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Strategic assessment of reproductive health in the Dominican Republic

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reproductive health situation in the Dominican Republic. We sincerely hope that this report reflects your findings and analysis.

This report would not exist today had it not been for the incredible efforts of Ms. Norma Paredes, who translated both the background paper and the first English draft of the report into Spanish.

Acronyms

ADOPLAFAM	Dominican Family Planning Association (Asociación Dominicana de Planificación Familiar)
AGI	Alan Guttmacher Institute
AIDS	Acquired immune deficiency syndrome
ALIRH	Latin American Association of Human Reproduction Investigators (Asociación Latinoamericana de Investigaciones Reproducción Humana)
CEA	State Sugar Advisory (Consejo Estatal de Azúcar)
CERSS	Executive Commission for Health Sector Reform (Comisión Ejecutiva para la Reforma del Sector Salud)
CPR	Contraceptive prevalence rate
CYP	Couple-years of protection
DHS	Demographic and Health Survey
DR	Dominican Republic
ECC	Expanding Contraceptive Choice program
FP	Family planning
GDP	Gross domestic product
GODR	Government of the Dominican Republic
HIV	Human immunodeficiency virus
IDDI	Dominican Institute for Integrated Development (Instituto Dominicano de Desarrollo Integral)
IEC	Information, education, and communication
ICPD	International Conference on Population and Development
IDB	Inter-American Development Bank
IDSS	Dominican Social Security Institute (Instituto Dominicano de Seguridad Social)
INSALUD	National Health Institute (Instituto Nacional de la Salud)
INTRAH	International Training in Reproductive Health
IUD	Intrauterine device
LAC	Latin America and the Caribbean
MCH	Maternal and child health
MMR	Maternal mortality rate
MUDE	Women in Development (Mujeres en Desarrollo)
NGO	Nongovernmental organization

OCP	Oral contraceptive pill
PAC	Postabortion care
PAHO	Pan-American Health Organization
PID	Pelvic inflammatory disease
PRIME	———
PRONAISA	National Integrated Health Care Program for Adolescents (Programa Nacional de Atencion Integral a la Salud del Adolescente)
RH	Reproductive health
RTI	Reproductive tract infection
SEM	State Secretary for Women (Secretaria de Estado de la Mujer)
SESPAS	Ministry of Health and Social Welfare (Secretaria de Salud Pública y Asistencia Social)
STI	Sexually transmitted infection
TGFR	Total global fertility rate
TFR	Total fertility rate
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
US	United States
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

This report documents the findings of a strategic assessment of reproductive health in the Dominican Republic (DR), carried out by the Ministry of Health and Social Welfare (SESPAS) and the Dominican Social Security Institute (IDSS) with technical and financial support from the Population Council's Expanding Contraceptive Choice program and its Latin American and Caribbean regional offices, and the United States Agency for International Development. The USAID/DR has been working closely with SESPAS to understand the major reproductive health problems in the DR. In order to better assist SESPAS and to plan the country's Reproductive Health Strategy for 2002–2007, USAID asked the Population Council's ECC program to conduct a strategic assessment of reproductive health in the Dominican Republic. This participatory study was designed to identify strengths, prioritize problems, and work with community, governmental, and nongovernmental stakeholders in order to develop recommendations for strategic interventions to improve reproductive health in the DR.

The public-sector health system of the Dominican Republic serves the majority of the poorest and most disadvantaged sectors. Public-sector reproductive health service-delivery programs are conducted by SESPAS. Recently the public-sector programs have undergone scrutiny, and the country has developed a series of health care norms and developed new models for health care. This health-sector reform includes the decentralization of management to the provinces and municipalities and an increase in public spending to cover the three-quarters of the population that relies on SESPAS.

Over the past decades, the Dominican Republic has achieved some major improvements in reproductive health, such as the decline in the total fertility rate (TFR) from 7.4 to 2.6 between l990 and l996. The contraceptive prevalence rate is 64%; however, this rate is skewed toward sterilization, and the pattern of childbearing is early sexual debut, early union, early first birth, little use of spacing methods, and rapid achievement of desired family size, followed by early surgical sterilization. These patterns may be of concern in that they fail to protect against the growing STI/HIV epidemic, do little to discourage high pregnancy rates among adolescents, and raise questions about quality of care and informed choice. Another cause of concern in the Dominican Republic is the high maternal mortality rate (MMR), which, depending on the sources cited, ranges from 110 to 229 deaths per 100,000 live births. Whichever figure is used, however, the rate is unusually high given the 97% institutional delivery rate and other indicators of socioeconomic and health status that prevail in the DR.

For the past decade, the World Health Organization and the Population Council's ECC program have worked together with ministries of health and NGOs to apply a rapid assessment methodology to define policy choices and research needs in reproductive health through the implementation of a strategic planning and assessment strategy.

A team from the Population Council conducted a literature review of existing documents on the status of reproductive health in the Dominican Republic, prepared a background document (Miller, Dabash, Mercado et al. 2001), and presented its findings at a dissemination workshop held at the Jaragua Hotel on October 19, 2001 (see Appendix A for agenda and participants). At this meeting stakeholders reacted to the findings of the background paper and worked in small groups to develop prioritized lists of RH problems.

During the remainder of October 2001, an RH assessment team was formed, comprising a multidisciplinary group of 11 Dominicanas/os and consultants (see Appendix B for a list of team members and affiliations). The following sites were selected for the assessment: The National District (ND), Region III, and Region IV (see Appendix C for a listing of individual sites within the three regions). Training was held November 5–9 during which the team solidified roles, learned about the strategic assessment methodology and qualitative research tools, refined the RH prioritized problem list developed at the October 19 meeting into three strategic questions, and developed and field-tested data collection tools. In the Strategic Assessment methodology, strategic questions are used to focus the assessment. The team developed the following questions:

- *Strategic Question 1: Maternal health care.* Is it possible to improve the quality of maternal health care given during the prenatal, intrapartum, and postpartum periods? If yes, how?
- *Strategic Question 2: Family planning.* Is it necessary to improve the family planning program (options, coverage, access)? If yes, how?
- *Strategic Question 3: Adolescent reproductive health.* Is it necessary to improve the quality and access to integrated reproductive and sexual health services for adolescents? If yes, how?

Data collection and synthesis occurred November 12–December 6, 2001. The data collection and synthesis sessions ended in a presentation on November 30 to the technical advisory group (see Appendix B for a list of members). The technical advisory group made recommendations as to what steps the assessment team should take next. Writing the report was a participatory process that took place November 28–December 21. The findings were verbally presented to SESPAS vice-secretary Tejada and Victor Calderon and their support for presenting these findings was obtained on December 2. The draft report was then completed, translated into Spanish, and distributed to the technical advisory group and other stakeholders, comments were incorporated, and the dissemination meeting to determine priority interventions was held on January 30, 2002, with a consultation meeting on January 31 (see Appendix D for the January 30 meeting agenda and list of participants).

FINDINGS

Maternal Health

Maternal mortality for the nation remains high despite actions instituted by the government and foreign donors to improve the long-recognized situation. Given the almost universal prenatal care attendance and institutional delivery, the answer as to why the MMR is so high becomes a matter of lack of quality of care and lack of adherence to protocols in the maternity hospitals where the majority of births occur. In addition, the physical space was found to be dirty and crowded, and the personnel rude. Complicated cases were not given the attention they deserved, and normal cases were overmedicalized. Community members, users of health services, providers, and most decisionmakers agreed that the MMR could be lowered if the following recommendations were implemented:

- More deliveries took place at lower levels of care (i.e., at community-level institutions rather than higher-level institutions);
- To encourage women to seek care at lower levels, women must be convinced that staffing at these lower levels of care is consistent and that clients would no longer be turned away;
- A better and more organized system of referral and transportation must be developed;
- Only truly high-risk patients should be scheduled for/referred to the highest-level institutions;

- The number and type of staff at the highest-level institutions must reflect the acuity of the patients admitted there;
- Protocols must be developed/reviewed and institutionalized at all levels;
- Adherence to protocols and norms should be recognized and nonadherence should be punished;
- IEC activities must be instituted to inform/educate women about their options in delivery and their rights to high-quality care;
- A human rights and reproductive rights training program should be instituted for all health care providers; and
- A research pilot project should be developed and implemented that incorporates (a) training and staffing of lower levels; (b) information, education, and communication (IEC) and social marketing promoting use of lower levels; (c) transport and referral systems; and (d) triaging of referrals to appropriate higher-level institutions.

Family Planning

The assessment found that family planning users were constrained in their choices of methods by lack of providers at regular times at service-delivery points (SDPs). Few SDPs were staffed, and when physicians did attend, they artificially limited access by a "rationing system," whereby only 25 of the women who attended on any given day received appointments. This rationing mean that women often made 3 or 4 visits to receive a family planning method and they often gave up and took whatever the provider was distributing on a given day. IEC and counseling were of low quality, except at PROFAMILIA/NGO sites. In addition, logistics and stocking were irregular at all public-sector family planning sites. As with the maternity sites, most of the public-sector sites were dirty and unpleasant.

Recommendations for change included:

- Implement Social Security Law 87-01;
- Create models of local autonomy and institutional strengthening;
- Implement participatory mechanisms to select hospital directors for their managerial skills;
- 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;
- Ensure quality of services by creating an executive FP committee at each SDP;
- Enforce adherence to FP norms and procedures; and
- Include the reproductive rights of women and SESPAS norms in medical, nursing, and other health professional curriculums.

Adolescent Reproductive Health, Particularly Family Planning and Maternity

Long-standing double standards and traditional patriarchal and religious traditions about gender roles of men and women are played out early with adolescents in the DR. School systems lack educational facilities for adequate sexual and reproductive health education, and what little there is seems to come too late to help many of the adolescents. Clients/users of RH services under age 21 face the same difficulties that adults do, but they are exacerbated by privacy and confidentiality concerns, costs of supplies, fear of parents findings methods such as pills, and a lack of understanding of the consequences

of unprotected sex (focus-group findings were that adolescents did not perceive themselves to be at risk for STIs/HIV). While the SESPAS norms on adolescents appear to have been written by youth-friendly advocates, few providers of youth services neither knew of nor adhered to the norms.
Suggestions for improvement included:

- All of the recommendations for maternity and FP for adults;
- Implementating strategic planning at each health center;
- Assigning youth-friendly specialists to care for pregnant adolescents;
- Encouraging women's advocacy groups to work closely with adolescents in the labor and delivery areas (*doula* concept);
- Providing services for adolescents free of charge;
- Providing alternative distribution of methods to allow for greater youth confidentiality;
- Giving youth-friendly counseling training to all personnel in contact with adolescents;
- Providing training in reproductive and citizens' rights of adolescents;
- Negotiationg with the Secretary of Education to allow a specialized team from SESPAS to create a strategic plan to implement sexual and reproductive health education at levels 6–8;
- Developing programs to include parent activities and training (information and communication skills); and
- Implementing research activities to study lessons learned in the DR and other countries in the region on livelihood and other skills-based programs to improve adolescents' life and communication skills.

The Strategic Assessment of Reproductive Health verified many assumptions and beliefs held by policymakers, researchers, providers, users, and health activists about the status and underlying causes of some of the long-standing indicators of poor reproductive health in the country. It was apparent to the team that the problems were interrelated, and that the lack of access—particularly for poor women, poorly educated women, and adolescents—to a wide range of reversible contraceptive methods and dual protection was a contributing factor to the other problems of high rates of adolescent pregnancies, increasing rates of transmission of STIs/HIV, unwanted pregnancies leading to abortion, and high rates of maternal mortality. All of these problems reflect deficiencies and gaps in the current system, including gaps of adequate access, gaps of coverage of all levels of population, deficiencies of high-quality reproductive health care, and a lack of attention to human dignity and reproductive rights.

The list of recommendations in response to each of the three strategic questions and the short-, medium-, and long-range plans developed through participatory process at the two dissemination workshops can help SESPAS, working with USAID and other donors, to improve the reproductive health of all Dominicans. Maintaining the participatory and collaborative process developed during the assessment process may help all stakeholders to move the reproductive health agenda forward during this period of health reform and increasing attention to quality of care and reproductive and health rights.

1: Strategic Assessment of Reproductive Health in the Dominican Republic

INTRODUCTION AND BACKGROUND

The Dominican Republic's Ministry of Health and Social Welfare (SESPAS), with technical assistance and support from international donors, including USAID, has been working to improve public health, particularly that of the country's most vulnerable populations, through diverse activities, including a series of health reforms. USAID's Office of Population, Health, and Nutrition is particularly interested in working with SESPAS to obtain high levels of health care and sustainability during this period of reform. In order to better assist SESPAS and to plan the Reproductive Health Strategy for 2002–2007, USAID asked the Population Council's ECC program to conduct a Strategic Assessment of Reproductive Health in the Dominican Republic. This participatory study was designed to identify strengths, prioritize problems, and work with community, governmental, and nongovernmental stakeholders in order to develop recommendations for strategic interventions to improve reproductive health in the DR.

The WHO Strategic Assessment Methodology

For the past decade, the World Health Organization (WHO) and the Population Council's ECC program have worked together with ministries of health and NGOs to apply a rapid assessment methodology to define policy choices and research needs in reproductive health through the implementation of a strategic planning and assessment program called the Strategic Approach (Spicehandler and Simmons l994; Simmons, Hall, Díaz et al. l997). Originally named the WHO Strategy for Contraceptive Introduction and Technology Transfer, this methodology has been modified and adapted as an analytic tool to determine underlying causes of reproductive health problems as well as to prioritize research and intervention activities at the national, regional, local, and neighborhood levels.

The Strategic Approach involves three stages of work:

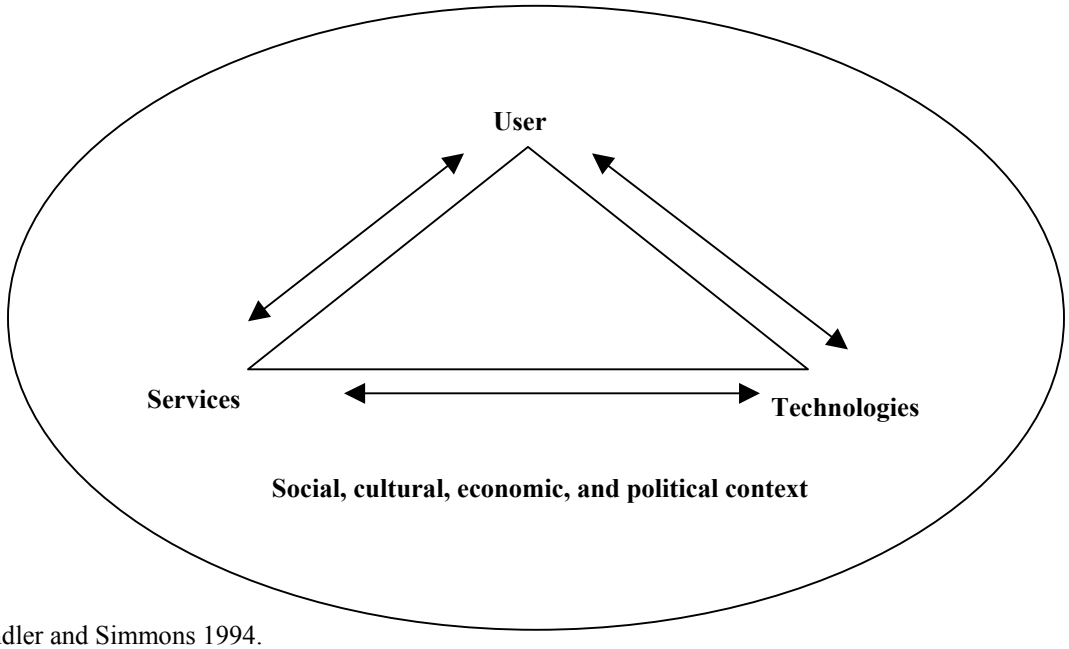
1. Strategic assessment
2. Action research
3. Expansion

This document is a report of the Stage One Strategic Assessment of the Reproductive Health Needs in the Dominican Republic. The first stage assesses the needs of users and the capacity of service-delivery systems to deliver high-quality care, programs, and policies. The Strategic Assessment relies on existing information to generate timely questions to certain strategic or focusing questions. The answers to these questions result in recommendations for policy changes and service interventions to improve reproductive health and the quality of health care services. The aim is to both fill information gaps and to identify and suggest the types of research and interventions necessary that will be tested in the second stage (the action research stage).

The Strategic Approach and the Stage One Strategic Assessment are based on a systems view of reproductive health care. A systems view considers not only the service delivery of health care, but also the perspectives of users, and, often even more important, nonusers of the health care system. This places services and users within the social, cultural, economic, and political contexts that affect

reproductive health and the way that services are perceived and used. These same contexts also affect health service providers, decision- and policymakers, government officials, women's advocates, and community leaders (see Figure 1.1).

Figure 1.1. Systems framework



Source: Spicehandler and Simmons 1994.

As a research methodology, the Strategic Assessment is a rapid and participatory process that involves a review of secondary data (e.g., DHS and other population-based surveys; operations research studies by NGOs; donor assessments conducted by PAHO, UNFPA, the World Bank, and USAID; and other public-and private-sector service delivery and reproductive health status analyses). These secondary analyses, summarized in a baseline document (Miller et al. 2001), were augmented by key informant interviews and/or focus groups with policymakers, service providers, logistics managers, users, women's health advocates, clients of STI/HIV reduction messages and care, and pregnant, delivering, and newly delivered women and their partners.

ICPD Expanded Definition of Reproductive Health Care, Human Rights, Reproductive Rights, and Public Health

In other countries, the Strategic Approach has made significant contributions toward achieving objectives of the ICPD's Programme of Action, including increasing understanding of quality of care, determining the factors that affect quality, and implementing appropriate actions to improve or maintain quality; defining new program and policy strategies that are client-centered and reflect a reproductive health approach to services; expanding access and increasing reproductive choice; and building support for program and policy changes by ensuring that the perspectives of communities, clients, providers, and other stakeholders are part of decisionmaking. Not only does the Strategic Assessment promote the expanded definition of reproductive health care of the ICPD, it involves the international recognition of

the right to health, the interrelatedness of all human rights with public health, and the contemporary efforts to put human rights into public health practice (Easley, Marks, and Morgan 2001).[1]

The Process of the DR Strategic Assessment

In March 2001 three members of the Population Council's ECC program, Dr. Suellen Miller, Dr. Juan Díaz, and Ms. Rasha Dabash, MPH, visited the USAID Mission in order to discuss the possibilities of beginning a Norplant® to Jadelle® transition study. In meetings with Dr. David Losk, Dr. Elena Brennerman, and Ms. Elba Mercado it was discovered that USAID was in the process of developing its five-year reproductive health strategy and that there were several unanswered questions about the reproductive health status of the populations USAID serves. These questions existed despite the ongoing studies of many other NGOs and the most recent interim DHS of l999. Major reproductive health questions included: (1) a highly contested maternal mortality rate ranging from 110 to 229; (2) suspected high abortion rates; (3) concern over the large number of adolescent pregnancies; and (4) a growing number of adolescent and adult STIs and HIV infections. USAID asked for technical assistance from the Population Council to conduct a qualitative strategic assessment of the RH situation. A team from the Population Council conducted a literature review of existing documents on the status of reproductive health, prepared a background document (Miller et al. 2001), and presented its findings at a dissemination workshop held at the Jaragua Hotel on October 19, 2001 (See Appendix A for meeting agenda and participants). At this meeting stakeholders reacted to the findings of the background paper and worked in small groups to develop prioritized lists of RH problems as well as to suggest sites for the RH assessment. In addition, the stakeholders, including IDSS, SESPAS, and some NGOs, contributed staff members to work on the data collection team. A technical advisory group of stakeholders was also formed. These stakeholders were unable to participate in the data collection process; however, they would serve as advisors and help the data collectors understand and interpret their findings.

During the remainder of October, an RH assessment team was formed under the co-leadership of Dr. Argelia Tejada and Ms. Pamela Putney, MSN. The 11-person team was a multidisciplinary group of psychologists, social workers, sociologists, adolescent health care experts, OB/GYNs, nurses, and statisticians (see Appendix B for a list of team members and their affiliations). Training was held November 5–9 at ADOPLAFAM, during which the team solidified roles, learned about the Strategic Assessment methodology and qualitative research tools, refined the RH prioritized problem list developed at the October 19 meeting into three strategic questions, and developed and field-tested data collection tools. The training was attended by all members of the team, and Dr. David Losk and Elba Mercado of USAID visited during the training period.

Site selection for data collection was based on the decisions made at the stakeholders meeting and subsequent conversations with the technical advisory group. The following sites were selected (see Appendix C for a list of individual sites within the three regions):

- The National District (ND): The ND is an essential site because of the concentration of population and variety of health services.

[1] Reproductive and human rights to health are promulgated in such documents as the United Nations Charter, the Declaration of Alma-Ata, the Universal Declaration of Human Rights, the right to health affirmed in the Convention on the Rights of the Child, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Racial Discrimination, and the Convention on the Elimination of All Forms of Discrimination Against Women.

- Region III, Duarte Province: the capital city of San Francisco de Macorís is the fourth largest city in the country. It is the economic center of the agricultural production of the northeastern region. The Cibao is the most populated region, with very different culture and socioeconomic conditions than that of the southwest and the east.
- Region IV, Barahona and Independencia Provinces: These provinces are sparsely populated and economically depressed with little enterprise. Haitian migrant workers who had previously been employed by the Barahona Sugar Mill are now settling the region as farmers. Tourism is not well developed. Barahona has traditionally been an area of high maternal mortality.

Data collection and synthesis occurred November 12–December 6, 2001. The team visited sites in the ND during November 12–19 and then returned to visit new sites or revisit sites November 26–December 10. In the ND they visited three major maternity hospitals, one NGO clinic, and four other clinical settings to examine the inpatient and outpatient RH services. Between November 19 and 23 the team broke into two subgroups: One visited Barahona Province and the other Duarte Province. Each subgroup comprised at least one clinician, one social scientist, one adolescent health specialist, and one psychologist. In Duarte the subgroup visited one regional hospital, three municipal hospitals, three rural clinics, and one PROFAMILIA clinic. In Barahona the subgroup visited one regional hospital, one IDSS hospital, two municpal hospitals, and one rural clinic. A variety of services were observed at each site, depending on what services were being offered (refer to subsequent sections to see the types of services observed). The team regrouped in Santo Domingo the week of November 26 to synthesize its findings. The sessions ended in a presentation on November 30 to the technical advisory group (see Appendix B for a list of participants). The technical advisory group made recommendations as to what steps the assessment team should make next.

Writing the report was a participatory process that took place November 28–December 21, with different team members and consultants writing different sections and then sharing them with one another for comments, corrections, and feedback. The findings were verbally presented to SESPAS vice-secretary Tejada and Victor Calderon and their support for presenting these findings was obtained on December 2 by David Losk and Suellen Miller. The draft report was then completed, translated into Spanish, and distributed to the technical advisory group and other stakeholders. Comments were incorporated and the dissemination meeting to determine priority interventions was held January 30, 2002, with a consultation meeting on January 31 (see Appendix D for January 30 meeting agenda).

National Context

The Dominican Republic is the second-largest nation in the Caribbean. It occupies the eastern two-thirds of the island of Hispaniola. It has a population of approximately 8.2 million and an annual growth rate of 1.8%. One of the fastest growing segments of the population is women of reproductive age (15–49 years), who now number 2.2 million and whose numbers will grow rapidly to nearly 3 million by 2005 (Macro International and CESDEM 1996). Currently, 62% of the population live in urban areas; the National District alone contains over 30% of the total population. National literacy is 82%, with male and female literacy about equal.

The DR has long been known as an agriculture exporter of coffee, sugar, and tobacco; recently, the service sector and the telecommunications industry have experienced rapid growth. The DR is now one of the fastest-growing and rapidly changing countries in the LAC region. Over the past three decades,

the country has experienced economic and social transition: macroeconomic adjustments in the 1980s, rapid growth of the service sector, and a decline in agricultural exports. After decreased social spending, soaring unemployment rates, devaluation of the peso, inflation, and social protest in the 1980s, the DR emerged in the 1990s a state ready for growth and stability. The recovery of the GDP by 1992 marked the beginning of increased purchasing power for the working class.

Although the DR is considered a lower-middle-income country by the World Bank with per capita income in 2000 at US$2,080 (World Bank 2001) the country continues to suffer from income inequality. The poorest half of the population receive less than one-fifth of the GNP, while the richest 10% enjoy 40% of the country's income. Approximately 25% of the population live below the poverty line. Poverty tends to be especially severe in rural areas, where prior agriculture policies and insufficient public investments have resulted in limited opportunities for rural residents. Those able to achieve higher levels of education tend to migrate out of rural areas, particularly those areas bordering Haiti. Between 1986 and 1990, health and education expenditures together received only 5% of public spending. In recent years, however, health and education expenditures have grown in response to the growing GDP and the introduction of health-sector reforms. In 1996, the change of administration, which brought an overhaul of social policies, resulted in the introduction of a new model of health care. This new model includes the decentralization of management to the provinces and an increase in public spending to cover the approximately three-quarters of the population who rely on SESPAS for health care. In addition to increased public spending on health, there has been a recent influx of foreign aid to modernize and restructure the health sector (including funds from the World Bank, the Inter-American Development Bank, as well as contributions from USAID and Europe). The present climate of change and the new financial and technical resources for health policy and programs necessitated a thorough understanding of the present system and the prioritization of spending for new programs.

Health-Sector Reform and Its Implications for Reproductive Health in the Dominican Republic

The health-sector reform process in the Dominican Republic began in the early 1990s as a response to demands from the community and health professionals to improve health care services. Reform was promoted by the government of 1996–2000. The Presidential Commission for Reform and Modernization of the State was formed in 1996 with the objective of promoting and facilitating the reform process. The Executive Commission for Health Sector Reform was created by presidential decree in 1997. In 1998 the Ministry of Health (MOH) initiated its strategy of deconcentration and decentralization through the establishment of Provincial Health Directorates (DPS in Spanish) and reorganization at the central level.

The country began a process of debate and a search for consensus on health and social security systems. This process resulted in the approval of two laws. The General Health Law 42-01 of March 2001 established guiding principles on the organization and function of the Dominican health system, especially as related to the "essential functions of public health." An important aspect of Law 42-01 is the oversight function of the MOH and its role in promotion and prevention, quality control in its health care centers, registration of products and medicines, attributes of the authorities, and sanctions. The Social Security Law 87-01 was approved in May 2001. It introduced a series of fundamental changes in the organization, management, and financing of the two components of health care and pensions.

The approval of these laws, especially the Social Security Law, will result in profound changes in the Dominican Republic's health and social security systems under "regulated competition," which combines elements of a competitive market with strong governmental regulatory functions and introduces the separation of functions, decentralization, and the financing of health services through mechanisms of mixed (public and private) insurance arrangements. The health sector oversight function will be managed by the MOH, which will focus its efforts on national planning, regulation and surveillance, illness prevention, and promotion of health services. The financing and insurance components, as well as the provision of services, will be the responsibility of other entities, private and public. The National Social Security Council will define a basic package of benefits and their financing, based on employee, employer, and government contributions, including a per capita assignment of resources and the purchase of services through contracts with providers. Users of health services will be able to elect their service providers, which will have implications for the provision of health services in general, and of reproductive health services specifically. The new legal framework contains significant changes in service provision. Insurers will purchase health services from public or private providers through contracts. Providers will be accredited by the MOH and must have the capacity to offer integrated services, according to the established package of health services.

These changes will require fundamental inputs, such as political will, technical capacity, economic resources, and time. The law assumes a transition period of ten years, in order to establish the new institutions, define their functions and capabilities, select and train the required human resources, and initiate the effective functioning of a new health and social security system.

While the establishment of provincial and municipal health offices is an important step forward, these offices need to develop their institutional capabilities. Financial decentralization has been slow and requires knowledge of the sources of financing and the processes of allocating resources. Decentralization of human resources has also been slow, and it has been noted that the participation of local levels in the designation of personnel, especially physicians, to rural clinics to meet local needs, will be an important advance.

Some of the challenges facing the provision of reproductive health care services in the DR are:

- The transfer of responsibility that accompanies decentralization implies a corresponding transfer of financial resources in order to execute the task of reproductive health service delivery;
- The transfer of functions from the central to the decentralized levels frequently is done without consideration of the need for qualified personnel to assume the new responsibilities;
- It is common that responsibilities are transferred to the local level, but the organizational structure continues to be centralized and vertical, which impedes the definition of local priorities, the cost and sustainability of programs and services, and an efficient and quality operation.

Some of the expected changes and their implications for reproductive health in the DR are the following:

- *Separation of functions.* The new legal framework establishes clear guidelines that the separation of functions, management, surveillance and control, provision and financing, for example, be executed by distinct institutions. For reproductive health, it will be necessary to define which specific services will remain under the responsibility of the MOH as a public benefit with financing from the national budget, and which will form part of the basic health services package, with financing from the family health insurance plan.

- *Mechanisms of payment related to performance.* The Social Security Law states that the financing of health services will be carried out on a per capita basis, paid for by a national health insurance fund. The fund will purchase services included in the basic health care package. Health service providers will receive payment only for services they render; not a salary whether they perform or not.
- *Effective decentralization.* In principle the functions of oversight, sanitary authority, and the provision of public health services will be deconcentrated to local levels of the MOH, such as the SDP. The provision of health care services, on the other hand, will be decentralized to local governmental authorities, for example, MOH regional health offices. The purpose of doing this will be to provide greater autonomy and decisionmaking authority at the local level for these functions in order to incorporate greater accountability and transparency in the health services system.
- *Public–private alliances*. The new laws establish the principle of "plurality" and "cooperation" between the public and private sectors for the organization, management, and financing of the health system. Private providers play an essential role in reproductive health. For example, 60% of the users of family planning methods receive their methods from the private sector. For maternal care, it is the private providers who have attained low levels of MMR, and, it is felt that safer, more humane deliveries will take place in the private sector.
- *Competition among providers.* The new health and social security system is based on the premise of "regulated competition." Users will choose their service providers. Given that price and the content of the basic services package will be predetermined, competition will be based on quality of care, which should help improve the low quality of care of reproductive health services noted during the assessment.
- *Social and community participation.* Under this system, there will be a new role for beneficiaries, as citizens with rights and obligations. The laws recognize the oversight role of the community in the control and management of the system. Administrative councils will be established in the service provider community, for example, with community participation to inject the concept of "social audits" into the system, so that the users will adopt a proactive role as stakeholders, capable of demanding accountability and assigning responsibility and sanctions, where and when necessary.

