

PERCEPTIONS OF MATERNAL HEALTH CARE AMONG HAITIAN WOMEN IN THE
DOMINICAN REPUBLIC: DO RACE AND ETHNICITY MATTER?

By

ERICA ANN FELKER-KANTOR

A THESIS PRESENTED TO THE GRADUATE SCHOOL
OF THE UNIVERSITY OF FLORIDA IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF ARTS

UNIVERSITY OF FLORIDA

2011

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To the Haitian and Dominican women of Elias Piña
Thank you for allowing me into your lives

ACKNOWLEDGMENTS

I am especially grateful to my thesis chair, Dr. Charles Wood. The quality of my work and depth of analysis are due to his invaluable feedback, support, and encouragement. I am indebted to him for seeing the potential of my research and for pushing me to become a better writer and critical thinker. I am also thankful to my other committee members, Dr. Alyson Young and Dr. Lance Gravlee, for exposing me to the world of medical anthropology. Their dedication to social medicine and knowledge about the social determinants of health has influenced my decision to continue my education in the field of public health. I also thank Dr. Richmond Brown and Dr. Phil Williams for their advisory support, and Dr. Benjamin Hebblethwaite for teaching me Haitian Creole and showing me the beauty of Haitian culture.

Thanks to Rosario Espiñal for introducing me to Sergia Galvan. Without Sergia's support and guidance this project would not have been possible. To the Haitian and Dominican women of Elias Piña and the staff of *La Colectiva*, I thank you for welcoming me into your lives. Your kindness, patience, and support gave me the courage to complete this project.

Finally, I thank my parents, Janet Felker and Harvey Kantor, for their unconditional support and love. I am forever indebted to them for the time they spent analyzing my research and revising my text. My success in academia would not have been possible without them. More importantly, I thank them for always believing in me and encouraging me to pursue my interests.

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Abstract of Thesis Presented to the Graduate School
of the University of Florida in Partial Fulfillment of the
Requirements for the Degree of Master of Arts

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Erica Ann Felker-Kantor

May 2011

Chair: Charles Wood

Major: Latin American Studies

Practitioners in the field of social medicine who seek to make health services more available to minority women point to the need for further research that documents and analyses the perceptions and attitudes of the women they intend to serve. They argue that health policy proposals and health care systems need to recognize the perspectives and needs of the most disadvantaged populations. Despite these admonitions, traditional solutions to the problems of inequitable health care are nearly always informed more by the perspective of the health policy makers than by the less advantaged populations that are the target of the intervention. This result has produced health care systems built on insensitive top-down policies, which have increased disparities in health care particularly among racial and ethnic minority women.

Based on the qualitative research approach, *grounded theory*, this study examines how Haitian women, as ethnic and racial minorities, perceive and experience maternal health care in the Dominican Republic. Specifically, it documents the factors they believe affect their access to maternal health care in the Dominican Republic, and their assessment of the quality of the treatment they receive. Given the context of a society historically known for its prejudices against Haitian people and their culture, at both the societal and institutional levels, capturing the

perspectives and experiences of Haitian women themselves adds to the limited research on minority women's perceptions of institutionalized maternal health care.

Findings suggest that Haitian women perceived the role of race and ethnicity in the Dominican health care system differently. Some Haitian women felt they were treated inferior to Dominican patients and did not receive the same quality of treatment because of their race and ethnicity. Other Haitian women however, did not perceive the health system as racially discriminatory. They felt the health care system treated Dominicans and Haitians equally. Skin color, nationality, language, and familial ties were also mentioned as important determinants that influenced the health care experience of Haitian women in the Dominican Republic.

CHAPTER 1
HAITIANS AND MATERNAL HEALTH CARE IN THE DOMINICAN REPUBLIC: THE
ROLE OF RACE AND ETHNICITY

They [Dominican doctors and nurses] treat the Haitians worse than the Dominicans, but they have to assist everyone, and it is better than in Haiti because in Haiti there aren't enough resources in the health system.

–Lillin Sevelin, Haitian woman living in Elias Piña, Dominican Republic

I sat in the small and sparsely furnished maternity ward in Elias Piña's public hospital, when a feeling of despair crept over me. I had just witnessed a hostile encounter between a Dominican nurse and a Haitian woman, which reinforced what seems to be the socially accepted way that people in the two cultures relate to one another. The Haitian woman (who was actually not a woman at all, but a nineteen year-old girl) had just given birth to a baby girl. Two Haitian friends who had come to visit her in the hospital decided to help give the baby a bath in a small plastic container on the floor of the maternity room. Just as they were putting the baby in the water-filled container, a Dominican nurse walked into the room and started yelling in Spanish that this was a Dominican not a Haitian hospital, and that the women had no business bathing the child. Instead of showing them the "proper" way to care for the baby, the nurse marched across the room where she administered an injection to a Dominican patient and then quickly left without further comment.¹

The way the nurse spoke to and interacted with the Haitian women appears to reflect a general belief in Dominican society that Haitians are ignorant and inferior to Dominicans. However, what I may have interpreted as racial discrimination may not in fact have much to do with the way the Haitian women in the room experienced the event. This observation prompts a number of questions: How did the Haitian women feel about this interaction? How do they view

