



USAID
FROM THE AMERICAN PEOPLE

DOMINICAN REPUBLIC

CONTRACEPTIVE PROCUREMENT POLICIES, PRACTICES, AND OPTIONS

DOMINICAN REPUBLIC

NOVEMBER 2006

This publication was produced for review by the United States Agency for International Development. It was prepared by the DELIVER and POLICY projects, and USAID | Health Policy Initiative Task Order 1.

CONTRACEPTIVE PROCUREMENT POLICIES, PRACTICES, AND OPTIONS

DOMINICAN REPUBLIC

DELIVER

DELIVER, a six-year worldwide technical assistance support contract, is funded by the U.S. Agency for International Development (USAID). Implemented by John Snow, Inc. (JSI), (contract no. HRN-C-00-00-00010-00) and subcontractors (Manoff Group, Program for Appropriate Technology in Health [PATH], and Crown Agents Consultancy, Inc.), DELIVER strengthens the supply chains of health and family planning programs in developing countries to ensure the availability of critical health products for customers. DELIVER also provides technical management of USAID's central contraceptive management information system.

POLICY and the USAID | Health Policy Initiative Task Order 1

The POLICY Project was funded by the U.S. Agency for International Development under contract No. HRN-C-00-00-0006-00, which ended on June 30, 2006. Subsequent work continued under the USAID | Health Policy Task Order 1 (contract No. GPO-I-01-05-00040-00). Task Order 1 is implemented by Constella Futures in collaboration with the Center for Development and Population Activities, the White Ribbon Alliance, and the World Conference of Religions for Peace. The Health Policy Initiative works with governments and civil society groups to achieve a more supportive policy environment for health, especially family planning/reproductive health, HIV/AIDS, and maternal health.

Recommended Citation

Agudelo, Juan, Varuni Dayaratna, Cristian Morales, Nora Quesada, David Sarley, Wendy Abramson, Jay Gribble, Carlos Lamadrid, Nadia Olson, and Verónica Siman Betancourt. 2006. *Contraceptive Procurement Policies, Practices, and Options: Dominican Republic*. Arlington, Va.: DELIVER, and Washington, D.C.: USAID | Health Policy Initiative TO1, for the U.S. Agency for International Development.

Abstract

In light of the phaseout of donor funds in Latin America and the Caribbean, the Dominican Republic will be facing increasing responsibility to finance and procure contraceptive commodities in the near future. The government of the Dominican Republic needs to look at regional and international procurement opportunities to ensure that contraceptive security is not compromised during this transition period.

This report presents findings from a legal and regulatory analysis and pricing study of various procurement options to identify efficient, economical, and timely distribution of high-quality contraceptives. A summary of the current country situation, procurement practices, laws, policies, and regulations is presented along with a comparison of regional contraceptive prices. Options and recommendations are presented for next steps.

The authors' views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

DELIVER

John Snow, Inc.
1616 North Fort Myer Drive, 11th Floor
Arlington, VA 22209 USA
Phone: 703-528-7474
Fax: 703-528-7480
E-mail: deliver_project@jsi.com
Internet: deliver.jsi.com

USAID | Health Policy Initiative TO1

Constella Futures
1 Thomas Circle, Suite 200
Washington, DC 20005 USA
Phone: 202-775-9680
Fax: 202-775-9694/9698/9699
E-mail: policyinfo@healthpolicyinitiative.com
Internet: www.healthpolicyinitiative.com

CONTENTS

Acronyms	iii
Acknowledgments	v
Executive Summary	vii
Background.....	vii
Objective and Methodology.....	vii
Summary of Main Points	viii
Introduction	1
Methodology.....	1
Country Situation	3
Legal and Regulatory Framework	5
Laws That Govern the Procurement of Medicines and Contraceptives.....	5
Procurement Practices and Mechanisms.....	6
Contraceptive Pricing	9
Oral Contraceptive Price Structure	9
Injectable Contraceptive Price Structure.....	11
IUD Price Structure	12
Options and Next Steps	15
Options to Consider	16
References	19
Tables	
1. Savings from UNFPA Procurement Agreement.....	7
Figures	
1. Flow of Contraceptives in the Dominican Republic.....	4
2. Price Components of Oral Contraceptives in the Dominican Republic.....	11
3. Price Components of Injectables in the Dominican Republic	12
4. Price Components of IUDs in the Dominican Republic	13

ACRONYMS

ADOPLAFAM	<i>Asociación Dominicana de Planificación Familiar</i> (Dominican Republic Family Planning Association)
ARV	antiretroviral
CARICOM	Caribbean Community and Common Market (regional agreement that established the Caribbean Common Market)
CENABAST	<i>Central de Abastecimiento</i> (Chilean national procurement agency for the National Health Service)
CIF	cost, insurance, and freight
CONAPOFA	<i>Consejo Nacional de Población y Familia</i> (National Family Planning Association)
DAIA	<i>disponibilidad asegurada de insumos anticonceptivos</i> (contraceptive security)
DR	Dominican Republic
EDL	essential drug list
GODR	Government of the Dominican Republic
IDSS	Social Security Institute of the Dominican Republic
IPPF	International Planned Parenthood Federation
IUD	intrauterine device
JSI	John Snow, Inc.
NGO	nongovernmental organization
LAC	Latin America and the Caribbean
PROFAMILIA	<i>Asociación Dominicana Pro-bienestar de la Familia</i> (IPPF affiliate)
PROMESE	<i>Programa de Medicamentos Esenciales</i> (Program of Essential Medicines)
SDP	service delivery point
SESPAS	<i>Secretaría de Salud Pública y Asistencia Social</i> (Ministry of Health)
SICA	<i>Sistema de Integración Centroamericana</i> (Central American Integration System)
TB	tuberculosis
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development
VAT	value-added tax

ACKNOWLEDGMENTS

This report could not have been completed without the contributions and participation of the Contraceptive Security Committee of the Dominican Republic; the Ministry of Health; the United Nations Population Fund (UNFPA); and PROFAMILIA, the national International Planned Parenthood Federation affiliate. The authors would like to express their gratitude to the many officials and health providers in the Dominican Republic who took time from their busy schedules to meet with the assessment teams. We are also grateful to the USAID Bureau for Latin America and the Caribbean, particularly to Lindsay Stewart, for supporting this initiative.

The authors also thank the following staff from the from the DELIVER and POLICY¹ projects who provided tremendous support in the implementation of the study and the writing and editing of this report: Cristian Morales, Anabella Sánchez, Roberto López, and Marie Tien.

This report is available in English and Spanish, as are the individual country reports on the eight other participating countries (Bolivia, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Paraguay, and Peru) and a regional practices and options report. All of these documents, as well as the full country assessment reports, are listed in the references for this report and may be obtained directly from the DELIVER and USAID | Health Policy Initiative TO1 projects. Summaries of the country assessment reports can be found on the DELIVER and USAID | Health Policy Initiative Web sites (www.deliver.jsi.com and www.healthpolicyinitiative.com).

¹ The POLICY Project ended June 30, 2006. Work on this activity continued under USAID | Health Policy Initiative Task Order 1, implemented by Constella Futures.

EXECUTIVE SUMMARY

BACKGROUND

The Dominican Republic (DR) will be taking on the responsibility of financing and procuring contraceptives as donations are phased out in the very near future by the U.S. Agency for International Development and the United Nations Population Fund (UNFPA). In preparation, the Government of the Dominican Republic (GODR) will need to consider all procurement options, prices associated with each option, and the legal viability of each option within the context of national laws and norms that regulate public-sector procurement practices.

Contraceptives are supplied and distributed through the public and private sectors in the DR through the following means:

- **Public sector:**²

Ministry of Health (SESPAS). The SESPAS began to purchase contraceptives from local suppliers and UNFPA in 1996–1997 when UNFPA reduced its donations. The Program of Essential Medicines (PROMESE) currently purchases all of its medicines and distributes them to all SESPAS establishments in the DR. The public sector serves 43.3 percent of family planning users, with 93.5 percent coming from the SESPAS.

Social Security Institute (IDSS). The IDSS depends on SESPAS donations for its supplies and also procures its own contraceptives through local vendors. The IDSS serves less than 5 percent of family planning users in the public sector.

- **Private sector.** Private doctors, pharmacies, and clinics purchase commodities from local representatives of international suppliers. As of 2002, the private sector was the main provider of modern methods of family planning.
- **Nongovernmental organizations (NGOs).** Since 2004, when donations ceased, NGOs have procured their own contraceptives.

