and accessible Commodities(condoms, dams, lubricants) island wide • Continue to provide high quality HIV/STI testing	• Additional Health Educators • Conduct Sero prevalence study with BSS among general population • Distribution of commodities island wide • Identify Non-conventional sites for condom distribution • Review Testing Guidelines • Validation of test kits to move to serial algorithm • Upgrade and maintain testing sites • Introduce Rapid RPR at testing sites • Training of testing providers
1.3: Improve quality controls for laboratory testing	• Implement National Laboratory Policies • Update Laboratory policies • Quality Assurance Program • Advocate for National Laboratory network • Adequate laboratory equipment with service contracts • Laboratory Quality Assurance Coordinator	• Advocate for quality control Officer position • Develop Monitoring guidelines • Develop reporting forms and timelines
1.4: Eliminate Mother-To-Child Transmission of HIV, syphilis & hepatitis B	• Strengthen/Expand key interventions to expand EMTCT primary and prevention services to include testing for viral hepatitis including the birth dose, partner testing and	• Continue to test of all pregnant women during first and third trimester for HIV, Viral Hepatitis and syphilis

	treatment, as well as family planning. • Update Guidelines for MCH Services • Ongoing training for health care providers on syphilis and congenital syphilis • Provide Treatment of all HEI within two months of birth -	• Testing of partners of pregnant women and document the results within each primary care fa • Pilot the use of rapid test for HIV and syphilis (including duo to support early diagnosis for women who access ANC late and at labour • Training for health care providers on the management of the seropositive pregnant women and the exposed infants based on WHO recommendations • Incorporate the functions of syphilis into that of the PMTCT Coordinator • Uitlize the GeneXpert to support the early diagnosis of HIV exposed infants • Continue to treat pregnant women who test positive for HIV • Treat HEI within two months of birth • Testing available at all seven Health Districts Type III Health Centres • Refresher for nurses and doctors to include private practitioners protocols and manuals for HIV/STIs TB

		• Refresher for Maternity Ward and Neonatal staff
1.5: Strengthen interventions to provide nondiscriminatory services to reach migrant populations	Provide sensitization/awareness for migrant groups	Develop culturally appropriate material for migrant groups

Strategic Priority 2: Strengthened and expanded comprehensive quality treatment, care and support services for PLHIV and their families.

Goal 3.3 of the 2015 Sustainable Development Goals state that, "by 2030, end the epidemics of AIDS tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases" (UNGASS 2015). As such the Pan Caribbean Partnership Against HIV/AIDS has committed to an AIDS Free Caribbean by 2030 and has adopted 90-90-90 targets which aim to ensure that by 2020 (UNAIDS 2016):

- 90% of all people living with HIV know their status
- 90% of people living with HIV who know their status are receiving treatment
- 90% of people on treatment have suppressed viral loads

As the number of people on ARVs increase, HIV treatment and care systems must be available and accessible to all those who need it. Key components of this include strengthening systems to improve service uptake, adherence and retention as well as effectively detect and manage HIV, STIs, TB and NCDs including mental illness. In order to do this capacity among health care workers must be increased to improve linkages, referrals, integration of essential health services. Additionally, a strong social and care system must be made available to PLHIV and their families.

Objectives	**Key Actions**	**Activities**
2.1: Strengthen treatment and care service delivery through decentracentralization of services training and implementation of protocols and procedures	• Build capacity among health care workers to better detect and manage HIV co-infections • Update Guidelines to include new treatments	• Conduct training for physicians and nurses on management of Infectious Diseases • Review existing guidelines • Update Protocols and Procedures • Training of District Teams Training of Laboratory staff

2.2 Improve systems for follow up and retention of people with HIV and STIs in treatment and care	• Adequate medication and technologies are available along the continuum-of-care cascade • Strengthen case based surveillance and referral system • Build capacity among health care workers to better detect and manage HIV co-infections	• Viral load and CD4 testing capacity available(service contracts for equipment) • Annual forecast of ARV and other testing supplies • Train doctors, Nurses and pharmacist on management of Infectious Diseases • Advocate for second Infectious disease specialist • Introduce at least 2 Case Managers • IDC nurse manager • Review surveillance Protocols and procedures • Sensitize Staff on Protocols and procedures • Manage NCDs and other co-morbidities
TB co-infection	• Advance toward TB elimination	• Implement protocols and procedures in the National TB Manual • Surveillance for TB implemented • Use of geneXPERT for rapid TB diagnosis
2.3: Provide adequate and appropriate social care and support services for PLHIV and their families	• Engage social services department, CSO and NGOs	• Develop MOUs for support services • Develop criteria for minimum package of care
	• Promote intervention for positive health, dignity and prevention for PLHIV	• Build capacity to support psychosocial services
		• Train Social Workers, counsellors in Infectious Diseases

Strategic Priority 3: Strategic information of HIV and STI system strengthened

The strengthening of information systems for HIV and STIs is also important to plan and deliver comprehensive and efficient systems and services. Data needs to be collected and disaggregated by sex, sexual orientation, gender identity, age, risk behaviour, ethnicity/ethnic origin and other equity stratifies as well as by subnational regions. HIV and STI information systems must also be linked to national health systems including central statistics and death registries.

