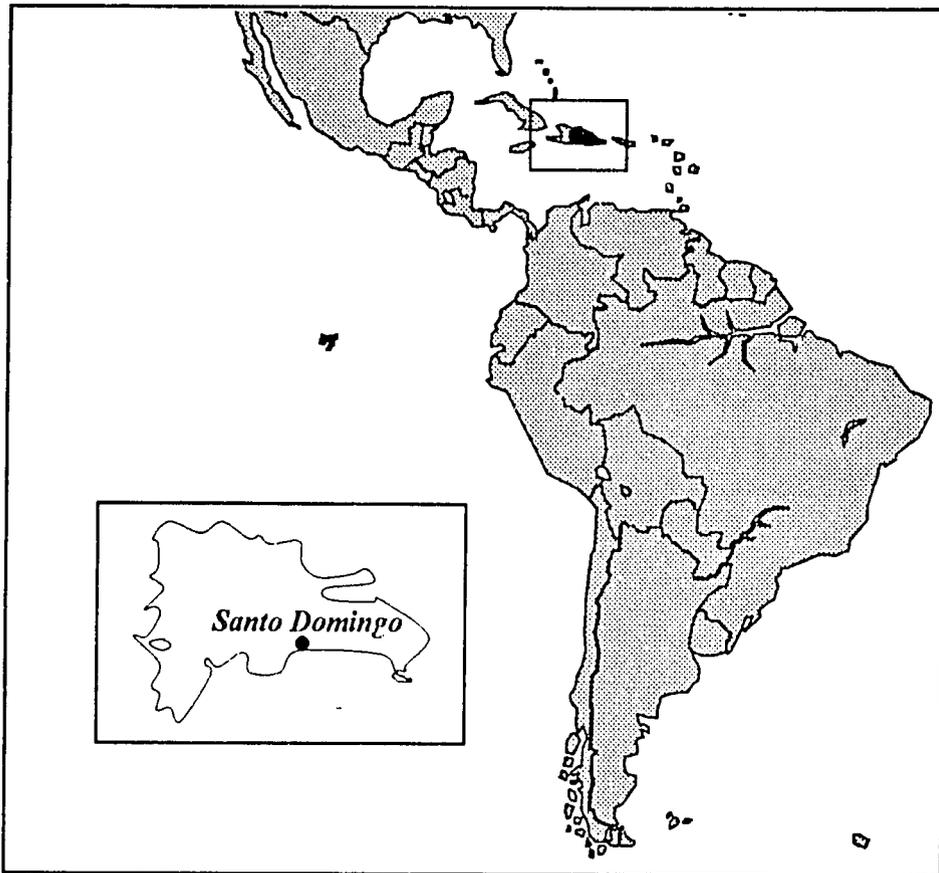


*A USAID Health Profile*

# **DOMINICAN REPUBLIC**

## **Health Situation & USAID Health Projects Descriptions 1993**



Center for International Health Information / ISTI  
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**The Center for International Health Information (CIHI), a division of International Science and Technology Institute (ISTI), operates the USAID Health Information System under the Child Survival Action Program-Support project, #936-5951.13, contract number DPE 5951-Z-00-8004-00 with the Office of Health, Bureau for Research and Development, U.S. Agency for International Development (USAID).**

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# DOMINICAN REPUBLIC

## USAID Health Profile

**T**his is one of a series of USAID Health Profiles produced by the Center for International Health Information/ISTI (CIHI). Each profile contains descriptive information, tables, and graphs about the country's health and demographic conditions, health indicators and trends, and the health care system when available. The profile also provides an overview of USAID health assistance and descriptions of USAID-supported health activities. Profile information is compiled from CIHI's databases and reference library, as well as through analysis from additional data sources and reports.

The profiles are intended to provide current and trend data in a concise format to policy makers, consultants, evaluation teams, and other interested individuals and organizations. They are not intended to provide a comprehensive description of the total health sector of a country. Contact CIHI for information on the availability of other health profiles and standard reports.

This profile contains national level health and demographic statistics available in CIHI's databases as of the date noted in each section. In order to enable CIHI to report the most current health and demographic statistics, please provide any more recent or more accurate data by contacting the center at the address on the previous pages or through USAID, Bureau for Research and Development, Office of Health.

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## I: COUNTRY OVERVIEW

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The Dominican Republic is the largest and most populous democratic nation in the Caribbean. The country is divided into three regions -- the Southwest, the Southeast and Cibao -- and seven subregions, which in turn make up 29 provinces and the national district of Santo Domingo.(PAH9002)\* A generally mountainous land, the country's most fertile area is the north-central region where rice, corn and coffee are produced. Predominantly populated with people of mixed European and African ancestry, the Dominican Republic also has small groups of European minorities.(GRI9301)

The island of Hispaniola, now shared by the Dominican Republic and Haiti, was colonized for several centuries by French and Spanish settlers. The Republic of Haiti was formed in 1804 and in 1822 it conquered the entire island. Haiti maintained control of Hispaniola until the Dominican Republic achieved its independence in 1844.(GRI9301) The century that followed brought military coups, foreign intervention and almost complete bankruptcy. In 1930, Rafael Trujillo took power and maintained absolute political and military control until his assassination in 1961.(LAC9301)

After five years of internal political struggle following Trujillo's death, democracy was established in the Dominican Republic in 1966 with the election of President Joaquin Balaguer and the framing of a constitution. Since then, the country has had a stable multiparty political system with national elections held every four years.(GRI9301) The national powers are divided among the president, a bicameral congress and the supreme court with the president commanding the nation's military. President Balaguer served until 1978, when he was upset in the national election; he was subsequently re-elected in 1986 and currently remains in office.(PRB9202)

The Dominican Republic's economy has always depended on agriculture, especially the production and export of sugar.(LAC9301) However, tourism accounts for almost one billion dollars in annual earnings and now represents the country's main economic growth area. Despite this important growth, the Dominican Republic's economic strength reached a low point in 1990 due in part to high inflation. This had an adverse impact on the delivery of social services to people in need, particularly the poor. In addition, the use of privately provided services also declined because of the reduced ability of people to pay for them.(AID9108)

Since 1990, however, the government has confronted widespread shortages of consumer goods and increasing inflation by enacting several market-oriented reforms. These efforts include the renewed commitment of the Dominican government to pay off foreign and domestic debt. Economic reforms have lowered inflation from 100 percent in 1990 to a rate of seven percent in early 1993. With almost 4.5 million people now living in poverty, the Dominican Republic must still overcome its problem of unequal distribution of wealth among its citizens.(LAC9301) However, if recent economic reforms are given time to be effective and political stabilization remains, the Dominican Republic will continue to be a strong member of the Caribbean region.

\* Sources in this profile are referred to by a seven-digit code. Generally, the first three letters refer to an organization, agency, etc., and the first two numbers indicate the year of the publication or other source document. A complete list of sources appears at the end of the profile.

## II: HEALTH & DEMOGRAPHIC OVERVIEW

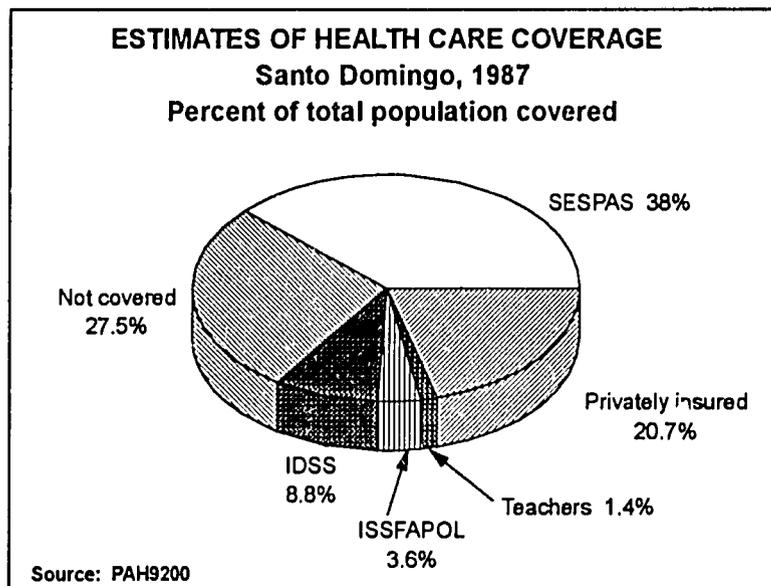
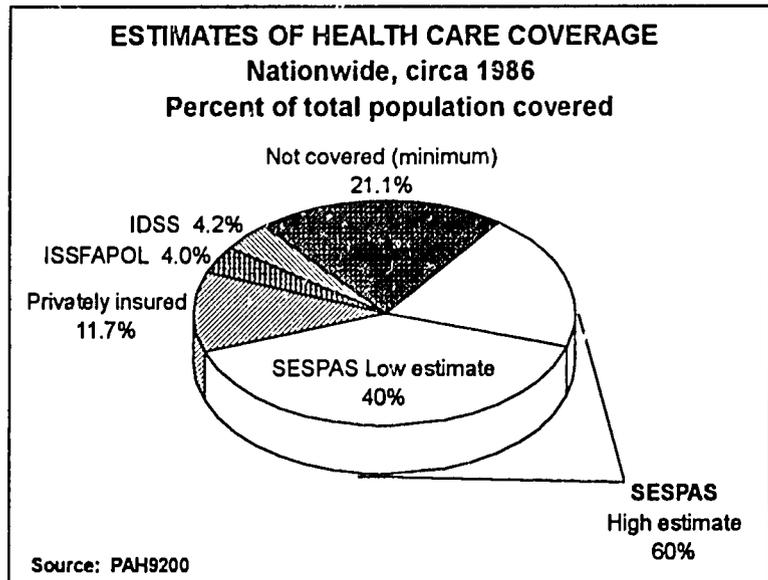
### Health Sector Description

OCTOBER 1993

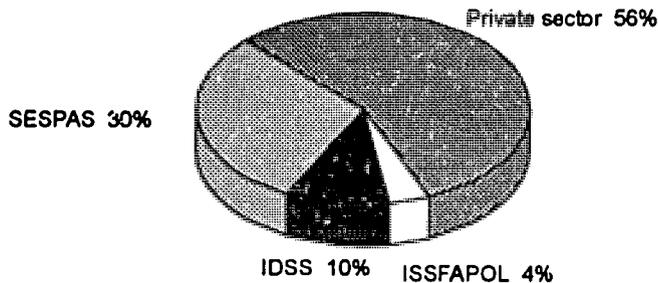
Health care in the Dominican Republic is provided primarily under the Ministry of Health (SESPAS) and in the private sector. The Dominican Social Security Institute (IDSS) and other social insurance funds offer services for only a very limited portion of the total population. The figures below illustrate recent estimates of each health care provider's share in covering the population's health needs. A recent assessment by the Pan-American Health Organization (PAHO) cited lack of coordination among major providers and minimal regulation of the private sector as two critical shortcomings of the Dominican health care system. (PAH9200)

Health resources and insurance coverage are concentrated in Santo Domingo, which in 1987 comprised 27 percent of the national population but had 55 percent of IDSS insured, 40 percent of SESPAS hospital beds, 40 percent of SESPAS hospital beds, more than half of each agency's physicians, 64 percent of private clinical beds and 69 percent of private physicians. Still, over one-quarter of the capital's population lacked coverage through SESPAS or public and private health plans. (PAH9200)

National estimates of the uninsured who lack access to public health facilities range from a very conservative 20 percent to a more realistic 40 percent (for 1986). (PAH9200) While households across income levels have displayed a clear preference for private care, (LAC8900) the diverse for-profit sector is a costly alternative for the nation's poor. In the figure on the following page, the results of a 1987 survey conducted under USAID's Health Care Financing in Latin America and the Caribbean (HCF/



**UTILIZATION OF HEALTH SERVICES IN SANTO DOMINGO**  
Outpatient visitors to doctors, by provider, 1987



Source: LAC8900 HCF/LAC Household Survey

LAC) project give an indication of health service utilization patterns in Santo Domingo.

