

Family Planning in
Dominican Republic
The Achievements
of 50 Years

April 2015

Roberto Santiso-Gálvez, MD
Victoria M. Ward, PhD
Jane T. Bertrand, PhD, MBA



USAID
FROM THE AMERICAN PEOPLE



Family Planning in Dominican Republic

The Achievements of 50 Years

Roberto Santiso-Gálvez, MD

Victoria M. Ward, PhD

Jane T. Bertrand, PhD, MBA



MEASURE Evaluation is funded by the U.S. Agency for International Development (USAID) under Cooperative Agreement AID-OAA-L-14-00004. MEASURE Evaluation, whose staff provided editorial, formatting, and distribution assistance, is implemented by the Carolina Population Center at the University of North Carolina at Chapel Hill, in association with Futures Group, ICF International; John Snow, Inc.; Management Sciences for Health, and Tulane University. The opinions expressed in this publication do not necessarily reflect the views of USAID or the United States government.



Preface

This publication is one of eight case studies that were developed as part of a broader review entitled *Family Planning in Latin America and the Caribbean: the Achievements of 50 Years*. As its title implies, the larger review documents and analyzes the accomplishments in the entire region since the initiation of U.S. Agency for International Development (USAID) funding in the early 1960s. The reader of this case study may wish to access the executive summary or the report in its entirety at:

<http://www.cpc.unc.edu/measure/publications/tr-15-101>

Acknowledgments

We want to thank the individuals who provided invaluable historical insight for this case study including Sonia Britto-Anderson, María Castillo, Héctor Eusebio, Sarah Julia Jorge, José de Lánser Despradel, Sarah Majerowicz, Angela Polanco and Ramón Portes Carrasco. In addition, Sonia Britto-Anderson and Maria Rosa Garate reviewed a previous version of this case study.

The co-authors owe a debt of gratitude to three individuals who devoted vast amounts of their time and energy to this case study and to the main report: Kime McClintock and Jerry Parks (lead research assistants at Tulane University School of Public Health and Tropical Medicine) and Maria Cristina Rosales (editorial assistant in Guatemala). Their dedication in conducting background research, fact checking, verifying references, and editing text greatly enhanced the quality of the final product. In addition, we thank Nicole Carter, Alejandra Leyton, and Maayan Jaffe for their contributions as research assistants to specific sections of the main report and/or case studies. Mirella Augusto and Maria Carolina Herdoiza provided valuable administrative and logistics support to this effort. At the University of North Carolina at Chapel Hill, we thank Erin Luben, Elizabeth T. Robinson, and Nash Herndon for their editorial assistance; as well as Denise Todloski, who designed the cover.

The USAID Latin America and the Caribbean Bureau (USAID/LAC) commissioned this work and provided constructive technical guidance in its development. We wish to thank Kimberly Cole for her skillful management of the process and detailed synthesis of reviewer comments. Other reviewers of this case study from USAID/LAC included Maggie Farrell, Amber Hill, Lindsay Stewart, Verónica Valdivieso, and Mary Vandembroucke. Finally, the authors thank a number of Latin American/Caribbean specialists from within and outside of USAID who reviewed the main report and are acknowledged by name in that document.

Suggested citations:

Bertrand JT, Ward VM, Santiso-Gálvez R. *Family Planning in Latin America and the Caribbean: The Achievements of 50 Years*. Chapel Hill, NC: MEASURE Evaluation; 2015.

Santiso-Gálvez R, Ward VM, Bertrand JT. *Family Planning in Dominican Republic. The Achievements of 50 Years*. Chapel Hill, NC: MEASURE Evaluation; 2015.

Contents

Preface	2
Acknowledgments.....	2
OVERVIEW COUNTRY SITUATION	4
THE EARLY YEARS (1966-1980)	8
PROGRAM CONSOLIDATION (1981-2000)	10
POST CONSOLIDATION OF THE PROGRAM (2001-PRESENT).....	11
THE GRADUATION PROCESS	14
Policies, Leadership, and Governmance	15
Family Planning and the Health System	15
Service Delivery Models.....	17
Human Resources	18
Information Systems	19
Contraceptive Security.....	20
Financing	21
LOOKING TO THE FUTURE.....	22

OVERVIEW

COUNTRY SITUATION

The Dominican Republic (DR) is the second largest country in the Caribbean after Cuba. It occupies two-thirds of the island of Hispaniola, which it shares with Haiti, and its population is estimated at 9.5 million inhabitants.¹ DR has one of the fastest-growing economies in Latin America and the Caribbean. The country's gross domestic product (GDP) has risen at an average rate of 5.4 percent annually, but 33.2 percent of its population lives in poverty due to significant income inequalities.²

The country is in the midst of a demographic transition,³ as evidenced by slower population growth, changes in the age structure of its population, and international migration. DR is characterized by large flows of in- and out-migration. The population of Haitian origin was estimated to be 500,000 inhabitants in 2012, and 1.3 million Dominicans have migrated, mainly to the United States.⁴ An estimated 69.1 percent of Dominicans have a relative living abroad and 38.1 of Dominican households receive remittances which contribute largely to their economy.⁵ Young people under 15 years of age constitute a third of the total population.⁶

Although the demographic transition is well underway in the DR, urban growth continues, with the most rapid increase in the capital city, Santo Domingo. Almost three-quarters (74.3 percent) of the population lives in urban areas and one quarter (25.7 percent) of the total population is concentrated in Santo Domingo and in DR's second-largest city, Santiago.

Maternal mortality has declined from 178 per 100,000 live births in 2002 to 150 per 100,000 live births in 2013, but remains one of the highest in Latin America and the Caribbean, trailed only by Haiti and Bolivia.⁷ The government is making efforts toward meeting the United Nation's Millennium Development Goals (MDG)⁸ through projects designed to reduce maternal and infant mortality, including a pilot project, started in 2011, to improve quality of care in 10 hospitals.

¹ Oficina Nacional de Estadística (ONE). *Características Demográficas Básicas*. Santo Domingo, Dominican Republic: IX Censo Nacional de Población y Vivienda 2010; 2012. Retrieved from:

<http://censo2010.one.gob.do/index.php?module=articles&func=view&ptid=2&p=6>

² United Nations Population Fund (UNFPA). *Plan de Acción del Programa de País 2012-2016 entre el Gobierno de la República Dominicana y el Fondo de Población de las Naciones Unidas*. New York, NY: UNFPA; 2012. Retrieved from:

<http://countryoffice.unfpa.org/dominicanrepublic/drive/CPAP2012-2016UNFPARD%28Oficial%29.pdf>

³ According to the ECLAC/Celade classification (2008).

⁴ Oficina Nacional de Estadística (ONE). *Primera Encuesta Nacional de Inmigrantes en la República Dominicana (ENI-2012)*. Santo Domingo, Dominican Republic: United Nations Population Fund; 2013. Retrieved from:

http://eeas.europa.eu/delegations/dominican/documents/press_corner/2013/20130715_es.pdf

⁵ Orozco M. 2008. *Migraciones y remesas en República Dominicana*. Sinopsis de los resultados de la última encuesta sobre remesas y migraciones [slide presentation]. Washington, DC: Inter-American Dialogue; 2008. Retrieved from:

http://www.thedialogue.org/PublicationFiles/Encuesta%20de%20Remesas%20a%20RDominicana1108_FINAL.pdf

⁶ ONE, 2012.

⁷ The World Bank. Maternal mortality ratio [Web page]. Washington, DC: The World Bank; 2013. Retrieved from:

<http://data.worldbank.org/indicator/SH.STA.MMRT>

⁸ UNFPA, 2012.

Fifty years ago, the average number of children per woman in the DR was 7.5.^{9,10} In 2013, the total fertility rate (TFR) was 2.5 children per woman, according to the Encuesta Demográfica y de Salud (ENDESA, Demographic and Health Survey) (table 1).

