EXPANDING SOCIAL HEALTH PROTECTION FOR MIGRANT WOMEN IN THE DOMINICAN REPUBLIC

RAPID ASSESSMENT PROCESS REPORT

Local Health System Sustainability Project

Task Order 1, USAID Integrated Health Systems IDIQ

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Local Health System Sustainability Project

The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ helps low- and middle-income countries transition to sustainable, self-financed health systems as a means to support access to universal health coverage. The project works with partner countries and local stakeholders to reduce financial barriers to care and treatment, ensure equitable access to essential health services for all people, and improve the quality of health services. Led by Abt Associates, the five-year, $209 million project will build local capacity to sustain strong health system performance, supporting countries on their journey to self-reliance and prosperity.

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Acronyms

ARS	Administradora de Riesgos de Salud (*Health Risks Administrator*)
DGM	Dirección General de Migración (*General Directorate for Migration*)
DR	Dominican Republic
ENI	Encuesta Nacional de Inmigrantes (*National Immigrant Survey*)
GODR	Government of the Dominican Republic
FAPPS	Formulario de Aplicación a Programas de Políticas Sociales *(HIV Patient Monitoring System)*
FUNCOVERD	Fundación Colonia de Venezuela en la República Dominicana (*Foundation Venezuelan Colony in the Dominican Republic*)
HIV	Human immunodeficiency virus
ID	Identification
IDDI	Instituto Dominicano de Desarrollo Integral *(Dominican Institute for Integral Development)*
ISWG	Inter-sectoral working group
LHSS	Local Health System Sustainability Project
M&E	Monitoring and evaluation
MEPYD	Ministerio de Economía, Planificación y Desarrollo *(Ministry of Economy, Planning and Development)*
MOSCTHA	Movimiento sociocultural para los Trabajadores Haitianos *(Sociocultural Movement for Haitian Workers)*
MSP	Ministerio de Salud Pública (*Ministry of Public Health*)
MUDHA	Movimiento de Mujeres Dominico Haitianas (*Dominican-Haitian Women's Movement)*
ONE	Oficina Nacional de Estadísticas (*National Statistics Office)*
PNRE	Plan Nacional para la Regularización de Extranjeros (*National Plan for Regularization of Foreign Citizens)*
R4V	Plataforma de Coordinación Interagencial para Refugiados y Migrantes de Venezuela (*Interagency Platform for Venezuelan Refugees and Migrants)*
RAP	Rapid assessment process
RFP	Request for proposals
SAI	Servicios de Atención Integral *(Integral HIV Services)*
SC	Steering committee
SENASA	Seguro Nacional de Salud *(National Health Insurance)*
SHP	Social health protection

SISALRIL	Superintendencia de Salud y Riesgos Laborales *(Superintendency of Health and Occupational Risks)*
SNS	Servicio Nacional de Salud (*National Health Service*)
SOP	Standard operating procedure
TB	Tuberculosis
2OiH	Two Oceans in Health
UNAP	Unidad de Atención Primaria (*Primary Healthcare Unit*)
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

The USAID Local Health System Sustainability (LHSS) Project helps low- and middle-income countries transition to sustainable, self-financed health systems as a means to support high performing health services. The LHSS Activity for Latin America and the Caribbean Bureau (LAC Bureau Activity) is providing technical assistance to the Dominican Republic (DR) to increase capacity to adapt, finance, and implement appropriate social health protection (SHP) platforms that provide adequate and equitable coverage for women migrants.

This report presents finding from a rapid assessment process (RAP), conducted by Two Oceans in Health for the LHSS LAC Bureau Activity, to understand the DR context for expanding SHP to migrant women. The RAP engaged key local stakeholders to thoroughly assess topics related to gaps in coverage, integration of migrants into the health system, current and potential financing strategies, as well as gender-based violence, human trafficking and other relevant social determinants. LHSS also conducted an extensive literature review and secondary data analysis of relevant programmatic data in the DR. Results have been triangulated with primary qualitative data collected through in-depth interviews and discussion groups and are presented in this report as inputs for the development of a five-year Strategic Roadmap to improve SHP for migrant women in the DR. The Strategic Roadmap provides an analysis of existing challenges and bottlenecks for migrants to access healthcare, key objectives and capabilities needed to achieve those goals, and initiatives to adapt an existing SHP platform to better meet the health needs of women migrants.

One key recommendation from stakeholder consultations is that the LHSS LAC Bureau Activity should broadly consider both male and female migrants, as feasible paths to expanding SHP are relevant for both groups. Other bottlenecks, opportunities, and strategies to be considered as a part of the Strategic Roadmap involve:

- Strengthening intersectoral coordination to overcome gaps in communication between providers and regulators of health services in public, private and civil society sectors. This would enable efforts to learn from previously successful programs involving migrant health, such as delivery of HIV and TB services. In addition to GODR and international agencies, coordination efforts should involve stakeholders from different migrant sub-groups (i.e., migrants from different age, sex and productive activities) as well as private sector investors, to explore opportunities for financing sustainable access and quality of health services for migrants.
- Establishing packages of basic health services that include the needs of migrants and health regions with higher density of migrant populations. Strategies to involve Haitian-born and descendant medical doctors and interns trained in the DR in the definition and delivery of those health packages should be explored, to take advantage of their linguistic and cultural capacities and personal motivation to support quality health services and access to SHP for Haitian nationals in the country.
- Providing temporary health ID documentation to migrants, including with unregulated immigration status, with the aim of tracking their health needs and affiliating them to insurance packages. This process should proactively address stigma and discrimination issues related to Haitian immigration in the DR, as well as political issues and challenges related to perception of migrants as a burden to the DR economy and the public health system. It should include dissemination of the available evidence on Haitian migrants' contributions to the DR economy (UNFPA 2019) and the potential to self-finance health services.
- Developing and strengthening national electronic health data registries, expanding on previously successful experiences of the HIV program (FAPPS), including variables to define the nationality and the migratory status of foreign-born residents. This type of nominal programmatic registry is crucial

not only for documenting, regulating and monitoring the provision, costs and quality of healthcare provided to Dominicans and migrants residing in the country, but also for effectively estimating the number of foreign residents travelling to the DR to access specific health services.

The RAP recommends that a Steering Committee (SC) be established to support operational planning, implementation, monitoring and evaluation of strategies to improve SHP for migrants while the full incorporation of these strategies into the DR health system is gradually negotiated. The SC should also participate in government efforts to develop and implement functional electronic health registries at the national level, as an important input for planning and monitoring future interventions aimed to improve access to SHP platform in the DR.

High-level key stakeholders have been involved in all stages of the RAP, through the participatory research methodology and as a part of the inter-sectoral working group (ISWG). The results of the RAP and ISWG consultations will be used to propose a 5-year Strategic Roadmap that builds on an in-depth analysis of long-term scenarios, bottlenecks, objectives, and capabilities needed to achieve them, to guide subsequent stages in project implementation.

1. INTRODUCTION

The USAID Local Health System Sustainability (LHSS) Project helps low- and middle-income countries transition to sustainable, self-financed health systems as a means to support high performing health services. The LHSS Activity for Latin America and the Caribbean Bureau (LAC Bureau Activity) is providing technical assistance to the Dominican Republic (DR) to increase capacity to adapt, finance, and implement appropriate social health protection (SHP) platforms that provide adequate and equitable coverage for women migrants.

The rapid assessment process (RAP) conducted for the LAC Bureau Activity aimed to understand the DR context for expanding SHP to migrant women by engaging key local stakeholders to thoroughly assess topics related to gaps in coverage, integration of migrants into the health system, current and potential financing strategies, as well as gender-based violence, human trafficking, and other relevant social determinants. LHSS also conducted an extensive literature review and secondary data analysis of relevant programmatic data in the DR. Results have been triangulated with primary qualitative data collected through in-depth interviews and discussion groups, and are presented in this report, as an input for the development of a 5-year Strategic Roadmap. One key recommendation from stakeholder consultations is that the LHSS LAC Bureau Activity should broadly consider SHP for migrants, both male and female, as feasible paths to expanding SHP are relevant for both groups. As such, some results and recommendations presented apply to both male and female migrants in the DR.

In keeping with a participatory action research approach, the RAP stage of this project has also served to identify and engage high-level key stakeholders for the expansion of the SHP platform for migrant women in the DR, involving them in the situation analysis and brainstorming of potential solutions to the major bottlenecks. These stakeholders have been involved in the inter-sectoral working group (ISWG), as an initial step towards the establishment of a project steering committee (SC).

2. STUDY OBJECTIVES

1.1. OVERALL

The objective of the primary research was to characterize opportunities and bottlenecks for the possible expansion of SHP for migrant women in the DR. The RAP involved key actors from different sectors in the analysis of health needs of migrant women, including related to gender-based violence,

human trafficking, and other relevant social determinants of health, current gaps in SHP and health service coverage, quality of services, integration of migrants in the health system, and potential financing strategies for expanding SHP.

1.2. SUB-OBJECTIVES

The research was also guided by the following sub-objectives:

- Develop a comprehensive description of opportunities and bottlenecks for the possible expansion of SHP for migrant women in the DR by identifying, reviewing, and systematizing the available sources of information and relevant gray literature.
- Identify and describe patterns of use and gaps in the access of the migrant population to health services in the DR, stratified by gender, age and province of residence, as well as the estimated costs of these services and their current financing mechanisms.
- Understand the perceptions of key stakeholders of the current situation and identify potential strategies and solutions for expanding SHP to migrant women in the DR.