¹Throughout my fieldwork, I witnessed similar interactions between Dominicans and Haitians as discussed in Chapters 5 and 6.

their experience with the Dominican health system? What do they think influences how they are treated? Do they even feel that they receive different treatment compared to Dominicans? If so, is it because of their race and ethnicity? Practitioners in the field of social medicine who seek to make health services more available to minority women point to the need for further research that documents and analyses the perceptions and attitudes of the women they intend to serve (Puentes-Markides 1992; Lubbock and Stephenson 2008). According to Lubbock and Stephenson, in order to create an equitable health care system in which all women feel culturally respected it is important to have “a clear understanding of women’s perceptions of maternal care services within their cultural context” (2008: 76). Crsitina Puentes-Markides supports this claim, arguing that health policy proposals and health care systems need to recognize the perspectives and needs of the most disadvantaged populations. Despite these admonitions, traditional solutions to the problems of inequitable health care are nearly always informed more by the perspective of the health policy makers than by the less advantaged populations that are the target of the intervention. This result has produced health care systems built on insensitive top-down policies, which have increased disparities in health care particularly among racial and ethnic minority women (Puentes-Markides 1992).

This study addresses how Haitian women themselves, as members of a racial and ethnic minority, experience and perceive maternal health care in the Dominican Republic. Specifically, it documents the factors they believe affect their access to maternal health care in the Dominican Republic, and their assessment of the quality of the treatment they receive. Given the context of a society historically known for its prejudices against Haitian people and their culture, at both the societal and institutional levels, capturing the perspectives and experiences of Haitian women

themselves adds to the limited research on minority women's perceptions of institutionalized maternal health care (Howard 2001; Gregory 2007; Human Rights Watch 2002; Wucker 1999).²

The aim of my study is to understand just that: namely, how culture, race, and ethnicity play into the process by which Haitian women, as members of a racial and ethnic minority, access and receive maternal health care, as seen through the eyes of the women themselves. The issue is all the more important given the recent earthquake in Haiti and the likelihood that women from that country will be seeking health care in the Dominican Republic in greater numbers than before. This study deepens our understanding of how race, ethnicity, and culture matter--that is, the processes through which they matter-- by viewing the health care system through the experiences of Haitian women themselves.

The Research Method

This study primarily uses qualitative methods of data collection. Because I am most interested in exploring the perspectives of the Haitian women themselves and their perceptions of the important issues with respect to the access of maternal health care in the Dominican Republic, an inductive research design is appropriate for this study. Ideally, I would have liked to use a mixed methods research design, but quantitative data sets discussing nationality, race, and health care in the Dominican Republic are limited. While *Demographic and Health Surveys* has carried out a number of health and population assessments in the Dominican Republic, questions about race, color, and ethnicity are not included, making it impossible to distinguish between Haitian and Dominican respondents.

²The majority of Latin American studies that examine the cultural, ethnic, and racial barriers minority women confront in access to maternal health care focus on indigenous women's experiences with institutionalized health care in Bolivia and Peru. There is a clear need for more research on how racial and ethnic *non-indigenous* minority women experience maternal health care.

The qualitative method of data collection and analysis is particularly valuable when the objective is to provide a deep understanding of the point of view of the population being studied (Silverman 2000). As Bernard states, “When you want to know about the *lived* experiences of fellow human beings,” nothing beats qualitative research (2000: 193).

The qualitative analysis is informed by a *grounded theory* research approach, an inductive method of data analysis and interpretation (Strauss and Corbin 1990). In the “grounded” method, the goal is to promote open-ended (yet still directed) conversations with knowledgeable and “narratively competing” individuals, allowing them to express their own understanding of the issues at hand (Holstein and Gubrium 1995). A distinctive feature of this approach is that the explanations, theories, and conclusion that are formulated in this manner are derived from the women themselves, or from the ground up – the origins of the term “grounded theory.”

In keeping with logic of grounded theory, this study does not set out to test an *a priori* hypothesis, but is nonetheless guided by a general question:

- As ethnic and racial minorities in the Dominican Republic, how do Haitian women experience race, culture, and ethnicity when accessing and receiving maternal health care in the Dominican Republic?³

In addition to using grounded theory, I incorporate personnel reflections and direct observations about my experiences in the field. Although I encountered a number of limitations while conducting this study, which no doubt influenced the final results (see chapter six), the data collected in the field combined with the theories and insights from published research makes for an in-depth analysis of the complex topic presented here.

³ Race and ethnicity are complex concepts that have no single definition. In the Dominican Republic, “when Dominicans talk of *la raza* it may include color, phenotype, nationality, or cultural traits” (Howard 2001: 17). In keeping with how Dominicans talk about “race,” I try to align my discussion of “race” with their conception of the concept. Thus, when I refer to “race,” I am not only talking about skin color, but also about cultural traits, ethnic traits, and nationality. I recognize however, that my interpretation of how Dominicans talk about race is biased by how I have come to understand the concept as a Westerner.