Table 1: Trends in Fertility, Contraceptive Use, and Unmet Need for Women Married/In-Union Aged 15-49, 1986-2013, Haiti

	1986	1991	1996	1999	2002	2007	2013
Total Fertility Rate	3.7	3.3	3.2	2.7	3.0	2.4	2.5
Contraceptive Prevalence Rate (%)	49.8	56.4	63.7	69.2	69.8	73.0	71.9
Modern Contraceptive Prevalence Rate (%)	46.5	51.7	59.2	64.1	65.8	70.0	68.6
Unmet Need (%)	n/a	19.4	14.3	13.8	12.4	11.1	n/a

Sources: ENDESA (1986, 1991, 1996, 1999, 2002, 2007, 2013).¹¹

Notes: n/a = not available.

The data presented in this table were obtained through DHS Statcompiler for the following years: 1986, 1991, 1996, 1999, 2002 and 2007. Data for 2013 in all categories were not yet available in Statcompiler and instead were obtained directly from the preliminary DHS survey report (ENDESA, 2013).

The contraceptive prevalence rate (CPR) for all methods is one of the highest in the Latin America and Caribbean (LAC) region: it has steadily increased, from 49.8 percent in 1986 to 71.9 in 2013. The same steady increase is evident in the prevalence of modern methods: from 46.5 percent in 1986 to 70.0 in 2007. Preliminary results from ENDESA-2013 indicate a MCPR of 68.6 percent.

As of 2007, the last year for which data were available, 11.1 percent of married women had an unmet need for family planning (FP). Unmet need was two and a half times higher for adolescents (28.0 percent). The need is even more critical in rural areas where much of the population lives in extreme poverty. While public health services are offered free of charge to

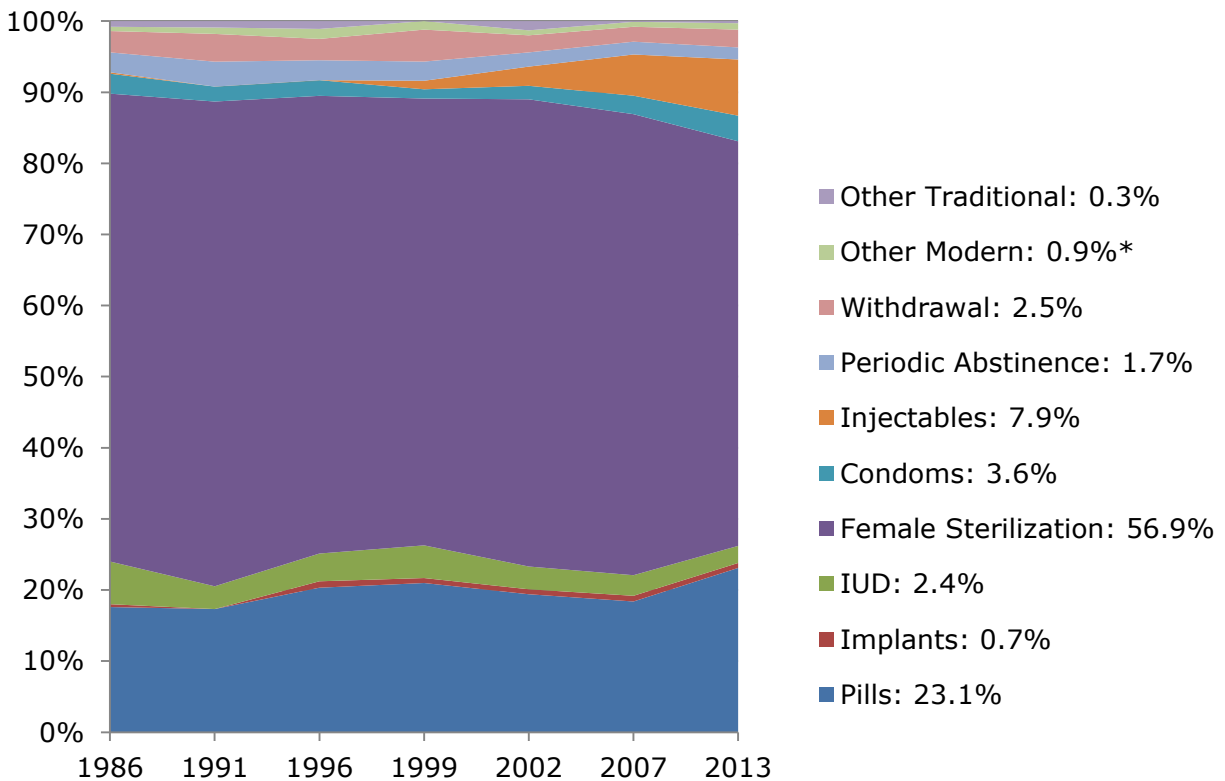
⁹ La Comisión Económica para América Latina (CEPAL). III. El Proceso de envejecimiento demográfico y sus tendencias futuras. In: *Colección de Documentos de Proyectos III*. Santiago, Chile: CEPAL; 2010. Retrieved from: http://www.cepal.org/publicaciones/xml/5/36675/lcw_262_2.pdf.

¹⁰ Miller S, Tejada A, Murgueyio P. *Strategic Assessment of Reproductive Health in the Dominican Republic*. New York: Population Council; 2002.

¹¹ Centro de Estudios Sociales y Demograficos (CESDEM). *Encuesta Demografica y de Salud (ENDESA) Republica Dominicana 2013*. Rockville, MD: ICF International; 2014. Retrieved from: <http://dhsprogram.com/pubs/pdf/FR292/FR292.pdf>; Centro de Estudios Sociales y Demograficos (CESDEM). *Encuesta Demografica y de Salud (ENDESA) Republica Dominicana 2007*. Calverton, MD: Macro International Inc.; 2008 Retrieved from: <http://dhsprogram.com/pubs/pdf/FR205/FR205.pdf>; CESDEM. *Encuesta Demografica y de Salud (ENDESA) Republica Dominicana 2002*. Calverton, MD: Macro International Inc.; 2003. Retrieved from: http://www.cesdem.com/html/endesa_2002.pdf; CESDEM. *Encuesta Demografica y de Salud (ENDESA) Republica Dominicana 1999*. Calverton, MD: ICF Macro; 2000; CESDEM. *Encuesta Demografica y de Salud (ENDESA) Republica Dominicana 1996*. Calverton, MD: ICF Macro; 1997; CESDEM. *Encuesta Demografica y de Salud (ENDESA) Republica Dominicana 1991*. Calverton, MD: ICF Macro; 1992; Consejo Nacional de Poblacion y Familia. *Encuesta Demografica y de Salud (ENDESA) Republica Dominicana 1986*. Calverton, MD: Macro International Inc. 1987.

both Dominicans and the population of Haitian origin, many health expenses often come out-of-pocket.

Access to FP information and education enables women to make more informed decisions regarding FP. The method mix in the Dominican Republic is skewed toward female sterilization, which has been the most prevalent method for more than 20 years (figure 1).



Sources: ENDESA (1986, 1991, 1996, 1999, 2002, 2007, 2013).

Figure 1: Dominican Republic method mix (1986-2013).

This marked preference for voluntary surgical contraception (VSC) as an FP method, even among young women, is a potential source of concern. However, according to local experts, the reason appears to be culturally rooted in this country. Women experience early sexual debut, early union, early first birth, little use of methods for spacing, and rapid achievement of desired family size, followed by early VSC.¹² This is reflected in the statistics: on average, women undergo surgery at 27.9 years of age; 64.0 percent of sterilized women had the procedure before age 29. Three-quarters (75.7 percent) of women who chose VSC had from three to four children when they underwent the procedure.¹³

According to ENDESA 2013 preliminary results, VSC has decreased as a percentage of the contraceptive method mix since it was previously reported. Whereas almost two thirds of

¹² Miller, Tejada & Murgueyio, 2002.

