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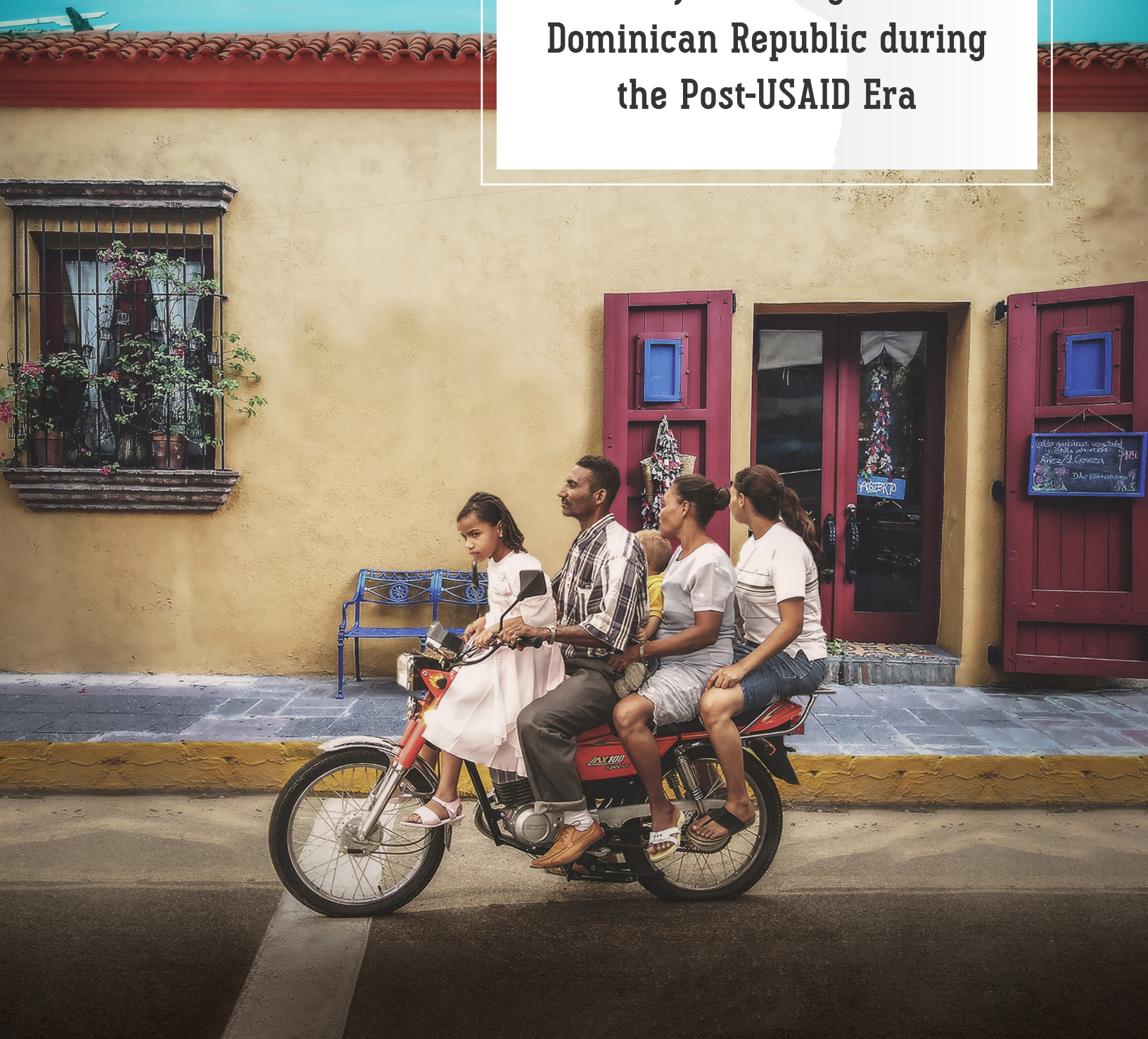
FROM DONOR TO DOMESTIC FINANCING

Family Planning in the Dominican Republic during the Post-USAID Era



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At PAI, we are motivated by one powerful truth: a woman who is in charge of her reproductive health can change her life and transform her community.

Our mission is to promote universal access to sexual and reproductive health and rights through research, advocacy and innovative partnerships. Achieving this will dramatically improve the health and autonomy of women, reduce poverty and strengthen civil society.

EXECUTIVE SUMMARY

Financing for family planning (FP) and reproductive health (RH) care, commodities and services is central to guaranteeing women's and girls' sexual and reproductive health and rights (SRHR).

Currently, though, many governments still depend heavily on donor investments to fund FP commodities and programs. At the same time, many low-income countries risk losing eligibility for donor funds as they transition to middle-income status and make other development gains. In an increasingly volatile donor environment, domestic resource mobilization for FP remains an issue needing urgent prioritization.