3. STUDY METHODS

2.1. DESIGN

The RAP methodology was applied to generate a picture of the current situation and the bottlenecks preventing migrant women's access to health services in the DR. This methodology, defined as a fundamentally qualitative, intensive and team approach, uses multiple techniques for data collection, iterative analysis, and compilation of additional data to approach a preliminary and rapid understanding of the situation from the perspective of key actors (Beebe, 2013).

According to the requirements of the RAP methodology, which relies on the quality of interactions and contributions from different perspectives and areas of knowledge, the study was implemented by a research team comprising interdisciplinary experts with extensive expertise in the subject areas. The research team met weekly, in person or online, to evaluate study progress and plan the next steps in its execution.

Quantitative findings from analysis of the programmatic databases of the SNS (without user identity data), were triangulated with the literature review and stakeholder interviews and discussion groups. The study team conducted a total of 14 interviews and two discussion groups with key informants on issues relevant to migrant women's access to health services in the DR. Participants included government sector, private sector, and civil society representatives (See Annex I: Study participants).

The transcripts of the qualitative interviews and discussion groups conducted with key informants for the RAP were organized by themes linked to study objectives, for processing and analysis purposes. This process was guided by the Grounded Theory Approach (Glaser & Strauss, 1967), whereby codes and categories of analysis were built from the information gathered around each defined theme, in a manner agreed upon by a minimum of three members of the research team. Starting from the constructed categories, the textual use of testimonies is used as a fundamental resource, taking the necessary measures to guarantee the anonymity of the informants.

2.2. DATA COLLECTION TOOLS AND TECHNIQUES

The RAP is based on qualitative interviews and discussion groups focused on relevant issues for understanding the current situation and potential future strategies to increase access of migrant women to SHP in the DR. The topics addressed in both tools (see Annex II: Interview and focus groups guides) include, among other aspects:

- Perceptions of key actors regarding current access to SHP for migrant women, as well as trends and determinants of the demand for health services among migrant women and men, with emphasis on groups, sectors, and services with the greatest demand
- Perceived impact of this demand in terms of cost, quality of services and the health indicators reported by the country
- Current management by government, private sector, and civil society of the demand for services by migrant men and women, with an emphasis on financing strategies
- Availability and quality of relevant evidence for decision-making and definition of strategies, including identification of sources of additional information in these areas
- Positions of key actors on ideal scenarios for access of migrant women to health services, in the short, medium, and long terms
- Proposed strategies to achieve the proposed scenarios, including the analysis of their feasibility and possible sources of financing
- The most relevant opportunities and bottlenecks, identified by the key actors, for the proposed scenarios and strategies
- Recommendations from other key stakeholders for the design and implementation of sustainable responses to the demand for health services by the migrant population.

The results of qualitative interviews and discussion groups were used to contextualize and interpret the quantitative analysis of the available databases, as well as for input for the Strategic Roadmap.[1]

2.3. ETHICAL CONSIDERATIONS

The study protocol and its implementation were reviewed, approved and supervised by the Research Ethics Committee of Two Oceans in Health, ensuring compliance with local and international ethical regulations, including the Declaration of Helsinki.

Confidentiality was guaranteed to all participants, with potentially identifiable information removed from databases and other data processing formats, including qualitative interviews and partial transcripts of focus groups, before analysis. All data was processed, analyzed, and reported as a group, without identification or reference to responses from individual participants.

All primary data collection was governed by an informed consent process carried out individually, establishing, among other aspects, the option of rejecting participation in the study or interrupting the process of data collection, without consequences for the work, social or family condition of the participants. In the case of virtual interviews or discussion groups, signed informed consent was requested in an electronic format.

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[1] The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ. June 2021. *Roadmap for strengthening social health protection platform*. Rockville, MD: Abt Associates

All the answers provided by the study participants were stored on the 2OiH secure server, with access granted exclusively to the research team. No adverse events were recorded during the data collection process or other study activities.

4. STUDY FINDINGS

The literature reviewed for this study includes recent publications related to barriers to access to health services and social protection for the migrant population (i.e., foreign-born individuals and their descendants) in the DR. The review also includes elements provided by the *Social Health Protection in High Migration Areas Landscape Analysis Report* (LHSS 2021).

The Second National Immigrant Survey [2] and its complementary studies serve as the basis for understanding the current context of the population to be impacted. Reports prepared by the National Health Service (SNS) of health expenditures related to providing care to migrants in the Dominican health system are also included, as well as studies on the demand for maternal-perinatal service of Haitian migrant women in different regions of the country. These studies provide the cost of providing these services in the networks of Dominican health centers for this population group.

3.1. MIGRATION TO THE DOMINICAN REPUBLIC

3.2.1 HAITIAN MIGRATION

The DR is considered a country of emigrants and immigrants. The population of foreign origin (including foreign born and Haitian descendants) was estimated by the Second National Immigrant Survey (ENI-17) to be 847,979, of which 750,174 (88.5%) is the population of Haitian origin, historically the migrant group with the largest presence in the DR. Haitian-born migrants represent 4.9% of the total population of the country (ENI-17). According to data from the ENI 17, women represent 86.9% of the population of Haitian origin while 89.9% are men, which means that migration of Haitian origin continues to be predominantly male. While the findings of ENI-2022 have not yet been released, multiple key stakeholders have reported an increase in female immigration after the 2010 earthquake in Haiti.

In 2018, the ENI-17 reported that Haitian migrants concentrated mostly in border provinces (96.5%) and in provinces involved in agricultural activities (92.0%) and sugarcane industries (90.0%). However, in recent years, changes in the socio-economic dynamics in the DR have caused the movement of Haitians to geographic areas other than where sugarcane is produced (Cáceres Ureña, F., Báez Evertsz, F., & Caamaño, CA 2021), implying an important shift in health needs and health-related risks in these population groups.

Relations between Haiti and the DR have always been characterized by racial and political tensions and these have risen to a deep anti-Haitian sentiment in the DR. These tensions can be traced to a series of conflicts that originated in the independence wars of the nineteenth century, culminating with the massacre of thousands of Haitians in the DR in the twentieth century. Since the 1980s, these tensions have principally focused on the use of Haitian labor in the Dominican sugar cane industry, which has resulted in a large population of Haitians and Dominicans of Haitian descent in Dominican agricultural zones and major cities. Stigma and discrimination associated with this history represent important barriers for access and utilization of health services among immigrants of Haitian origin and their descendants, as well as for the regularization of their immigration status and inclusion in SHP mechanisms (Miric M. & Pérez-Then E., 2019). A recent study on perceived discrimination on *bateyes*

[2] https://dominicanrepublic.unfpa.org/sites/default/files/pub-pdf/ENI-2017_Descendientes%20de%20inmigrantes%20-%20web.pdf

(agricultural towns of sugarcane workers) among three ethnic groups—Dominican-born persons with Haitian descent, Dominican-born persons without Haitian descent, and Haitian-born persons—found that poverty was a common reason for discrimination experienced by all three groups. Both Haitian-born and Haitian-descended individuals also faced discrimination based on their origin, documentation status, and/or skin color (Keys, et.al, 2019).

3.2.2 VENEZUELAN MIGRATION

The population of migrants of Venezuelan origin is a growing group in the migratory dynamics of the DR. It is a relatively new population, and while various research studies are in progress, this report integrates general data collected from national registries and the press, as well as qualitative inputs from Venezuelan civil society organizations.

According to the National Statistics Office (ONE), in 2010, there were 5,123 Venezuelan migrants in the country. By 2018, this figure had increased significantly to nearly 26,000, a population growth of 653%. Venezuelans are now the second largest migrant group in the country (Listín Diario, May 19, 2018). The Interagency Response Platform to Venezuelans (R4V) reports the DR currently hosts the largest number of Venezuelan refugees and migrants in the Caribbean sub-region. The General Direction for Migration (GDM) estimated that 115,000 Venezuelans with irregular migratory status reside in the country. The Venezuelans consulted in this study, as representatives of their population group, are awaiting the normalization process (targeting only migrants from Venezuela), announced in April of this year by the Dominican authorities.