¹³ CESDEM, 2008.

married FP users had undergone VSC with very little variation over time (65.8 percent in 1986 and 64.9 percent in 2007), the 2013 Demographic Health Survey (DHS) shows that 56.9 percent of married users selected this method.

The pill is the second most prevalent method, representing 23.1 percent of the total method mix among married women in 2013, with no substantial changes since 1986. Other modern methods (IUDs, implants, condoms and “other modern methods”) have also not changed during this time period. Together, they represented 7.6 percent of the method mix in 2013. Use of injectables increased from 0.2 percent in 1986 to 7.9 percent in 2013. The decrease in TFR in the DR over the last four decades is evidence of a cultural shift towards smaller families, driving demand for FP services and contributing to the increase of the country’s CPR.

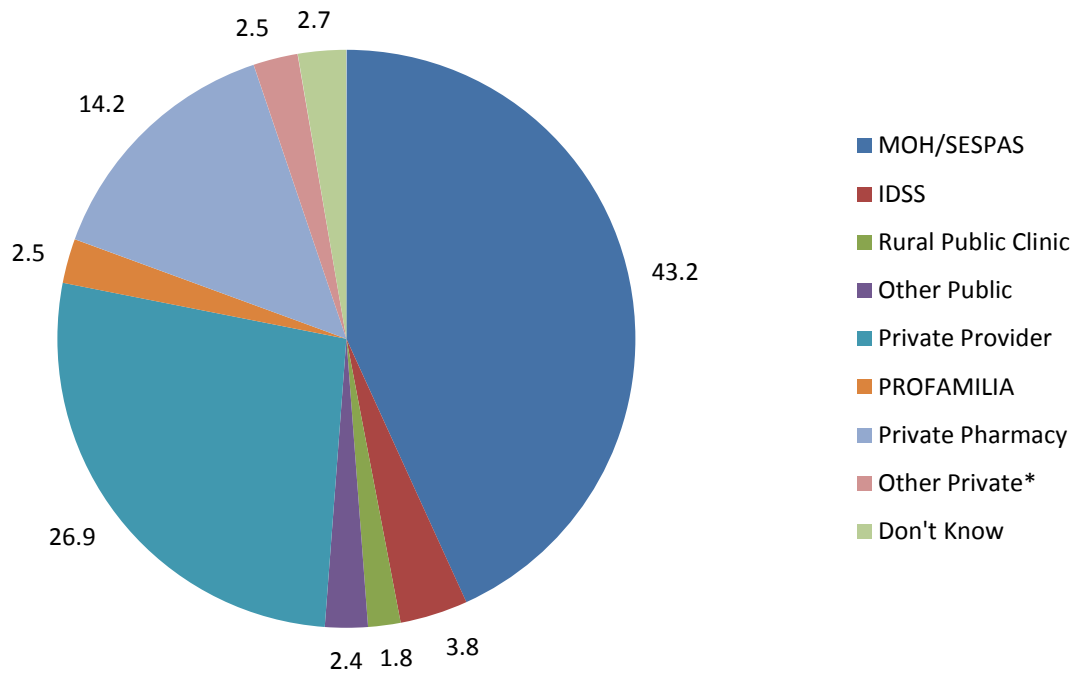
One interesting finding in the ENDESA 2007 was a higher CPR in rural areas (74.0 percent) than in urban areas (72.4 percent); similarly, MCPR was higher in rural (72.5 percent) than urban areas (69.0 percent).¹⁴ The 2013 ENDESA shows the same trend; rural CPR (73.2 percent) is higher than urban CPR (71.4 percent), and rural MCPR (70.7 percent) is higher than urban MCPR (67.9 percent).¹⁵

Several factors may explain the increase in CPR in the DR. Access to FP information and services has increased. The role of the non-governmental sector, both in provision of services and in advocacy for sexual and reproductive rights has also been important. In addition, the new social security system began to offer services in 2001 and FP was included in the service package covered by the Seguro Familiar de Salud (Family Health Insurance), particularly in the subsidized system, which has more than two million affiliates, mostly women and children.

As of 2007, 51.2 percent of FP users of modern contraception obtained their methods from the public sector, mostly hospitals of the Dominican Republic Ministry of Public Health (MOH). Of those who relied upon the private sector (46.1 percent), 26.9 percent used private clinics or doctors; 14.2 percent used pharmacies; 2.5 percent used Profamilia, the International Planned Parenthood Federation (IPPF) member association; 2.5 percent used other nongovernmental organizations (NGOs) or private sources, which included grocery stores, supermarkets, hotels and motels; and 2.7 percent of FP users did not say where they obtained their methods (figure 2).

¹⁴ CESDEM, 2008.

¹⁵ ENDESA, 2013.



Source: ENDESA 2007.

Figure 2: Dominican Republic method source 2007.

THE EARLY YEARS (1966-1980)

The FP movement began formally in the DR in the mid-1960s, during a difficult period of political transition following the 1961 assassination of the dictator, Rafael Trujillo, who had ruled the country for 31 years.

The pioneer NGO, Asociación Pro Bienestar de la Familia Dominicana (Dominican Family Welfare Association), was founded in March 1966 as a private FP institution. It focused on informing and educating the population about the benefits of FP to improve maternal health and prevent illegal abortions that contributed to high levels of maternal deaths. The programmatic focus was to promote responsible parenthood and couples' right to decide the number and spacing of their children. This institution became an associate member of IPPF in 1969 and changed its name to Profamilia a few years later.¹⁶

As in other countries of Latin America, FP in the DR faced strong opposition from many sectors during the 1960s and 1970s. Some politicians held the opinion that FP was a means used by foreign interests to control population growth. They supported a pro-natalist position, arguing

¹⁶ International Planned Parenthood Federation (IPPF). Dominican Republic [Web page]. London, United Kingdom: IPPF; 2013. Retrieved from: <http://www.ippf.org/our-work/where-we-work/western-hemisphere/dominican-republic>.

that the growth of the Dominican population should not be hindered in light of the great number of Haitian immigrants.¹⁷ In addition, the Roman Catholic Church expressed strong opposition to the promotion of any “artificial” contraceptive method. For several years, many public hospitals were run by nuns; therefore, they did not participate in FP programs. However, according to local experts, while governments tended to show indifference or lack of support for FP, some gave at least limited endorsement to the program, depending on the incumbent administration.

The U.S. Agency for International Development (USAID) started providing FP technical and financial assistance to Profamilia in the 1960s.¹⁸ Initial efforts were directed to information, education, and communication (IEC) activities and counseling. Together with IPPF, USAID provided support to Profamilia to conduct well-designed IEC campaigns that used the media to promote responsible parenthood, FP and the benefits of small families, and to encourage young people to delay sexual activity. During the 1970s, Profamilia produced a one-hour radio program entitled “Hacia una nueva familia (Towards a new family)”, the first program of its kind in the country. This program discussed FP, responsible parenthood, contraceptive methods, sex education, the relationship between population and development, and other related issues. The program became quite popular and was used as a model for the entire Latin American region.

During the 1970s, Profamilia devoted efforts to increase access to contraception in the country, and started an innovative community-based distribution program nationwide, which brought education and contraceptive methods to potential clients as part of a home visiting system. This represented the start of a female volunteer network that, at one point, reached more than 700 members, many of whom are still linked to Profamilia.¹⁹ As a novel strategy, condoms and informational materials on FP were distributed in barbershops and beauty salons in the slums of Santo Domingo and other cities.

Profamilia also developed an innovative service delivery model, working with associated clinics that promoted annual Pap smear tests and offered modern contraceptives through a cost-sharing system that helped women buy contraceptives at lower prices.

Additionally, Profamilia conducted biomedical research on fertility and contraceptive technology and promoted socio demographic studies through the Instituto de Estudios de Población y Desarrollo (IEPD, Institute of Population and Development Studies). Profamilia also created the Centro de Investigación y Servicios en Reproducción Humana y Anticoncepción (Research and Service Center on Human Reproduction and Contraception), which became a valuable resource for training in female VSC techniques and a prestigious clinical research center in Latin America.