Domestic—specifically, public—financing of FP is critical to the sustainability of funding for services and commodities after transitioning from donor support. It also ensures that women and girls do not bear the responsibility for filling funding gaps through out-of-pocket payments. Mobilizing domestic resources as the primary funding source is a major shift for many donor-dependent governments and requires a new financial model with supportive systems and technical capacity.

The Dominican Republic was one of the first countries in Latin America and the Caribbean (LAC) to graduate from the United States Agency for International Development (USAID) FP/RH program in 2010. Before graduation, the Dominican government financed most FP commodities and programming through USAID funding. While a key outcome of USAID graduation was for the government to assume responsibility for domestic funding, how the government did so—specifically the alternative financing arrangements to make up for the loss of donor funds and processes through which they were established—is unclear.

KEY FINDINGS

Through key informant interviews and analysis of existing data in 2018, PAI found that ultimately the government reconciled the loss of USAID FP/RH funding solely through funds from the treasury. It did so by creating a new budget allocation for the *Ministerio de Salud Publico* (Ministry of Public Health, MSP) for FP. Importantly, though, there is no evidence of the government having generated additional revenue to account for the new budget line—which could implicate trade-offs with other programming if government funds were redirected. Additional funds could have (but did not) come from taxes or even social security funds, including the public health insurance scheme.

While MSP secured a budget allocation for FP/RH programs, to date, most of those funds are directed toward contraceptive procurement, leaving little for programming. Likewise, from the government perspective, the speed of transitioning FP financing roles and responsibilities from donor to domestic ownership proved to be a challenge. Thus, the way the Dominican government has financed FP and mobilized domestic sources of funding to replace donor funds raises concerns about the sustainability of that funding as well as the ability of the government to sufficiently meet women's and girls' FP needs.

RESEARCH OBJECTIVES

Many countries depend heavily on donor investment to fund FP commodities and programs. When countries make increasing progress on key development indicators, donors expect that they will graduate from this support and carry forward activities with domestic funding. This requires a major shift in which governments must create new domestic financing streams for FP and designate new systems with new roles and responsibilities.

The Dominican Republic historically financed FP primarily through donor funding, but lost that financial support upon graduating from the USAID FP/RH program in 2010, along with other countries in the LAC region.[1] A core component of graduation was for the Dominican government to assume responsibility for funding FP services and commodities domestically. While USAID was tasked with supporting the government, specifically MSP, in assuming the new purchasing role based on domestic funding sources for commodities and services, the alternative financing arrangements to make up for the loss of donor funds and processes through which they were established is unclear, and gaps in funding for FP remain.

In 2018, PAI conducted in-depth interviews with MSP officials, United Nations Population Fund (UNFPA) representatives, members of *Comités de Disponibilidad Asegurada de Insumos Anticonceptivos* (National Contraceptive Security Committee, DAIA), USAID stakeholders and civil society organizations (CSOs) involved in the lead-up to and aftermath of the Dominican Republic's graduation from USAID FP/RH support to explore how the Dominican government financed FP commodities and services—including the revenue sources and purchasing roles—after losing its primary source of FP funding upon USAID FP/RH graduation.

INTERVIEW PURPOSES

IDENTIFY how the Dominican government financed FP before and after the withdrawal of the primary financial support.

UNDERSTAND if and how the government mobilized domestic sources of funding to fill the loss of donor funds.

UNDERSTAND the financial preparation for assuming new financing roles and responsibilities during the graduation transition.

Uncovering how the government reconciled the loss of USAID assistance for FP/RH programs illuminates an example of domestic resource mobilization and provides key insight into the new domestic financing arrangement and transition process, as well as factors that may contribute to current financing gaps between commodities and programming.

THE DOMINICAN HEALTH SYSTEM

To serve its population of 10.7 million, the health system is comprised of both private and public providers.[2] There are approximately 6,000 health facilities across the spectrum of care. While three-quarters of them are private, most of the population accesses public health services.[3]

MSP oversees and supplies the public sector facilities and services provided by the public system—the National Health Service (SNS). The private sector oversees its own private health facility network, services and supplies.