The Research Setting

One of the challenges of conducting fieldwork in a country I had never been to before was establishing an affiliation with a local institution. While I am sure a number of anthropologists have carried out their work without any local connections, I did not want to take this route. From previous experiences in the field, I found it easier and more appropriate to work through a community organization that works in a similar field as the area of my study. Colleagues who previously studied or worked in Latin America put me in touch with Sergia Galvan, the director and founder of *La Colectiva Mujer y Salud* (The Women's Health Collective), an NGO in the Dominican Republic that focuses on women's rights, health education, and women's health care. The headquarters of *La Colectiva* is based in Santo Domingo, yet the organization works primarily on the Haitian-Dominican border where it runs a women's medical clinic that serves both Haitian and Dominican women. Since the January 12th, 2010, earthquake in Haiti, *La Colectiva* has also been contracted by a number of international organizations to carry out women's health education campaigns and to distribute aid to the Haitian women who were displaced by the quake and relocated to the Haitian borders town of Belladère, Hinche, and Lascahobas.

This study mainly takes place in the Dominican border town of Elias Piña, the poorest region in the Dominican Republic (Demographic Health Survey 2007).⁴ With the help of the *La Colectiva* staff, I was introduced to women patients at the clinic as well as at the main public hospital in Elias Piña. I usually conducted interviews in the women's homes and observed events that took place in the maternity and children wards in the public hospital and at *La Colectiva*

⁴ Due to the time limitations of this study, I did not have the opportunity to interview Haitian women in other regions of the Dominican Republic. The information presented in this study represents the views of a limited number of Haitian and Dominican women in the border towns of Elias Piña (Dominican side) and Belladère (Haitian side). The findings cannot be generalized to the other regions of the Dominican Republic.

clinic.⁵ Additionally, I spent several days in Haiti where I helped the *La Colectiva* translate documents, distribute aid, and organize women's health workshops. I also had the opportunity to observe the primary Haitian hospital in Belladère. Chapter 5 presents an in-depth description of the research setting.

The Chapters that Follow

Chapter 2 reviews the academic literature that discusses the importance of gender, ethnicity, and culture in accessing and using maternal health care services. Awareness of previous studies of this topic make it possible to distinguish between the common barriers that all racial and ethnic minority women face from those that pertain to the specific context of Haitian women in the Dominican Republic. Furthermore, in addressing global health inequities, I discuss why global health policies have enhanced health disparities particularly for marginalized populations, and why reform efforts can benefit from an understanding of women's perceptions of the health care system.

Chapter 3 provides an overview of the scholarly literature that addresses the historical relationship between the Dominican Republic and Haiti, specifically focusing on the origins of anti-Haitianism and racial ideologies in the Dominican Republic.⁶ Chapter 4 explains the qualitative research methods used in this study, beginning with a discussion of grounded theory as a social research method, followed by a detailed description of my experience using the inductive approach. Chapter 5 describes the research setting, commenting on the Haitian/Dominican dynamics and spatial organization of Elias Piña. The Dominican health care system and Elias Piña's public hospital are also described. Chapter 6 presents the results of the

⁵ All interviews were conducted by the author in either Spanish or Haitian Creole.

⁶ The importance of race, ethnicity, and nationality in Haitian-Dominican relations is a complex, controversial, and sensitive issue. Given the design of this project, the findings presented here apply only to my research site, and my discussion of race and ethnicity is not intended to be comprehensive.

data collected in the field. This is the most important chapter in that it conveys the realities of what is happening on the “ground” by presenting the opinions and experiences of the Haitian and Dominican women in relation to maternal health care in Elias Piña. I highlight and analyze the themes that appear in the interviews and observations. Finally, I draw general conclusions about the factors that influence Haitian women’s access to maternal health care in the Dominican Republic.

Chapter 7 summarizes the significance of the data, stressing the importance of incorporating the perspectives of the Haitian women into the Dominican health care system, and emphasizes the need to improve the quality of health care provided to Haitians and Dominicans. Given that more Haitians will be migrating to the border region due to the earthquake and cholera outbreak, it is important to properly address the social barriers of the Dominican health system. I conclude this study with a discussion of the challenges and limitations of qualitative methods, and with recommendations for future research on health disparities along the Haitian-Dominican border.



Figure 1-1. Map of Haitian-Dominican Border Region. Source: CIA, Washington D.C., 1961.

CHAPTER 2
WOMEN AND MATERNAL HEALTH CARE: MORE THAN A PROBLEM OF
AFFORDABLE ACCESS

The Importance of Gender, Culture, and Ethnicity

Literature that discusses the barriers women face in relation to accessing health care often cites poverty and low socioeconomic status as the primary factors that restrict their ability to obtain care. According to Thaddeus and Maine, the financial cost of accessing and receiving care is an important factor affecting the use of health care services by women (1994). However, while poverty is unquestionably a critical determinant in women's ability to access health care services, scholars have also pointed to sociocultural and gender-related factors (Thaddeus and Maine 1994).

Puentes-Markides argues that the processes by which women are able to get health care depends on a number of factors in addition to socioeconomic status such as women's status as a "socially disadvantaged group," their inferior position as decision-makers in the home, and their culture and ethnicity (1992: 619). For many women, especially racial and ethnic minority women in the developing world, the direct and indirect cost of health care services is often less important than the "cultural appropriateness and perceived quality of care" (Timyan, Brechin, Measham, Oqunleye 1993). Even when health care is financially and physically accessible, Timyan et. al (1993) assert that women often opt not to seek care because the services provided are not culturally appropriate. The question is not only about providing equitable access to care, but also about providing culturally appropriate and acceptable care.