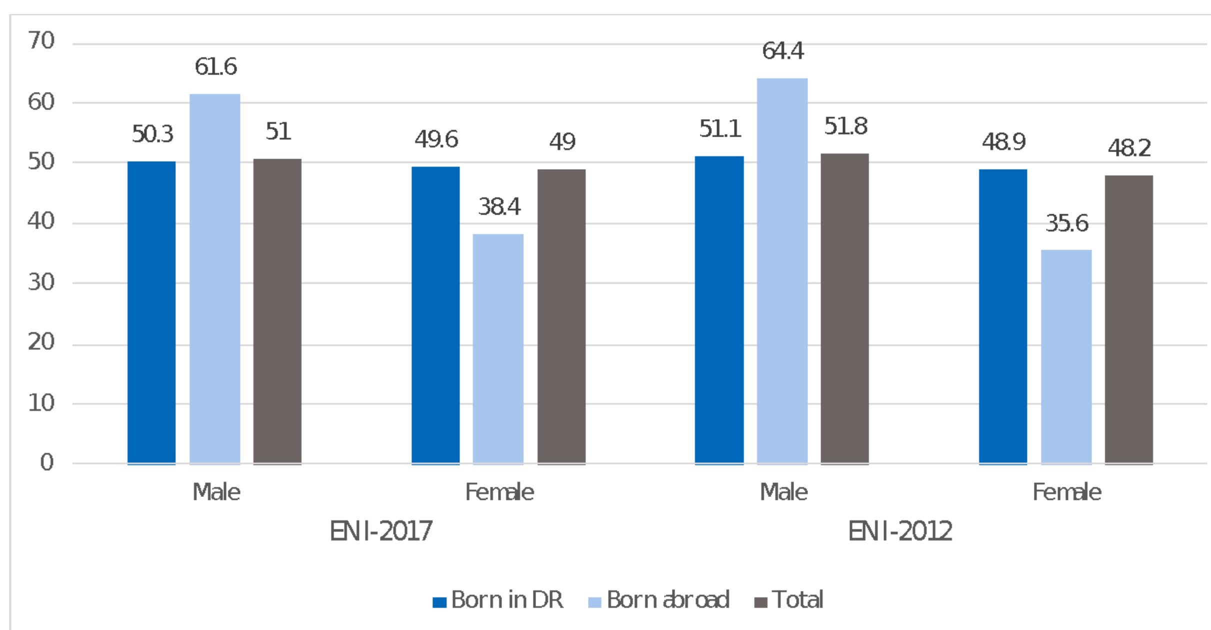
The 2022 National Immigrant Survey is expected to provide more data on more recent migration trends.

3.1.1 MIGRANT POPULATION IN THE DOMINICAN REPUBLIC

The Second National Immigrant Survey ENI 2017, carried out by ONE together with the Ministry of Economy, Planning and Development (MEPYD), is the main source of official data for the estimation and characterization of the resident immigrant population in the DR. In 2017, the survey estimated there were approximately 570,933 people living in the DR who were born abroad, which represents 5.6% of the total population of the country (ENI-17). Migrant women constitute 38.4% of this population. Comparisons with the first National Immigration Survey conducted in 2012 (ENI-2012) suggest that, between 2012 and 2017, there was an increase in Haitian descendants (10.7%), immigrants from other countries (9.6%), and Haitian immigrants (9.2%). Figure 1 shows the composition of the migrant population[3] between 2012 and 2017.

[3] In this report, "migrants" refer to foreign-born residents and their descendants, many of whom are born in the DR but lack government-issued identification and are therefore perceived as immigrants.

Figure 1. Composition of the immigrant population by sex and survey year (ENI-17, 2018, p.69)



By country of origin, the migrant population born in Haiti is the majority, reaching 497,825 (87.2%); those born in Venezuela are next highest (4.5%), followed by the United States (1.8%), Spain (1.3%), Italy (0.7%) and other South American countries (0.6%) (ENI-17, ONE, 2018).

3.1.2 DEMAND FOR HEALTH SERVICES

According to ENI, most migrants seek care while sick. Regarding specific health establishments, 77% of those born in Haiti and 78% of those born in the DR to foreign parents attend public facilities; while those born in other countries reported attending mostly private clinics (61.8%) (ENI -17).

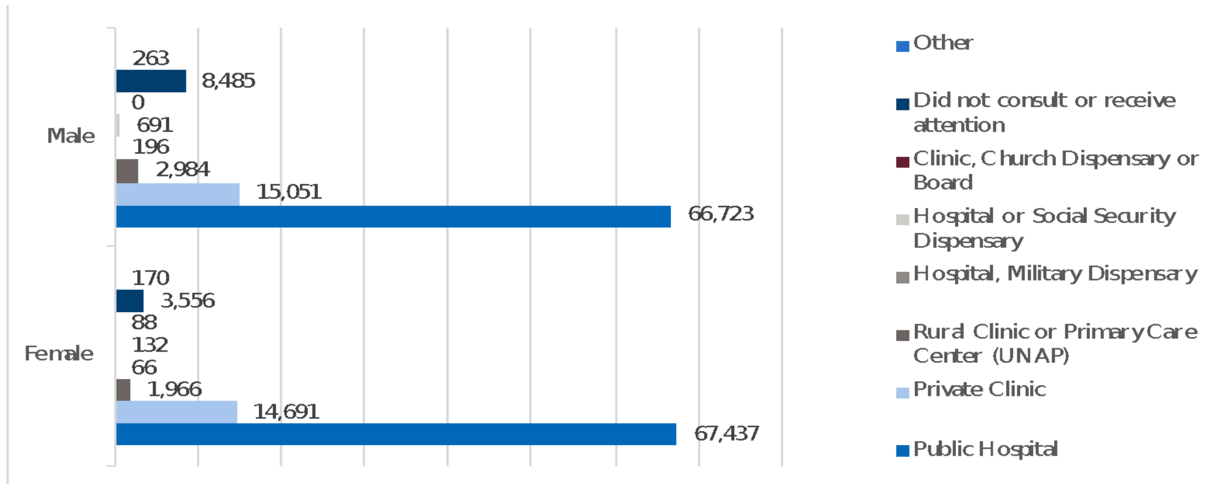
3.1.3 MIGRANTS' RIGHT TO HEALTH AND SOCIAL PROTECTION

The DR has ratified and signed international normative instruments that guide the state parties to guarantee access to health and social protection services for migrants, including the United Nations International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (Adopted 18 December 1990), the United Nations International Covenant on Civil and Political Rights (Adopted 16 December 1966), and the United Nations International Convention on the Elimination of All Forms of Racial Discrimination (Adopted 21 December 1965). Similar guidelines are included in the national regulatory framework (Dominican Constitution, General Health Law, Law that creates Social Security), guaranteeing access to public health services and social security for migrants. The 2001 General Health Law prescribes the universality of health services, which are accessible to all migrants, irrespective of their migratory status. Under Presidential Decree 96-16, the Social Security Treasury has adjusted its system to allow employers to register migrant workers in the social security system, with the relevant documentation.

The ENI-17 complementary study titled, "The access of migrants and their descendants to health and social protection in the Dominican Republic", characterizes health coverage for migrant populations (including the descendants of foreign-born residents), social security and the different financing regimes and mechanisms that establish the regulatory framework for social security (Bosch, M. UNFPA, 2018). The analysis suggests that most migrants (93.4%) and descendants of migrants (96.0%) visited a health center when they were sick, while only a small proportion of those sick or injured (6.6%) did not seek

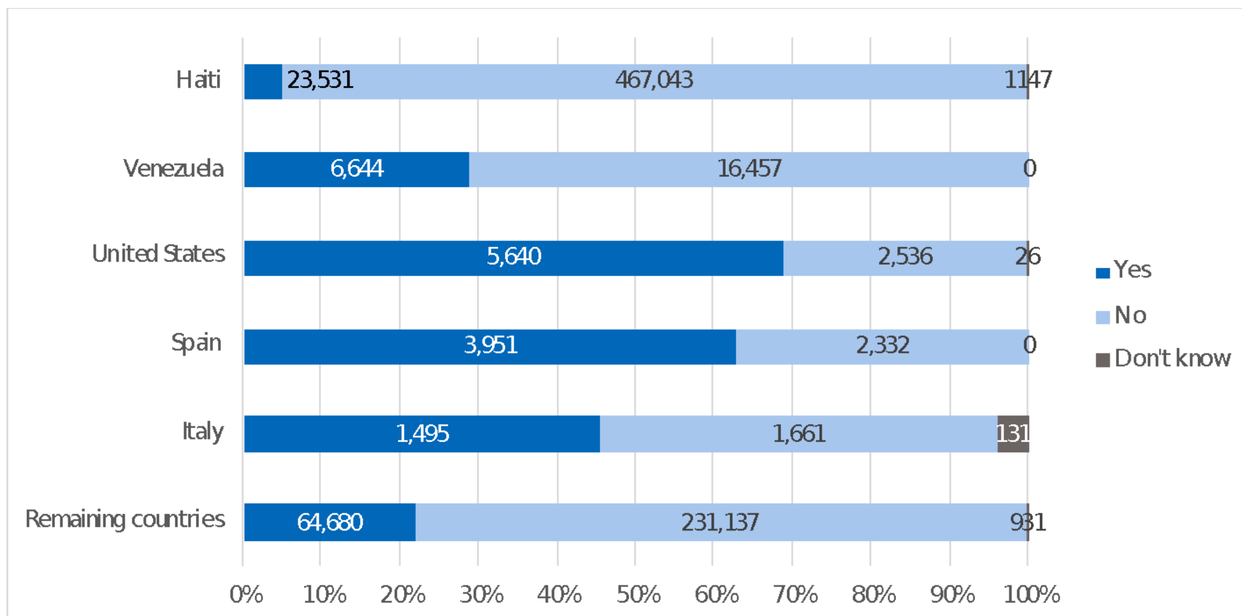
medical attention. It also reports that 67,437 migrant women received care in public hospitals while 14,691 received care in private facilities (see Figure 2), suggesting a tendency to attend public healthcare facilities (Bosch, p.49).

Figure 2. Type of health establishment accessed by migrant men and women (Bosch, 2018, p.57)



The percentage of migrants and descendants of migrants who were enrolled in health insurance was 12.8%. A similar percentage of migrant women (90.7%, n=194,532) and men (89.8%, n=303,417) reported having no health insurance. As depicted in Figure 3, Haitian migrants are significantly less likely to be enrolled in any type of health insurance in the DR. The relatively high rate of Venezuelan migrants enrolled in insurance programs may be linked to much higher educational levels and empowerment than that of Haitian immigrants. Despite low income levels, Venezuelan migrants have been able to organize advocacy groups very quickly and to negotiate access to insurance programs.