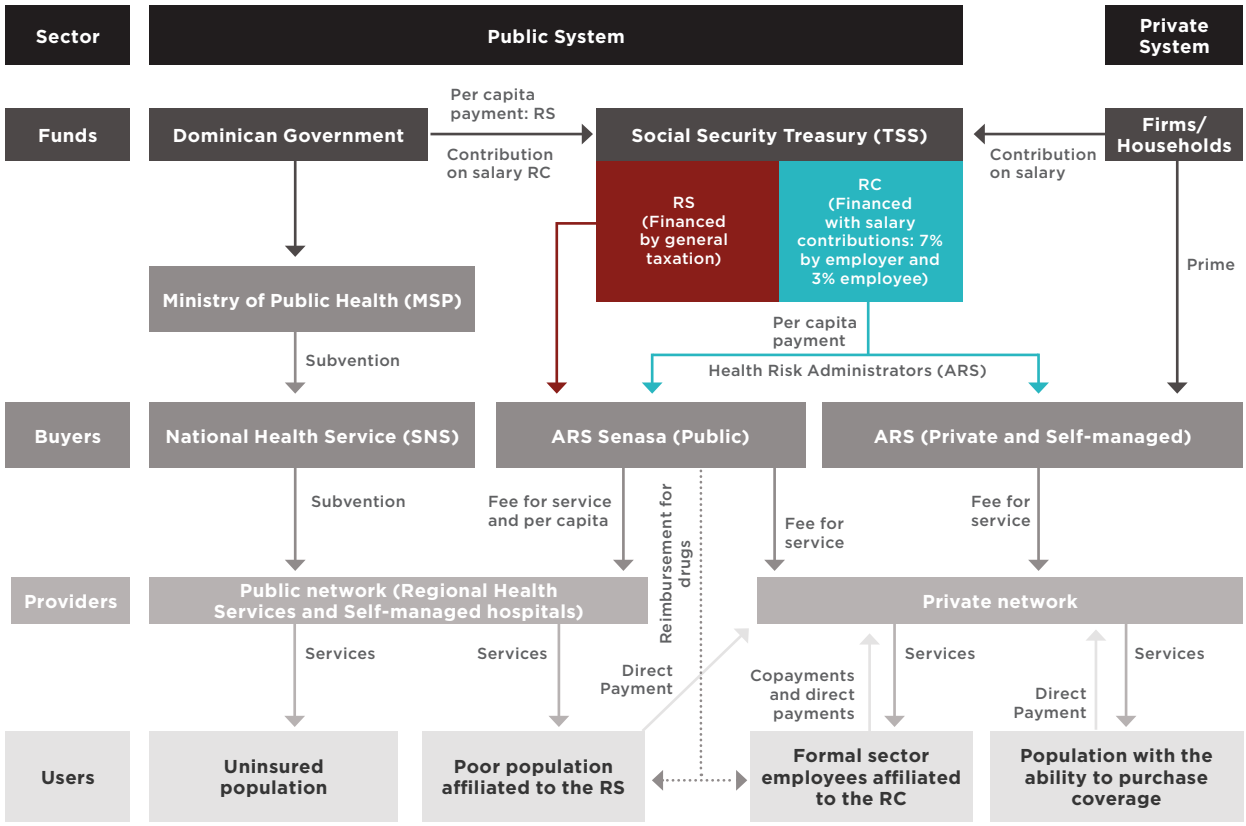
Likewise, the Dominican Republic employs a social health insurance model as part of its health financing system, with two primary insurance networks that correspond with the public and private health sectors respectively. SENASA is the public health insurance scheme, and the private health insurance network is its counterpart. Each is supervised and regulated by a public entity through their own respective Health Risk Administrators (ARS), but outside of MSP. Though they are managed separately, SENASA and MSP have a close working relationship because SENASA helps finance the public health network overseen by MSP. This is because citizens covered by SENASA insurance utilize only the public health network. SENASA reimburses public facilities per capita based on a fee-for-service depending on services provided. The government subsidizes a separate health insurance scheme through tax revenue for low-income individuals, and they access health care through the same public health network as those under SENASA.

Formal sector employees have the option of the public or private network, depending on which insurance scheme they pay into. SENASA now covers approximately 28% of the population, while private health insurance providers cover approximately 29%.[4] As of 2016, there were still around three million people without health insurance coverage, many of whom are likely among the poor and vulnerable who do not meet the government's official poverty criteria to qualify for the subsidized insurance scheme, but cannot afford the voluntary informal sector contributions.[5]

Between 2000 and 2001, the government introduced a series of major health reforms to reorganize the health system and create the *Seguro Familiar de Salud* (Family Health Insurance, SFS) with the mandate to offer financial protection—health insurance—to the whole population through the same benefits package delivered at both public and private facilities.[6,7] SFS created a new national health financing structure with multiple funding sources for health—including salary-based employer and employee contributions from formal sector, voluntary contributions from the informal sector and existing government resources from taxes to help pay for those live in poverty.