OBJECTIVE AND METHODOLOGY

This report presents findings from a legal and regulatory analysis and pricing study of different procurement options available in the DR. It is intended to inform the Ministry of Health in its efforts to identify the best options—low prices, high quality, and efficient and timely delivery—for contraceptive procurement. The DR analysis forms part of a broader regional study that assesses the impact of various procurement regulations on the price of contraceptives in nine countries and identifies viable strategies for countries to adopt in ensuring access to low-priced, good-quality contraceptives.

The country work included the analysis of laws and regulations that govern the purchase of medicines and contraceptives with public-sector funds as well as the collection and analysis of data on contraceptive prices by method at both the central and regional level. The prices analyzed represent the total direct costs to each sector, including cost, insurance, and freight (CIF) costs; duty and value-added tax (VAT);

² SESPAS and the IDSS serve approximately 98.5 percent of public sector family planning users, with the remaining 1.5 percent covered by the armed forces and other smaller public agencies.

administrative and social marketing costs, transport costs,³ and other margins. Field work consisted of interviews with key stakeholders about written laws and regulations and procurement practices, as well as the collection of quantitative price data from various sources, including pharmacies.

SUMMARY OF MAIN POINTS

LEGAL AND REGULATORY FRAMEWORK

- The DR has national procurement laws that govern public-sector purchases when public funds are used in government agencies, institutions, and social security institutes. The most commonly used mechanism by the GODR for purchasing medicines is the public tender, a multistep process usually limited to local suppliers. Although the procurement law does not mention international tenders as a legal option, the GODR uses UNFPA as a procurement agent.
- The national procurement law and its regulations allow for exceptions only in the case of emergencies, defined as situations in which the preservation of life and public security are at stake or when significant harm to individuals, loss of state property, or program delays with considerable cost implications can be avoided. Under these circumstances, exceptions to legally required procurement procedures may be authorized by the National Procurement Commission and/or the country's national controller's office (*Contraloría General de la República*). In comparison with other countries in Latin America, the DR permits fewer exceptions to its procurement laws and regulations. For example, of the nine countries studied, the DR is the only country in which government purchases made within the context of international or multilateral agreements and contracts fall under the jurisdiction of public-sector procurement laws.
- The government charges value-added tax (VAT) on commodities in the private sector but not in the public sector.
- The essential drug list for the SESPAS includes all hormonal contraceptives, condoms, and intrauterine devices (IUDs). All drugs must be registered within the country, and a registration fee must be paid before distribution can occur.
- The National Contraceptive Security Committee is the formal entity responsible for family planning in the SESPAS that participates in providing health services at the national level. It is responsible for establishing conditions and criteria to influence the facilitation of contraceptive procurement in the DR.
- There is no coordination among PROMESE, the IDSS, and the SESPAS; they procure their medicines separately. PROMESE pools procurement for its medicines and, as a result, saves between 56 and 1,017 percent on individual medicines. The IDSS does not participate in pooled procurement with PROMESE to take advantage of the efficiencies through high-volume orders or use its distribution network and laboratories for quality control. The SESPAS procures items for its TB, vaccine, and contraceptives programs separately from the other institutions.
- In 2004, the SESPAS signed an agreement with UNFPA as a procurement agent. The switch from procuring from local suppliers to UNFPA has resulted in considerable savings in CIF costs for Depo-Provera, IUDs, and oral contraceptives.

³ Transportation costs for the DR public sector were not available, but a regional average estimate of nearly 6 percent of the CIF price was used for the purpose of estimating total costs. It was not possible to separate transportation costs for the NGO sector, so they are included with all other margins and costs, which also include administrative costs, distributor margin, and costs associated with repackaging commodities.

- The IDSS purchases contraceptives from local suppliers through a noncompetitive procurement process, resulting in very high prices. The IDSS experiences frequent stockouts and does not yet have the warehouse capacity to receive and store large quantities of contraceptives.

CONTRACEPTIVE PRICING

- The purpose of the pricing analysis was to quantify the direct costs associated with contraceptive procurement. There was no attempt to quantify any indirect costs associated with the procurement process or with individuals' access to contraceptive commodities.
- Comparisons of public and NGO sector CIF prices and CIF prices plus margins (duty, taxes, administrative, social marketing, and transport costs) in the DR were made with El Salvador, Guatemala, Nicaragua, and Honduras.
- The direct cost of a cycle of oral contraceptives (including margin costs) in the public sector is U.S.\$0.36 (86 percent is CIF cost), compared with U.S.\$2.01 in the NGO sector (46 percent is CIF cost).
- The full direct cost of an injectable is U.S.\$1.28 in the public sector and U.S.\$2.99 in the NGO sector. The CIF cost of the NGO sector represents only 46 percent of the total direct cost, with the rest attributed to duty, VAT, and administrative costs. The CIF cost in the public sector makes up 84 percent of the price.
- The total direct cost of an IUD in the public sector is U.S.\$0.84, of which U.S.\$0.71 is the CIF (85 percent). In the NGO sector, the total direct cost is U.S.\$1.63, of which U.S.\$0.75 is the CIF (46 percent).

OPTIONS AND NEXT STEPS

- Plan for better communication and coordination among the public sector entities that procure medicines so as to realize valuable cost savings. Price comparisons and lessons from PROMESE, the SESPAS, and others involved with the purchase of contraceptives can provide important information to the GODR in determining the best procurement options.
- Consolidate and centralize the current fragmented procurement processes, taking advantage of PROMESE's established network of suppliers, warehousing capacity, distribution networks, and quality control systems.
- Explore alternative procurement sources and transport options for delivery of contraceptives to the local level.
- Advocate to the GODR to do an annual allocation of funds into a protected budget line item to maximize price advantages gained through centralized bulk purchases.
- Explore regional integration initiatives, such as the CARICOM (Caribbean Community and Common Market agreement) or SICA (the Central American Integration System), to identify potential opportunities for the GODR as it seeks to improve procurement efficiency, expand contraceptive procurement options, and obtain better prices.
- Institutionalize procurement of contraceptives to protect it from changes in political will and other unforeseeable factors that could jeopardize contraceptive security in the DR.

INTRODUCTION

For over three decades, countries in Latin America and the Caribbean (LAC) have relied on donations from international agencies such as the U. S. Agency for International Development (USAID) to meet the contraceptive needs of their populations. These donations are now being phased out gradually throughout the region. The Dominican Republic (DR) stopped receiving USAID-donated contraceptives in 2004, although four of its health regions will continue to receive donations from UNFPA through 2007. Currently, the Government of the Dominican Republic (GODR) is purchasing all of its contraceptives utilizing the United Nations Population Fund (UNFPA) as a procurement agent. The financing and procurement of contraceptives for the entire public sector will become the sole responsibility of the national government by the beginning of 2008.

Contraceptive security exists when individuals are able to choose, obtain, and use contraceptives and condoms whenever they need them. Achieving contraceptive security requires efficient contraceptive procurement mechanisms and procedures that are designed to secure low prices and prevent product shortages and stockouts.

As the GODR takes greater responsibility for contraceptive procurement, it will need to consider all available procurement options (both national and international). It will need to examine the prices associated with each option and the legal viability of each option within the context of the national laws and norms that regulate public-sector procurement practices.

METHODOLOGY

This report presents findings from a legal and regulatory analysis and pricing study of the contraceptive procurement options available in the DR between June 2005 and March 2006. It is intended to inform the Ministry of Health in its efforts to identify the best options—low prices, high quality, efficient and timely delivery—for contraceptive procurement. The DR analysis forms part of a broader regional study that assesses the impact of various procurement regulations on the price of contraceptives in nine USAID-presence countries in LAC—Bolivia, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Paraguay, and Peru—and it identifies strategies that countries might adopt to ensure access to low-priced, high-quality contraceptives.

The country work included the analysis of laws and regulations that govern the purchase of medicines and contraceptives with public-sector funds as well as the collection and analysis of data on contraceptive prices by method at both the central and regional levels. Field work consisted of interviews with key stakeholders about written laws, regulations, and procurement practices, as well as the collection of quantitative price data from various sources, including pharmacies in Santo Domingo and Santiago de los Caballeros.

The report begins with a general overview of the situation in the Dominican Republic, followed by an analysis of the principal characteristics of policies and laws that govern public-sector procurement. The following section presents information on contraceptive prices for different methods within the country. A lessons-learned section, based on the experiences of different countries in the region, follows. The report ends with a series of concrete recommendations directed at improving the efficiency of contraceptive procurement policies and processes.

