

Mental Health Development within the Dominican Republic

A descriptive analysis of mental health development and treatment option availability in the Dominican Republic through the study of a medical clinic in Monte Plata

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Introduction

The Dominican Republic is a country on the brink of change both socially and economically. It is marked by a complex system whose aims have fallen short in distributing adequate health services to its indigent populations. Solutions in resource allocations are difficult as little research has been done with the intent of monitoring which subgroups and regions require additional servicing. Mental Health service monitoring for populations in both urban and rural societies is gaining interest, but needs to be researched to understand what problems are prevailing and to identify what links, if any, occur with other national problems such as substance abuse, HIV/AIDS, and the effects on families and its' members.

The Research Study

Background of the Study

Mental disorders account for 22% of diseases within Latin America and the Caribbean as noted within the World Health Organization's (WHO) recent mental health assessment in 2009 ("WHO-AIMS," pg. 9). In 1990, rough estimations showed that neurological and mental disorders within these regions were reported at 8.8% (pg. 11). This shows a dramatic increase in rate of occurrences for countries located in this region. The Pan-American Health Organization (PAHO) states in their 2005 study on community-based mental disorders that there is a 1% annual increase for affective psychoses, 4.9% for major depression, and 5.7% for alcohol abuse and dependence (pg. 11).

Within this framework the majority of services available to populations in need are located within capital cities and urban areas (pg. 37; Santana & Rathe, pg. 93). Though most servicing is centralized, the current most affected areas are located within rural societies due to lack of agency availability. Of the six countries evaluated by the WHO, Dominican Republic positively reported that rural users are substantially under-represented in their use of inpatient and outpatient services ("WHO-AIMS," pg. 22). Under this situation it is of extreme importance to identify what services are available to rural users and the rates of occurrence in order to provide servicing and highlight any links that may occur with other national problems such as drug usage and HIV/AIDS.

While servicing is limited to rural populations, they have managed to persevere with certain resources, though limited, at their disposal. Primary care providers are the main vehicles that provide mental health servicing in rural areas though they are poorly trained to handle psychosocial problems. Data collected on mental health training for physicians and nurses in the Dominican Republic shows that 4% of training hours are devoted to mental health in nursing schools and 3% in medical schools or faculties ("WHO-AIMS," pg. 25, Table 9).

While solutions to an evolving social and health system are not readily accessible, new explorations need to occur to better understand how to efficiently address mental health disorders within the Dominican Republic. Mental Health disorders have a tremendous impact on a country's amount of resources, level of poverty and future projections. The need to begin research on this topic must to be addressed to optimize the health resources available to this population in need and highlight any pertinent findings.

Treatment gaps identified within studies show a correlation between lack of servicing, poor health and premature deaths (Celentano et al, 2008). Research shows that there is a strong link between development outcomes and mental health status (WHO, 2004; Herman et al, 2005). Beginning research in this area will contribute to closing this gap by creating unique intervention strategies to reduce the severity of symptoms.

Objectives of the Study

- Contribute to the body of literature on mental health development on Latin American and Caribbean countries.
- Observe and report on the current situation of mental health development at the primary care level in the Dominican Republic. Identify strengths and weaknesses within the system and formulate needed recommendations.
- Identify stakeholders and the links between mental health care and overall developmental goals.
- Provide information on the impact of mental health law within the primary care level through a case study of BRA Dominicana.
- Formulate recommendations with the intent to advance and strengthen the development of mental health at a primary level in the Dominican Republic.

Methodology

A descriptive research study design was used to investigate a known concern in an understudied population. Below is an overview of the methods used in this study. Areas that are covered include the sample and sampling technique, data collection and analysis.

Sample/ Sampling Technique

A non-probability sampling method was used in finding an agency located within a rural sector within the Dominican Republic.

Data Collection

Data was collected through observation, in-depth interviews and questionnaires.

Demographic and clinical variables were collected through extensive research of government documents. Questionnaires were conducted from a primary care health facility and community-based agency in a rural sector to compare and contrast treatment availability between rural and urban sectors. In-depth interviews of primary care doctors, agency administrators, government officials, and academic institutions were established to understand occurrences within the community of mental health disorders, servicing available to individuals, and correlations between other national problems. In addition, in depth interviews were conducted and documentations were reviewed with the following organizations: Fundación Global Democracia y Desarrollo (FUNGLODE) and Global Foundation for Democracy and Development (GFDD), Colegio Dominicano de Psicólogos (Dominican College of Psychology), Universidad Iberoamericana (Iberoamericana University), Colegio Medico Dominicano (Dominican College of Medicine), Instituto Nacional de la Salud (National Institute of Health), Batey Relief Alliance (BRA) Dominicana, and well as with Dr. Alberto Fiallo, Presidential Advisor on Public Health.

Overview: Mental Health in the Dominican Republic

The objectives and scope of this study come under the stated need of countries to develop an adequate plan of action to tackle the problem of developing appropriate mental health plans for countries in need. It is important to keep in mind that creating a blind carbon copy of mental health assessments and monitoring instruments frequently used in developed nations are not completely appropriate in meeting the treatment gaps identified in developing nations. This approach will not adequately suffice in meeting the increasing needs of the citizens of the Dominican Republic.

The Dominican Republic is a country not only rich in culture, but uniquely different amongst other Latin and Caribbean countries. The social system, its various forms of racial classification, and the inimitable dilemma of managing a permeable border shared with Haiti places this country in a precarious position to not only observe its problems through a multifaceted lens, but to find a unique approach with regards to integrating appropriate medical practices that meet the complex needs of its inhabitants.

There is an increasing social necessity to facilitate the effective incorporation of preventive measures to address the increased morbidity faced by the nation's inhabitants. Psychosocial vulnerability is extremely high for this population. Preventive strategies need to directly target the lack of completed urban planning and the gross discrepancies that exist economically between members of society. Populations living in extreme poverty, both in urban and rural settings, and marginalized rural populations are classified as high risk. Sub-populations of children and women experience higher morbidity rates than others within the social spectrum as they receive the backlash of national problems such as HIV/AIDS and violence.

Developing mental health services will assist in bridging the treatment gap for high risk populations in the Dominican Republic. Improving the lives of these individuals will increase their longevity and help to create the ample-bodied workforce required to advance national sustainable development. Identified within this study is the need to create plans of action to decentralize servicing. It is important for the country to fully incorporate a community-based rehabilitation strategy to unburden government systems whose resources are severely strained.

The need to invest in training health care workers in mental health disciplines is evident. Currently, the Dominican Republic spends 0.4% of the health expenditures on mental health (WHO, 2009). The most difficult aspect of providing needed recommendations is creating solutions that do not over tax an already burdened bureaucracy that faces high demands in other areas. Psychiatrists, psychologists and nurses are not the only figures that need to be targeted to achieve a viable solution. At present there is a shortage of workers within the country. Dominican Republic has, upon the last study conducted by the World Health Organization, a nine fold difference between the number of health care workers per persons within the country; 3.17 workers per every 100,000 persons (2009). There is an escalating need to involve the other specialized mental health practitioners that make up the system. Incorporating these personnel, with the objective of creating a stronger social service workforce, is key to creating a system that can sustain itself. Individuals afflicted with mental disorders, their families and the communities they reside in are principle actors that need to be integrated within mental health planning.

The most interesting aspect of this proposed development is that additional monies are not needed for advanced technology, as is the case with other divisions in the field of medicine. Reallocating resources would be sufficient to adequately train and retain human resources personnel. The idea behind a community-based strategy is to create a system that does not rely solely on doctors. Creating an adequate restructuring plan will not only assist in removing strain for doctors, but will support the establishment of a system that has multiple points of self-monitoring. The aim of this strategy is to enable clients receiving services to be the key voice pushing the development of such services. Decentralizing servicing also assists to create a new workforce solely focused on promoting health and preventing the onset of debilitating disorders.

Latin American & Caribbean Health Policy Trends

Developing nations pose a tremendously interesting perspective on global health development. Latin American and Caribbean nations in particular, hold a unique position on producing health outcomes as stated in the United Nations Millennium Development Goals. Through their rich economic and social cultures they provide a multifaceted lens for creating health programs that enrich societies. The knowledge created in understanding these systems is not only

instructive for policy but important in understanding difficulties that arise in resource allocation to an ever changing global environment.