Since then, all of those resources are directed into a single fund overseen by the Ministry of Finance—the *Tesorería de Seguridad Social* (Social Security Treasury, TSS). To fund health services, providers and related costs, the TSS then transfers per capita-based payments to SENASA and the private insurance network. Meanwhile, MSP receives funding to support the public health system through a direct budget allocation from the Ministry of Finance—a separate pool of funding.[8]

FIGURE 1: HEALTH SYSTEM OF THE DOMINICAN REPUBLIC[9]



Because FP was primarily donor financed, it was not included in this flow of resources prior to USAID graduation. Between 1991 and 1997, MSP relied entirely on contraceptive donations from UNFPA, and distributed those for free to its facilities as well as what is now SENASA. All methods were provided at no cost to users.[10]

Since USAID graduation, FP integration into the country's core health financing system has been incomplete. By law, women and girls are entitled to free contraceptive methods at public facilities through their SENASA public insurance coverage, but there have been reports that some still pay out of pocket.[11] Subsidized insurance does not cover FP and private insurance does not typically cover these methods either, except female sterilization. In some cases, private nonprofit organizations including *Profamilia*—an affiliate of the International Planned Parenthood Federation, Western Hemisphere Region—and local organization *Asociación Dominicana de Planificación Familiar* (ADOPLAFAM) offer low-cost contraception in areas with limited public sector coverage. Otherwise, any method not covered must be purchased by women and girls.

DONOR FINANCING: USAID SUPPORT FOR FP

In the early 2000s, USAID determined the process by which countries in the LAC region would phase out from critical support for FP/RH programs —known as graduation.[12,13]

USAID had provided FP assistance in the Dominican Republic since the 1960s, and for the most part, provided the majority of funding for commodities and programs for over 50 years.[14] UNFPA also provided technical support in coordination with USAID since the 1970s, in addition to contraception between 1991 and 1997.[15]

According to one USAID official who helped manage the project, USAID once financed around 75% of all FP activities in the country. The agency provided contraceptives directly to its implementing partners—funds did not flow through the government budget.

In addition, USAID supported and provided technical assistance to MSP on contraceptive promotion strategies and institutional capacity building. The agency also directly funded local organizations like *Profamilia, Mujeres en Desarrollo Domincano* and ADOPLAFAM for FP/RH programmatic activities.[16] The National Council of Population and Family (CONAPOFA)—created with support from USAID—was responsible for contraceptive procurement prior to USAID graduation.[17] The decentralized body was part of MSP and procured 85% of contraceptives in the country until graduation.

GRADUATION FROM USAID FP/RH SUPPORT

According to USAID, a country's FP program is considered a candidate for graduation when the following conditions apply:

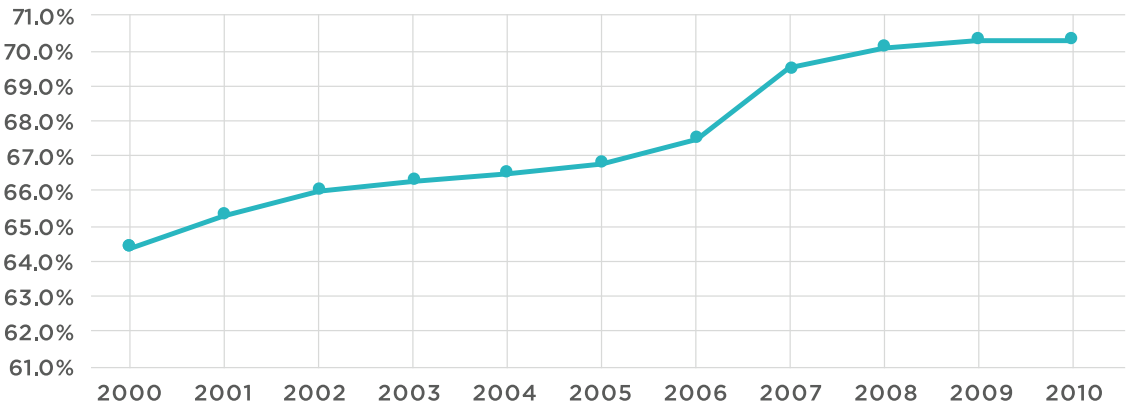
- Total fertility rate (TFR) is fewer than three children per woman;
- Modern contraceptive prevalence rate (MCPR) is greater than 55% among married women of reproductive age;
- At least 80% of the population can access at least three FP methods within a reasonable distance;
- No more than 20% of FP products, services and programs offered in the public and private sectors are subsidized by USAID; and

- Major service providers—including the public sector, private commercial sector and NGOs—meet and maintain standards of informed choice and quality of care.[19]

According to USAID, though, achievement of the first two indicators is what generally triggers an assessment of graduation readiness.[20] In 2009, the year before graduation, MCPR was 71.1% among 15- to 49-year-old women,and TFR was 2.6 births per woman in the Dominican Republic.[21,22]