Figure 3. Migrant populations enrolled in health insurance, by country of origin (Bosch, 2018, p.65)



3.1.4 HEALTH EXPENDITURES RELATED TO THE MIGRANT POPULATION

In 2018, the SNS used the ENI-17 data as a reference for estimating health expenditure for health services for the migrant population (SNS 2018), comparing these numbers with the reports submitted by the nine Regional Health Services (SRS), The SRS integrates the SNS national service networks.

The SNS includes the estimated expenses based on the services provided by public health facilities for: surgeries; hospital admissions; deliveries (vaginal and cesarean section); emergencies; and consultations. However, it excludes prenatal visits, laboratories, transfusions, pap smears, imaging services and diagnostic support (X-ray, sonography), dental services and vaccinations. It does not consider the consumption of medicines or the medical transfer of patients. In the case of outpatient consultation services, post-natal and family planning visits are included for the first time.

The estimated expenditure for health services available to foreign-born patients in public health facilities between January and November 2018 was RD$ 2,522.0 million (US$ 51.5M), of which RD$ 2,269.9 million (US$ 45.8M, 90%) included only services delivered to Haitian nationals (SNS 2018).[4]

3.1.5 MATERNAL AND REPRODUCTIVE HEALTH SERVICES FOR MIGRANT WOMEN

The studies reviewed conclude that the health care demands of migrant women are concentrated in services related to maternal and reproductive health. Among other sources, the ENI-17 data reports that 96.6% of the interviewed women attended prenatal check-ups during their last pregnancy, almost all of them in a public health facility. While this demand is frequently perceived as a burden to the public health system, as affirmed by key stakeholders interviewed in this assessment, it is an important opportunity to provide an entry point for basic health services for Haitian women, as well as for their children and male partners.

The most recent study on the subject was published by the National Institute of Migration (INM-RD), titled "Maternal health and family planning of Haitian migrant women, case of two localities in the Dominican Republic" (2019), which collected the experiences and perceptions of Haitian migrant women when seeking health services. The study focused especially on care related to pregnancy, looking closely into aspects related to language, economic, social and other barriers that could represent bottlenecks for access or utilization of health services.

Among other findings, this study points out a generalized perception, among health providers, of Haitian migrants as women who come to the Dominican Republic exclusively to give birth. Haitian migrants are blamed for the significant increase in maternal mortality and other negative health system indicators. However, the authors highlight that this perception is based on a shared social stereotype, rather than on evidence, which also matches the perception of the interviewed key stakeholders, as discussed below.

3.2. MIGRATION STATUS AND ENROLLMENT IN HEALTH RISK ADMINISTRATORS (ARS)

The migration status of a person is understood as the legal condition under which a person resides in a country other than their place of birth. Migrant status is a challenge for the majority migrant groups in the DR (Haitians and Venezuelans) in ensuring full access to their essential rights such as health and social protection, given that government issued documentation is required for this access. Even though in June 2015 the DR government implemented the National Regularization Plan (PNRE), achieving the

[4] The average exchange rate for 2018 was: 1 USD = 49.59 DOP

registration of 288,467 of foreign-born residents (including Haitians), additional challenges have arisen for the migrants registered in the PNRE, due to the political and social impact of Covid-19.

> *"We have a population that joined the PNRE, but the measures adopted to stop the pandemic have slowed down the process of renewing their migratory status, mostly of Haitian migrants. At present, these migrants do not have the economic resources to complete the process and the logistical limitations imposed by the pandemic" (ID-02).*

Migrants were required to renew their status between 2017 and 2018, and 196,471 permits expired or will expire between 2020 and 2021. A total of 183,718 (98% Haitian) have applied for renewal, but the new process is very rigid and consists of 13 steps. As of November 2020, only 14,763 of all applicants of the program had achieved permanent migratory status (5% of all applicants).[5] The PNRE places each migrant it registers in a different category (resident, non-resident, temporary worker, permanent worker), according to the requirements established by the General Directorate of Migration (DGM). However, key civil society stakeholders supporting legal aspects of Haitian migrant population state that:

> *"Categories such as, for example, ¨temporary worker¨ have not guaranteed them the full access to rights. With this temporary permit, Haitian migrants cannot open a bank account or join the social security platform." (ID-02).*

The majority of migrants are not affiliated with health insurance. In 2018, of the estimated 497,949 foreign-born residents, 54,321 (10.0%) reported that they had health insurance. Among Haitian migrants who have been granted some type of document after the implementation of the PNRE, only 0.1% have been able to enroll in any health insurance (ENI-17).

Interviews with civil society stakeholders, who work directly or indirectly with migrant populations, suggest that this situation limits migrants' access to integrated health services and the social protection of the Dominican state. Key stakeholders indicate that integration in the public and, when feasible, private health insurance system, has been more effective for Venezuelan migrants – although this is still far from complete. A possible explanation is the significant differences in the sociodemographic profile of the migrants; among other aspects, the generally higher educational and income levels among the Venezuelan migrants, and their greater social cohesion and organization into civil society groups, has led to more effective political and social lobbying initiatives. As stated by one Venezuelan migrant:

> *"We have made agreements, after a lobbying process of about 4 years, and it has been possible to gain access to one of the private ARS [name omitted], to establish a low-cost health insurance package" (ID-06).*

3.3. ACCESS AND USE OF PUBLIC HEALTH SERVICES BY HEALTH REGION

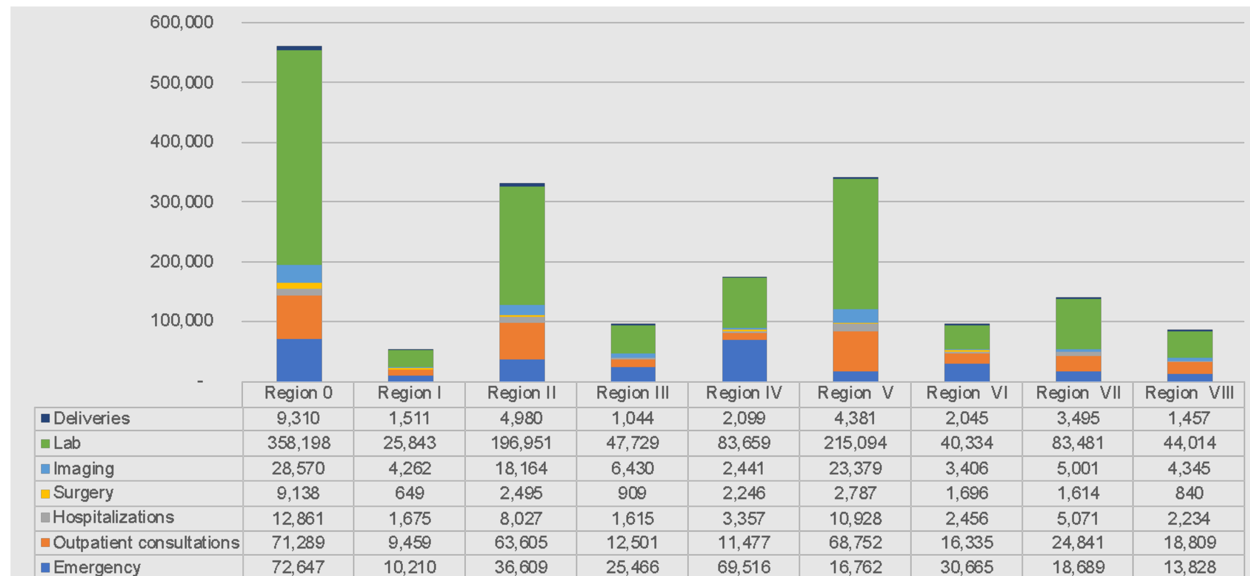
An in-depth analysis was conducted to describe access and use of public health services among Haitian migrants residing in different health regions during the period 2019-2021. The analysis used the Service Production Database that is managed and updated on a monthly basis by the SNS and covers emergency services, outpatient consultations, hospitalizations, surgeries, imaging, laboratory and births and deliveries.

As depicted in Figure 4 below, the health regions with the largest number of health services provided to Haitian nationals in 2020 are Region 0 (Metropolitana), Region V (East), Region II (Norcentral) and Region VII (Cibao Occidental). The most frequently used services involve laboratory, emergency and

[5] https://acento.com.do/actualidad/parece-necesario-renovar-el-plan-nacional-de-regularizacion-de-extranjeros-pnre-8882654.html, https://www.programamesoamerica.iom.int/es/noticia/la-oim-en-republica-dominicana-apoya-esfuerzos-de-informacion-y-regularizacion-relacionados

outpatient consultations, although specific areas and underlying diagnoses cannot be inferred from the SNS data.