Recommendations for action to improve the quality of reproductive health services under health sector reform include:

- *Assigning resources and financing*. The new legal framework clearly establishes how financial resources will be collected and assigned. An important aspect of the process is the definition of the basic package of services. While it is presently known that reproductive health services will be included in the basic package, the exact complement of services has yet to be decided. In addition, it is important to define health services to include programs of promotion and prevention. Studies are needed to establish clearly the types of services, their financing, and their appropriate management.
- *Mechanisms of payment, incentives, and motivation of service providers*. It is advisable that USAID support demonstration projects in different regions of the country that put these concepts into practice. It is necessary to disprove the idea that health service providers will lose financially under a system that links payment with productivity and performance. The experience of other Latin American countries provides evidence to the contrary. A potential obstacle to take into account is the existence of Law 60-97, which "guarantees" the employment of physicians.

- *Organizational redesign and/or change*. Regulated competition will require service providers to develop capabilities, skills, and management systems in order to effectively participate in a new system. Interesting experiences already exist in the DR, led by the NGOs PRIME and EngenderHealth, for example, that allow us to observe institutional change and its relation to improved quality of reproductive health services. It is necessary to publicize these experiences.
- *Legal framework*. The current legal framework offers an excellent opportunity to develop a new health and social security system that offers equity, quality, and efficiency. Accordingly, it is important to insist on elaboration of the regulations to support the broad application of these laws.

Focus on the Public-Health Sector

While the Dominican reproductive health service delivery system is dependent on both the public and private sector, the public-sector system serves the poorest and most disadvantaged members of the population. Currently, the major public-sector service-delivery programs are run by SESPAS, which is responsible for the general health care of approximately 75% of the uninsured population entitled to free care. Of the population with health care insurance, 8% are insured by IDSS, which covers private-sector employees and selected household care workers. Twelve percent are insured by private insurance and 5% are covered by other types of insurance.

According to the 1996 DHS, one-third of women of reproductive age reported obtaining their FP methods/services from SESPAS facilities and an additional 2.5% from IDSS. Additionally, the governmental State Sugar Advisory (CEA) provides limited health coverage in *bateyes* (sugarcane settlements), where no SESPAS and few IDSS or NGO services exist. The combined public sector is responsible for about 50% of all sterilization services, 39% of IUD services, and 28% of pill coverage. However, the degree of reversible contraceptive method prevalence attributable to the public sector is variable and seems dependent on the availability of reversible FP methods in public facilities (where stockouts are common).

The private sector's role in the provision of reproductive health services has grown, perhaps because of the instability of public-sector stock commodities. Approximately 15% of private-sector clients are covered by NGOs, primarily one of the four that deliver FP services (ADOPLAFAM, INSALUD, MUDE, or PROFAMILIA). The NGO contraceptive prevalence rate is considered high by LAC standards, where NGOs normally account for only 2%–5% of users. The for-profit portion of the private sector provides FP services to about 40% of users. This sector comprises pharmacies, private clinics, and physicians' private practices.

Many factors necessitated that this assessment of the status of reproductive health in the DR focus on the public-sector system. First and most compelling is that the public sector provides care for the poorest and most disadvantaged. It is hoped that an assessment and prioritization of the services available to this population will lead to an improvement of their health status. Second, the poorest and most vulnerable populations are also the target populations for USAID assistance. Third, the public health sector in the DR was traditionally based on a model of free healthcare for the uninsured through public financing. As such, the recent climate of health system reform requires prioritizing needs to most effectively appropriate the available resources. Finally, high sterilization rates may be attributed to the unavailability of long-term, reversible contraceptive methods and to the public sector's inability to provide long-term, reversible methods on a consistent basis.

Assessment Objectives

The data collection team met November 6–9 to determine the scope of the assessment. In the Strategic Assessment methodology, strategic questions are used to focus the assessment. The team used the prioritized lists of reproductive health problems developed by the working groups during the afternoon sessions of October l9, 2001 stakeholders' meeting and developed a trio of integrated reproductive health questions that took into consideration the information from the background paper about the high rates of maternal mortality despite nearly universal prenatal and institutional delivery, the high rate of adolescent pregnancies and growing rates of STI/HIV, and the high rate of unmet need for long-term reversible contraceptive methods among both adolescents and adults. While each question could have been the basis for an entire assessment, the problems identified were so interrelated that all three were deemed equally important.

- *Strategic Question 1: Maternal health care.* Is it possible to improve the quality of maternal health care given during the prenatal, intrapartum, and postpartum periods? If yes, how?
- *Strategic Question 2: Family planning.* Is it necessary to improve the family planning program (options, coverage, access)? If yes, how?
- *Strategic Question 3: Adolescent reproductive health.* Is it necessary to improve the quality and access to integrated reproductive and sexual health services for adolescents? If yes, how?

Structure of This Report

The remainder of this report includes separate sections addressing each of the strategic questions, which present data from interviews and observations that illuminate understanding of gaps in knowledge or quality, failure to fulfill norms, strengths and positive examples, and recommendations for future research and interventions. The Conclusions section, written after the dissemination meeting on January 30 (see Appendix D for a list of the participants and the meeting agenda), refers readers to Appendix H, which includes input from all stakeholders on recommendations and activities suggested in the previous sections and at the meeting. After the conclusions and references are appendixes that contain more detailed statistics on findings from the background paper and from the assessment.

2: Maternal Health

SUMMARY OF MATERNAL HEALTH IN THE DR[2]

Using Macro International/CESDEM data, Family Care International (2001) has estimated that 62.3% of all parturients in the Dominican Republic deliver with a general physician, 29.4% with an obstetrical specialist, and 3.8% with a nurse (see Table 2.1). The overall cesarean section rate is 27.5% (Macro International and CESDEM l999), ranging from 24.0% in rural areas to 30.2% in urban areas, rates that approximate rates in more highly developed countries, but that are found with high rates of institutional deliveries. SESPAS (l998) gave the following information on maternity services in the country: 124 hospitals (provincial and municipal) offer prenatal visits and labor and delivery services, and 602 rural clinics and dispensaries provide prenatal care only. IDSS provides one maternity hospital, 20 polyclinics, 12 urban clinics, and 128 rural clinics; births occur in 15 IDSS institutes. FAA has two hospitals where births take place; the private sector has 261 centers for deliveries.

Table 2.1. Estimate of human resources in attending deliveries

Human resources	% attending delivery (Macro International and CESDEM l999)	% attending delivery (Macro International and CESDEM 1996)
Doctor	95.8	91.7
Nurse	1.9	3.8
Midwife	1.3	3.0
Relatives and others	0.6	1.3
General practitioner	No data	62.3
OB/GYN	No data	29.4

MATERNAL MORTALITY

As discussed in the introductory section and the background paper, the MMR is high in the Dominican Republic, however, the absolute number of maternal deaths and the estimated MMR remain unclear. Báez (2001) estimated that of 5,434 deaths of women of reproductive age, 260 were confirmed maternal deaths and another 1,648 were probable maternal deaths for a total of 1,908 maternal deaths. Cáceres estimated an MMR of 110/100,000 for the National District in l996, while Miller (2001)—using only SESPAS data and hospital birth statistics for the ND—estimated 140/100,000.[3] The 1996 DHS data put the MMR at 229/100,000 using the Sisterhood Method, a method intended for use with out-of-hospital deliveries, not with institutional deliveries such as in the DR.

[2] The discussion of maternal health in the background paper was based primarily on findings of both the l996 and l999 DHS, Miller's (2001) rapid assessment of SESPAS figures for 2000, a study of adolescent maternal mortality (IPED/PROFAMILIA and FNUAP 1996), Family Care International 2001, Cáceres l998, and Báez 2001. Not included in the background document, but used for the preparation of this paper were PAHO, OMS, and INSALUD l996, Cerda l999, and ONGS del Area de la Mujer l996.

[3] As a rare event, MMR will always demonstrate fluctuations when taken from year to year, however, real changes in MMR can generally be demonstrated over 5–10-year periods.

The causes of maternal deaths are contested, with the main causes identified as toxemia (45.8%), complications of abortion (19.4%), hemorrhage (11.1%), cardiopathies (9.7%), and "other causes" (13.9%) (Cáceres l998). Six percent of maternal deaths are attributed to obstructed labor. Both the high rate of toxemia and the relatively high rate of obstructed labor are puzzling in light of the prevalence of institutional delivery. The Sistema Nacional de Vigilancia Epidemiological de MM estimated that 86.4% of all maternal deaths were preventable (Báez 2001). Cáceres (1998) put the riskiest period as during or within the first 2 weeks postpartum, with over 50% of maternal deaths occurring during that period.

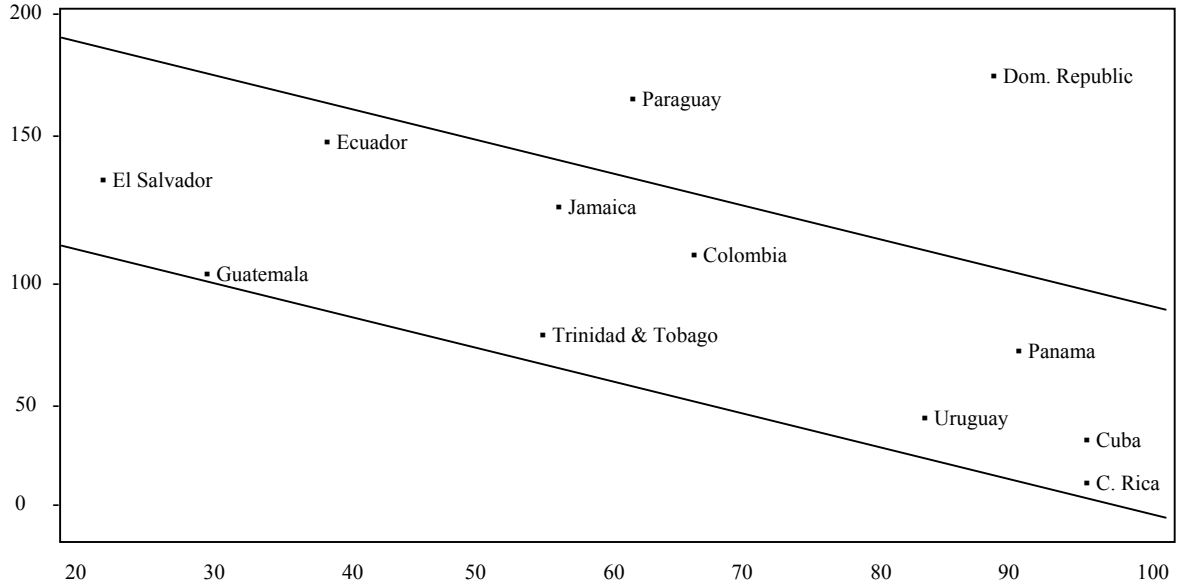
The rates for maternal mortality, whether the highest 229 or the lowest 110, are very high for the LAC region, and are astonishingly high given the other demographic, health, social, and economic characteristics of the DR, such as high rates of literacy, moderate rates of anemia during pregnancy, the relatively well-developed and maintained road system, the high percentage of private and public vehicles, and accessibility of health care institutions. The rates are particularly alarming when set in a context of 97.7% institutional delivery and 95% of deliveries covered by health personnel (Macro International and CESDEM l996).

In one study (Cerda l999), 28 cases of maternal deaths were analyzed. In 23 cases, the death occurred in an institution with basic obstetrical functions. In 21 of the cases the centers reported that they had the resources necessary to manage the case. In only three cases were there problems with resources (two lack of blood and one lack of transportation). In 20 cases it appeared that the basic norms of attention had not been followed. Twenty-four maternal deaths (86%) occurred in public institutions, two in private, and two en route to an institution. Fifteen of the cases occurred in the postpartum period, seven prenatal, two intrapartum, one in labor, and in three cases there were no data on time of death.

Theoretical Association Between High Institutional Delivery and Low Maternal Mortality

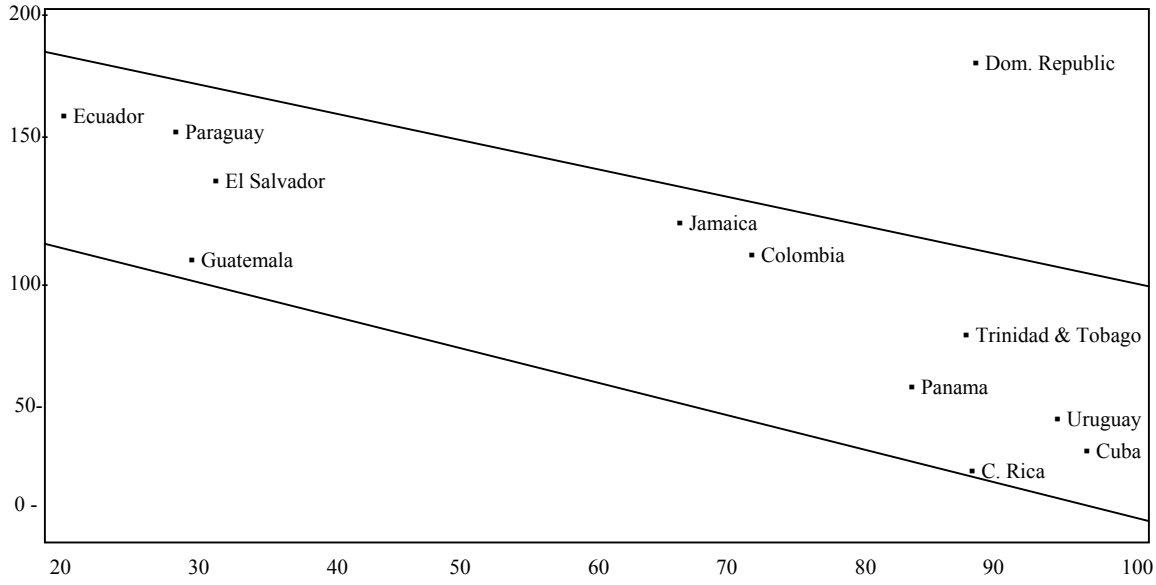
For the past 15 years, since the l987 Safe Motherhood Meeting in Nairobi, a leading theory regarding making pregnancy and childbirth safer and reducing maternal mortality rates has been the concept of institutionalized delivery and skilled attendance at childbirth. The inverse association of high prevalence of institutional delivery and decreasing maternal mortality rates is demonstrated in Figures 2.1 and 2.2. Note that the trend seems to hold for all LAC countries, except for the Dominican Republic (Cáceres l998).

Figure 2.1. Relationship between specialized prenatal care and maternal mortality in several Latin American and Caribbean countries, 1990



Source: Cáceres 1996.

Figure 2.2. Relationship between specialized attention in labor and delivery and maternal mortality in several Latin American and Caribbean countries, 1990



Source: Cáceres 1996.

Response of SESPAS to High MMR:
Baseline, Mobilization Plan, and Commissions on MMR

In response to concerns over the high MMR, SESPAS created the Linea de Base de la Mortalidad Materna en Republica Dominicana, under the Dirección General de Epidemiologia. This investigation of all deaths of women of reproductive age was carried out in order to create a baseline to follow the rate of MMR in the country, to evaluate the progress of the Plan de Movilización Para la Reducción de la Mortalidad Materna e Infantil, and to evaluate the development of the system of epidemiological monitoring of MMR. In addition SESPAS formed committees to determine whether maternal deaths were inevitable or preventable. These committees are organized at the institutional level and include the hospital director; the chiefs of obstetrical services, pediatrics, surgery, and internal medicine; the hospital epidemiologist; and the head of nursing, who meet whenever there is a maternal death to analyze the cause of death and determine who and what was responsible. Of 154 cases reported by the Systema de Vigilancia in l998, 37 cases (24%) were analyzed by a committee; in l999 of 159 cases, 47 (30%) were reviewed.

Maternal Health Norms

The current status of high MMR, despite high rates of prenatal care and institutional delivery, calls into question the quality of maternity care in the DR. Among the Serie de Normas Nacionales of SESPAS and CERSS, three specifically address maternity care: Number 2 (Vigilancia Epidemiológica de la Mortalidad Materna), Number 5 (Atención a la Mujer Durante el Embarazo, Parto, Puerperio y del Recién Nacido), and Number 7 (Normas Nacionales para el Manejo de las Principales Urgencias Obstétricas). Norms 5 and 7 in particular are intended to improve the quality of medical care in institutional deliveries in both the public and private sectors. Likewise, SESPAS has created El Plan de la Movilización Nacional in order to reduce the MMR from 120 to 80 maternal deaths per 100,000 live births (Norm no. 7, SESPAS 2001, p. 12).

However, technical quality alone is not the sole goal of the norms. They also recognize health rights and reproductive health rights and the rights of women and children to dignified and ethical care and to the social welfare that attends the reproductive health norms:

> *This also represents the promise and the moral responsibility of those whose daily interventions will be on the side of women and children at all service sites and whose activities will result in positive welfare, not only of health, but social welfare, that is a necessary component of reproductive health. It is for this reason that the attention that is given no women in labor should not be routine, but must be given with elements of quality and of high ethics so that all are treated with respect and dignity.* (Norm no. 5, SESPAS and CERSS 2001b, pp.11–12)

MATERNAL HEALTH NEEDS ASSESSMENT

These norms and the norms for nursing care in institutions (Norm no. 18, SESPAS and CERSS 2001c) are the guidelines against which the team viewed quality of care, technical aspects of care, and interpersonal skills and attitudes in all areas of maternity care in SESPAS, IDSS, and

one NGO institution across varied levels of care in the three regions. The team examined the availability, quality, and access of maternal health services at 14 prenatal clinics at the clinic, municipal hospital, and referral center (maternity) level. During this assessment they observed and/or interviewed 57 prenatal patients, 55 women in labor, 21 women having vaginal deliveries, and 6 cesarean deliveries. They also interviewed and/or observed 88 providers of prenatal, labor, delivery, and postpartum care, including nurses, general doctors, specialists, residents, interns, and students. (Note: This number does not include the hospital directors, administrators, or other administrative or laboratory personnel.)

A summary of the main findings of the assessment, divided by area of care (prenatal, delivery, and postpartum) is described below, followed by recommendations for change and improvement.

Prenatal Care

According to the l996 DHS, 93.8% of all pregnant women receive prenatal care in the first trimester, with a median of 7.6 prenatal visits per woman. The team noted that quality of care varied both between levels of care and among different institutions at the same level of care. Overall quality of care was consistently highest at the PROFAMILIA clinics visited in both the National District and in one of the regions.

Clinicas rurales/consultarios periféricos. Located where clients can access them most easily, these lowest levels of care range from excellent to substandard. In general they provide prenatal consultations along with other aspects of integrated reproductive health care (family planning) and other forms of primary health care. Prenatal visits might be scheduled for five days per week or all day, or be restricted to only certain days, or to certain hours of the day (morning or afternoon). Sometimes high-risk patients are seen only on specific days, particularly if there are no specialists or general doctors available on a daily basis. The prenatal visits observed generally consisted of two parts, a nurse or other staff member would bring the pregnant woman in and weigh her and take her blood pressure, then a physician would listen to the fetal heart rate, measure the growth of the uterus, order lab work, and, perhaps, check for edema. All of the prenatal visits observed at these clinics were very short, with little exchange of information or education.

Municipal hospital. The care at the municipal hospitals was basically the same as at the clinicas or consultarios, with the exception that more laboratory studies were available onsite. Again, visits were two-part and very short, waits for appointments were very long, and the waiting time was not used for education or information exchange.

Maternity and referral centers. Opportunities for education and counseling were greater at the maternity and referral centers. The team observed some IEC materials—particularly posters for breastfeeding—in the waiting rooms of some of these institutions, including a large room for counseling with numerous brochures in one maternity center. However, little in the way of counseling was observed, waits were long, and the consultation itself was short. At one institution women appeared for their first visit and received only an appointment for one month later; they were not seen, educated, or counseled during their first contact. Some hospitals have

special services for adolescents. (See Section 4: Adolescent Reproductive Health for information on maternal care of adolescent pregnant patients.)

NGOs. The only maternal health service the team observed at the PROFAMILIA clinics was prenatal care. As with other services observed at PROFAMILIA, the quality of care was high. Clients waited in clean waiting rooms that had printed informational materials and television and video available. Group education and counseling took place in waiting areas as well. Services were performed cheerily by all personnel. Adherence to norms was noted. At the ND clinic a physician is in charge of quality control and is very attentive to adherence to norms and protocols. The services at these two NGO prenatal clinics could be used as a model for prenatal care throughout the country. Currently at the two sites visited no delivery services are available, but negotiations are under way for PROFAMILIA to "purchase" these services from local private clinics, and/or to build delivery areas in some their integrated facilites.

Delivery Care

In the levels of service-delivery points assessed, complicated pregnancies are attended only at the maternity/referral level, while normal deliveries can occur at any of the levels. However, as complications can occur at any time, even to the most normal of pregnant women, all institutions should be capable of early identification and treatment, stabilization, and referral (essential basic obstetric care) of complications (WHO l991). Currently the lower-level institutions are not prepared, stocked, or staffed to handle complications (i.e., they lack surgeons and anesthesiologists necessary for cesarean deliveries and capability to perform blood transfusions); therefore, all such complications must be referred.

Regional and maternity hospitals. The majority of births take place at maternity and regional hospitals. Although we were conducting a rapid assessment, the hospitals and institutions the team visited accounted for approximately 54,000 of the 135,000 births for 2000–2001. For the institutions visited by the team in the three regions, statistics compiled over the preceding 6–10 months (January–June or October 2001) the following pattern emerged (see Appendix C for more detail).

Table 2.2. Birth rates, regional and maternity hospitals

Institution	Total women giving birth	Vaginal births (%)	Cesarean sections (%)	Mean births per month	Deaths (MMR)
Maternity AG	10,711	8,323 (78%)	2,388 (22%)	1,766 (for 6 months)	N/D
Maternity LM	12,111	8,399 (69%)	3,712 (31%)	1,211 (for 10 months)	12 (99/100,000)
IDSS Mujer	4,747	2,599 (55%)	2,149 (45%)	475 (for 10 months)	N/D
Regional Jaime Mota	362	248 (69%)	114 (31%)	One month figure only	0
IDSS Jaime Sanchez	4,989	3,943 (79%)	1,046 (21%)	416 (for 12 months)	0
Regional SVP	2,549	1,484 (58%)	1,065 (42%)	255 (for 10 months	0

While SESPAS data for l999 show a cesarean section rate of l7.4% for the 135,546 births in the country, our data for 2001 for the assessment institutions revealed an average of 32.5% at the highest-level institutions.

Referrals in regional and maternity hospitals. One of the problems in determining what percentage of patients are referrals at the major institutions is that there is no record keeping of which patients are referrals from lower levels, which percentage of maternal deaths are attributed to referred patients, and so forth. Likewise there is no formal system of transport for women from lower to higher levels. Women generally use public transportation or private vehicles, although some institutions have ambulances.

There are several institutions in the National District dedicated to receiving high-risk or complicated referrals—Altagracia, José Morgan, José Aybar and, to some extent, Los Minas. However, Los Minas is not equipped to handle major medical complications, such as renal failure, and those clients are transferred/referred to either Altagracia or José Aybar.

Altagracia had 25,054 births in 11 months (August 2000–September 2001). In that same period, there were l9,546 surgical procedures and 99,114 consultation visits (for reproductive health and other health problems). Altagracia has 280 adult beds and 60 perinatal beds, however, according to some, the hospital was built to serve 40 births a day. One of the problems is that as a public institution, Altagracia takes care of all the patients who come there, not just the high-risk patients whom the hospital is intended to serve.

One of the regional hospitals the team visited was also very active and served as a referral center for high-risk pregnancies. The nurses in this institution are aware of the norms, but they say that the physicians do not apply the norms and procedures. According to nursing staff, physicians either do not come or spend less time than they are hired for (i.e., while they are paid to work for four hours they only come for two hours; or they come only twice per week instead of daily). Nurses also reported that the principal causes of maternal mortality in this regional hospital were lack of physician presence and supervision. Many of the deliveries at this institution and the implementation of emergency care are carried out by the nurses who receive only telephone instructions from the physicians. Again, these physicians should be physically on duty in the hospital, but fail to appear. These absent physicians are not disciplined for not being at work. According to nurses, nurses are left alone to deliver most of the babies at this institution, and in many cases women deliver their own babies, because there is only one nurse available and she is busy with another delivery.

Delivery at the maternity hospitals. In the following description of labors and births observed during a three-day period at the two hospitals in the ND, the norms are used as the lens through which to view the activities. Each activity or procedure that violates a norm is followed with the series number and page number of the norm. The composite description covers 55 laboring women, 21 vaginal deliveries, and three cesarean sections.

The smaller of the two main maternity hospitals observed has 66% as many deliveries per month as the larger hospital (approximately 1,200 births per month vs. 1,800), the “sala de partos” has beds for 7–8, while the other could hold 14 in one sala and an additional 14 in an identical ward across the hall. The “sala de expulsivos” was also different; that in the smaller institution contained three beds, with no partitions between beds, while that in the larger hospital had six semi-private cubicles, closed on one end and open to a main corridor.

The greatest violation of norms (both in number of norms violated and degree of violation) was found in the larger institution. The smaller institution was better organized, cleaner, less crowded, had better ventilation, a stronger sense of management of labor (rather than women laboring without attention), stricter regulations about asepsis and infection prevention, friendlier interpersonal relations between staff and patients, and more IEC and patient education posters and materials. In other words, while it was overcrowded (i.e., there was more than one person per bed), noticeable attempts were made to ameliorate negative conditions for staff and patients. However, while the smaller hospital had improved adherence to the norms, adherence was not complete.

At the larger hospital, the team was most struck by the lack of adequately trained attendants, despite the presence of multiple staff members (in contrast to the understaffing seen at the regional and district hospitals). In one hour at the larger maternity hospital 12 births took place; the most experienced person in the delivery ward was a first-year resident with five months of service. The other eight providers were interns and medical students, and at least four nurses. Although more experienced providers did lead the students on educational rounds, and occasionally higher-level providers were seen walking through the area, perhaps on their way to a clinic or to surgery, during the time of our team's observations (generally between the hours of 9:30 a.m. and 2:00 p.m.) few of these non-resident providers were seen caring for patients or teaching hands-on care to interns or students.

In the smaller maternity hospital this was not the case, as there was a specialist overseeing all staff and patients. This person was clearly both a skilled provider—highly experienced and able to teach—and a manager, who gave the entire labor and delivery area a clear sense of purpose, management strategies for each of the patients, and oversight to the residents, interns, and students.

Table 2.3 summarizes activities observed at the major maternity and referral institutions that violate written norms. Following that table are narrative descriptions of observations from the labor and delivery wards of the two ND maternities.

Table 2.3. Adherence to norms for care of labor and delivery at ND maternity hospitals

Norm	Observation
Series no. 5: Norms for the attention of women in labor and delivery	
Bring to the delivery room when the woman is dilated 10 cm (primiparous) and 8 cm (multiparous)	Sometimes done, often multiparous women were complete and delivering when brought to delivery room
Guarantee the laboring woman quality care, a clean birth, and a safe delivery	Sometimes done
Protecting the perineum is the principal way to prevent tearing	Not done
An episiotomy should not be performed routinely, when an episiotomy needs to performed the laboring woman should be informed*	Not done
During delivery never push on the uterus to hasten the delivery	Not done

Table 2.3 *(continued)*

Norm	Observation
Wait for spontaneous delivery of the placenta	Not done
Examine the placenta and membranes to see that they are normal and complete	Always done
Put the baby to the breast immediately	Not done
Counsel about postpartum family planning	Not done
Series no. 7: Managing obstetrical emergencies	
Wash the perineal area and vulva with an antiseptic solution	Sometimes done, often with water only
The left lateral side is the preferred position for labor	Not done
Monitor the fetal heart rate and contractions every 15–30 minutes	Rarely done
Monitor the progress of labor through vaginal exams that are performed under strict aseptic conditions, use a partograph or follow the curve of labor	Sometimes done, charts kept but monitoring not always timely
Place the delivering woman in the modified lithotomy position	Sometimes done
Catheterize the bladder only if it is necessary	Not done
Cover the patient with sterile clothes	Not done
For nuliparous women always perform an episiotomy, for multiparous women only when necessary*	Not done
Perform episiotomy after giving local infiltration anesthesia	Sometimes done
Continue to monitor the fetal heart rate in the delivery room	Not done
It is necessary to control the speed of delivery to allow the fetal head to go through the normal deflection and progressive and gradual delivery	Not done
After the delivery of the head, aspirate the nares and oral pharynx	Not done (births occurred too rapidly, suctioning was performed after delivery of body)
Place the baby to breast as rapidly as possible	Not done
Deliver the placenta by maintaining sustained traction on the cord while gently holding the uterine fundus in the superior part of the abdomen	Sometimes done
Immediately inspect the cord, membranes, and placenta	Always done
Immediately inspect the cervix with ring forceps	Always done, but not always with adequate light
Repair the episiotomy or laceration	Always done, but not always with adequate light
Inspect the vagina after the repair and remove all gauze or tampons	Always done
Take the pulse, blood pressure, and monitor if the uterus is firm and if there is genital bleeding	Sometimes done
Take the patient to recovery when you are sure that there is no abnormal bleeding and vital signs are normal and stable	Not done

*Note: These two norms are in conflict

Sala de parto/pre-parto (labor ward). As the team entered the labor ward they were assaulted with a foul, unidentifiable odor. Since several team members were experienced clinicians, they were used to the normal smells of a crowded labor area, yet this was a foul odor they could not identify. They entered one of the two labor wards and found 14 women each in advanced labor. The women labored alone, unaccompanied by family or friends. Although many students, interns, residents, and nurses were present, they paid little attention to the laboring women. Vital signs, fetal heart rates, and a vaginal exam were taken and recorded about every four hours. Women were not informed of the results of their examinations. Low- and high-risk women labored together in the one large, brightly lit and noisy room. Some women were naked, most were lying on bare plastic mattresses, the one sheet having been soiled with urine, feces, or drenched in amniotic fluid. There was no privacy, no dignity. One woman stood at the side of her bed, bellowing, "!Da me agua!" but no one responded. The bathroom was at the end of the long ward and some women managed to get up and walk, barefooted, past all of the other laboring women to the toilet, while others soiled themselves where they lay.

At one point a large group of residents, interns, and medical students made rounds on all of the patients, led by a professor or senior attending provider. This provider asked questions about labor management and diagnosis and got the students thinking; however, no attempt was made to teach the students how to relate to the women as women, not just laboring bodies. At one point a woman gave birth unattended while a group of students stood around the bed across the aisle from her. No one noticed the very clear sounds of impending delivery (grunts) amid the noise, cries, and conversations.

At either end of the ward lay two women with diagnosed pre-eclampsia, one severe, one light. Neither woman was afforded the attention the norms describe for pre-eclampsia, (privacy, dim lights, quiet) in order to avoid eclamptic fits (SESPAS, Series No. 7, 2001). One woman was receiving IV magnesium sulfate (per protocol), and was unresponsive. There was no evidence of her vital signs being monitored for signs of magnesium sulfate toxicity, there was no crash cart nearby, and the observers did not note the availability of calcium gluconate.

Overall cleanliness and orderliness of the ward were poor. Needles, intravenous catheters, and other dangerous waste were found in the beds and on the floor. Body fluids were also in the beds and on the floor. Trash containers were woven plastic with no lids, so that even when trash was placed in containers it could fall out easily.