¹⁷ Profamilia. Historia [Web page]. Santo Domingo, Dominican Republic: Profamilia; 2013. Retrieved from: <http://www.profamilia.org.do/pageview.aspx?ArticleID=2>.

¹⁸ U.S Agency for International Development (USAID). 2014. *Five Decades of USAID Assistance in the Dominican Republic: USAID Assistance During the 1960s*. Washington, DC: USAID; 2014.

¹⁹ Profamilia, 2013.

PROGRAM CONSOLIDATION (1981-2000)

By the mid-1980s, with technical and financial assistance from USAID, FP services were available in all urban and rural MOH clinics nationwide, public hospitals and Profamilia clinics.

A second private FP institution — the Asociación Dominicana de Planificación Familiar (ADOPLAFAM, Dominican Family Planning Association) — was created in 1986, with the aim of providing FP services in the capital city and the southeastern provinces. ADOPLAFAM conducted several FP knowledge, attitudes, and practice (KAP) studies, as well as surveys on supply and demand for FP services, responsible parenthood, STI/HIV and others, with support from USAID and the United Nations Population Fund (UNFPA).

Access to FP and reproductive health services expanded in rural and marginal urban areas, with participation of various civil society organizations, such as Mujeres en Desarrollo (MUDE, Women in Development), Centro de Investigación para la Acción Femenina (CIPAF, Research Center for Women’s Action), Colectiva Mujer y Salud (CMS, Women and Health Collective), and others. These institutions advocated for sexual and reproductive rights; provided medical, legal and psychological counseling to women; distributed modern contraceptive methods; and worked to increase men’s participation in FP/sexual and reproductive health (SRH). They also provided training in community mobilization and social marketing through networks of health promoters.

In 1986, Profamilia promoted and supported the creation of the National Family Planning Program. It also helped establish the Consejo Nacional de Población y Familia (CONAPOFA, National Population and Family Council) as a decentralized MOH entity where the FP program operated during more than two decades.

As in other countries in the region, in the mid-1990s, IPPF began to explore strategies with Profamilia to achieve self-sustainability. To this end, IPPF provided technical assistance with strong support from USAID, which allowed Profamilia to increase its number of clinics, establish social marketing of contraceptives for low-income population, and offer a wide range of health services at subsidized rates. Profamilia also incorporated commercial marketing of contraceptives with its own brands, using traditional and non-traditional channels.²⁰ New services were provided to help subsidize FP services, including early detection of cervical and uterine cancer, HIV testing, and treatment of sexually transmitted infections (STIs).²¹

Using a gender-based approach that incorporated prevention of sexual violence, Profamilia expanded its maternal and child health care services to include emergency contraception and later infertility treatment. A firm defender of SRH rights, Profamilia pioneered youth-accessible services through its espacios amigables (“friendly spaces”), where comprehensive services are offered to adolescents and young people recruited through a peer approach.

²⁰ Profamilia, 2013.

²¹ International Planned Parenthood Federation (IPPF). Asociación Dominicana Pro-bienestar de la Familia (Profamilia) [Web page]. New York, NY: IPPF; 2013. Retrieved from: <http://www.ippfwhr.org/es/where-we-work/rep%C3%BAblica-dominicana>.

USAID's technical and financial assistance during this period of program consolidation contributed to the training of health workers, nurses, and doctors in postpartum and post-abortion IUD insertion techniques and to the establishment of service delivery standards and protocols.

The international donors that supported FP/SRH during this period included USAID and its cooperating agencies, UNFPA, GTZ and later South Korea through the Korean Family Planning Federation.

One of the challenges to the evolution of health and other development programs in DR is corruption. In 1997, during the first administration of President Leonel Fernández, the government admitted that administrative corruption existed in DR, mainly due to systems that allowed and promoted generalized corruption in government and other entities. The government acknowledged that these systems were well established and functioned to the detriment of the country's interests, favoring instead the interests of individuals and groups that were socially, economically and politically well connected. These parties had used the government as a source of power and enrichment. The government announced a series of plans and initiatives to fight corruption, including the creation of the Department of Corruption Prevention in accordance with Decree No. 322-97.²² However, according to analysts and experts, administrative corruption in DR has been very difficult to overcome.

POST CONSOLIDATION OF THE PROGRAM (2001-PRESENT)

At the dawn of the new millennium, high rates of maternal and infant mortality persisted in the Dominican Republic, despite the work of the government and external donors. A high percentage of women gave birth in health facilities (95 percent) and received antenatal care (97 percent); however, high mortality rates persisted. This contradiction was explained in part by unfavorable work conditions for health care providers, inadequate referral systems, poor quality of care and deficiencies in training of health personnel. The incidence of HIV/AIDS was also increasing.²³

Research on adolescent pregnancy, FP, and maternal mortality was carried out with USAID support to better understand reproductive health conditions in the Dominican population. Findings indicated that the high MMR resulted from a lack of adherence to protocols in the maternity hospitals where the majority of births occurred. In addition, facilities were overburdened and inadequate, many patients felt poorly treated by facility personnel, and complications were not given the attention they deserved.²⁴

According to the assessment, FP users often faced problems of limited choice of temporary methods due to lack of regular attendance by providers at service-delivery points. When

²² Castellanos P. *Corrupción Administrativa, el Caso de República Dominicana. Foro Iberoamericano sobre el Combate a la Corrupción, Centro Latinoamericano para la Administración del Desarrollo (CLAD)*. Caracas, Venezuela: CLAD; 1998. Retrieved from:

<http://old.clad.org/documentos/otros-documentos/corruccion-administrativa-el-caso-de-republica-dominicana>.

²³ United Nations Development Programme/United Nations Population Fund (UNDP/UNFPA). *Programa de País 2002-2006 República Dominicana*. New York, NY: UNDP/UNFPA; 2001. Retrieved from:

<http://countryoffice.unfpa.org/dominicanrepublic/drive/COUNTRYPROGRAMME2002-2006FINAL.pdf>.

²⁴ Miller et al., 2002.

physicians did attend, they artificially limited access, by giving appointments to only 25 of the women waiting to be seen. For this reason, women often had to make three or four visits to receive a short-acting method, and they often gave up and took whatever method the provider was distributing on the day they were finally able to go in. This was true in many public-sector facilities.²⁵

High rates of adolescent pregnancies also afflicted Dominican Republic. Research confirmed what policymakers, researchers, providers, users, and health activists assumed were the underlying, interrelated causes of some of the long-standing indicators of poor reproductive health: access to contraception and dual protection was limited for adolescents, especially those who were poor or lacking education.

In addition, many factors exacerbated the situation: patriarchal and religious traditions about gender roles, lack of educational facilities in school systems for adequate SRH education, privacy and confidentiality concerns for visiting RH services, costs of supplies, fear of parents finding methods, and lack of understanding of the consequences of unprotected sex.²⁶

Conclusions pointed to the need to create mechanisms for accountability and supervision; expand the method mix of reversible FP methods; initiate social marketing of reversible FP methods; update medical eligibility criteria; improve staffing at all FP sites; and improve training of health personnel and the quality of services, among others.²⁷

A technique known as total quality management (TQM)²⁸ — innovative at the time — was implemented for quality improvement. In addition, UNFPA and USAID supported the design, production, distribution, and implementation of IEC materials and communication campaigns. Throughout those years, the FP program was coordinated by CONAPOFA.

In February 2001, the government launched an initiative known as Paquete Social (Social Package) that gave heightened importance to improving SRH and the status of women. The strategy aimed at benefiting the most vulnerable groups and increasing government investment in social programs. Two new laws were enacted that year: the general health law (42-01) and law 87-01 that established the Dominican Social Security System. Both laws formed part of the legal framework for health sector reform, which proposed decentralizing services and demand-based financing, along the lines of Colombian and Chilean reforms. However, although some progress has been achieved, the DR has not been able to fully implement decentralization, according to key informants (and discussed in more detail, below).