### Public Sector

The Secretary of Public Health and Social Assistance (SESPAS) is mandated to provide free health care for all uninsured Dominicans but lacks the resources required to fulfill such a duty. Although the uninsured represent roughly 80 percent of the national population, estimates of real coverage by SESPAS for the late 1980s range from 40 to 60 percent of

the population. SESPAS hospitals, subcenters and clinics offer chiefly curative care, though recent programs have introduced some preventive and primary health care for rural and marginal urban populations. PAHO's recent health sector assessment found inefficiency and lack of adequate supplies to be chronic problems at all three types of facilities. (PAH9200) Deteriorating facilities and doctors' strikes are thought to have significantly reduced utilization of SESPAS services since 1987. (LAC9000)

A separate public agency, the Program of Essential Medicines, was created in 1984 to provide SESPAS facilities and "popular" pharmacies with low-cost medicines. It is currently the largest supplier of medicines to the public sector, but it has received harsh criticism for administrative inefficiency and excessive profits, among other charges. (PAH9200)

### Social Security Institutes (IDSS, ISSFAPOL)

The IDSS (Instituto Dominicano de Seguros Sociales) administers sickness-maternity and work injury programs in addition to providing benefits to affiliates for old age, invalidity and death. In 1986, IDSS covered the health needs of only roughly four percent of the national population, the lowest coverage level of all major social insurance funds in the LAC region, according to a study conducted by the World Bank. (WBK9000) IDSS coverage in the city of Santo Domingo has been estimated at 8.8 percent for 1986. The sickness-maternity program provides predominantly curative care for blue collar and lesser-paid white collar workers in the private sector. While IDSS may legally provide services through private clinics under contract, practically all care is provided at its own facilities, which in 1985 included 16 hospitals, 22 polyclinics, and 122 outpatient consultation centers. (PAH9200) Dependent coverage is limited to maternity care only for spouses and one year of curative care only for children of insured women. (IDB9101)

The armed forces and police are covered by an independent institution (ISSFAPOL) which offers similar benefits, more liberal dependent coverage, and reportedly higher quality health care services. Coverage by ISSFAPOL for 1986 was estimated at four percent of the national population. (PAH9200)



### Private Sector

The 1987 household survey conducted in Santo Domingo by the HCF/LAC project found that 56 percent of outpatient visits to doctors took place at private facilities for patients across income levels. (LAC8900) Private health insurance covers roughly 10 percent of the national population, the majority in the form of “*iguales médicas*,” competitive organizations comparable to health maintenance organizations (HMOs) which for a monthly fee provide predominantly curative care to a half million members (primarily lower- and middle-income workers) and their dependents. (IDB9101, LAC8900) Most civil servants are covered by these private organizations with state financing; much of the organized labor force has access to private services through collective agreements. (PAH9200)

Traditional medicines and private voluntary organizations (PVOs) such as the Dominican Red Cross are frequently the only health care alternatives for the poor who cannot afford modern, private sector services. (PAH9200) A survey conducted in 1990 by the Pan-American Health Organization found 95 Dominican PVOs active in the health sector, half of which had been established in the 1980s. PVOs are most active in and around Santo Domingo and near the border with Haiti, most commonly offering community-based maternal and child health and family planning services. Two regional consortia of PVO, SESPAS and Peace Corps representatives, COSASO (Coordinadora de Salud del Suroeste) and CMI (Comité Materno-Infantil), have emerged to coordinate PVO health activities in two health regions located on the border with Haiti. (LAC9200)

## Health Situation Analysis

OCTOBER 1993

In recent decades, the Dominican Republic has experienced a continual population shift from rural to urban areas, particularly in the capital city of Santo Domingo and parts of the Puerto Plata province. Between 1960 and 1991, the percent of the total population living in urban areas doubled, growing from 30.3 percent in 1960 to 60.7 percent in 1991.(DHS9111) With this steady migration, rings of impoverished slums have emerged around urban centers.(PRB9202)

The 1991 Demographic and Health Survey (ENDESA-1991) indicates that in the past 10 years, infant mortality has declined by 35 percent, from 66 deaths per thousand live births in the 1977-81 period to 43 deaths during the years 1987-91. Similar declines are reported for neonatal deaths (during the first month of life) and post-neonatal deaths (between the end of the first month of life and the end of the first year), with rates falling by 33 and 36 percent, respectively. Nevertheless, neonatal mortality continues to account for 55 percent of all deaths in the first year of life, and for 40 percent of under-five deaths.(DHS9111)

Between the periods 1977-81 and 1987-91, under-five mortality fell from 82 to 60 deaths per thousand live births, largely due to the decline in infant mortality. However, under-five mortality rates in rural areas reached 84 deaths during the period 1981-91, compared to an urban rate of 47 deaths.(DHS9111)

After steady improvement in vaccination coverage from 1988 to 1990, with 1990 levels reaching 69 percent for DPT3, 90 percent for Polio3, and 96 percent for measles, rates have declined. Coverage rates in 1992 had dropped to 48 percent for DPT3, 53 percent for Polio3, and 75 percent for measles.(WHE9100, WHE9301)

Twenty-eight percent of children with diarrhea are treated with oral rehydration therapy (ORT); oral rehydration salts (ORS) packets are used more frequently than home solutions. Sixty-eight percent of children with diarrhea received neither ORT nor increased fluids, although 95 percent of mothers know of ORS packets and 66 percent have used them.(DHS9111)

Ten percent of children under five years of age are malnourished (low weight-for-age), with twice as many children malnourished in rural areas than urban areas. In the Elias Pina, San Juan, and Azua districts, one-quarter of children are malnourished, compared to 1 in 15 children in the national district and 1 in 11 children in neighboring southern and southwestern districts. Nationwide, 98 percent of children receive some breastfeeding, while only 9.5 percent of infants under four months of age are exclusively breastfed.(DHS9111)

Twenty-one percent of children had a respiratory infection in the two weeks preceding the ENDESA-1991; 43 percent of these children were taken to a health facility or health care provider.(DHS9111)

The Government of the Dominican Republic has finalized a national program of action to guide its efforts in achieving basic World Summit for Children goals.(UNI9312)



## Current Demographic and Health Indicators

OCTOBER 1993

Demographic Indicators			
INDICATOR	VALUE	YEAR	SOURCE
Total Population	7,617,000	1993	UNP9200
Urban Population	4,797,600	1991	DHS9111
Women Ages 15-49	1,931,600	1993	UNP9200
Infant Mortality	43	1989	DHS9111
Under 5 Mortality	60	1989	DHS9111
Maternal Mortality	300	1985	WHM9106
Life Expectancy At Birth	68	1993	UNP9200
Children Under Age 1	206,783	1993	CALXX01
Annual Infant Deaths	9,168	1993	CALXX01
Total Fertility Rate	3.3	1993	UNP9200

Child Survival Indicators			
INDICATOR	PERCENT	YEAR	SOURCE
Vaccination Coverage			
BCG	48	1992	WHE9301
DPT 3	48	1992	WHE9301
Measles	75	1992	WHE9301
Polio 3	53	1992	WHE9301
Tetanus 2	78	1991	DHS9111
DPT Drop Out	42	1991	DHS9111
Oral Rehydration Therapy			
ORS Access Rate	13.0	1989	WHD9100
ORS and/or RHF Use	28.7	1991	DHS9111
Contraceptive Prevalence			
Modern Methods (15-49 yrs.)	51.7	1991	DHS9111
All Methods (15-49 yrs.)	56.4	1991	DHS9111
Nutrition			
Adequate Nutritional Status	86.0	1991	DHS9111
Appropriate Infant Feeding	NA		
A) Exclusive Breastfeeding	9.5	1991	DHS9111
B) Complementary Feeding	23.1	1991	DHS9111
Continued Breastfeeding	29.0	1991	DHS9111

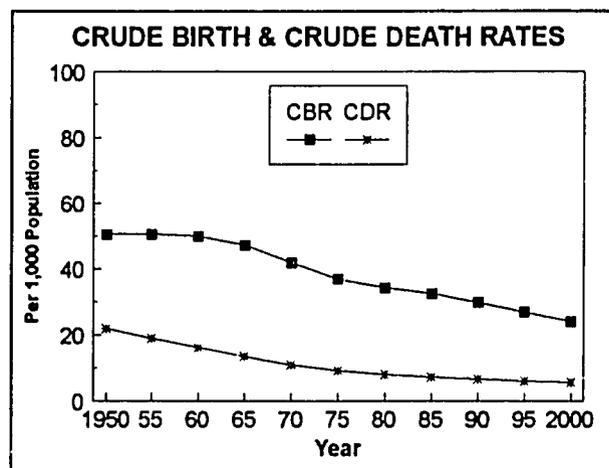
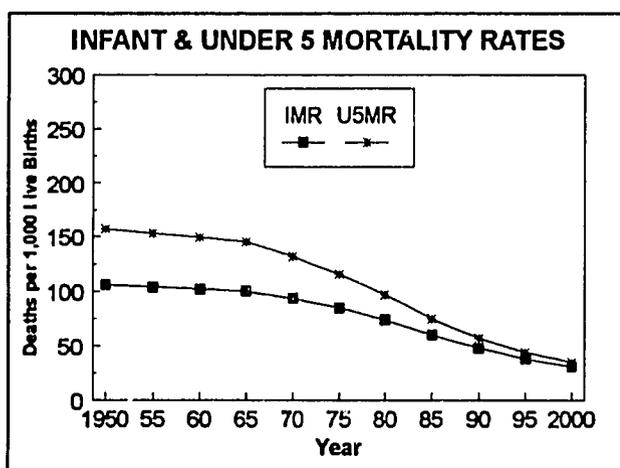
Other Health Indicators			
INDICATOR	PERCENT	YEAR	SOURCE
HIV-1 Seroprevalence			
Urban	1.30	1991	BUC9103
Rural	NA		
Access to Improved Water			
Urban	82.0	1990	WHO9200
Rural	45.0	1990	WHO9200
Access to Sanitation			
Urban	95.0	1990	WHO9200
Rural	75.0	1990	WHO9200
Deliveries/Trained Attendants	92.0	1991	DHS9111

NA = Not available

## Trends in Selected Demographic and Health Indicators

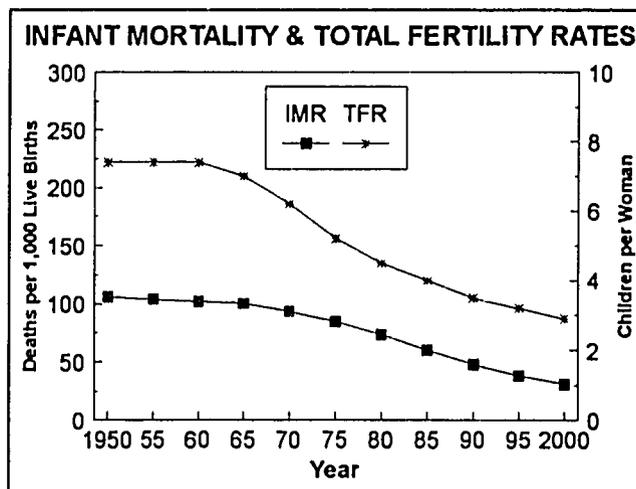
OCTOBER 1993

INDICATOR	1950	1955	1960	1965	1970	1975	1980	1985	1990	1995	2000	SOURCE
Infant Mortality	105.9	103.9	102.0	100.1	93.3	84.8	73.7	60.1	47.9	38.3	31.0	WBK9302
Under Five Mortality	157.6	153.5	149.6	145.7	132.0	115.7	96.6	75.1	57.2	44.2	34.8	WBK9302
Crude Birth Rate	50.5	50.5	49.9	47.1	41.8	36.8	34.2	32.4	29.8	26.8	24.0	UNP9200
Crude Death Rate	21.8	18.9	16.1	13.5	11.0	9.1	8.0	7.2	6.5	6.0	5.7	UNP9200
Avg. Annual Growth Rate	2.9	3.2	3.3	3.1	2.8	2.5	2.4	2.3	2.1	1.8	1.6	UNP9200
Total Fertility Rate	7.4	7.4	7.4	7.0	6.2	5.2	4.5	4.0	3.5	3.2	2.9	UNP9200



### IMR and TFR

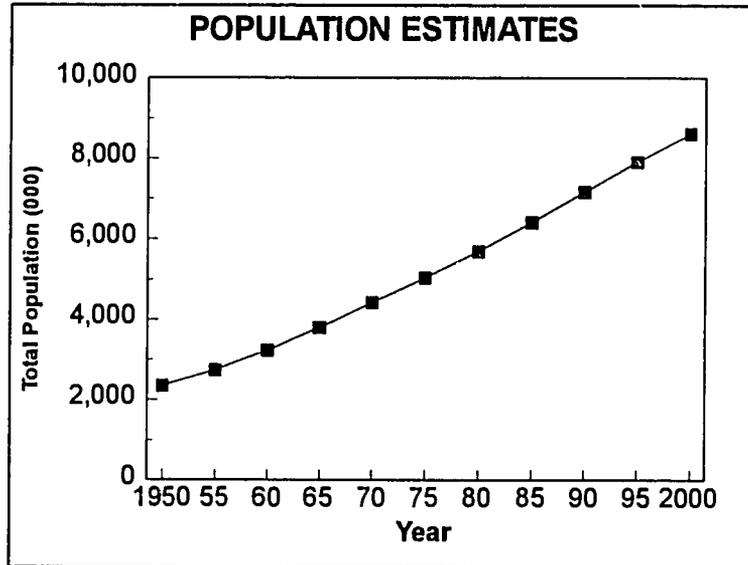
The relationship between IMR and TFR is currently a subject under review by the scientific community. While there is not conclusive evidence that the IMR and TFR are causally linked and necessarily decline together, there is empirical evidence for suspecting that such a reinforcing relationship exists as the pattern is observable in most countries.