Care of an HIV-positive patient

The source of the foul odor that the team noticed in the ward was traced to the running sores of one woman who was diagnosed as an AIDS patient. Her legs were swollen to twice their normal size and covered with large, pus-filled sores. Staff changed the soiled bandages while the team was observing, but they allowed the soiled bandages to lie on the floor or tossed them into the open plastic waste receptacles that were overflowing with soiled, foul-smelling, contaminated waste.

The overall impression of the labor ward was of noise, dirt, overcrowding, lack of privacy and dignity, lack of attention, and over-medicalization of women having normal births, while women with high-risk deliveries were ignored or undertreated.

Sala de expulsivo (delivery ward). Each client, regardless of her gravity, parity, or presence or absence of complications, was accorded exactly the same treatment for delivery—she was rushed into the delivery ward ("sala de expulsivo") in a wheelchair, made to walk in bare feet across the often dirty, glass- and needle-strewn floor to the delivery table (a table whose mattress pad had just rapidly been washed with cold water and set on the floor during the change in its plastic bag type covering), put flat on her back with her legs in stirrups, naked, in front of between one and seven residents, interns, and students. A nurse would come up and pour a liter bottle of cold water over the patient's abdomen and perineal area as a form of scrub (no soap or antiseptic was used). Next, one of the many providers would cut a large medio-lateral episiotomy (Series no. 5, p. 77, "episiotomy should not be routine" and "protecting the perineum is the principal method to prevent tearing"), again without attention to whether the patient was primiparous, multiparous, or the baby needed rapid delivery or not. In fact, while fetal heart rate was occasionally observed to be monitored in the labor ward, this was not the case in the delivery ward.

Once the patient was on the table in the very cold ward, doused with cold water, and cut, often without benefit of perineal anesthesia or head compression anesthesia, her contractions would sometimes become further apart (a normal occurrence in second-stage labor). Rather than waiting for the rhythm of contractions to recur the woman would be manually stimulated by a nurse or other attendant roughly jabbing at her uterus (Series no. 5, p. 77, "never push on the uterus to hasten delivery"). No patients were helped to empty their bladders nor were they catheterized, even though that procedure would have helped to bring the babies' head down on the perineum to stimulate pushing.

The client by this time was being shouted at to push or yelled at to stop pushing. The entire experience in the delivery ward was one of yelling, cries of pain, screams during the episiotomy, and cries of porters yelling "!Completa!" as they ran into the delivery room wheeling the patients, or providers yelling "!Guantes!" or "Agua aquí."

A buzz of conversation was constant, with nurses, doctors, and students conversing among themselves, often about matters other than the women in labor or birthing (Series no. 5, p. 77, "guarantee the laboring woman quality care").

After the episiotomy was cut, it was common for the attending personnel to switch places, and a person who would deliver the baby would replace the person who performed the episiotomy. The delivery was conducted as rapidly as possible, with nurses and doctors yelling at the woman and using extreme force to pull the baby out of the woman's body. As one observer stated, "The resident did everything except put her foot up on the woman's bottom and pull. I've never seen anything like it. The baby was yanked out." Indeed, the trained clinician observers noted that basic obstetrical anatomy and physiology, such as allowing the baby to rotate spontaneously, and the slow delivery of the head first down and then up along the curve of caras, was not followed in the ND maternity hospitals.

All of the births observed resulted a similar neonatal response. The babies, roughly hurried out of the warm bodies into the cold delivery wards, were blue and limp. The team did not observe a single newborn put to breast or even given to the mother to hold (Series no. 5, p. 77, "put the baby to the breast immediately"). The babies were handed off to pediatric residents or students.

Babies were only rarely received into a blanket or rubbed to stimulate them at the bedside; rather the wet, cold, limp babies were rushed out of the labor ward, often with the running pediatric resident shouting over her/his shoulder, "What is the mother's name?"[4]

The baby was thus removed from the mother immediately after birth and taken to be identified, bathed, weighed, measured, and so forth, while the mother endured more procedures. Often a third provider would be called to deliver the placenta. This was generally followed by a manual exploration of the mother's vagina and uterus, an unnecessary procedure that is very painful and can risk infection. More cold water is then poured over the woman's abdomen and perineum. The placenta was inspected for completeness.

For the repair of the episiotomy it would be possible that yet a fourth person would be involved, or that one of the previous providers (perhaps the one who cut the episiotomy or who delivered the baby or the placenta) would repair the episiotomy. In most cases there was no special light used to illuminate the multiple layers of tissue involved in this complicated surgical procedure; rather a medical student or intern would be left alone with some suture and occasionally a nurse would wander by and pour water over the perineum. Very little communication was observed to take place between providers and clients, and none of it was observed to be counseling or education.

After the woman's perineum was repaired, the doctor would leave and the woman was often left to lie in her own blood, urine, feces, and/or cold water on the plastic sheet with her legs in stirrups until a nurse came along to check vital signs or a porter arrived with a wheelchair. The observers noted that women brought their own towels and clothes and would get themselves up, dry themselves off with their own towels, and change from their wet bloody clothes (if they weren't already completely naked) into their own nightclothes. They then walked barefoot across the bloody, slippery floor to the wheelchair. The porter would wheel them into the hall where they would wait. Sometimes they would receive their babies, sometimes not. Little information was given to the woman regarding the condition of her newborn, if he or she was not given to the woman.

Interviews with women in the immediate postpartum period

During one observation four newly postpartum women were sitting in wheelchairs in the hallway outside of the newborn nursery. Some had their babies; others did not. We asked each of them how they felt about their experiences; all replied that they were quite satisfied: "This was the best place to have a baby." Some had traveled long distances to have their baby in this "special place." One woman, whose baby had been rushed away at birth, had still not seen her infant and had no idea what had happened. We asked her what she thought. She said, "Something bad must have happened to my baby; he is in there but I don't know why." We asked her how she knew to bring her own clothes and towels. She said, "Oh, my sister told me you had to have your own things, so I brought them." We asked if she was worried about her baby, and she replied, "Oh, yes, very, I wish they would tell me what is wrong."

In contrast to the major hospitals, at the IDSS hospital in the National District the team found the following: 15–16 births occur every day in the labor rooms, and 8–9 cesarean sections are

[4] Although the team did not observe the identification process for newborns in the nursery, the fact that the babies were not banded in the presence of the mother may lead to losing track of which infant belongs to which mother if two infants are born at the same time and rushed into the nursery simultaneously.

performed every day. Someone is on duty in the hospital 24 hours a day. Specialists and/or senior residents supervise the services and the students, which is different than the students observed in the SESPAS facilities. First-year residents care for parturients without complications while those with complications are cared for by the specialists and the fourth-year residents. Adolescents are given analgesia during their labors. While we did not observe any births, we did observe a labor, which was strictly monitored by the medical specialists. The woman was treated with respect, the area was clean, and the woman was dressed in hospital clothing. The personnel were kind. High-risk patients were watched closely. There was a special area for women with pre-eclampsia. The hospital did not have an intensive care unit, so women with severe complications were referred to the Hospital Salvador Gautier. This presents a problem, as this fourth-level hospital receives a very high number of at-risk cases and may be overcrowded, thus reducing the quality of care.

Municipal hospitals are instructed to refer high-risk patients to higher levels, therefore the low percentage of cesarean sections reflects this trend. Some municipal hospitals do not provide birth services.

Table 2.4. Birth rates, municipal and lower-level institutions

Institution	Total women giving birth	Vaginal births (%)	Cesarean sections (%)	Mean births per month	Deaths (n, MMR)
Engombe	496	464 (94%)	30(6.5%)	50 (over 10 months)	0
Alcarrizos II	402	398 (99%)	4 (1%)	40 (over 10 months)	0
Alicia de Legendore	109	109 (100%)	0	10.9 (over 10 months)	0
Villa Duarte	No deliveries				
Las Caobas	No deliveries				
Vicente Noble	No data				
DuVege José Pérez	No data				

The lower-level institutions in the regions, those that either don't have maternity beds or personnel, or are not equipped for emergency obstetric care (i.e., don't have blood banks or surgical and anesthesia facilities), should refer patients to central institutions that do have those services. However, according to those interviewed, the system of referral is not smooth. In many of the municipal hospitals all patients, whether high- or low-risk, are sent on to the regional hospitals and maternities. The definition of high-risk is also contested; for example in one region high-risk is defined as any primiparous woman. This has resulted in a problematic overcrowding situation in the higher-level centers, which have far too many normal patients who are taking the space, fiscal resources, supplies, and attention of specialists that should be devoted to the higher-risk patients.

Lower-level institutions are also low-volume institutions. In the institutions observed, rates of deliveries were quite low, often less than one birth per day (See Table 2.4 above). Often this was due to inappropriate triage, admitting, and referral practices. Sometimes this was due to clients' preference; having heard by word of mouth that the institution was understaffed, clients would purposely bypass the lower level and go directly, without referral, to one of the higher-level centers. However, clients also said that even when they came to the municipal hospital with the

idea of delivering there they would often be sent to the referral center without the benefit of screening/triage for level of care necessary. In addition, other clients related experiences of having arrived at the municipal institution only to be sent home until "labor was more advanced." Some of these women delivered at home, or on the way home, or on the way back to the hospital. Others returning to the hospital in "advanced labor" with no history of high risk and no labor complications would still be referred to the higher-level institutions. Again, many deliveries occurred on the way to the referral hospital.

In some of the lower-level institutions trained staff were rarely available, leaving untrained nurses[5] to attend labor, determine risk categories, and make decisions about who should be referred and why and/or how to handle complications as they arose in labor. While it is true that around the world trained nurses and midwives have proven to be as safe or safer than doctors in performing triage, normal labor management, early problem identification and management, and appropriate referral (Miller, King, Lurie et al. l997; Rooks, Weatherby, Ernst et al. l989; Starrs l998), the nurses who are left alone to attend labor in the lower-level institutions lack this kind of training. The nursing staff are not only inadequately trained, they also are understaffed. At one of the lower-level institutions the team visited, an adolescent had just delivered alone; the only nurse available had been busy with another patient when this adolescent had her baby.

The death of Maribel's baby

Maribel is 20 years old and having her first pregnancy. She arrived at the hospital on Friday at 1:30 p.m. with a diagnosis of 41 weeks pregnancy, in labor, no risks, has had prenatal exams. When she was admitted she had a blood pressure of 110/70, fetal heart beat of 144, moderate contractions, cervix dilated 2 cm. She did not see a doctor on Saturday or Sunday. On Monday, an auxiliary nurse examined her and found her cervix completely dilated, but the fetal head was still high. She still did not see a physician.

At 4 p.m. on Monday (three days after Maribel was admitted), the assessment team observed that she was in great pain and bleeding very heavily. At this time the nurse took her to the bathroom for a "good bath, that will help make her pain seem less." When Maribel came back to bed, a physician on our assessment team noted that the uterus seemed to be hypersonic and tried to listen to the fetal heart beat, but could not get it. She performed an exam and found the cervix to be dilated 8 cm, and the baby's head at –2 station. Our team advised the obstetrician on the service on rapidly performing a cesarean section. The baby, an 8-pound, 6-ounce male, was dead on delivery. The placenta was found to be 40% detached. Maribel received a 500cc transfusion.

When we asked Maribel what she thought had happened, she said, "The baby had problems and died because of them."

The team feels that if it had not been there during this birth that the woman as well as the baby would have died, because the nurse did not realize the severity of the situation.

Postpartum Care

Given that at the time of death of the 25 maternal mortality cases studied by Cerda (l999)—in which the time of death was known—15 (60%) occurred postpartum, it is clear that postpartum care is crucial to saving mother's lives. In hospital, immediate postpartum care as mentioned above is lacking in the delivery area. There was no formal postpartum recovery area noted in the two major ND institutions. Norms exist for the two hours immediately following delivery (Series

[5] The nurses were trained nurses, but not trained as midwives or obstetrical nurse specialists, and certainly not as well trained as the physicians. Therefore despite being called "trained personnel" they were not adequately prepared for the tasks of labor management, triage, and delivery.

no. 5, p. 81), especially the taking of vital signs and uterine firmness checks every 30 minutes, but this was not observed by the team.

The overcrowding at the major referral centers also rendered the postpartum period in the wards neither a time of close supervision, a time for education, nor a restful time for the parturient. While there were many posters on breastfeeding, and the norms state that breastfeeding is encouraged postpartum (Series no. 5, p. 77), there were no lactation specialists to help women get started. In some of the institutions, women are in wards and can learn from one another, although what they learn is not always appropriate and adequate knowledge. In other institutions 3–4 women share a smaller room with a bathroom in between it and another room. Again, younger, less experienced women can learn from more experienced women. Discharge time, except for complicated or operative deliveries, is at 24 hours or the morning after the delivery. The mothers and their new babies gather outside the birth registration area, and, although no teaching takes place at these sites, it would be a good opportunity for educational efforts.

The Dominican Republic does not keep statistics on postpartum care. Although the norms call for three postpartum visits (at one week, two weeks, and one month postdelivery; Series no. 5, p. 82), according to staff at one of the regional hospitals, only 33% of patients return for a postpartum follow-up visit. Fewer return to the hospitals at the municipal and lower levels, and then the visit is usually a vaccination visit for the baby. Although women can return for postpartum family planning, according to personnel in the clinics, few do. Postpartum family planning did not appear to be a major goal of postpartum care in the institutions observed (see Section 3: Family Planning for "lost opportunities" postpartum). The majority of women who did receive a FP method postpartum were there for tubal ligation. Reversible methods were not given on discharge.

In the words of women we interviewed in the the postpartum area:

- "After we deliver we leave after 6–8 hours, they don't tell us when we should return."
- "There is no family planning. We need to go to PROFAMLIA. There they tell us about methods."

Abortion/Postabortion Care

Postabortion care was offered at the referral hospitals and at many of the lower -evel institutions as well. Many of the care providers and administrators noted that the caseloads had fallen greatly since public knowledge had spread about misoprostol (Cytotec®). "I am a great fan of Cytotec," more than one provider told us. When asked why, providers replied that Cytotec had greatly reduced the numbers of infected, perforated, and hemorrhaging cases. "The woman privately takes the Cytotec, begins to bleed, and comes in for a missed or threatened abortion. We can than safely and legally evacuate the uterus and treat her well." However, patients noted that they were yelled at and abused when they came in for the uterine evacuations. Also, at one institution, those patients waiting for uterine evacuation were kept in the same waiting room as the patients who were awaiting tubal ligation. We noted three beds for the eight pre-tubal ligation clients to sit on waiting for surgery, however, two sick pre-uterine evacuation patients were lying among them. Both women were hot, sweating, and likely septic. In addition, the uterine evacuation procedures took place in the delivery ward. As there were no curtains for privacy, one woman

was delivering a baby on a table just a few feet away from a woman receiving a uterine evacuation.

Since abortion is illegal in the DR we did not ask service providers or clients about it. However, we did gather the following statistics on postabortion care delivered at the sites visited. All statistics are for 10 months, unless otherwise indicated:

Table 2.5. Postabortion care

Institution	Surgical abortions	MVA abortions	Procedures per month
Maternity AG	1,168 (6 months)	0	194.7
Maternity LM	3,824	0	82.4
IDSS Mujer	371	0	37
Regional Jaime Mota			
IDSS Jaime Sanchez			
Regional SVP	530	0	53
Regional Engombe	501	128	63
Alcarrizos II	17	0	2.1
Alicia de Legendore	2	0	0.2
Maternity Villa Duarte			
Maternity Las Caobas			
Maternity Vicente Noble			
DuVege José Pérez			

User Perspectives on Maternal Health

The following quotes were collected in the IDSS Hospital de La Mujer in the ND:

- One woman brought her one-month-old baby in for a checkup. She told us about the treatment she received during labor: "Here the nurses don't help you, or even watch you. If you don't know someone here, you are without attention."
- "Here they don't have good equipment and the doctors treat us poorly."
- "The doctors and nurses could be so much nicer, they give the impression that they want you to finish rapidly and get out."
- "The nurses and the cleaners are animals with clothes on."
- "The appointment hours are not kept, we arrive at 6:00 a.m. and are not seen until the afternoon."
- "I went for a sonogram and the students were all talking as if the patients weren't there. One doctor even bought clothes from a wandering salesperson."
- "We don't get good education about dangers and how to care for ourselves after we leave, because of this we get infected postpartum."
- "The wait for visits is very long. We arrive at 5:00 a.m. and return in the middle of the afternoon. This is a problem for us at work, we get permission from our employers for an appointment, but not to be gone all day. Often we have to return another day because on the day we came the doctor wasn't there. Often we have forms that need to be signed by the doctor, but the doctor is not there…"
- "We haven't heard about deaths in this hospital, but we hear that women die in Los Minas and in Altagracia."

Users at a regional hospital described their experiences:

- "The waits are very long."
- "The doctors arrive late."
- "The laboratory services are very expensive, and you can't find out about the results until you return for your next visit."
- "The consultations are very short; there is no time to ask questions. If we ask about our symptoms, they minimize them, or tell us about folk remedies, like if we say 'I am *hinchada pareja*,' they tell us to eat pinneaple with honey."
- "I have high blood pressure. They told me to drink ginger tea." (Note: This woman had a blood pressure of 180/100, and later she *tuvo de ser ingresada*).
- "When we come for our visit at 40 weeks they tell us to stay at home and come back when we begin labor, for this reason you often see women at 41–42 weeks who have not had a visit." (Note: There is an increased risk of neonatal complications and difficult deliveries after 41.5 weeks.)
- "We are never checked by doctors. They never explain our conditon nor why we have cesarean deliveries."
- "When a baby dies, they say the baby came with problems, and in many cases they blame the patients for their complicatons."

The following quotes were drawn from the conversations, observations, and interviews at the two public maternity hospitals and augmented by qualitative data from a l993 study in which 130 prental, 69 gynecologic, 95 postpartum, and 6 gynecologic surgery patients were interviewed at the larger institution (PAHO, OMS, and INSALUD 1996). In the l993 study, 290 users were asked if they received any type of maltreatment while in the hospital. 243 (84%) said no, and 47 (16%) said yes.

Comments from users in the maternity hospitals included:
- "I was alone, by myself, I had no one familiar nearby."
- "I was afraid and sad. I didn't have a familiar face, and the nurses were very mean."
- "There was no water to bathe in, no water to drink."
- "When I had labor pains they left me alone in my bed, no one came by to check up on me or see how I was doing."
- "The doctor spoke badly to me, he never explained anything, never told me how my baby was doing, and one time they blamed me because they couldn't find my records!"
- "It was very noisy and it smelled very bad."
- "You are being watched by a lot of different people during a very private time, it is all out in the open."
- "The doctor spoke to me and the other patients as if we were animals."
- "One nurse told me: 'Lady can't you see that you are in the way? Go over there, you aren't anything but an animal and talking to you is like talking to an animal!'"

Provider Perspectives on Maternal Health

Interviews with providers about why so many women died in childbirth included the following:
- "The users are not well educated and therefore they have complications."
- "They don't get the tests we order."
- "The users don't come to their checkups."

- "The adolescents don't cooperate."
- "We need more general doctors to help during the consultations so that we can decrease the number of women seen by nurses."
- "There aren't doctors to oversee the labor and deliveries. All of the work falls on the nurses."
- "Some cases require the care of specialists, but there aren't enough."
- "The women die because they arrive with established complications, and we don't have intensive care, it is also the fault of poor education of pregnant women during their prenatal consultations."
- "The doctors don't have time during the consultations, particularly with high-risk pregnancies. Doctors must understand that all pregnant/laboring women are high risk, that is the only way to decrease morbidity and mortality."

CONSTRAINTS TO LOWERING THE MMR AND DELIVERING HIGH-QUALITY MATERNAL HEALTH SERVICES

Attention to the problem of the high MMR and the question of the low quality of maternal health in the Dominican Republic is a long-standing one (Báez 2001; Calderón 2000; CONAPOFA, FNUAP, and SESPAS l999; IPED/PROFAMILIA and FNUAP l997; Miller, Dabash, Mercado et al. 2001; Miller 2001; PAHO, OMS, and INSALUD l996). When the team reported its findings to the technical advisory group on November 30 and again to SESPAS on December 7, no one expressed surprise or shock at what we told them. Responses included:

- "We know this information, previous studies have shown this, the present assessment only confirms what we already know."
- "These results are not unknown to us . . . the triangle you show is floating in the surrounding health atmosphere."
- "This is not new information, we know this."
- "I do not have high expectations that you will find the reason for the high level of maternal mortality. It is common knowledge that it is an issue of quality having to do with providers' attitudes. Specialists are not present when problems arise; there is not good management of complications. I don't see a way to resolve this. It is a problem of culture and power."
- "MMR is our number one problem and is due mainly to attitudes in physicians. Specialists are never in their work places and do not follow up on patients. Regional hospitals lack proper equipment, do not provide information to the users, do not apply norms, and there are no physicians on duty 24 hours."

Despite many efforts over time from SESPAS, CONAPOFA, international and bilateral donors, cooperating agencies and other NGOs, and the development of norms, the problems persist. Many structural, social, political, and economic reasons have been given for the persistence of high rates of maternal mortality despite the attention to the problem. However, the team believes that if the norms—which are well-written and reflect current accepted obstetrical practice according to WHO standards—were followed, care could be improved. Unfortunately, the norms are not adhered to, nor do there seem to be real consequences for non-adherence. Understaffing or lack of appropriately trained staff appears to be another constraint to improving maternal

health care. This situation is made worse by the lack of authority of hospital directors and managers to discipline non-adherence to norms and/or non-attendance by trained providers.

One of the main consequences of the attention to the MMR has been the overmedicalization of users and the overcrowding of the main institutions, which leads to both a degradation of quality of care necessary for those who need high-level institutionalization and to compassion fatigue of the interpersonal relationships necessary to keep such institutions running well. Overwhelmed as they are with normal patients, staff fail to recognize and treat true obstetrical complications in a timely fashion. In addition they have institutionalized many unnecessary procedures for normal clients who don't require such interventions. This may contribute both to an unnecessarily high cesarean section rate among normal clients and the unacceptably high MMR.

Another constraint to improving care is non-adherence to the epidemiological tracking system and maternal mortality review committees. While these could help determine causes of death (and therefore help to plan strategies for prevention), the low percentage of cases in which the cause of death is actually determined prevents this from being a useful tool for improving conditions. Finally, as many of the providers and decisionmakers interviewed noted, the overall constraint to improving maternal health is one of attitude—the attitudes of providers toward clients, of persons in authority toward providers, and of women, who have low expectations of a system that should be there to serve them, but instead places them at risk.

RESPONSE TO STRATEGIC QUESTIONS

From the above descriptions of non-adherence to norms and to the lack of civil treatment of patients by all levels of staff, it should be a foregone conclusion that the response to the strategic question "Is it possible to improve the quality of maternal health care given during the prenatal, intrapartum, and postpartum periods?" is yes.

RECOMMENDATIONS

The following are some recommendations for improving the quality of maternal health care, which were examined by the readers and then used as starting points for the discussion at the meetings that took place on January 30 and 31. They were reviewed by the participants at these meetings. Further conclusions are in Section 5: Conclusions.

- Train staff with good role models of quality of care; for this to be effective there would need to be several steps:
  - Begin in the pre-service medical and nursing curriculum;
  - Have role models from the private sector or NGO sector train faculty and trainers within the institutions;
  - Increase supervision of providers on the job;
  - Provide incentives for performance and disincentives (sanctions) for non-adherence/non-performance/low performance and for non-attendance;
  - Provide ongoing sensitization of human and reproductive rights; and
  - Provide ongoing training and technical updates.

- Encourage low-risk women to seek care at the lower-level centers near their homes. This may also need to be done by incentives or disincentives. (This recommendation will only work if women are convinced that the next recommendation has taken place.)
- Improve staffing and training at lower-level centers, Lower-level centers need to be responsive to the needs of women in labor, need to have highly trained staff and equipment and supplies available, and/or need to be able to stabilize and refer/transport women who develop high-risk conditions.
- Adapt a midwifery model of care (examples abound in the Caribbean, where there is a system of high-level referral centers for high-risk and low-level care by highly trained midwives—see information coming from Altagracia regarding program in planning stages).
- Pay physicians according to productivity (Social Security Law).
- Ensure humanization of treatment—application of human rights approach to maternal health.
- Adhere to norms and evaluation/supervision by persons with authority.
- Improve access to PAC and postpartum family planning for the purpose of spacing and preventing the next unwanted child.
- Provide more long-term FP methods and increased access before the first birth, as well as IEC and other educational materials.
- Provide functioning committees on MMR (i.e., surveillance system), which include all of the persons associated with a maternal death, including nursing staff and other non-medical providers. MMR committees should become a means of teaching students and nurses that each death requires a complete investigation, not to lay blame, but in order to learn and prevent its recurrence. These committees should not be closed; they should carry out open discussions of the causes of maternal deaths.
- Provide postabortion training at all institutions to keep women closer to home and decrease load at referral centers.
- Develop a clear system of referrals, for what cases, at what point, transportation, referral forms, information returned to location where client began.
- Develop mass-media campaign to inform community members of warning and danger signs of pregnancy and to the importance of keeping low-risk women in the local institution.
- Ensure deconcentration of services.
- Develop accreditation system for OB/GYNs and other maternal health providers.
- Implement system of total quality that takes into account everyone from janitors to the director of the hospital
- Eliminate political appointments in the hospitals and public health provider systems.
- Work toward societal-level changes, improving gender equity—different role perception for young women and girls.
- Educate users to demand their rights.
- Improve political will to do something and demand results.

3: Family Planning

BACKGROUND

Norms

The Consejo Nacional de Población y Familia (CONAPOFA) was the official institution created in 1968 to establish and implement national population policies. In 1999, CONAPOFA coordinated the development and publication of the Serie de Normas Nacionales de Planificacion Familiar, as part of the wider series of health norms (SESPAS 1999–2001). The purpose of the FP norms is to unify principles, criteria, policies, strategies, and practices offered by the family planning services in all health centers throughout the Dominican Republic. They are also meant to guarantee "that the decision and the responsible and informed consent of users must be respected in an absolute way" (Serial no.14, 41) by providing counseling and technical services that enable users to make informed contraceptive choices.

The family planning norms address the quality of services, including: (1) users' decisions based on an available method mix; (2) accurate, updated information; (3) providers' technical competence; (4) positive interpersonal relations; (5) privacy, discretion, comfort, and other conditions that enhance the rights of contraceptive users; (6) follow-up procedures to enhance the continuity of contraceptive use; and (7) an appropriate package of integrated health services for women, men, and adolescents. By following these procedures, the user should be able to make a "free decision" to choose a contraceptive method. Counseling and an enabling environment are key elements in the quality of family planning care framework (Bruce l990) and are included in the Dominican Republic's family planning norms.

Unmet Need for Family Planning in the Dominican Republic

There are three different types of unmet need: (1) for methods to delay the first birth; (2) for methods to space children; and (3) for methods to limit the total number of children. Women express each of these needs differently across the life span. Often these needs can only be met by different methods of contraception. There are no data in the DR for the unmet need to delay the first birth. Among all women-in-union, unmet need for spacing is 7.1% (Macro International and CESDEM 1996, Table 6.5). However, among subpopulations, unmet need for spacing is highest for adolescents (25.1%) and for young women 20–24 years old (17.4%).

In the Dominican Republic, intergenesic[6] spacing patterns are short and have changed little in the last decade. The median duration in the 1996 DHS was 29 months. The median of the interval increases with the age of the woman; 36.9% of women 15–19 years old have an intergenesic interval of 7–17 months and 36.8% have a longer, but still risky, 18–23-month spacing interval. In 1996, the unmet need for limiting was 5.3% for women-in-union, lower than the unmet need for spacing (Macro International and CESDEM 1996, Table 6.5). Forty-nine percent of women-in-union had satisfied their demand for limiting the number of children, mainly by female sterilization as shown below.

[6] Number of months between births since the last pregnancy that ended with a live birth.

Method Mix Limitations and Opportunities

Contraceptive use. Data from the 1996 DHS show that among women-in-union, 59.2% were using a modern method and 4.0% were using traditional methods; approximately one woman in three (36.3%) did not use any method. Female sterilization was the method used most frequently (40.9%) followed by oral contraceptives (12.9%). The IUD was used by only 2.5% of women-in-union. The small percentage of users of condoms (1.4%), implants (0.6%), and the aggregate category for injections, diaphragm, gels, vaginal tablets, and vasectomies (0.9%) demonstrates the skewed method mix of pills and sterilization. The 1999 DHS found the same pattern with a slight increase in both sterilization (44%) and oral contraceptives (15%).

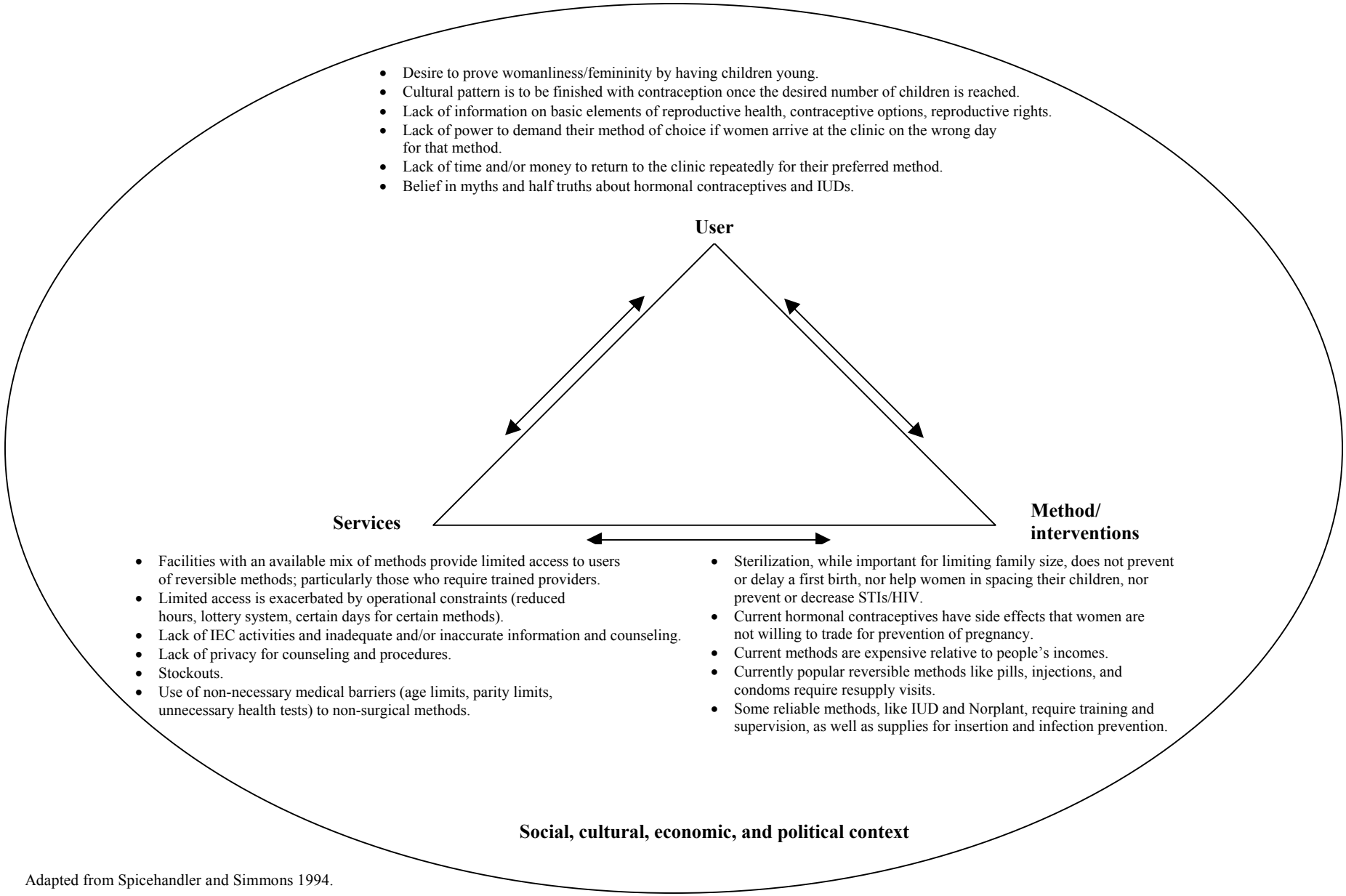
Bias and the skewed method mix. The bias toward female sterilization is most likely a reflection of the high proportion of women-in-union (49.7%) who have reached their desired family size. On the other hand, the proportion of women using reversible modern methods, approximately 20%, suggests that fewer women use contraceptives to space their children. Indeed, the reproductive pattern in the country is for women to have all the children they want without spacing and then to undergo surgical sterilization.