COUNTRY SITUATION

The Dominican Republic, the second-largest nation in the Caribbean region, occupies the eastern two-thirds of the island of Hispaniola and is classified as a lower-middle-income country (World Bank 2006a), with a gross national income per capita of U.S.\$6,863 (World Bank 2006b). It has a population of approximately 8.8 million and an annual growth rate of 1.3 percent (USAID 2006). According to 2003 estimates, 11 percent of Dominicans live below the international poverty line of U.S.\$2 per day (World Bank 2006a). In addition, one of the fastest growing segments of the population is women of reproductive age (15–49 years old), who number 2.2 million (Miller et al. 2002). Approximately 67 percent of the population lives in urban areas (World Bank 2006b); the capital city alone has more than 25 percent of the total population (ENDESA 2002). The national literacy rate is 87 percent, with no difference between men and women (World Bank 2006a).

The total fertility rate in the Dominican Republic is low—2.6 children per woman (2005). The contraceptive prevalence rate among women in union between 15 and 49 years of age is high, at 87 percent for modern methods (DHS 2002). The most commonly used family planning method is oral contraceptives (61 percent among women in union who use contraceptives), followed by female sterilization (45.8 percent).

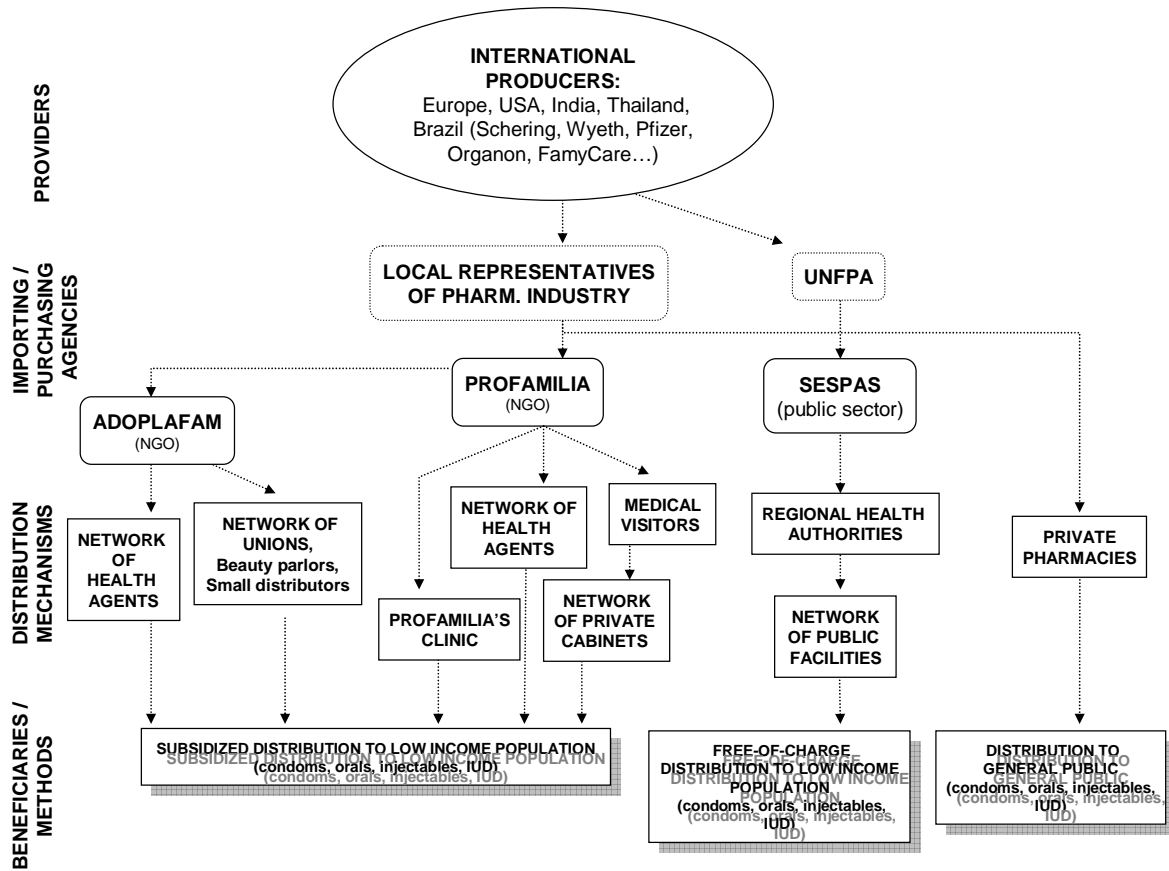
As of 2002, the private sector—private doctors, clinics, and pharmacies—is the main source of modern methods of family planning. The public sector serves 43.3 percent of family planning users, with 93.5 percent of these users relying on the Ministry of Health (SESPAS). The Social Security Institute (IDSS) accounts for less than 5 percent of the modern method market share and depends largely on SESPAS donations for its supplies. The remaining 1.5 percent of public sector services is provided by the armed forces and other smaller public agencies.

Until 1997, the SESPAS relied completely on donated contraceptives from UNFPA to meet the needs of its clients. Since 1996–1997, as UNFPA began to gradually cut back its donations, the GODR started to buy contraceptives with its own resources, first from local suppliers and then through UNFPA. Public-sector contraceptive purchases in 2004 and 2005 amounted to RD\$45,670,257 (U.S.\$1,455,908). Although the GODR has assigned funding for contraceptive purchases, there is no formally established mechanism for this budgetary allocation, and the availability of public-sector resources for contraceptive procurement is left to the discretion of government officials. As UNFPA completely phases out contraceptive donations in the coming years,⁴ the GODR will need to commit firmly both to increasing its budgetary allocations for contraceptives and collaborating closely with the private sector, which represents a predominant and complementary source of modern contraceptive methods.

The DR relies on multiple suppliers, including UNFPA, for contraceptives (see figure 1). The public sector purchases contraceptives from UNFPA, while pharmacies and nongovernmental organizations (NGOs) purchase commodities from local representatives of international suppliers. The public sector provides contraceptives free of charge to the low-income population through its network of public health facilities. The NGO sector distributes its commodities for a subsidized fee through its own clinics and health agents, as well as through nontraditional outlets, such as smaller distributors, beauty salons, and medical visitors.

⁴ UNFPA still donates contraceptives and provides logistics technical assistance and training in three of the nine health regions and four health areas in Santo Domingo.

Figure 1. Flow of Contraceptives in the Dominican Republic



LEGAL AND REGULATORY FRAMEWORK

LAWS THAT GOVERN THE PROCUREMENT OF MEDICINES AND CONTRACEPTIVES

The national procurement law (*Ley 295 de Aprovisionamiento*, 1966) and the accompanying regulations that govern public-sector purchase and contracting of goods and services are intended to regulate and guarantee the efficient and transparent use of public-sector funds in the DR. The law applies to all government agencies and institutions, including social security institutes, and to most transactions in which public-sector funds are used. Operational units responsible for public-sector procurement exist in government institutions at both the central level (ministries) and decentralized levels.

The procurement regulations clearly establish the procurement modalities to be used for purchasing goods with public-sector resources, which include the following:

- public tenders—open to all vendors, for procurement amounts over U.S.\$233,000
- tenders by invitation—when at least five suppliers must participate, for procurement amounts between U.S.\$16,666 and U.S.\$233,000
- restricted tenders—when suppliers, preselected on the basis of specific characteristics, are invited to participate, for procurement amounts between U.S.\$3,333 and U.S.\$16,666
- direct contracts with a specific vendor for procurements that do not exceed U.S.\$3,333

The most common procurement mechanism that the GODR uses for purchasing medicines is the public tender, which is a long multistep process typically limited to local suppliers. The procurement law in the DR does not mention international tenders as a legally viable option. Despite this, as in most countries in the region whose laws clearly favor purchase from local suppliers, the GODR uses UNFPA as a procurement agent through which it engages in international purchases.

The national procurement law and its regulations allow for exceptions only in the case of emergencies, defined as situations in which the preservation of life and public security are at stake or when significant harm to individuals, loss of state property, or program delays with considerable cost implications can be avoided. Under these circumstances, exceptions to legally required procurement procedures may be authorized by the National Procurement Commission and/or the country's national controller's office (*Contraloría General de la República*). In comparison with other countries in Latin America, the DR permits fewer exceptions to its procurement laws and regulations. For example, of the nine countries studied, the DR is the only one in which government purchases made within the context of international or multilateral agreements and contracts fall under the jurisdiction of public-sector procurement laws.

The essential drug list (EDL) of the SESPAS includes all hormonal contraceptives as well as condoms and IUDs. This is an important step on the path to contraceptive security; however, it does not in itself guarantee contraceptive availability in sufficient quantities in health establishments. All drugs on the EDL must be registered within the country before distribution. The cost of registration is RD\$7,000 (U.S.\$233)

for both new products and those with expired registration. The cost of registering more commonly used drugs is lower: RD\$3,000 (U.S.\$100).⁵ These registration costs are relatively low.