There is a continual battle between the role of government and the role of non-statutory welfare institutions in providing adequate servicing for their populations. James Midgley, in his study of global welfare states, asserts that non-governmental welfare institutions have a responsibility of meeting government half way (1997). Non-governmental institutions, as direct service providers in a restricted economic environment, have demonstrated an inability to become a key provider in the field of social welfare. The role of key service provider has unceremoniously landed at their feet due to the increased economic restrictions faced by governments in developing nations.

One approach that is taken to health policy within this context is a reconstructionist's approach, which is highlighted in many welfare pluralist's states (Midgley, 1997; Mkandwire, 2007). This policy approach takes on a pluralist form where government has involvement, but insists that rebuilding of the welfare state should involve increased privatization and some budgetary reduction of expenditures (Midgley, 1997; Figuiera, 2002). What is important to note within this form of policy analysis is the need for a progressive agenda in development of social welfare. Social welfare in this context is the responsibility of both government and non-governmental sectors. Government should be held accountable in monitoring and providing aid. Non-statutory institutions are also liable in this process as they hold direct contact and understanding of local agendas with regards to health.

Challenges Faced in Health Policy Development

It is public knowledge that cuts in social spending have reduced availability of services for communities in need. Rural clinics in many countries have no drugs; schools are overcrowded; social service staff numbers are low; and income programs are not being created. In the backdrop of this context, globalization poses inimitable problems related to availability of funds and the dissemination of health care services.

A popular idea with post-industrialist policy analysts is the need for new structures that meet government's limited resources and budget limitations. Figuiera, in his study of social policy implementation in Latin America, attests that the major problems experienced by these states are centralized authoritarianism, general inequality, and bureaucratic weaknesses shown by states in organizing and dispensing of services (2002). Identifying where the difficulties lie is only half the solution. Understanding the role of both the private and public sectors is crucial in finding a solution that meets the needs of the people. Non-formal, voluntary and/or commercial sectors have developed in many countries in spite of government restrictions as a way to meet the gaps in need (Backwith, 2007). Many claim that these sectors already are afloat and prospering (Midgley, 1997; Mkandwire, 2007). With this understanding in mind, social programs are tremendously important in reaching the needs of the populace.

The beauty of understanding development is that it offers its participants and outside viewers a multitude of different practices to raise standards of living. Economic and social mechanisms need to be fine-tuned to actively contribute to society. Reframing of social problems, its victims and perpetrators, is required to assist in the reduction of poverty, or rather the generation of wealth, a term first introduced to me by Andrew Mwenda, an African journalist who focuses on aid development (2007). This perspective is important as it treats difficulties faced by developing nations not as a gap in need but rather as a push for social investment. Social programs that generate an economic rate of return will have higher levels of success and sustainability. Mkandwire's address on universalism in developing nations, says it succinctly: social policy is intended to enhance the efficiency of resource allocation; this in turn makes reform palatable for many governments (2007).

Aid from developing governments needs to be specifically targeted to include their most vulnerable populations. This aid

should not be given with the sole intent to consume, but rather should be spent on new endeavors that provide the largest rate of social return. This means that need should be prioritized and allocation of resources should be based on comprehensive planning. Establishing new partnerships between government and non-government organizations will create a less centralized approach and shift levels of inequality so that programs are driven with the sole purpose of addressing social needs and maintaining sustainability.

Different Models of Care Based in Latin America

In a shifting global environment it is important to consider the option availability in restructuring health care models. Countries within Latin America and the Caribbean hold an international distinctiveness from others as they pose a variety of set-backs, while at the same time create unique markets in tourism and trade. Comprehending the nature of emerging health problems in comparison to neighboring countries allows policy makers to tailor interventions specifically to their population needs. This is critical as no one model completely fits any given country, much less the Dominican Republic. With this in mind, I compare the health models of two neighboring countries, with the hopes of providing the Dominican government with recommendations for health care policy.

Two models identified within this review are the community oriented social work model adopted in Cuba during the 1990s and the social reform model of Chile. The latter effects partial and in some cases full privatization of health care, including pensions and other social assistance systems. Both systems have been highly productive in achieving health care outcomes and are considered, with regards to health, strong internationally (De Vos et al, 2008; Mesa-Lago, 2008). These two models while very different can help shape Dominican health care policy by demonstrating works in practice, difficulties faced and challenges that are to be experienced in the future.

Cuban Health Care Model: Community Oriented Social Work

The Cuban health care approach, community oriented social work (COSW), was put into practice during the 1990s and continues to be a strong and productive model today. It was endorsed during an economic crisis and managed to meet the needs of the population even through a serious lack of resource and budget constraints. Highlighted within this section are the key points within the model and the challenges the system is currently facing.

The Cuban health model adapted well to the social and economic conditions being felt by the country in the wake of the economic crisis that occurred at the end of the twentieth century, following the collapse of the Soviet Union. The crises experienced left the country with a shortage of drugs, medical supplies and most importantly medical personnel, as they fled to other countries, (De Vos et al, 2008). The model, currently still in use, has managed within a short time frame to raise the life expectancy to 78 years of age, a life expectancy typical of fully developed nations. This notable success has made Cuban health care personnel renown worldwide for their field expertise and unique handling of social etiology (De Vos et al, 2008; Strug, 2006).

The COSW model has at its roots a main focus in addressing social inequalities by filling gaps in governmental systems. It embodies two useful concepts that demonstrate the health inequalities that are present within systematic government occurrences, the health gradient and the health gap (Backwith et al, 2009). This means that there is not only a distinction of outcomes between the rich and the poor, but that the severity of the problem worsens the lower the individual stands within socio-economic ranking. The COSW model in this context holds well as it reduces inequality by ensuring behavioral changes amongst the individuals worst affected by this disparity.

This model uses primarily public health oriented social work that focuses on collaborative work not only amongst individual community members, but within mass organizations. Working within the community allowed for an in depth

needs assessment to understand the behavioral causes of the problem. Once the need was nationally understood the model of instruction was also applied to inter-agency negotiations (Strug, 2006; Backwith, 2009). In order to address the need, government also gave welfare agencies the opportunity to dissect amongst themselves the issues and to collaborate with each other on best practice interventions that could be undertaken. As a result of this collaborative model, Cuba experienced an enormous diminution of infectious diseases and sweeping improvements of socio-economic conditions (Spiegel et al, 2005).

Challenges currently being faced within the system are a changing economy and population restructuring. Cuba is increasing its international interactions with non-socialist governments and as such the dynamics of its economic infrastructures are different than what they used to be. This is causing a foreign exchange crisis where unemployment and labor productivity are low (Perez-Lopez, 2003). In addition to this, the elderly population in Cuba is experiencing a rise in comparison to its low birth rate. Soon Cuba will join Barbados, the country with the highest elderly population in both Latin America and the Caribbean (De Vos et al, 2008). This means that the diseases noted when the COSW model was in place are now changing to chronic and degenerative illnesses due to the construct of the current population. With this in mind, it could potentially be in Cuba's foreseeable future to lean towards privatization of the health sector as health care will face difficulty remaining free of charge with an increasing elderly population.

Chilean Model of Social Reform

Chile's model of social reform is an attractive model for Latin American and Caribbean countries as it created vast social improvements within the last decade. Chilean reforms have elevated the country to second rank within this region in the human development index (Mesa-Lago, 2008). This is partly due to sustained economic growth, but also to improvements in social indicators that created the basis for structural reforms within the health system. Chilean reforms are useful for policy analysis in the Dominican Republic as many systematic difficulties faced in Chile are being experienced currently in the Dominican Republic. This section will provide a brief overview of the needs present within Chile that spurred social reform policy with the hopes of providing an additional lens for the Dominican Republic to analyze and interpret the current socio-political obstacles facing the country.

The Chilean health model contains a dual system approach, having both a private and public sector. This system established during the close of the twentieth century was marked by increasing inequality with regards to service provisions (Mesa-Lago, 2008; Saracostti, 2003). There were striking inequalities present at the local government level with unequal access and distribution of education, housing, drinking water supply and sanitation (Saracostti, 2003). The private sector did not provide in rural zones and persons who had income had access to care while those that had low or no income were placed on tremendous waiting lists for care. Private health care agencies took part in discriminatory practices, providing lower coverage based on age and health risks while still obtaining government subsidies (Mesa-Lago, 2008).