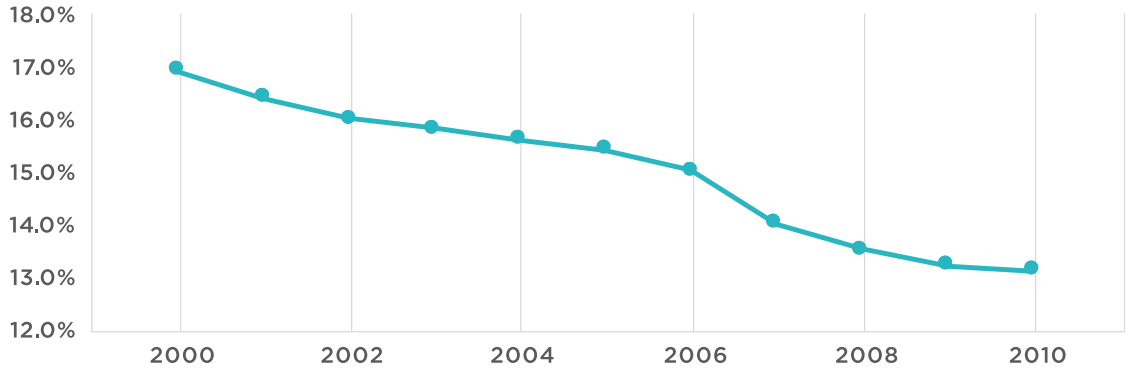
MCPR

(% of women ages 15-49, median estimate)



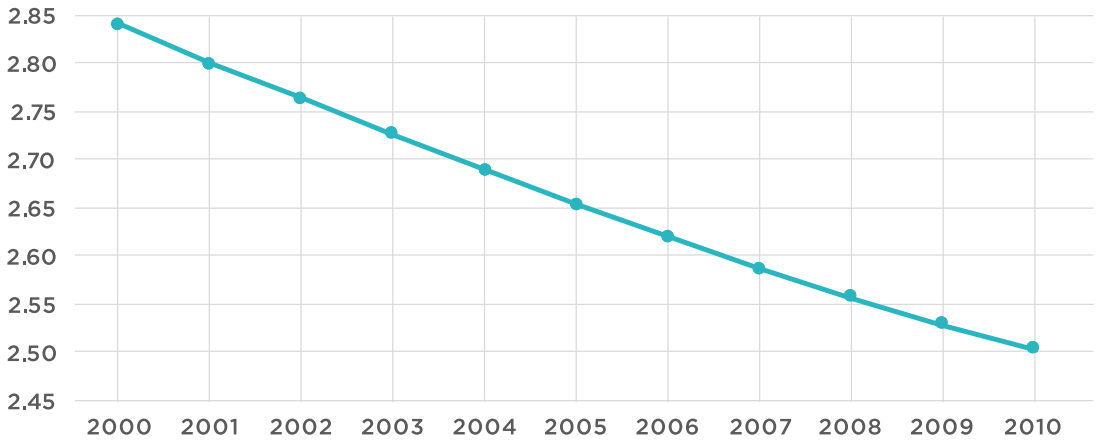
UNMET NEED FOR CONTRACEPTION

(% of women married or in union between ages 15-49, median estimate)



TFR

(births per woman)



POST-GRADUATION DOMESTIC FINANCING: NEW GOVERNMENT ROLES AND BUDGETS

MSP ASSUMES FP PURCHASING FUNCTIONS

As part of the graduation process in 2007, MSP established the DAIA committee through presidential decree with support from USAID and UNFPA. DAIA was intended to be the lead entity, comprised of both government and civil society counterparts, to guarantee contraceptive security.[23,24] According to an MSP official, a large part of DAIA's role at the time was to provide estimates of FP funding needs to the government and ensure that MSP receives a budget line for the purchase of contraceptives. Another stakeholder who helped lead the process added, "There was a large advocacy process to get MSP to assume responsibility for contraceptive supply purchases." Another reinforced that the DAIA, as a multisectoral committee, supported civil society as well as technical experts in MSP with leading advocacy and forecasting for contraceptive procurement and distribution.

As part of the transfer of responsibilities, MSP assumed responsibility of securing funding for purchasing all FP commodities, which would be distributed for free in public facilities throughout the country.[25] The Division of Maternal, Infant and Adolescent Health (DIMIA) within MSP would be the specific department leading the effort. According to a UNFPA official, the new process began in partnership with UNFPA, which would assist with contraceptive procurement and provide MSP with the corresponding proformas. MSP was then in charge of purchasing the contraceptives and distributing them. According to an MSP official, the amount of money for procurement was estimated in the very first proforma, which determined the initial budget allocation figure from the treasury.