This pattern of behavior may pose health and social problems for women and children. One of the prominent findings of the Analysis of the World Fertility Surveys in developing countries is the extremely high mortality rate among children born after a short birth interval (National Research Council 1985, p. 266). For women living in poverty who are already at risk for poor health, a short interval between pregnancies may not provide sufficient time for the required nutritional and physiological rebuilding of the body. For all women, early and close childbearing may interfere with educational and career possibilities, and continue a cycle of low skills, low self-esteem, and lack of development.

The Strategic Question

The strategic question for family planning determined by the research team was: Is it necessary to improve the FP program (options, coverage, and access)? From quantitative data alone the causes of the high demand for surgical sterilization and the poor mix of reversible methods are not clear. This Strategic Assessment seeks to illuminate this issue. In terms of the three points of the conceptual triangle (services, users, technologies), the assessment found interrelated problems detailed in Figure 3.1 below:

Figure 3.1. Family planning systems framework in the Dominican Republic



Adapted from Spicehandler and Simmons 1994.

ASSESSMENT OF FAMILY PLANNING SERVICES

A number of causes determine the current bias toward sterilization in the method mix and interact to decrease informed choice. The following sections provide information on findings from the Strategic Assessment teams, augmented by national data from previous DHS studies on selected indicators.

Availability of Contraceptives

Sources and supply of contraceptive methods. Table C3.1 (Appendix C) presents data on sources of contraceptive methods from 1996. The main providers of contraceptive methods are the public sector, which includes SESPAS, IDSS, the armed forces, and CEA (in the past), followed closely by private clinics. Together they provide 70% of all methods and 87% of female sterilization. OCPs, the second most prevalent contraceptive method in the country, are mainly purchased at pharmacies, supermarkets, small stores (*colmados*), barbershops, beauty parlors, and other locations without a prescription or counseling. NGOs are the main source of implants (38%), injectables (30%), and male sterilization (15%).

During data collection, focus groups and interviews with community members from Region III confirmed the importance of private stores as sources of contraceptives, but also their limited mix of pills, contraceptives, and vaginal tablets. The main sources of contraceptives were pharmacies for pills and *colmados* for condoms. Adolescents preferred the latter because they were less embarrassed to obtain contraceptives from young staff attending the stores. Diaphragms, gels, and injectables were not purchased at pharmacies, beauty salons, or stores.

Sources of public-sector contraceptive methods. CONAPOFA provides storage and distribution of contraceptives for the public sector. Supplies originate mostly from donors, like USAID (before 2001) and UNFPA. Table C3.2 (Appendix C) presents data on the inventory of contraceptives made by CONAPOFA in October 2000. Considering the size of the population, the supply of contraceptive methods seems low.

Statistics from the SESPAS Family Planning Program indicate that the only service-delivery points that receive contraceptives from the UNFPA program are San Juan de la Maguana and Barahona, and selected locations in areas II (Los Minas), VI, VII (Herrera), and VIII (Alcarrizos) of the National District. The three maternity hospitals also received contraceptives from UNFPA and other donors.

All health centers observed in the ND and Region IV had a stock of contraceptive methods provided by UNFPA and distributed by CONAPOFA. On the other hand, no Region III health centers were recipients of UNFPA donations, a situation found in the majority of regions outside the National District. In Region III, the team found differences among regional, municipal, and rural clinic levels. The regional hospital did not receive any type of contraceptives, did not assign any staff to family planning, and did not have any formal type of FP program. All centers reported that they had not received any methods in the last 7–14 months, with the exception of condoms. Table E3 (Appendix E) shows that since November 2000 one of the municipal hospitals in the province received only condoms and pills. The situation was similar in the remaining municipal hospitals and in the three rural clinics observed.

Constraints to alternative FP methods from SESPAS hospitals. According to some officials interviewed, the lack of FP services at the regional hospital was due to the hospital being administered by the sisters of the Saint Vincent de Paúl (SVP) religious congregation.[7] However, the team heard mixed, often contradictory, opinions among officials. Some said that the presence of one nun in the hospital should not be an obstacle to the FP program, while others stated that the presence of the bishop in the city of San Francisco de Macorís (SFM) was the obstacle.

To satisfy the demand for contraception, the hospital refers women to the Centro de Atención Integrada (CAI). This clinic, founded in March 2000, is managed by PROFAMILIA, with the collaboration of SESPAS and the SFM Rotary Club. The staff comprises eight physicians (three gynecologists, one pediatrician, one surgeon, one family doctor, and two odontologists), two bioanalysts, and three nurses. SESPAS pays the salary of seven physicians and contributes a free bonus to women unable to pay for PROFAMILIA services. The providers we consulted indicated that 50% of adult users and 30% of adolescents benefit from the bonus; approximately 10–15 users are seen daily through the bonus referral system.

The CAI offers services for diagnosis of reproductive health problems, with sonography, mammography, and laboratory facilities. The results are provided onsite. FP services include a range of reversible methods.[8] The most frequently requested method at this clinic is female sterilization, followed by OCPs and injectables. At the CAI and two associated private clinics—the Centro Materno Infantil in Salcedo Province and the Clinic Dr. Gatón in SFM—30–40 post-cesarean sterilizations take place monthly.

Although the CAI offers high-quality services to the community, it is not a substitute for services that could and should be provided at the regional hospital. The center has only been in operation for one year and lacks an effective IEC program to inform the public about its FP services. Results from 12 focus group discussions in the SFM area indicated that the institution is barely known outside of SFM itself. In addition, the CAI lacks an integrated adolescent program; currently adolescents receive the same services as the adult population.

The most important limitation found in referring regional hospital FP candidates to the CAI are the lost opportunities for women who actually attend the SVP hospital for delivery or postabortion care (see Table E1, Appendix E). SVP hospital has a monthly average of 255 deliveries and 53 postabortion care cases. These 300 women are not provided postpartum and postabortion family planning. In addition, women who come for prenatal care and delivery at the hospital are not informed or counseled about future FP decisions. This was confirmed by interviews and focus groups from the province.

Access to Contraceptive Services

Physical access to contraceptives is not the only limiting factor. Although IUDs, implants, and injectable methods are only provided at hospitals, the country has a wide network of health facilities and transportation systems potentially capable of making access to a mix of

[7] If a FP program was initiated in the hospitals, the religious congregation would no longer provide administration.

[8] The center offers RD$65.00 consultations and provides five years of IUD protection for RD$190.00; surgical sterilization for RD$400.00; three months of Depo-Provera protection for RD$85.00, monthly Cyclofem injectable for RD$117.00 and five years of Norplant protection for RD$605.00. The latter was not available, and demand for barrier methods like condoms, gels, and tablets is minimal, even thought they sold at prices of 1 peso for condoms and 2 pesos for gels and tablets.

contraceptive methods relatively easy. In addition, these long-term methods require fewer visits to health facilities than oral contraceptives and condoms. However, it was found that public hospitals limited the number of users by means of a daily rationing system (which limits the number of hours the service is provided). As a result, some women had to wait between three and six hours before they could get a ticket and select their first method. In Region III, a lack of contraceptives (except condoms) had the effect of destroying a program that previously existed, fulfilling the premise of "No product, no program." At present, only condoms are distributed at the municipal hospitals.

Access is limited by the few hours the service is open. In one municipal hospital, only two physicians provided services in the afternoon, one from 2:00–5:00 p.m. and the other from 5:00–7:00 p.m. The physicians used a rationing system by which each physician was assigned 25 tickets for consultation, excluding those receiving results or subsequent injections. (During the previous month one of the physicians was out and therefore only 25 consultation tickets were available each day.) Women arrived at the hospital before noon to be able to obtain their tickets. Most of them needed to return on another day at an earlier time to try again. On the day of the observation, more users left the hospital without tickets than those who remained with tickets. The physician arrived at 3:00 p.m. and was finished by 5:00 p.m. All 25 clients plus one drop-in patient were seen in two hours; the mean visit time was 4.4 minutes.

The rationing system by ticket is not limited to this institution. It was observed at all municipal hospitals visited, not only for family planning, but for prenatal visits as well. The rationing system allows a shorter time for services so that physicians see fewer patients, and finish their work in approximately two hours. This system seems to benefit only the physicians and has the effect of denying and/or impeding access to family planning services to large numbers of women. In addition, certain family planning activities or methods were only available on specific days of the week (see Table 3.1). There were no signs on the walls to indicate this distribution of services. As a result, some women came for a particular method and found out that they needed to come back on a different day to receive it.

Table 3.1. Sample weekly schedule of FP activities limited to specific days in a maternity hospital, one physician and two assistants providing services from 2:00–5:00 p.m.

Day	FP activity
Monday	Evaluation of new Norplant users
Tuesday	IUD, injectables, and first-time oral contraceptive users
Wednesday	Pap smears
Thursday	IUD, injectables, first-time oral contraceptive users, and implant removals
Friday	IUD, injectables, and first-time oral contraceptive users

The stories that follow (names have been changed) demonstrate the denial of access to contraceptives of choice because of poor communication at the hospital, lack of staff to meet the demand, and implementation of the rationing system. Often a potential user must return several times before she can see a doctor, get counseling, and receive a family planning method. Women leave and do not receive the method they select or that the doctor suggests, but rather, the method provided that day. For some women, the system means no choice, she leaves without a method, and while waiting for her next visit she becomes pregnant. Some of the stories we heard and witnessed demonstrated that women were spending a great deal of time, effort, and their own money in an attempt to space and/or limit their families, but that they were thwarted by the very system that claims to help them.

Luisa's story. Luisa is 30 years old. She had six children, but three died. Today is Friday and Luisa is currently using the IUD because a physician told her that pills are not good for her health. She made the decision to select the IUD, even though she was afraid of the pain from the method. However, she does not like the heavy bleeding and wants to switch to Norplant. This is her third visit to obtain a ticket. (She did not know that she could not get Norplant on Fridays and will not be able to get it today.)

Carmen's story. Carmen is 24 years old with three children, the first one born when she was 15. This is the third time that Carmen has come to the maternity with her 6-month-old baby to get an IUD insertion. She has used the IUD before but had it removed to become pregnant. Now the baby is six months old and Carmen wants to use the IUD again. Although she has never before received IEC from providers, in the long waiting lines for tickets and methods she has heard many stories about bleeding problems from those women who used injections and implants.

To get to the clinic Carmen traveled over an hour in each direction, with a round trip cost of 40 pesos.

The first time she came to the maternity was a Wednesday, on that day she had a consultation and a Pap smear, but could not get a method, as no methods are available on Wednesdays. On Thursday she arrived at 1:30 p.m. to find that all the tickets had been distributed. On Friday she came at 11:30 a.m. and obtained a ticket. The doctor did not show up until 3:00 p.m., and no one took the time to explain or talk to the long line of women waiting for him on the long dark narrow corridor. Carmen waited for her turn, which came at 4:45 p.m.; her baby was crying and Carmen had not eaten. Although she had been told that IUDs were inserted on Fridays, she discovered that the maternity did not have any IUDs in stock. Since she was sure she did not want to become pregnant, she decided to get an injection instead, with no orientation about the new "choice" she had made. Carmen spent three days and over 120 pesos (about US$17.50) and still did not get the method of her choice.

Miriam's story. Miriam is 23 years old and has three children. Today she arrived at 12:00 p.m. At 4:00 p.m. she was still waiting for her turn. In the past, Miriam had used oral contraceptives, but she often forgot her pills and became pregnant. After her last birth, she did not want more babies and wanted to be sterilized, but the doctor told her she was too young and would not allow it. The doctor gave her an injectable method instead. She told us she was not satisfied with this method, as she does not like the bleeding irregularities. She has also developed dark spots on her face, which she feels are due to the injection.

She stated that it was not easy to get a method at the maternity. She came to the maternity looking for a Norplant implant on two different occasions, but she was not able to get it because she came on the wrong day. "Sometimes they do not have the method you want, never Norplant. They only have IUDs, injections, and pills. I decided to get the IUD because they did not have Norplant, but I need an appointment for next Tuesday. My injection protection expires today, and I already have experienced three pregnancies I did not want. Many women do not get contraceptives because of the side effects. Some use Norplant and bleed constantly. They cannot do physical exercise, because the implant may break. Yet, a friend of mine is using Norplant and she is doing well." Miriam also told us that she did not get counseled or educated about the method. "The doctor only asked me if I had the menstruation and what method I wanted."

Juana's story. Juana is 24 years old with one child born when she was 20. She came to the maternity to have the doctor check her Norplant implant. She is going to high school and does not want more children. She made her own decision about the method, even though she was once amenorrheic for four months and now has been for two months. In the past she had used oral contraceptives, but she forgot her pills and became pregnant. She is not satisfied with FP services at the maternity. To get Norplant she arrived at 11:00 a.m. to get a ticket and discovered that staff gave away only five tickets for Norplant. She was finally seen at 2:00 p.m. She told us that the hospital should get more physicians or demand punctuality from them.

Quantity of Methods Provided

Table C3.3 (Appendix C) presents data from hospitals on the staff assigned and the schedules for family planning services. In almost every case, the situation described above for the maternity is repeated. However, at municipal hospitals the demand for FP services is not as high, particularly in those hospitals where women already know through word of mouth that most methods are not available. Even when methods are available, there is not sufficient staff to provide the services, often because physicians arrive late and leave early. In Region IV, nurses are responsible for family planning, but are dependent (as are the users) on the sporadic visits of physicians for Norplant and IUD insertions. This dependence may have implications for reorganization of the system of providers and increased training for nurses in Norplant and IUD insertions.

As a result of the constraints to meet the demands for FP services, the provision of methods to users by the public sector is low. This hinders the availability of a mix of reversible methods for birth spacing. Table C3.4 (Appendix C) presents the monthly average of methods provided at the maternity hospitals, municipal hospitals, and PROFAMILIA's Evangelina Rodríguez Clinic. The statistics show that the monthly uptake of methods is small. Pills and surgical sterilization procedures are sought mainly at private clinics. Only 330.4 female sterilizations per month were reported by the maternity hospitals and Evangelina Rodríguez Clinic combined, plus six per month at one municipal hospital. All hospitals together provide a monthly average of 1,162.5 cycles of pills, and 221.1 cycles of mini-pills. The provision of condoms, at 3,812.1 condoms per month, is insignificant, and given the deficiencies of data collection, we do not know the number of condom users.

The PROFAMILIA clinic has the largest monthly rate of injectable users (908.1), followed by the Los Minas Maternity (116.8), the IDSS Hospital de la Mujer (51.6) and the Engombe municipal hospital (40.1). The other hospitals average fewer than 20 users per month. The monthly average of Norplant users is also small. The maternity hospitals and Evangelina Rodríguez Clinic have a monthly average of 99 users and the municipal hospitals 48.7 users. IUD users averaged 207.9 at the maternity hospitals and PROFAMILIA clinic, and 64.0 at the municipal hospitals. Male sterilization continues to be extremely low, with only the NGO clinic providing services, at a rate of 3.8 sterilizations per month.

Quality of Care

The quality of FP services depends on many factors, as mentioned at the beginning of this section, including technical competence of providers, counseling that provides complete and accurate information about the different methods, attention to client needs, and the availability of the desired method, client follow-up, comfort, privacy, and confidentiality. The

absence of one or more of these factors may diminish the quality of services, resulting in the dissatisfaction of the user with the selected method.

Counseling. To assess the type of counseling provided by FP programs, the team observed FP counseling sessions between users and providers. In addition, providers, hospital directors, and users were interviewed at the health centers and in the communities. Table C3.5 (Appendix C) synthesizes the main findings from the consultations observed. Users are generally treated well once they enter the room for counseling and/or physical examination. Usually counseling is preceded by an orientation. However, information provided on the method is usually incomplete. In many situations no information was provided about other methods, only the one requested by the user. Often information was given hurriedly and the provider relied on brochures. Little, if any, time was spent explaining the side effects. No time was taken to verify that the woman understood the side effects, signs of alarm, or had given her informed consent to the method selected. The National District's PROFAMILIA clinic (and, to a lesser extent, the IDSS women's hospital) showed counseling services of a higher quality.

Technical competence and productivity. The technical capacity of staff to provide services varied at the institutions the team visited. In the National District and Region IV most gynecologists and general physicians, and to a lesser extent the nurses and auxiliary staff, have been trained to provide services. In many cases, training has been provided by PROFAMILIA. However, in most places visited the main problem was not that personnel were not trained, but that the trained personnel do not come, or, if they do attend, they do so for only two hours per day. In the interior health regions the problem is compounded; at municipal levels only the directors reside in the city where the hospital is located. Physicians disregard the duty schedule, appearing for work only once, twice, or at most three times per week (see Figure 3.2 below, and, for more detail, Tables E4–E8 in Appendix E for a four-month detailed record of patients seen per doctor in a municipal hospital.)

Figure 3.2. General and specialized medical personnel at municipal hospitals

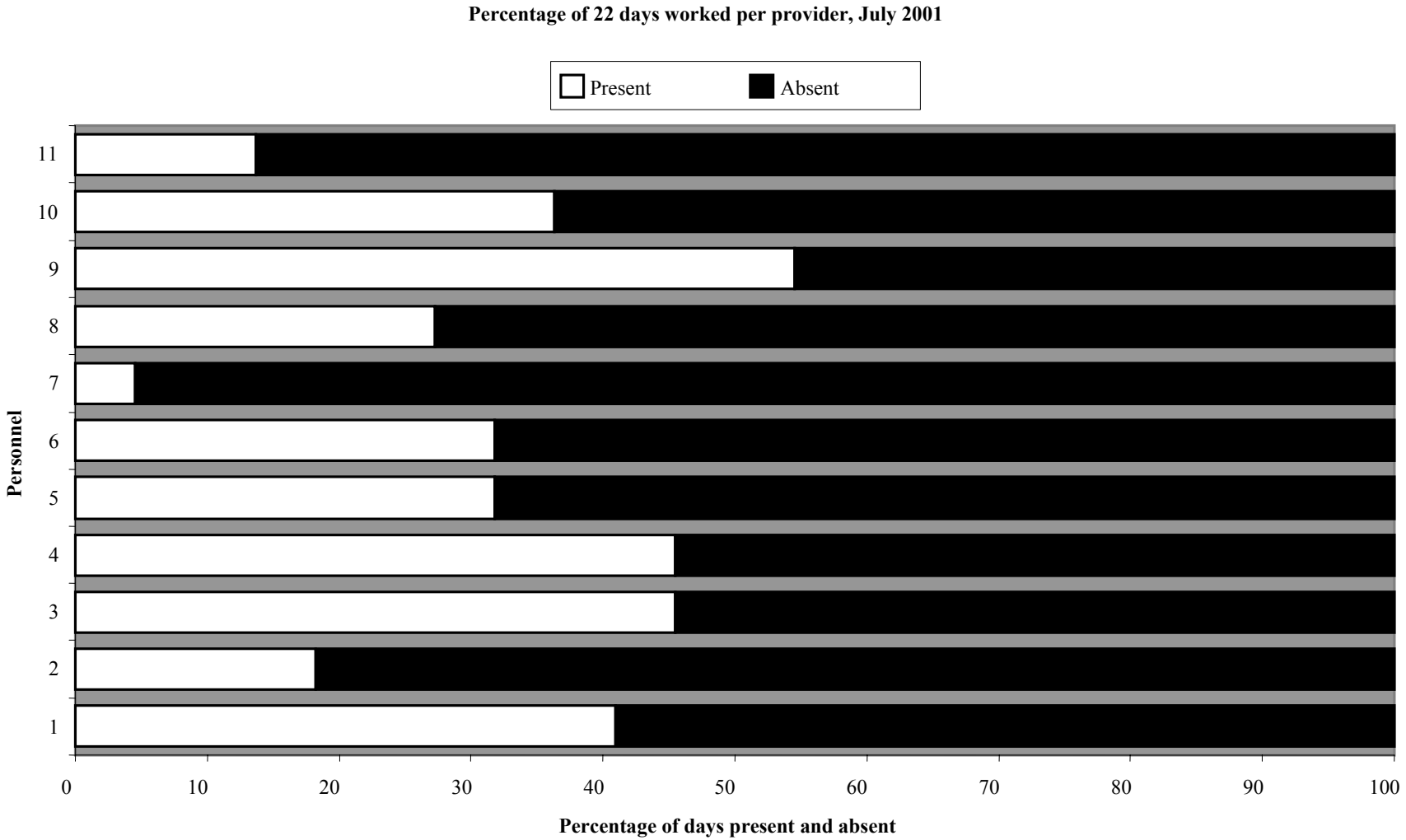


Table C3.4 (Appendix C) also shows that PROFAMILIA's Evangelina Rodríguez clinic has the largest average monthly distribution of pills, condoms, and injectables. It is also the only institution performing male sterilizations. It has a larger monthly average distribution of pills, injectables, condoms, IUDs, and both types of sterilization than the five municipal hospitals combined. Given the small size of this clinic, with 46 health staff functioning on a productivity and not a salary basis (Table F6, Appendix F), and the larger size of municipal hospitals with an average of 70.3 health staff, (Table G7, Appendix G), it is easy to observe that the cost of providing services at the public sector increases while the quality of the services is considerably lower. The output of the Evangelina Rodríguez clinic (clients seen and methods provided) is comparable to the large maternity hospitals (La Altagracia Hospital alone has 399 nurses, 138 physicians, and 107 residents).

Providers' Perceptions About Contraceptive Methods

The team observed that the clinical staff had difficulty allowing the user to choose a method. It seemed that the clinical staff acted as if only they had knowledge and that users were ignorant about their bodies and health. It appeared that the staff did not trust users to make their own health decisions. From a sociological perspective, the provider–patient relationship involved a situation of power and control that transcended gender; women physicians and nurses tended to share an attitude of superiority equal to that of men.

Providers offered us their perceptions of contraceptive methods. Some said that it would be good to include a male contraceptive method other than the condom: "Males are always looking for an injection." Others said they thought oral contraceptives were the most sought-out method because "pills are cheap and available." Their opinion on injectables was "They are convenient, because women only need to return every three months to the hospital and the bleeding is not as bad as with other methods." Regarding sterilization, some said that "the procedure to get the surgical operation is very slow. Women are given an appointment, but by the time they return for the operation they are already pregnant." Others said that "the best method is Depo-Provera, because it is more economical and there is no possibility of forgetting it."

Examples of provider misconceptions and biases

Director of a fourth-level hospital
"We mostly advised women to use Norplant, but it has a large rate of removals."

Family planning provider in a fourth-level hospital
"Women want to get Norplant because they know that it is an expensive method and they can get it for free at the hospital. That is why there are so many removals."

Director of a municipal hospital
"Norplant causes infection in the area inserted, amenorrhea, prolonged and abundant bleeding, and reduces women's libido. Depo-Provera is not a good method because it provokes inflammation on the place of the injection, amenorrhea for six months, and it has high hormonal level. The IUD produces abundant bleeding during menstruation, pain during sexual relationships, and chronic cervicitis. The pill is the most reliable, most accessible, and safest method of contraception. It does not have side effects if used properly and it has the lower hormonal level."

Health promoters
"The condom stays inside and the woman becomes pregnant."
"Norplant can ruin your health."
"This is why we were told by physicians to use the pill up to 35 years of age and then to end reproduction with sterilization, because the pill is no good for your health."

Perspectives of Leaders of NGOs and Private Clinics

According to the leaders interviewed in the DR, the preference for surgical contraception may lay in popular wisdom that says that to resolve a problem, the root cause has to be eliminated. There has always been demand, but since the public sector provides it without cost, it has become more popular. There is a need to expand options for Dominican women by offering them temporary methods that are easy to use, effective, and, above all, continuously available.

One leader's opinion on quality of attention

One male leader interviewed said, "There is an important problem of quality of attention. The human resource component is failing." He identified the problem as the "attitude of the medical staff, because they provide the services under their own perspective of quality and don't take into consideration reproductive rights or any kind of rights of the users. For example, even if they identify obstetrical risk, they do not offer FP methods, they impose their biases, their prejudices. They are prejudiced against prevention activities since these do not generate income; they would rather work on curative services, which are more lucrative. For example, when the Santo Domingo Obstetrics/Gynecology Society sponsors training in updated FP technology, hardly four or five members attend; whereas if they sponsor training in sonography, all of them will attend.

"To provoke changes in quality of services, one has to generate the change both in the users as well as in the providers. Educate users to demand their rights, and train and educate the providers under the concept of human rights. In that way, you can start working on the root causes of unethical attitudes, and not simply on the effects. Of course there should be specific strategies to work on more practical service issues, which are also useful, but never lose sight of the root causes.

"What should be done is to intensify FP to avoid unwanted pregnancies, to give strict follow-up to clinical quality of attention, with clinical audits as part of the supervision, and to sanction acts of negligence."

Users' Perspectives on Contraceptive Methods

Without a steady supply of methods and/or an effective IEC program, women are not able to make free, informed choices or to find methods suitable to their particular age, condition, and need. Data from the 1996 DHS show that users in the DR have a high rate of discontinuation. During the first 12 months of use, 59.2% of oral contraceptive users, 32.7% of IUD users, and 83% of condom users had discontinued their methods (Macro International and CESDEM 1996, Table 4.10). Negative side effects were the main reason for discontinuation for 32% of oral contraceptive users, 39.5% of IUD users, 59% of injection users, and 71.3% of implant users. These results support the FP national norms that users' decisions must be based on a mix of available contraceptive methods and that complete and accurate information and proper counseling must be provided before the method selection takes place.

Even though knowledge of methods is widespread (Macro International and CESDEM 1996), it is superficial. Little is known about side effects, and many myths prevail. During a focus group with 11 women 20–25 years old from an urban area (some with high school degrees), it was found that these women ignored the risks involved in unprotected sex and did not like to use contraceptives, despite accessibility. The following represents summary data from the focus groups.

Sterilization. The popularity of surgical sterilization may be related to women's desires to have their children when they are young. This behavior may be a result of low status of single women in society, which elevates the role of mothers and wives. Sterilization is a secure and permanent way to limit the number of children. After the desired number is reached, women feel they can stop reproduction, once and for all, without worrying about methods with side

effects that disrupt daily life (like bleeding and headaches) or that require troublesome trips to hospitals or clinics.

Oral contraceptives. One of the reasons for the popularity of pills is that they can be obtained easily at any drugstore from RD$35.00–$50.00 per cycle (US$1.00=RD$16.40). Although some women complained of weight gain and dizziness, the main reason for changing to another method is difficulty remembering to take the pill. In rural areas, the majority of the women in focus groups had used oral contraceptives before, in particular Microginon, which they call PROFAMILIA, and the monthly pill Norgex, which is not as well liked because of bleeding effects. They are also familiar with different emergency methods to prevent pregnancy after sexual relations.

Injectables and IUDs. Injectables are sought for their convenience and security, as an alternative to oral contraceptives. Many women feel that even though injectables may cause bleeding, it is less than the bleeding caused by the IUD or Norplant. Other reasons for their use is their availability at many hospitals and their convenience, since women only have to use them every three months. Particularly with adolescents or single women in need of greater privacy, injectables are an appealing method. Injectables are available at SESPAS hospitals receiving UNFPA donations. In the focus groups, most women showed little or no accurate knowledge about injectables and IUDs. However, there are many myths about IUDs related to a foreign body being inserted in the uterus. Many women feel that IUDs may cause infections and increased bleeding. Others fear that they may cause many types of illnesses including cancer; some women said IUDs caused a widening of the vagina.

Men's perspectives. Many men stated that since it is the woman who gets pregnant, she should be the one to use contraception. Many men stated that both of the methods available to them—vasectomy (male sterilization) and condoms—adversely affected erections. Furthermore, many said that condoms should only be used as a protection against STIs/AIDS when they are with sexual partners other than their wives.

Often, women make the decision regarding which method to use, frequently without the husband. Yet men have preferences, believe the myths related to certain methods, and transmit these myths to partners, particularly adolescents and younger women, who feel that men are more experienced and knowledgeable. Some of these male myths are related to IUDs and condoms. They tell their wives that IUDs cause cancer, because they are a foreign object that moves during sexual relations. They also say that both IUDs and condoms cause loss of sensation in the sexual organs. Women appear to have accepted these views, particularly regarding condoms, and agree with the men about not liking condoms.

Constraints to Expanding Contraceptive Options

Based on the interviews, observations, and secondary analysis of quantitative data, the team identified the following constraints to expanding the contraceptive method mix of reversible long-term methods and to improving the quality of FP care in the DR.

Centralization/accountability

- *Subordination of women's RH to partisan and providers' interests*. Interviews with directors of hospitals, nurses, supervisors, and administrators help explain the reasons for physicians' absenteeism, the imposition of a rationing system to limit the number of users, and the absence of adequate supervision and sanctions. Directors feel

powerless to evaluate and supervise physicians and nurses, given that the source of their assignment is the official political party. In addition, using hospital funds for partisan needs creates a scarcity of physicians, since some are in "license" with official approval to cash checks without doing any work. On the other hand, the physicians' union and the nurses union protect their members against cancellations and sanctions.