Cause associated with difficulties of services at this time were difficulties in funding and improper monitoring of government funds (Saracostti, 2003; Mesa-Lago, 2008). Insurance agencies were overly selective and often turned down persons who they felt were higher risk and less profitable. This forced the government to take responsibility for the majority of the population, including providing additional subsidies for private insurance agencies. While the system had a strong base, improper management led to increases in debt, lowering of health expenditures, and consequently low achievement of social outcomes.

The current system in place has greatly assisted the Chilean population. They are receiving better care and the truly poor are receiving free health care with improved access to facilities. This policy implementation has propelled Chile to hold a high standing position amongst Latin American and Caribbean countries. In 2005, Chile was ranked second in the region

according to the human development index, which is based on two indicators, education and health (2008). Currently the government is extending its public interventions through programs such as *Chile Crece Contigo*, a program geared to address the changing family composition by providing services for children, similar to the U.S. Early Head Start Program (Saracostti, 2010). Another program currently in place is the *Chile Solidario* program that uses a social work intervention model to include social integration of the poorest communities (Saracostti, 2003). This program provides assistance to disabled and elderly populations, including the mentally ill.

Similar to the Cuban model, these programs were able to be created because of the crucial role social workers played in implementing and designing a multitude of services. The model used by Chilean social workers is a multi-dimensional approach in which income is only one factor in defining poverty (2003). They conduct economic, psychosocial and cultural evaluations to continuously redesign practices used by agencies. Within the *Chile Solidario* program they provide intensive care over 24 months to families entering the system and provide incentives to maintain full family participation (2003). This is critically needed to provide individualized support, which links the family to both public and private agencies depending on the specific needs identified.

Challenges currently being faced within this country consist of the following. While many illnesses have been included in the needs analysis, the number of pathologies must increase so that coverage can be provided for by both private and public insurance agencies. There is also an explicit need to include self-employed individuals. Due to the changing economy they represent an increasing portion of the working class. Monitoring needs to be fine-tuned so that double reimbursements do not occur, especially within the private health care system. Additionally, with the increasing contribution of women to the labor force, the health care system needs to find more productive ways of seeing to their needs, such as through extended maternity leave, assistance in childcare and child rearing subsidies for families in need.

Dominican Health System Review:

Policy review in the Dominican Republic is a function that needs to be explicitly developed to assist government in creating and monitoring the most adequate programs to assist in poverty reduction. Currently the country ranks 88th in the human development index, an improvement over the last during which they were in the 98th and 100th ranking. According to a recent review from the Pan American Health Organization (PAHO), the Dominican Republic is showing strides in providing coverage to its' population and consequently in reducing the health disparities present (PAHO, 2007).

Established in the PAHO health system review are the current developments accomplished by the country and the challenges the system is facing in terms of policy implementation. The Dominican Republic in the last decade has managed to successfully create laws and governing bodies that are contributing to reducing poverty within the country through health coverage. The general health law no. 42-01 and the social security system law no. 87-01 have been created, which establish that health coverage is a government responsibility. These laws have assisted in some of the population obtaining coverage, forming new personnel contracts and strengthening the system to promote and execute transparency throughout sectors. These laws create the needed ground for the development of an extensive social protection system through universal coverage via social contributions (PAHO, 2007).

Agencies have been developed to begin the process of policy implementation at the ground level, though some difficulties are being experienced. SENASA, the national health insurance authority, has been developed to distribute finances to health care services. SESPAS, the Ministry of Public Health and Social Assistance, is the health care system's lead agency and currently is in a transitional period to separate functions and decentralize services (2007). Achievements identified in PAHO's extensive review are the creation of new financial steering agencies within SESPAS to process funds from the central government (2007). One such agency is the Regional Health Services agency, whose sole

mission is to provide access to health based on geographical distribution in three levels of care: 1) primary health strategies; 2) specialized care that may require hospital stays; and 3) regional and specialized hospitals covering delivery of more complex services.

Deficiencies identified within the system, according to the PAHO review, occur with difficulties in systems and policy implementation. Decentralization still needs to occur in many aspects of government agencies to ensure the direct service delivery to the population. Increased need for transparency between agencies was highlighted as a main difficulty in assessing the different functions of public health agencies (2007). Currently no methodologies are in place for analysis, which leaves policy makers at a standstill concerning best practices needed to reduce the high level of inequity. The lack of methodology also contributes to skewed numbers that lead many agencies to under-report their findings, in turn establishing ill-defined causes for public health issues.

Human resource administration was defined as a clear need in government strategizing. Health service professionals are not placed where they are most needed and many members of the population go without access to care. As of the 2007 review, there is a shortage of medical personnel, particularly in rural areas (2007). Government should strategize and increase incentives in this area to develop human capacity to address health issues.

Another main deficiency identified within the review is the lack of preventive population health services. Preventive health services, a major necessity in lowering health disparities, are not included in the basic health plan. There exist ongoing discussions, as the basic health plan administration feels that this responsibility relies solely on the state (2007). Preventive health practices are important as they create explicit vehicles aimed at reaching targeted populations that for multiple reasons are marginalized and do not receive care. These practices also impede the population from over using public hospitals, which consume 40% of the health budget, as a method of treating acute illnesses.

Extending the health budget, which has been lowered considerably in the last couple of years to include preventive measures, can assist the government greatly in managing health crisis. Currently, the country is in an epidemiological transition with a noted decline in infectious diseases and a noted increase in chronic non-communicable diseases (2007). Preventive health models can assist in self-management of illnesses and can include populations that absorb direct services from government without contribution, such as the disabled and elderly populations.

Increasing preventive strategies should establish the inclusion of social work practices, as their functions are particularly designed to fill in the gap between policy and implementation of policy. An assessment of essential public health functions by PAHO highlights that public involvement is not taken into consideration with regards to health plan implementation (2007). Identified deficiencies were: participation by members of society; human resource development; and training of adequate health care professionals (2007).

It is beneficial to create comparisons between the Dominican Republic and other Latin American and Caribbean health models. The Dominican Republic health model is fashioned after the Chilean health model and perhaps in the process of development is experiencing the same transitional difficulties. In the current stage of development the deficiencies identified within the model are similar to difficulties faced by both the Cuban and Chilean health models. Lessons learned from the Cuban experience indicate that strengthening the Dominican preventive health model would be a beneficial move for the country, as it would address similar difficulties such as the one faced in Cuba regarding deficiencies in human resources. An important first step would involve creating a needed assessment of services being delivered to the population. Adopting a reformist policy might also assist in creating transparency between systems and truly decentralizing services.

Mental Health Law and Norms:

The establishment of law no. 12-06 in 2006 establishes the responsibility of the government to address the mental health needs of the population. The law assists in de-stigmatizing the nature of the illness within the population. This is an initial step in a positive direction, as the majority of the members of this cohort suffer tremendous public ostracization and consequently do not receive the care necessary for them to become contributing members of society.

The law contains a couple of key points important to highlight, as they will set the basis for the creation of agencies that will be responsible for implementing the law at the ground level. The law establishes the promotion of action to create and administer programs that support the mental health of workers both in private and public sectors. It certifies the need for epidemiological studies to be conducted to understand the rates of occurrences and to begin to understand treatment options. This is particularly important as understanding what is occurring and its frequency will consequentially be the key information needed to develop treatments that will assist this population to become fruitful members of their communities.

The mental health law also states the need for facilitating an intersectoral system within primary, secondary and tertiary levels of care. Key activities that are to occur at the primary level are assisting primary teams within practice; attending to needs of the patients; assisting in natural disasters, and developing programs and activities geared towards mental health promotion. This is important as it will assist in the deinstitutionalization of persons in psychiatric hospitals and will set the basis for conducting investigational studies to assist persons with mental illnesses.

The focus within the established norms and protocols is based on a community-centered approach. This model is particularly helpful as it works within a limited resource system and creates advocates of community members so that they can be in charge of their recovery. Objectives identified within state norms are: to promote and organize multi-disciplinary teams within the mental health field; to organize a system of reference; to arrange a registry of health and mental health indicators; and to promote informational sessions with themes related to assistance and rehabilitation among health care workers.