This chapter begins with a review of case studies of racial and ethnic minority women's experiences and perceptions of maternal health care in different sociocultural settings. In addition to discussing the relative importance of poverty, I will explain why culture and gender status cannot be ignored as determining factors in the use of maternal health care services.

Drawing on the literature, I further discuss why merely making health care services accessible in many cases will not decrease maternal mortality. Drawing on global health literature, the chapter concludes with a discussion of why global health policies have influenced health disparities particularly for marginalized populations, noting the importance of listening to and incorporating the needs of racial and ethnic minority women into the local health system.

Access to Care: Financial Costs and Distance

Studies indicate that access to health care services depends primarily on an individual's socioeconomic status, whereas use of health care services is more dependent on gender and cultural status within a society. "While distance and cost are major obstacles in the decision to seek care, evidence shows that utilization of care is often determined by the quality of care" (Thaddeus and Maine 1994: 1091). Given my interest in gender, ethnicity and culture in relation to the use of maternal health care services, I cannot talk about use of services without first discussing the role of poverty in relation to accessing health care.

In order to access care, one must be able to pay for the indirect and direct financial costs associated with receiving care. In the rural communities of Matagalpa, Nicaragua, for example, Lubbock and Stephenson found that the use of maternal health services was highly dependent on the economic costs associated with accessing care (2008). The barriers that women most often cited included their inability to pay for indirect costs associated with receiving maternal care such as paying for transportation to and from the clinic, paying for medicines, the "cost" of losing a days work, and the need to prioritize spending on food and school supplies According to one woman from the rural community La Dalia, "There is an ambulance here, but there is no gas, and if you do not have [money] for gas you have to hold out here or die...those who don't have 200 córdobas cannot be transported. [Women must] look for how to borrow [money]" (Lubbock and Stephenson 2008: 79). Another woman from the same community stated, "Yes, it is the most

difficult- the money- because I was alone. I did not have anyone to lend it to me” (Lubbock and Stephenson 2008: 78).

In her study of the Miskito Indians in Honduras, Arps similarly discovered that Miskito women frequently experience life threatening pregnancy complications because of limited access to maternal health services. According to Arps, there are only two local health clinics in the region, which are physically and financially out of the reach of most Miskito women (2009). Moreover, the local clinics do not provide emergency obstetric care. Thus, because of the financial difficulties in traveling to a regional hospital, Miskito women in need of emergency care often die. In her interviews with Miskito women, Arps found that the majority of women cited poverty as the leading cause of maternal mortality. A number of women stated, “If a woman doesn’t have money, she just has to die” (Arps 2008: 582).

In addition to being poor, it is also important to recognize that the women in the Nicaraguan and Honduran studies are ethnic minorities in their respective countries. According to Puentes-Markides, in most societies, women, especially ethnic and racial minority women, comprise the “largest proportion of the population within or below poverty lines,” resulting in their inability to pay for the costs associated with accessing health care (1992: 620). The Pan American Health Organization reports that in many Latin America countries, “Poverty affects 20% of the non-indigenous inhabitants of urban areas, while 75% of the indigenous inhabitants of rural areas suffer from it” (2004: 38). While a Miskito woman’s ability to access care is directly dependent on her economic status, it is also apparent that her economic status is directly affected by her inferior position as a woman and as an ethnic minority in Honduran society. A person’s quality of life, according to economist Amartya Sen (1995), depends not only on his or

her social class status, but also on a number of physical and social conditions such as gender and ethnicity.

Thaddeus and Maine argue that making health care more readily available by building more clinics or using mobile clinics in rural and isolated areas will result in lower transportation costs and reduce the “cost” of time spent traveling to and from the clinic. While this does not solve the problem of being able to pay for medicines and medical supplies, it does decrease the overall cost associated with accessing health care for poor women (1994). Thaddeus and Maine (1994) also point out that even when health services are physically and financially available, this does not guarantee that ethnic minority women will use the services. If the health care is not provided in a culturally acceptable and appropriate manner ethnic minority women will not seek care. In Nigeria for example, women belonging to the Hausa ethnic minority group reported that distance and financial cost were the least important factors in their decision to use available health care services. More important to them was the quality of care and the perceived acceptability and efficacy of care (Thaddeus and Maine 1994). Studies of maternal mortality rates in the developing world confirm that maternal mortality among ethnic minority women highly correlates with the cultural appropriateness of the health care that is made available (Camacho et. al, 2006).

Maternal Mortality Among Ethnic Minority Women in the Developing World

In many developing countries maternal morbidity and mortality rates among indigenous and ethnic minority women is significantly higher compared to non-ethnic minority women (Camacho, Castro, Kaufman 2006). According to the Pan American Health Organization “As of the year 2000, the maternal mortality rate for indigenous populations in Guatemala was 300% higher than the national rate” (PAHO 2004). In Honduras, the maternal mortality ratio in the Miskito region, home to the Miskito Indians, was an estimated “878 maternal deaths per 100,000

live births,” the highest in the nation (Arps 2009: 579). Although there may be various biological reasons for the observed mortality differentials between ethnic and non-ethnic minority women, it is evident that gender factors and discriminatory health care delivery practices play a major role (Camcho et. al, 2006).