A major political action that signaled a greater commitment to FP in the new millennium was the transfer of the reproductive health program from CONAPOFA to the Secretaría de Salud Pública y Asistencia Social (SESPAS, Public Health and Social Welfare Secretariat).²⁹ The process

²⁵ Miller et al., 2002.

²⁶ Miller et al., 2002.

²⁷ Miller et al., 2002.

²⁸ TQM describes a management approach to long-term success through customer satisfaction. In a TQM effort, all members of an organization participate in improving processes, products, services, and the culture in which they work.

²⁹ SESPAS is referred to in this document as the Ministry of Health (MOH).

began in 2006 and concluded in late 2009, with the establishment of a central warehouse where all FP commodities, now administered and distributed by the MOH Health Service Network, were transferred from CONAPOFA warehouses.³⁰ Problems occurred during the process of transfer, in particular with regard to contraceptive procurement that resulted in recurrent stock-outs at a national level during 2009. However, subsequently positive results have been achieved, in particular in regard to logistics and information systems, quality of care, staff training, monitoring of and availability of a wider variety of contraceptive methods at MOH facilities. Nevertheless, key areas, such as staff coordination and elimination of barriers to medical and service providers need to be addressed.³¹

The DR has received significant technical and financial support for FP/SRH from other donors, including the European Community, the Spanish Agency for International Cooperation for Development (AECID), the Japan International Cooperation Agency (JICA), the World Bank, and others. UNFPA is currently working with the Government on a national health program for 2012-2016, in support of reproductive rights, population and development, and gender equity. A strategic plan has been developed for the prevention and control of STIs and HIV/AIDS. New donor countries have invested in the DR, including South Korea, which funded a program from 2003 to 2008 involving IEC activities for prevention of adolescent pregnancy.³²

However, international donor support to the DR has declined due to its improved economic situation and comparatively high national level indicators. More recently, donors have encouraged greater coordination among FP agencies and the government to avoid duplication of efforts and achieve better results.

In 2004, USAID supported the creation of the Comité para la Disponibilidad Asegurada de Insumos Anticonceptivos (DAIA, National Contraceptive Security Committee), which became operational in May, 2005.³³ Coordinated by the MOH, the Committee included members from several health divisions, as well as CONAPOFA, SESPAS, Profamilia, ADOPLAFAM, the Commissioner for Health Sector Reform, the Ministry of the Armed Forces, the Dominican Social Security Institute IDSS), PROMESE-CAL,³⁴ the Ministry for Women, National Health Insurance (SENASA), the Autonomous University of Santo Domingo, the Women and Health Collective (an NGO), PSI International, and the Obstetrics and Gynecology Society, among others. USAID, UNFPA, and the Pan American Health Organization (PAHO) provided financial support and technical guidance for this process.

³⁰ USAID/DELIVER Project. *República Dominicana: Manual de Procedimientos Logísticos*. Arlington, VA: John Snow, Inc.' 2008. Retrieved from: http://deliver.jsi.com/dlvr_content/resources/allpubs/countryreports/DO_ManProcLog_ES.pdf.

³¹ USAID/DELIVER Project. *República Dominicana: Evaluación Cuantitativa de Indicadores Logísticos para Medicamentos Trazadores y Anticonceptivos*. Arlington, VA: John Snow, Inc.; 2010. Retrieved from: http://deliver.jsi.com/dlvr_content/resources/allpubs/logisticsbriefs/DR_EvalCuantIndiLogi.pdf.

³² Young MH. "New" donors: a new resource for family planning and reproductive health financing? [commentary] *Pop Action Intern*. 2008. 3(2). Retrieved from: <http://populationaction.org/wp-content/uploads/2012/01/EmergingDonors.pdf>.

³³ USAID/Health Policy Initiative. *Contraceptive Commodity Security Committees: Their Contribution in Latin America and the Caribbean*. Washington, DC: Constella Futures; 2007. Retrieved from: http://www.healthpolicyinitiative.com/Publications/Documents/404_1_404_1_CS_Committees_Case_Study_English_FINA_L_acc.pdf.

³⁴ Promese-Cal is a government program in charge of supervising quality and transparency in acquiring medicines and supplies for the National Public System established in 1974 by the Dominican government.

One of the major achievements of the DAIA was to create and implement the National Family Planning Standards in 2006. The purpose of these norms was “to unify principles, operating criteria, policies and strategies for providing FP services, to enable users to select the most appropriate contraceptive methods, after receiving counseling, in order to ensure the well-being of individuals, the family and the community”.³⁵

The DAIA committee has played an important role in expanding coverage of the FP Program, achieving significant savings in contraceptive procurement through UNFPA, and incorporating FP into the agenda of the MOH and other health-related government agencies.³⁶ The DAIA was successful in achieving contraceptive security within the IDSS; also, it ensured inclusion of contraceptives in the Essential Drugs Program, which operates nationwide to provide medicines and commodities at very low cost.³⁷ According to local experts, as of 2014, contraceptives are indeed included in the MOH and SENASA’s catalogue of essential medicines. Nevertheless, despite efforts promoted by the FP program, some pharmacy providers restrict access to contraceptives at will, due to personal attitudes towards FP.

THE GRADUATION PROCESS

The process for graduation from USAID FP assistance in the DR started with a visit from a USAID/Washington team in 2006 to identify priority areas that needed strengthening to guarantee future program sustainability. A phase-out strategy was designed and implemented with USAID technical and financial support to assist participating institutions throughout the process. The strategy focused basically in the following areas: political dialogue to achieve specific budget lines for transparent contraceptive procurement and contraceptive security for the FP program; technical capacity and leadership, in particular for the logistics process; and increased access to FP information and services for vulnerable marginalized populations (mainly low-income, poorly educated women, adolescents, Haitian immigrants and their descendants). The strategy was completed in 2007 and graduation occurred in 2009.

Upon withdrawal of USAID assistance, the DR government took over leadership of the DAIA committee and allocated financial resources for annual contraceptive procurement. At the same time, the government initiated a public policy initiative to increase reproductive health services and formulate comprehensive health and adolescent pregnancy prevention plans. As happened in other countries, USAID’s withdrawal represented a radical change for the national FP program, from donor-supported to government-supported procurement of contraceptive methods. According to some experts, the DAIA committee continues to meet, mainly to discuss issues directly related to contraceptive security, but it has lost some of its influence and power to convene.

³⁵ Secretaria de Estado de Salud Pública y Asistencia Social (SESPAS) 2006. *Normas Nacionales de Planificación Familiar*. Santo Domingo, Dominican Republic: SESPAS; 2006. Retrieved from: <http://salud.gob.do/download/docs/Normas/NormasPlanFamiliar2006.pdf>.

³⁶ USAID/Health Policy Initiative, 2007.

³⁷ USAID/DELIVER Project. *Diagnóstico sobre la Logística y la Disponibilidad Asegurada de Insumos Anticonceptivos en República Dominicana*. Arlington, VA: John Snow, Inc.; 2008. Retrieved from: http://pdf.usaid.gov/pdf_docs/PNADP624.pdf.

Policies, Leadership, and Governance

The DR has implemented national policies on population, gender, and SRH that are in line with international agreements endorsed by the country. In addition, the 2030 National Development Strategy, which represents the official regulatory framework for public sector planning, includes SRH and the rights of women, youth, and adolescents. From a normative perspective, the National Family Planning Norms and the National Condom Strategy are also in place. The country has made important strides by enacting these policies, but implementation has been a challenge.