Need within Protocols:

Assessing protocols obtained from the national norms published by the Secretary of Public Health (SESPAS) throughout this research study produced the following results. With regards to promotion, attention and prevention tasks are not divided between primary, secondary and tertiary levels. Diagnosis is not identified except within hospitals. This leaves many rural health agencies without resources needed to identify if a problem exists. While psychologists are tasked with developing diagnostic protocols and assessments, a more basic screening tool should also be developed and disseminated to primary health centers throughout the region. It is important to create basic screenings in order to assess when a problem occurs and to refer for more specialized care so that a diagnosis can be established and consequently an appropriate treatment plan developed.

Noted within the protocols is an explicit need for mental health workers. According to the human resource objectives, there exists a lack of available workers and a low application rate within schools for social workers, psychologists and other mental health workers. Demographic statistics published by SESPAS in 2004 find that there is on average 2 mental health professionals per 100,000 inhabitants. The majority of the mental health workforce is centered in metropolitan areas such as Santo Domingo and Santiago¹. Furthermore, within the framework of human resource administration, the tasks regarding the creation of a database and referral system were not clearly delineated. Tracking of referral is left to individual agencies as opposed to having a centralized system.

It is important for the protocols to establish an agency responsible for overseeing and monitoring practice implementation. In review of the information, no clear designation was given to reviewing the functions and

¹ Please refer to the Appendix for chart titled Distribution of Professionals by Region across the State to get specific numbers regarding number of mental health professionals.

responsibilities of each individual sector. This is particularly important as it will contribute to the establishment of an investigative body needed to understand which practice interventions are most adequate and for which groups throughout the country. This system of monitoring will also be valuable as a way to self-evaluate the stage of policy implementation and how it should be advanced.

Promotion as a Form of Prevention

An important step in developing an appropriate mental health policy is through the creation of a culture that allows for planning to take place. Promotion should be a main focus of government as a preventive measure to normalize mental health practices. Dominican culture still does not fully embrace the idea that mental illness is a form of illness that can be as debilitating as any other physical disability. Lack of knowledge and awareness of mental illness allows for interpretation of misguided views on mental health. This may imply that members of this community do not support certain treatment options such as therapy and open dialoguing either amongst themselves and/or between a medical professional and a patient. Promotion is a critical tool in community based rehabilitation because it gives members of society the tools to become advocates for themselves and others. This in turn opens communication between the government and its' populace so that officials in charge can create and abide by laws that seek to strengthen communities.

According to Llopis, a principal researcher on public health strategies, creating a strong basis in promotion allows for lower rates of occurrences of diseases within both developed and developing nations (2004). Llopis' article highlights the correlation between promotion and the advancement of mental health by stating that promotion creates an ideal platform to not only create a shared responsibility amongst all participants, but also to establish culturally sensitive intervention strategies (2004). Through the field of promotion research scientists can open communication and identify key risk factors affecting populations. In the case of Dominican Republic, where large community groups may be completely ostracized due to lack of knowledge, promotion becomes a vital tool that can be used to empower individuals with mental illnesses.

Promotion can be a key preventative method as it allows the educator to market a solution that is completely client-centered. It is noted in both Llopis and other articles that promotion can work as a major strategy to inform and prepare both students and parents, particularly in schools. It is important to shape policy that targets the most vulnerable populations ensuring that problems do not escalate into bigger societal dilemmas.

Noted particularly within schools is the effect mental health promotion has been shown to have on outcome effects. Amongst students alone, it has been shown to alter psychological adjustment; reduce learning difficulties; and control conduct disorder development (Llopis, 2004). Within other community agencies, promotion within mental health has shown to reduce suicide rates, alcohol and drug dependency, greatly lowering rates of depression and anxiety.

Promoting mental health provides a unique venue for government to be in tune with a culture that is becoming increasingly more sensitive to world trends. In the case of the Dominican Republic, promoting mental health allows the government to gain access to its immigrant population, a sector that is steadily growing, yet is easily overlooked with regard to service provisions. Creating an atmosphere where every member of society is socially invested through incorporation of information, assessment and outcomes establishes a strong foundation for community rehabilitation. In a country whose society is clearly divided into those that have access to care and those that do not, promotion can be a key method that not only protects, but that is cautious of allowing each individual a voice.

Ensuring that each member has a voice can permit medical care to move past the primary level. When members of society participate by voicing concerns and receiving knowledge they rely less on inpatient care. This in turn creates shared responsibility as the field of stakeholders widens. When this happens communities are more adept at managing national disasters, economic downturns and/or political instability. Giving citizens the tools they need to become independent, allows an overtaxed government to address depletion of servicing by finding adequate solutions to

common problems.

The essence of promotion is creating a multi-faceted approach that can be adapted to a wide range of cultures. It can and should be continuously reinforced and modified to meet the needs of its people. Llopis (2004) and Celentano et al (2008) in their separate studies recommend that promotion incorporate age-specific approaches, calling for multiple sessions for children to assist in retention and short term interventions to inform and educate adults. This allows programs to have an adaptable blueprint that can be beneficial not only in the field of mental health development, but also in other social fields.

While focus on promotion is significant, it is also crucial to monitor which strategies work best and which require additional incentives. Giving this tool to community based organizations creates a culture focused solely on prevention and not on symptom management. Testing the efficacy of practice is important with regards to budgeting, and becomes vital in terms of program design. Mismanagement of funds is a chronic condition in many developing nations. Attaching an evidence-based framework to promotion and program design allows for clarity within bureaucracy.

The Dominican government needs to cultivate this approach to better facilitate service handling. Focusing on prevention should be a main aim for this country as it works to stabilize situations and produce long-term, sustainable outcomes. Prevention is an ideal focus, as it works from a strength-based perspective allowing the persons in need to regain some level of independence.

Bra Dominicana: A Case Study

History:

BRA Dominicana operates inside the Dominican Republic by coordinating local efforts, including alleviating the plight of individuals within sugarcane producing plantations known as *bateyes*. Migrant Haitian workers seek out meager existences toiling for multi-national sugar and construction corporations under substandard living conditions. In *bateyes*, Haitians and Dominicans of Haitian origin live in shantytowns with limited access to basic education, health care, and economic opportunities. The inhabitants live in extreme poverty and face serious health problems. They often share tiny, flimsy shacks made of mud and split cane with no sewage systems, electricity, sanitation facilities, running water or trash collection.

Mission:

The humanitarian mission of the Batey Relief Alliance (BRA) is to help promote equity and self-sufficiency; improve human rights conditions; raise public awareness; and facilitate dialogues and bona fide collaborative endeavors geared towards creating a productive environment for the world's most vulnerable people. Representing a broad spectrum of organizations interested in improving human conditions, the Batey Relief Alliance is apolitical and unites local grassroots organizations and government agencies, international groups and recipient communities in a strategic partnership. Each member organization operates locally and independently of the Batey Relief Alliance.

Objective:

The Batey Relief Alliance develops new partnerships and undertakes initiatives to address issues affecting Hispaniola, the island shared by both the Dominican Republic and Haiti. Toward this end, the organization is actively involved in addressing the precarious socio-economic ills facing poverty-stricken populations, including *batey* residents, the urban poor and the migrant community.

Project Overview:

The organization is equipped with a 'hands-on, no-waste' philosophy. The Alliance makes every effort possible to use its internal resources, complemented by international grants and in-kind support, to implement high impact and culturally appropriate projects. Each year, BRA seeks financial assistance, receives donated supplies and equipment, recruits volunteers with specialized skills and partners with humanitarian institutions and universities to deliver quality servicing to residents in the *bateyes*.

Fields of practice open for interns, working towards or having received a degree, are in the following fields:

- Health Care [Doctors/Nurses]
- Education
- Economic Development
- Community Development
- Agriculture & Sustainability

Current Projects:

- Arco Iris—HIV/AIDS
- Prevention of HIV/AIDS and Marketing of Condoms
- Transferring Skills and Capacities of Communities to Address HIV / AIDS in a Comprehensive-Bateyes Alliance
- Unit of Integral Attention to HIV / AIDS
- Social Mobilization on Tuberculosis in Monte Plata Bateyes
- Primary Health (Mobile Clinic and Medical Center)
- Water/Waste
- Prevention of Malnutrition – Multi-vitamin Program
- Prevention of Hunger - Food Assistance
- Program Medical Missions, Ophthalmologic and Disaster
- "I Can See " - Prevention of Blindness

Patient Profile

This section discusses my findings based on interviews with patients in BraDominicana's primary medical care facility located in Monte Plata, a rural sector an hour outside of Santo Domingo. Patients were observed inside and outside the clinic while waiting to be seen by medical personnel. Patients gave consent to be interviewed before and after meeting with a medical practitioner. The majority of patients interviewed were patients receiving medical care for HIV/AIDS. A main focus of BraDominicana's medical practice in Monte Plata is treating patients who are diagnosed with HIV/AIDS. This cohort was identified as a rich group to interview because medication adherence has shown to be of increasing difficulty within this unit. BraDominicana also felt that it would assist in providing needed assessments with the intent to

open future clinics in other rural areas in the Dominican Republic.