Unlike many other countries, in the DR the National Contraceptive Security Committee is a formal entity that is part of the SESPAS family planning program. It is a recognized part of the health structure and is considered a stakeholder in “general health services at the national level” (SESPAS 2005). Within this context, the committee is required to create a “subcommittee for the purchase of contraceptive products,” which would assume the responsibility for establishing conditions for contraceptive procurement, thereby giving the committee a mechanism through which to directly influence contraceptive procurement (SESPAS 2005). Subcommittees for various tasks have already been created.

PROCUREMENT PRACTICES AND MECHANISMS

Donations from USAID were provided only to NGOs, and those donations ended in 2004. Now, NGOs are procuring individually from local representatives of the pharmaceutical industry. The public sector has had to begin examining mechanisms for contraceptive procurement. The timely and uninterrupted availability of high-quality contraceptives in the public sector is essential to achieving contraceptive security, particularly for those in the lowest socioeconomic quintiles. As UNFPA phases out contraceptive donations to the DR’s public sector, the government must prepare to assume the responsibility of procuring contraceptives. Product price and quality are important factors in this process.

COMBINATION OF BULK AND FRAGMENTED PROCUREMENT

One mechanism for obtaining low prices for products is bulk (pooled) procurement. The Program of Essential Medicines (PROMESE), which is administered under the Presidency of the Republic, purchases and distributes medicines and supplies for all SESPAS establishments in the DR. In accordance with the law, PROMESE is required to purchase products from the supplier that offers the lowest price, given the necessary qualifications and ability to deliver the specified product in sufficient quantities. Because of this requirement and the high volume of purchases, PROMESE achieves savings of between 56 and 1,017 percent for individual medicines. PROMESE’s procurement budget (approximately U.S.\$40 million) comes from two sources: the individual health establishments (97 percent) and the Presidency of the Republic (3 percent). PROMESE retains a percentage of the budgetary allocations of the health establishments for its services, which include the free distribution of products to health establishments. PROMESE has its own distribution network and laboratories for quality control.

Alongside this example of bulk procurement, there is some fragmentation in public-sector purchase of medicines. The IDSS and the armed forces, which also belong to the public sector, purchase their medicines separately, thereby missing out on an opportunity for savings that could be achieved by purchasing through PROMESE. Furthermore, the SESPAS directly procures medicines for special programs, including TB, vaccines, antiretrovirals, and contraceptives. There appears to be little communication among the procurement arms of these public-sector agencies.

PUBLIC-SECTOR CONTRACEPTIVE PROCUREMENT MECHANISMS

SESPAS

From 1997, when UNFPA curtailed its contraceptive donations to most of the regions in the DR, to 2003, the SESPAS suffered contraceptive stockouts. In 2003, it started purchasing contraceptives with public-sector funds. Between 2003 and 2004, these purchases were made from local suppliers. In 2004, the SESPAS signed an agreement with UNFPA, establishing it as a procurement agent. In 2005, the SESPAS increased its procurement of contraceptive supplies with public-sector funds, purchasing Rigevidon and

⁵ Presidency of the Dominican Republic; Decree No. 5-96; 7.01/96, establishes the rights to pay for services from the Division of Drugs and Pharmacies of the SESPAS.

Microval (orals), condoms, IUDs, and Depo-Provera through UNFPA at prices that were significantly lower than those offered by local suppliers. Table 1 shows the cost, insurance, and freight (CIF)⁶ prices that the SESPAS paid between 2004 and 2005 for various contraceptive commodities and the savings that it achieved by procuring through UNFPA 2005. For purposes of comparison, all other costs are assumed to be constant during this two-year period.

Of particular interest in table 1 are the highlighted cells. For each of the commodities, there was a considerable decrease in the unit CIF price between 2004 and 2005, corresponding to the transition from using local suppliers to using UNFPA as a procurement agent. The unit CIF prices fell by 83, 89, and 94 percent for orals, Depo-Provera, and IUDs, respectively. The second major result of using UNFPA to procure contraceptives is that the SESPAS was able to purchase considerably more products in 2005 and was consequently able to better serve consumer demand. The “Comparison Purchase” lines of table 1 quantify this result by showing a hypothetical scenario in which the total direct expenditures for each commodity in 2005 (“Total Cost” line) are divided by the 2004 local unit CIF price. The total number of units the government would have been able to procure in 2005 had the 2004 unit CIF price been paid is then compared to the actual number of commodities purchased in 2005 under UNFPA prices. The results, also highlighted in the “Percent Change” column, show that the SESPAS was able to procure between 493 and 1,472 percent more contraceptive supplies by using UNFPA than if it had purchased on the local market.

Table 1. Savings from UNFPA Procurement Agreement

	2004	2005	Percentage Change
Depo-Provera			
Units	10,500	248,000	2262%
Unit CIF Price (U.S.\$)	9.46	1.08	-89%
Total Cost (U.S.\$)	99,297	267,840	170%
Comparison Purchase (2005 Total Direct Expenditure / 2004 Unit CIF Price)		28,322	776%
IUD			
Units	3,750	240,000	6300%
Unit CIF Price (U.S.\$)	11.11	0.71	-94%
Total Cost (U.S.\$)	41,646	169,600	307%
Comparison Purchase (2005 Total Direct Expenditure / 2004 Unit CIF Price)		15,271	1472%
Duofem/Rigevidon*			
Units	20,000	1,600,000	7900%
Unit CIF Price (U.S.\$)	1.82	0.31	-83%
Total Cost (U.S.\$)	36,372	490,667	1249%
Comparison Purchase (2005 Total Direct Expenditure / 2004 Unit CIF Price)		269,801	493%
Total Expenditure (U.S.\$)**	177,316	928,107	

*SESPAS purchased Duofem locally during 2004. In 2005, SESPAS purchased both Rigevidon and Microval from UNFPA.

**Excluding condoms and Microval

Source: SESPAS, Dominican Republic, cited by J. Agudelo (2005), “Diagnostico Sobre Disponibilidad de Insumos Anticonceptivos (DAIA): Resultados,” *Conference at the Ministry of Health*, September 23, 2005.

⁶ CIF is the cost of the commodity including the cost of insurance and transport to the port of destination or entry.

IDSS

The Social Security Institute of the DR (IDSS) has typically received contraceptives free of charge from different sources, including the SESPAS. The IDSS did not provide any family planning services until 1997 when it established a Reproductive Health Division that received donated contraceptives from UNFPA and CONAPOFA (the National Family Planning Association). In 2001, the IDSS started purchasing contraceptives. However, stockouts in IDSS facilities are commonplace.

The IDSS purchases contraceptives from local vendors through a procurement process that is noncompetitive and results in very high prices. For example, in 2005, the IDSS procured Depo-Provera from local suppliers at a unit price of U.S.\$12.26, which is over 13 times more expensive than the estimated unit price offered by UNFPA (U.S.\$0.93) for the same product. IDSS warehouses have neither the conditions nor capacity to store large quantities of medicines and contraceptives. Although this situation would not necessarily preclude the possibility of bulk procurement through UNFPA or another source that requires central storage before distribution, adequate storage will need to be created for contraceptives as IDSS coverage grows.

The DR is currently undergoing a health care reform process that is expected to be finalized in 2011. At present, several important issues regarding the health system are under debate. During this transition period, there is little clarity about the future role of the IDSS. One possibility is that the IDSS will be converted into an administrative arm of the health system, which may preclude it from directly providing services to clients. If this is the case, it will be important for the GODR to develop contingency plans for transferring contraceptive procurement and family planning service delivery responsibilities to another agency.

CONTRACEPTIVE PRICING

Obtaining comparable information on the price components of different contraceptive methods across the public, NGO, and commercial sectors is a challenge in the DR. Similarly difficult is appropriately comparing the performance of the various procurement processes used by the different sectors. Nonetheless, the purpose of the pricing analysis was to attempt to quantify the direct costs associated with contraceptive procurement within the public, NGO, and private sectors. There was no attempt to quantify any indirect costs associated with the procurement process or with an individual's access to contraceptive commodities. This comparison is still useful for policymakers in identifying specific procurement practices and policies that yield the most efficient use of resources and create the most effective purchasing power for the buyer, both of which may drive down the costs of contraceptives. To help policymakers deal with these issues, this section of the report presents price information for the DR, together with regional and international reference prices for selected contraceptive methods. The regional prices refer to the average prices in the public and NGO sectors across the Central American and Caribbean countries included in the study that receive assistance from UNFPA and/or USAID to procure contraceptives.⁷ International reference prices are those that are available from international suppliers.