Figure 4. Total number of health services delivered to Haitian women and men in the DR per health region in 2020 (SNS Service Production Database)



	Region 0	Region I	Region II	Region III	Region IV	Region V	Region VI	Region VII	Region VIII
Deliveries	9,310	1,511	4,980	1,044	2,099	4,381	2,045	3,495	1,457
Lab	358,198	25,843	196,951	47,729	83,659	215,094	40,334	83,481	44,014
Imaging	28,570	4,262	18,164	6,430	2,441	23,379	3,406	5,001	4,345
Surgery	9,138	649	2,495	909	2,246	2,787	1,696	1,614	840
Hospitalizations	12,861	1,675	8,027	1,615	3,357	10,928	2,456	5,071	2,234
Outpatient consultations	71,289	9,459	63,605	12,501	11,477	68,752	16,335	24,841	18,809
Emergency	72,647	10,210	36,609	25,466	69,516	16,762	30,665	18,689	13,828

This is consistent with data analyzed for 2019 and the first quarter of 2021, although usage trends seem to be impacted by the COVID-19 epidemic, including:

- Consistent reduction in number of health services provided to Haitian nationals in 2020, except for an increase in deliveries
- Pronounced reduction of health services provided to Haitian nationals in Region V during 2020, potentially on account of fewer job opportunities in the tourism industry during this period. This situation seems to be gradually reversing with the progressive re-opening of tourist establishments in this health region.

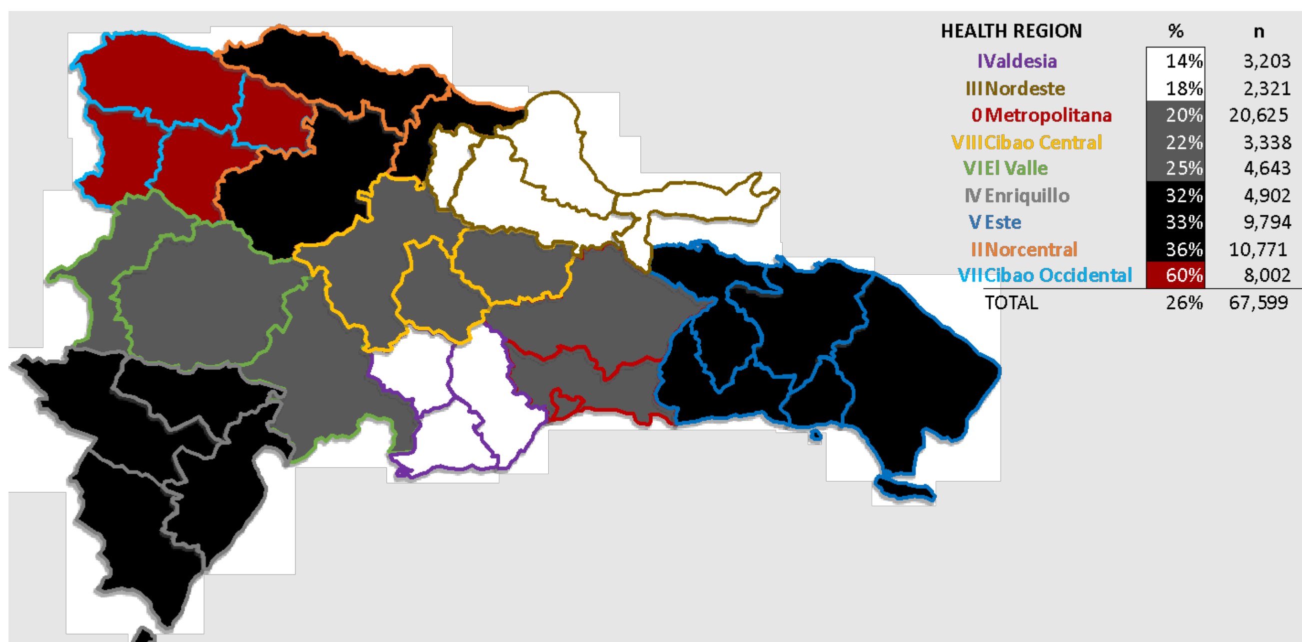
While deliveries represent only a minor proportion of services delivered to Haitian nationals, these represent 25.8% of all deliveries at national level, and exceed 30% in four health regions (IV. Enriquillo, V. Este, II. Norcentral, VII. Cibao Occidental), as depicted in Figure 5. In addition to a greater density of Haitian immigrants and their descendants (still considered to be ¨Haitian¨ as they frequently lack any kind of DR ID documents), it is very likely that Dominican women, whenever possible, seek care in private or urban health facilities, as these are considered to deliver higher quality services. Furthermore, in the border regions, anecdotal reports suggest that Haitian citizens living in Haiti will cross the border to access healthcare services and return to Haiti afterwards.

This contributes to high visibility of the use of delivery services by Haitian migrants and the perception that they are a major burden for the Dominican health system, both in terms of financial resources and the increasingly critical maternal maternity indicators. This perception could be aggravated by the increase in the number of deliveries for Haitian women during 2020, in contrast to the reduced number of deliveries reported for Dominicans in public health services. While we have found no evidence to explain this marked difference that coincides with the COVID-19 pandemic, it is possible that a greater number of Dominicans have moved to private sector services.

Key stakeholders explain that this situation resulted from a decline in acceptable labor and delivery services in Haiti, as compared to the DR health system:

"I perceive the number of Haitian women giving birth in our hospitals to be increasing in the past 10 years, as the DR health indicators are gradually improving, and the Haitian [indicators] are decreasing. That is a perfectly logical situation to me. If I was a Haitian woman with limited resources, living in Haiti, and I cannot find a suitable hospital there, there are no medical doctors and I am facing death as a perspective, where should I go? To the DR, naturally" [Discussion Group - DG]

Figure 5. Percentage of deliveries in Haitian women per health region, January 2019 - April 2021 (SNS Service Production Database)



HEALTH REGION	%	n
I Valdesia	14%	3,203
III Nordeste	18%	2,321
0 Metropolitana	20%	20,625
VIII Cibao Central	22%	3,338
VI El Valle	25%	4,643
IV Enriquillo	32%	4,902
V Este	33%	9,794
II Norcentral	36%	10,771
VII Cibao Occidental	60%	8,002
TOTAL	26%	67,599

3.4. SOCIAL DETERMINANTS OF ACCESS AND USE OF HEALTH SERVICES BY THE MIGRANT POPULATION

Key stakeholders from different sectors agree that, in general, foreign nationals do have access to public health services in the DR regardless of their migratory status. This access is only exceptionally denied, by individual healthcare providers, due to stigmatizing beliefs and attitudes. These attitudes are frequently explained or justified by the low educational level and limited financial resources of undocumented migrants, who tend to present higher morbidity and mortality rates due to the lack of regular health checkups, as stated by the participants in the high-level discussion group.

The political and social instability that Haiti is experiencing contributes to constant movement of its citizens, and the DR is the first destination choice. The use of health services by Haitian migrants, particularly women, is a politically charged issue for Dominican society. There is a general perception that Haitian migrants are a financial burden on the Dominican government, including on the health budget, and this is acknowledged by key stakeholders as one of the major sources of stigma that interferes with Haitian migrants' access to health services.

This perception belies data from studies such as the recently published analysis on the *Contribution to the added value of the population of foreign origin in the Dominican Republic* (UNFPA, 2019), which shows that the migrant workforce added value equivalent to 9.54%, with Haitian migrants contributing 7.41%. This was highlighted by the civil society stakeholders:

"Haitian migrants cannot be seen as a burden to the state. It is important to make this clear. They have contributed to the economic development of the DR. They offer their workforce, previously in the sugar industry, today in agriculture, the hotel industry and now in domestic services provided by women" (Study ID-03).

Stakeholders also reported differences in the access and quality of health services provided to Haitian and Venezuelan migrants, partially explained by previously mentioned differences in educational and social empowerment levels. Social determinants and barriers tend to vary between the two groups. Table 1, below, summarizes the information provided by the key stakeholders on identified barriers to access the health services and the potential solutions for each migrant sub-group.

Table 1. Barriers for access to health services and potential solutions in Haitian and Venezuelan migrants, as reported by the key stakeholders

Nationality	Barriers to access to health services	Potential strategies to improve access
Haitian	Legal • Irregular migrant status • Difficult to prove identity (errors in birth records, false names)	Legal • Revisit and expand the PNRE strategy initiated in 2015 to provide access to legalization for more Haitian migrants • Streamline the migration status renewal process for migrants whose local documents have expired
Haitian	Health System • Cultural issues and social determinants of health, including stigma and discrimination • Reported cases of verbal abuse and service denial • Fear of arrest and subsequent deportation due to unregulated migratory status • Limited access to social protection and health insurance	Health System • Involve medical doctors and interns of Haitian nationality in primary care services for migrants • Develop and strengthen cultural and social integration mechanisms • Provide stigma-reduction experiential trainings for health care providers and decision makers • Create facilities for formal incorporation to the state health insurance company (ARS-SENASA)
Haitian	Other • Transportation costs • Low literacy and empowerment levels • Language barrier	Other • Promote solidarity networks with Dominican residents • Provide interpreters in health establishments
Venezuelan	Legal • Irregular migrant status	Legal • "Regularization" process for Venezuelans
Haitian/ Venezuelan	Legal • Informal labor market and inconsistent income interfere with inclusion in Health Risk Administration plans	Legal • Involve civil society and NGOs to identify health needs of specific migrant groups and advocate for their health rights
Haitian/ Venezuelan	Health System • Low wages and limited financial resources (for transportation and other indirect health-related costs)	Health System • Pathways for incorporation into private ARS, low-cost health packages
Haitian/ Venezuelan	Other • Sexual exploitation, particularly in women migrants	Other • Expanded health packages for migrants include screening for GBV, testing for STDs, and mental health • Training health providers to identify victims of sexual exploitation and provide appropriate care and referrals

3.5. AVAILABLE RESOURCES AND INITIATIVES TO IMPROVE SHP FOR MIGRANTS

Attempts to improve access to health services for migrants in the public sector have been limited. Multiple key stakeholders have reported disjointed actions of CSOs, the public and private sectors. The exceptions are the control programs for diseases such as HIV and TB, which frequently constitute a gateway for the migrant population to the health system.