Political support for FP has been inconsistent and opposition from conservative groups continues. In 2010 a constitutional amendment that prohibits and penalizes all forms of abortion was enacted, despite staunch criticism from advocates of SRH rights, particularly women's groups in civil society that defend reproductive rights, women's political participation, and awareness of gender violence.³⁸ These groups, among them Profamilia, have actively worked to obtain changes in the penal code that would decriminalize abortion when the mother's life is in danger and when pregnancy is a product of rape or incest.³⁹

In July 2013, Profamilia launched an IEC campaign to promote respect for adolescents' sexual and reproductive rights and urged education authorities to provide information in schools about these issues. The Roman Catholic Church strongly opposed this campaign and filed an injunction to suspend it, but the injunction was overruled by the Supreme Court and the campaign was allowed to continue.

Family Planning and the Health System

For several decades, tax revenues have financed the public health care system with the intention of covering a large portion of the population in DR. The MOH network has 1,853 facilities, composed of 1,703 primary care units and 150 specialized second- and third-level treatment centers (consisting of 15 specialized hospitals, 11 regional hospitals, 20 provincial hospitals, and 104 municipal hospitals). However, deficiencies in the public health system have resulted in an increased reliance on private sector health coverage. For years, out-of-pocket expenses have been the main source of health care financing.⁴⁰ The per capita health care expense (public and private) in the DR is relatively high, and the system is inefficient.

The design adopted for the National Health System (Law 42-01, Law 87-01) in DR is complex and gives priority to health prevention and promotion under the SESPAS. The public sector consists of two primary entities: (1) the MOH, and (2) the Sistema Dominicano de Seguridad Social (SDDD, Dominican Social Security System), which is comprised of the Consejo Nacional

³⁸ BBC Mundo. R. Dominicana: aborto es inconstitucional [Web page]. London, United Kingdom: British Broadcasting Corp. 18 September 2009. Retrieved from: http://www.bbc.co.uk/mundo/america_latina/2009/09/090918_dominicana_aborto_ip.shtml.

³⁹ Profamilia. Memoria de labores [Web page]. Santo Domingo, Dominican Republic: Profamilia; 2012. Retrieved from: www.profamilia.org.do/media/ProFamiliaMemorias.

⁴⁰ Rathe M, Moliné A. 2011. Sistema de Salud de República Dominicana. *Salud Pública De México*. 2011. 53:255-264.

de Seguridad Social (CNSS, National Health Council), the Tesorería del Seguro Social (TSS, Social Security Treasury) and the Seguro Nacional de Salud (SENASA, National Health Insurance), which is the main public insurer. In March 2011, there were over four million persons affiliated with the Family Health Insurance program. The private sector consists of Administradoras de Riesgos de Salud (ARS, Health Risk Administrators), private health service providers, and nongovernmental organizations working in health.⁴¹ The main public insurer, the National Health Insurance program, covers the population in the subsidized regime. There are 27 other insurance providers, most of them private. With this large number of insurance providers, the system is highly fragmented and cost-inefficient.⁴²

FP/SRH services and commodities are offered in public health facilities. Most long acting reversible contraceptives (LARCS) and permanent methods are only available at secondary and tertiary levels, with referrals from the primary level. The network of public and private providers has increased access to FP, but there are still a number of unresolved problems.

One of the primary problems in the Dominican Republic health system is quality of care; complaints persist about the poor quality of government services, inadequate counseling, and limited availability of contraceptive methods. Studies indicate that many persons require medical attention, but lack the economic resources to obtain it. They consider health care provision to be deficient, and medical products, including contraceptives, are often difficult to procure. The hours of service are inconvenient and waiting times are long. In short, implementation of Law 87-01 and Law 42-01 has advanced at a much slower pace than originally planned, and the goal of global coverage by the Seguro Familiar de Salud for the year 2011 was not accomplished.⁴³

The MOH faces the challenge to improve quality of service provision through the public health network and to strengthen primary health care. Problems, such as limited hours in which services are provided, have a negative impact on access to services. The National Health Plan recognizes that quality of services, not coverage, is the main challenge facing the health sector. Problems exist in clinical and administrative management of services and poor supervision.⁴⁴ Corruption within the health system adds to these other challenges.

The MOH offers voluntary male and female surgical contraception along with five basic modern methods.⁴⁵ It is mandatory for FP/SRH services and commodities to be offered free of charge at approximately 1,500 MOH facilities nationwide, which include secondary and tertiary care hospitals and primary care units. Efforts have been made to strengthen primary care by implementing the FP program in rural clinics. Some centers have implemented post-abortion

⁴¹ Rathe & Moliné, 2011.

⁴² Pan American Health Organization (PAHO). Dominican Republic. In: *Health in the Americas* [2012 ed, country volumn]. Wasington, DC: PAHO; 2012. Retrieved from: www.paho.org/saludenlasamericas/index.php?option=com_docman&task=doc_view&gid=127&Itemid.

⁴³ Ministerio de Economía, Planificación y Desarrollo. *Propuesta de Estrategia Nacional de Desarrollo 2010-2030: Un Viaje de Transformación Hacia un País Mejor*. Santo Domingo, Dominican Republic: Consejo Nacional de Reforma del Estado; 2010. Retrieved from: http://www.unicef.org/republicadominicana/Documento_base_propuesta_END_2010_2030.pdf.

⁴⁴ Rathe & Moliné, 2011.

⁴⁵ Pineda Gadea Z. 2012. *Avances y Desafíos Para el Aseguramiento de Anticonceptivos en la Región LAC* [regional report]. Coalición para el Aseguramiento de Insumos Anticonceptivos; 2012.

services, available 24 hours a day. However, there are reports that users often have to make additional out-of-pocket payments to obtain these and other health supplies.⁴⁶

According to a 2008 study, 97 percent of women entering a public hospital to give birth expressed interest in postpartum contraception. However, only 12 percent received a method before leaving the hospital. For post-abortion clients, the situation was even worse; only 12 percent received FP counseling, and only 9 percent received a FP method before leaving the hospital.⁴⁷ According to official sources, the social security offers the same five contraceptive methods that are provided by the MOH.⁴⁸ In terms of coverage, according to the Observatorio Político Dominicano (Dominican Political Observatory) 47.4 percent of the population was enrolled in the new social security system by the end of 2011.⁴⁹ However, implementation of this program has been slow and it still does not operate in all social security clinics. Some observers claim that the social security has not purchased any contraceptives with its own funds and frequently refers its affiliates to MOH to obtain contraception.

As part of the health sector reform and, in an effort to decentralize and provide funding for all services based on actual demand, the MOH has transferred programmatic and service provision responsibilities from provincial health directorates to regional offices. Under this system, health and commodity managers at the regional and district levels need to promote FP and manage the supply chain.⁵⁰

Service Delivery Models

With strengthened FP service delivery through the MOH and the IDSS, other mechanisms have varied or declined in importance. For example, community-based distribution has practically disappeared and is only used for condom distribution through the dual-protection strategy (i.e., protecting against pregnancy and HIV/AIDS). Profamilia and other NGOs participate in social marketing strategies to offer FP and SRH commodities to segments of the population with some ability to pay, and to help secure their financial sustainability.

In 2010, the MOH established the National Strategic Plan for Integrated Adolescent Health 2010-2015. This plan defines the official lines of action to be taken by the MOH for the provision of comprehensive adolescent health care. A new service delivery model, the Unidades de Atención Integral para Adolescentes (Units for Comprehensive Care for Adolescents), also

⁴⁶ Rathe & Moliné, 2011.

⁴⁷ Center for Health and Gender Equity. The case for comprehensive: Dominican Republic [brochure]. Washington, DC: Center for Health and Gender Equity; 2009. Retrieved from: <http://www.genderhealth.org/files/uploads/change/publications/dominicanrepubliccasestudy.pdf>.