Also conducted in conjunction with the interviews were analyses of patient medical files that chronicle the medical history of patients. Reading in depth the patient medical files allowed me the opportunity to identify key issues expressed by the entire community. There is a distinct need identified by many patients to receive additional therapeutic servicing not only to assist patients in practicing healthier lifestyles, but also to aid them in becoming independent contributors to the society in which they reside. Interviewing this demographic group was key in understanding the complex social systems that exist within the Dominican Republic and additionally underscored the tremendous resilience shown by patients.

Symptoms expressed by patients were categorized in the following categories: emotional and physical. While no clinical diagnosis were identified, as that would fall outside the realm of my expertise, it was evident in the patients that expressed concerns that symptoms being felt were a tremendous impediment to maintaining and successfully following through with medical adherences. Identified below are symptoms expressed by patients who are undergoing HIV/AIDS medical treatment.

Symptoms Expressed

Symptoms expressed by patients receiving HIV/AIDS treatment included: vivid memories of seeing the deceased; recurrent nightmares of deaths; feelings of loss, emptiness and abandonment; inability to accept the loss of deceased family members; anxiety; fear; depression; suicide ideations; loss of appetite and sleep disturbances; problems remembering; difficulty concentrating; little to no motivation; low physical activity; isolationism; feelings of guilt [faith-based and non-faith based]; feelings of being overwhelmed; low levels of all daily living skills; reoccurring physical ailments (that may or may not be imagined) such as dizzy spells, headaches, trembling, shakes, increased heart palpitations, dry mouth; loss of interest in activities that previously were interesting; lowered attention span; loss of appetite.

Correlations Identified with Patients

Correlations between the symptoms identified by patients show a clear need for adherence to medical treatments. Patients showed to be at a loss regarding how best to proceed when leaving the clinic grounds and confronting either their families or other members in their communities. Patients living with the illness for a number of years showed signs of being overburdened and often resorted to self-medicating through their own means, such as taking medication from herbal healers and creating their own elixirs from recipes that they received through word of mouth.

Alternative forms of treatment are of major importance as these methods seriously affect treatment prescribed by medical practitioners. All BraDominicana medical staff expressed that patients would frequently undergo a treatment respond well to it, but end treatment abruptly when they heard of medical cures professed by individuals whose main interests were to obtain heavy monetary compensation. After an extended period, patients would return in a more advanced stage of their illness and with additional infections. This places the agency in a precarious position, as medication needs change as individuals approach advanced stages of illness. Pending the receipt of grant funds, BraDominicana may or may not have the appropriate medication to treat a worsened case.

Another major obstacle linked to medication adherence is navigating a proper treatment that coincides with the patient's religious practices. A patient's faith is critical to his or her well being, especially in a faith-based society such as Dominican society where faith is a main point of reference when confronting difficult obstacle. Noted in the rich culture that exists in the Monte Plata area, as with many other areas in the Dominican Republic, a patient's resiliency stems

from and grows stronger based on his or her ties to his or her faith. Lack of understanding of religious beliefs and practices of indigenous populations (i.e. *voodooism*, *santería* and *brujería*) poses substantial challenges for doctors in this clinic and others in terms of patients' fears and tremors. It is of increasing importance to educate patients through their faith, as it will provide a level of sustainability to the treatment given by doctors.

The cost of not providing assistance with counseling and other therapeutic forms is at a mere glance alarming. All women interviewed reported issues of domestic violence and all children interviewed showed difficulties in learning, with some presenting behavioral challenges. Many of the women interviewed did not have jobs, but were solely responsible for the maintenance and keeping of the home. Husbands, both absentee and present, showed signs of alcohol and substance abuse, as stated in their medical files. Morbidity rates for both women and children rise due to these causes. Children did not attend schools regularly and when they did they were extremely behind on the material, which caused loss of interest and lack of continuation.

Overview of Findings

Conducting a case assessment of BraDominicana is an important step in breaking down barriers that impede the successful incorporation of mental health practices in the Dominican Republic. Reviewing agencies at a ground level not only assists in planning and policy development, but provides a key starting point in understanding what are the primary indicators that affect populations. Identifying these key indicators is a critical step in establishing adequate resource allocations and in creating sustainability in government monitoring systems.

A developing nation, such as the Dominican Republic, that is on the brink of further expansion needs to assess what the primary impediments to future growth are. Learning how to correctly monitor problems is the solution to managing the limited financial resources allocated for mental health budgets. It also assists in highlighting underlying problems that can otherwise go undetected. The design and implementation of an extensive needs assessment has the potential to bring about changes that can possibly push a country fully in line with other competing nations. This in turn raises the living standard of a country's population, allowing its members to live fruitful lives by contributing back to the system that exists to aid them.

The assessment will be broken down into the following categories: normative, expressed, and perceived needs. This breakdown stages the problem from different viewpoints, both at a macro and micro level. It identifies key stakeholders and consequently provided the backdrop for the creation of a plan of action that can be implemented in policy planning. It is the intent of this study to begin to provide much needed scientific research to assist the Dominican government in overcoming hurdles currently present in the development of mental health practices.

1. Normative Needs

Assessing the normative needs of the agency is a primary step in identifying gaps between policy and practice. In order to conduct a normative needs assessment, primary stakeholders identified were separated into three categories: primary care workers, patients and caretakers, and government and nongovernmental agencies responsible for service allocations. To obtain information regarding their needs, open-ended questionnaires were conducted, accompanied by a review of patient files and government statistics on the issue at hand.

Obtaining this information highlighted the following needs. Significant difficulties arise in understanding problems, as clear definitions of words have not been identified at the primary-care level. Doctors, the main port of entry in providing servicing to patients, are not adequately trained to identify what constitutes a mental disorder and what type of assistance is needed when a case is identified. Some doctors are aware of diagnostic tools available, but a clear

definition of what are the most frequent diagnoses and how the symptoms are expressed is lacking. This can be remedied through training and the promotion of mental health as a national initiative. Promoting mental health will bring to the service words such as case management, counseling, and rehabilitative care.

Another major normative need identified is the establishment of a registry of services given and what additional servicing can be used for referrals. Discussions with different personnel within government and within three major academic institutions, Universidad Iberoamericana, Colegio Medico Dominicano (Dominican College of Medicine) and Colegio Dominicano de Psicólogos (Dominican College of Psychology), indicate that plans are in place to create a national registry. As of yet, doctors are not aware of any steps either within government or within academic institutions to create a registry, and have specified a specific need to develop a national registry in which referrals can be made for patients that present with any disturbances.

Establishing which resources are available will create smoother functioning amongst medical workers. This will relieve burdens for both doctors and nurses, and, not to mention, will allow for more independence of members so that they can begin to navigate the health system alone and rely less on inpatient treatment. There are tremendous organizations such as Instituto Dominicano de Desarrollo Integral (IDDI – Dominican Institute for Integral Development), Fundación CIDEAL de Cooperación y Investigación (CIDEAL- Foundation for Cooperation and Research), Oficina Nacional para los Fondos Europeos de Desarrollo (ONFED – National Office, European Funds for Development), Pasion por el Desarrollo (Passion for Development), and Programa de Iniciativas Locales de la Sociedad Civil (PRIL – Program of Civil Society Local Initiatives) both for profit and non-profit agencies whose main focus is to provide servicing in capacity building for the country. Programs such as the ones mentioned above and BraDominicana are working completely independent of one another. Creating a market where they are all registered and visible would increase usability and smooth transitioning from inpatient care to community care, which is critical to maintaining a cost-effective approach, which will help an already taxed government system to alleviate economic burden.