Monitoring systems must also be strengthened along with increased capacity to report on the national HIV and STI response through use of core global and national indicators. Monitoring and evaluating progress towards 90-90-90 targets, regional HIV prevention and HIV and syphilis EMTCT targets will assist in achieving 2020 and 2030 goals.

Objectives	**Key Actions**	**Activities**
3.1: Improved national HIV and STI surveillance system to deliver quality data for evidence informed programming and policy decisions	• Build capacity of surveillance personnel in line with international standards • Strengthen HIU with IT specialist. • Complete or finalize outstanding manuals i.e. pandemic influenza preparedness plan ; Communicable Disease Manual	• Re-orientation of health care professionals i.e. doctors and nurses on the surveillance system • Advocate for Private Sector Reporting • Periodic training/re-sensitization • Hire consultants/outsource expert to complete them • Develop/Review budget for electronic platform.
	• Strengthen surveillance of HIV, AIDS and other co-morbidities, within the framework of national system	• Integrate HIV surveillance systems into the national Information Systems for Health (IS4H) • Implementation of HIVMS - need financial resources • Implementation of Dominica Medical Information System (DMedIS) • Develop/Review Budget to support implementation

	• Build capacity in MORTBASE (Mortality Database) and epidemiology	• Review existing Surveillance Guidelines • Prepare cabinet papers to make representation for positions • Advocate for inclusion in National training priorities • Training for International Classification of Diseases (ICD coder) • Training data entry clerks • Training in epidemiology
	• Advocate for the established position for National Surveillance and Quality control officers	• Prepare cabinet papers to make representation for positions • Include in National training priorities
3.2: Strengthen Monitoring and Evaluation (M&E) capacity to measure impact and effectives of the HIV response	• Generate strategic information • Build capacity of staff in M&E concepts • Monitor with the support of national committee EMTCT plus targets to ensure the maintenance and sustainably of the services and to support programmatic changes as necessary	• Advocate for M&E Officer Position • Develop M&E Framework with indicators • Prepare cabinet papers to make representation for position • Training of HIU and Surveillance staff in M&E • Upgrade mechanisms for data collection • Establish MoH Planning Unit
		• Advocate for M&E Training as National Priority

Strategic Priority 4: Funding mobilised from national and external donors to sustain the HIV and STI response

In order to improve impact, efficiency, sustainability, and resilience, integration of HIV programming is necessary to rationalise the health sector and social development resources, systems and processes; this is especially true in light of diminishing donor funds. Donors have begun to insist on cost sharing assurances from governments of low- and middle- income countries (WHO 2015). Treatment programmes continue to be very expensive. WHO Antiretroviral Use Survey 2013 (CARICOM 2014) estimates that Dominica is highly dependent on external funding (75-100%) for ARV therapy costs. Funding for ARV to OECS countries has already been cut for only newly diagnosed cases. (OECS Multi Country Grant 2018)

Integration of programmes and services can be examined from three different perspectives:

- National level policy and planning processes: joint budgeting for HIV and other disease programmes; HIV monitoring included in national IS4H
- Management perspective: donor requirements should support rather than hinder the integrated planning and programme processes and government systems should be strengthened to support integration. One Infectious Disease Programme to cover HIV, STI and TB, as well as other new and emerging diseases, will minimize staffing and implementation costs.
- Point of service delivery: HIV services fully integrated with health and other services

The PAHO Strategic Fund is available for use for the purchase of strategic commodities related to HIV, STIs and OIs through regional and sub regional agreements which allow for price negotiation and procurement (PAHO 2016).

Objectives	Key Actions	Activities
4.1: Reduce overall expenditure through the integration of programmes and services	• Identify opportunities and potential cost savings for integration of programmes and departments (HIV/STI/TB) • Diversify resources to fund the NHARP through donors and domestic resources	• Prepare cabinet paper for one National Infectious Disease Program • Advocate for Introduction of fees for HIV testing while NHIS is being organized
4.2: New sources of funding to support specific areas of the national response identified.	• Explore other Donors outside of Global Fund • Identify new sources of funding such as the National Health Plan and insurance mechanisms	• Conduct mapping exercise of organizations which provide funding for Health Services • Advocate for National Health Insurance scheme
4.3: Strengthened multi-sectoral approach for a more effective national HIV response	Improved networks and partnerships with government departments, NGOs and CSOs	• Establish umbrella organization

	Improve internal capacity to accommodate and collaborate with CSOs and NGOs	• Establish linkages with community based organizations offering care and support to PLHIV and their families • Develop Referral systems for care and support within government social services and NGOs • Develop reporting Mechanisms

Strategic Priority 5: Legal framework revised in keeping international human rights and gender equality standards

It is crucial to upgrade Dominica's legal framework to ensure an effective inter-programmatic and multi-sectoral response to HIV and STIs. This strategic priority advocates for the review and reform of HIV-related legal policies and regulatory frameworks. It will seek to address access to health prevention services, treatment, care and support. It is hoped that all services and systems adhere to antidiscrimination policies and gender equality particularly among key populations, youth, adolescents and children who may be particularly vulnerable to the ills of the society.