Currently, Haitian migrants have access to certain health services, such as HIV care, however, accessing other services is challenging due to stigma and discrimination, fear of deportation while seeking care, and out-of-pocket expenses (including transportation costs). In other words, health services generally are not tailored to meet migrant-specific needs. Even assistance from CSOs that provide information regarding how to access available health services is limited to individuals at risk of HIV transmission or people living with HIV.

In the case of Venezuelan migrant groups, strategic alliances involving the private sector, international organizations, and Venezuelan health professionals have provided specific solutions. For example, they have established support networks for specific health services (cancer and mental health) that have been frequently used by Venezuelans, in the last two years.

> *"We have articulated an alliance with the Rosa Duarte Cancer Center. Here they partially receive extremely vulnerable cancer cases. But, when the time comes for the cost, we go to the department of social work, and they tell us that they cannot afford the processes since we do not have the valid or updated documentation" (ID-06)*

The limited public sector response also includes projects that assist with chronic diseases, laboratories, and other services that are supported financially through agreements with specific health centers. Another strategy is to identify Venezuelan health professionals established and practicing in the country, to link them to health support programs for Venezuelan migrants. While this was suggested also as a solution for Haitian migrants, no organized implementation efforts have been identified.

According to the report estimating the investment in health (SNS) for foreign patients, public health programs such as those for high-cost drugs do not exclude migrants. However, in practice, access is limited and discretionary, according to civil society key stakeholders. While positive experiences and initiatives have been reported, key stakeholders agree that collaboration across government, private sector, and civil society to provide sustainable and long-term solutions for inclusion of migrant populations in existing SHP platforms has been limited.

Likewise, while bilateral health initiatives have been developed, the key stakeholders agree that these have failed--mostly due to the lack of commitment on the part of Haitian health authorities. In general, more specific site-based collaborations between DR and Haitian health facilities – such as the one developed by the National TB Program for referral and counter-referral of patients between DR and Haiti health centers – have performed better than the high level, government-to-government bilateral initiatives.

3.6. COSTS AND FINANCING OF HEALTH SERVICES FOR THE MIGRANT POPULATION

As previously stated, public health services are provided to migrant populations in the DR free of cost, or with a minimal fee that also applies to Dominican citizens. Due to limited data, it is difficult to estimate the exact cost of these services for the National Health System. Based on the recent estimates established by the SNS, the total public health expenditures on services provided in 2019 to foreign

citizens amount to 4,351 million DOP (84.5 M US$), of which 4,195 million DOP (81.7 M US$, 96.4%) corresponds to services provided to Haitian migrants (see Table 2).[6]

Table 2. Health expenditures (RD$) on services offered to foreign nationals in 2019 (*SNS, Health Expenditure Analysis: migrant population*)

Services	Haitian patients		Other migrant patients		Total no. services	Total expenditures (RD$)	Percentage of total expenditures
	No. of services	Expenditures (RD$)	No. of services	Expenditures (RD$)			
Outpatient s.	536,688	427,212,975	14,931	11,885,335	551,619	439,098,311	10.09%
Emergencies	413,152	2,116,707,930	20,287	103,936,696	433,439	2,220,644,626	51.03%
Hospitalizations	55,578	922,795,166	1,301	21,601,290	56,879	944,396,456	21.70%
Surgery	26,998	396,149,508	926	13,587,467	27,924	409,736,975	9.42%
Vaginal births	19,289	172,494,499	188	1,681,215	19,477	174,175,714	4.00%
C-sections	8,708	160,372,570	187	3,443,922	8,895	163,816,491	3.76%
Total	**1,060,413**	**4,195,732,648**	**37,820**	**156,135,926**	**1,098,233**	**4,351,868,574**	**100.00%**

A major percentage of this expenditure corresponds to emergency health services (51.0%), followed by hospitalizations (21.7%) and outpatient services (10.09%). Despite this, vaginal births and c-sections tend to receive much more visibility both among health authorities and public opinion. This is potentially related to their presumed contribution to elevated maternal mortality rates, under the assumption that migrants experience more complicated deliveries resulting from limited access and utilization of prenatal care services. There is limited anecdotal evidence to support these assumptions and more in-depth analysis, including the detailed audits of maternal mortality cases, is needed to develop appropriate public health interventions.

Some participants in the high-level discussion group with the DR government health authorities suggest that the lack of the basic health insurance for undocumented migrants contributes to the perception that theses migrants are a burden on the health system. This may be linked to discrimination at site level as health facilities cannot request payments based on the provided services:

> *"With deliveries of Dominican women there is at least a minimum payment of these services to the hospital by SENASA (National Health Insurance). This does not happen with Haitian women, since they usually arrive with no valid documentation, have no health insurance, so they represent an expense charged directly to the hospital" (DR government discussion group).*

This may also explain lower c-section rate deliveries among Haitian women (32%) compared to Dominicans (54%), as a strategy to reduce delivery-related costs in this population group. However, several key stakeholders have affirmed that the sub-optimal quality of maternal and child health services, and the poor health indicators, reflect the generalized and long-term limitations of the DR public health system rather than the nationality of the healthcare users:

> *"The Haitian and Dominican women have equal access to health services. The only difference is that Dominican women are accessing these services in their territory, but they still face the same deficiencies of the health system" [DR government discussion group].*

It is important to note, however, that migrant women often have weaker social support networks and might not be able to rely on family support and solidarity to compensate for any deficiencies of the

6 **The average exchange rate for 2019 was used: 1 USD = 51.34 DOP.**

public health system, including the purchase of medications and other resources for adequate medical attention.

3.7. GENDER DETERMINANTS OF HEALTH

According to the ENI-2017, most migrants in the DR are men (62%), and both genders seem to be equally represented in access to health services (49% women, 51% men). This supports the perception of key stakeholders that men also face barriers to health services. Possibly due to prenatal care and delivery services (included, along with immunizations, in Table 2 under outpatient services), women tend to reach the DR health system more efficiently. In this context, Haitian men, and specifically those involved in informal commercial activities such as construction, represent a particularly vulnerable population group.

Haitian women, on the other hand, tend to have more access to health services through prenatal check-ups and delivery, although they face discriminatory practices. Hence, the Primary Healthcare Units (UNAP), represent the important first step in the access of Haitian women to the DR health system:

> *"The population of Haitian migrant women are frequent in the use of the Primary Care Units (UNAP), they are frequent in the prenatal and pregnancy services. But they are not users of planning methods, which is reflected in the rise in assistance to UNAPs for pregnancy check-ups, here in the area (Cibao)" (ID-05).*

It should be noted that the 2019–2021 programmatic data provided by the SNS Service Production Database, reports a consistently lower percentage of c-section deliveries among Haitian women (32%) compared to Dominicans (54%). While this lower percentage of c-sections is closer to the ideal rate range of 10-15%, established by the World Health Organization (WHO), the reason for this difference is not clear. It could be related to discriminatory treatment of Haitian women in health services more than to medical indication of vaginal versus c-section delivery. Some of the key stakeholders involved in the discussion group have also highlighted the cultural determinants of health as a possible explanation, with Haitian women being more willing to deliver vaginally as compared to Dominicans. Another explanation is the perception of vaginal birth as a "punishment" as opposed to the c-section as a VIP standard of care, present among some healthcare providers, as reported by the interviewed key stakeholders, which exemplifies discriminatory practices towards migrants. In the public healthcare setting, given inadequate policy enforcement and structural regulations, decision-making relies on individual healthcare providers.

Given the importance of the delivery services provided to Haitian women in the public health sector, based on visibility and the perceived high cost, the DR government has recently announced the construction of maternity wards on the Haitian side of the border, in order to guarantee quality of health services to Haitian women and avoid the need to cross the border.[7] While this project has been positively received by the civil society and migrant group stakeholders, who point to the opportunity of involving Haitian health professionals in these new establishments, others have expressed doubts about the feasibility of reducing maternal mortality rates with this type of intervention.

As stated by the DR government representatives, the use of delivery services by Venezuelan migrants has also increased:

> *"Some 20 years ago it was unthinkable that you would find a woman from Venezuela delivering in a public hospital in the DR. But now we are increasingly seeing this type of situation."*

However, the demand for prenatal and delivery services among Venezuelan migrants tends to be concentrated in the private sector, despite its high cost:

[7] https://proceso.com.do/2021/02/27/abinader-confirma-construccion-de-hospitales-del-lado-haitiano/.

"Venezuelan migrants usually seek care in general medicine in the public sector. In the case of gynecology services, they look to private clinics, for the security that this guarantees. They seek Venezuelan doctors whom they prefer, because of their training and experience with this population" (ID-07).

3.8. DATA AVAILABILITY

The availability of reliable and current data on migrant access and utilization of health services in the DR is limited by the long-term structural constraints in the national health information system. While major private health establishments frequently develop an electronic patient registry system, adapted to their specific needs, data in the public health hospitals is usually registered manually, on paper and consolidated into pre-established categories required by the monthly service production reports.