## Population Estimates/Pyramid

OCTOBER 1993

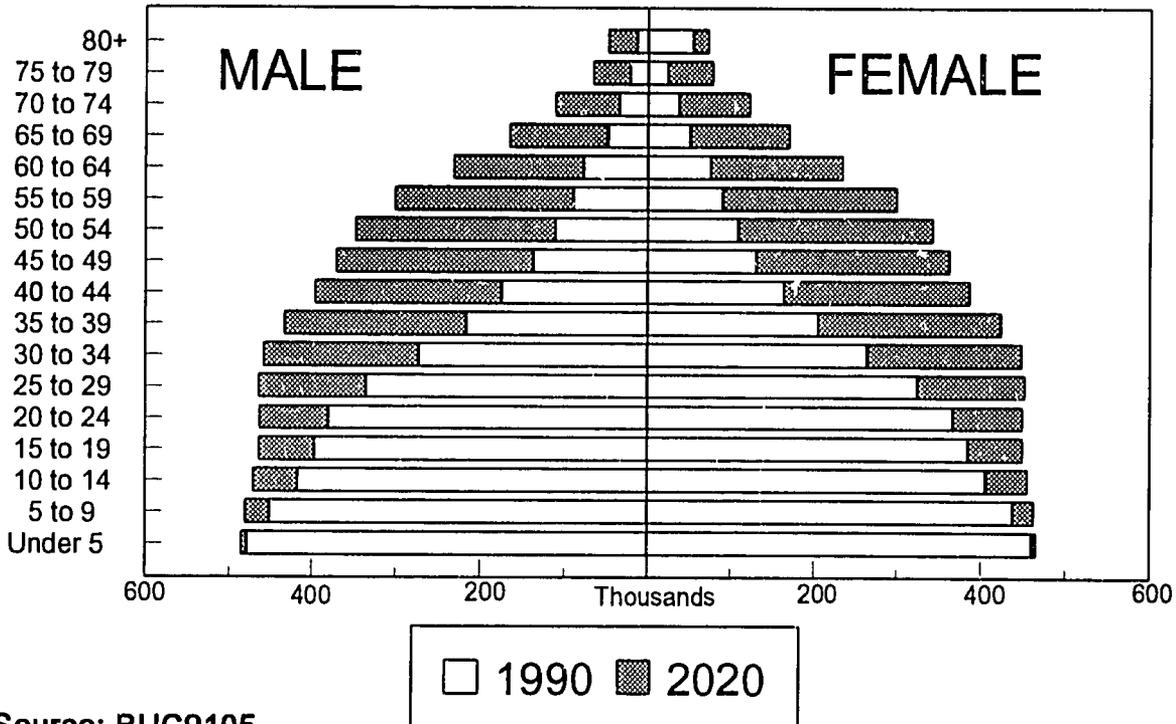
POPULATION ESTIMATES (000s)		
YEAR	VALUE	SOURCE
1950	2,353	UNP9200
1955	2,737	UNP9200
1960	3,231	UNP9200
1965	3,806	UNP9200
1970	4,423	UNP9200
1975	5,048	UNP9200
1980	5,697	UNP9200
1985	6,416	UNP9200
1990	7,170	UNP9200
1995	7,915	UNP9200
2000	8,621	UNP9200



## CURRENT & PROJECTED POPULATION

By Age & Gender: 1990 - 2020

Total Population 1990: 7,240,793 Total Population 2020: 11,439,054

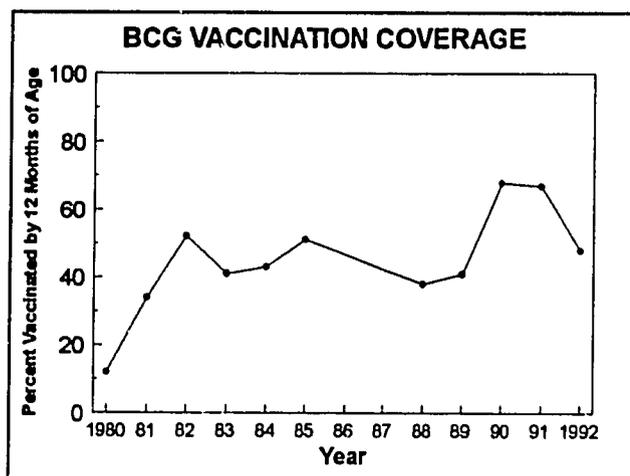


Source: BUC9105

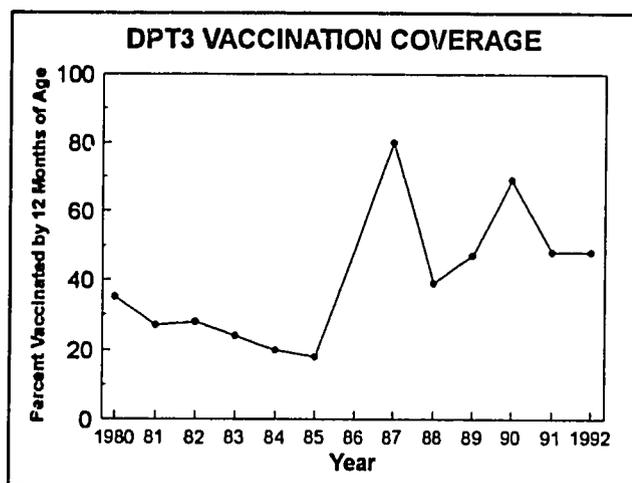
## Trends in Selected Health and Child Survival Indicators

### Vaccination Coverage Rates

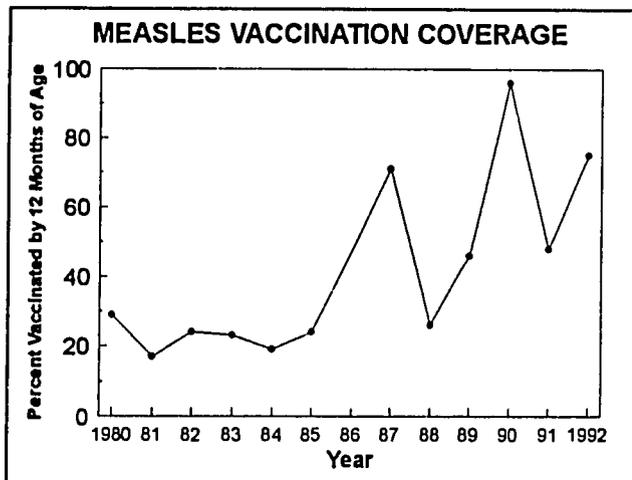
OCTOBER 1993



BCG COVERAGE		
YEAR	PERCENT	SOURCE
1980	12	WHE8700
1981	34	WHE8700
1982	52	WHE8700
1983	41	WHE8900
1984	43	WHE8700
1985	51	WHE8700
1986		
1987		
1988	38	WHE8900
1989	41	WHE9001
1990	68	WHE9100
1991	67	DHS9111
1992	48	WHE9301

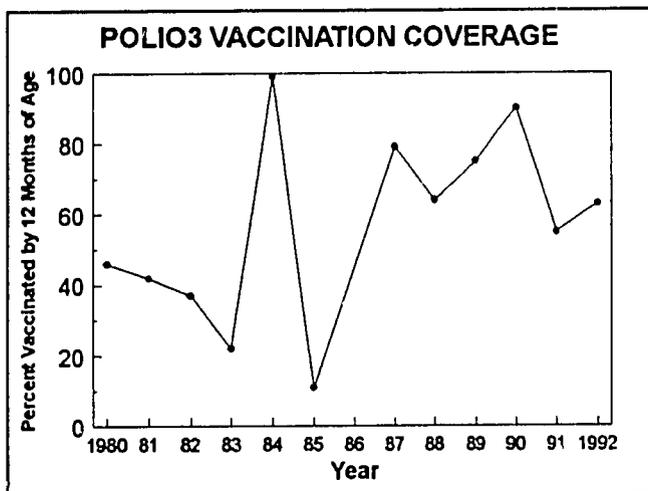


DPT3 COVERAGE		
YEAR	PERCENT	SOURCE
1980	35	WHE8700
1981	27	WHE8700
1982	29	WHE8700
1983	24	WHE8900
1984	20	WHE8700
1985	18	WHE8700
1986		
1987	80	WHE8900
1988	39	WHE8900
1989	47	WHE9001
1990	69	WHE9100
1991	48	DHS9111
1992	48	WHE9301

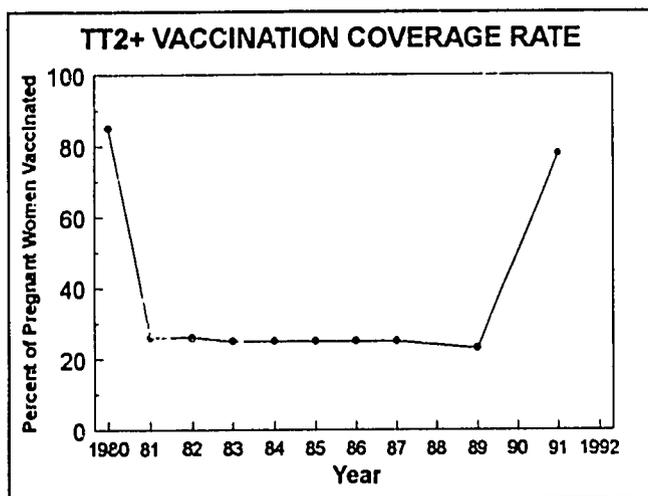


MEASLES COVERAGE		
YEAR	PERCENT	SOURCE
1980	29	WHE8700
1981	17	WHE8700
1982	24	WHE8700
1983	23	WHE8900
1984	19	WHE8700
1985	24	WHE8700
1986		
1987	71	WHE8900
1988	26	WHE8900
1989	46	WHE9001
1990	96	WHE9100
1991	48	DHS9111
1992	75	WHE9301

Vaccination Coverage Rates, continued



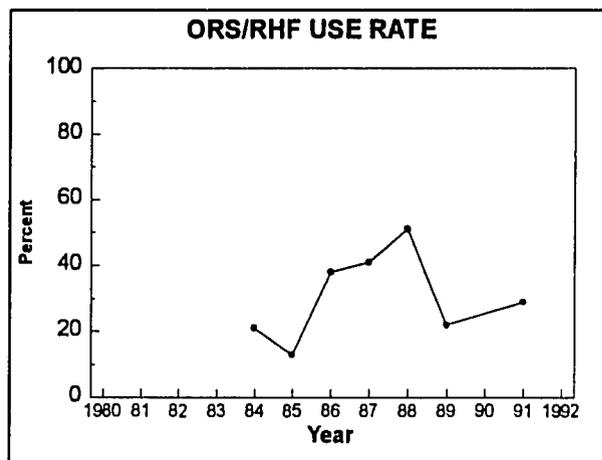
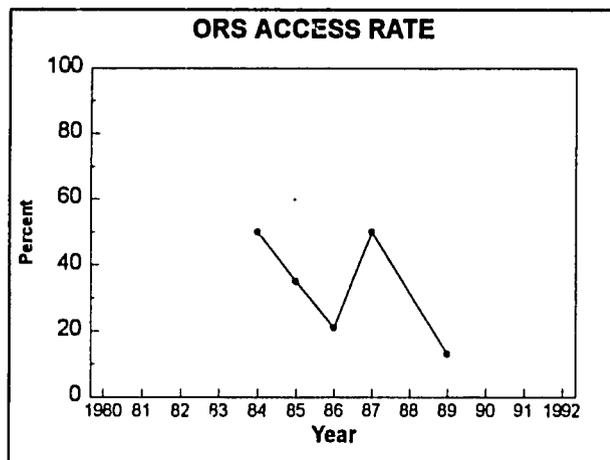
POLIO3 COVERAGE		
YEAR	PERCENT	SOURCE
1980	46	WHE8700
1981	42	WHE8700
1982	37	WHE8700
1983	22	WHE8900
1984	99	WHE8700
1985	11	WHE8801
1986		
1987	79	WHE8900
1988	64	WHE8900
1989	75	WHE9001
1990	90	WHE9100
1991	55	DHS9111
1992	63	WHE9301



TT2+ COVERAGE		
YEAR	PERCENT	SOURCE
1980	85	WHE8700
1981	26	WHE8700
1982	26	WHE8700
1983	25	WHE8700
1984	25	WHE8700
1985	25	WHE8700
1986	25	WHE8800
1987	25	WHE8900
1988		
1989	23	WHE9202
1990		
1991	78	DHS9111
1992		