PANCAP policy and strategy working group recognizes the importance of stigma and discrimination, more so, in the delivery of health Care to key populations. The committee provides an avenue to provide support for CARICOM countries to bring to the fore anti stigma strategies and management of HIV related human rights actions.

Objectives	**Key Actions**	**Activities**
5.1 Legal framework to meet international human rights and gender equality standards upgraded	• Advocate to update the laws and regulation on HIV and AIDS in line with international human rights policies	• Establish Steering Committee • Make representation to cabinet and Ministry of Legal Affairs • Develop and implement advocacy plan to lobby for the human rights of key populations
	• Implement anti-discrimination interventions for all vulnerable groups in the provision health care	• Develop/Review work place policies • Training of Health Care Workers, NGOs and CSOs in the delivery of

		antidiscrimination services to key populations
5.2 Strengthened BCC and IEC programmes to reduce stigma and discrimination	• Evaluate BCC/IEC programmes	• Hire Behavior change specialist • Conduct evaluation of media campaigns
		• Revise programmes • Design new targeted interventions in response to evaluation findings for general population and service providers

7. Implementation of the NSP

The NSP will be reviewed and may be modified at mid-term (as required) and the need for changes will be determined by programme results determined by NSP M&E framework, changes in the epidemiological situation, research findings, available capacities, and organisational possibilities. An operational plan, incorporating the NSP strategic priority areas, objectives and actions, will be prepared every two years and will provide details of programme implementation. The oversight for the implementation will be supported by the Country Coordinating Mechanism (CCM) as well the administration of the Ministry of Health.

8. Conclusion

The 2020-2025 strategic plan will provide the guidance for key decision making over the next five years for the management of the HIV and AIDS pandemic in Dominica. The themes of the priority areas are in keeping with identified challenges and lessons learned and have been crafted to guide the response to mitigate the negative effects of HIV on the population. With sound governance and continuous monitoring and evaluation, during the lifespan of the plan, the country would be well on its way in getting close to the UNAIDS 90/90/90 targets and 2030 goal.

Annexes

Annex A: Analysis of National HIV and AIDS Strategic Plan 2010-2014

Component	Progress	Challenges
PREVENTION		
HIV Testing and Counseling	-Increased testing coverage to all 7 districts & three new same-day testing sites established with quality assurance processes. -Certified trainers in TC and provider-initiated TC -Island-wide testing campaign -Campaigns (NGO-MoH) executed to encourage testing among high risk groups.	-Gap in identifying those with HIV through outreach and TC -TC among vulnerable populations
EMTCT	-95% of pregnant women accepting HIV testing -100% success to date -Routine HIV and syphilis testing among pregnant women	-Need for partner testing, and testing during 3rd trimester
At-risk populations	-Studies conducted with MSM and prison inmates for prevalence and size estimation -Training of Kalinago leaders and TC outreach -Prison officers trained as HTC provides as well as there is the nurse and nurse who are attached to the prison with HTC skills -IEC with youth in and out schools	-Evidence that stigma and discrimination persists, barrier to reaching at-risk groups -Low condom use of sex workers with regular partners.
TREATMENT		
Treatment	-86 clients (74 active)—31F, 51M, 58 ART. -Civil society and Ministry of Health partnerships for care and supplemental services (nutrition, etc)	-Integration of treatment, care, support -Need to incorporate more of those with HIV & AIDS in care.
SUPPORTIVE ENVIRONMENT: PROGRAM COORDINATION/POLICY		
Surveillance/strategic information	-Training of health care providers on HIV case reporting to improve incidence information -Case-based surveillance for HIV, TB and STIs	-No dedicated M&E Officer at National Program. -Need to generate strategic information: early alert indicators, individual client progress reports and drug resistance information.
Policy	-Policy developed by Ministry of Education to address HIV/AIDS in the sector - Work Place policy for the public sector developed with Ministry of Labor	-Stigma and discrimination among health care workers needs to be addressed

Component	Progress	Challenges
	-National HIV/AIDS Policy to be submitted to Cabinet for approval	
Cross cutting		Need for further coordination of human resources across sectors and departments

Annex B: Stakeholder Representation

University of West Indies Open Campus	Educational Institution
Princess Margaret Hospital	Health Management
National Youth Council	Youth
CHAP	Key Population
National Drug Abuse Prevention Unit	
Pharmacy, Roseau Health Centre	
Supervisor Region 1 Primary Health Care	
Health Information Unit	
All Saints University	Medical School
Dominica Association of Persons with Disability	
Clinician IDC	Treatment Care and Support
District Medical Officer (Roseau Health District)	
Health Promotion Department	
Staff National HIV and AIDS Response Program	
MIRIDOM	Key Population
Fouche La Vie	PLHIV Organization
Dominica State College	Educational Institution
Supervisor Region II Primary Health Care	

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