⁴⁸ Centro de Estudios Sociales y Demograficos (CESDEM). *Situation Analysis of the Integration of Family Planning Services in Postpartum, Postabortion and Prevention of Mother to Child Transmission Programs in the Dominican Republic.* Santo Domingo, Dominican Republic: U.S. Agency for International Development, Population Council; 2009. Retrieved from: http://pdf.usaid.gov/pdf_docs/PNADL819.pdf.

⁴⁹ Observatorio Político Dominicano. *Estadísticas.* ; Santo Domingo, República Dominicana: Observatorio Político Dominicano; 2011. Retrieved from: www.opd.org.do

⁵⁰ USAID/DELIVER Project. *El Enfoque Regional Mejora el Acceso a los Anticonceptivos. Creación de Programas de PF Sostenibles Mediante la Colaboración entre Países.* Arlington, VA: John Snow Inc.; 2010.

known as *Servicios Amigables de Salud* (Friendly Health Services), was thus created by the MOH, mainly for adolescents and youth. There are currently 103 of such units.⁵¹

However, these services have been underutilized and have not performed as expected in reaching adolescents with SRH; nor have they assisted pregnant adolescents to continue their education or obtain remunerated work.⁵² By contrast, Profamilia appears to have had greater success in attracting adolescents to its SRH services, which operate with voluntary peer promoters.

Private pharmacies, supermarkets and other commercial distributors have increased their participation in providing contraceptives and continue to serve middle and high income population who are able to pay directly for their FP needs.

Human Resources

The DR has an extensive network of public and private providers in place, which reach even the most rural communities. The country is aware that human resources are the most important asset in any health system; however, historically health workforce problems have limited the efficiency and quality of the DR health system. During the last decade, numerous efforts have been made to strengthen the capacity of service providers to deliver efficient, high-quality, and timely care.

While the total number of doctors in DR has increased from 13,262 in 2006 to 16,419 in 2010,⁵³ the distribution of doctors and nurses throughout the country remains very unequal. In the National District there are 37.1 doctors per 10,000 inhabitants, while in the province of La Romana, for example, there are only 8.3 doctors per 10,000 inhabitants. The unequal distribution of human resources impairs access, equity and efficiency of health care.

Two additional challenges to administering health care in the DR are administrative corruption and high turnover of personnel. Local observers speak of “ghost workers” in its payroll: individuals who receive a salary but do not work or persons who have been in the process of retirement for several years. This wasteful spending, representing an estimated 30 percent of the central budget (over U.S. \$600,000 per month), has resulted in hospitals having to use their internal funds to hire additional staff to fill gaps and provide sufficient coverage. Based on these findings, USAID provided assistance to the MOH through one of its CAs to audit and update its payroll system, an initiative that resulted in considerable savings. The MOH is reinvesting these savings to hire new health workers, provide salary increases for doctors and nurses, and raise health workers’ retirement benefits. The DR Ministry of Finance mandated that the MOH

⁵¹ Ministerio de Salud Pública y Asistencia Social. *Plan Estratégico Nacional para la Salud Integral de Adolescentes 2010-2015* [Serie de Normas Nacionales No. 13]. Santo Domingo, Dominican Republic: United Nations Childrens Fund; 2009. Retrieved from: http://www.unicef.org/republicadominicana/Plan_Estrategico_Salud_Integral_Adolescentes_2010-15.pdf.

⁵² PAHO, 2012.

⁵³ PAHO, 2012.

complete the cleanup process and remove all remaining ghost workers from the payroll before MOH can be provided with its 2014 budget.⁵⁴

The problem of turnover results whenever a new administration takes office and qualified personnel are replaced or move on, disrupting government health services. Congress in 2014 enacted the Health Career Law, which had yet to be ratified by the executive branch that year. This law has been heralded as a mechanism for creating a technical cadre of civil servants in the health sector. In addition to helping to reduce high turnover of qualified personnel, it is designed to obtain a better return on the investments made in training and to improve operative systems, which would in turn strengthen the health system.⁵⁵

Information Systems

The Sistema de Información para la Administración Logística (SIAL, Logistics Management Information System) was designed and implemented in the DR in 2009, with USAID support. This tool records daily data of contraceptive utilization, and generates monthly reports to track use, inventory levels, and quantities received; as such, forecasting of procurement estimates is based on actual needs and not on historical patterns of use. SIAL tracks storage, shipment, distribution and final delivery to the user, which is the ultimate goal.

SIAL is seen as a breakthrough for data gathering. According to key informants, only five years ago, more than 1,500 public network facilities sent monthly reports to the central level (CONAPOFA) for processing. Now, the automated system allows facilities throughout the 32 provinces to report at the provincial level on a monthly basis, and the provinces in turn report to the central level.

SIAL has its supporters and detractors. Supporters report that that this mechanism works well. Contraceptive logistics specialists have been trained in all aspects of the system; considerable investment has been made in ensuring proper use of the SIAL tool. Despite the discontinuation of USAID FP support in 2009 to the DR, data accuracy on contraceptive service utilization is high. Critics argue that SIAL is a complex system that needs constant monitoring which has not occurred. Transfer of the data through the system has been problematic, which yields lower quality data of questionable value for monitoring and decision making. As in some other countries post-USAID graduation, the logistics system has encountered problems. The intention remains to strengthen these systems to become the useful tools that were designed to be, but doing so will require commitment and constant monitoring.

ENDESA continues to be the main source of demographic, maternal and child health, and FP/SRH data, which are used for decision making in many countries. In DR, the ENDESA surveys have been carried out every four to five years since 1986. An ENDESA was conducted in 2013, and some of the preliminary results are included in this case study. ENDESA-2013 was executed by the Centro de Estudios Sociales y Demográficos (CESDEM, Center for Social and

⁵⁴ U.S. Agency for International Development (USAID), Capacity Plus. *Dominican Republic: Significant Reinvestment through Elimination of Ghost Workers*. Washington, DC: USAID; 2013.

⁵⁵ Global Health Initiative (GHI). *Dominican Republic Global Health Initiative Strategy*. Washington, DC: GHI; 2011.

Demographic Studies), in coordination with the MOH, USAID, CONAVIHSIDA (Consejo Nacional para el VIH y el SIDA), National Program for Tuberculosis Control (MSP-PNCT), and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). The surveys received technical assistance from the DHS program, ICF International, Inc., and U.S. Centers for Disease Control and Prevention (CDC), Atlanta. Although USAID had an important role in supporting the most recent survey, the MOH took full responsibility for conducting and coordinating the data collection

Contraceptive Security

On July 9, 2007, the DR's president established the DAIA Committee as the lead government entity to guarantee contraceptive security. The MOH was assigned the responsibility of securing funding for the procurement of all commodities to be delivered free of charge at public services nationwide.⁵⁶

USAID provided the MOH with financial and technical support for contraceptive logistics, which contributed to improving contraceptive forecasting, acquisition, warehousing, and distribution. Nevertheless, some key informants express concerns that the acquisition process has been fragmented, inefficient, and not totally transparent.

As part of health reform, the country is in the process of gradually implementing the Sistema Único de Gestión de Medicamentos e Insumos (SUGEMI, Unique System for Acquiring Medicines and Supplies) in the public health service network. SUGEMI is designed to guarantee quality of services, transparency in the financial processes and improve access to high quality essential medicines and health supplies. The effort also aims to support decentralization and optimal use of existing resources. Implementation of this process began with medicines and supplies for HIV/AIDS, STI, and tuberculosis (TB) programs. A second stage of the process has begun; it is expected to incorporate maternal-child health medicines and supplies, including contraceptives.

Despite the efforts made by the health system and the DAIA committee, some weaknesses persist: lack of timely procurement and non-availability of commodities leading to stock-outs in the Unidades de Atención Primaria (UNAPs, Primary Care Units) and in rural clinics.

Part of the problem stems from irregular procurement of contraceptives due to delays in the MOH payment allocation procedures. Even after the funds become available, there may be additional delays due to UNFPA's internal procurement process.