Also found through review of government data was the lack of specialized medical personnel required to provide servicing to individuals. Looking into the published statistics of the Secretario de Estado de Salud Pública y Asistencia Social (National Secretariat of Public Health and Social Assistance) for 2004 shows that there are 2.9 psychologists, and 1.37 psychiatrists per 100,000 inhabitants. Within these figures there are no additional human resources identified. This presents a severe gap in primary care. Doctors find themselves at odds with how best to proceed with patients experiencing mental problems. As they are often overburdened, patients that are identified to have disturbances frequently do not receive any care at all.

2. Expressed Needs

Identifying expressed needs provides program planners the opportunity to evaluate procedures already in place by agencies regarding dispersal of services and future plans for expansion of servicing. In order to complete this objective, agencies such as BraDominicana need to provide a comprehensive depiction of their current human service system. This means that they need to explicitly state who is on board and for what reasons, how they disperse services, and how they maintain the servicing that they currently have.

This analysis is particularly difficult as it requires not only a system of tracking to be in place, but also an overview of budgets. More time is needed not only to analyze the budgets within agencies, but also to alleviate any trepidations felt by agencies in showing their budgetary figures. Based on my time spent with BraDominican, it is clear that more time needs to be devoted to service tracking, not only to maintain a company's own financial books, but also to assist them in maximizing resource allocation. Conducting a thorough analysis of financial data will help agencies such as this one to meet long-term goals, which is critical to financial sustainability.

While this approach is advantageous for agencies, in that it keeps track of rates of incidence, it does not provide a clear picture of what needs are not being met. It does, however, assist agencies in maintaining their operations, so that they can continue to provide the critical services they offer, particularly in rural areas and with marginalized populations. A serious impediment to conducting this research was the lack of available data, as the aforementioned form of data collection is not the norm within agencies. What is the norm within agencies is living grant by grant, which causes tremendous stages of upheaval, in particular when awaiting medication for patients. Agencies such as BraDominicana often run the risk of medication shortages as they are dependent upon grant funding availability, which can be detrimental to the communities with which they work.

3. Perceived Needs

Perceived need, while often overlooked in importance, is vital to understanding problems at the ground level. It provides the starting point from which to understand where the consumer is, and isolates barriers to aid in service utilization. Perceived needs were discovered through administering open questionnaires to patients within the BraDominicana primary medical facility, examining patient files and sitting-in on patient-doctor consultations. Through these processes, patients' perceptions of need and level of knowledge about existing agency services were identified.

As observed within the normative needs segment of this study, patients expressed lack of awareness with regards to their own illnesses. Their statements expressed their desire to receive support regarding understanding how to live with a terminal illness, how to provide for their families, and how to access resources provided by government agencies. Patients expressed feelings of frustration concerning arriving weekly and sometimes daily to receive medication. They expressed serious concerns with regards to meeting primary needs. Lodging constituted the most critical need and often placed patients and their families in dire predicaments due to lack of hygiene and clean water.

In relation to mental illness, patients positively identified feelings that caused an impediment to their daily functioning. Patients also expressed serious concerns with regards to domestic violence and substance abuse. When asked, patients articulated feelings of guilt at having expressed feelings and feared chastisement for not being able to deal with the problems at hand. Many women with children with emotional disturbances, behavioral issues or learning difficulties conveyed a lack of awareness of the issue at hand. Those that understood or requested assistance from a specialized worker did not know who they could go to for assistance. Medical issues took precedence for all patients during their consultations. When interviewed separately, all patients expressed a positive need to have someone to help them deal with personal issues, be they detrimental to their daily functioning or not. Attitudes expressed by patients concerning mental health assistance were mixed. Some expressed a serious need to obtain any type of servicing that might alleviate stress in the home and all expressed a fear of being labeled incapacitated.

Implications for Future Practices

The circumstances described above often lead to new pathologies within patients. Additional pathologies identified were substance and alcohol abuse. Females and children showed to have an increased risk within Dominican society. They suffer additional stressors such as bearing full financial responsibility for the home, increased incidences of domestic violence, and forced unprotected sexual exposure.

Issues exist in terms of navigating an appropriate passage through patients faith, both universally organized and indigenous faith based religions, such as *voodooism*, *santería* and *brujería*. Many patients did not believe they were ill and when they accepted their illness related it often with ideas of punishment from God. Feelings of being persecuted, going to Hell, and other fears of receiving retribution by God caused severe stress in many patients. Outside of their own inner turmoil they were confronted daily with social ridicule and community ostracization and feelings of shame.

It is also of importance to navigate self-medicating practices through traditional healers, both those established in an organized faith and those that are not. Patients identified often expressed usage of teas that work against HIV medication, and powders that are sniffed to 'cleanse evil spirits'. Self-medicating practices often impede patients from adhering to medication. Such interruptions in medication might mean that the patient will wait until he or she gets progressively worse to return for medical care. Interruption of medication could potentially mean that medication previously given might no longer work in the system due to lowered t-cell counts. The agency at times did not have appropriate medications to treat worsened symptoms.

Treating patients that are dealing with additional traumas such as national tragedies is also critical, especially in times of flood and hurricanes. Near the center there were some families who experienced direct losses from the January 2010 earthquake in Haiti and that experienced intense migratory shifts due to flooding during hurricane seasons. These factors along with the aforementioned ones all affect a patient's well-being and impede the proper steps in medication adherence. Integrated within these practices is the additional need to provide counseling and other forms of therapeutic care to ensure that medication treatment adherence occurs and patients receive optimum care.

Recommendations

Recommendations for BRA Dominicana

Planning recommendations based on needs expressed are the following:

- Create a more adequate system of tracking services administered, especially as care becomes highly individualized between doctor and patients.
- Open dialogue within the community regarding mental health and the types of assistance available.
- Set aside additional time within consultations to address any mental disturbances that might impede daily functioning.
- Establish a mental health component to assist patients experiencing difficulties with medication adherence due to alcohol and substance abuse. This may include classes to educate on alcohol and substance abuse and effects of medication, individual counseling and family group sessions, community open forums to educate on the occurrences of mental illnesses.
- Cultivate relationships with other important community allies to alleviate resource strain and to create a reliable referral system.
- Include families in planning for social programs.
- Decentralize leadership roles to spread accountability amongst all workers and provide for easier transition when workers are absent.
- Identify indicators with regards to service monitoring for use in future evaluations. This is critical to identifying any underlying trends found in patients that might impede successful implementation of care
- Financial recommendations cannot be made as financial data was not submitted for review.

Recommendations for Policy Development

- Encourage stakeholder collaboration to build public and political support for improved community based

partnerships.

- Ensure mental health services are available and accessible as part of primary health care services in all development and emergency relief programs by creating jobs for specialized workers in primary health care agencies.
- Create adequate budget for resource allocation in mental health services.
- Create an ample body workforce to meet lack of trained specialists both in psychiatric care, psychology and human resources.
- Create incentives to encourage specialists to work in rural areas.
- Develop a national marketing strategy as a method of prevention in the field of mental health. Greater focus should be placed on targeting families and youth. This can assist in moving medical care past the primary level and can ensure for longitudinal success, as it can reduce reliance on inpatient care. Incorporating community participation helps create the basis for community rehabilitative care. This not only improves emotional well-being, but also overall behavioral functioning and school performance, and reduces contact with law enforcement.
- An important strategy to incorporate within the mental health system is assistance with the development of programs that have multiple objectives and provide more than one service. This will assist in mainstreaming mental health development within overall healthcare and in incorporating it within other social development programs. Benefits of this plan of action are greater access to preventive care, lesser degree of stigmatization, and increased community involvement.
- Incorporate mental health interventions within broader poverty reduction strategies.
- Include mental health professionals in income generating programs.
- Develop community based support services, with special emphasis on appropriate housing for persons with disabilities. This will assist in moving the country from institutionalization to community-based care and monitoring.
- Establish agencies that generate employment for individuals who are diagnosed with mental illnesses.
- Increase accountability by visiting communities and evaluating agencies and hospitals. This is critical to addressing human rights violations.
- Create strategy to disseminate policy development related to mental health.
- Develop a national registry that is public to document the availability of programs as they are created. This will be an invaluable community resource for families as well as an excellent tool of referral for primary care workers. This will also allow programs to become inter-dependent of one another, and will help facilitate care by increasing accessibility and creating a multi-agency collaborative approach.
- Fully incorporate international assistance in development of culturally appropriate assessment tools, such as the WHO Assessment Instrument for Mental Health Systems (WHO-AIMS).
- Collaborate and fund academic and research institutions that specifically assist in mental health policy development by obtaining and organizing disability statistics, disseminating information on evidence based

practices that can serve this population and promote mental health policy both within academic institutions and communities.