Figures 2 through 4 show the price components—CIF, duty and taxes, and administrative and social marketing costs—for oral contraceptives, injectable contraceptives, and IUDs in the DR. The figures also present the mean CIF prices for the public and NGO sectors for countries participating in the study: the DR, El Salvador, Guatemala, Nicaragua, and Honduras. Finally, the figures show the average retail price for the contraceptive commodities, as determined by visiting pharmacies in the DR.

ORAL CONTRACEPTIVE PRICE STRUCTURE

Figure 2 shows that the public-sector CIF price for oral contraceptives is U.S.\$0.31 per cycle, which is the lowest CIF price paid in the region. It is significantly lower than the NGO sector's CIF price of U.S.\$0.93. By comparison, the mean CIF prices for all the regional countries in the study that procured their own oral contraceptives were U.S.\$0.33 and U.S.\$0.44 for the public and NGO sectors, respectively. The public sector in the DR is therefore paying CIF prices that are about 6 percent lower than the regional public average for orals, while its NGO sector pays CIF prices that are 111 percent higher than the regional NGO average. It is interesting to note that the product included in the analysis from the NGO sector in the DR is Microlut, a progestin-only pill, while the products analyzed from the other countries are combined oral contraceptives.⁸ Comparing prices between the two pill types is valid, however, since international reference prices between their generic counterparts are comparable.⁹ The CIF price of Microlut in the Dominican Republic NGO sector is approximately three times more expensive than a comparable combined pill from any of the other NGO sectors analyzed in the region. The reason that orals in the Dominican Republic NGO sector are so much higher might be that Schering, the producer of Microlut, is attempting to extract higher profit margins through different marketing tactics for this particular product.

⁷ Regional prices were calculated separately for Central America and the Caribbean and for South America to account for the similarities of countries within these two regions.

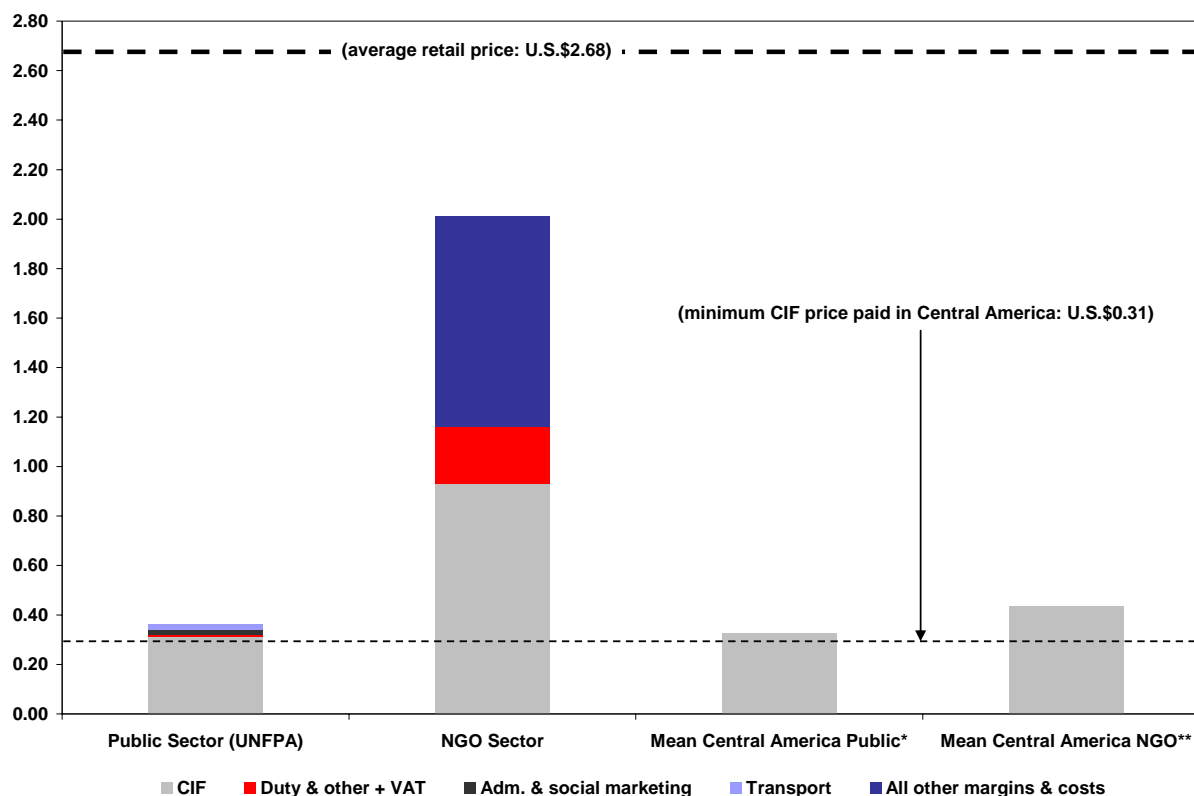
⁸ The combined pills analyzed in the DR public sector, as well as in the other countries' public and NGO sectors, are composed of 0.15 mg Levonorgestrel and 30 mcg ethinyl estradiol. Brand names in the DR and in other regional countries analyzed include Microgynon, Duofem, Nordette, Rigevidon, and Lo-femenal.

⁹ The international reference price for oral contraceptives is U.S.\$0.26.

While the CIF price represents the cost of purchasing the commodity and importing it into the country, it does not include the full costs of getting commodities to service delivery points. For a more realistic estimate of the price in the public sector, it is necessary to add duty and other importing-related costs as well as transportation costs. The GODR charges VAT on commodities for the private sector but not for the public sector. Transportation costs for the public sector were not available, so a regional average estimate of nearly 6 percent of the CIF price was used for the purpose of estimating the total direct costs of the procurement process. It was not possible to separate transportation costs for the NGO sector, so they are included in the label “all other margins and costs,” which also includes administrative costs, distributor margin, and costs associated with repackaging commodities. Thus, the average total direct cost of a cycle of oral contraceptives in the NGO sector is U.S.\$2.01, of which only 44 percent represents the cost of the commodity. On the other hand, the total direct cost for the public sector is U.S.\$0.36, which consists primarily of the CIF cost (86 percent).

At U.S.\$2.68 per cycle, the average retail price between Microgynon (U.S.\$3.22 per cycle) and Duofem (U.S.\$2.14 per cycle) in private pharmacies in the regions of Santo Domingo and Santiago was lower than prices observed elsewhere in Central America and comparable to the lowest prices observed in South America. A direct comparison between the average retail price and the NGO price is misleading, however, since PROFAMILIA imports Duofem and sells it to distributors, who in turn sell it to private pharmacies. Removing the Duofem data allows a comparison between the private- and public-sector prices that indicates the average retail price of Microgynon is almost 800 percent more than the estimated total public-sector price (U.S.\$0.36) for orals. This further reflects the savings that the SESPAS realized when it chose to use UNFPA as a procurement agent.

Figure 2. Price Components of Oral Contraceptives in the Dominican Republic



Source: Data collected by JSI (2005 U.S. dollars).

* Countries included in this average are DR, El Salvador, and Honduras.