GETTING THE FP BUDGET ALLOCATION

According to a former MSP official, the DAIA committee engaged in significant advocacy efforts with MSP leadership to secure the budget allocation, amidst some resistance. USAID also commissioned training and sensitization for key stakeholders like the Ministry of Finance to "make them aware of the importance of contraception in development, investing for development and that it was a strategy to target health indicators like maternal mortality or birth rates," according to a former USAID official. Thanks to these efforts, MSP received the budget allocation for FP, housed under the DIMIA budget.

At present, according to an MSP official, DIMIA is assigned $100 million for adolescent, infant and maternal health activities, including FP/RH. However, that budget allocation is not secure. In previous years, the Ministry has reallocated funds from the DIMIA budget to other program areas. A comparable total budget for CONAPOFA under USAID support is not available, nor is USAID data for FP/RH prior to graduation. In 2009, the United States government obligated $15.4 million to FP/RH with just under that being spent by USAID.[26]

WHERE THE DOMESTIC FP FUNDS CAME FROM: GOVERNMENT BUDGET

All interviews confirmed that UNFPA provided the initial funding support for FP to the Dominican government immediately following graduation, though the official length of time was uncertain. Soon after, DIMIA assumed FP purchasing responsibility with its new budget allocation in the MSP budget directly from the government's global budget—also known as treasury. Those interviewed reinforced that the budget came only from the treasury, and were not aware of any additional revenue that went into the treasury pool to provide for or offset the cost of the new budget line—which, according to an MSP official was just over $2 million. This is significant, because there may have been other trade-offs that the government had to make in assuming the cost of FP programs. This also means, ultimately, the government paid for FP from general treasury funds after graduation, with no additional revenue contributions to that pool, or contributions from other possible funding sources such as SENASA, additional taxes or earmarks.

With the new FP financing structure, MSP purchases and provides about 70% of FP that goes to the public sector, and the private sector finances the remaining approximate 30% for its respective networks and facilities.[27] MSP purchases FP for the public sector from its budget allocation, provides FP to the SNS in first-level centers and hospitals that serve both the SENASA-covered and subsidized regime.

WHERE FUNDS DID NOT COME FROM: THE PUBLIC INSURANCE SCHEME

A core part of the USAID's graduation financing strategy involved developing agreements for SENASA's contribution to FP purchasing. Under these agreements, SENASA would reimburse MSP for contraceptives provided.[28] According to the stakeholders interviewed, that did not happen.

Because the Ministry purchases contraceptive methods and provides them to public facilities, FP is covered free of charge to users through SENASA and the subsidized health insurance for those living in poverty.[29] In this way, SENASA does not purchase contraceptive commodities with its own funds because it receives them by donation from MSP, nor has it come to a reimbursement agreement.[30] According to an official in MSP, because SENASA does not purchase contraceptive methods, "the insurer benefits from this because they do not invest in it."

Likewise, private insurers also generally fail to include FP in their coverage, aside from female sterilization.[31]

As a result, according to one former MSP official,

> *"Many of their users go to the public facilities, [and the users] receive their method and [the public health system] assumes the cost. We don't have a registry to demand that SENASA pay per capita for those supplies and that's a weakness. You go to the public health system where it's free … they give you these methods even though you have insurance. The public health services don't have a fortified system capable of holding SENASA accountable. It continues being free … and the State continues to assume the costs in entirety … These are things we know we need to strengthen."*

This places a significant burden on the MSP budget to provide most of the country's FP supply when there could be additional financial contributions.

FP/RH BUDGET ALLOCATION CHALLENGES

Since graduation, the DIMIA budget allocation for purchasing FP commodities and providing RH programming is aggregated as one budget line. This presents a significant challenge because after DIMIA purchases contraceptives, little remains for supporting FP/RH programmatic activities.

An MSP official explained,

> *"If you take all that is sexual and reproductive health—including breastfeeding; breast cancer; cervical cancer; growth and development; violence against girls, boys and adolescents; adolescent pregnancy; maternal mortality; infant mortality … the budget isn't enough to do all these programmatic activities. So then there is a dichotomy between, 'I want to increase the budget because I need it, because the country needs much greater quantities of contraceptives, but I also don't want to be left without a budget for SRHR activities.' It's not enough for DIMIA's programmatic activities."*

As another stakeholder put it, there should be a separate budget line for programs because of the inherent trade-offs:

> *"That means for example, if you want to do neonatal mortality reduction because it's really high, you reduce the pool for contraceptives."*

Prior to graduation, USAID supported the programmatic activities listed above, including community training and educational materials. However, given the budget challenges, DIMIA has been unable to fill those gaps.

Additionally, the FP budget within DIMIA is not earmarked, which, according to a current MSP official, means that portions of the budget can be directed elsewhere, even outside of DIMIA.