The Dominican Republic continues to face challenges in maintaining a continuous stock of a full range of contraceptive methods at service delivery points throughout the country. Key informants mentioned that more flexible distribution mechanisms are needed.

⁵⁶ USAID/DELIVER Project. *La Adquisición de Anticonceptivos en América Latina y el Caribe: Un Análisis de Opciones Actuales y Futuras en Ocho Países*. Arlington, VA: John Snow Inc.; 2010. Retrieved from: http://deliver.jsi.com/dlvr_content/resources/allpubs/policypapers/LaAdquAnticoncept_LAC.pdf

To safeguard the progress made on SRH issues and to prevent the disruption of FP activities every time a new administration takes office, the DAIA has been successful in creating an executive secretariat within the committee. In a changing political environment, this secretariat acts as the committee's operational arm to retain leadership and ensure the continuous flow of financial resources.⁵⁷

Financing

Starting in 2004, the MOH appropriated national treasury funds for contraceptive procurement through a third-party purchase agreement with UNFPA. While funding levels have varied since then, some informants believe that the resources allocated to sustain the current supply of FP methods are sufficient. By 2011, 100 percent of commodities required by public services were purchased with national budgetary funds, which are protected under the General Health Law.⁵⁸ A number of laws, such as the State Procurement Law, have been enacted to ensure transparency in fund management. This law decrees freedom of access to information to anyone interested in monitoring execution of expenditures through a government website.⁵⁹ The advocacy efforts of the DAIA Committee have resulted in approval of semiannual disbursements instead of quarterly ones; this allowed for larger orders, better management of stock levels, and timely availability of commodities.⁶⁰ However not everybody is optimistic about the long-term prospects for government financing of contraception. The fact that the DR government has not yet allocated a specific budget line or a specific amount for procuring these commodities worries DAIA members.

In 2014, the MOH projected contraceptive needs totaling U.S. \$1.5 million dollars. However, technical estimates made by the SUGEMI project calculated twice as much (U.S. \$3 million), in order to avoid stock-outs nationwide. According to a knowledgeable source, every year the MOH requests the required amount to the DR Ministry of Finance. In 2013, this amount was authorized, as was reported in the annual survey for reproductive health indicators collected by one of USAID's CAs. However, this has not always occurred. Since FP is not specified as a public policy, approval depends on the political will of current authorities.

Other key informants believe that FP is not a priority in budget allocation. Much of the funding for FP services comes from out-of-pocket expenses of users and from social marketing programs. Sometimes funding is affected by shifting priorities (e.g., a vaccination campaign, a dengue outbreak) or other needs that are considered more urgent.

The Dominican Social Security Institute, the military and national police institutions that provide FP services have not purchased contraceptives with their own funds and still receive them as donations from the MOH.⁶¹

⁵⁷ Pineda Gadea, 2012.

⁵⁸ Pineda Gadea, 2012.

⁵⁹ Pineda Gadea, 2012.

⁶⁰ USAID/DELIVER Project, 2010.

⁶¹ USAID/DELIVER Project, 2010.

LOOKING TO THE FUTURE

More than a third (36.0 percent) of the Dominican is adolescent or younger.⁶² Adolescent fertility rates are high. To address this problem adequately, the demand for contraceptives will need to increase sharply in the near future. According to ENDESA 2007, 20.3 percent of adolescents were mothers or were pregnant, and some of them reported as many as three pregnancies. The ENDESA 2013 preliminary report did not report data on adolescent pregnancy, yet no major changes from recent years are expected.

The Secretaría de Estado de Educación (Ministry of Education) began implementation of the Programa de Educación Afectiva Sexual (PEAS, Sexual and Affective Education Program) in 1996.⁶³ A baseline study was conducted in 2012 to determine the status of sexual and gender-based violence (GBV) education and in public sector schools. The study revealed that 39.2 percent of educational facilities have incorporated PEAS in some form, with support of USAID and CONAVIHSIDA. Profamilia also offers sexual education for youth, as does the Asociación Dominicana de Profesores (ADP, Teachers Dominican Association) in different programs.⁶⁴ UNFPA has entered into a cooperative agreement with the Dominican Government to increase sex education in secondary schools.⁶⁵ Despite these efforts, there is still great need for comprehensive sexual education in schools. Opposition from conservative groups to such initiatives remains a challenge.

Availability of modern contraceptive methods other than condoms remains limited at adolescent and youth facilities. Some informants believe this is part of the stock-out situation described earlier, but others believe there are different reasons, including providers who are resistant to providing contraceptives to adolescents. According to key informants, quality of FP counseling to adolescents needs to be strengthened and more comprehensive. Barriers to access, such as limited hours of operation and lack of adequate information, need to be removed.

It is evident that the FP program in the DR has made tremendous strides, particularly in expansion of coverage. However, program sustainability requires coordination of efforts, political will, technical capacity, and financial support to reduce unmet need. Key issues to address include:

- ensuring permanence of the DAIA Committee and broadening participation with new sectors, (e.g., the private sector, pharmaceutical manufacturers, community organizations, civil society, and women's organizations);
- strengthening advocacy actions with civil society and local authorities at the central and regional levels to guarantee contraceptive security (technical support is vital for DAIA to accomplish its goals);

⁶² Alcántara ZE. *Educación Sexual en la Escuela como Base para la Equidad Social y de Género*. Santo Domingo, Dominican Republic: United Nations Population Fund; 2012.

⁶³ United Nations Children's Fund (UNICEF). *Estudio de Línea Basal del Programa de Educación Afectiva Sexual (Peas): Informe Final de Investigación*. New York, NY: UNICEF; 2011. Retrieved from: http://www.unicef.org/republicadominicana/Estudio_PEAS_final_2011.pdf.

⁶⁴ Alcántara, 2012.

⁶⁵ UNFPA, 2012.

- strengthening the resource allocation process to ensure sufficient amounts and timely delivery of funds to the MOH in order to meet the growing demand for contraceptives from all segments of the population (advocacy is important to ensure that funds budgeted for FP are in fact allocated to contraceptive procurement);
- continuing to segment the market with a total market approach so that people with higher socioeconomic status continue to pay for contraceptives out-of-pocket or through private insurance, and those who cannot afford them have access to subsidized or free public services (better contraceptive distribution and well-informed communities can contribute to this end);
- improving the quality of services, maintaining and updating training of medical and paramedical personnel who provide FP services at all levels, including new staff; monitoring compliance with standards and protocols; and eliminating existing barriers, (such as “machismo”, negative attitudes among service providers, provider bias in the selection of methods, and lack of adequate knowledge about contraceptive technology, particularly among new staff);
- implementing strategies and plans to meet adolescents’ needs according to their specific circumstances; ensuring provision of quality sex education in schools; increasing adolescent access to contraceptive information and services that promote behavior change and responsibility in terms of SRH;
- strengthening information and logistics systems with trained, qualified personnel to eliminate stock-outs; generating accurate and timely information for decision-making and ensuring that information is used appropriately by decision makers;
- coordinating external assistance to the DR Ministry of Health, Social Security, NGOs, and the private sector to leverage donations received and avoid duplication of efforts; and
- advocating for more flexible procurement mechanisms, both within the MOH and with appropriate purchasing agents.

The DR is committed to achieving excellence in its development efforts, recruiting qualified personnel, and providing quality health services to meet the needs of its entire population. The recent health reform being implemented in the country includes decentralization of services. Family planning needs to be adequately incorporated into this ongoing process, so that its performance is not hindered by any changes the reform brings. Technical support to help achieve these goals is important.

Over the past 50 years, the DR has overcome major obstacles to improve the living conditions of its population. Family planning has changed the lives of many people, allowing them to enjoy the benefits of a safe, healthy, reproductive life and to achieve the small family size they desire.

MEASURE Evaluation

Carolina Population Center
400 Meadowmont Village Circle, 3rd Floor
Chapel Hill, NC 27517

<http://www.measureevaluation.org>