Use of Care: The Role of Gender, Culture and Ethnicity

In recent years, attempts have been made to better incorporate and recognize gender differences and cultural diversity in the health care sector. Yet many women who are ethnic and racial minorities in their country continue to have negative perceptions and experiences with institutionalized maternal health care. In Bolivia, indigenous women cite gender and ethnic discrimination and lack of respect and understanding of cultural beliefs by the health providers as deterrents to using institutionalized care (Paulson and Bailey 2003). In Nigeria, women who are of a different ethnicity than the health care staff report feeling ignored by doctors and ridiculed for their ethnic traditions (The Prevention of Maternal Mortality Network 1992). The following case studies indicate that the use of maternal health care services and the quality of care received are directly related to gender and culture.

Bolivia

Even though 55% of the Bolivian population is indigenous (30% Quechua, 15% Aymara, 10% Other), health clinics and hospitals fail to deliver culturally appropriate maternal health care. The result has contributed to one of the highest maternal mortality ratios in the region with 496 deaths per 100,000 live births (PAHO 2004). According to PAHO, “In the last two administrations only 24% of the indigenous women went to the health services to give birth, while midwives attended twice as many women in labor, since 76% of births took place at home” (2006: 2). PAHO’s 2006 report on maternal mortality among the Quechua and Aymara women of Bolivia concludes that “the underrating and ignorance of traditional cultural practices

on the part of the professional teams in charge of maternity care,” as well as the culturally inappropriate delivery of care by institutionalized public health services, are among the primary reasons indigenous women do not use health services even when it is available to them (2006: 2).

Quechua and Aymara speaking peoples use traditional knowledge and rituals when giving birth (PAHO 2006). According to Camacho et al. birth takes place in a “private setting where the mother’s intimate parts are not touched,” and the birthing position should be vertical or “crouching in a cat-like position” (PAHO 2006). Additionally, Quechua and Aymara women believe that during the delivery process there is a “symbolic opening” of the body and the women should not be exposed to cold, thus women are to remain fully clothed when giving birth (Camacho et al. 2006). None of these cultural traditions are incorporated into the birthing process in health clinics and hospitals. As a result, Quechua and Aymara women, choose not to use the maternal health care services these clinics provide. Also relevant are language barriers and the “shamefulness” of being examined by a male doctor, which go against traditional Aymara birthing beliefs (Camacho et al. 2006).

Paulson and Bailey argue that the hierarchical structure of Bolivian health centers and the unequal relationship between health care workers and indigenous women further discourages Quechua and Aymara women from using maternal health care (2003). In their study of maternal and reproductive health, Paulson and Bailey found that “People (non-health care users who tend to be poor and more indigenous with less power in the system) have the strongest perceptions of discrimination, while those in more powerful structural positions (health care providers) seem largely unaware of the problem” (2003:492). Paulson and Bailey further assert that the barriers to the use of health services among Quechua and Aymara women has less to do with access and more to do with cultural ignorance and disrespect by the health care providers (2003).

The following study in West Africa similarly stresses the importance of culture and gender in relation to using maternal health care. It reinforces the conclusion that cultural insensitivity poses a major barrier for many ethnic minority women.

West Africa

In the rural community of Bo, Sierra Leone, the expectation is that women will give birth vaginally. According to the Prevention of Maternal Mortality Network (PMM), “A woman who does not deliver vaginally is thought to have failed in her essential role” (1992: 284). In their discussions with Bo women, the PMM learned that in the event of an obstetrical emergency, Bo women “would rather die than be taken to a hospital for surgical delivery” (1992: 284). Bo women do not use hospitals during pregnancy for fear of being forced to have surgery, which they consider a shameful act and will ultimately ostracize them from their community (PMM 1992). Women reported that they often were not consulted about their birthing preferences and were made to feel inferior because of their ethnicity. Cultural and societal beliefs within the Bo community thus contribute to women’s reluctance to use maternal health services, as does the perceived quality of care that is given. In Sierra Leone, Ghana, and Nigeria, the PMM documented similar instances in which minority women were subject to ridicule derogatory comments by health practitioners (PMM 1992).

Other researchers have noted an incompatibility between the criteria used by health professionals to identify health problems and the perceptions of health problems among people they intend to serve. Gleit et al. argue that “the ‘official’ definition of maternal risk- those factors identified by national and international policy makers- do not always coincide with the risks viewed as valid at the community level” (2003: 2450). Health workers recognized the importance of cultural perceptions of risk, yet often blamed ethnic women for seeking care at “inappropriate” times. Ethnic women who experience verbal abuse and discriminatory practices

by health care workers are less likely to use health services in the future, and their negative experiences are likely to influence other women's decision to seek care (Lubbock and Stephenson 2008).