- *Lack of autonomy.* Because hospital directors lack authority and autonomy, they have lost the capability to supervise and sanction, thereby losing control over the quality of the services performed at the hospitals and the possibility for improving those services.
- *Lack of accountability from physicians.* There is no culture of accountability by physicians. Some concerned directors acknowledge the problem and suggest changing the physician's salary to a fee for service, or a salary based on productivity.
- *Delegation of responsibilities to students without supervision.* At large hospitals, residents, interns, and students are performing sterilizations and inserting IUDs without supervision.

Infrastructure/maintenance/supplies

- *Crowded physical space.* In most places visited, there was little space for orientation and counseling. Many of the hospitals look crowded and run-down. As a result, comfort and privacy for counseling are not possible.
- *Irregular supply of reversible contraceptive methods from the government.* Without methods, programs cannot continue, as the socioeconomic situation of many public-sector clients does not allow them to purchase methods in the marketplace.
- *Lack of other equipment necessary for service provision.* Method availability is limited by lack of equipment to insert IUDs or Norplant.
- *Insufficient equipment and supplies*. Most directors interviewed reported that the monthly subsidies (from SESPAS) to run the hospitals have been reduced from last year to approximately 40%, and supplies sent by PROMESE were insufficient, lasting only one-third of the month.
- *Few cleaning personnel.* Many hospitals look unclean, and there is no water for the toilets. There are many complaints regarding a lack of adequate cleaning personnel.

IEC and community-based outreach activities

- *Limited IEC activities.* Hospitals have limited IEC activities to educate women on advantages of birth spacing. There is an occasional talk in the waiting areas, handing out of brochures, and some reserved material is kept at the health centers. However, there is a lack of knowledge about the consequences of short spacing between births and little understanding regarding side effects of different reversible methods. Demonstration of methods are not included as part of the orientation of clients at health facilities or at community outreach activities.
- *Lack of IEC materials on contraceptive methods.* In hospitals that do not receive UNFPA methods, there is a lack of IEC materials on contraceptive methods.
- *Lack of community IEC outreach programs*. Very few hospitals have community IEC outreach programs.
- *No coordination with community-based organizations to promote birth spacing, knowledge of reversible contraceptive methods, and women's reproductive rights.* Present IEC activities are mostly limited to health facilities.

RECOMMENDATIONS

Decentralization and Autonomy

- Initiate immediate application of Social Security Law 87-01 that provides a social security system and establishes decentralization of the health sector in Article 160. Sufficient evidence has been provided to conclude that it is not possible to improve the quality of FP services without decentralizing services to allow for local autonomy, supervision, and control of the institutions and their human resources presently providing these services.
- During the transitional period of application of the General Health Law, create models of local autonomy and institutional strengthening. Decentralization must be accompanied by a process of institutional strengthening to make local autonomy a reality. Human resources within the hospital need managerial training accompanied by personal integrity and commitment.
- Implement participatory mechanisms to select hospital directors for their managerial skills, and pay them on the basis of hospitals' productivity and achievements. Hospital directors have not been able to assume their managerial roles due to a long history of centralization and partisan control of the health sector. All directors observed were appointed by the 2000 government. Although some directors recognized the need for autonomy and feel frustrated and powerless to assume their roles, others are politicians looking for congressional posts and higher positions in the sphere of power. None of them have been able to confront and apply the norms, some out of fear of losing their own positions.
- Create mechanisms for accountability and supervision of quality of services within the service-delivery point and ND areas other than the market competition of providers contemplated in the new health legislation.

Observations of family planning services at a municipal hospital

FP users were very satisfied with a particular municipal hospital because services were provided much faster than at other hospitals. Many users came to the hospital from different geographical zones of the ND to receive services. However, the assessment team found questionable practices at this hospital. For instance, an IUD insertion was observed in which the clinical history of the user was ignored, and the provider did not take the user's blood pressure or weight. The prescribed counseling for informed consent was ignored; instead, a brochure on the demanded method was handed out during this and other counseling sessions observed and the user was expected to read it at home. Even though gloves were used for pelvic exams, the rooms lacked washbasins and providers did not wash their hands between patient examinations. In addition, breast exams were not observed even with new users, and Pap smears were done only on Tuesdays.

Services were not better for adolescents or for women making prenatal visits (deliveries were referred to maternity hospitals). Consequently, SESPAS has to assume the creation of mechanisms within SDPs and areas in the ND to regulate, monitor, and evaluate services. Poor populations do not know their reproductive health rights and are used to, and even expect, low-quality services.

Access to Methods and FP Services

- Make a mix of reversible FP methods and proper instrumentation for insertion of methods available at all SESPAS facilities and maintain a steady stock.
- Initiate social marketing of methods, available at pharmacies, beauty parlors, food stores, and so forth.
- Update medical eligibility criteria in accordance with WHO standards (1996).
- Assign sufficient staff to the FP program to provide services according to demand.

- Make FP services available every working day for all reversible methods, in all public hospitals.
- Institutionalize access to FP services by intradepartmental coordination and proactive information during prenatal, intrapartum, and postabortion care.

Quality of Services

- Create an executive FP committee at each SDP and area in the ND to ensure quality of services. FP services are complex and demand constant evaluation and interventions to ensure quality. Some of the suggested functions of this committee are: (1) FP data gathering and analysis (the statistics will reflect demands, methods' induction, preferences, quality of counseling, and so forth, and will provide opportunities for improvement); (2) adherence to the FP norms and procedures; (3) timely distribution of all reversible methods and accessible referrals for surgical sterilizations; (4) organization of training for providers; (5) distribution of IEC materials; and (6) promotion of IEC activities in the hospitals and communities.
- Train all FP staff in application of all reversible methods, counseling techniques to ensure informed consent, application of the FP norms and procedures, and use of IEC materials.
- Include demonstrations of all appropriate reversible methods and explanations of side effects as part of the FP orientation before counseling and method selection.
- Teach all physicians, nurses, guards, and cleaning staff the reproductive rights of women and establish mechanisms for sanctioning violations.
- Include the reproductive rights of women and SESPAS norms in medical, nursing, and other health professional curricula.
- Do not allow students or untrained nurses, residents, or interns to perform surgical sterilizations and IUD insertions without expert supervision.
- Sanction hospitals that do not supervise students by forbidding their practice at these health centers.
- Ensure comfort and privacy by expanding and remodeling infrastructures.
- Organize municipal advocacy groups to oversee services and to create mechanisms to ensure that the RH rights of women are not violated and that violators are sanctioned.

IEC and Community-Based Outreach Activities

- Create a network of IEC activities at health centers, through mass media, and by coordination with different NGOs and community organizations.
- Provide each hospital with a steady supply of quality IEC materials.
- Make IEC activities to educate women about birth spacing and FP options.
- Coordinate with advocacy groups and community-based organizations to educate about birth spacing, knowledge of reversible contraceptive methods, and women's reproductive rights.

4: Adolescent Reproductive Health

BACKGROUND

Adolescent Fertility

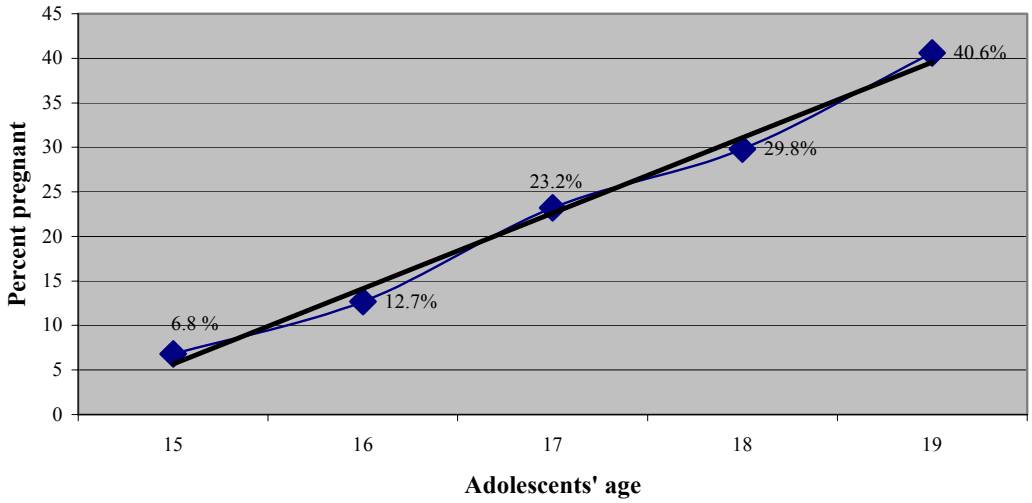
Adolescent sexual debut. The adolescent population of reproductive age (15–19 years old) is estimated at 800,000 for 2000. For many, adolescence is the period of sexual debut and thus is an important time to have access to appropriate reproductive health services. The median age of first intercourse in the DR is 18.7 years for women and 16.1 for men. (Macro International and CESDEM 1996, Tables 5.6 and 5.15). Age at sexual debut for men does not appear to be affected by socioeconomic differences, however, there does seem to be a slight difference between urban (15.9 years) and rural men (16.3 years). (Macro International and CESDEM 1996). Unlike men, rural women have a lower median age of sexual debut (18.0 years) than urban women (20.0 years). The median age increases with the literacy rate (16.1 years for women without formal education, 17.9 years for women with primary education, 21.3 years for women with secondary education, and 24.8 years for women with superior education) (Macro International and CESDEM 1996).

Age at first union. Differences between the genders are greater with respect to age at first union. The median age for first union is 24.1 years for males, and 19.3 years for women (Macro International and CESDEM 1996, Tables 5.13 and 5.4). Urban women and women with greater education marry at older ages than their rural and less-educated counterparts.

Adolescent use of contraception. The prevalence of contraceptive use among adolescents is lower than other age groups. Only 10.1% of adolescents 15–19 years old use contraceptive methods; the pill is the most prevalent contraceptive method. Among all adolescents, 5.8% use oral contraceptives, and 28.8% of adolescents in union use pills to delay their first pregnancy or to space their children (Macro International and CESDEM 1996, Table 4.4).

Adolescent pregnancy. The age at which women begin reproduction is an important factor for the natural growth of the population, for the individual's health, for the life cycle of the mother, and for the health and socioeconomic development of the family. Despite decreases in total fertility, the adolescent pregnancy rate increased from 18% in 1991 to 23% in 1996. As demonstrated in Figure 4.1, pregnancy increase followed a linear trend of growth from 6.8% for 15-year-old girls to 40.6% for 19-year-old girls.

Figure 4.1 Percent of adolescents some time pregnant, 1996



The strategic question. The high prevalence of adolescent pregnancies and a growing rate of STI/HIV infections were among the key reproductive health problems prioritized at the October 19 stakeholders' meeting. The RH assessment team gathered data to answer the following strategic question: Is it necessary to improve the quality and access to integrated reproductive and sexual health services for adolescents?

The following findings demonstrate the assessment team's responses to this strategic question.

Concepts and Norms for Adolescent Reproductive Health Needs

In recent years, the special needs of adolescent populations in the DR have been the target of protective legislation, although efforts to implement norms and procedures are still in the early stages. The General Youth Law 49-2000 recognizes young people as a subpopulation whose specific needs should be addressed by the health sector in an integrated way, guaranteeing national health coverage that includes confidential and quality sexual and reproductive health services. Services should be provided from a gender perspective that recognizes the varying needs of young men and women. In addition to legislation, SESPAS has produced its own set of norms (Series no. 17) that focus on the role of social influences and cultural expectations in helping adolescents deal with the biological changes that take place between the ages of 10 and 20.

SESPAS's norms establish certain requirements for adolescent service provision. These include an Adolescent Information System, based on the instrument developed by the Latin-American Perinatology and Human Development Center and the clinical norms for gynecologic and obstetric care; the informed consent of all adolescents; and the right to privacy and confidentiality, including the right to decide whether parents and/or husbands shall be present during consultations. Further, the norms require the right to community-based services offered through a network of service provision and referrals. Finally, the norms require the right to appropriate services by a trained team of physicians, nurses,

psychologists, health educators and social workers. These norms should be kept in mind when reading the assessment findings.

ASSESSMENT FINDINGS

Social Factors Contributing to Unplanned Adolescent Pregnancy

Community social control. Adolescent girls are subject to a strict moral code. Family values and dignity depend on women's fidelity and adherence to traditional submissive patterns of acceptable behavior. Sex remains a taboo topic and parents deny rather than acknowlede their unmarried daughters' sexual activity. At the same time, young men feel pressured to prove their manliness through frequent and irresponsible sex. The popular expression "The woman belongs in the house and the man in the street" reflects these traditions. Such beliefs were also reflected by the young men who participated in focus group discussions. They stated that women should be responsible for family planning "because they are the ones that get pregnant." While male adolescents are permitted to explore and enjoy different types of activities that will help them mature, the same opportunities are not always available for young women. Many young women are sheltered and rarely permitted to make their own decisions. To escape, girls will seek work that keeps them away from home, or may leave home, often before they finish school. Such familial pressures and double standards for girls were mentioned by focus group participants as demonstrated in the words of the pregnant, unmarried adolescents below.

Experiences of unmarried female adolescents with pregnancy: Focus groups from Region III, adolescents ages 15–18

- "Because of pregnancy many girls lose their families. Many families also become divided and do not talk to each other."
- "The suffering is more for girls than for boys. If you remain at your parents' home, they punish you by making you do more housework. If you move to your boyfriend's parents' house, it is even worse."
- "Parents blame their daughters, not their sons. They lose confidence and make you feel guilty."
- "With pregnancy we are taking our lives in our hands. Some lose their lives trying to have an abortion and others even commit suicide."
- "With pregnancy I feel like I am already 30 years old."
- "Pregnancy makes you old and wrinkled."

While socioeconomic class further differentiates these gendered double standards, there is a cross-class sanction against pregnancy out of wedlock. For middle and upper classes, only lawful marriage—religious or legal—is acceptable. For the poor, there may be no negative sanction if the couple establishes a consensual union and the bride leaves the maternal home. If the girl remains at her parents' home, she is sometimes shamed and punished during her pregnancy, a situation that may improve after the child is born.

The institutions of family, school, and church seem to reinforce these traditional double standards. Until very recently, the school system forced pregnant girls to stop their education (as it was thought their presence adversely influenced the other students). With little opportunity to attain education elsewhere, unmarried pregnant girls and young mothers were further marginalized. Religious social control also contributed to adolescent stigmatization and lack of sexual knowledge. The Catholic Church has a strict code forbidding premarital sex, use of contraceptives, and abortion, and opposes teaching of sex education in schools. Thus, pressure against unmarried pregnant girls may be felt from family, school, and church, creating feelings of guilt and rejection.

Lost opportunities and personal freedom with untimely marriage

"Now I have less freedom. The hold of a husband is worse than that of a father."

"Because of the child, my husband had to drop school to start working. I also had to leave school to do housekeeping and to take care of him and the child."

Comments from an adolescent focus group

From focus group discussions with 13 adolescents (mixed-gender high school group, ages 14–17)

"We lack orientation and guidance. No one tells us the consequences of a pregnancy. We need sexuality education and we should get it at school, but teachers do not know how."

From focus group discussions with 19 adolescents (12 females and 7 males, mostly high school students, ages 14–18)

"We need sex education at schools but not given by teachers, because they are an obstacle. The doctor in this community is a nice woman; she should be the one providing sex education. They should include our parents in these classes and the priest too."

"Parents place too much pressure on girls at home, and we start believing men on the streets. Parents mistreat their children instead of talking to them."

"Girls become pregnant because they are too often on the street without guidance. Parents do not know how to give guidance. All they know is how to give commands: 'Don't go away,' 'Come back early,' 'Don't go out with so and so . . .'"

New values and influences. In addition to reproductive health behavior, social values and influences in the DR are also undergoing change. Mass media exerts an influence on adolescents by presenting models of assertive female behavior. Newer role models are portrayed as independent decisionmakers, no longer waiting for males to take the initiative nor remaining at home doing housework. Some males in the focus groups attributed female pregnancy to "girls are watching too much TV."

At the same time, middle-class women have become models for less-privileged young women. Middle-class female adolescents may achieve a university education and compete with males in the professional market, enjoying greater independence and higher societal status. Young female adolescents are often torn between modern role models and traditional norms and values.

Violence against women. While it is not possible to make generalizations from this assessment on the conditions in which sexual acts take place, recent literature suggests evidence of sexual harassment, violence, and need for community education. Using a sample of 400 adolescents, nurse providers from San Francisco de Macorís concluded that early adolescent pregnancies are mainly the result of girls' conflict with their parents or sexual abuse by an acquaintance or family member.[9] The nurse supervisor of a large regional hospital explained that three of ten pregnant women are adolescents. "Most of them have problems with their families and have had abortions. In addition, many have been victims of sexual violence." In an earlier health study from the Barahona Batey communities (Tejada Yangüela 1992) women from 18 focus groups suggested that adolescent pregnancies are mainly the result of rape.

Disregard for sex-related health risks. During focus group discussions with both adolescents and adults, participants voiced concerns about the risks of early pregnancy. Social risks are viewed as more traumatic than health risks, however. The social stigma associated with unmarried pregnancies and abortion seems to overshadow any concern with physical or

[9] The study was part of a university thesis requirement that was not completed at the time of the survey.

health risks. For example, in the focus group discussions, adolescents did not express a fear of STIs/AIDS. Some girls mentioned that their boyfriends would use condoms for protection if they had sex with other women, but not with the girlfriend. Other adolescents did not express any fear of unprotected sex because, they said, they did not know anybody with AIDS in their community. This lack of concern regarding personal risk associated with unprotected sex is in contrast to the fears and beliefs of health risks and side effects related to use of contraceptive methods (see Section 3: Family Planning for data on the large proportion of discontinuation of contraceptive methods due to side effects). Adolescents share the same fears and myths as adults; they have heard stories from relatives and friends, but have little or no information from informed sources.

Adolescents' perspectives on contraceptive methods

From focus group discussions with 13 adolescents (mixed-gender high school group, ages 14–17)

"Programs for adolescents should promote natural methods, because other methods have side effects."

From focus group discussions with 10 adolescents (mixed-gender eighth-grade group, ages 15–17)

"Girls do not use pills for fear of being discovered. It is easier to get pills than any other method, but causing an abortion is also easy. You can get an abortion by drinking bitter beverages using oak bark peelings, orange leaves, cloves, and cinnamon. You can also use peelings from avocado seed or, you can buy an abortion pill call Cytotec that costs you 30–75 pesos."

From focus group discussions with 19 adolescents (12 females and 7 males, mostly high school students, ages 14–18)

"Males do not use condoms with their girlfriends but they do with other women. Condoms can protect you from AIDS and other infections. However, no one has died from AIDS in this community, so we are not too concerned about it."

Adolescent Access to RH Services

Barriers to contraception. Section 3: Family Planning describes the constraints that prevent all women, adult and adolescent, from finding and selecting an appropriate contraceptive method at public health centers. With adolescents, privacy and confidentiality are even greater concerns. Many female adolescents fear going to local pharmacies, rural clinics, and municipal hospitals, where they can be easily recognized. For this reason, girls reported sending their boyfriends to buy pills. Males reported preferring to get condoms from *colmados* (small food stores) "because clerks are young" and they are not "embarrassed to buy contraceptives from them."

During focus group discussions adolescents gave the following reasons for not using oral contraceptives: (1) pills are costly and female adolescents do not have money; (2) female adolescents do not use pills for fear their parents will find out; (3) nobody takes the time to explain the consequences of a pregnancy; and (4) adolescents lack knowledge and sexuality education. These statements suggest that it may be possible to increase adolescent contraceptive prevalence and reduce adolescent pregnancy given adequate adolescent access to IEC materials and the availability of an assortment of long- and short-term reversible contraceptives, including dual protection methods.

Interviews with adolescent maternal health patients

Mary, 19 years old, first delivery at a maternity hospital
Mary, a tall slim girl with an outgoing personality, is again pregnant. She removes her skirt to show us the long diagonal two-inch-wide scar that runs across her abdomen; a sign of an earlier infected surgery. Sewn hurriedly by inexperienced hands, the scar made the skin corrugated. "After my baby was born, the doctor left a piece of gauze inside of me. I overheard it, but they just told me I was bleeding. They took me to surgery and I heard the nurse saying 'There is nothing clean, no clean cloths, and we do not have any water.' The doctor said, 'This is an emergency, do what you can.' They gave me anesthesia and completed surgery, with no explanation provided. I was infected after the operation. I was left in a room with another woman who had been hospitalized with an infection for over two months."

Grace, 18 years old at a regional hospital
Grace was 17 years old when she attended a rural clinic for her prenatal care. When her time for delivery came she waited until the last minute to go to the regional hospital. She did it because she had been told that hospital staff would send her back to her village unless she was ready to deliver. There was only one nurse at the delivery room when Grace arrived. She cried for help, but the nurse was busy attending someone else. Grace delivered the baby on her own, but she was badly hurt, her perineum was torn, and the nurse did not know how to repair it. Back in the village women told Grace's story, emphasizing that she was still not able to walk erect.

Focus groups at urban areas with access to PROFAMILIA clinics and/or large hospitals provide evidence that when adolescent girls are offered a mix of methods many will choose hormonal methods, primarily injectables. This preference for injectables seems to be related to privacy and convenience of use. Many adolescents said they forget to take the pill. Adolescents interviewed at health facilities indicated that they preferred injectables because they did not have to buy pills every month. They also said they preferred fewer clinic visits in order to reduce the likelihood that they would be recognized by relatives or neighbors. Adolescents also said that their mothers or other family members were likely to find pills at home, since young women often share rooms with other family members and have little space of their own.

Regarding access to FP services, adolescents face obstacles similar to those faced by adults (see Section 3: Family Planning). Yet, adolescents are in a more difficult position, given their dependence on their parents for money, transportation, and sometimes permission to travel to FP facilities more distant from their own communities. Providers seem to feel the need to advise adolescents on which methods to choose because of their age and presumed inexperience. In addition, some of the counseling observed took place in groups in which the provider tried to convince all adolescents to select the same method. In these cases, young people felt compelled to select methods based on provider judgments and/or limited availability of methods, not their individual preferences.

Adolescent Maternity Services

Experiences with maternity services. Pregnant adolescents receive the same services as adult women. However, they are frequently referred to regional hospitals because their pregnancies are considered high-risk (see Section 2: Maternal Health). Therefore, the experiences of adolescents, while similar to those of older women, are frequently more difficult given their young age, inexperience, fear, and the possibility of less family support as a result of stigma associated with adolescent pregnancy.

Adolescent IEC at maternity and municipal hospitals. Table 4.1 presents data on interviews with directors, providers, and users of services, as well as direct observation of services provided at maternity hospitals. Larger maternity and regional hospitals have services specifically designed for adolescents, including separate waiting, labor, and delivery rooms.

With the exception of the NGO and one ND municipal hospital observed, SESPAS and IDSS municipal health facilities have no outreach or IEC activities in schools or communities, and no agreements with other state institutions or NGOs to work with adolescent clients. Directors and providers from maternity, regional, and municipal hospitals from Santo state that they have an integrated care program for adolescents. In practice, however, SESPAS norms on adolescent care are generally unknown, and, where recognized (e.g., in municipal hospitals in the ND), the program consists of assigning one or more staff for prenatal care and psychological counseling (see Table 4.1 and Table C4.1, Appendix C).

IEC activities at the hospitals observed were limited to posters on lactation and nutrition. Occasionally FP brochures were distributed at centers that received UNFPA funding. Some FP talks are given to clients; however, little information is provided about the advantages and disadvantages of contraceptive methods, including possible side effects, the most common reason for method discontinuation. Often the centers had distributed all their brochures; no action was taken to acquire more. As with adult clients, young pregnant women spend long hours waiting in lines and waiting rooms, often hearing myths, fears, rumors, and horror stories about hospital services and reproductive health in general.

Table 4.1. Integrated adolescents' health program at maternity hospitals and the IDSS women's hospital, by services provided, personnel assigned, schedule, average number of daily users, and types of FP methods available

Hospital	Adolescents' integrated attention program and constraints	Services offered	Staff assigned	Prenatal schedule/ per day consultations	FP scheduled/FP methods available
B Maternity Hospital La Altagracia	Yes/Incomplete Limitations: • No community/school outreach program • Overcrowded, little privacy for consultations • Dehumanized care during labor and delivery • Technical limitations for labor and delivery • Technical aspects (see Section 2: Maternal Health) • Little access to FP methods and orientation • Few staff for prenatal and postdelivery care • Difficult to get appointments due to rationing system and physicians' lack of punctuality and absenteeism	• Prenatal care • Intradelivery care • Postdelivery care • Orientation and counseling program by psychologists • Emergency contraception • STI/AIDS attention • Family planning	• 3 physicians • 2 psychologists • 1 licensed nurse • 2 auxiliary nurses • 1 counselor	8:00a.m.–12:00 p.m. 1:30–4:30 p.m. Daily • 65 prenatal adolescents per day	1:30–4:30 p.m. Tuesday and Thursday • Only IUD and pills available
A Maternity Hospital Los Minas	Yes/Incomplete Limitations: • Only offered in afternoon and provided by student residents without supervision • Technical aspects: chapter two on adults. • No data on IEC or community outreach • Students allowed no observations the day visited	• Prenatal care • Intrapartum care • Postdelivery care No data on other services	• 2 student residents • 1 counselor	2:00–5:00 p.m. Daily	• No data
C IDSS Hospital de la Mujer	Yes/Incomplete Limitations: • For only five months • No IEC activities in hospital • No community/school outreach program • Extremely limited physical space • No specific FP program for adolescents • Lack of intensive care unit; high-risk cases are referred • Prenatal and intradelivery care together with adults • Dehumanized care during and after childbirth • Difficulty getting appointments due to rationing system and physicians' lack of punctuality and absenteeism	• Individual guidance with psychologist • All other services are offered together with adults	• OB/GYN in service always • Licensed nurse • Auxiliary nurses • Psychologist	8:00a.m.–12:00 p.m. 12:00–4:00 p.m. 4:00–8:00 p.m. Daily • 5–6 adolescents per day	• Lack specific FP services for adolescents • Recommend IUD for adolescents, although injections and implants are in greater demand

Adolescent Perspectives and Recommendations

During focus groups, adolescent participants shared their perspectives on why adolescents become pregnant. They listed three main factors: inexperience, lack of parental communication, and the absence of sex education at school. To address these needs they suggested different types of IEC programs to teach parents and teachers communication skills and facts about sexuality and reproductive health. The focus group participants did not consider teachers capable of providing sex education, seeing them as "part of the problem, stigmatizing us and making bad judgments about us." They acknowledged that both teachers and parents too often keep silent about sex but yet "both blame unwed, pregnant adolescents." Adolescents also focused on socioeconomic factors that contributed to early pregnancy, such as early school drop-out and lack of opportunities for young women, including suitable employment options.

Recommendations from adolescents to reduce adolescent pregnancy

- "Increase adolescent reproductive health knowledge through talks and presentations."
- "Use the media and TV to relay FP messages to adolescents."
- "Implement programs and activities aimed at retaining adolescents in school (particularly girls)."
- "Create opportunities for young people to work and gain life skills (especially girls)."
- "Implement frequent IEC activities aimed at pregnant adolescents or new mothers, in order to delay their second pregnancy."
- "Conduct values clarification exercises and communication training for parents and teachers."

Provider Perspectives on Adolescent RH Programs

In addition to the quality of and access to adolescent services, health providers often associated the educational system with poor adolescent RH status. Many providers said they thought that the schools were inflexible, condemning all sexual activity, which left little room for adolescents to express their concerns or learn about topics considered relevant to their daily lives. Teachers frequently stigmatized students and commented negatively on pregnant students. Some providers said that there must be wider community outreach, including parents, teachers, and adolescents, and that youth participation must be made available at school. Some providers said that while in-school educational efforts would not be possible, given religious and parental opposition, they would recommend outreach outside these traditional models, beginning with educational programs that promote and provide barrier contraceptives and dual protection in barrios and youth clubs. Some NGO providers said that sex education should include an understanding of sexual and reproductive rights. In their opinion, education should begin with public-sector physicians and nurses, as they too seem unaware of these rights.

Individual interviews with providers of adolescent reproductive health

Directors and nurses on insufficient personnel assigned to integrated attention of adolescents

"There are insufficient staff to attend to adolescents, but, at the same time, many providers are paid and do not work, while other show up once a week for two hours. So, the problem is not one of insufficient staff but of politics inside the hospitals. Take politics out of the hospitals and there will be staff to provide services."

Providers on means to reduce adolescent pregnancy

"Do not focus programs on contraceptive methods. The problem has more to do with parents, teachers, and community perception of female adolescents' sexual behavior. Parents must be educated. They do not accept that their adolescent children are sexually active."

"Make contraceptives free and available. At present there are no free FP methods. Choice is conditioned by availability."

Providers on quality of services for adolescents

"The waiting room for adolescents should always be private. When an adolescent becomes pregnant, she fears meeting known persons, and for that reason stops attending the prenatal clinic."

"A trained adolescent specialist should always provide counseling, given that the behavior of an adolescent is different from that of an adult. When the provider is not trained, he or she expects adult behavior and thus becomes incapable of communication and proper care, assuming a judgmental attitude towards a pregnant adolescent."

Leader Perspectives on Adolescents

The leader of a national family planning NGO said she felt that adolescents are at high risk because they tend to lack a perception of danger. They initiate sexual activities out of curiosity or a desire for pleasure. They are informed about STIs and HIV, but do not necessarily associate themselves with the danger, assuming an attitude of "It will never happen to me." Adolescent pregnancy often takes place in the context of poverty, promiscuity, need, and machismo. Some older men consider that having unprotected sex with young girls is a way of affirming their masculinity. On the other hand, young people also receive mixed messages about sexuality and what may be interpreted as encouragement to be sexually active from the media and their peers. In the meantime, they do not have adequate access to information and/or contraceptive methods.

Recommendations from leaders to reduce adolescent pregnancy

- "Implement IEC activities on the consequences of unprotected early sexual activity, emphasizing the possibilities of delaying pregnancies. They should not be terrorized; prevention and birth spacing should be emphasized."
- "Improve FP efforts and programs to reach more adolescents. Implement strict follow-up to clinical quality of care, with clinical audits as part of the supervision and to sanction negligence."
- "Disseminate accurate and appropriate information at all levels.
- "Approach reproductive health from a human rights and gender equality perspective in the medical schools curricula. There is an urgent need to modify these curricula to incorporate these themes from a holistic health vision, to give more information on user rights and avoid the manipulation of data for religious considerations."

Other NGO leaders said that they believed that pregnancy in early life affects the adolescent's ability to exercise her civil rights, in addition to her mental and emotional health. They stated that unplanned adolescent pregnancy provokes serious personal conflicts with parents. They mentioned the lack of cultural or recreational activities available for young people. They suggested that while youth might know about contraceptive methods, their information was incomplete and distorted by rumors. They noted cultural myths and beliefs that pregnancy is a woman's problem.