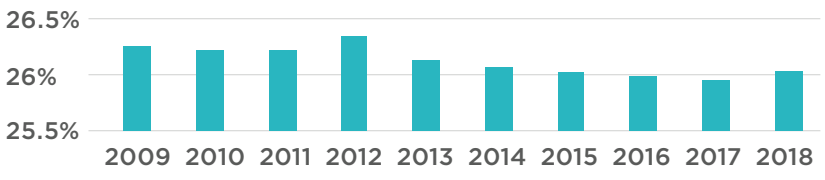
Another remaining challenge relates to the original proforma in the contractual agreement between UNFPA and the Dominican state. The original procurement agreement between MSP and UNFPA included a proforma with a contraceptive needs estimate and corresponding price that became codified in the overall government contract. This static inclusion hinders DIMIA's ability to secure a budget increase matched to the population's contraceptive needs.

As a former MSP official explained,

> *"The original contract with UNFPA—the invoice we used—which is the instrument that states the requested [FP] quantities to procure [and] the funds required for that purchase—that document was annexed to the signed agreement for procurement between the Dominican State and the contraceptive supply products through UNFPA. When one has tried to increase the [FP] budget, they [Finance] go back to the proforma. They don't understand and this is where we are now—that the quantities might vary, because [the quantity] depends on demand."*

This means FP commodities are procured and purchased based on historical consumption and not based on current need. To remedy this, DIMIA is currently working on a system to forecast demand based on the need.

WOMEN OF REPRODUCTIVE AGE (15-49) IN THE DOMINICAN REPUBLIC
(% of total population)



ANALYSIS

The way the Dominican government financed FP after graduation and mobilized domestic sources of funding to make up for the loss of donor funds yields concerns for sustainability as well as the ability of the government to sufficiently meet women's and girls' FP needs.

Many of the financing arrangements after USAID graduation in 2010 are the same today, and the related challenges affect the current situation. The domestic financing arrangement for FP post-graduation threatens sustainable financing because of the way that financing comes solely from the government's general treasury, the lack of additional revenue sources, the shared FP/RH budget allocation, as well as the speed of transitioning roles and responsibilities and creating a new FP financing system that did not previously exist.

DOMESTIC FUNDING FOR FP COULD HAVE COME FROM MULTIPLE SOURCES

Post-graduation, the government solely financed FP through funds from the treasury by creating a new budget allocation for FP, which is neither sufficient nor sustainable, especially because the government did not generate additional revenue to account for the additional budget line.

There are potential additional revenue sources for FP, such as financing drawn from taxes or earmarked SENASA funds through TSS. The absence of the latter was a failure on the part of the graduation transition because there was supposed to be a reimbursement agreement between MSP and SENASA for all FP purchased on behalf of the public insurer. Given that SENASA covers nearly one-third of the population in the Dominican Republic, financing from SENASA would provide a significant contribution to FP commodities and programs and help MSP better meet the needs of women and girls in the public sector.

MSP is responsible for meeting most of the country's needs since only 29% of the population has private insurance. However, even some individuals covered under private insurance utilize public sector resources to obtain free contraception. As such, omitting SENASA's contributions to help pay for FP commodities is a missed opportunity. Moreover, it reinforces the negative consequences of the government having to pull funds from the general resource pool without generating additional funds to make up for the difference previously financed by USAID. This context showcases why it was unique but also problematic for the Dominican government to offset the loss of donor funds by relying only on the global budget.

ONE MSP BUDGET LINE FOR BOTH FP/RH CANNOT MEET EITHER FP/RH NEEDS

As outlined by MSP officials, FP commodities share the same budget allocation as RH programs, which is a significant problem. While the amount allocated for FP commodities is already insufficient, MSP's decision-making process entails trade-offs between FP commodities and RH programming, which are complementary to meeting the spectrum of women and girls realizing their SRHR. Instead, the prioritization of commodities over programming due to budget constraints puts the two facets in competition and both suffer at the expense of one another. Worse, the overall budget allocation has not increased over the years. More importantly, the allocation is insufficient, largely because not enough revenue is directed toward FP financing.

ADEQUATE PLANNING TO ASSUME NEW FINANCING ROLES AND REVENUE STREAMS IS CRITICAL

While perspectives differ between USAID and government officials on the pace of graduation, it's clear that in hindsight, there was insufficient planning around the development of systems, roles and financing structures where none had existed before. Furthermore, some involved in the transition process felt that there was not adequate transition of technical capacity or the appropriate mechanisms in place for the government to assume their new financing role. One official involved in the logistics said, "The country didn't really do a transition."

It takes time and careful planning to establish additional systems of generating domestic resources prior to assuming core funding responsibility. If countries do not adequately account for the time, technical capacity and coordination needed to assume the new financing structures and corresponding roles and responsibilities required to take over funding for FP, they may be ill-equipped and long-term sustainability for FP financing, as well as women's and girls' access to FP/RH commodities and services—and sexual and reproductive rights—may suffer.