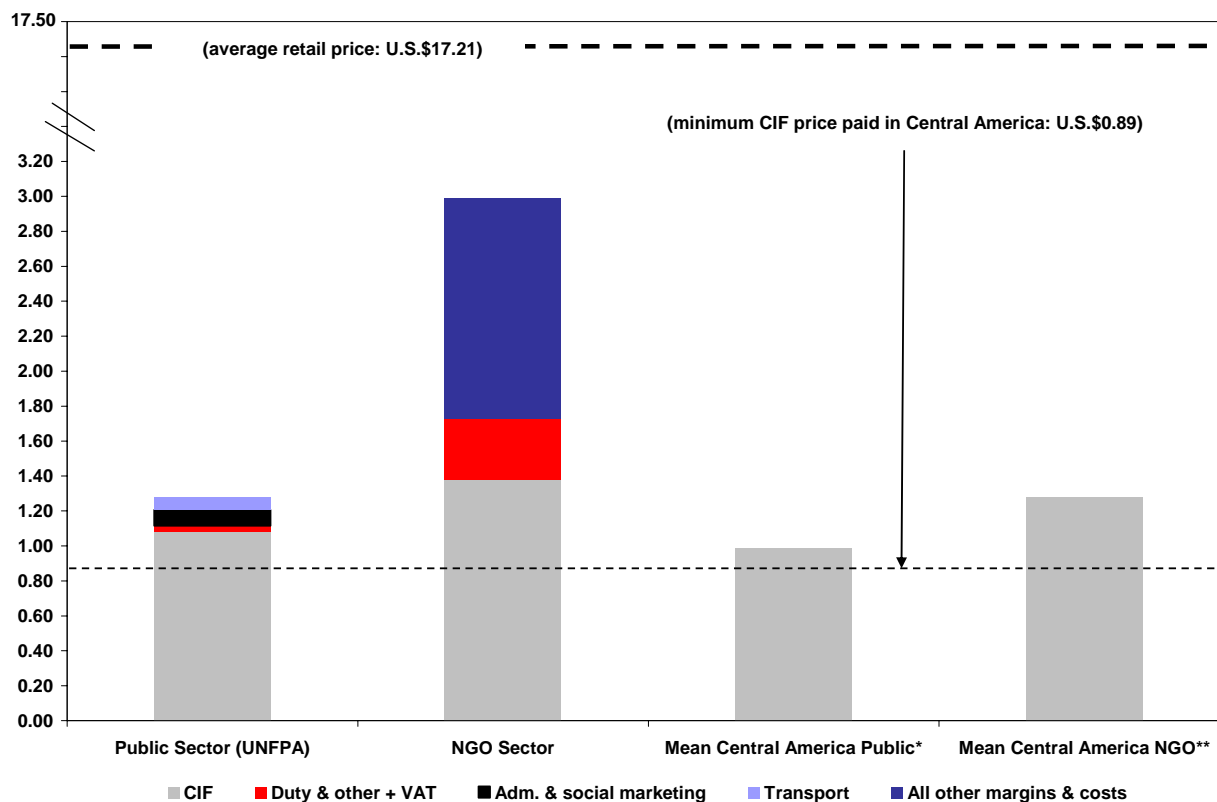
** Countries included in this average are DR, El Salvador, Guatemala, Honduras, and Nicaragua.

INJECTABLE CONTRACEPTIVE PRICE STRUCTURE¹⁰

Figure 3 shows similar information for the prices of injectable contraceptives in the DR. The public-sector CIF price is U.S.\$1.08 per injection, which compares favorably to the NGO CIF price of U.S.\$1.38. The mean regional CIF prices for public and NGO sectors that procured their own injectable contraceptives are U.S.\$0.99 and U.S.\$1.28, respectively. The public-sector CIF price for injectables in the DR is therefore 9 percent higher than the regional average public-sector CIF price, while the country's NGO CIF price is 8 percent higher than the regional average.

¹⁰ Prices for injectable contraceptives are based on a three-month dosage (e.g., Depo-Provera).

Figure 3. Price Components of Injectables in the Dominican Republic



Source: Data collected by JSI (2005 U.S. dollars).

* Countries included in this average are DR and El Salvador.

** Countries included in this average are DR, Guatemala, and Nicaragua.

When other cost components are taken into account, the total direct cost of an injectable for the public sector rises to U.S.\$1.28 per injection and U.S.\$2.99 for the NGO sector. As figure 3 shows, duty and VAT costs represent approximately 12 percent of the total direct cost to the NGO sector, while other margins and costs represent 42 percent of total direct cost. All cost components considered, the CIF cost represents only 46 percent of the total direct cost for the NGO sector, compared with 84 percent for the public sector. The average price of an injectable in retail pharmacies was U.S.\$17.21 (for Depo-Provera).

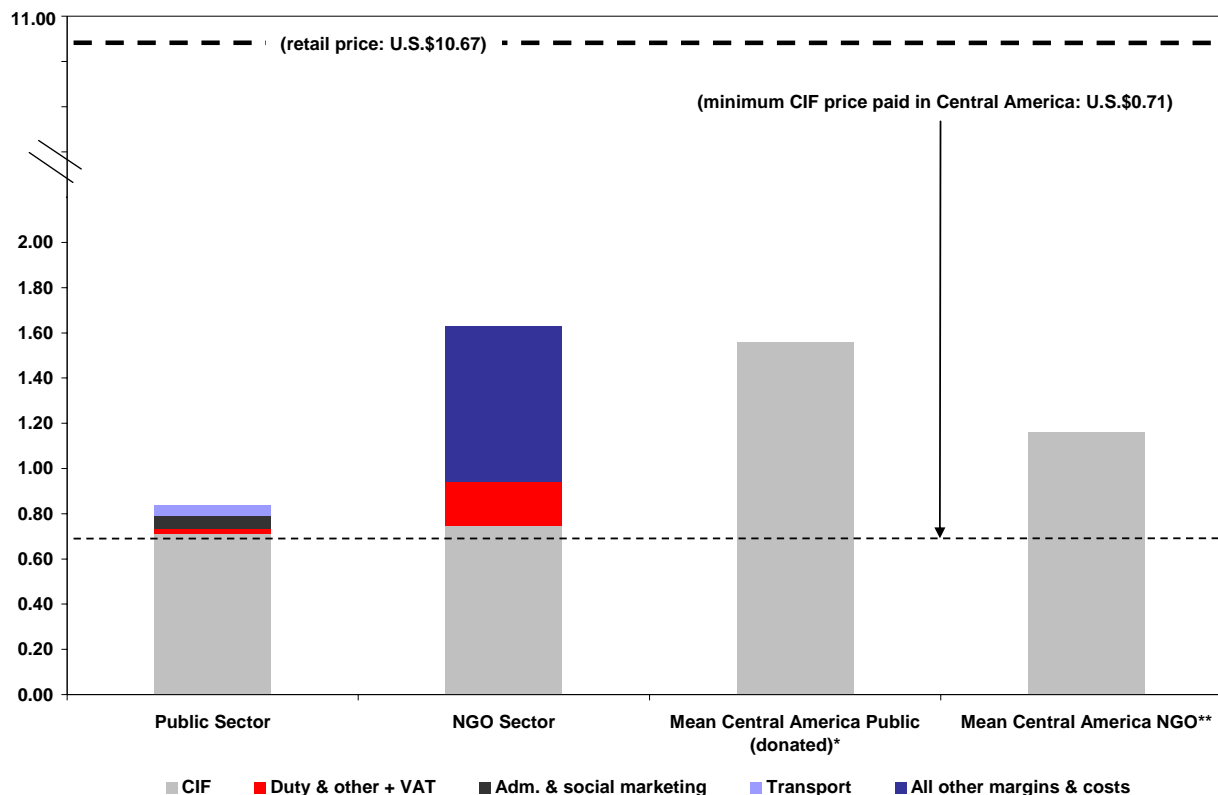
IUD PRICE STRUCTURE

Figure 4 presents similar information on prices and costs components for Copper-T 380A IUDs.

The CIF price for IUDs in the public sector is U.S.\$0.71, which is 5 percent lower than the CIF price in the NGO sector (U.S.\$0.75). The DR public sector is, in fact, the only public sector in the region that procures its own IUDs. To put prices of IUDs in the region into perspective, therefore, figure 4 presents the average price of donated IUDs from Guatemala and Nicaragua (U.S.\$1.56), which turns out to be more than twice the price paid by the DR public sector. The NGO sector CIF price, meanwhile, is 35 percent lower than the regional mean NGO CIF price (U.S.\$1.16). International reference prices for IUDs, which are between U.S.\$1.30 and U.S.\$1.55 per IUD, are higher than the DR public-sector CIF price.

After accounting for the additional costs over and above CIF, the total direct cost of an IUD to the public sector reaches U.S.\$0.84 per unit, while the average total direct cost for the NGO sector is almost twice as high, at U.S.\$1.63 per unit. Taxes (duty and VAT) and other margins and costs represent 54 percent of the total direct cost per IUD for the NGO sector. The average pharmacy retail price for an IUD in urban areas is U.S.\$10.67 per IUD.

Figure 4. Price Components of IUDs in the Dominican Republic



Source: Data collected by JSI (2005 U.S. dollars).

* Countries whose public sectors received donations of IUDs are Guatemala and Nicaragua.

** Countries included in this average are the DR and Guatemala.

Comparing method-specific costs within the public and NGO sectors suggests that the public sector has a comparative cost advantage in procuring oral contraceptives, while the NGO sector has an advantage in procuring injectable contraceptives. The public sector can provide women with three months of protection using either three cycles of oral contraceptives, for a total direct cost of U.S.\$1.08 (U.S.\$0.36 per cycle), or one three-month injection, for a total direct cost of U.S.\$1.28. It is clear that the public sector saves approximately U.S.\$0.20 for each three-month coverage when it supplies women with oral contraceptives instead of injectables. The NGO sector can provide coverage with injectable contraceptives at a lower cost to consumers (U.S.\$2.99 per three-month injection) than with oral contraceptives (three cycles at U.S.\$2.01 per cycle costs U.S.\$6.03 for three-months protection). These sector- and method-specific cost savings do not necessarily translate into organizational strategies; rather, they suggest the relative cost advantages available to each sector.