CONCLUSION

There are multiple causes and constraints contributing to poor reproductive health outcomes for adolescents, including early pregnancy and risk of STIs/HIV. Many of these constraints are present as the result of a patriarchal social system that determines a sexual division of labor and a double standard for male and female behaviors. These values are upheld by the school system and the Catholic Church. Adolescents consulted during focus group discussions and personal interviews stated that they lacked sex education and guidance from both home and school. Some youth accept religious guidance, while others see it as alien to their lives.

Pressure from the family and other social institutions often compel young unmarried pregnant adolescents to establish a family before they have completed their education. Thus, they enter into marriage unprepared for independence and substitute economic dependence on their parents for dependence on their husband. Under these circumstances, many adolescent girls become victims of harassment and other forms of abuse at home. It was not until the promulgation of Domestic Violence Law 24-97 that women, adolescents, and children were legally protected from domestic violence.

The health sector recognizes the consequences of early marriage as a result of these pressures and constraints and as a result SESPAS has produced norms to address the health needs of adolescents. However, many health providers do not know about these norms, and they are not reflected in the delivery of most adolescent RH services. At best, some hospitals have different prenatal consultations and separate waiting and postpartum rooms for adolescents.

In addition to the lack of implementation of programs for the integrated attention of adolescents, institutional constraints resulting from partisan and provider interests make the quality of services poor and risky for adolescents. Lack of accountability results in health centers' risking adolescent lives and those of their babies by delegating prenatal and birthing services to untrained students and unsupervised nurses who must rely on phone consultations with the absent physicians in high-risk cases and complications (see Section 2: Maternal Health). Adolescent rights to information, counseling, comfort, and privacy are commonly violated due to space limitations, insufficient equipment and supplies, and inadequate maintenance.

While part of the integrated adolescent norms, hospitals lack IEC programs specific to adolescents. Only rarely do they coordinate program activities with other governmental or nongovernmental organizations that target adolescents. There is little coordination with community-based organizations to promote delay of first pregnancy, encourage birth spacing, or increase knowledge of reversible contraceptive methods. Sustainable efforts to raise the age at first pregnancy require long-term interventions, including strategies that address the limitations of sex education in schools, programs that encourage young people to stay in school, and strategies to make jobs available to adolescents.

RECOMMENDATIONS

Decentralization and Autonomy of RH Services

- Apply Social Security Law 87-01 to decentralize and increase access to FP and prenatal services. New legislation supporting providers' accountability and payment of salaries based on competence and productivity will increase access to services, presently limited by constraints on the number of daily FP and prenatal consultations through the ration system imposed by providers from SESPAS and IDSS institutions.
- Implement strategic planning at each health center. There is great need to create and implement a strategic plan directed at increasing adolescent use of services. Staff trained to attend adolescents should be assigned to all institutions.
- Create accountability and supervision of quality of adolescent services within SDP and ND areas, other than the market competition of providers contemplated in the new health legislation. As explained in Section 3: Family Planning, competition will be limited to certain areas and subpopulations; therefore, making decisions about quality of health services will require special monitoring.
- Assign specialists to care for pregnant adolescents and to allow for close monitoring of them as they give birth. Two constraints impede specialized care to adolescents. First, OB/GYNs are not required to perform emergency services and second, general physicians are allowed to conduct consultations and services by telephone. It is suggested that specialists be required to perform emergency services; that nurses receive training to upgrade their clinical care skills so they can essentially function as nurse-midwives; and that telephone consultations be allowed only in low-risk cases.
- To ensure sustainable changes, women's advocacy groups must be allowed to closely monitor labor, birthing, and postdelivery rooms. They should also work closely with NGOs and SESPAS to upgrade deficient facilities and providers and to plan for continual community education and participation. Trained adult or peer labor companions could serve the dual purpose of monitoring adherence to norms and providing a badly needed comforting presence to both adolescents and adult women in labor.

Access to FP Methods and RH Services

- All recommendations made in Section 3: Family Planning are applicable to adolescents, but with special concern for privacy, proper counseling, and IEC for youth and the community, including school outreach activities. To achieve this goal, the adolescent FP program must have a wide mix of reversible contraceptive methods available and accompanied by an extensive IEC program. IEC must focus on not only the risks of unwanted adolescent pregnancy, but also on the other negative effects of risky sexual activities, including HIV infection and other STIs.
- Given many adolescents' economic dependence, RH services should be free for those who cannot afford the fees. Services should include access to free FP methods, laboratory tests, and consultations.
- Create alternate means of distribution of FP methods at the community level, given adolescents' sensitivity about privacy and confidentiality. Alternate distribution mechanisms need to be found, and further research in this area is recommended.

Quality of Care and RH Services

- All recommendations on quality of services suggested in Section 3: Family Planning apply to adolescents. However, in addition, physicians need to be trained to be sensitive to adolescent needs and conditions, and to provide adequate counseling and allow informed consent of the user in the selection of FP methods.
- Train all adolescent health program staff in counseling techniques, in the application of the norms and procedures for the integrated attention program to adolescents, and in the use of IEC materials.
- Teach all physicians, nurses, and even guards and cleaning staff the reproductive and citizens' rights of adolescents and establish mechanisms for creating accountability in cases where those right are violated.
- Include the reproductive rights of adolescents and SESPAS norms in medical school training and curricula.
- Do not allow medical students and untrained nurses to attend adolescents' labor and delivery without the presence of specially trained medical staff, who are responsible for providing these services.
- Organize municipal advocacy groups to oversee services and to create mechanisms to ensure that the rights of adolescents are not violated.

IEC and Community-Based Outreach

- Initiate negotiations with the secretary of education to allow a specialized team from SESPAS and the Ministry of Education to create a strategic plan for the implementation of sex education in grades 6–8 of basic education and in all high school grades.
- Implement IEC activities to educate and motivate adolescents to delay the initiation of sexual activity, to use contraception and dual protection methods to prevent pregnancy and STIs, and to space births. Assign health educators and promoters to the implementation of IEC programs at community level. Provide each hospital and rural clinic with adequate supplies to implement this program (e.g., videos and a steady supply of brochures and other written information on FP methods and STI/AIDS prevention).
- Involve advocacy groups and community-based organizations to increase knowledge of RH rights among adolescents.
- Involve parents and teachers in IEC activities. Further research is needed to study the lessons learned in attempting to engage adults in the DR and other countries.
- Implement research activities to study lessons learned in the DR and other countries in the region on livelihood and other skill-based programs to improve adolescents' life and communication skills.

5: Conclusions

The Strategic RH Assessment in the Dominican Republic conducted in the fall and winter of 2001 verified many assumptions and beliefs held by policymakers, researchers, providers, users, and health activists about the status and underlying causes of some of the long-standing indicators of poor reproductive health in the country. To the team it was apparent that the problems were interrelated, and that the lack of access—particularly for poor women, poorly educated women, and adolescents—to a wide range of reversible contraceptive methods and dual protection was a contributing factor to the other problems of high rates of adolescent pregnancies, increasing rates of transmission of STIs/HIV, unwanted pregnancies leading to abortion, and high rates of maternal mortality. All of these problems reflect deficiencies and gaps in the current system, gaps of adequate access, gaps of coverage at all levels of population, and deficiencies of high-quality reproductive health care.

The fact that the indicators of poor reproductive health are highest among adolescents and poor women makes the focus of this study and of its recommendations for change clearly in the public sector. Long-standing cultural, traditional, religious, and other economic and social factors also contribute to the poor RH health status in combination with a lack of demonstrated political will, a lack of adherence to the new health norms, and the slow introduction of health sector reform.

The list of recommendations in response to each of the three strategic questions and the short-, medium-, and long-range plans developed through participatory process at the two dissemination workshops can aid SESPAS, working with USAID and other donors, to improve the reproductive health of all Dominicans. Maintaining the participatory and collaborative process developed during the assessment process may help all stakeholders to move the reproductive health agenda forward during this period of health reform and increasing attention to quality of care and reproductive and health rights. For a summary of the recommendations from the January 30 meeting, see Appendix H.

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Appendix A

Workshop participants, October 19, 2001

Institution	Name
Secretario de SESPAS	Dr. José Rodríguez Soldevila
SESPAS, Subsecretario de Atención Primaria	Dr. Manuel Tejada Beato
SESPAS, Director Materno/Infantil and Subdirector	Dr. Víctor Calderón Dr. José Antonio Matos
IDSS, Dir. Salud Reproductiva Jefe Depto. Servicios Salud	Dr. Clavel Sánchez Dr. Johnny Díaz Chávez
CONAPOFA, Director	Dr. Fausto Báez
CERS Asesor	Dr. Jesús Feris Iglesias
Banco Mundial/CERS	Ms. Gisela Quiterio
IDB/CERS	Dr. Alejandro Moliné
Asoc. Nal. De Clínicas y Hospitales Privados	Dr. Víctor Suero
OMS/OPS	Dr. Oscar Suriel, Dra. Virginia Camacho, Dra. Socorro Gross
FNUAP	Dr. Gilka Meléndez, Dr. Luz Mercedes
UNICEF	Dr. Herno Laakkonen
DIGECITS	Dr. William Hernández
INSALUD	Dr. Guillermo de La Rosa
USAID HPT	Dr. David Losk and Licenciadas Sarah Majerowicz, Maria Castillo, Kelva Pérez, Norma Paredes, Marina Taveras, Elba Mercado
CDC	Dr. Victoria Martínez
PRIME	Dr. Milton Cordero and Lic. Ann Lion Coleman
Acción SIDA	Ms. Tito Coleman
GTZ	Ms. Irmela Riedlberger and Dra. Betania Laeger
JICA	Ms. Shoko Saito
ADOPLAFAM	Dr. Ramón Portes
PROFAMILIA	Ms. Magaly Caram
MUDE	Ms. Rosa Rita Álvarez
EngenderHealth	Dr. José Figueroa and Lic. Mélida Núñez
REDSALUD	Dr. Patricio Murgueytio
Colectiva Mujer y Salud	Dr. Jenny García and Lic. Jeannette Tineo
FCI	Dr. Maria Artola Faget
PROSISA, CEE	Ms. Antonio Sánchez

Stakeholder meeting agenda, October 19, 2001

9:00	Opening remarks *Dr. José Rodriguez Soldevila, Secretary of Health* *Dr. David Losk, Health and Population Official, USAID*
9:15	Presentation of the participants
9:30	Presentation on the Strategic Framework *Dr. Juan Díaz, Population Council*
10:15	Coffee
10:30	Experience with Strategic Assessment in Bolivia *Dr. Virginia Camacho, OPS*
11:00	Preliminary background review of the reproductive health status in the Dominican Republic *Dr. Suellen Miller, Population Council*
11:30	Group work *Green and orange teams:* Identifying program and research priorities *Pink team:* Team composition and site seclection
12:30	Lunch
13:30	Presentation of group conclusions and discussion in plenary
15:00	Description of the Strategic Assessment methodology
15:30	Coffee and project video projection
16:00	Conclusion (in plenary) Priorities, strategic research questions, and next steps

Appendix B

Participants

Investigation team

(Defined strategic questions, developed tools, collected data and synthesized results)

Ámbar team: National District and Region IV
Supervisors: Pamela Putney, CNM and Mélida Núñez, Engenderhealth, Nurse
Suellen Miller, PhD, CNM, (in ND)
Nancy Vásquez, Clinical Psychologist, IDSS
Gladys Caraballo, Social Worker, consultant
Wilme Vargas, Rural Development, consultant

Larimar team: National District and Region III
Supervisor: Argelia Tejada, PhD Sociologist
Sonia Brito, OB/GYN, Plan de Lucha contra la Pobreza
Ana Julia Hernández, Clinical Psychologist, SESPAS
Leda Herasme, Health Educator, SEE
Héctor Rodríguez, Social Worker, ONE

Technical Advisory Group

Dr. Milton Cordero, PRIME
Ms. Ann Lion Coleman, PRIME
Dr. Ramón Portes, ADOPLAFAM
Dr. José Figueroa, EngenderHealth
Dr. Patricio Murgueytio, REDSALUD
Dr. Jenny García, Colectiva Mujer y Salud
Dr. Maria Artola Faget, FCI
Dr. Guillermo de La Rosa, INSALUD
Dr. David Losk, USAID/Salud y Población
Ms. Elba Mercado, USAID/Salud y Población

Appendix C

List of Selected Sites
(Data from the 1993 National Census, revised by ONAPLAN in 1997)

National District
1. Maternity Hospital La Altagracia
2. Maternity Hospital San Lorenzo de Los Minas
3. Municipal Hospital Los Minas
4. Municipal Hospital Las Caobas
5. Municipal Hospital Villa Duarte
6. Municipal Hospital Engombe
7. IDSS Hospital de la Mujer
8. PROFAMILIA clinic Santo Domingo

Region III: Communities in Duarte Province (62,396 households)
1. Regional Hospital San Vicente de Paúl, San Francisco de Macorís (SFM) City (37,245 households in SFM municipality)
2. Municipal Hospital Villa Riva, municipality of Duarte Province
3. Municipal Hospital Castillo, municipality of Duarte Province (4,664 households)
4. Municipal Hospital Pimentel, municipality of Duarte Province
5. Rural clinic Hoyo de Jaya, section (1,206 households)
6. Rural clinic Guaraguao, section
7. Rural clinic Ceiba del Pájaro, section
8. PROFAMILIA clinic Centro de Atención Integrated, SFM City

Region IV: Communities in Barahona and Independencia Provinces
1. Regional Hospital Jaime Mota, Barahona City (urban population contains 13,023 households, and Barahona municipality contains 14,222 households)
2. IDSS Hospital, Batey Central, Barahona
3. Municipal Hospital Vicente Noble, municipality of Barahona Province (2,168 households in urban site, and 3,944 households including rural households)
4. Municipal Hospital Duvergé, municipality of Independencia Province (1,780 households in urban site)
5. Rural clinic Vengan a Ver, sección from municipality of Duvergé, Independencia Province (484 households, urban and rural)

Table C1.1. Interviews and observation of services provided at health centers in the ND

	Men	Women	Adolescents	Type of interview	Observation of services	Total
Maternal mortality						
Directors	5	2				7
Administrators	2	3				5
Program leaders	1	9				10
Service providers	18	14				32
Prenatal service users		33			15	48
Perinatal						
Delivery					24	24
Postpartum		2			1	3
Family planning						
Program leaders		2				2
Service providers	6	5				11
Service users		25			12	37
Nonusers		2				2
TL procedures performed					5	5
Counselors					5	5
Adolescents						
Program leaders		3				3
Service providers	1	4				5
Family planning users			8			8
Prenatal care			6			6
Delivery						
Postpartum			3			3
Adolescents' mothers		2				2
Counselors					1	1
Members of the community						
Municipal authorities						
Community leaders						
Prenatal service providers	5	5		FG		10
Delivery room service providers						
Adolescents' service providers			12	FG		12
Family planning providers						
Health educators						
Service users						
Nonusers						
Focus groups			2	2 FGs		2
Group interviews			1			1
Total	**38**	**111**	**29**		**63**	**241**

Table C1.2. Interviews and observation of services provided in Region III, November 2001

	Men	Women	Adolescents	Type of interview	Observation of services	Total
Maternal mortality						
Directors	7					7
Administrators	2	4				6
Program leaders	1	7				8
Service providers	2	14				16
Prenatal service users		23			9	32
Delivery		2			1	3
Postpartum		1				1
Family planning						
Program leaders	1	2				3
Service providers	1	3			1	5
Service users	1	5				6
Nonusers	4	3				7
Counselors					5	5
Adolescents						
Program leaders		1				1
Service providers		4				4
Family planning users			4			4
Prenatal care		7	1			8
Delivery						
Postpartum		1				2
Adolescents' mothers						
Counselors						
Community						
Municipal authorities	6					6
Community leaders	1	4				5
Community/nonusers		5				5
Community/users		2				2
Adolescents' service providers						
Family planning providers						
Health educators		2 FGs				
Service users		29	18	FG		47
Nonusers	26	26	29	FG		81
Focus groups	3 FGs	4 FGs	4 FGs			
Group interviews						
Total	**52**	**143**	**52**			**247**

Table C1.3. Interviews and observation of services provided in Region IV, November 2001

	Men	Women	Adolescents	Type of interview	Observation of services	Total
Maternal mortality						
Directors	3					3
Administrators	3					3
Program leaders	1	8				9
Service providers	2	12			14	28
Prenatal service users		12				12
Prenatal						
Delivery					1	1
Postpartum						
Family planning						
Program leaders		1				1
Service providers		5				5
Service users		7				7
Nonusers		3				3
Prenatal		1				1
Delivery						
Postpartum						
TL procedures performed						
Counselors						
Adolescents						
Program leaders						
Service providers						
FP users						
Prenatal care			6			6
Delivery						
Postpartum						
Adolescents' mothers						
Counselors						
Community						
Municipal authorities						
Community leaders		4				4
Prenatal service providers						
Delivery room service providers						
Adolescents' service providers						
FP providers						
Health educators						
Service users		24	8	FG		32
Nonusers			10	FG		10
Focus groups		2 FGs	2 FGs			4 FGs
Group interviews		1 FG				
Total	**9**	**77**	**24**		**15**	**125**

Table C3.1. Sources of contraceptive methods

	Public sector	Private clinics	NGOs	Stores	DK/ND	Total
Pills	18.3	2.1	12.5	66.6	0.6	100.0
IUD	59.2	27.9	12.9	0.0	0.0	100.0
Injectables	22.7	24.7	30.1	22.5	0.0	100.0
Diaphragms, gels	6.9	0.0	24.5	68.6	0.0	100.0
Condoms	9.3	0.0	2.2	83.7	4.8	100.0
Female sterilization	41.1	45.6	13.1	0.0	0.2	100.0
Vasectomy	0.0	66.5	14.9	0.0	18.6	100.0
Implants	52.0	9.8	38.2	0.0	0.0	100.0
% of total	**36.1**	**33.8**	**13.1**	**16.5**	**0.5**	**100.0**

Source: Macro International and CESDEM 1996, Table 4.9.

Table C3.2. Inventory of contraceptive methods distributed and stored by CONAPOFA up to October 30, 2000

				Expiration before use		Next expired	
Contraceptive type (%)	CONAPOFA warehouse[a]	Distribution to health centers[b]	Total quantity	Quantity	Date	Quantity	No. of SDPs/areas with data[c]
Rigevidon pills	80 (0.1)	90,027 (99.9)	90,107 (100.0)			43,839	27
Minipill Microval	5,183 (24.5)	15,984 (75.5)	21,167 (100.0)			9,420	27
Vaginal tablets	42,300 (55.2)	34,391 (44.8)	76,691 (100.00)			1,679	8
Norplant	650 (25.0)	1,953 (75.0)	2,603 (100.0)			1,778	22
IUD	14,798 (69.3)	6,547 (30.7)	21,345 (100.0)	5,367	1/10/2000	1,778	28
Injectable Depo-Provera	9,475 (58.2)	6,809 (41.8)	16,284 (100.0)	5	10/2000		28
Condoms	1,245,168 (73.2)	456,596 (26.8)	1,701,764 (100.0)			141,142	29

[a] CONAPOFA gives no data on expiration date of its own contraceptive methods.
[b] Data is not available for the provinces of Hato Mayor, El Seybo, Higüey, and Santiago.
[c] The total number of SDPs and areas is 33.
Source: CONAPOFA, physical inventory by establishment and contraceptive methods, October 30, 2000.

Table C3.3. Personnel assigned to FP program, schedule, average number of users, and methods provided in hospitals observed

Hospital	Personnel	Established schedule	Days service is offered	Average no. of users	Methods provided
National and regional hospitals: 3rd and 4th levels					
A Maternity Hospital Los Minas	• 1 OB/GYN • 2 aux. nurses • 1 secretary • Training from PROFAMILIA	2:00–5:00 p.m. • Rationing system and lack of staff limit access to FP services	Monday–Friday	• 25 tickets per day are allowed, and 60–75 users demand services	• OCPs, injectables, condoms • IUDs and Norplant on certain days
B Maternity Hospital La Altagracia	• 1 RH manager • 2 physicians • 1 resident student of OB/GYN • 2 nurses for reversible methods and 8 aux. + 1 licensed nurse for sterilization • 1 secretary • 6 educators/ counselors	8:30 a.m.–12:00 p.m. 1:30–4:30 p.m. • Rationing system limits access to FP services	Monday–Friday	• 15 per day • 12 per day receive permanent sterilization	• Only methods available were IUD, OCPs and surgical sterilization
C IDSS Hospital de la Mujer	• 2 OB/GYNs • 2 nurses • 2 secretaries • 1 social worker • Training from PROFAMILIA	8:00 a.m.–12:00 p.m. 1:00–5:00 p.m. • Rationing system limits access to FP services	Monday–Friday	Not determined	• OCPs, injectables, condoms • Surgical female sterilization • IUD • No Norplant
D Regional Hospital IV	• 1 physician in p.m. (does IUD and Norplant) • 1 nurse in a.m.	8:00 a.m.–12:00 p.m. 2:00–4:00 p.m. • Rationing system limits access to FP services	Monday–Friday	Not determined	• OCPs, injectables, condoms • Surgical female sterilization • IUD (interval) • Norplant • Vaginal tablets • No vasectomy
E Regional Hospital III	None	None	None	None	None
NGOs: Salaries based on productivity, and clients pay for services					
F NGO Clinic Evangelina Rodriguez (ND)	• 3 GYNs in a.m.; 2 in p.m. • Method selection: 2 counselors, health educator	8:00 a.m.–12:00 p.m. 12:00–4:00 p.m. • Demand limited by required fees • Free bonuses increase demand	Monday–Friday		• All reversible methods except gels and diaphragms • Female sterilization • Vasectomy • Research on other methods: vaginal ring, male implants, and emergency contraception
G Centro de Salud Integrated (SFM)	• 3 physicians • 3 aux. nurses • 1 counseler	8:00 a.m.–12:00 p.m. 12:00–4:00 p.m. • Demand limited by required fees • Free bonuses from SESPAS increase demand	Monday–Friday	• 30–40 sterilizations per month	• All reversible methods except gels and diaphragms • Female sterilization, not vasectomy

Table C3.3 *(continued)*

Hospital	Personnel	Established schedule	Days service is offered	Average no. of users	Methods provided
Municipal hospitals from the ND and Regions III and IV: 2nd level					
H Municipal Hospital Villa Duarte	• 1 general physician • 1 OB/GYN • 1 aux. nurse • All trained in FP, nurse technically limited	8:00 a.m.–12:00 p.m. • Rationing system and lack of supervision limit access to methods	Monday–Friday	• 15 users per day	• OCPs, condoms • Injectables and gels occasionally • No permanent methods (referred to Los Minas maternity) • Lack of equipment to insert IUD
I Municipal Hospital Engombe	• 1 general physician trained in FP • Medical students for adolescents • 1 educator • 2 nurses • 1 physician for steril.	8:00 a.m.–12:00 p.m. • Surgical sterilization only on Fridays	Monday–Friday	• 15 users per day	• All reversible methods except for vaginal tablets • Not enough equipment for Norplant (5 per day) and IUD • Only MH that does surgical sterilization
J Municipal Hospital Las Caobas	• 1 OB/GYN • 1 educator	8:00 a.m.–12:00 p.m. • Rationing system limits access to FP	Monday–Friday	• 15 users per day	• All reversible • Insufficient equipment for Norplant (10 per day). • Scarcity of clinical supplies • Limited space for the demand of services
K Municipal Hospital Los Alcarrizos	• 1 nurse	8:00 a.m.–12:00 p.m .Wednesday 2:00–5:00 p.m. Friday • Rationing system limits access to services; only 1 nurse available		Not determined	• All reversible methods except vaginal tablets • No permanent methods
L Municipal Hospital Los Minas	• 1 trained general physician	2:00–5:00 p.m. • Rationing system limits access to FP	Monday–Friday	Not determined	• Injectables, pills, IUD • No permanent methods • Sterilizations referred to Los Minas maternity
M Municipal Hospital Pimentel	• 1 nurse distributes condoms • 1 GYN on Tuesdays only	8:00 a.m.–12:00 p.m. • Rationing system and lack of methods limit access to FP	Monday–Friday	• 10 injectables per month	• Condoms • 11 IUDs in existence over 2001 • No OCs since March 2001 • No injectables since September 2001
N Municipal Hospital Villa Riva	• 1 aux. nurse distributes condoms	8:00 a.m.–12:00 p.m. • Rationing system and lack of methods limit access to FP	Monday–Friday	Not determined	• Condoms • No methods from CONAPOFA since August 2000
O Municipal Hospital Castillo	• 1 aux. nurse distributes condoms	8:00 a.m.–12:00 p.m. • Rationing system and lack of methods limit access to FP	Monday–Friday	Not determined	• Condoms • No methods from CONAPOFA since November 2000
P Municipal Hospital Vicente Noble	• 1 OB/GYN • 1 aux. nurse • 4 nurses trained in FP	8:00 a.m.–12:00 p.m. 2:00–5:00 p.m. • Rationing system limits access	Monday–Friday	Not determined	• OCPs, IUD, injectables, minipills, Norplant, condoms
Q Municipal Hospital Duvergé	• 1 aux. nurse, trained • Untrained for IUD or Norplant	8:00 a.m.–12:00 p.m. • Rationing system limits access to methods	Monday–Friday	Not determined	• Pills, minipills, injectables, IUD, vaginal tablets, and female steril. • Delays from Jimaní limit accessibility at Duvergé MH

Table C3.4. Comparison of average monthly contraceptive methods used January–October 2001 (monthly average distribution of methods provided at the Santo Domingo maternities, the PROFAMILIA clinic, and five municipal hospitals observed)

	Maternity hospitals (average/month)			NGO clinic Evangelina Rodríguez	Total
Method	**Los Minas**	**Altagracia[a]**	**IDSS[a]**	**(average/month)**	**(average/month)**
Pills (cycles)	350.7	n/d	41.2	450.4[b]	842.3
Minipills (cycles)	74.0	n/d	2.3	66.7[c]	143.0
Vaginal tablets (units)	242.0	n/d	0.0	0.0	242.0
Injectables (units)	116.8	n/d	51.6	908.1	1,076.5
Condoms (units)	1,224.9	n/d	5.3	1,508.5	2,738.7
Gel (tubes)	0.0	n/d	0.0	0.0	0.0
Other	0.0	n/d	0.0	0.0	0.0
Procedure (users)					
IUD total	87.5	n/d	48.2	72.2	207.9
IUD postpartum	28.9				
IUD postabortion					
IUD interval	58.6				
Norplant (units)	66.1	n/d	0.0	32.9	99.0
Female sterilization	117.0	213.4	0.0	98.8[a]	330.4
Male sterilization				3.8	3.8

	Santo Domingo municipal hospitals (average/month)					
Method	**Villa Duarte**	**Alcarrizos II**	**Engombe**	**Las Caobas**	**Los Minas**	
Pills (cycles)	85.5	36.1	81.1	59.4	58.1	320.2
Minipills (cycles)	17.8	19.5	Included in pill cycles	Included in pill cycles	40.8	78.1
IUD[a] (units)	7.8	12.5	4	22.8	16.9	64.0
Vaginal tablets (units)	314.2	12.5	0	0.0	82.7	409.4
Norplant (units)	0.0	2.2	19.7	26.8	0.0	48.7
Injectables (units)	15.7	14.9	40.1	n/d	18.5	89.2
Condoms (units)	348.5	49	160.9	4.4	510.6	1,073.4
Gel (tubes)	0.0	0	0	0.0	0.0	0.0
Other	0.0	0	0	0.0	0.0	0.0
Female sterilization	0.0	0	6	0.0	0.0	6.0

[a] Users as a unit
[b] Total
[c] Conceptrol
Source: Sites visited during strategic assessment, November 2001.