In many developing countries, an ethnic woman's decision to seek care is influenced by her culturally defined status as a woman (Timyan et al. 1993). In the Quechua culture, women have a relatively high degree of autonomy and power in the decision making process to seek care (compared to other indigenous or ethnic women), and usually do not need their husband's permission to seek care (Camacho et al. 2006). However, in a number of West African cultures, women can only seek care if their husband grants them permission (PMM 1992). In Mali, women are subordinate to men and "are required to live in seclusion, [and] they are not allowed to leave the family compound" (PMM 1992: 283). In the event of an obstetric emergency, Malian women need their husband's permission to seek care. Thus, Malian women can face serious health risks if they have to wait for long periods of time to receive permission. Even when their husbands grant them permission to seek care, Malian women often prefer not to use maternal health services, which are deemed culturally inappropriate (PMM 1992). "The existence of facilities," as Mensch concludes, "is not sufficient to reduce maternal deaths; the facilities need to be providing adequate services which are acceptable to women" (1993: 242).

Global Health Policies

Global health policies have played a role in creating health care systems that are deaf to local needs. As the case studies demonstrate, in addition to the socioeconomic, cultural, and gender-related barriers ethnic women have to contend with when accessing health care, they are also confronted with the 'westernization' and 'globalization' of local health care systems. In her study of international and global health policies, Linda Whiteford argues that local identities are often overlooked as "too amorphous, too changing, too ambiguous, and too great a complication

in already complex processes” (Whiteford and Manderson 2000: 59). Whiteford’s study concludes that global health policies which fail to recognize cultural and ethnic identities actually increase the physical and social suffering of marginalized populations.

International health policies and programs often assume that every country shares the same “level playing field” and that the health policies that have evolved in the West can be directly transferred to the developing world without concern for cultural and ethnic differences (Whiteford 2000). Whiteford argues that interventions by international agencies “transform health experiences into forms of commodification” (2000: 58). She concludes that uniformly applied health programs by virtue of their insensitivity to local conditions, may even be detrimental to the very populations that the programs are designed to help (Whiteford 2000).

In conclusion, while it is important to recognize the inappropriate and unacceptable ways in which health care is being delivered, the issue is not just about providing culturally appropriate care for women, but also about empowering women so that they have a strong voice and power over how care is given. The examples show that women, especially ethnic minority women in patriarchal societies, are often unable to make the decision to seek care because of their inferior status as women. Thus, while uniform global health policies and western health care systems, which do not consider the needs of ethnic women, are certainly barriers to the use of health care services, the patriarchal values of many cultures and the subordinate position of women are also factors influencing women’s decision to seek care. Studies in Latin America and Africa point to the same general conclusion, namely that, in their attempt to extend health services to minority women in the developing world, health practitioners would benefit from a greater sensitivity to what women have to say and to the assumptions that inform their perceptions of the health care system.

CHAPTER 3 HAITIAN-DOMINICAN RELATIONS: RACE, ETHNICITY, AND NATIONALITY

I was familiar with the academic literature on the racial tensions between the Dominican Republic and Haiti, but it wasn't until I began my fieldwork that I realized how important race, ethnicity, and nationality are in the everyday lives of Haitians and Dominicans in the Dominican border town Elias Piña. This chapter discusses the historic relations between the two countries, emphasizing the key events that made race, ethnicity, and nationality central issues in Dominican society.

The racial situation and racial discourses embedded in the Haitian-Dominican border region are pertinent to understanding how Haitian women as racial minorities access the Dominican health care system in the border town Elias Piña. I begin the chapter reviewing the critical periods in Haitian-Dominican relations that contributed to the rise of anti-Haitianism in the Dominican Republic. Drawing on the works of historian Richard Turits and Lauren Derby, I examine how the Haitian-Dominican border area was transformed from a once porous bicultural and transnational frontier to a demarcated, racist region controlled by state-led anti-Haitian ideologies and discourses that are still prevalent today (Turits 2002). I further discuss the social construction of race and ethnicity in the Dominican Republic as it pertains to Dominican and Haitian racial and national identity (Gregory 2007; Howard 2001).¹

Anti-Haitianism in the Dominican Republic

According to anthropologist David Howard, the racial discrimination of Haitians and the anti-Haitian sentiment in the Dominican Republic are linked to its historical and political relationship with Haiti. In *Coloring the Nation: Race and Ethnicity in the Dominican Republic*,

¹ While the academic literature paints a negative image of the Dominican Republic, this does not reflect my personal view of the country.

Howard states that, “racial prejudice against Haitians is self-evident” (2001: 37). He argues that Haitians exist in the Dominican Republic “as marginalized individuals in a society that demands their labor,” but refuses to assimilate them physically and socially (Howard 2001: 30).

Dominican identity and nationalism is comprised of racial prejudice and the rejection of anything Haitian. Haitians living in the Dominican Republic are seen as outsiders, needed only for cheap labor, but are excluded from all other aspects of Dominican society (Howard 2001).

In his work with Haitian immigrants in the Dominican Republic, anthropologist Steven Gregory found that the racial discrimination of Haitians goes well beyond their skin color. He states that the structural racialization of Haitians, which has been embedded in Dominican society for centuries, is cultural and ethnic as well as racial. Gregory argues that the Dominican construction of Haitian identity “radically externalizes” Haitians from Dominican society (Gregory 2007: 199). One example Gregory uses to portray the Dominican constructs of Haitian identity is the belief that HIV/AIDS is a disease associated with Haitian culture. Many Haitians in the Dominican Republic who have HIV/AIDS-like symptoms avoid going to the doctor for fear of being further stigmatized and excluded by Dominican society (Gregory 2007).