### ORS Access, ORS and/or RHF Use Rates

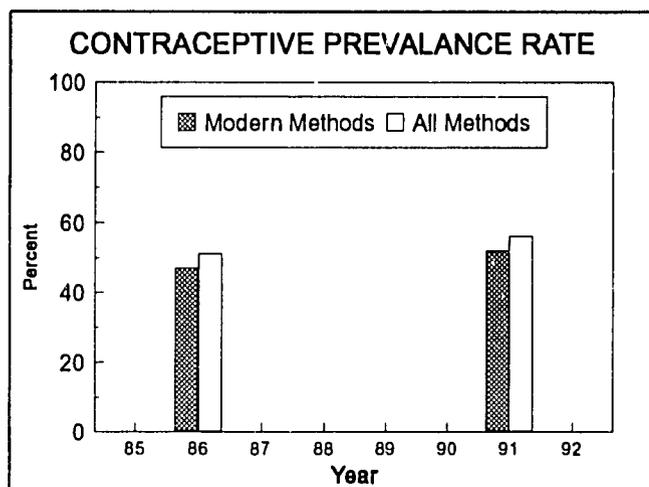
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INDICATOR	1984	1985	1986	1987	1988	1989	1990	1991	1992
ORS Access	50	35	21	50		13			
Source	WHD8601	WHD8700	WHD8800	WHD8900		WHD9100			
ORS/RHF Use	21	13	38	41	51	22		29	
Source	WHD8601	WHD8700	DHS8702	WHD8900	WHD9000	WHD9100		DHS9111	

### Contraceptive Prevalence Rate

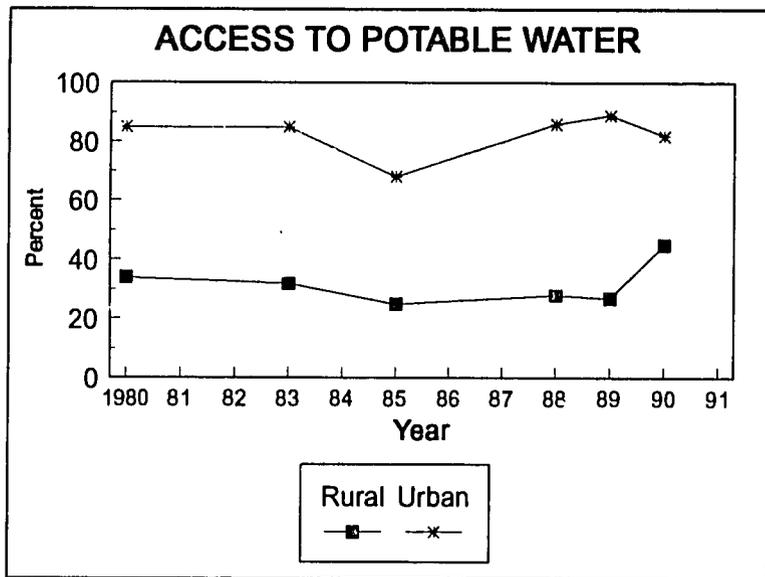
OCTOBER 1993



YEAR	MODERN METHODS	SOURCE	ALL METHODS	SOURCE
1985	47	DHS8702	51	DHS8702
1986				
1987				
1988				
1989				
1990				
1991	52	DHS9111	56	DHS9111
1992				

### Access to Potable Water

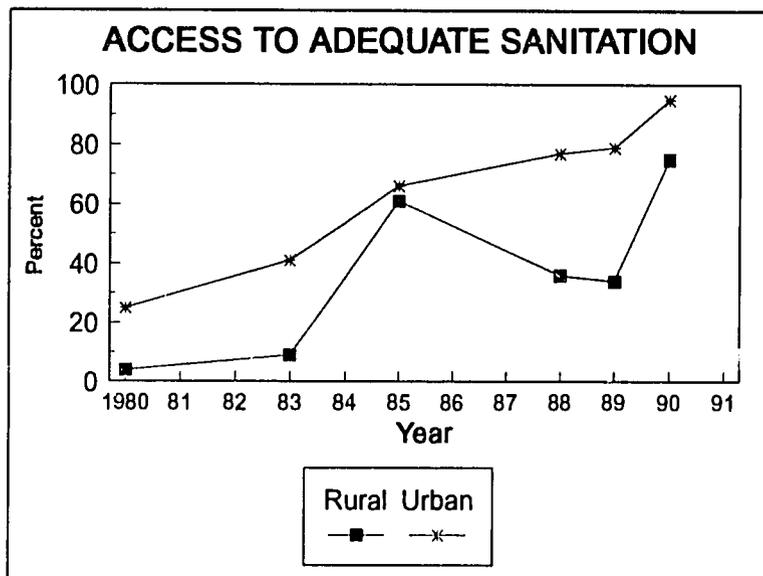
OCTOBER 1993



YEAR	RURAL SOURCE	URBAN SOURCE
1980	34 WHO9101	85 WHO9101
1981		
1982		
1983	32 WHO9101	85 WHO9101
1984		
1985	25 AID9201	68 AID9201
1986		
1987		
1988	28 WHO9101	86 WHO9101
1989	27 AID9201	89 AID9201
1990	45 WHO9200	82 WHO9200
1991		

### Access to Adequate Sanitation

OCTOBER 1993

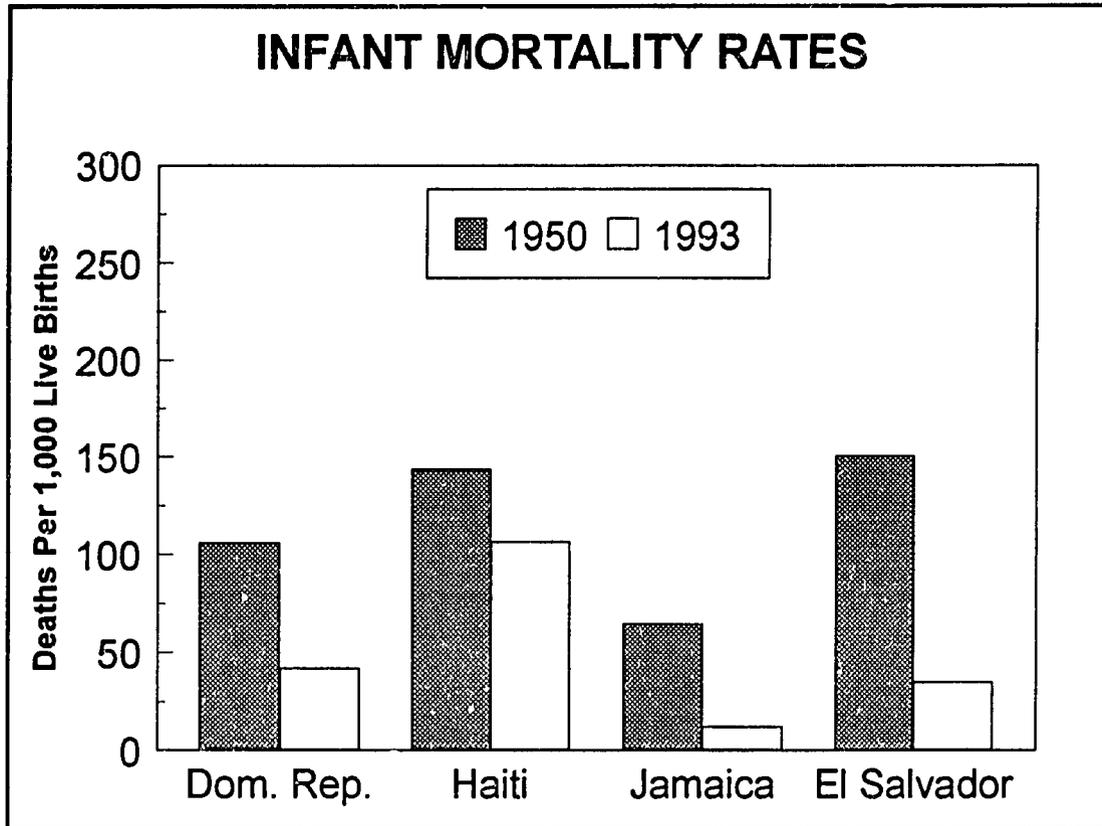


YEAR	RURAL SOURCE	URBAN SOURCE
1980	4 WHO9101	25 WHO9101
1981		
1982		
1983	9 WHO9101	41 WHO9101
1984		
1985	61 AID9201	66 AID9201
1986		
1987		
1988	36 WHO9101	77 WHO9101
1989	34 AID9201	79 AID9201
1990	75 WHO9200	95 WHO9200
1991		

COMPARATIVE INDICATORS

Comparative IMR Rates

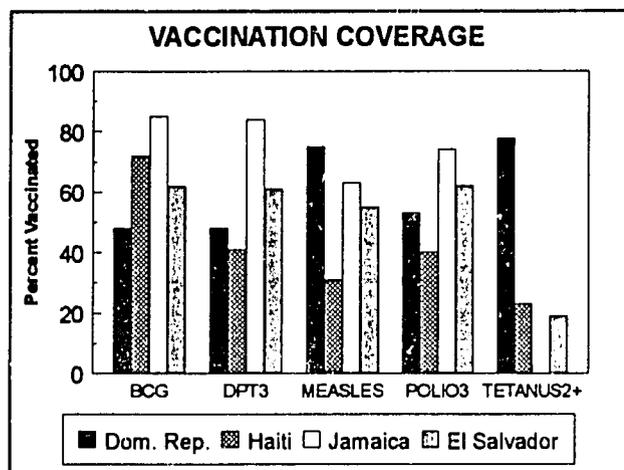
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COUNTRY	1950	SOURCE	1993	SOURCE
DOM. REP.	105.9	WBK9302	41.9	WBK9302
HAITI	143.4	WBK9302	106.6	WBK9302
JAMAICA	64.3	WBK9302	12.1	WBK9302
EL SALVADOR	150.4	WBK9302	34.8	WBK9302

### Comparative Vaccination Coverage Rates

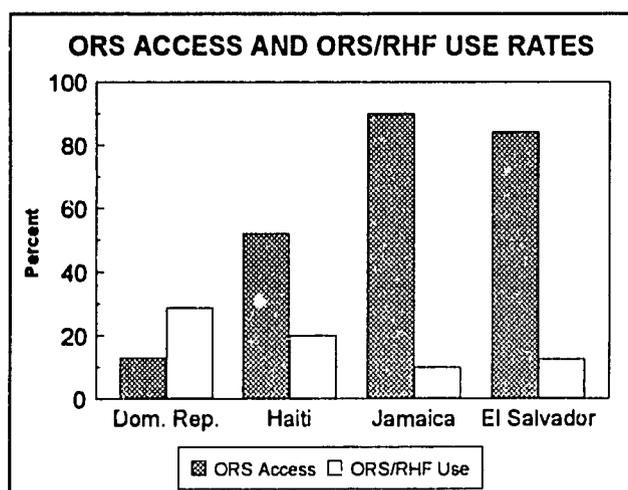
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COUNTRY	INDICATOR	YEAR	VALUE	SOURCE
DOMINICAN REPUBLIC	BCG	1992	48	WHE9301
	DPT 3	1992	48	WHE9301
	Measles	1992	75	WHE9301
	Polio 3	1992	53	WHE9301
	Tetanus 2	1991	78	DHS9111
HAITI	BCG	1990	72	WHE9100
	DPT 3	1990	41	WHE9100
	Measles	1990	31	WHE9100
	Polio 3	1990	40	WHE9100
	Tetanus 2	1988	23	WHE9000
JAMAICA	BCG	1992	85	WHE9301
	DPT 3	1992	84	WHE9301
	Measles	1992	63	WHE9301
	Polio 3	1992	74	WHE9301
	Tetanus 2			
EL SALVADOR	BCG	1992	62	WHE9301
	DPT 3	1992	61	WHE9301
	Measles	1992	55	WHE9301
	Polio 3	1992	62	WHE9301
	Tetanus 2	1989	19	WHE9001

### Comparative ORS Access, ORS and/or RHF Use Rates

OCTOBER 1993



COUNTRY	INDICATOR	YEAR	VALUE	SOURCE
DOMINICAN REPUBLIC	ORS Access	1989	13	WHD9100
REPUBLIC	ORS/RHF Use	1991	28.7	DHS9111
HAITI	ORS Access	1991	52	WHD9201
	ORS/RHF Use	1991	20	WHD9201
JAMAICA	ORS Access	1991	90	WHD9201
	ORS/RHF Use	1991	10	WHD9201
EL SALVADOR	ORS Access	1989	84	WHD9100
	ORS/RHF Use	1988	12.6	HHS8801