OPTIONS AND NEXT STEPS

The DR has already taken several steps to improve the efficiency and value for money of contraceptive procurements. Key elements include the following:

- **Purchase of contraceptives through a United Nations procurement agent.** The use of UNFPA as a procurement agent by the SESPAS has resulted in the DR getting access to prices that are comparable to or lower than those available to the other countries analyzed within the region. These dramatic savings have enabled the SESPAS to purchase larger quantities of contraceptives than would have been possible through a local supplier or at the local level. Furthermore, the use of an independent procurement agent helps improve transparency and accountability in the contraceptive procurement process.
- **An active, dynamic, and formally recognized contraceptive security committee.** The Contraceptive Security Committee has achieved an institutional status within the SESPAS that few of the committees in other countries have accomplished. It is an officially recognized actor within the health system and has been charged with establishing conditions and criteria for the procurement of contraceptives. Committee members have the opportunity to help choose vendors offering good-quality products at the most competitive prices.
- **An essential drugs list that includes an expanded contraceptive method mix, including condoms and IUDs.** This facilitates the procurement of a wide range of methods by the SESPAS. Drug registration in the DR is relatively low cost and, hence, does not serve as a barrier to entry.
- **Competitive pricing in the private-sector pharmacies within the region.** While observed pharmacy prices are several times higher than public procurement prices in the DR, they are generally lower than comparable pharmacy prices elsewhere in Latin America.

Nonetheless several issues still need to be addressed:

- **There is no tool or system in place to facilitate the comparison of prices** offered by various local and international suppliers of medicines and contraceptives. Such a tool would be very useful for identifying the best sources and mechanisms for contraceptive procurement.
- **There is no formal mechanism for the public and NGO sectors to coordinate their procurement activities** and take advantage of the potential savings resulting from each sector's comparative cost advantage.
- **There is no explicit budget line for contraceptives**, and the availability of public-sector resources for contraceptive procurement is left to the discretion of government officials.
- **There is no clarity as yet on which organization(s) will take ultimate responsibility for contraceptive procurement.**

We address these issues and make recommendations for improving procurement options below.

OPTIONS TO CONSIDER

ENGAGE IN A MORE FORMALIZED INFORMED PURCHASING ON THE BASIS OF PRICE COMPARISONS

At present, the SESPAS procures contraceptives through UNFPA at very favorable prices. UNFPA can provide a short-, medium-, and even long-term solution as the GODR tries to expand and diversify its procurement options for the future. Prices are one of the most important factors to consider in identifying new procurement options.¹¹ Securing the best possible price for good-quality contraceptives is vital for achieving contraceptive security in the absence of donor funding. Thus, comparative information about prices of both brand name products and generics offered by different local and international suppliers is critical for decision makers engaged in identifying contraceptive procurement options.

Box 1. Informed buying

Informed buying corresponds to the capacity of the public sector to take advantage of all the procurement alternatives available to ensure that high-quality contraceptives are available to the population at the best possible price.

Pharmaceutical companies offer different prices for the same product to different countries. As a result, countries with better economic conditions may pay more for a given product. Exchanging price

Box 2. Peru—the advantage of price comparisons

In Peru, the Ministry of Health’s decision to purchase ethynil estradiol from ESKE/FamyCare was based on a price study showing that the new local supplier could offer a lower price for the product than could UNFPA. This experience demonstrates the benefit of price comparisons to identify the best possible price for a given contraceptive method. Such price comparisons need to be updated regularly as new suppliers enter the market, and they need to include both national and international players.

information with other countries will provide the GODR with information about such discrepancies, thereby giving it stronger negotiating power with local representatives of international companies. Sharing such information with other countries may also inform the GODR about new sources that may be options for the DR in the future. Creating and advocating for a regional price comparison tool will help countries identify the best prices offered by different local and international suppliers of contraceptives and medicines. The tool would include regularly updated information on generic and brand name products as well as new suppliers to keep decision makers informed about supply options available in the local, regional, and national markets. The price comparison tool will facilitate better transparency in prices and give countries more negotiating power with suppliers.

While a price comparison tool would come with plenty of benefits, it is important to note that specific effort should be made to ensure that the tool is used primarily for informing decision makers in the region, as opposed to a means by which the private sector can collude and extract higher profits from targeted markets.

Price information for a variety of methods within and across countries is available in USAID’s *Options for Contraceptive Procurement: Lessons Learned from Latin America and the Caribbean* (Sarley et al. 2006). This report can serve as an initial reference guide for decision makers in the DR as they explore opportunities to improve procurement options.

Additional price comparisons between the SESPAS and various NGOs working in the DR, such as PROFAMILIA, could yield valuable insight into the comparative advantage that each organization has in the procurement of different contraceptive methods. As suggested in the previous section, each of these

¹¹ Other important factors include quality, availability of product in sufficient quantities, and timeliness.

sectors could realize additional savings if they coordinate their procurement efforts through a formal work agreement.

IMPLEMENT CENTRALIZED AND CONSOLIDATED PROCUREMENT

At present, the SESPAS directly procures contraceptives for the government through UNFPA. IDSS and the armed forces purchase their own contraceptives separately. IDSS, for example, purchases contraceptives from local vendors at prices as much as 10 times higher than UNFPA prices. Centralizing contraceptive procurement under one institution would contribute to economies of scale and better prices. The identity of this institution—the SESPAS, CONAPOFA, PROMESE—is likely to be determined during ongoing health care reform discussions. PROMESE, with its well-established network of suppliers, warehousing capacity, distribution networks, quality control systems, and experience related to procurement of all nonprogram medicines for the SESPAS, may be a good candidate for the central consolidated procurement of contraceptives as well.

Maximizing the price advantage of centralized bulk procurement will require the GODR to make the annual contraceptive budgetary requirement for the public sector available in its entirety once a year, rather than on a quarterly basis as is the current practice.

EXPLORE PROCUREMENT OPTIONS THAT INCLUDE DISTRIBUTION TO SERVICE DELIVERY POINTS IN TOTAL DIRECT COST

One important issue to consider in the DR is the delivery of the contraceptive methods to the service delivery point (SDP) level. Warehousing and transportation logistics often constitute a major problem. Therefore, it may be interesting to look at different procurement sources and delivery alternatives, including a model in which family planning methods are delivered directly from the seller to the SDP (local level). Alternatively, the government could hold a separate contract for the actual delivery of the products with an entity such as PROFAMILIA or could consider PROFAMILIA as a potential supplier, if its prices are competitive with those obtained through UNFPA (considering additional savings from local delivery).

ESTABLISH A PROTECTED BUDGET LINE ITEM FOR CONTRACEPTIVE COMMODITIES

Although the GODR has assigned funding for contraceptive purchases on a quarterly basis since 2003, there is no budget line item for contraceptive commodities. The availability of public-sector resources for contraceptive procurement must be negotiated year after year and is left to the discretion of government officials. Similar to other countries in LAC, the DR does not give family planning a legally protected status that would guarantee full disbursement of required funding each year. Therefore, cash flow and treasury management constraints, as well as competing health demands, can undermine the ability of the Ministry of Finance to make all the necessary funds available. Establishing a legally protected line item for contraceptives in the DR could provide some key advantages: it would increase the probability that the GODR will transfer the entire amount of resources budgeted for the purchase of contraceptives in any given year; prevent funding earmarked for contraceptives from being used for other health issues and essential medicines; and increase the cost-effectiveness of the procurement process since transfers could occur as yearly rather than quarterly. The SESPAS could make one large annual bulk purchase of contraceptives rather than four smaller purchases, thereby facilitating greater economies of scale and substantial savings to the government.

ELIMINATE LEGAL AND REGULATORY BARRIERS TO PUBLIC TENDERS

The DR should consider making exceptions to its requirement of public tenders when public funds are used. Entering into international or multilateral agreements currently falls outside of the procurement laws. All of the other eight countries in the study allow exceptions so that their governments can take advantage of lower prices offered through the international market.

TAKE ADVANTAGE OF REGIONAL INITIATIVES

Regional integration initiatives, such as the Caribbean Community and Common Market (CARICOM) or Central American Integration System (SICA), may provide important opportunities for the GODR as it seeks to improve procurement efficiency, expand contraceptive procurement options, and obtain better prices. Box 3 presents some examples of regional harmonization that have facilitated drug registration and inspection processes in Central and South America. The GODR should explore similar possibilities with other countries in the Caribbean. In the longer term, the GODR could also look into options for regionally pooled procurement or regional price negotiations (such as the case of antiretrovirals in the Andean countries) and the use of regional laboratory networks for quality assurance. Such regional initiatives have the benefits of significant cost savings through economies of scale and simplifying bioequivalence testing processes.