Scholars in the fields of Caribbean anthropology and history, such as Howard and Gregory, point to three catalysts in Haitian-Dominican relations that spurred this anti-Haitian ideology in the Dominican Republic: Haiti’s occupation of the Dominican Republic between 1822-1844; the U.S. military occupation of both Haiti (1915-1934) and the Dominican Republic (1915-1924); and the 1937 Haitian massacre and Trujillo dictatorship in the Dominican Republic (Gregory 2007; Human Rights Watch 2002; Sagás 2000; Wucker 1999).

The 1822 Haitian occupation of the Dominican Republic is often referred as the “Ur moment” in the construction of anti-Haitian ideology in the Dominican Republic (Gregory 2007:

179). The Dominican elites, who were typically of lighter skin than most lower-class Dominicans and Haitians, resented being ruled by black skinned individuals (Sagás 2000). When the Dominican Republic finally gained independence in 1844, anti-Haitian ideology had become a central component of Dominican identity and nation building. According to Gregory, “After independence, Dominican nationalists aimed to fashion a national identity against the persisting Haitian threat—one that emphasized the new republic’s Hispanic, rather than African, origins and its racial distinctiveness from black Haiti” (2007: 180). Thus, in order to socially and racially distinguish themselves from Haitians, Dominicans stopped identifying themselves as *black* or *mulatto* and started calling themselves *indios*:

The formation of the Dominican nation served as a point of reference for all those Dominicans who, for the color of their skin, could never hope to be called white and Spanish, but desperately wanted to get rid of the negative stamp of being called black and African. Thus, the term *indio* became current, instead of *mulatto* [or *black*], invoking an indigenous and romantic past rather than that of African tribalism and slavery (Fennema and Loewenthal 1987 in Howard 2001: 45).

While the term *indio* was not official recognized by the state as the racial description of the Dominican people until the Trujillo dictatorship, the social construction and importance of identifying as ‘light-skinned’ formed during the mid nineteenth-century (Howard 2001).

U.S. influence in the deepening of *antihaitianismo* in the Dominican Republic was most prominent during the early twentieth-century when the U.S. military occupied the island of Hispaniola. Following independence, the Dominican Republic –primarily due to the economic value of its sugar industry--became integrated into the global economic system (Gregory 2007). In 1915, when both Haiti and the Dominican Republic struggled with political instability, the U.S. military intervened and the island fell under U.S. rule. Conveniently, however, this was also the time when the Dominican sugar industry started booming. Given the large number of U.S.

sugar plantations in the Dominican Republic, there is no doubt that the U.S. military intervention had ulterior motives (Gregory 2007).

Shortly after the U.S. military intervention, the Dominican Republic experienced an influx of Haitian migrants in the sugar producing provinces. According to Gregory and Sagás, the United States (which was also occupying Haiti at this time) considered Haitians to be a source of cheap and exploitable labor, and therefore, advocated for the importation of Haitian laborers for the sugar industry, ultimately deepening the anti-Haitian sentiment in the Dominican Republic (2007; 2000). “Haitian migration added an important element to *antihaitianismo* ideology. Haitians were no longer the powerful and feared enemies of the past. Now Haitians were increasingly stereotyped as poor, illiterate migrants in a foreign country” (Sagás 2000: 41).²

While today’s anti-Haitian ideology and discourse in the Dominican Republic is attributed to all three periods in the nations’ histories, the intensity with which the Dominican state practiced and reinforced this ideology dramatically increased with the rise of the Trujillo dictatorship in the 1930s (Turits 2002). Turits and Sagás argue that following the 1937 massacre of 15,000 Haitians and Dominico-Haitians living along the Haitian-Dominican border a “newly hegemonic anti-Haitian discourse” spread across the nation, forever influencing Haitian-Dominican relations (Turits 2002: 593; Sagás 2000).³ According to Sagás, even though the Trujillo regime did not invent anti-Haitianism in the Dominican Republic, the regime “did take *antihaitianismo* to new intellectual heights and convert it into a state-sponsored ideology”

² While the United States contribution to *antihaitianismo* in the Dominican Republic was most prominent during the U.S. military occupation of Hispaniola, scholars like Torres-Salliant note: “It is not inconceivable that the texture of negrophobic and anti-Haitian, nationalist discourse sponsored by the official spokesperson in the Dominican state drew significantly on North American sources dating back to the first years of the republic” (1998: 129).

³ The exact number of Haitian deaths in the 1937 massacre is unknown. Estimates tend to range from 15,000-30,000 (Turits 2002).

transforming the elitist popular anti-Haitian prejudice “into a complex dominant ideology” (2000: 46).