### III: HIV / AIDS

OCTOBER 1993

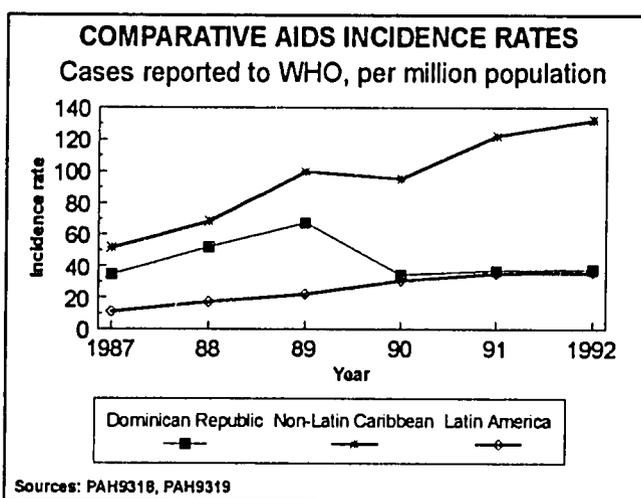
The information below is based on reports to WHO through June 30, 1993: (PAH9318)

Total reported AIDS cases	2060
Deaths attributed to AIDS	229
1992 Incidence rate (per 1 million population)	37.7
Male/female ratio (1992)	3.0:1
Pediatric cases	44 (2.1% of total)
Perinatal cases	21 (1.0% of total)

Since 1987, annual incidence rates for AIDS cases reported in the Dominican Republic have been relatively high for Latin America but remain below the average for the Caribbean region. Underreporting of actual cases has been estimated by the Ministry of Health (SESPAS) to be as high as 75 percent, largely due to a lack of systematic notification by doctors and laboratories and, since mid-1990, an acute shortage of materials for blood-testing. (PAH9201) SESPAS, which initiated a sentinel surveillance system in 1991, acknowledges that some underreporting continues and estimates a total of 50,000 HIV-carriers nationwide. (PAH9201)

Although the earliest AIDS cases were reported among homosexuals starting in 1983, within five years 70 percent of cases were reported to have resulted from heterosexual transmission. (AID0002) The greatest impact has occurred around Santo Domingo and Puerto Plata and in sugar-producing regions utilizing migrant labor. Increasing levels of HIV infection among women and children indicate that the epidemic has spread to the general population. While the non-Latin Caribbean (the Caribbean excluding Cuba, Haiti, the Dominican Republic and Puerto Rico) has just recently reached a ratio of less than two males for each female reported with AIDS, the Dominican Republic had a ratio of 1.9 in 1987 and stabilized around there through 1991, maintaining the lowest such ratio of any Spanish-speaking nation in Latin America. (PAH9301)

AIDS: New cases and incidence rates (PAH9318, PAH9319)				
Year	New cases	Comparative incidence rates (per million)		
		Dominican Republic	Non-Latin Caribbean	Latin America
1983	5	--	--	--
1984	8	--	--	--
1985	47	--	--	--
1986	70	--	--	--
1987	226	34.8	51.8	11.1
1988	357	52.0	68.6	17.4
1989	473	67.4	99.9	22.2
1990	248	34.6	95.4	30.8
1991	272	37.2	122.2	35.3
1992	282	37.7	132.2	36.0





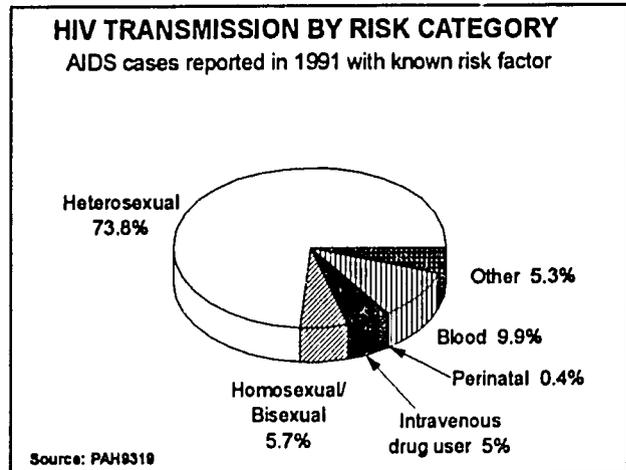
## National AIDS Control Program

(PAH9304)

**Programa de Control de Enfermedades de Trasmisión Sexual y SIDA (PROCETS)**, Secretario de Estado de Salud Pública (SESPAS), Santo Domingo.

Advised and guided by a multi-sectoral National AIDS Commission (CONASIDA), PROCETS has concentrated on improving screening of blood for HIV and establishing a sentinel surveillance system. Another priority, the collection and dissemination of AIDS information, has been facilitated through SESPAS' Centro Nacional de Comunicación Educativa para la Salud (CENACES). Other activities include intervention programs among high-risk groups in Santo Domingo and Puerto Plata and mass media campaigns for the general population. Integrated health care needs of persons affected by HIV and AIDS are to be addressed by a special reference and training center in Santo Domingo, a project that commenced in mid-1992.

USAID, through the AIDSCAP project, plans to continue support for the health ministry's sentinel surveillance system and quality control programs for blood banks and laboratories.



**HIV-1 Seroprevalence from selected studies (BUC9301)**

Population sampled	Sex	Year	% HIV-positive	Sample size
Prostitutes at STD Clinic, Santo Domingo	F	1987-89	2.60%	3,000
Blood Donors, Location Unspecified (LU)	B	1988	0.60%	20,444
Blood Donors (LU)	B	1989	0.80%	18,560
Sugar Cane Workers	B	1990	9.30%	397
Pregnant Women, Santo Domingo	F	1991	1.25%	400
Pregnant Women (LU)	F	1992	0.80%	1,056
STD Clinic Patients (Private)	B	1992	4.00%	867
STD Clinic Patients (Public)	B	1992	5.00%	818
Prostitutes at STD clinics (LU)	F	1992	3.40%	265

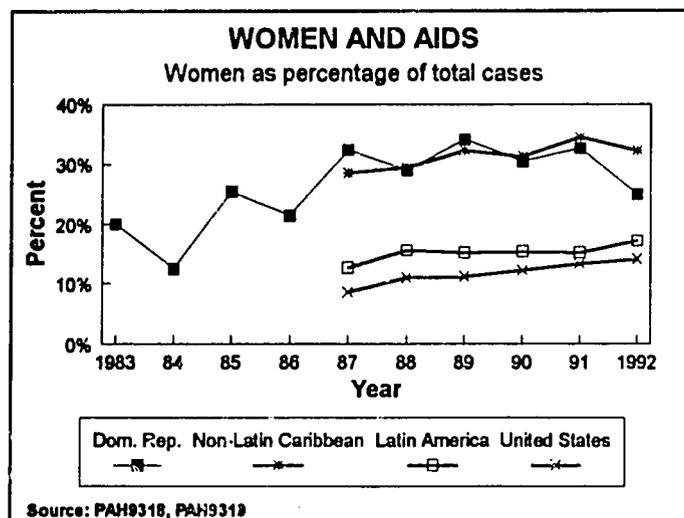
## Local Non-Governmental Organizations with AIDS Activities

(AID0003, IPP9300, AID0002, PAH0001, PAN9100)

**ADOPLAFAM (Asociación Dominicana de Planificación Familiar)** offers HIV/AIDS education and prevention services with its community-based family planning program.

**ASA (Amigos Siempre Amigos)** has promoted peer education among gay and bisexual men in four cities and conducted outreach, training and condom distribution activities to prevent the spread of HIV/AIDS. ASA collaborates with COIN in supporting peer education activities of the "Avancemos" group.

**Association of Blood Banks** has worked to improve blood screening and contributed to AIDS communications activities.



Year	Dom. Rep.	Non-Latin Caribbean	Latin America	United States
1983	20.0%			
1984	12.5%			
1985	25.5%			
1986	21.5%			
1987	32.4%	8.6%	12.7%	
1988	29.0%	11.0%	15.6%	
1989	34.1%	12.2%	15.2%	
1990	30.5%	14.1%	15.4%	
1991	32.7%	17.2%	15.2%	13.3%
1992	25.0%	17.2%	17.2%	14.1%

**CASCO (Coordinadora de Animación Sociocultural)** conducts AIDS awareness outreach for youth and trains community health messengers in Santo Domingo. CASCO also participated in intervention research supported by USAID's AIDSCOM Project in Haina.

**COIN (Centro de Orientación e Investigación Integral)** has conducted research, outreach and training activities and provided logistical support to other NGOs combatting HIV/AIDS. Peer education projects in several cities include the "Avancemos" group, which has trained hundreds of "health messengers" for outreach, education and condom distribution in Santo Domingo, Puerto Plata, Santiago, and La Romana.

**COVICOSIDA (Comité de Vigilancia y Control del SIDA)**, a local AIDS control committee in Puerto Plata, conducts AIDS prevention activities targeting high-risk groups.

**FUCES (Fundación Cultural y Educativa para el Salud)** promotes AIDS awareness throughout the Dominican Republic through drama performances followed by discussion sessions for youth and community volunteers.

**Free Trade Industrial Association** has collaborated with COIN in AIDS prevention activities targeting male and female factory workers in Haina.

**ID (Dermatologic Institute)** has collaborated with COVICOSIDA, COIN and the health ministry in AIDS prevention activities targeting commercial sex workers and their clients in Puerto Plata.

**IDDI (Dominican Institute for Integral Development)** integrates HIV/STD prevention into a broader urban community-based development program. A special intervention project in two marginal neighborhoods in Santo Domingo involves training of volunteer educators, developing educational materials and establishing information and condom distribution points.

**INSAPEC (Instituto APEC de Educación Sexual)** has provided counselling and counselor training, conducted research, and supported HIV/AIDS education efforts in Santo Domingo.

**PLUS (Patronato de Lucha contra el SIDA)** is a group of professionals and technical specialists formed to promote HIV/AIDS awareness and to organize AIDS prevention groups. PLUS has facilitated technical and financial support for community groups and medical researchers, offered



emotional support programs for HIV-positive patients and their families, and established condom distribution sites and a country-wide, community-based AIDS information and referral network for young adults. PLUS volunteers have conducted outreach and promoted peer education among adolescents, commercial sex workers, and the general population.

**PROFAMILIA (Asociación Dominicana Pro Bienestar de la Familia)**, an IPPF affiliate, runs a community-based family planning program offering services to help prevent HIV/AIDS and other sexually-transmitted diseases.

### **International NGOs with AIDS activities in the Dominican Republic**

(NCI9201,IPP9300)

American Red Cross  
Center for Population Options  
Christian Children's Fund  
International Planned Parenthood Federation (IPPF)  
St. Clare's Hospital and Health Center

### **International Donors supporting AIDS activities in the Dominican Republic**

(PAH9201,UNF9200)

Canadian International Development Agency (CIDA)  
European Economic Community (EEC)  
Pan-American Health Organization (PAHO)  
United Nations Population Fund (UNFPA)  
United States Agency for International Development (USAID)  
World Health Organization, Global Programme on AIDS (WHO/GPA)

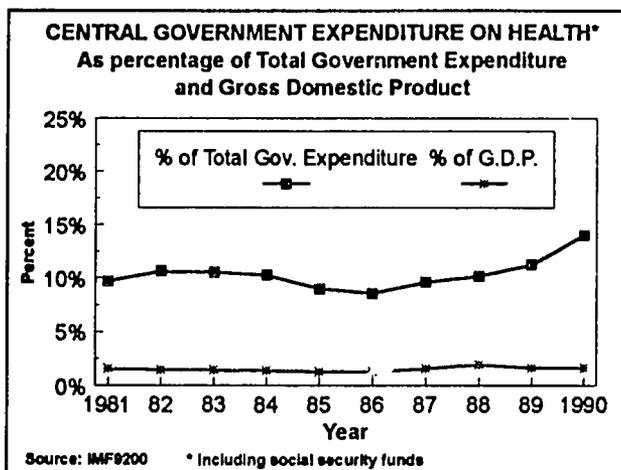
## IV: HEALTH CARE FINANCING

OCTOBER 1993

According to the World Bank, total health expenditures in the Dominican Republic accounted for 3.7 percent of the gross domestic product (GDP) in 1990, one of the lower levels of health spending relative to GDP in the Latin America and Caribbean (LAC) region. This expenditure amounted to about \$37 per person, just below the estimated \$41 per-capita spent on health in developing nations in 1990. Public expenditures on health, including those under the social security system, accounted for roughly 57 percent of total spending with private outlays accounting for the remaining 43 percent. Official foreign aid flows (included under public expenditures) amounted to an estimated four percent of total health expenditure in 1990.(WBK9303)

### Public Sector

During the past decade, the Secretary of Public Health and Social Assistance (SESPAS) received just 53 percent of non-private health revenues to cover, in theory, 91 percent of the population not using the private sector.(IDB9101) The capacity of SESPAS to fulfill this ambitious mandate was reduced by decreasing central



government health allocations in the economic crisis of the 1980s. (See figure at left) After a 50 percent cut in per-capita government spending on health between 1981 and 1984, SESPAS maintained its personnel budget but sharply reduced capital expenditures.(PAH9200)