Recommendations for Academic Institutions

- Identify culturally appropriate evidence-based interventions that build local capacity and also inform integrated programming and mental health policy development.
- Work with government to create a national marketing strategy as a method of prevention in the field of mental health. A greater focus should be placed on families and youth. This can assist in moving medical care beyond the primary level and in ensuring longitudinal success as it can reduce the use of inpatient care.
- Use evidenced-based practices as a method to integrate servicing and promote national development of mental health strategies.
- Create independent authorities that monitor efficacy of programs and policies, which is critical to increasing accountability.
- Develop initiatives to increase human capacity in the field of specialized care in mental health.
- Collaborate with government to create research institutions that specifically assist in mental health policy development by obtaining and organizing disability statistics, disseminating information on evidenced based practices that can serve this population, and promote mental health policy both within academic institutions and communities.

Recommendations for Non-governmental Organizations

- Emphasis needs to be placed on monitoring services to evaluate and test program efficiency.
- Create programs that create job opportunities for individuals afflicted with mental illnesses.
- Cultivate relationships with other significant community allies and create a network of local partnerships to alleviate resource strain and to create a reliable referral system.
- Decentralize leadership roles to spread accountability across all workers and provide for easier transition when workers are absent.
- Identify indicators with regards to service monitoring to use in future evaluations. A critical step towards identifying underlying trends found in patients that might impede successful implementation of care.
- Create programs that use multiple methods of intervention (preventive and others), which have been proven to achieve double efficacy.
- Create programs that focus on creating appropriate housing for persons with disability. This will assist in moving the country from institutionalization to community-based care and monitoring.

Recommendations in terms of Primary Care

- Provide integrated mental and physical treatment.
- Integrate mental health during and after emergencies.

- Include mental health issues within social service agencies.
- Mainstream mental health into education during doctor-patient consultations.
- Use direct referral servicing for secondary care and other community-based organizations.
- Incorporate psycho-social assessments in patient profiles.
- Formulate counseling services.
- Increase awareness of mental health law amongst medical personnel.
- Increase awareness of established mental health protocols, common diagnosis and their symptoms.
- There is a need for assistance in documentation and reporting due to large numbers of clients seen.
- Advocate for greater human resource capacity to handle administrative and follow-up care. This is important for documentation of service provisions.

Recommendations in terms of Secondary Specialized Care

- Decentralize servicing by increasing primary care workers' accessibility to specialists.
- Collaborate with the government to create an educational campaign to promote mental health development at the national level.
- Collaborate with non-governmental agencies in the creation of community activities and forums to educate communities and change public opinion so as to lower stigma and shame attached with receiving care.

Conclusions

The need for development within the mental health field is evident and becomes more critical as time wears on. The Dominican Republic is a country that is ripe in the middle of change and as such constitutes a tremendous example for the region. Assisting government to better implement development strategies is vital to overcoming obstacles within the mental health field. While identifying the problem is a step in the right direction, creating an ample body workforce to deal with the issues highlighted is critical.

Vital gains can be achieved through the implementation of a serious mental health promotion strategy and the creation of employment opportunities for outreach specialists. Promotion has proven to be an excellent form of intervention. Incorporating a national marketing strategy will not only reduce severity of symptoms as the public becomes more educated, but will also provide a cost-effective strategy to unburden inpatient care at the primary level.

It is important to recognize the vulnerability of the populations identified within this observational study, not only so they may lead healthier lives, but also to assist government in becoming more competitive internationally. Recognizing the vulnerability of this group means including them in the development and design of services through open forums and educational lessons, just to name a few. Using non-governmental organizations and community and faith-based organizations is the easiest way to reach marginalized communities. Patient profiles indicate that primary care workers need to receive additional training to meet the psycho-social needs of the populations they serve. This is central to providing proper medical attention, ensuring medication adherence and evaluating treatment effectiveness.

Limitations of the Study

A main limitation of this study was not having sufficient time to assuage agency fears. Ensuring a good relationship is important so that information can be more easily accessible for evaluation. Financial data was not given for evaluation, so recommendations on how to best expand certain services could not be given. A high level of bureaucracy often impeded the research from further extending its reach, as certain data was not available.

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Appendixes

Appendix A: Demographic Statistics

Demographic Statistics for the year of 2004, as noted in Analisis Situación de la Salud Mental by Secretaría de Estado de Salud Pública y Asistencia Social (SESPAS)

Chart 1

Total Population	Masculine		Feminine	
	Population	%	Population	%
8,562,215	4,265,215	49.81	4,297,329	50.19

Chart 2

Population Distribution

Age	Masculine	Feminine	Total
0-4 years	494,884	478,760	973,644
5-9 years	492,845	479,036	971,881
10-14 years	485,882	473,456	959,338
15-19 years	418,089	420,150	838,239
20-29 years	718,924	754,663	1,473,587
30-39 years	606,037	630,825	1,236,862
40-49 years	406,463	428,212	856,675
50-59 years	282,136	282,553	564,689
60 - above	337,955	349,671	687,373

Chart 3

Schizophrenia

Overall prevalence rate: 1.65%

Rate of patients within	
Area	Percentage
Community	50%
Public Psychiatric Hospitals	2%
Private Psychiatric Hospitals	5%
Public Institutions	20%
Private Institutions	1%

Chart 4

Alcohol Dependency Rate

Alcohol Consumption per capita (liters/age): 6.11 (age 15 yrs and older)

General Consumption of alcohol: 67.0

Alcohol Dependency		
Alcohol Dependency	Harmful Use	Hazardous Use
5%	9%	12%

Chart 5

Treatment based on drug type between January-December 2004

Type of Drug	No. of Cases	%
Crack	1733	67.9
Cocaine	408	16.0
Marijuana	194	7.6
Alcohol	93	3.6
Heroin	67	2.6
'Juegos Deazar'	9	0.4
Psychotropic	8	0.3
Inhalants	6	0.2
Ecstasy	3	0.1
'Conductas Adictivas'	31	1.2
Total	2552	100

Chart 6

Diagnostic Rates

Diagnostic Categories CIE_10		Percentage
F30	Manic Episode	15
F31	Bipolar Affective Disorder	35
F32	Depression	25
F33	Recurrent Depressive Disorder	10
F34	Persistent Mood Disorder [Affective]	7
F38	Other Affective Disorder	3
F39	Mood Disorder [Unspecified]	5

Chart 7

Rate of available Professionals in the Mental Health Field per 100,000 inhabitants

Psychiatrist		Psychologist		Others	
No.	Index	No.	Index	No.	Index
117	1.37	249	2.90	0	0.0

Chart 8

Distribution of Professionals by Region across the State

Region	No. of Psychiatrist	No. of Psychologists	No. of other Mental Health Professionals	Professional Index per 100,000 inhabitants
Region 0	70	199	269	8.9
Region 1	13	5	18	1.7
Region 2	16	20	36	2.5
Region 3	03	08	11	1.6
Region 4	02	02	04	1.0
Region 5	08	08	16	1.9
Region 6	01	02	03	0.9
Region 7	01	00	01	0.2
Region 8	03	05	08	1.0
Total	117	249	366	4.2

Chart 9

Medication Availability

Medication	Availability	
	Yes	No
Carbamazepine	√	
Ethosuximide		√
Phenobarbital	√	
Phenytoin	√	
Sodium valproate		√
Amitriptyline	√	
Chlorpromazine		√
Diazepam	√	
Trifluoperazine		√
Haloperidol	√	
Lithium		√
Biperidone		√
Levodopa		√
Frendamin	√	