METHODOLOGY

The purpose of the case study was not to evaluate the impact or pace of USAID FP/RH graduation; rather, to uncover how the Dominican government funded FP commodities after the loss of donor support.

Data were derived from multiple sources, the most prominent of which were semi-structured in-depth interviews with key participants, with supporting data from official government documents. Participants were purposefully selected based on information-rich purposive sampling strategy with maximum variation. Accordingly, key informants for this study were representative of the following groups: MSP officials, UNFPA, DAIA members, USAID stakeholders and CSOs.

A total of seven in-depth key informant interviews were conducted with each lasting approximately one hour. Each participant had a unique role in the USAID FP/RH graduation process and realm of FP financing. Written informed consent was obtained from all study participants prior to data collection, with both PAI staff and participants retaining copies of the signed informed consent form in both Spanish and English.

All interviews were guided by an interview protocol and conducted, recorded and transcribed in Spanish and then translated to English to ensure accuracy. PAI researchers then read and cleaned the data by reviewing all transcripts and correcting for translation errors. All interview transcripts were then imported into MAXQDA data analysis software for coding. Transcripts were coded and analyzed in this manner to provide a record of analysis, maintain a systematic review of patterns and allow for the possibility for others to review and replicate the work. In this process, the researcher coded the transcripts and grouped codes primarily with structural coding methods, in addition to In Vivo and simultaneous coding. All data collection techniques and methods were standardized in a systematic process to ensure the rigor of the obtained information.

This case study employs an inductive, qualitative methodology to:

- Understand how the Dominican government financed FP before and after the withdrawal of significant donor support;
- Understand if and how the government mobilized domestic sources of funding to fill loss of donor funds; and
- Understand the financial preparation for assuming new financing responsibilities during the graduation transition process.

LIMITATIONS

The findings of this study should be considered with two limitations. First, historical data pertaining to FP/RH financing is not publicly available and impacts the analysis of changes in budget allocations prior to and after graduation. Specifically, UNFPA does not have data available on contraceptive donations prior to 1997, which is when the agency began phasing out its support for commodities in the Dominican Republic. Available data from UNFPA reports that the Dominican Republic received $1.48 million in 1997 for programs and contraception, but this figure is not disaggregated, making it difficult to compare direct contraceptive expenditures before and after donor financing. Similar data from more recent years is inconsistent. For example, an analysis from UNFPA in 2000 reports that the Dominican Republic received only $258,568 in commodity support that same year, but the amount received since then is not available nor is there any indication of UNFPA funding to the country completely ending. In terms of overall FP/RH financing, the U.S. government has general data on money obligated and spent by USAID in country for only 2009, limiting a detailed comparison of changes in financing in the years leading up to graduation. The absence of publicly available data is likely linked to the transfer of the FP/RH program from the USAID supported CONAPOFA to MSP during the graduation period.

This research study is not an impact study or an evaluation of the USAID graduation in the Dominican Republic; rather, its meant to provide insight on the process through which the Dominican government and key partners underwent in the lead-up to and aftermath of transitioning from primarily donor to domestic financing for FP commodities and services, as well as to yield lessons for the future.

CONCLUSION

Mobilizing domestic resources as the primary source of FP/RH funding is a major shift for many governments and, as the Dominican Republic case indicates, requires a new financial model with supportive systems and technical capacity.

Inadequate mechanisms to develop additional revenue to offset the decrease in donor assistance can lead to critical trade-offs in programming and threaten the sustainability of FP financing. To mitigate these trade-offs, the preparation process for the transition from donor funding to domestic financing must allow enough time to create an alternative financing plan as well as establish and ensure the mechanisms to generate revenue are working prior to phasing out donor contributions. This financing plan should identify actual and projected programmatic needs during the transition period, including FP commodities, and utilize all possible revenue streams such as earmarked funds from taxes.

In the Dominican Republic, the failure to utilize social security funds for FP has placed a disproportionate burden on MSP, as well as limited total FP/RH budget and its ability to increase contraceptive availability in line with rising demand. In addition to the appropriate financing mechanisms, major donors such as USAID must allot sufficient time to transition capacities, roles and responsibilities to country governments. Consolidating and transferring over 50 years of programmatic structures and technical experience in a three-year period is complex and in the Dominican Republic, a stronger and perhaps lengthier planning process to ensure a complete transition to national ownership of the FP program is necessary. As countries in East Africa and South Asia approach the conditions for graduation, it is critical to understand the issues in building the capacity of country governments for domestic financing to facilitate a smooth transition to national ownership.

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DESIGN AND PRODUCTION
Andres de la Roche, ADELAROCHE DESIGNS

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