Since 2019, these reports are systematized in a user-friendly Power-bi dashboard and published by the SNS on their web portal, allowing for analysis of major categories. However, as there are no nominal service data registries, it is impossible to conduct more in-depth analysis, crossing different report categories, which would be necessary for a comprehensive understanding of the health services provided to migrants. This leads to multiple additional limitations of the national service production database, including:

- The quality of entry-level data varies between different establishments, and different registers are used as data sources, making it difficult to assess the reported data
- The criteria used to define nationality as Haitian or Dominican varies across facilities, which could lead to significant biases in consolidated reports
- This database does not include health services provided by the private sector, which could present very different tendencies.

HIV services are an exception to these public health sector limitations, as a coordinated nation-wide nominal patient monitoring system (FAPPS, Spanish acronym) has been progressively expanded since 2016, with SNS leadership and PEPFAR-funded technical support. Haitian migrants are defined as one of the PEPFAR prioritized populations for the outcomes of the national HIV program, A biometric registry (fingerprint) identification (ID) system has been added to allow for a reliable nominal data registry of undocumented Haitian migrants, including the possibility of future referral and counter-referral with the Haitian HIV services. The FAPPS database information could not be extrapolated to general tendencies in migrant access to health services in the DR, given the characteristics of the population accessing HIV services. However, this experience is considered to be a best practice and a potential platform for more comprehensive health information solutions.

While a broad estimate of services provided to foreign citizens in the private sector could be derived from the databases managed by SISALRIL (Superintendency of Health and Occupational Risk), collecting the national public and private ARS (Health Risk Administrators) data, these only include migrants with regularized migratory status and exclude undocumented population groups. These limitations result in multiple important gaps in the programmatic data on migrant access and utilization of health services in the DR, including:

- Limited data on demand, access and utilization of health services by different sub-groups of migrants - particularly those with unregulated migratory status - does not allow for reliable cost estimates
- The number of Haitian nationals reported to cross the border to access specific health services is currently unknown, making it difficult to estimate the burden of unregulated health tourism
- The undocumented status of a large percentage of Haitian migrants and their descendants represents a challenge for accurate population estimates and characterization, including geographic

distribution and utilization of health services

- Gender, occupation, and age-related differences in public and private health service utilization are unknown
- Immigration status and current residence of persons accessing the public health services is unknown, including the percentage of persons accessing services in DR who currently reside in Haiti
- Sources of financing of services used by the migrant men and women are unknown, including the out-of-pocket co-payment amounts required in some of the DR health establishments.

To fill these gaps, the organizations involved in the expansion of SHP platforms for migrant populations in the DR rely mostly on the national immigrant surveys conducted in 2012 and 2017 (ENI-12 and ENI-17, respectively) and complementary studies derived from this data. The upcoming ENI-2022 is expected to expand on the available information, highlight trends in the migrant utilization of health services and reflect more recent immigration trends in the country. However, more systemic solutions are urgently needed to support evidence-based decision making in the DR health service planning and monitoring activities, not only in the case of migrant populations but also in the general population.

4. CONCLUSIONS

Table 3 presents the conclusions and the proposed strategies for different areas identified as relevant for the expansion of SHP platforms for migrant women in the DR. This table is a starting point for the upcoming project activities, including the participatory development of a Strategic Roadmap, involving high-level key stakeholders as a part of the ISWG.

Table 3. RAP Study conclusions and proposed strategies

Area	Conclusions		Proposed strategies
	Bottlenecks	Opportunities	
Intersectoral coordination	Limited integration and communication between providers and regulators of health services in public, private and civil society sectors in the DR Low priority assigned by the DR government to health services provided to migrant populations, and perception of these services as a burden for the economy and a threat for the quality of health services provided to DR citizens Preoccupation by the DR government health authorities that providing high-quality health services for migrant populations could contribute to an increased demand of these services, and a consequent	Previous coordination experiences in specific health conditions (HIV & TB) Potential interest of the private sector in participating in solutions and financing of the health services for migrants.	• Constitute a high-level intersectoral Steering Committee (SC) including government, private sector, and civil society representatives, to define, validate and lead the implementation of feasible and sustainable solutions to guarantee access and quality of basic health services to foreign nationals in the Dominican territory. The ISWG would serve as an advisor to the SC. • Ensure regular and continued exchange of SC members through regular working meetings, coordinated, and supported by the project team, strengthening SC advocacy efforts and anti-stigma initiatives • Explore potential investment opportunities for the private sector stakeholders, as a platform for sustainable access and quality of health services for different groups of migrants in the DR • Involve key stakeholders from different migrant groups in the SC meetings, to

Area	Conclusions		Proposed strategies
	Bottlenecks	Opportunities	
	increase in unregulated migration		ensure that their interests and priorities are adequately represented
Access to packages of basic health services with sustainable sources of financing	Limited data on demand, access and utilization of health services provided to different sub-groups of migrants residing in the DR - particularly those with unregulated migratory status- which does not allow for reliable cost estimates and financial projections The undocumented status of a large percentage of Haitian migrants and their descendants living in the DR, represents a challenge for accurate population estimates and characterization, including their geographical distribution, as well as for their access to the available health services The low educational level of a significant percentage of Haitian migrants, and their frequent involvement in informal productive activities, limit both their advocacy abilities and sources of financing for health services, further reinforcing the perception that they are an economics burden	Positive experiences with low-cost packages negotiation initiated by Venezuelan migrants with private health insurance companies could provide input on the feasible negotiation strategies Current provision of basic health services to migrants in public hospitals, regardless of their migratory status	• Establish standardized health service packages and insurance schemes for different sub-groups of migrants living in the DR, considering gender, age and main productive activity, proposing sustainable sources of financing appropriate for each sub-group • Prioritize the definition of packages for low-income migrant sub-groups in the DR, with emphasis on health regions and services accessed by a larger number of migrants, including antenatal care, deliveries, family planning, emergency and specific laboratory and imaging services • Conduct site-level primary data collection and analysis in selected and prioritized health regions and specific establishments, to provide additional evidence required for the definition of service packages and their potential financing strategies • Involve potential investors and private sector stakeholders to identify feasible and sustainable financing opportunities for specific packages of health services, compatible with the current DR health system regulations • Explore feasible and sustainable strategies to involve Haitian born and Haitian descendant medical doctors and interns in direct service provision for Haitian migrant populations • Promote community and CSO-led monitoring of quality of health services delivered to migrants, establishing mechanisms for prevention and reporting of stigmatizing and discriminative treatment within health services
Migratory, political, and social barriers	Political issues and challenges related to perception of immigration – particularly low-income Haitian immigration – as a burden to the DR economy and, even more so, to the public health system.	Available evidence on the contributions of migrants to national economy (UNFPA, 2019) Previous private sector experiences with providing basic	• Provide health documentation to migrant groups currently living in the DR with unregulated immigration status, with the aim of tracking their health needs, and affiliating them to insurance packages adapted to their current productive activity and related risks • Explore existing private sector initiatives and best practices that could support access to temporary ID documents for

Area	Conclusions		Proposed strategies
	Bottlenecks	Opportunities	
	The important number of undocumented Haitian migrants and their descendants residing in the DR, who are unable to regularize their status in the DR nor Haiti, behave as a hidden population for national health authorities	health insurance to migrant workers involved in local agriculture	migrants for health service purposes, within the framework of current migratory and insurance policies • Explore insurance options for migrants involved in informal economy, with no stable sources of income and unregularized migratory status • Explore and negotiate potential binational strategies to provide temporary documentation to Haitian migrants for health service purposes
Availability of data for decision-making	The exact number of Haitian nationals anecdotally reported to cross the border to access specific health services (particularly maternity and delivery services), while permanently residing is Haiti, is currently unknown, making it difficult to estimate the cost and the burden of this unregulated health tourism for the Dominican Health system and specific health indicators Limitations of the DR health system, including the lack of standardized electronic patient registries in public health services, represent a challenge for adequate tracking, referral and follow up of both Dominican and foreign citizens using these services.	National interest in improving health data registry and reporting within the public health system (including nominal data bases on health services production) Positive experiences of the HIV program with the nominal data registries in public health facilities (FAPPS, HIV patient monitoring system), including a successful implementation the biometric registry module for undocumented migrants Trained and experienced personnel for the development of nominal data registries at the SNS IT Team Private sector experiences in nominal health data registry in the DR and Haiti	• Document, regulate and monitor the provision, costs and quality of health services provided to foreign citizens who do not permanently reside in the DR, including formal and informal health tourism practices • Explore and expand best practices and lessons learned in registering, tracking and monitoring undocumented and low-income migrant populations, generated by existing migrant-friendly services, such as PEPFAR-funded HIV clinics in the DR, including the use of biometric registers

5. RECOMMENDATIONS

Based on the information gathered from the literature review, analysis of programmatic data, and qualitative inputs provided by the DR government, private sector, international agencies and civil society key stakeholders, the following recommendations can be made for the expansion of the SHP platform for migrants in the DR:

Above-site level strategies (sub-national and national level):

Strengthen intersectoral coordination and operationalization of strategies through the ISWG

- Continue regular meetings of the ISWG to obtain feedback on the situation analysis presented in this report and input on the next steps in the operational planning process for the proposed strategies in this report.
- Constitute a high-level intersectoral Steering Committee (SC) including government, private sector, and civil society representatives, to define, validate and lead the implementation of feasible and sustainable solutions to guarantee access and quality of basic health services to foreign nationals in the Dominican territory. The ISWG would serve as an advisor to the SC.
- Ensure regular and continued exchange of SC members through regular working meetings, coordinated and supported by the project team, strengthening SC advocacy efforts and anti-stigma initiatives.
- Involve key stakeholders from different migrant groups in the SC meetings, to ensure that their interests and priorities are adequately represented.
- Identify sources of financing to cover the operational costs (such as planning, M&E activities, implementation reports) of the SC and the supporting technical team during the implementation of the Strategic Roadmap, in order to produce the deliverables and project documents expected during this 5-year period.
- Evaluate the pilot roadmap implementation initiative, as input for the national-level expansion of the SHP platform for migrants.
- Establish an operational plan for phased rollout of the Strategic Roadmap, initiating its pilot implementation in a limited number (four) of public health facilities located in the health regions with the largest number of health services provided to foreign nationals in the period January 2019 – April 2021 (0. Metropolitana, V. Este, II. Norcentral and VII. Cibao Occidental).