Table C3.5. Quality of family planning services provided at hospitals visited, November 2001

Hospital	Interpersonal relations	Information/orientation	Physical exam	User satisfaction
National and regional hospitals: 3rd and 4th levels				
A Maternity Hospital Los Minas	• Amiable but consultation very fast	• Counseling too fast and inadequate • No physical conditions for privacy • Incomplete but clear information • Did not explain STI/AIDS protection • Sometimes provided brochures	• Did not weigh or take blood pressure • No breast exam • Did not explain results of Pap smear • Did not provide comfort	• Very unsatisfied because of delays and difficulty in obtaining desirable method.
B Maternity Hospital La Altagracia		• Sometimes talk given while waiting for counseling • No physical conditions for privacy • Incomplete but clear information • Counseling occasionally not done • Respect for user selection but no verification of informed consent • Brochures to support counseling	• Not observed	• Not observed
C IDSS Hospital de la Mujer	• Amiable • Users are told ahead the steps taken	• Secretary gave information and explained reversible methods, but not on STI/AIDS protection or permanent methods • Correct and clear information on method selected • Brochures handed out • Respect for user selection but no verification of informed consent	• Weight and blood pressure taken • No breast exam • Explained steps taken • Provided comfort • Explained results of exam	• Satisfied with service • Unsure about risks and safety of the method. • Lack of electricity is problematic for users
D Region IV Regional Hospital	• Amiable • Users are told ahead the steps taken	• Explained reversible methods • Did not explain protection for STI/AIDS • Did not explain secondary effects • Did not explain surgical risks • Respected decision of user • IEC not used properly	• Not observed	• Not satisfied due to long hours of waiting and ration system
E Region III Regional Hospital	None	None	None	None
NGOs: Salaries based on productivity				
F NGO Clinic Evangelina Rodriguez (ND)	• Amiable • Users are told ahead the steps taken	• 2 psychologists provide counseling for method selection before physical exam • Complete information on all methods with secondary effects and signs of alert • IEC material handed out • Respect of user's decision, unless counterindication on particular user • Adolescents receive group information with little privacy	• Attractive and clean environment but small for demand of users • Signs on all areas • Equipment complete • Always take weight, blood pressure, and breast exam • Time to answer questions • Detailed explanation on result of exams • One bathroom for two exam offices • Prevention of infectious practices	• Conducts surveys to improve services • Audits • Complete and clear information is offered and users are very satisfied
G Centro de Salud Integrado (SFM)	• Amiable • Users are told ahead the steps taken	• Explained reversible methods • Did not explain protection for STI/AIDS • Did not explain secondary effects of all methods • Limited space and too many interruptions during counseling	• Weight and blood pressure taken • No Pap test • No breast exam • Explained risks of surgery • Provided comfort • Washed hands between pelvic exams	• Conducts surveys to improve services • Users very satisfied

Table C3.5 *(continued)*

Hospital	Interpersonal relations	Information/orientation	Physical exam	User satisfaction
Municipal hospitals from the ND and Regions III and IV: 2nd level				
H Municipal Hospital Villa Duarte	• Amiable • Users are told ahead the steps taken	• Used educational brochures, not verbal counseling, including new users • Occasional talks during waiting time • Little information provided about variety of methods • Correct and clear information on method selected	• Incomplete physical exam • Clinical history not requested for new users • Only gynecol. check • Not weighed and blood pressure not taken • No breast exam • Must return for Pap smear • No handwashing between patients, although disposable gloves and speculums used	• Users satisfied with service because it is fast • Nonavailable services referred to Los Minas Maternity
I Municipal Hospital Engombe	• Not observed • Data from interviews: Rushed and careless	• Only MH that coordinates activities with NGOs and community groups. • Social work gives talks at hospital • Orientation provided by medical students, nurses and educators • Users only received information on method solicited (interviews)	• Not observed • Lack of equipment for IUD insertion, for measuring blood pressure, and for weighing	• Not satisfied with 2–3-hour wait • Approximately 15% are Haitian women from *bateyes*
J Municipal Hospital Las Caobas	• Not observed	• Not enough information given • Information on method mix not provided, only preselected method considered • Educator gives group talks • Space is small for demand • Lacks office for counseling	• Not observed	• Users complain of mistreatment from receptionist • No specific area for counseling • Not satisfied with 2–3-hour wait
K Municipal Hospital Los Alcarrizos	• Not observed	• No signs to let women know that services are only provided Friday afternoon and Wednesday morning	• Not observed • No IEC • Conflict of nurse with union's role, absent on Friday	• Services hardly provided • Found users from this community at other hospitals
L Municipal Hospital Los Minas	• Very small space	• Only one physician for FP and no counseling is offered; women come with a predetermined method choice, and method is provided • No IEC	• Not observed • Lack of equipment for exam and gooseneck lamps	n/d
M Municipal Hospital Pimentel	• No methods, no program	• No methods, no program	• No methods, no program	• No methods, no program
N Municipal Hospital Villa Riva	• No methods, no program	• No methods, no program	• No methods,no program	• No methods, no program
O Municipal Hospital Castillo	• No methods, no program	• No methods, no program	• No methods, no program	• No methods, no program
P Municipal Hospital Vicente Noble	• Not observed	• Only one set of FP brochures for all users • Use of video for educational activities • Visit schools and communities for discussions	• Not observed	• Methods available but users not satisfied with information provided
Q Municipal Hospital Duvergé	• Not observed • Lack of private FP office	• No counseling service • Group discussions sometimes offered • Individual orientation • Lack of IEC materials • No trained person for IEC	• Not observed • No trained physician for consultation	• Methods sometimes not available • Delays when physician is required • Mixed feelings about experience

Table C4.1. Integrated adolescent health programs at regional and municipal hospitals by services provided, personnel assigned, schedule, average number of users and types of family planning methods available

Hospital	Integrated program and constraints	Services offered	Staff assigned	Prenatal schedule	FP scheduled/FP methods available
National and regional hospitals: 3rd and 4th level					
A Maternity Hospital Los Minas	Yes/incomplete Limitations: • Only offered in afternoon and provided by student residents without supervision • For technical aspects see Section 2: Maternal Health • No data on IEC or community outreach • Students allowed no observations the day visited	• Prenatal care • Intrapartum care • Postdelivery care • No data on other services	• 2 student residents • 1 counselor	2:00–5:00 p.m. Monday–Friday	n/d
B Maternity Hospital La Altagracia	Yes/incomplete Limitations: • No community/school outreach program • Overcrowded, little privacy for consultations • Dehumanized care during labor and delivery, just as adults • Technical limitations for labor and delivery as for adults • Technical aspects: see secion two on adults • Little access to FP methods and orientation • Few staff for prenatal and postdelivery care • Difficult to get appointments due to rationing system and physicians' lack of punctuality and absenteeism	• Prenatal care • Intradelivery care • Postdelivery care • Orientation and counseling program by psychologists • IEC • STI/AIDS attention • FP	• 3 physicians • 2 psychologists • 1 licensed nurse • 2 aux. nurses • 1 counselor	8:00 a.m.–12:00 p.m. 1:30–4:30 p.m. Monday–Friday • 65 prenatal adolescents per day	1:30–4:30 p.m. Tuesday and Thursday • Only IUD and pills available
C IDSS Hospital de la Mujer	Yes/incomplete Limitations: • New program, in operation only 5 months • No IEC activities in hospital • No community/school outreach program • Extremely limited physical space • No specific FP program for adolescents • Lack of intensive care unit; high-risk cases referred • Prenatal and intradelivery care together with adults • Dehumanized care before and after childbirth • Difficult to get appointments due to rationing system and physicians' lack of punctuality and absenteeism	• Individual guidance with psychologist • All other services offered together with adults	• OB/GYN always present • Licensed nurse • Aux. nurses • Psychologist	8:00 a.m.–12:00 p.m. 12:00–4:00 p.m. 4:00–8:00 p.m. Daily • 5–6 adolescents per day	• Lacks specific FP services for adolescents • Recommends IUD for adolescents, although injections and implants in greater demand

Table C4.1 *(continued)*

Hospital	Integrated program and constraints	Services offered	Staff assigned	Prenatal schedule	FP scheduled/FP methods available
D Region IV Regional Hospital	No Limitations: • No community/school outreach program • No differentiated activity or space for adolescents • Lack of evaluation/supervision of physicians • Rationing ticket system limits access to services • For technical aspects see Section 2: Maternal Health	• Similar to adults	• No specific staff	8:30 a.m.–12:00 p.m. 2:00–5:00 p.m. Monday–Friday • Rationing system, licenses, and lack of evaluation limit access to services	• UNFPA offers methods but no formal counseling done • Educational materials not properly used • All reversible FP methods and female sterilization
E Region III Regional Hospital	Yes/incomplete Limitations: • No community/school outreach program • No separate delivery and postdelivery rooms • Labor and delivery as adults • For technical aspects see Section2: Maternal Health, same as adults. • No access to FP methods and orientation • Difficult to get appointments due to rationing system and physicians' lack of punctuality and absenteeism • Untrained nurses and/or medical students at labor or delivery • Lack of evaluation/supervision of physicians • Rationing ticket system limits access to services	• Prenatal care with separate room • Separate space for consultations and waiting • Orientation and counseling program by psychologists • STI/AIDS attention • Gynecology • Promotion of maternal lactation • Pediatrics • No FP services	• 2 physicians • 1 gynecologist • 1 psychologist • 2 aux. nurses	8:30 a.m.–12:00 p.m. 2:00–5:00 p.m. Monday–Friday • Rationing system, licenses, and lack of evaluation limit access to services	• None for adults or adolescents

Table C4.1 *(continued)*

Hospital	Integrated program and constraints	Services offered	Staff assigned	Prenatal schedule	FP scheduled/FP methods available
NGOs: Salaries based on productivity					
F NGO Clinic Evangelina Rodriguez (ND)	Yes: Clinic and community outreach • Prenatal services similar to those offered to adults, but stress psychological orientation; limited space for adolescents • Community outreach: Adolescent program targets prevention of STIs/AIDS and first pregnancy • Youth network visits schools and communities: STIs/AIDS and pregnancy prevention, abuse, and domestic violence topics • Other community orientation targets school counselors, teachers, and psychologists • Use of videos, sociodramas, discussions	• Gynecology, prenatal, and pediatric • Pap smears, mammography, sonography, lab analysis for STIs/AIDS • Psychology, counseling • FP, sterilization and fertilization • IEC • Violence against women • Adolescents want postpartum services	• 2 gynecologists • 2 psychologists • 1 therapist • 1 educator • 1 lawyer	8:00 a.m.–12:00 p.m. 1:00–4:00 p.m. • Adolescents like this clinic because it is not difficult to access services, physicians treat them well, and correct information is provided, supported by videos	• Largest mix of methods offered, including fertility and emergency contraception counseling in groups, favors use of Norplant and injections • Insufficient staff for demand, brief-counseling sessions • Methods costly for adolescents
G Centro de Salud Integrado (SFM)	No • Still does not have adolescent program because center started March 2000, but coordinates with CASCO youth network • About 30% of counseling sessions are for adolescents with coupons (free) • Observations: Small physical space and many interruptions during counseling, with little or no privacy • Interruptions due to other functions, such as giving out coupons for free services, and answering phone	• Gynecology, prenatal • Pap smears, mammography, sonography, lab analysis • Pediatric • STIs/AIDS • Psychology • FP, Pap, sterilization, and fertilization • IEC • Violence against women • Counseling • Adolescents want postpartum services	• Not particularly assigned	8:00 a.m.–12:00 p.m. 12:00–4:00 p.m. • Observed prenatal exam was complete	8:00 a.m.–12:00 p.m. 12:00–4:00 p.m. • Methods similar to adults • Users very satisfied with services. • 3–4 of 10 users are adolescents and prefer injectables

Table C4.1 *(continued)*

Hospital	Integrated program and constraints	Services offered	Staff assigned	Prenatal schedule	FP scheduled/FP methods available
Municipal hospitals from the ND and Regions III and IV: 2nd level					
H Municipal Hospital Villa Duarte	Yes/incomplete • Program consists of 2 physicians diagnosing cases and referring them to appropriate specialist; yet, they have a separate room and talk with parents about adolescents' problems Limitations: • No separate prenatal or FP services • No IEC and no school or community outreach activities • No educational material for last 6 months	• General consultations • Guidance with parents • Lab tests provided same day for adolescents • All other services together with adults • Constraints due to rationing system and no supervision	• 2 general physicians, one in the morning and other in the afternoon	• Adolescents referred to prenatal care together with adults	• FP services together with adults
I Municipal Hospital Engombe	Yes • Excellent counseling offered • Offers audiovisual IEC at hospital • School and community outreach talks given by medical resident students • Constraints due to rationing system and no supervision	• General consultations • Orientation • Counseling • Lab tests • FP • Prenatal, intrapartum and postpartum	• General physician • Gynecologist • Sexual therapist • Nurse	• Prenatal, intrapartum, and postpartum care offered together with adults	• All reversible methods except for vaginal tablets and sterilization • 2 or 3 hours' wait makes adolescents dissatisfied with services
J Municipal Hospital Las Caobas	Yes • Offers audiovisual IEC at hospital • School and community outreach talks given by medical resident students • Constraints due to rationing system and no supervision	• General consultations • Orientation • FP counseling • Lab tests • Prenatal, intrapartum, and postpartum	• General physician • Gynecologist • Sexual therapist • Nurse	• Only prenatal control together with adults • Physicians do not inform patients of exam results	• - All reversible methods except for vaginal tablets and sterilization • 2 or 3 hours' wait makes adolescents dissatisfied with services
K Municipal Hospital Los Alcarrizos	Yes/Limited • No school or community outreach activities • Program limited to providing greater emotional support to adolescents • Violence program for all populations • No IEC or mechanisms to contact adolescents • Health promoters canceled (had done community outreach in the past) • Constraints due to rationing systen and no supervision	• Orientation and counseling • IEC at hospital • Prenatal, partum and postpartum • Pap smears, lab analysis, vaccinations • Intra-family violence • 20% of deliveries are adolescents • Rationing system	• Psychiatrist • Psychologist • OB/GYN	• Every Friday morning for prenatal visits but there no counseling • No postpartum orientation • Other services as adults	• As adults, Wednesday morning and Friday afternoon

Table C4.1 *(continued)*

Hospital	Integrated program and constraints	Services offered	Staff assigned	Prenatal schedule	FP scheduled/FP methods available
L Municipal Hospital Los Minas	Yes/limited • Community IEC talks to parents and adolescents • Little privacy for consultations • Poor personal relationships • Constraints due to rationing system and no supervision	• Orientation and counseling • IEC at hospital and community • Prenatal, gynecologist • Pap smears, lab analysis, vaccinations	n/d	n/d	• All reversible methods • Provided with adults • Disrespectful • Inducement to use certain methods
M Municipal Hospital Pimentel	None Limitations: • Adolescents treated as adults • Constraints due to rationing system, no supervision, and absenteeism	8:00 a.m.–12:00 p.m.	• Physicians and specialists reside in SFM	• Average of two hours	• Condoms and IUD • Occasionally injectables: 10 per month.
N Municipal Hospital Villa Riva	None Limitations: • Adolescents treated as adults • Constraints due to rationing system, no supervision, and absenteeism	8:00 a.m.–12:00 p.m.	• Physicians and specialists reside in SFM	• Average of two hours	• Condoms
O Municipal Hospital Castillo	None Limitations: • Adolescents treated as adults • Constraints due to rationing system, no supervision, and absenteeism	8:00 a.m.–12:00 p.m.	• Physicians and specialists reside in SFM	• Average of two hours	• Condoms
P Municipal Hospital Vicente Noble	None Limitations: • Adolescents treated as adults • Constraints due to rationing system, no supervision, and absenteeism	8:00 a.m.–12:00 p.m.	• Physicians and specialists reside in SD and Barahona	• Daily	• All reversible methods
Q Municipal Hospital Duvergé	None Limitations: • Adolescents treated as adults	8:00 a.m.–12:00 p.m.	• Physicians and specialists reside in SD and Barahona	• Daily	• No IUD/Norplant insertion capacity • Delays from region diminish supply

Appendix D

Dissemination meeting agenda, January 30, 2002

8:30	Opening *Dr. José Rodríguez Soldevila (or his representative)/SESPAS*
8:45	Introduction *Dr. David Losk/USAID*
8:50	Team presentation *Dr. Suellen Miller/Population Council*
9:00	Methodology and process of diagnostic *Dr. Juan Díaz/Population Council*
9:20	Findings: Maternal health *Dr. Suellen Miller*
9:50	Coffee
10:10	Findings: Family planning *Dr. Argelia Tejada, Consultant*
10:40	Findings: Adolescent reproductive health *Dr. Sonia Brito/Plan de Lucha Contra la Pobreza*
11:10	Discussion *Dr. Juan Díaz*
12:30	Lunch
1:30	Introduction to working groups *Dr. David Losk*
1:45	Working groups
3:00	Coffee
3:15	Group presentations
4:15	Closing

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Héctor B. Rodríguez		
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Note: Other people were present (temporarily) but did not sign in.

Appendix E

Data from regional and municipal hospitals in Regions III and IV

Table E1. Regional Hospital San Vicente de Paúl, services and hospitalizations by month, January–October 2001

	Year 2001											
	Jan	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Total**	**Av/ mon**
Services												
Cesarean sections (c/sections)	94	80	80	86	91	75	111	156	144	148	1,065	106.5
Deliveries	158	136	152	140	143	121	150	103	206	175	1,484	148.4
Total deliveries and c/sections	252	216	232	226	234	196	261	259	350	323	2,549	254.9
% c/sections among all deliveries	37.3	37.0	34.5	38.1	38.9	38.3	42.5	60.2	41.1	45.8	41.8	
Maternal mortality[a]	0	0	0	0	0	0	0	0	0	0	0	0.0
Live births	251	208	228	222	228	192	250	251	321	318	2,469	246.9
Stillborns	3	9	6	7	6	4	11	9	6	5	66	6.6
Births	254	217	234	229	234	196	261	260	327	323	2,535	253.5
Surgical abortions	39	45	72	55	29	63	67	45	62	53	530	53.0
MVA abortions												
FP methods												
No methods distributed												
Adolescent services												
Deliveries	49	52	46	42	53	48	54	35	73	67	519	51.9
Cesarean sections	0	0	0	0	0	0	41	0	40	0	81	8.1
Total deliveries and c/sections	49	52	46	42	53	48	95	35	113	67	600	60.0
% c/sections among all deliveries	0.0	0.0	0.0	0.0	0.0	0.0	43.2	0.0	35.4	0.0	13.5	1.4
Abortions	10	18	22	18	9	19	0	12	17	15	140	14.0
No FP services offered for adolescents												
Obstetric/pediatric hospitalizations and deaths[a]												
Admissions	424	305	356	294	377	437	456	617	480	400	4,146	414.6
Registration	400	262	316	244	358	393	411	579	454	262	3,679	367.9
Maternal deaths <48 hours	0	0	0	0	0	0	0	0	0	0	0	0.0
Maternal deaths >48 hours	0	0	0	0	0	0	0	0	0	0	0	0.0
Outpatients seen/day	1,600	1,048	1,264	1,561	1,432	1,572	2,170	2,320	1,774	1,638	16,379	1637.9
Child deaths <48 hours	5	9	6	4	6	5	4	5	4	9	57	5.7
Child deaths >48 hours	0	2	3	2	2	3	3	1	1	6	23	2.3
Available rooms	60	60	60	60	60	60	70	70	70	70	640	64.0
Services provided November 2000–October 2001												
Normal deliveries											1,808	
Complicated deliveries											3	
Total deliveries											1,811	
Abortions											593	
Cesarean sections											1,199	
% of c/sections among all deliveries											39.8	

[a] Maternal deaths are registered under obstetrics; during 2001, two unregistered deaths occurred.
Source: Archives and Statistics Department of the SVP, San Francisco de Macorís, November 2001.

Table E2. Regional Hospital San Vicente de Paúl, adult and adolescent services and administrative services personnel

			Staff	
	Staff	**24-hour services?**	**Active on staff**	**Political appointment**
Adults				
Director	1	No	1	
Subdirector	1	No	1	
Total nurses	235	Yes	n/a	n/a
Trained nurses	n/a			
Auxiliary nurses	n/a			
Doctors[a]	144	General practitioners	n/a	n/a
OB/GYNs	20	No	16	5
Odontologists	5	No		
Perinatologists	6	No		
Subtotal	412			
Adolescents				
General practitioners	2	Yes	2	
OB/GYNs	1	No	1	
Auxiliary nurses	2	Yes	2	
Psychologists	1	No	1	
Subtotal	6		6	
Administrative services				
Administration	7			
Pharmacy	9			
Medical warehouse	3			
X-rays	7			
Yesado	2			
Information, reception	6			
Social workers	8			
Accounting	4			
Statisticians	21			
Counselors	4			
Transport	4			
Kitchen	12			
Messengers	2			
Laundry	19			
Subtotal	108			
Rooms/internment	352			

[a] Includes all specialized and general personnel.
Source: Department of Archives and Statistics of the Hospital SVP, San Francisco de Macorís, November 2001.

Table E3. Municipal Hospital Alicia de Legendore de Villa Riva, services and hospitalizations by month, January–October 2001

	Year 2001											
	Jan	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Total**	**Av./ month**
Services												
Cesarean sections (c/sections)	0	0	0	0	0	0	0	0	0	0	0	0.0
Deliveries	11	7	8	10	6	7	12	16	15	17	109	10.9
Maternal mortality	0	0	0	0	0	0	0	0	0	0	0	0.0
Live births	10	7	7	10	6	7	12	15	15	16	105	10.5
Stillborns	1	0	1	0	0	0	0	1	0	1	4	0.4
Births	11	7	8	10	6	7	12	16	15	17	109	10.9
Surgical abortions	0	0	0	0	0	0	0	1	1	0	2	0.2
MVA abortions												
FP methods delivered during the months												
	Year 2000		**Year 2001**									
	Nov	**Dec**	**Jan**	**Feb**								
Pills	44	82	58	60	n/d	n/d	n/d	n/d	n/d	n/d	n/d	61.0
Minipills	0	0	0	0	n/d	n/d	n/d	n/d	n/d	n/d	n/d	0.0
IUD	0	0	0	0	n/d	n/d	n/d	n/d	n/d	n/d	n/d	0.0
Vaginal tablets	0	0	0	0	n/d	n/d	n/d	n/d	n/d	n/d	n/d	0.0
Norplant	0	0	0	0	n/d	n/d	n/d	n/d	n/d	n/d	n/d	0.0
Injectable	0	0	0	0	n/d	n/d	n/d	n/d	n/d	n/d	n/d	0.0
Condoms	115	77	75	188	n/d	n/d	n/d	n/d	n/d	n/d	n/d	113.8
Gel	0	0	0	0	n/d	n/d	n/d	n/d	n/d	n/d	n/d	0.0
Contraceptive methods remaining at the end of the month												
Pills	25	46	46	0	n/d	n/d	n/d	n/d	n/d	n/d	n/d	29.3
IUD	11	11	11	11	n/d	n/d	n/d	n/d	n/d	n/d	n/d	11.0
Condoms	288	211	288	102	n/d	n/d	n/d	n/d	n/d	n/d	n/d	222.3
Adolescent services												
Deliveries	1	3	1	2	1	4	4	4	3	6	29	2.9
Cesarean sections	0	0	0	0	0	0	0	0	0	0	0	0.0
Abortions	0	0	0	0	0	0	0	0	1	0	1	0.1
No FP services offered for adolescents												
Obstetric/pediatric hospitalizations and deaths												
Admissions	11	7	8	10	6	7	12	16	15	17	109	10.9
Registrations	11	7	8	10	6	7	12	16	15	17	109	10.9
Maternal mortality <48 hours	0	0	0	0	0	0	0	0	0	0	0	0.0
Maternal mortality >48 hours	0	0	0	0	0	0	0	0	0	0	0	0.0
Obstetric patients seen/day	23	18	16	20	12	14	24	32	30	34	223	22.3
Child mortality <48 hours	0	0	0	0	0	0	0	0	0	0	0	0.0
Child mortality >48 hours	0	0	0	0	0	0	0	0	0	0	0	0.0
Rooms available	10	10	10	10	10	10	0	10	10	10	100	10.0

Source: Department of Archives and Statistics of the Hospital de Villa Riva, November 2001.

Table E4. Municipal Hospital Villa Riva, monthly activities by physician, July 2001

	General							Gynecol.		Pediatr.	Cardiol.	Average
	1	**2**	**3**	**4**	**5**	**6**	**7**	**10**	**11**	**12**	**13**	
Sunday 1												
2	18	21						6				4.1
3	14		23						12	31		7.3
4			18		9				15		15	5.2
5					7				5	42		4.9
6							13					1.2
Saturday 7												
Sunday 8			14									1.3
9			26	25	4			4				5.4
10				7	6				31	30		6.7
11				9							14	2.1
12	13							34	21	23		8.3
13	10		14									2.2
Saturday 14						30						2.7
Sunday 15				26		3						2.6
16				9								0.8
17				25	13				21	30		8.1
18	23										8	2.8
19	10		15						20	30		6.8
20			2		4	50		22				7.1
Saturday 21				23		2						2.3
Sunday 22				7								0.6
23		18			7				22	30		7.0
24		1										0.1
25	7		15			14			10			4.2
26			18			39			15			6.5
27				30		15		21	4			6.4
Saturday 28				8								0.7
Sunday 29												
30	15	10						12				3.4
31	7		30						17	39		8.5
Total patients/month	117	50	175	169	50	153	13	99	193	255	37	119.2
Days worked/month	9	4	10	10	7	7	1	6	12	8	3	7.0
Average patients/day	13.0	12.5	17.5	16.9	7.1	21.9	13.0	16.5	16.1	31.9	12.3	16.2
Monthly cost/patient[a]	102.6	240.0	68.6	71.0	240.0	78.4	923.1	121.2	62.2	47.1	324.3	**207.1**
Minimum physicians' salary based on DR$12,000.00 monthly salary												
Salary/4 hrs/day (DR$)[b]	1,333.3	3,000.0	1,200.0	1,200.0	1,714.3	1,714.3	12,000.0	2,000.0	1,000.0	1,500.0	4,000.0	**2,423.8**
Salary/4 hrs/day (US$)	79.1	178.0	71.2	71.2	101.7	101.7	712.2	118.7	59.3	89.0	237.4	**143.8**
Real salary/2 hrs/day (US$)	158.3	356.1	142.4	142.4	203.5	203.5	1,424.3	237.4	118.7	178.0	474.8	**287.7**

[a] Based on $12,000.00 physicians' salary only; salary increases with years of experience and specialization.
[b] DR$16.85=US$1.00
Source: Municipal hospital data, November 2001.

Table E5. Municipal Hospital Villa Riva, monthly activities by physician, August 2001

	General						Gynecol.		Pediatr.	Cardiol.	Average
	8	**3**	**4**	**5**	**6**	**9**	**10**	**11**	**12**	**13**	
1		21			45					14	8.0
2			26		6			20	30		8.2
3			15								1.5
Saturday 4											0
Sunday 5		14									1.4
6		14			30		17				6.1
7			30		9			17	25		8.1
8			5								0.5
9				14				24	21		5.9
10		29					27				5.6
Saturday 11		7			42						4.9
Sunday 12			16		16						3.2
13	20		23				12				5.5
14								16	37		5.3
15	20	14									3.4
16		7			31				17		5.5
17			29		7		23				5.9
Saturday 18				21							2.1
Sunday 19						34					3.4
20		15				15					3.0
21	28	9			29			18	34		11.8
22	4		16		12					20	5.2
23	9		10					16	23		5.8
24				15			24				3.9
Saturday 25		25									2.5
Sunday 26					30						3
27	35		15		4		3				5.7
28	3		9					16	29		5.7
29	1		16	12							2.9
30	31		2	4				17	17		7.1
31	31	17	2				30				8.0
Total patients/month	182	172	214	66	261	49	136	144	233	34	149.1
Days worked/month	10	11	14	5	12	2	7	8	9	2	8.0
Average patients/day	18.2	15.6	15.3	13.2	21.8	24.5	19.4	18.0	25.9	17.0	18.9
Monthly cost/patient[a]	65.9	69.8	56.1	181.8	46.0	244.9	88.2	83.3	51.5	352.9	**124.0**
Minimum physicians' salary based on DR$12,000.00 monthly salary											
Salary/4 hrs/day (DR$)[b]	1,200.0	1,090.9	857.1	2,400.0	1,000.0	6,000.0	1,714.3	1,500.0	1,333.3	6,000.0	**2,309.6**
Salary/4 hrs/day (US$)	71.2	64.7	50.9	142.4	59.3	356.1	101.7	89.0	79.1	356.1	**137.1**
Real salary/2 hrs/day (US$)	142.43	129.48	101.74	284.87	118.69	712.17	203.48	178.04	158.26	712.17	**274.13**

[a] Based on $12,000.00 physicians' salary only; salary increases with years of experience and specialization.
[b] DR$16.85=US$1.00
Source: Municipal hospital data, November 2001.

Table E6. Municipal Hospital Villa Riva, monthly activities by physician, September 2001

	General							Gynecol.		Pediatr.	Cardiol.	Average
	2	**3**	**4**	**5**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	
Saturday 1		8										0.7
Sunday 2							11					1.0
3		28				28	8	14				7.1
4		9	26						17	33		7.7
5			13			9					20	3.8
6				19					18	20		5.2
7				13		15	23					4.6
Saturday 8		25										2.3
Sunday 9			24									2.2
10	33		10			10		13				6.0
11	16			6					12	31		5.9
12			10	10		20					10	4.5
13		30	1						16	34		7.4
14		26	10									3.3
Saturday 15												0.0
Sunday 16				9			17					2.4
17		12				14	4					2.7
18		28							25	42		8.6
19		7				23					9	3.5
20					4				19	27		4.5
21	21			26								4.3
Saturday 22				8			5					1.2
Sunday 23		7										0.6
Festive Day 24		23										2.1
25	6				25							2.8
26						28					7	3.2
27							9		23	32		5.8
28		30					20					4.5
Saturday 29		6			9							1.4
Sunday 30												0.0
31												0.0
Total patients/month	76	239	94	91	38	147	97	27	130	219	46	109.5
Days worked/month	4	13	7	7	3	8	8	2	7	7	4	6.4
Average patients/day	19.0	18.4	13.4	13.0	12.7	18.4	12.1	13.5	18.6	31.3	11.5	16.5
Monthly cost/patient[a]	157.9	50.2	127.7	131.9	315.8	81.6	123.7	444.4	92.3	54.8	260.9	**167.4**
Minimum physicians' salary based on DR$12,000.00 monthly salary												
Salary/4 hrs/day (DR$)[b]	3,000.0	923.1	1,714.3	1,714.3	4,000.0	1,500.0	1,500.0	6,000.0	1,714.3	1,714.3	3,000.0	**2,434.6**
Salary/4 hrs/day (US$)	178.0	54.8	101.7	101.7	237.4	89.0	89.0	356.1	101.7	101.7	178.0	**144.5**
Real salary/2 hrs/day (US$)	356.1	109.6	203.5	203.5	474.8	178.0	178.0	712.2	203.5	203.5	356.1	**289.0**

[a] Based on $12,000.00 physicians salary only.
[b] DR$16.85=US$1.00
Source: Municipal hospital data, November 2001.

Table E7. Municipal Hospital Villa Riva, monthly activities by physician, October 2001

	General					Gynecol.		Pediatr.	Cardiol.	Average
	2	**3**	**5**	**7**	**9**	**10**	**11**	**12**	**13**	
1			24			18				4.2
2			11		14		19	38		8.2
3		35			20		3		15	7.3
4		11		5			16	32		6.4
5			19	28		37				8.4
Saturday 6										
Sunday 7		19								1.9
8		37		21		24				8.2
9			28	18			25	39		11.0
10			24						17	4.1
11		19			13		37	42		11.1
12		25		13		30				6.8
Saturday 13			16							1.6
Sunday 14										
15		36			39	23				9.8
16		27		5			22			5.4
17			14	11			8		15	4.8
18			17		10		31			5.8
19		42			27	43				11.2
Saturday 20		11								1.1
Sunday 21			19							1.9
22			26		31	16				7.3
23	19				41		33			9.3
24	27	33							19	7.9
25		37		6			35			7.8
26				16		44				6.0
Saturday 27			8							0.8
Sunday 28	14									1.4
29	12	52				11				7.5
30		25		17			36			7.8
31			4	11					7	2.2
Total patients/month	72	409	210	151	195	246	265	151	73	177.2
Days worked/month	4	14	12	11	8	9	10	4	11	8.3
Average patients/day	18.0	29.2	17.5	13.7	24.4	27.3	26.5	37.8	6.6	20.1
Monthly cost/patient[a]	166.7	29.3	57.1	79.5	61.5	48.8	45.3	79.5	164.4	**73.2**
Minimum physicians' salary based on DR$12,000.00 monthly salary										
Salary/4 hrs/day (DR$)[b]	3,000.0	857.1	1,000.0	1,090.9	1,500.0	1,333.3	1,200.0	3,000.0	1,090.9	**1,407.2**
Salary/4 hrs/day (US$)	178.0	50.9	59.3	64.7	89.0	79.1	71.2	178.0	64.7	**83.5**
Real salary/2 hrs/day (US$)	356.1	101.7	118.7	129.5	178.0	158.3	142.4	356.1	129.5	**167.0**

[a] Based on $12,000.00 physicians salary only.
[b] RD$16.85=US$1.00
Source: Municipal hospital data, November 2001.

Table E8. Municipal Hospital Villa Riva, monthly activities by physician, July–October 2001

	July	August	September	October	Total average
Total patients/month	119.2	149.1	109.5	177.2	138.7
Days worked/month	7.0	8.0	6.4	8.3	7.4
Average patients/day	16.2	18.9	16.5	20.1	17.9
Monthly cost/patient	207.1	124.0	167.4	73.2	142.9
Minimum physicians' salary based on DR$12,000.00 monthly salary					
Salary/4 hrs/day (DR$)	2,423.8	2,309.6	2,434.6	1,407.2	2,143.8
Salary/4 hrs/day (US$)	143.8	137.1	144.5	83.5	127.2
Real salary/2 hrs/day (US$)	287.7	274.13	289.0	167.0	254.5

Notes: (a) Averages are based on 5–7 general physicians, 2 OB/GYNs, 1 cardiologist, and 1 pediatrician; (b) Based on $12,000.00 physicians' salary only; salary increases with years of experience and specialization; cost to the hospital is greater, since it includes supplies, maintenance, facilities, equipment, medicine, administrative, and other staff salaries, etc.; (c) DR$16.85 = US$1.00
Source: Municipal hospital records, July–October 2001.