The central government provides between 74 and 95 percent of the SESPAS budget, with the remainder coming from user fees and international aid and loans.(PAH9200) The latter source has been less significant since the late 1980s, when international donors began to channel more health sector funding through private voluntary organizations

(PVOs).(LAC9200) Although user fees are prohibited for inpatient care, a consultant with USAID's Resources for Child Health (REACH) project found that all SESPAS facilities studied charged various fees for outpatient care and estimated user fee revenues to cover 20 percent of hospitals' operating expenses in 1987, representing the most important financing source for non-personnel expenses.(LAC8700)

EXPENDITURES ON HEALTH As percent of:		
Year	Total Gov. Expenditure	G.D.P.
1981	9.70%	1.57%
1982	10.66%	1.44%
1983	10.55%	1.47%
1984	10.29%	1.38%
1985	8.99%	1.27%
1986	8.54%	1.28%
1987	9.62%	1.58%
1988	10.20%	1.93%
1989	11.28%	1.64%
1990	14.03%	1.63%

A survey by USAID's Health Care Financing in Latin America and the Caribbean (HCF/LAC) project found that 10 percent of SESPAS patients (including inpatients) in Santo Domingo paid for services and that increased fees could raise revenues without significantly decreasing coverage.(LAC8700) Various studies indicate that increased user fees could

not only raise the quality of public health care in some circumstances, but also facilitate increased levels of coverage for the poor, many of whom already pay far more for private health care.(PAH9200)



## Social Security System

Social insurance institutes covered the health care needs of the remaining nine percent of the publicly-served population with 47 percent of non-private health revenues in the 1980s, according to the Inter-American Development Bank.(IDB9101) Combined IDSS programs are financed by one of the lowest levels of salary contribution for social security in the region, 14.5 percent in 1988 (9.5 percent from employers, 2.5 percent from the insured, and 2.5 percent from the state, though the latter has consistently reneged on its obligation).(WBK9000,PAH9200) Imbalances in the sickness-maternity program, often covered through surpluses in the employment injury program, have commonly resulted in overall IDSS deficits.(PAH9200)

Several factors have contributed to the institute's financial woes and its inability to extend coverage to a larger segment of the population. Unusually low salary ceilings exclude civil servants and higher-income workers, depriving the institute of more substantial earnings.(PAH9200) Administrative costs have been among the highest in the LAC region (22 percent for 1983-86) and the institute's 1980s ratio of roughly one employee for each 50 insured was far and away the highest.(IDB9101) Cost recovery through user fees has also been limited. The HCF/LAC survey found that IDSS facilities regularly treat non-beneficiaries free of charge, for almost a third of outpatients surveyed were non-beneficiaries, 86 percent of whom were not charged for services rendered.(LAC8900)

## Private Sector

Private sector health care services are financed under both fee-for-service and considerable prepaid arrangements. Despite fees more than 50 percent higher than those charged by SESPAS, preference for private care is evident across all household income levels.(LAC8900) According to the Inter-American Development Bank, two-fifths of Santo Domingo's poor, theoretically covered by SESPAS, resort to private services which consume roughly 12 percent of their income.(IDB9101)

Coverage of low-income workers and their families through private health plans known as "*iguales médicas*" has been facilitated through employer contributions of 75 to 100 percent of the required premium. USAID has funded several studies of the possibility of expanding coverage to excluded groups, such as microenterprise employees, who do not qualify for existing "*iguales*" but could be incorporated through trade or credit associations.(LAC9000)

In the non-profit sector, most PVOs are 90 to 100 percent dependent on international donors for financing health care programs. Cost recovery through user fees can be a secondary source of income; direct support from the Dominican government is minimal, though SESPAS does provide medical staff for sexually-transmitted disease clinics operated by one PVO, the Centro de Orientación e Investigación Integral (COIN). The prospect of decreasing external support in the 1990s means that many PVOs must develop alternative financing sources to ensure their survival.(LAC9200)

# V: USAID PROJECT ASSISTANCE

## TIMELINE: USAID Activities Related to Health & Population

OCTOBER 1993

Project Information						Fiscal Year																	
Project #	Project Name	Life-of-Project	Begin FY	PACD		Pre 85	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	2000	
517-0000	Program Development and Support	*	1962	1993**																			
517-0050	Special Development Activities	*	1962	1992**																			
517-0107	Health And Nutrition Sector Development	\$5,487,000	1975	1981																			
517-9999	Private and Voluntary Organizations	*	1978	***																			
517-0120	Health Sector II	\$8,000,000	1979	1986																			
517-0153	Health Systems Management	\$2,769,000	1979	1990																			
517-0116	Institute for Population and Development Studies	\$405,000	1982	1986																			
517-0176	Primary Eye Care:OPG	\$415,000	1982	1984																			
517-0174	Health And Nutrition Education:OPG	\$495,000	1983	1988																			
517-0232	Rural Water:OPG to CARE	\$430,000	1985	1989																			

(Timeline continued on next page)

This chart contains USAID-funded projects active since 1980 known to contain a child survival, HIV/AIDS, other health, or population component. The Life-of-Project (LOP) column indicates total authorized funding planned for all project activities from the beginning until the conclusion of the project, and not an amount allocated to a specific project component. The project beginning year and project completion date (PACD) appear after the LOP. OPG is the abbreviation for Operational Program Grant. Please see Data Notes.

\* Total LOP is not available

\*\* Fiscal year of final obligation

\*\*\* Project is ongoing

Source: AID0000



Project Information					Fiscal Year																		
Project #	Project Name	Life-of-Project	Begin FY	PACD	Pre 85	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	2000	2001	
517-0229	Family Planning Services Expansion	\$6,950,000	1986	1992																			
517-0235	Vector Control	\$1,500,000	1986	1990																			
517-0216	Development Training (Nutrition and Population)	\$15,000,000	1986	1991																			
517-0242	Accelerated Immunization Program	\$705,000	1987	1991																			
517-0239	Child Survival	\$5,472,000	1987	1993																			
517-0256	AIDS Support	\$2,800,000	1988	1992																			
517-0247	PVO Co-Financing: OPG (Health and Nutrition)	\$9,500,000	1989	1995**																			
938-PLAN	Child Survival Grant to Foster Parents Plan	\$550,000	1989	1992																			
938-WVRD	FY91 Child Survival Grant to World Vision Relief & Dev.	\$225,000	1991	1994																			
517-0259	Family Planning and Health	\$30,000,000	1993	2001																			

# Fiscal Year Obligations for USAID-funded Projects Related to Health

OCTOBER 1993

Project #	Project Name	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92
517-0000	Program Development and Support	197	249	450	123	25	150	140	0
517-0050	Special Development Activities	0	0	0	0	0	13	0	0
517-0153	Health Systems Management	821	0	0	950	319	0	0	0
517-0232	OPG:CARE Rural Water	430	0	0	0	0	0	0	0
517-0235	Vector Control	0	1000	500	0	0	0	0	0
517-0239	OPG:Child Survival	0	0	2700	1310	642	0	745	255
517-0242	Accelerated Immunization Program	0	0	705	0	0	0	0	0
517-0247	OPG:PVO Co-Financing	0	0	0	0	2420	683	170	1281
517-0256	AIDS Support	0	0	0	300	700	950	850	0
938-PLAN	FY 89 Child Survival Grant to PLAN	0	0	0	0	550	0	0	0
938-WVRD	FY91 Child Survival Grant to WVRD	0	0	0	0	0	0	225	0
<b>Total:</b>		<b>\$1,448</b>	<b>\$1,249</b>	<b>\$4,355</b>	<b>\$2,683</b>	<b>\$4,656</b>	<b>\$1,796</b>	<b>\$2,130</b>	<b>\$1,536</b>

Funding is based on reported attributions for child survival, HIV/AIDS and other health activities from all funding accounts, except population account funding in FY 1985-91. FY 1985-92 funding figures are actual. Please see Data Notes.

Source: AID0000, AID9308

## USAID-Funded Health Projects Active During Fiscal Year 1992

OCTOBER 1993

Project #	Project Name	U.S. Contractor/Grantee
517-0000	Program Development and Support	Multiple Organizations
517-0050	Special Development Activities	Multiple Organizations
517-0239	Child Survival	Save the Children Federation, Ministry of Health, University Research Corporation
517-0247	OPG:PVO Co-Financing	Multiple Private Voluntary Organizations
517-0256	AIDS Support	Academy for Educational Development, Family Health International
938-PLAN	FY89 Child Survival Grant to PLAN	PLAN International (CHILDREACH)
938-WVRD	FY91 Child Survival Grant to WVRD	World Vision Relief and Development

Please see Data Notes.

Source: CIH0001

## Descriptions of USAID-Funded Child Survival, HIV/AIDS, and Other Health Projects

OCTOBER 1993

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### Bilateral Projects

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#### *No Longer Funded*

**Project Number:** 517-0239  
**Project Title:** Child Survival  
**Country:** Dominican Republic  
**Project Area:** Areas covered by private voluntary organization (PVO) grantees  
**Project Duration:** FY 1987 - 6/30/93  
**Implementing Organization(s):**  
**Host Country:** Secretaria de Estado de Salud Publica y Asistencia Social (SESPAS) and 11 local PVOs  
**U.S.:** University Research Corporation (URC), Plan International, CARE, World Vision Relief and Development

#### **Project Overview:**

The Child Survival project sought to expand child survival services in the southwest of the Dominican Republic and the urban barrios of Santo Domingo. Originally implemented by Save the Children Federation, the project supported child survival service delivery by the public sector -- SESPAS -- and through grants to U.S. and indigenous private voluntary organizations (PVOs).

Basic child survival services were provided by community health promoters. Through a system of monthly home visits, each health promoter taught families about child survival interventions and made referrals for serious problems. Health promoter services included growth monitoring and nutrition education; providing families with packets of oral rehydration salts and teaching them how to prepare and use them; and teaching families the value of birth spacing, breastfeeding, and vaccination.

The Child Survival project also supported service improvement activities for SESPAS's health service centers including hospitals, clinics, supplementary feeding posts, and participating PVOs. The areas for service improvement included

- strengthening health care planning, training methods, and management information systems;
- upgrading supervision of the health promoters by establishing a supervisory system with worker performance goals for each level;
- conducting operations research;
- developing a mass media campaign; and
- implementing logistics support and health information systems to track progress at the family level (including family health records, vital events registers, and health promoters activity reports).

During an initial phase of the project, training and educational materials were developed that included a set of community volunteer health worker training modules, durable flip-charts on each of the intervention areas for home-visits, a diarrheal disease control poster, and a breastfeeding promotion pamphlet.

A February 21, 1991 project amendment narrowed the range of project activities and contracted with URC to provide technical assistance. The amended project served as a model integrated public/private child survival and health delivery system providing services in diarrheal disease control/oral rehydration therapy (ORT), vaccination, breastfeeding, and birth spacing promotion.



**Project Highlights:**

■ In 1992, the Child Survival project achieved notable advances. Data collected from one sample project area showed a 35 percent decline in the infant mortality rate in one of Dominican Republic's poorest urban barrios. The same data revealed that 78 percent of mothers were now exclusively breastfeeding their infants during the first four months of life. Prior to the project, exclusive breastfeeding was almost non-existent in the Dominican Republic.

■ The project finally worked with 12 local PVOs and two U.S. PVOs (which receive centrally funded child survival grants through the Bureau for Food and Humanitarian Assistance). Participating PVOs delivered services in approximately 250 communities. Coverage expanded much faster than expected because additional health promoters were recruited and trained. Over 42,000 families with 55,000 children under five years of age (115 percent of the end-of-project target) and 52,000 women of child-bearing age received services from volunteer community health promoters.

■ Using the newly developed training modules, the project trained over 8,000 persons including physicians, nurses, community health workers, traditional healers, community leaders, and mothers. Formal training in diarrheal disease control, birth spacing, and breastfeeding was extended to 1,500 health professionals, while informal training in subjects including hygiene, cholera prevention, AIDS prevention, community participation, supervision and monitoring was extended to nearly 7,000 people.

■ Activities were undertaken with significant local support that contribute to increasing the sustainability of the project:

\* A mass media campaign for diarrheal disease control/ORT was launched in June 1992. The launching ceremony was widely attended with guests including the Minister of Public Health as well as representatives from UNICEF and the Pan American Health Organization. Between June and September 1992, approximately RD\$4,417,940 (about US \$350,000) worth of television time was donated to the project from local television stations broadcasting campaign messages.

\* Several local groups expressed interest in financing some supplies and promotional materials for the project. Talks were begun to determine the extent of these donations.

\* The participating PVOs worked to organize a consortium of PVOs working in child survival in order to ensure that their activities would continue when the current project ended.