Tailor available health services into standardized packages to better meet migrants needs

- Establish standardized health service packages and insurance schemes for different sub-groups of migrants living in the DR, considering gender, age and main productive activity, proposing sustainable sources of financing appropriate for each sub-group.
- Prioritize the definition of packages for low-income migrant sub-groups in the DR, with emphasis on health regions and services accessed by a larger number of migrants, including antenatal care, deliveries, family planning, emergency and specific laboratory and imaging services.
- Identify sources of financing available to cover the costs of different service packages (such as insurance, health insurance, taxes, international funding), including potential innovative solutions in the private sector.
- Explore insurance options for migrants involved in informal economy, with no stable sources of income and unregularized migratory status.

Develop or adapt ID mechanisms that facilitate undocumented migrants' access to health services

- Support the Government of the Dominican Republic (GODR) in the development and implementation of nominal programmatic service production registries, including the expansion of previously successful experiences in health ID solutions for migrant and undocumented clients (FAPPS, SIRENP).
- Explore and negotiate potential binational strategies to provide temporary documentation to Haitian migrants for health service purposes.
- Provide health documentation to migrant groups currently living in the DR with unregulated immigration status, with the aim of tracking their health needs, and affiliating them to insurance packages adapted to their current productive activity and related risks.
- Explore existing private sector initiatives and best practices that could support access to temporary ID documents for migrants for health service purposes, within the framework of current migratory and insurance policies.

Improve data collection and analysis for informed decision-making

- Document, regulate and monitor the provision, costs and quality of health services provided to foreign citizens who do not permanently reside in the DR, including formal and informal health tourism practices.
- Explore and expand best practices and lessons learned in registering, tracking, and monitoring undocumented and low-income migrant populations, generated by existing migrant-friendly services, such as PEPFAR-funded HIV clinics in the DR, including the use of biometric registers.

Site-level strategies:

- Propose basic health service packages for different sub-groups of migrants, based on the health needs and specific risks related to gender, age and occupational activity. These packages should prioritize:
    - Sexual and reproductive health services, with emphasis on family planning, HIV and other STIs, prenatal care and safe deliveries
    - Pediatric services, with access to national vaccination program
    - Emergency services
    - Basic laboratory and imaging diagnostic procedures
- Conduct a baseline assessment and define specific interventions to be implemented in each selected facility, required for the successful rollout of the roadmap, including the development of a nominal data registry and health ID mechanisms.
- Conduct site-level primary data collection and analysis in selected and prioritized health regions and specific establishments, to provide additional evidence required for the definition of service packages and their potential financing strategies.
- Define mechanisms to reinvest the income generated by health services provided to migrants in improvements of the overall quality of public health services, prioritizing migrant-friendly establishments. While these services currently do not generate income, key stakeholders suggest that they have the potential to do so if covered by health insurance.
- Design referral and counter-referral procedures between the hospitals and the primary healthcare units in their catchment area. Explore feasible and sustainable strategies to involve Haitian born and

Haitian descendant medical doctors and interns in direct service provision for Haitian migrant populations.

- Promote community and CSO-led monitoring of quality of health services delivered to migrants, establishing mechanisms for prevention and reporting of stigmatizing and discriminative treatment within health services.

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ANNEX 1: STUDY PARTICIPANTS

Sector	Institution	Representative	Position
Government	Ministry of Women	Dr. Noris Gómez Riva	Social Policy Coordinator in the Department of Migration Policy and Trafficking
		María Esther	Point of Contact (POC) COIN (Centro de Orientación e Investigación Integral) / Ministry of Women
	National Council for HIV and AIDS (CONAVIHSIDA)	Rosa Sánchez	Social Mobilization Coordinator
Civil Society Organizations (CSOS)	Dominican-Haitian Women Movement (MUDHA)	Sirana Solis	President
		Elizabeth Cruz	Health Promotion Manager
	Scalabrinian Association at the Service of Human Mobility (ASCALA)	Sister María Eugenia	Director
	Socio-Cultural Movement of Haitian Workers (MOSCTHA)	Dr. Joseph Cherubin	Director
		Ing. Tony Contreras	Health Awareness Department
		Dr. Viere Franco	Health Manager
	Women in Development (MUDE)	Dr. Betania Libanesa	Health Project Manager MUDE Santiago
	Center for Promotion and Human Solidarity (CEPROSH)	Dr. Fátima Colombo	Health Manager
	Dominican Institute of Integral Development (IDDI)	Santa Sánchez	Health department manager
		Francisco Tejeda	Migrant Health Project Coordinator
	Center for Orientation and Integral Research (COIN)	Dr. Fernando Díaz	Clinical Manager
	Venezuelan Settlement Foundation in the DR (FUNCOVERD)	Miguel Otaiza	President

Sector	Institution	Representative	Position
	Venezuelan diaspora in the Dominican Republic (DIAPOVERD)	Ana María Rodríguez	Coordinator
International Agencies	United Nations Population Fund (UNFPA)	Dr. Dulce Chahín,	National Sexual and Reproductive Health Officer
	Heartland Alliance Health	Alexander Vallejo	Country Manager
Private sector	YUNEN Group	Dr. José Rafael Yunén	President

ANNEX II: INTERVIEW AND FOCUS GROUP GUIDES

Access and Use of Health Services Among Migrant Women In the Dominican Republic

CP -		
Date:	**Start Time:**	**End Time:**
Interview Location:		
Observations:		
P.1. Sex:	**P.2.** Age:	**P.3.** Profession:
P.4. Institution:		
P.5. Time in the institution:		
P.6. Actual Position:		

1. Perception of the current situation regarding immigration and its impact on the health system
    a. Trends in recent years: Increase, decrease, migrant profiles, etc.
    b. Explanation of the trends described: immigration reasons, changes in dynamics, etc.
    c. Impact of immigration on the health system
        i. Groups of migrants with the greatest impact on the health system
        ii. Most impacted sector (explore public vs. private)
        iii. Services most impacted / demanded (explore mother and child, HIV, etc)
    d. Current measures to mitigate the impact on health system
        i. Financing sources
        ii. Offer and quality of services
        iii. Other intervention measures
2. Availability of data on immigration dynamics and their impact on health services
    a. Available data (sources, quality, utility, etc.)
    b. Data NOT available (required for evidence-based decision making)
    c. Suggested sources and mechanisms for obtaining required data
3. Proposals regarding the current situation and the impact of immigration on health services
    a. Ideal scenario that the country should pursue to this issue, in the medium and long term
        i. Goals in terms of quality of services, cost, sources of financing, etc.
        ii. Strategies to achieve this scenario and its feasibility
        iii. Institutions and key actors (explore their expected positions on this issue)
    b. b. Solutions and scenarios proposed in the immediate (short term)
        i. Goals in terms of quality of services, cost, sources of financing, etc.
        ii. Strategies to achieve this scenario and its feasibility
        iii. Institutions and key actors (explore their expected positions on this issue)
    c. Specific suggestions for strategies and priorities to take into account immediately
    d. Key actors at the strategy negotiation table (institutions and people)
    e. In the case of constituting an intersectoral table to identify solutions to the demand for health services by the migrant population in the country, ¿would you like to be part of the table?

- High-Level Discussion Group -

Thematic Guide

Date: Start time:	End time:
Place:	
Observations:	

PRELIMINARY ACTIVITIES*

- Informed consent
- List of Contestants

PHASE I. Group Presentation / Introduction

- Presentation of facilitators / co-facilitators of the group.
- Presentation / explanation of the objectives of the discussion.
- Presentation of the participants in the group
- Rules of discussion (confidentiality, equitable participation, mutual respect, etc.)

PHASE II. Development / Discussion of Topics

•Current situation

o Trends and determinants of the demand for services (groups, sectors and services with the highest demand)
o Impact on services: costs, quality, health indicators
o Current management from the government / private sector / civil society
o Availability of evidence for decision making

•Solution Proposals

o Ideal scenarios in the short, medium, and long term
o Strategies and sources of financing for each scenario
o Opportunities and anticipated bottlenecks for the proposed strategies
o Institutions and key actors in the design and implementation of defined strategies (intersectoral table)

•Final Comments

CLOSING THE DISCUSSION

- Summary of the conclusions of the discussion
- Closure

**Complete the list of participants and the informed consent forms prior to the start of the session. In the case of virtual sessions, send the consent form to all participants, attached to the access link to the virtual platform.*