Appendix B: Questionnaires

Questionnaire 1

DOMINICAN GOVERNMENT AGENCIES / NONGOVERNMENTAL ORGANIZATIONS / HEALTH CARE AND PUBLIC HEALTH OFFICIALS

- 1) Investigate the level of knowledge and dissemination of law: Dominican Social Security System, 01.del No.87-2001. Request opinions on the levels of knowledge about its use in various social groups (both for providers and users of health services).
- 2) Investigate the level of knowledge and dissemination of the General Health Law 42-01 enacted in 2001.
- 3) Request opinions on the levels of knowledge about its use amongst various social groups (both for providers and users of health services).
- 4) Investigate the level of knowledge and dissemination of the Mental Health Act 12-06 of 2006.
- 5) Request opinions on the levels of knowledge of use amongst various social groups (both for providers and users of health services).
- 6) Inquire about the existence, knowledge and / or use of national programs for prevention and promotion of mental health (PYPSM).
- 7) Inquire about the level of knowledge and / or use of providers, both in primary and specialized sectors, regarding the National Standards for Mental Health Care for substance abuse and dependency (national standards series no.35 enacted in 2006).
- 8) Inquire about the existence of equipment for mental health providers and / or supportive activities in specialized care (i.e. hospitals).
- 9) Inquire about the existence of equipment and Mental Health Services and / or support for services at the primary-care level (PAC and UNAP).
- 10) Inquire about the involvement of psychologists in health teams at the primary-care level (and UNAP CAP). Request statistics such as quantity, number of inhabitants, beds and geographic distribution.
- 11) Investigate the roles of psychologists within the health team in primary care. (Primary Care Center-CAP-area or network of health posts).
- 11) Inquire about the following activities, amongst others:
 - Participation in activities and programs geared towards prevention advocacy and mental health;
 - Participation in activities and programs geared towards advocacy and prevention of major causes and / or factors associated with morbidity and mortality in the community;
 - Development of advisory services and technical support for individuals and families with mental health needs;
 - Factors associated with morbidity and mortality in the community with regards to HIV / AIDS and Tuberculosis;
 - Participation in community rehabilitation activities for persons with disabilities and / or for persons with addictions to psychoactive substances;
 - Location and availability of mental health resources available to the community for timely referral of cases; home care

- Coordination and participation in programs to prevent violence in all its manifestations;
 - Participation in coordination, planning, and evaluation meetings as an integral part of the multidisciplinary team;
 - Records kept of activities, development of weekly, monthly or quarterly schedules
- 12) Inquire about the knowledge and / or use of the National Standards for Mental Health Care. Request opinions on the state of their knowledge and use by the various service providers.
- 13) Inquire about the use of knowledge and / or use of international standards for mental health care. Request opinions on level of knowledge and level of use amongst various service providers
- 14) Request information on the status of using various neuropsychological assessment tools in primary and specialized health services.
- 15) Inquire about what relationships, coordination and / or partnerships have been established to create jobs in Mental Health at the primary care level and to develop both public and private specialty care centers.
- 16) Request a description of the actual characteristics and / or ideals of mental health care at the community and family level.
- 17) Inquire about the existence of initiatives for families and schools.
- 18) Inquire about services for the elderly, children, adolescents, adults, people with addiction problems, people living with HIV / AIDS, etc.
- 19) Inquire about the status of community-based psychosocial programs at the primary care level (including the state of design and implementation of strategies).
- 20) What policies and strategies exist to create mental health care at the community level? Investigate the existence of initiatives or tools to:
- Promote community participation and increase awareness of mental health
 - Establish specific plans for at- risk and vulnerable groups
 - Establish training and educational programs for mental health and community leaders

What are the most at risk groups within this population? What are the programs available to these groups? Give special attention to: psychosocial risk prevention (promotion of peaceful conduct, tolerance and respect for differences amongst peers).

Questionnaire 2

- 1) **Doctors** In your daily work as a medical professional, do you treat people with mental health disorders?
- How frequent are the care requirements?
 - What are the problems / disorders most commonly found?
 - What are the demographics of the people who come to seek care? (Sex, age, occupation)
 - What are the most common treatments for these problems? Medication, counseling, or both?
 - Do you have the opportunity to receive assistance with the treatment of a patient from a licensed mental health professional?
 - How are your colleagues supervised? Have you received minimal training in the field of Mental Health Promotion?
 - Is there a record of the mental health care given to patients? If there is, is it manual or automated?

If so, are recorded cases of patients kept confidential?

2) Monitoring of cases:

- Are cases monitored?
- What is the method or procedure used (i.e. successive consultations, home visits)?
- Is there an administrative staff dedicated to monitoring the up-keep of this information?
- Does monitoring of cases depend solely on communication provided by caregivers or are inputs from other sources also considered (i.e. family, neighbors, church members, religious, etc.)?
- Is assistance given to caregivers (i.e. meetings, regular visits, training in the home, training center, delivery of printed educational material, school radio, Internet, etc.)?
- In general, would you say that the caregivers are collaborative and / or understand the value of the information they provide for the treatment plan established?

3) How would you judge the role of traditional medicine and practitioners of traditional medicine in the treatment and monitoring of people with mental health disorders (i.e. healers, herbalists, etc.)? If it is valued as positive, have there been efforts to incorporate traditional medicine within mental health education?

4) What facilities are available for providers in the mental health service field for consultations and counseling sessions?

5) What prescription drugs are available to you in the field of mental health?

6) How is medication made available to families? Do they rely on pocket expenses, social security dollars, government subsidies, grants or medical insurance?

7) What opportunities are there in your educational or professional field to familiarize yourself with common practices and performed methods of care (i.e. health education networks, community health programs from the Ministry of Health, self-help groups, social networks of solidarity, etc.)?

8) Inquire about the level of knowledge and / or use of the National Standards for Mental Health Care. Inquire about knowledge of and / or use of standards amongst various service providers.

9) Inquire about the level of knowledge and / or use of the National Standards of Care for substance abuse and dependency (national standards set no.35 enacted in 2006).

10) Request information on the status of using various neuropsychological assessment tools in primary health services and specialized care?

11) Inquire about what relationships, coordination and / or partnerships have been established to develop work on Mental Health at the primary care level by both public and private institutions. Specific entities to consider are:

- Community-based organizations (neighborhood committees, parent associations and school friends, cultural clubs, social solidarity networks, etc.)
- Schools and other educational venues
- Faith-based organizations (Catholics and non-Catholic Christian and faith-based non-Christian organizations)
- Non-governmental organizations or other organized community groups, unions, etc.
- Private business organizations in the community (grocery stores, brewery centers, lounges, carwash, etc.).
- Government organizations (community health programs, municipalities, ministries, etc.)

Questionnaire 3

Patients and Caretakers - Bra Dominicana

- 1) Inquire about how patient learned about health service provider. When and how was the first contact with the health team?
- 2) Investigate the degree of satisfaction with the care received at the health center. Identify satisfaction related to:
 - a) Results of intervention / treatment;
 - b) Health care staff;
 - c) Physical space;
 - d) Availability of drugs;
 - e) Access to the health center
- 3) Inquire about the level of awareness of the disease / disorder the person is receiving counseling and/or treatment for. Take note of whether the responses are the result of popular wisdoms (such as popular culture, folklore) or knowledge originating from a medical professional.
- 4) If you identify that knowledge of the disease / disorder was obtained from a member of the healthcare team (doctor, nurse, psychologist), identify the source and whether this source contains a detailed description of the cause, intervention and treatment.
- 5) Inquire whether the explanations received by the health team have been understood by both the patient and caregiver, to the extent where the receipt of information enhanced the results of the intervention / treatment plan.
- 6) Inquire whether patient or patient's family have received home visits by a health team member. If delivered, inquire about whether or not educational materials were distributed.
- 7) Find out, based on patient or family knowledge, whether a personal profile on the patient was kept in office..
- 8) Inquire to what extent adherence to the treatment plan was maintained.
- 9) Inquire about the social and economic level of the family and the patient. Demographics to inquire about should include: jobs, occupations, professions, housing characteristics, means of transport, education of members, etc.
- 10) Find out about the resources that are available to support the intervention / treatment. Identify:
 - a) Economic (i.e. own resources, family resources, gifts, etc.)
 - b) Social security or tax subsidies
 - c) Community solidarity (i.e. community centers, social solidarity networks, religious groups, etc.)
- 11) Inquire about difficulties with daily living experienced by both the caretaker and caregiver? Do you encounter negative attitudes, stigma, rejection and/or discrimination by family, neighbors, relatives and/or co-workers due to the disease/disorder?
- 12) Inquire about recommendations to:
 - a) Improve services (physical and human resources)
 - b) Improve the quality of the interventions / treatments

- c) Improve access to services
- d) Improve home care
- e) Reduce negative effects (i.e. stigma, rejection and discrimination by family, neighbors, relatives and/or colleagues)
- f) Improve access to drugs
- g) Improve the quality of life of caretakers/caregivers who undergo treatment

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