**Sources:**

AID0001, CAB9107, QUE9200

**No Longer Funded**

**Project Number:** 517-0256  
**Project Title:** AIDS Support  
**Country:** Dominican Republic  
**Project Area:** Santo Domingo, Haina, Puerto Plata, La Romana, the entire country (Mass Media Campaign)  
**Project Duration:** FY 1988 - 9/20/92  
**Implementing Organization(s):**  
**Host Country:** Ministry of Health - PROCETS, CONASIDA, COIN-ASA, COVICOSIDA, CASCO, FUCES, and other non-governmental organizations.  
**U.S.:** AIDS Technical Support Projects: AIDSCOM, AIDSTECH

**Project Overview:**

This four-year project was designed to assist in the development and implementation of appropriate interventions and activities to reduce the impact of the AIDS epidemic in the Dominican Republic. AIDSTECH and AIDSCOM provided technical assistance, and the project was implemented through PROCETS and a number of non-governmental organizations (NGOs). Major intervention areas included the prevention of sexual and blood supply transmission of AIDS, educational campaigns, and institutional development. The project also included research activities that allowed for the design of more effective interventions in the Dominican Republic which may have significant value internationally.

**Project Highlights:**

- The project recruited over 400 prostitutes to serve as peer educators for direct contact with 3,500 prostitutes and indirect contact with 10,000 prostitutes in Santo Domingo and Puerto Plata.
- A comic book was the centerpiece of the education program. This comic book empowered prostitutes with creative ways to counter client refusal to use condoms. Effectiveness studies showed a dramatic increase in knowledge of AIDS and condom use among the prostitutes. A second flipchart and comic book helped peer educators correct the misconceptions about sexually transmitted diseases and the importance of seeking diagnosis and treatment. The peer educators have also organized a theater group and performed skits in bars and entertainment establishments encouraging the use of condoms.
- A mass media campaign was designed for the general public while high-risk behavior target groups received specially designed health messages.
- Training modules were designed for adolescents and school counsellors.
- Peer education and condom promotion was a central activity targeting workers in the free trade zone and industrial zones and the sugar mill/port zone. Tourist hotels, the gay community, barrio neighborhoods and boy scouts were other groups targeted.
- Activities were carried out to prevent the spread of AIDS through blood transmissions. The project assessed the costs and resources needed to upgrade the safety of the national blood supply system. Collection and central storage of data from all blood banks and laboratories was begun. A computer simulation model enabling users to illustrate on a graphic map where resources are most needed will be presented to decision makers to promote cost-effective blood transfusion policies. In a related effort, PROCETS conducted a survey of existing transfusion practices. Results suggested the need for training in blood banking and laboratory quality assurance.
- Several lessons were learned through the project:
  - \* High-risk groups are identifiable and willing to participate in peer education and condom intervention programs.



\* There is a rich and diverse community of new PVOs in the Dominican Republic which have proved to be capable and innovative players in the AIDS prevention community.

\* Sexually transmitted diseases services remain a weak link in AIDS prevention strategy due to the instability of the public sector clinic network. There is a great potential for using existing public sector buildings to house privately managed services.

\* Behavior change regarding condom use can be achieved fairly effectively among the female population, but is severely limited by the male population's reluctance to use the condom. Effective preventive programs among males is the primary challenge of the next phase of the AIDS prevention program.

**Sources:**

AID9210, AID9211, QUE9200

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**Project Number:** 517-0247  
**Project Title:** PVO Co-Financing  
**Country:** Dominican Republic  
**Project Area:** Urban and rural subproject grantee areas  
**Project Duration:** FY 1989 - 96  
**Implementing Organization(s):**  
    **Host Country:** Local private voluntary organizations (PVOs)  
    **U.S.:** No organizations

**Project Overview:**

The PVO Co-Financing project provides about 35 subgrants to local PVOs to strengthen the delivery of selected services to the urban and rural poor. The project seeks to develop a PVO development fund financed with project funds, host country owned local currency generated under Public Law 480, Economic Support Funds, and PVO funds. The project is designed to include an administrative mechanism to undertake programming, subgrant development and design, pre-approval and review, as well as support to the USAID/Santo Domingo in budgeting, implementation monitoring, financial management (including auditing), and sub-grant closeout.

The project provides technical assistance and training to local PVOs in improving proposal presentation, project administration, and financial management. It is estimated that about 300,000 rural and urban poor will directly benefit from activities supported by the project.

**Project Highlights:**

■ To date, there have not been any health-related activities funded through this project. In 1992, however, the centrally funded Water and Sanitation for Health project field-tested its environmental guidelines for potable water and sanitation projects on three pending PVO water and sanitation proposals. Preliminary training on the use of guidelines was provided to interested PVOs.

**Sources:**

AID0001, AID9212, CAB9203

**Project Number:** 938-WVRD.12  
**Project Title:** FY91 Child Survival Grant to WVRD  
**Country:** Dominican Republic  
**Project Area:** 31 Communities in the Province of Barahona  
**Project Duration:** FY 1991 - 9/30/94  
**Implementing Organization(s):**  
    **Host Country:** World Vision Dominican Republic  
    **U.S.:** World Vision Relief and Development, Inc. (WVRD)

**Project Overview:**

WVRD forms partnerships with the Ministry of Health's regional offices, health centers, and communities to strengthen curative and preventive health services in order to reduce infant and child mortality. Thirty-one communities are targeted for assistance by FY 1994. The project finished its first year with service delivery to 15 underserved communities in the Barahona province, reaching a total of about 10,000 people.

Start-up activities dominated the project's first year, including the completion of a baseline survey, registration of families and priority groups, development of a health information system, and implementation of training sessions for project staff and volunteers.

Baseline survey data indicated low vaccination coverage prior to WVRD activities. Vaccination campaigns were organized in collaboration with the Secretary of Public Health. These campaigns have been so successful that target coverage vaccination rates were exceeded for children 12 to 23 months old and women of childbearing age.

Health education is predominately provided through health promoters who make home visits and conduct information sessions for mothers' groups. During home visits, health promoters demonstrate correct preparation of oral rehydration salts (ORS), as well as the use of "rice water" in home management of diarrhea. (Rice water is a recipe recommended and prepared at the Mother/Child Investigation Center.)

Acute respiratory infection (ARI) activities have focused on educating mothers about the danger signs and symptoms of moderate and severe ARI, as well as where to go for referral.

To strengthen the base of community participation, the project trained 45 volunteer health promoters and organized 14 mothers' clubs, one fishermen's club in a coastal community, and 15 health subcommittees -- one in each community. The committees support the delivery of health services and provide moral support to the health promoters.

The community is encouraged to take responsibility for the project by displaying on a bulletin board the health conditions found before the implementation of the project and the monthly accomplishments of the health promoters.

**Project Highlights:**

Information from home visits in August 1992 indicated that about 50 percent of mothers/caretakers knew how to correctly prepare and administer ORS. Health center staff link this intensive education to a significant reduction in the number of diarrhea cases and referrals seen at the centers.

- The use of rice water accompanied by an intensive education campaign has produced excellent results. Mothers use this recipe when they lack ORS. The severity of diarrhea has been reduced through the use of this home-based solution.

- Home visits in August 1992 indicated that 40 percent of mothers with children 0 to 59 months knew two or more signs and symptoms of ARI.

**Sources:**

QUE9200, WVR9200



**No Longer Funded**

**Project Number:** 938-PLAN.01  
**Project Title:** FY89 Child Survival Grant to PLAN  
**Country:** Dominican Republic  
**Project Area:** Six neighborhoods in a peri-urban slum of Santo Domingo  
**Project Duration:** FY 1989 - 8/31/92  
**Implementing Organization(s):**  
    **Host Country:** PLAN International Santo Domingo, Instituto Dominicano de Desarrollo Integral  
    **U.S.:** PLAN International

**Project Overview:**

PLAN International worked in a peri-urban slum of the Herrera sector on the outskirts of Santo Domingo. Child survival services were delivered to a target population of 114,000, of which over 8,000 are children under 59 months old. A final evaluation, completed in August 1992, indicated a significant improvement in children's health in the Herrera sector. The project's success has been largely attributed to the community-based strategy involving volunteer health promoters and close collaboration with the Ministry of Health's (MOH) immunization program.

**Project Highlights:**

- A final evaluation survey indicated that the project achieved its stated objectives for vaccination coverage, household management of diarrhea, nutritional status of children aged 12 to 23 months, and the practice of exclusive breastfeeding. The survey also compared children's health status from the project area to the health status of children in other non-project area peri-urban slums. The survey found that children in the project area were more likely to have an immunization card, more likely to be vaccinated with DPT1, DPT3, and measles vaccines, and less likely to drop out between DPT1 and DPT3, compared to those living in the control area. For children aged 12 to 23 months who were vaccinated before 12 months of age, 75 percent and 62 percent were vaccinated with DPT3 and measles, respectively, in the project area, compared to 44 and 39 percent in the control area. These percentages are also significantly higher than the national average of 23 and 32 percent, as reported in a 1991 immunization coverage survey conducted by REACH. The drop-out rate was 11 percent for the Herrera area, compared to 27 percent in the control area and 30 percent nationwide.
- The project achieved its objective in the household management of diarrhea. The survey indicated a significant improvement throughout the project area in the use of oral rehydration salts (ORS), the administration of liquids and foods, and the continuation of breastfeeding during diarrheal episodes. These indicators worsened in the control area. Survey results comparing the project and control areas show that the use of ORS packets was 76 versus 17 percent, respectively, and the increased administration of liquids during diarrhea was 91 versus 50 percent. While exclusive breastfeeding practices worsened in the control area, falling from 28 to 15 percent between July 1991 and July 1992, adherence to these practices increased in the project area from 29 to 57 percent during the same period.
- Some of the lessons learned through the project include
  - \* Communities and ministries recognize the importance of child survival interventions. The implementing private voluntary organization (PVO) needs to work deliberately with both communities and organizations to build collaborative relationships. Specific responsibilities of each party should be established. This process is slower but more sustainable than independent PVO actions.
  - \* Communities are willing and able to contribute some costs and considerable effort to child survival activities. In turn, they should expect to share in decision making. A skilled PVO community development approach is needed to mobilize and commit communities to share in the responsibility for their health.
  - \* MOH staff often can provide expertise in developing child survival activities. The interchange enriches both the PVO and the MOH and leads to increased coordinated activities. PVOs with separate child survival resources

and more flexible structures need to make a serious commitment to work toward sustainable structures rather than implement projects quickly which have limited chances of being continued once projects end.

**Sources:**

LAC9206, QUE9200

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**Project Number:** 517-0259  
**Project Title:** Family Planning Extension Service  
**Country:** Dominican Republic  
**Project Area:** Country-wide  
**Project Duration:** FY 1993 - 2001  
**Implementing Organization(s):**  
    **Host Country:** Not available  
    **U.S.:** Not available

**Project Overview:**

A follow-on to the Family Planning Services Expansion project, #517-0229, the Family Planning Extension Service project is designed to support family health services in the Dominican Republic. Activities will include low-cost interventions in child survival, family planning and maternal health, AIDS prevention, and drug awareness, with special attention to preventive measures.

Interventions begun under project #517-0229 will continue under this project, including vaccinations, breastfeeding, and promotion of oral rehydration. The project will continue to support the national family planning association (PROFAMILIA) and other NGOs in such activities as social merchandising of contraceptives in the commercial sector, AIDS education and condom distribution. Work with the National Council on the Control of Drugs will also continue.

The project plans to investigate and/or test a number of service delivery modes to increase or improve services. These activities would focus on "iguales medicas," private insurance companies, social merchandizing of oral rehydration or weaning food products, increased product availability for contraceptives, collaboration with pharmacists and private doctors' associations, and increased used of qualitative research to improve effectiveness of information and behavior change activities at the family level.

Combining private and commercial sector delivery systems under this project is an innovation intended to produce synergism among various project components. To this end, the project will encourage the growth of a private sector institution similar to the EDUCA organization for education which can act as a catalyst in developing sector-wide solutions to health problems.

**Sources:**

AID0001



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## USAID/Washington Support (AID9300)

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### ■ Regional Projects

**Accelerated Immunization II** initiated activities in cold chain maintenance and surveillance to control measles, neonatal tetanus, and other vaccine-preventable diseases.

**Health and Nutrition Technical Services Support**, through the LAC Care and Nutrition Sustainability project, assessed PVO needs for marketing, financing, and delivering child survival services and assisted MotherCare's national assessment of breastfeeding practices.

### ■ U.S. Private Voluntary Organizations/FHS/PVC Projects

**PLAN International** works in peri-urban slums surrounding Santo Domingo, providing services to 114,000 people, 8,000 of whom are children under five years old. By August 1992, the project had achieved a 75 percent vaccination coverage rate for measles and DPT3, increased use of ORS packets to 76 percent, improved the nutritional status of children aged 12 to 23 months, and increased exclusive breastfeeding practices from 29 to 57 percent.