STREAMLINE PROCUREMENT OF CONTRACEPTIVES

The DR must consider a number of issues for fluid, reliable, and cost-effective procurement. One of the main challenges that the DR needs to plan for as contraceptive donations diminish and eventually end is how to efficiently institutionalize the procurement of contraceptives to ensure that procurement will not depend on political will or other conditions that may vary over time. Within this context, the example of Chile's autonomous procurement agency may be instructive to the GODR (see box 4).

In the DR, who could play a role equivalent to Chile's CENABAST? Should a new agency for public-sector procurement be created? Or is it preferable to assign this responsibility to PROMESE or CONAPOFA? In the context of the health care reform process currently taking place in the DR, these and other matters should be discussed strategically to ensure the continuous, cost-effective availability of quality contraceptives to those who need them.

Box 3. Some examples of regional harmonization

- Central American countries have harmonized their drug registry (*registro sanitario*) by establishing common pharmaceutical norms and technical criteria. Hence, a drug registry in one country can be officially recognized by any or all other countries in the region, obviating the need for a drug to be registered multiple times in different countries.
- Both MERCOSUR (*Mercado Común del Sur*) and Central American countries have established common standards for good manufacturing practices in the pharmaceutical industry and harmonized inspection procedures.
- The negotiation of low antiretroviral (ARV) prices by 10 Andean countries is an example of how a group of countries successfully negotiated with pharmaceutical companies to obtain regulated prices for ARVs (i.e., economies of scale).

Box 4. CENABAST in Chile

CENABAST is an autonomous procurement agency that manages the procurement of contraceptives for Chile's entire public sector, with decision making and planning performed at the local level. CENABAST can purchase contraceptives and essential drugs from local representatives of international companies, from local producers and, occasionally, directly in the international market.

CENABAST distributes contraceptive methods to the 26 regional health authorities, which in turn distribute them to public facilities. Because of its autonomy, CENABAST's operations do not rely on political conditions.

REFERENCES

- Abramson, Wendy, Jay Gribble, Nora Quesada, Varuni Dayaratna, David Sarley, Carlos Lamadrid, Nadia Olson, and Verónica Siman Betancourt. 2006. *Contraceptive Procurement Policies, Practices, and Options: Nicaragua*. Arlington, VA: DELIVER, and Washington, DC: USAID | Health Policy Initiative TO1, for the U.S. Agency for International Development.
- Beith, Alix, Nora Quesada, Wendy Abramson, Nadia Olson, and Anabella Sánchez. 2006. *Decentralizing and Integrating Contraceptive Logistics Systems in Latin America and the Caribbean, With Lessons Learned from Asia and Africa*. Arlington, VA: DELIVER, for the U.S. Agency for International Development.
- Dayaratna, Varuni, Juan Agudelo, Cristian Morales, Nora Quesada, David Sarley, Wendy Abramson, Jay Gribble, Carlos Lamadrid, Nadia Olson, and Verónica Siman Betancourt. 2006. *Contraceptive Procurement Policies, Practices, and Options: Dominican Republic*. Arlington, VA: DELIVER, and Washington, DC: USAID | Health Policy Initiative TO1, for the U.S. Agency for International Development.
- Dayaratna, Varuni, Nora Quesada, Jay Gribble, Wendy Abramson, David Sarley, Carlos Lamadrid, Nadia Olson, and Verónica Siman Betancourt. 2006. *Contraceptive Procurement Policies, Practices, and Options: Peru*. Arlington, VA: DELIVER, and Washington, DC: USAID | Health Policy Initiative TO1, for the U.S. Agency for International Development.
- Gribble, Jay, Nora Quesada, Varuni Dayaratna, Wendy Abramson, David Sarley, Carlos Lamadrid, Nadia Olson, and Verónica Siman Betancourt. 2006. *Contraceptive Procurement Policies, Practices, and Options: Honduras*. Arlington, VA: DELIVER, and Washington, DC: USAID | Health Policy Initiative TO1, for the U.S. Agency for International Development.
- Miller, Suellen, Argelia Tejada, Patricio Murgueytio, Juan Díaz, Rasha Dabash, Pamela Putney, Sandra Bjegovic, and Gladys Caraballo. 2002. *Strategic Assessment of Reproductive Health in the Dominican Republic*. New York: Population Council, for the U.S. Agency for International Development.
- Quesada, Nora, Verónica Siman Betancourt, Wendy Abramson, Varuni Dayaratna, Jay Gribble, David Sarley, Carlos Lamadrid, Nadia Olson, and Juan Agudelo. 2006. *Contraceptive Procurement Policies, Practices, and Options: Ecuador*. Arlington, VA: DELIVER, and Washington, DC: USAID | Health Policy Initiative TO1, for the U.S. Agency for International Development.
- Quesada, Nora, Wendy Abramson, Verónica Siman Betancourt, Varuni Dayaratna, Jay Gribble, David Sarley, Carlos Lamadrid, Nadia Olson, and Juan Agudelo. 2006. *Contraceptive Procurement Policies, Practices, and Options: Bolivia*. Arlington, VA: DELIVER, and Washington, DC: USAID | Health Policy Initiative TO1, for the U.S. Agency for International Development.
- Quesada, Nora, Varuni Dayaratna, Wendy Abramson, Jay Gribble, Verónica Siman Betancourt, David Sarley, Carlos Lamadrid, Nadia Olson, and Juan Agudelo. 2006. *Contraceptive Procurement Policies, Practices, and Options: Paraguay*. Arlington, VA: DELIVER, and Washington, DC: USAID | Health Policy Initiative TO1, for the U.S. Agency for International Development.
- República Dominicana: Encuesta Demográfica y de Salud, 2002 (ENDESA 2002). Calverton, MD: ORC Macro/MEASURE DHS+.

- Sarley, David, Varuni Dayaratna, Wendy Abramson, Jay Gribble, Nora Quesada, Nadia Olson, and Verónica Siman Betancourt. 2006. *Options for Contraceptive Procurement: Lessons Learned from Latin America and the Caribbean*. Arlington, VA: DELIVER, and Washington, DC: USAID | Health Policy Initiative TO1, for the U.S. Agency for International Development.
- Secretaría del Estado de Salud Pública y Asistencia Social (SESPAS)—Consejo Nacional de Población y Familia (CONAPOFA). 2005. *Comité para la Disponibilidad Asegurada de Insumos Anticonceptivos del Programa de Planificación Familiar de Republica Dominicana: Normas del Comité Nacional para el Aseguramiento de Anticonceptivos*. Santo Domingo, República Dominicana.
- Siman Betancourt, Verónica, Nora Quesada, Wendy Abramson, David Sarley, Varuni Dayaratna, Jay Gribble, Carlos Lamadrid, and Nadia Olson. 2006. *Contraceptive Procurement Policies, Practices, and Options: El Salvador*. Arlington, VA: DELIVER, and Washington, DC: USAID | Health Policy Initiative TO1, for the U.S. Agency for International Development.
- Siman Betancourt, Verónica, Nora Quesada, Wendy Abramson, Nadia Olson, Varuni Dayaratna, Jay Gribble, David Sarley, and Carlos Lamadrid. 2006. *Contraceptive Procurement Policies, Practices, and Options: Guatemala*. Arlington, VA: DELIVER, and Washington, DC: USAID | Health Policy Initiative TO1, for the U.S. Agency for International Development.
- USAID. June 2006. *Country Health Statistical Report*. <http://dolphn.aimglobalhealth.org>.
- World Bank. 2006a. “Beyond Economic Growth.” <http://www.worldbank.org/depweb/beyond/global>.
- . 2006b. “World Development Indicators.” <http://devdata.worldbank.org/wdi2006/contents/index2.htm>.

For more information, please visit <http://www.deliver.jsi.com> or
<http://www.healthpolicyinitiative.com>.

DELIVER

John Snow, Inc.

1616 North Ft. Myer Drive, 11th Floor

Arlington, VA 22209 USA

Tel: 703-528-7474

Fax: 703-528-7480

www.deliver.jsi.com

USAID | Health Policy Initiative

Constella Futures

1 Thomas Circle, Suite 200

Washington, DC 20005 USA

Tel: 202-775-9680

Fax: 202-775-9694/9698/9699

www.healthpolicyinitiative.com