Figure E1. Average rates per physician from a municipal hospital

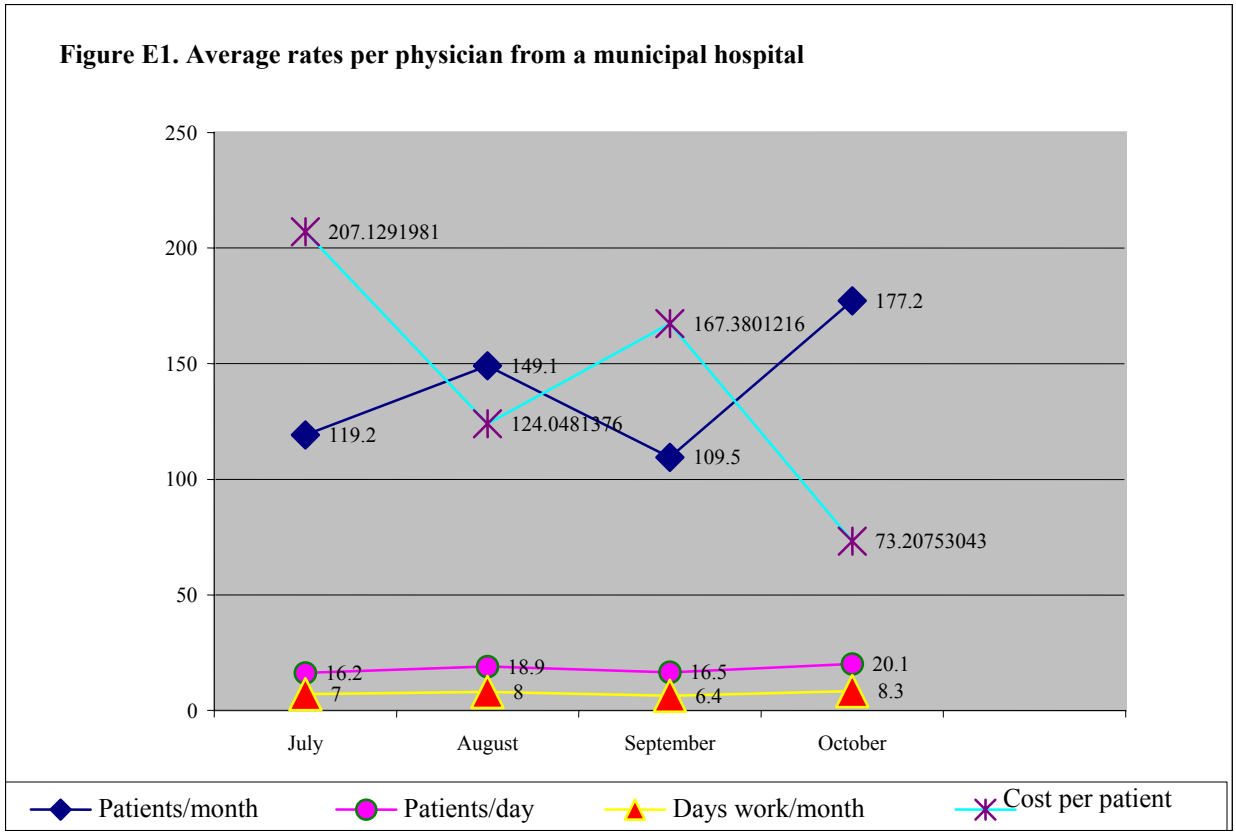

Table E9. Municipal Hospital Vicente Noble, FP services January–August 2001

	Year 2001									
	Jan	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Total**	**Av./month**
Contraceptive methods provided										
IUDs	1	—	1	2	4	1	2	1	12	1.5
Pills	22	47	41	20	34	4	—	36	204	25.5
Depo-Provera	16	25	33	14	21	24	14	26	173	21.6
Norplant	—	—	1	—	—	—	—	—	1	0.1
Minipills	2	—	6	2	—	1	—	2	13	1.6

Source: SESPAS, Family Planning, Santo Domingo, December 2001.

Appendix F

National District 4th-level hospitals and PROFAMILIA

Table F1. Maternity Hospital La Altagracia, services and methods provided and number of users, January–June 2001

	Year 2001							
	Jan	**Feb**	**Mar**	**Apr**	**May**	**June**	**Total**	**Average/month**
Services								
Cesarean sections (c/sections)	425	430	417	379	408	329	2,388	398.0
Deliveries	1,629	1,234	1,371	1,386	1,370	1,333	8,323	1,387.2
Maternal mortality	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Live births	2,032	1,645	1,771	1,748	1,762	1,638	10,596	1,766.0
Stillborns	34	27	31	33	30	46	201	33.5
Births	2,066	1,672	1,802	1,781	1,792	1,684	10,797	1,799.5
Surgical abortions	166	203	188	179	216	216	1,168	194.7
MVA abortions	—	—						
FP methods (users)								
Postpartum IUD	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Postabortion IUD	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Interval IUD	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
OCPs	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Depo-Provera	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Norplant	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Condoms	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Interval TL	128	147	188	143	218	n/a	824	164.8
Postpartum TL	6	14	32	38	28	n/a	118	23.6
Postabortion TL	3	5	6	1	2	n/a	17	3.4
TL at time of c/section	13	23	27	15	30	n/a	108	21.6
FP methods and services for adolescents								
Deliveries	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Cesarean sections	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Abortions	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Postpartum IUD	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Postabortion IUD	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Interval IUD	2	6	7	9	7	6	37	6.2
OCPs	21	12	31	49	15	8	136	22.7
Depo-Provera	20	26	12	0	69	51	178	29.7
Norplant	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Condoms	30	0	45	22	0	0	97	16.2
Sexual and reproductive health (SSR) counseling								
Referring SSR	n/a							
FP orientation	n/a							

Source: Hospital Department of Archives and Statistics, Santo Domingo, December 2001.

Table F2. Maternity Hospital San Lorenzo de Los Minas, services and methods provided and number of users, January–October 2001

	Year 2001											
	Jan	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Total**	**Average/month**
Services												
Cesarean sections	408	288	352	380	355	357	328	435	412	397	3,712	371.2
Deliveries	896	765	870	680	726	659	780	958	980	1,085	8,399	839.9
Maternal mortality	2	—	1	2	1	1	2	2	—	1	12	1.2
Live births	1,301	1,044	1,219	1,050	1,070	1,007	1,085	1,379	1,390	1,469	12,014	1,201.4
Stillborns	13	14	8	13	18	22	24	22	11	20	165	16.5
Births	1,314	1,058	1,227	1,063	1,088	1,029	1,109	1,401	1,401	1,489	12,179	1,217.9
Surgical abortions	313	363	301	407	418	417	481	390	345	389	3,824	382.4
MVA abortions												
FP methods (users of methods provided)												
Postpartum IUD	49	39	45	32	24	29	22	5	19	25	289	28.9
Postabortion IUD	Including pp										0	
Interval IUD	112	45	97	96	83	13	93	9	—	38	586	58.6
OCPs	329	328	517	443	445	66	—	480	299	600	3,507	350.7
Depo-Provera	28	75	45	26	71	43	121	218	210	331	1,168	116.8
Norplant	80	48	81	81	96	32	94	41	43	65	661	66.1
Condoms	1,296	1,044	1,416	1,092	1,743	1,014	1,370	1,126	456	1,692	12,249	1,224.9
Interval TL	105	109	152	124	134	61	n/a	n/a	n/a	n/a	685	114.2
Postpartum TL	1	3	3	4	6	0	n/a	n/a	n/a	n/a	17	2.8
Adolescent family planning services												
Deliveries	263	208	203	183	203	186	207	313	295	331	2,392	239.2
Cesarean sections	111	66	99	120	107	101	81	117	104	112	1,018	101.8
Abortions	78	104	85	106	95	88	100	97	81	112	946	94.6
Postpartum IUD	n/a										0	
Postabortion IUD	n/a										0	
Interval IUD	18	13	27	8	10	16	27	3	—	3	125	12.5
OCPs	47	36	73	56	63	1	—	43	23	62	404	40.4

Source: Hospital Department of Archives and Statistics, Santo Domingo, December 2001.

Table F3. Maternity Hospital San Lorenzo de Los Minas, contraceptive methods delivered and available per month, for adults and adolescents, January–October 2001

	Jan		Feb		Mar		Apr		May		June		July		Aug		Sept		Oct		Total		Av./ month	
	Regist	Avail	Regist	Avail	Regist	Avail	Regist	Avail	Regist	Avail	Regist	Avail	Regist	Avail	Regist	Avail	Regist	Avail	Regist	Avail	Regist	Avail	Regist	Avail
Methods for adults																								
Pills	329	273	328	349	517	342	443	305	445	66	66	0	0	0	480	338	299	671	600	208	3,507	2,740	350.7	249.1
Minipills	93	19	77	33	82	44	38	38	95	10	87	13	63	100	82	81	40	41	83	48	740	495	74.0	45.0
IUD	112	1	45	100	97	53	96	56	83	13	13	0	93	7	9	0	0	0	38	182	586	477	58.6	43.4
Vaginal tablets	420	370	190	180	290	190	170	20	165	60	405	155	310	345	160	285	50	235	260	75	2,420	2,305	242.0	209.5
Norplant	80	75	48	27	81	96	81	67	96	21	32	39	94	45	41	119	43	81	65	26	661	631	66.1	57.4
Injectables	28	250	75	175	45	137	26	112	71	41	43	48	121	127	218	106	210	146	331	292	1,168	1,712	116.8	155.6
Condoms	1,296	150	1,044	446	1,416	30	1,092	90	1,743	219	1,014	69	1,370	139	1,126	309	456	429	1,692	753	12,249	2,784	1,224.9	253.1
Gel	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0	0.0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0	0.0
Methods for adolescents																								
Pills	47	29	36	93	73	20	56	64	63	1	1	0	0	0	43	57	23	92	62	55	404	487	40.4	44.3
Minipills	33	15	26	49	38	41	39	1	47	13	27	44	36	31	28	33	14	13	3	10	291	298	29.1	27.1
IUD	18	15	13	2	27	25	8	17	10	7	16	6	27	1	3	0	0	0	3	16	125	102	12.5	9.3
Vaginal tablets	0	100	0	100	0	100	0	100	0	100	0	100	0	100	0	0	0	0	0	0	0	800	0.0	72.7
Norplant	24	6	11	45	35	30	17	12	18	14	19	44	40	4	43	11	37	56	13	2	257	254	25.7	23.1
Injectables	0	16	25	16	3	28	2	26	12	14	14	0	36	31	42	1	42	37	56	14	232	199	23.2	18.1
Condoms	288	237	132	102	135	89	89	0	94	190	33	157	60	25	60	253	193	205	84	84	1,168	1,892	116.8	172.0
Gel	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0	0.0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0	0.0

Source: Monthly Registers from the Los Minas Maternity, Santo Domingo, December 2001.

Table F4. Method use by IDSS structure, 1999

Structure	OCPs	Minipills	Vaginal tablets	IUD	Condoms	Norplant	Depo-Provera	Total
Hospital de la Mujer, SD	386	175	0	137	504	0	174	1,376
Hospital Valverde-Mao	173	0	0	59	0	157	12	401
Hospital José A. Columna	64	2	6	2	121	0	65	260
Hospital Armida García	26	8	0	10	0	0	15	59
Hospital F. Lavandier, SFM	96	0	0	6	2	0	0	104
Hospital Jaime O. Pino	30	0	0	0	8	0	1	39
Zona A National District	82	0	0	11	11	0	47	151
Zona Franca, Baní	384	0	30	0	62	0	18	494
Zona Franca Santiago	330	0	0	9	0	0	26	365
Zona Franca Villa Mella	491	81	0	2	19	0	14	607
Hospital Ramón Báez, Cotuí	21	0	0	3	8	0	0	32
Pol. PSDC, Santiago	40	0	0	0	4	0	1	45
Zona Franca, San Pedro	1	0	0	0	8	0	1	10
Total	2,124	266	36	239	747	157	374	3,943

Table F5. IDSS Hospital de la Mujer, services and methods provided and number of users, January–October 2001

	Year 2001											
	Jan	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Total**	**Av./month**
Services												
Cesarean sections	222	167	208	203	178	189	210	257	270	244	2,148	214.8
Deliveries	304	226	238	229	240	235	240	275	289	323	2,599	259.9
Maternal mortality	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0	0.0
Live births	526	393	446	432	418	424	450	532	559	567	4,747	474.7
Defects	8	6	12	8	11	1	4	8	16	8	82	8.2
Births	526	393	446	432	418	424	450	532	559	567	4,747	474.7
Surgical abortions	8	40	41	38	43	45	57	43	35	21	371	37.1
MVA abortions												
	New users		**Returning clients**									
FP methods, January–September 2001												
IUD	206		228								434	48.2
OCPs	114		257								371	41.2
Depo-Provera	464		0								464	51.6
Minipills	15		6								21	2.3
Norplant	0		0								0	0.0
Condoms	15		33								48	5.3
Total users	814		524								1,338	148.7
Adolescent FP and sexual and reproductive health (SSR) counseling												
Referring SSR	13	12	0	10	22	15					72	12.0

Source: FP Team, Hospital's Division of Reproductive Health; and Pediatrics Department Statistical Summary, 2001.

Table F6. PROFAMILIA's Evangelina Rodríguez clinic, sterilizations, consultations/procedures, and contraceptive sales, January–October 2001

	Year 2001											
	Jan	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Total**	**Av./month**
Sterilizations	38	36	60	144	158	53	53	105	126	215	988	98.8
Female	32	34	55	140	152	51	48	103	124	211	950	95
Male	6	2	5	4	6	2	5	2	2	4	38	3.8
Consultations/procedures												
IUD insertion	87	65	73	57	64	60	78	70	82	86	722	72.2
Implant insertion	37	39	30	26	38	22	30	9	53	45	329	32.9
IUD removal	51	22	32	25	29	22	35	20	22	30	288	28.8
Implant removal	86	56	83	48	73	59	68	60	43	69	645	64.5
Contraceptive sales												
Injectables	914	860	999	810	937	924	912	927	804	994	9,081	908.1
Cyclofem	90	72	125	96	112	102	120	101	98	114	1,030	103
Depo-Provera	824	788	874	714	825	822	792	826	706	880	8,051	805.1
Condoms	1,133	934	2,642	946	1,927	1,232	1,430	1,627	1,405	1,809	15,085	1508.5
Condoms w/out logo	1,118	913	2,621	931	1,919	1,215	1,403	1,587	1,392	1,790	14,889	1488.9
Other types	15	21	21	15	8	17	27	40	13	19	196	19.6
OCPs	439	358	410	385	468	439	680	494	398	433	4,504	450.4
Norplant	37	39	29	26	37	22	30	9	53	44	326	32.6
IUD	87	64	72	55	66	61	78	70	82	87	722	72.2
Conceptrol	352	264	24	4	0	0	23	0	0	0	667	66.7
Diaphragm	1	0	0	0	0	0	0	0	0	0	1	0.1
Contraceptive gel	0	0	0	0	0	0	0	0	0	0	0	0

Source: PROFAMILIA, Research Department, Santo Domingo, December 2001.

Appendix G

National District Municipal Hospitals

Table G1. Municipal Hospital Villa Duarte, contraceptive methods provided and available, December 2000 and January–September 2001

	Dec 00	Jan		Feb		Apr	May		July		Sept		Av./month	
	Avail	Regist	Avail	Regist	Avail	Regist	Regist	Avail	Regist	Avail	Regist	Avail	Regist	Avail
Contraceptive methods provided and available per month														
Pills (cycles)	58	122	36	75	61	92	142	21	0	0	82	73	85.5	41.5
Mini-pills (cycles)	70	21	49	19	60	15	20	70	25	83	7	92	17.8	70.7
IUD (units)	32	6	33	7	26	4	11	22	11	22	8	7	7.8	23.7
Vaginal tablets (units)	220	270	260	245	0	365	400	135	550	61	55	0	314.2	112.7
Norplant (units)	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0
Injectables (units)	38	25	16	15	31	22	9	22	18	8	5	21	15.7	22.7
Condoms (units)	642	583	59	570	1,361	695	785	686	970	268	288	0	648.5	502.7
Gel (tubes)	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0
Sterilization/TL	0	0	0	0	0		0	0	0	0	0	0	0	0
FP methods (users per month)														
No data														
Adolescent FP														
Included with adult data														
Services														
No deliveries or major surgeries														
Training/participants														
Sterilization/ TL doctors	1													
Sterilization/ TL nurses	1													
Others TL	—													
APA doctors	—													
APA nurses	—													
FP doctors	2													
FP nurses	1													

Source: Nurse in charge of FP and monthly registers for 2001.

Table G2. Los Alcarrizos II Municipal Hospital, services and methods provided and number of users per month, January–October 2001

	Year 2001											
	Jan	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Total**	**Av./month**
Services												
Cesarean sections	1	0	1	0	2	0	0	0	—	—	4	0.5
Deliveries	65	37	48	48	38	47	87	28	—	—	398	49.8
Maternal mortality	0	0	0	0	0	0	0	0	—	—	0	0.0
Live births	66	38	49	47	39	46	59	28	—	—	372	46.5
Stillborns	2	0	0	1	1	1	0	0	—	—	5	0.6
Births	68	38	49	48	40	47	59	28	—	—	377	47.1
Surgical abortions	2	1	3	3	2	0	3	3	—	—	17	2.1
MVA abortions	0	0	0	0	0	0	0	0	—	—	0	0.0
FP methods provided per month												
IUD	8	4	2	2	5	4	0	0	0	0	25	2.5
Pills	48	44	40	30	30	28	44	18	35	44	361	36.1
Minipills	35	35	25	18	22	18	0	8	18	16	195	19.5
Vaginal tablets	40	0	0	20	0	45	0	0	0	20	125	12.5
Injectables	25	9	10	18	5	20	8	16	18	20	149	14.9
Norplant	6	4	2	3	3	4	0	0	0	0	22	2.2
Condoms	70	75	35	40	45	60	30	40	35	60	490	49.0
FP methods (users per month)												
Postpartum IUD	8	4	2	2	5	4	0	0	0	0	25	2.5
Postabortion IUD	Including postpartum											
Interval IUD	Including postpartum											
Pills	24	22	30	17	18	19	22	15	20	20	207	20.7
Minipills	30	30	18	16	18	17	0	8	16	16	169	16.9
Vaginal tablets	2	0	0	2	0	3	0	0	0	2	9	0.9
Injectables	25	9	10	18	5	20	8	16	18	20	149	14.9
Norplant	6	4	2	3	3	4	0	0	0	0	22	2.2
Condoms	5	5	2	2	3	4	1	3	2	2	29	2.9
Adolescent FP												
Deliveries	6	7	10	10	8	8	12	5	—	—	66	8.3
Cesarean sections	1	0	0	0	0	0	0	0	—	—	1	0.1
Abortions	0	0	1	1	0	0	0	1	—	—	3	0.4
Interval IUD	18	13	27	8	10	16	27	3	—	3	122	13.6
OCPs	47	36	73	56	63	1	n/a	43	23	62	404	44.9
Training/participants												
Sterilization/TL doctors	1		Domestic violence									
Sterilization/TL nurses	1		Doctors		35							
FP doctors	2		Nurses		21							
FP nurses	1		Admin.		2							

Source: Nurse in charge of FP, Santo Domingo, November 2001.

Table G3. Municipal Hospital Engombe, services and methods provided and number of users per month, January–October 2001

	Year 2001											
	Jan	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Total**	**Av./month**
Services												
Cesarean section (c/section)	2	2	2	2	7	2	2	4	4	3	30	3.0
Deliveries	44	41	35	22	42	45	41	70	63	61	464	46.4
Maternal mortality	0	0	0	0	0	0	0	0	0	0	0	0.0
Live births	46	45	37	24	49	47	43	74	67	64	496	49.6
Stillborns	1	0	0	0	0	2	0	1	0	1	5	0.5
Births	47	45	37	24	49	49	43	75	67	65	501	50.1
Surgical abortions	20	9	9	6	19	24	15	8	8	10	128	12.8
MVA abortions												
FP users	163	121	189	160	150	150	49	150	114	—	1,246	138.4
FP methods provided												
IUD	7	4	5	4	4	2	—	4	6	—	36	4.0
OCPs	77	69	118	96	79	89	—	123	79	—	730	81.1
Depo-Provera	52	32	40	37	36	49	36	47	32	—	361	40.1
Norplant	22	19	19	19	14	20	12	20	32	—	177	19.7
Condoms	260	120	60	140	400	120	140	180	28	—	1,448	160.9
Interval sterilization/TL	6	4	5	7	3	4	7	5	5	6	52	5.2
Postpartum sterilization/TL	0	0	0	0	0	0	0	0	0	0	0	0.0
Postabortion sterilization/TL	0	2	0	0	3	0	1	1	0	0	7	0.7
TL at time of c/section	0	0	0	0	0	0	0	0	1	0	1	0.1
Adolescent FP												
Deliveries	8	6	7	7	7	7	8	8	11	10	79	7.9
Cesarean sections	1	0	0	1	0	0	0	1	1	0	4	0.4
Abortions	1	2	0	2	2	—	—	—	—	—	7	1.4

Source: SESPAS, FP Director, Santo Domingo, December 2001.

Table G4. Municipal Hospital Las Caobas, contraceptive methods provided and number of users per month, FP and sexual and reproductive health counseling, April–October 2001

	Year 2001										
	Jan	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Av./month**
Services											
No internment											
FP methods provided											
IUD	n/a	n/a	n/a	19	41	13	21	20	n/a	n/a	22.8
OCPs	n/a	n/a	n/a	79	54	55	45	64	n/a	n/a	59.4
Depo-Provera	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
Norplant	n/a	n/a	n/a	31	40	21	19	23	n/a	n/a	26.8
Condoms	n/a	n/a	n/a	3	3	4	6	6	n/a	n/a	4.4
Adolescents											
Consultations	n/a	n/a	n/a	26	25	24	24	25	n/a	n/a	24.8
Condoms	n/a	n/a	n/a	10	5	6	8	6	n/a	n/a	7.0
Sexual and reproductive health (SSR) counseling											
Referring SSR	n/a	n/a	n/a	466	n/a	564	646	643	531	574	570.7
FP orientation	n/a	n/a	n/a	181	168	49	43	142	144	191	131.1
Training/participants											
TL doctors	No TL										

Source: SESPAS, FP Director, Santo Domingo, December 2001.

Table G5. Municipal Hospital Los Minas, contraceptive methods provided by month, January–October 2001

	Year 2001											
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Total	Av./mont
	Provid	Provid	Provid	Provid	Provid	Provid	Provid	Provid	Provid	Provid	Provid	Provid
FP methods provided and available by month												
Pills (cycles)	49	62	51	78	72	46	2	52	75	94	581	58.1
Minipills (cycles)	39	39	45	34	44	56	81	52	8	10	408	40.8
IUD (units)	18	22	25	21	29	18	29	0	0	7	169	16.9
Vaginal tablets (units)	90	40	80	72	115	45	45	140	170	30	827	82.7
Norplant (units)	0	0	0	0	0	0	0	0	0	0	0	0.0
Injectables (units)	9	7	14	5	8	13	12	31	41	45	185	18.5
Condoms (units)	395	668	712	434	312	568	755	396	240	626	5,106	510.6
Gel (tubes)	0	0	0	0	0	0	0	0	0	0	0	0.0
Other	0	0	0	0	0	0	0	0	0	0	0	0.0
TL	0	0	0	0	0	0	0	0	0	0	0	0.0
FP methods (Users per month)												
No data												
Adolescent FP												
Included with adult data												
Services												
No deliveries or major surgeries; referrals to Los Minas Maternity												

Source: Nurse in charge of FP and monthly registers for 2001, Santo Domingo, December 2001.

Table G6. Municipal Hospital Los Minas medical personnel, 2001

			Sex		Staff	
	Staff	24-hour services?	Male	Female	Activos	Licencia política
Director	1	No	1		1	
Subdirector	1	No	1		1	
Total nurses	35		0	35	28	7
Trained nurses	—	Yes	—			
Auxiliary nurses	—	Yes	—			
General practitioners	17	No	8	1	12	5
OB/GYNs	3	No	1	2	3	
Anesthesiologists		No				
Pediatricians	3	No	2	1	3	
Cardiologists	2	No	2		2	
Dermatologists	1	No	1		1	
Epidemiologists	1		1		1	
Endocrinologists	1		1		1	
Gastroenterologists	2	No	2		2	
Otorrinolaringologists	1		1		1	
Ophtalmologists	1		1		1	
Physiologists	1		1		1	
Psychiatrists	1	No	1		1	
Psychologists	1	No		1	1	
Odontologists	n/a	No				
Bioanalysts	n/a	No			n/a	
Delivery room		Yes				
Total	72		24	40	60	12
Total without nurses	37		24	5	32	5

Source: Interviews with administrative personnel, Santo Domingo, November 2001.

Table G7. Medical personnel from Municipal Hospitals Villa Duarte, Los Minas, Las Caobas, and Los Alcarrizos II, November 2001

Description	Villa Duarte	Los Minas	Las Caobas	Los Alcarrizos II
Director/OB/GYN	1	1	1 (intern)	1 (oncologist)
Subdirector/epidemiologist	1	1	1	1
Trained nurses	3	35 (incl. aux.)	24 (incl. aux.)	3
Auxiliary nurses	17		—	19
General practitioners	21	17	12	2
OB/GYNs	3	3	8	5
Pediatricians	3	3	6	4
Cardiologists	2	2	2	1
Psychologists	2	1	2	3
Odontologists	4	n/a	8	4
Anesthesiologists	0	0	0	3
Epidemiologists	1	1	2	0
Dermatologists	1	1	0	1
Gastroenterologists	2	2	0	1
Neurologists	0	0	1	0
Urologists	0	0	0	1
Endocrinologists	1	1	0	0
Surgeon general	0	0	0	4
Psychiatrists	0	1	1	1
Sex therapists	0	0	0	1
Orthopedists	0	0	0	1
Otorrinolaringologists	0	1	0	0
Physiologists	0	1	0	0
Ophtalmologists	1	1	0	0
Bioanalysts	6	n/a	8	5
Technicians (laboratory)	1		0	0
Pharmaceutical aides	2		n/a	n/a
Total	72	72	76	61
Total without nurses	52	37	52	39

Source: Interviews with administrative personnel, Santo Domingo, November 2001.

Appendix H

Recommendations from the Stakeholders' Dissemination Meeting, January 30, 2002

After presentations of the findings and a discussion, the plenary divided into three working groups, one for each strategic question. Each group met and brainstormed recommendations for ways to improve reproductive health in the DR.

MATERNAL HEALTH

The maternal health group comprised Victor Calderon, José Figueroa, Suellen Miller, Patricio Murgueytio, Carl Houk, Ricarda Peña, Sonia Aqauino, Oscar Suriel, and Magaly Caram.

Management Issues

- Revise and apply the regulations of the SESPAS hospitals.
- Improve the capacity of the lower levels and make appropriate referrals.
- Improve planning through the directors and hospital teams.
- Use the positive role models of the donors, NGOs, PROFAMILIA, and the examples in this report.
- Strengthen the institutionalization of the Committee of Maternal Mortality in each hospital, and at the provincial, municipal, and national level as well, in order for them to take necessary actions.
- Incorporate community and women's groups into the work of organizing and managing public and private maternity services.

Human Resources

- Provide for sensitization, humanization, and training of personnel.
- Apply the civil service laws.
- Apply sanctions for violations of the malpractice laws.
- Evaluate the payments to public and private providers.

Legislation

- Revise Law 60-97 in the form of contracts and payment to providers.
- Apply and evaluate the effects of Law 420.
- Apply Law 89-01.
- Legislate training, licensing, accreditation, and continuing education for physicians.
- Spread the information in this report to all levels of SESPAS, CERS, IDSS, CNSS, political parties, senators, journalists, investigators, and all means of communications.

Recommendations

- Emulate the private-sector system of payment for services.
- Make a formal presentation on these findings to AMD, ANDECLIP, and other physicians' organizations.
- Create a video with an executive summary to present data and testimonials regarding these findings.

Interventions

- Implement a system of monitoring and evaluation to assure application of the SESPAS norms.
- Establish accreditation system that includes sensitization to human rights.
- Establish a system, as in Barahona, to reduce directly maternal deaths.

FAMILY PLANNING

Members of the family planning group included: Dr. Villanueva, Juan Díaz, Ana Julia Hernández, Elba Mercado, Mélida Núñez, Ramón Portes, Irmela Riedberger, Luz Mercedes, Indiana Barinas, Maite Hernandez, Argelia Tejada, and Gianna Sangiovanni.

Recommendations

Short-term/relatively inexpensive

- Design transitional strategies to cover the time between the international donations of contraceptives (logistics and financing) and sustainability.
- Redefine and position reproductive health attention at all levels; it is necessary to raise the level of maternal and infant health and include it as well in reproductive health. Reproductive health is not only family planning; position family planning solidly within reproductive health.

Medium-term/medium cost

- Conduct a training needs assessment of personnel in family planning and in the family planning norms.
- Design a training plan based on the assessment.
- Design and implement an IEC and social marketing scheme for family planning.

Long-range/expensive

- Develop plans for sustainable and widespread method mix.
- Develop training for all personnel in schools and universities in sexual and reproductive health.

Interventions

- USAID, develop a transition plan and training in the norms; he high cost of contraceptives is lower than the cost of abortions.
- Guarantee plan that women can obtain services at low cost.

ADOLESCENTS

The adolescents' group comprised Dr. Matos, Sonia Brito, David Losk, Norma Paredes, Jhonny Díaz, Nancy Vásquez, Betania Betances, Wilme Vargas, Hector Rodriguez, Tito Coleman, Leda Herasme, and Gladys Caraballo.

Recommendations

- Strengthen the work of PARES.
- Articulate programs with schools, NGOs, and hospitals.

- Obtain participation from community leaders and coordinate with community multipliers.
- Include adolescents as active participants in IEC activities.
- Without social embarrassment, include pregnant adolescents in school programs.
- Strengthen technical education programs so that adolescents can get the preparation necessary to find work.
- Develop a permanent form for IEC activities for adolescents and pregnant mothers to prevent second pregnancy.
- Strengthen the educational curriculum on sexuality in all levels of schools and coordinate with SESPAS and civil society in raising the level and quality of education and information.

Interventions

- Implement monitoring, evaluation, and a system of following lapses.
- Increase work with adolescent partners.
- Investigate with youth who state that their parents and teachers do not know about sexual and reproductive health.
- Augment the findings of this assessment with other studies that have been done so that the findings are more complete.