**World Vision Relief and Development** initiated vaccination and health education interventions in 15 communities of Barahona province, whose 10,000 inhabitants previously lacked such services. Health center staff have linked oral rehydration instruction provided by project-trained volunteers to a significant reduction in the number of diarrhea cases and referrals seen at the centers.

### ■ Bureau for Research and Development Projects

**MotherCare** (Breastfeeding and Maternal and Neonatal Health) completed and distributed **The State of Breastfeeding in the Dominican Republic: Practices and Promotion**, an assessment of breastfeeding practices.

### ■ Short-term technical assistance and support

**Demographic and Health Surveys II** collaborated in the collection, analysis, and reporting of demographic and health data.

**Health Care Financing and Sustainability** conducted research on the operations of PVO child survival programs and recommended options for strengthening their service delivery capacity.

**IMPACT** (Food and Nutrition Monitoring and Support) helped design a system to monitor household-level impact of nutrition interventions.

**Peace Corps** (Health Resources Support) supported child survival training for volunteers.

**REACH II** (Technology and Resources for Child Health) assisted with an vaccination coverage survey.

**VITAL** (Vitamin A for Health) assisted a community development organization to promote solar-drying of mangos and other vitamin A rich foods.

**WASH** (Water and Sanitation for Health) established guidelines and trained PVOs to undertake water and sanitation projects.

**Wellstart** (Women and Infant Nutrition) promoted improved breastfeeding practices.

## VI: DATA NOTES

OCTOBER 1993

*Notes On Mortality Estimation*

Throughout this profile, references are made to infant and under 5 mortality rates for individual countries or groups of countries. In past years, the primary source of data on infant mortality was the World Population Prospects, a set of estimates updated every two years by the Estimates and Projections Section of the Population Division of the Department of International Economic and Social Affairs, United Nations. The primary source of data on under 5 mortality was a special report published in 1988 by the same group. Where another source, such as a recent Demographic and Health Survey or a national census, was available for a given country, the reported values from that source were cited in place of the United Nations estimates if the technical staff of USAID in the Country Mission and/or the appropriate regional bureaus confirmed the validity of the alternative source.

Known as indirect estimates, those of the United Nations are generated from accepted demographic models which combine the results of all available surveys and censuses in a given country to produce a single time series of estimates and projections. When new empirical data becomes available for a given country, the entire time series of estimates and projections is updated. Thus, using conventional demographic approaches, a survey done in 1990 may generate a new estimate of a mortality rate for 1970 or 1980.

During 1993, a new set of estimates for mortality was generated for 82 countries for publication in the World

Development Report 1993 and a forthcoming UNICEF publication entitled The Progress of Nations. Based on a curve-fitting model, the methodology applied to generate these new estimates purports to depict more accurately the trend derived from all available data sources for a country. Like the estimates generated using conventional demographic models, the entire time series might change upon the addition of a new empirical source. These estimates were made available to USAID through the courtesy of the World Development Report of the World Bank and UNICEF.

The selection of the mortality rates was done through a consultative process involving representatives of the Office of Health in USAID's Research and Development Bureau, USAID's Regional Bureaus and, in many cases, the USAID Country Missions. The source determined to best reflect the reality in a country for the current values of infant and under 5 mortality was identified and one of a number of a computation procedures, depending on the source selected for the current value, was applied to estimate the longitudinal rates. The consideration of the additional source of data developed for the World Development Report and UNICEF during the consultative process has prompted some changes in the reporting of mortality rates from those reported in recent years.

*Definitions**Demographic Indicators*

**Total Population:** The mid-year estimate of the total number of individuals in a country.

**Average Annual Rate of Growth:** An estimate of the rate at which a population is increasing (or decreasing) in a given year.

**Infant Mortality Rate:** The estimated number of deaths in infants (children under age one) in a given year per 1,000 live births in that same year. This rate may be calculated by direct methods (counting births and deaths) or by indirect methods (applying well-established demographic models).

**Under 5 Mortality Rate:** The estimated number of children born in a given year who will die before reaching age five per thousand live births in that same year. This rate may also be calculated by direct or indirect methods.

**Maternal Mortality Ratio:** The estimated number of maternal deaths per 100,000 live births where a maternal death is one which occurs when a woman is pregnant or within 42 days of termination of pregnancy from any cause related to or aggravated by the pregnancy or its management. Although sometimes referred to as a rate, this measure is actually a ratio because the unit of measurement of the numerator (maternal deaths) is different than that of the denominator (live births). The measure would be a rate if the units were the same. Extremely difficult to measure, maternal mortality can be derived from vital registration systems (usually underestimated), community studies and surveys (requires very large sample sizes) or hospital registration (usually overestimated).

**Crude Birth Rate:** An estimate of the number of live births per 1,000 population in a given year.



**Crude Death Rate:** An estimate of the number of deaths per 1,000 population in a given year.

**Life Expectancy At Birth:** An estimate of the average number of years a newborn can expect to live. Life expectancy is computed from age-specific death rates for a given year. It should be noted that low life expectancies in developing countries are, in large part, due to high infant mortality.

**Children Under Age 1:** Mid-year estimate of the total number of children under age one.

**Annual Infant Deaths:** An estimate of the number of deaths occurring to children under age one in a given year.

**Total Fertility Rate:** An estimate of the average number of children a woman would bear during her lifetime given current age-specific fertility rates.

#### *Child Survival Indicators*

**Vaccination Coverage In Children:** An estimate of the proportion of living children between the ages of 12 and 23 months who have been vaccinated before their first birthday -- three times in the cases of polio and DPT and once for both measles and BCG. Vaccination coverage rates are calculated in two ways. Administrative estimates are based on reports of the number of inoculations of an antigen given during a year to children who have not yet reached their first birthday divided by an estimate of the pool of children under one year of age eligible for vaccination. Survey estimates are based on samples of children between the ages of 12 and 23 months.

**Vaccination Coverage In Mothers:** An estimate of the proportion of women in a given time period who have received two doses of tetanus toxoid during their pregnancies. This indicator is being changed in many

countries to account for the cumulative effect of tetanus toxoid boosters. A woman and her baby are protected against tetanus when a mother has had only one or, perhaps, no boosters during a given pregnancy so long as the woman had received the appropriate number of boosters in the years preceding the pregnancy in question. (The appropriate number of boosters required during any given pregnancy varies with number received previously and the time elapsed.) The revised indicator is referred to as TT2+. Rates are computed using administrative methods or surveys.

**DPT Drop-out Rate:** An estimate of the proportion of living children between the ages of 12 and 23 months who received at least one DPT vaccination but who did not receive the entire series of three vaccinations before their first birthdays.

**Oral Rehydration Salts (ORS) Access Rate:** An estimate of the proportion of the population under age five with reasonable access to a trained provider of oral rehydration salts who receives adequate supplies. This is a particularly difficult indicator to measure and, therefore, it may fluctuate dramatically from year to year as improved methods of estimation are devised.

**ORS and/or Recommended Home Fluid (RHF) Use Rate:** An estimate of the proportion of all cases of diarrhea in children under age five treated with ORS and/or a recommended home fluid. ORT use may be determined using administrative means or surveys. In general, administrative estimates are based on estimates of the number of episodes of diarrhea in the target population for a given year and the quantity of ORS available. Thus, changes in the estimates of the frequency of diarrhea episodes can alter the ORT use rate as well as "real" changes in the pattern of use.

Surveys are more precise in that they focus on the actual behavior of mothers in treating diarrhea in the two-week period prior to the survey.

**Contraceptive Prevalence Rate:** An estimate of the proportion of women, aged 15 through 44 (or, in some countries, 15 through 49), in union or married, currently using a modern method of contraception. Where sources fail to distinguish modern and traditional methods, the combined rate is shown.

**Adequate Nutritional Status:** An individual child of a certain age is said to be adequately nourished if his/her weight is greater than the weight corresponding to "two Z-scores" (two standard deviations) below the median weight achieved by children of that age. The median weight and the distribution of weights around that median in a healthy population are taken from a standard established by the National Center for Health Statistics, endorsed by the World Health Organization (WHO). The indicator for the population as a whole is the proportion of children 12 through 23 months of age who are adequately nourished.

**Appropriate Infant Feeding:** A composite estimate of the proportion of infants (children under age one) being breastfed and receiving other foods at an appropriate age according to the following criteria: breastfed through infancy with no bottle-feeding, exclusively breastfed through four months (120 days) of age, and receiving other foods if over six months of age (181 days). Water is not acceptable in the first four months (120 days). ORS is considered acceptable at any age. Surveys are the only source of data to form this indicator. Surveys yield an estimate of how many infants are being fed correctly at the moment of the survey. They do not give an indication of the proportion of individual children fed appropriately throughout their first year of life. A number of sub-

indicators may be calculated from the data used to form the composite, of which two are presented in this report.

**Exclusive Breastfeeding:** An estimate of the proportion of infants less than four months (120 days) of age who receive no foods or liquids other than breast milk.

**Complementary Feeding:** An estimate of the proportion of infants six to nine months of age (181 days to 299 days) still breastfeeding but also receiving complementary weaning foods.

**Continued Breastfeeding:** An estimate of the proportion of children breastfed for at least one year. In this report, all values presented for this indicator are the proportion of children 12 to 15 months of age at the time of the survey still receiving breast milk.

#### *Other Health Indicators*

**HIV-1 Seroprevalence, Urban:** An estimate of the proportion of all persons (pregnant women, blood donors, and other persons with no known risk factors) living in urban areas infected with HIV-1, the most virulent and globally prevalent strain of the human immunodeficiency virus.

**HIV-1 Seroprevalence, Rural:** An estimate of the proportion of all persons living in rural areas infected with HIV-1.

**Access to Improved Water, Urban:** An estimate of the proportion of all persons living in urban areas (defined roughly as population centers of 2,000 or more persons) who live within 200 meters of a stand pipe or fountain source of water.

**Access to Improved Water, Rural:** An estimate of the proportion of all persons not living in urban areas with a source of water close enough to home that family members do not spend a disproportionate amount of time fetching water.

**Access to Sanitation, Urban:** An estimate of the proportion of all persons living in urban areas with sanitation service provided through sewer systems or individual in-house or in-compound excreta disposal facilities (latrines).

**Access to Sanitation, Rural:** An estimate of the proportion of all persons not living in urban areas with sanitation coverage provided through individual in-house or in-compound excreta disposal facilities (latrines).

**Deliveries By Trained Attendants:** An estimate of the proportion of deliveries attended by at least one physician, nurse, midwife, or trained traditional birth attendant.

#### *Notes on Project Information*

The primary source for information related to USAID projects is the USAID Health Projects Database (HPD) operated by the Center for International Health Information/ISTI.

The HPD tracks bilateral, regional and centrally-funded USAID projects and sub-projects with a health component, including child survival, HIV/AIDS, nutrition, water supply and sanitation, and other health related activities. Projects are identified for the HPD through the annual USAID Health and Child Survival Project Questionnaire, Annual Budget Submissions (ABS), Congressional Presentations (CP), and the Activity Code/Special Interest (AC/SI) System. Information on project activities, organizations implementing these activities, and project assistance completion dates is also taken from other official USAID documents such as project reports.

**In the Timeline: USAID Activities Related to Health and Population table, Life-of-Project (LOP) funding indicates the total authorized funding**

planned for all project activities from the beginning until the conclusion of the project. Projects may contain components which are not directly related to health, and therefore, LOP totals reported here may not be used to describe funding for health activities specifically. Please refer to the Fiscal Year Obligations for USAID-funded Projects Related to Health table to determine funding attributed to health activities. Where project assistance completion dates are not available, the timeline reports the planned final year of funding for the project and notes this with \*\*. Project activities may extend beyond this reported final year of funding.

The Fiscal Year Obligations for USAID-funded Projects Related to Health table does not include total project obligations; it includes only totals for health, child survival and HIV/AIDS activities. These funding totals are based on calculations of annual obligations reported in the USAID Congressional Presentation and on reported attributions for health activities. These attributions are reported through the annual USAID Health and Child Survival Project Questionnaires for Fiscal Year (FY) 1985-91, and the AC/SI System for FY 1992. Reported obligations include all accounts except population account funds for FY 1985-91. Public Law 480 funding is not included in this report.

## VII: SOURCES

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- AID0000 Data for the timelines is a consolidation of data from: a) annual USAID Health and Child Survival Project Questionnaires, b) USAID Congressional Presentations (CPs), and c) the USAID Office of Private Voluntary Cooperation/Bureau for Food and Humanitarian Assistance.
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- AID9211 United States Agency for International Development. Letter to the Administrator.
- AID9212 United States Agency for International Development. Letter from Tim Truitt, Child Survival Coordinator. November 12, 1992.
- AID9300 United States Agency for International Development. Child Survival: An Eighth Report to Congress on the USAID Program. (Forthcoming)
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