When dictator Rafael Trujillo came to power in 1930, the border region was a bilingual frontier, and “Dominican identity was far from uniformly imagined as antithetical to or exclusive of Haitians and Haitian culture” (Turits 2002: 593). According to Turits and Derby, “The Haitian population had been well integrated into the border region, and despite the local consciousness of racial differences, the division of labor was class based not race based” (1993: 67). Trujillo and his elitist government viewed the Haitian border population as a national threat. In 1936, Trujillo officially demarcated the border that exists today, yet “the border remained entirely porous and held limited meaning for local residents” (Turits 2002: 594). Thus, in order to “save” the Dominican nation from the dreaded ‘Africanization’ of Haitian immigrants, Trujillo ordered the massacre of all Haitians living in the Dominican border provinces (Howard 2001; Sagás 2000; Augelli 1980). Following the 1937 massacre of an estimated 15,000 Haitians, the Trujillo dictatorship increased its “negrophobic,” anti-Haitian state ideology, which profoundly altered Haitian-Dominican relations especially in the border region (Gregory 2007).

In her study of Haitian-Dominican border relations, Lauren Derby examines the meaning of race and ethnic identity before and after the massacre. Derby states that the 1937 massacre “introduced a hierarchy into a previously horizontal ideology of difference: As frontier Dominicans became part of the nation as citizens, the Haitian community came to be labeled as foreigners threatening the body politic” (1994: 489). Derby argues that before the “Dominicanization” of the border zones, the majority of “border Dominicans did not hold an unequivocal set of negative stereotypes related to Haiti and Haitians” (1994: 513). According to an interview with a Haitian border resident prior to the massacre, “Although there were two

sides, the people were one, united” (Turits 2002: 595). Furthermore, as Turits explains, the majority of border residents were neither pure Dominican nor pure Haitian, but a mix of both nationalities. While there were certain cultural, religious, linguistic, and physical characteristics associated with being “Haitian,” the elitist anti-Haitian ideology of Santo Domingo had “no social or economic” presence in the borderlands (Turits 2002: 599).

The closing of the Dominican side of the border and the assassination of thousands of border residents, who may in fact have been as much Dominican as they were Haitian, transformed the identity of border Dominicans.⁴ As Dominican border residents were further incorporated into Dominican society, and further exposed to anti-Haitian rhetoric, they began to see themselves as the superior “race,” and, as a result, “a set of unequal relationships between [Haitians and Dominicans] was essentialized and concealed by a system of signs emblematic of racial differences” (Derby 1994: 525). A new level of racism and social exclusion unfolded along the border. Haitians, who had once been valued for their economic achievements and characterized as “the hard-working border residents,” became “inferior and permanent outsiders” in the border region, and according to Turits, have remained as such today (2002: 634). As Derby states, today, “after fifty years of anti-Haitian socialization through schools and the press, virtually all border residents echo at least the metaphors of official anti-Haitianismo” (1994: 490).

Although the Trujillo dictatorship ended over forty years ago, his anti-Haitian ideology remains an integral part of Dominican identity. In his study on race and ethnicity in the

⁴ According to Turits, the manner in which the Dominican military distinguished Haitian border residents from Dominican residents was not clear. As Turits questions, “Were Haitians whose families had lived in the Dominican Republic for several generations and who spoke Spanish fluently still “Haitian?” And how should children of Haitians and Dominicans be identified?” (2002: 616). Today, this question concerning national identity is still present, and problematic for many border residents, especially for Haitian children (meaning their parents are Haitian) born and raised in the Dominican Republic. How do they identify, as Haitian or Dominican?

Dominican Republic, Howard found that “few Dominicans have grown up without hearing private or public defamation of the neighboring country. The Haitian population, subconsciously and consciously, becomes a threat. A phobia is openly promoted through racist discourse, everyday language, and stereotypes” (2001: 40). For more than thirty years, Dominican society was bombarded with Trujillo’s anti-negritude rhetoric, which biased the light aesthetic. This bias towards whiteness continues to be a fundamental aspect of Dominican identity, and is regularly used to differentiate Dominicans from Haitians. In contemporary Dominican society, Dominicans, even black Dominicans, are identified as the “white race,” and all that is good, pure and civilized. Haitians on the other hand, are identified as the “real” “black race,” and all that is dark, evil, and barbaric (Howard 2001; Sagás 2000). As Sagás concludes, “when nation becomes equated with race, as *antihaitianismo* ideology effectively does, no Dominican has any incentive to consider himself (or herself) black, while all Haitians are labeled as black. Haitians are thus, dehumanized, reduced to a deprecated race, the black race” (2000: 87). Ultimately, the anti-Haitian state ideology of the Trujillo era conceptualized race “as a ‘problem,’” which, as Howard argues, has become “fundamental to the perception of racial identity” in the Dominican Republic (2001: 21).

Race, Ethnicity, and Class

The object of the following section is to briefly analyze the terms ‘race’ and ‘ethnicity’ as they pertain to racial and ethnic identity in the Dominican Republic, followed by a brief discussion of the scholarly literature on the relationship between race and class in that country.

The general consensus among anthropologists is that “ethnicity refers to ‘cultural’ differences, whereas race refers to phenotypical differences” (Wade 1997: 16). Yet, as Wade argues, it is often difficult to differentiate between race and ethnicity. “Racial and ethnic identifications do overlap both analytically and in practice” (1997: 21). In the Dominican

Republic, the concept of race, ethnicity, and nationality are interrelated, making it difficult to draw clear and discrete distinctions among the three concepts. “When Dominicans talk of *la raza* it may include color, phenotype, nationality, or cultural traits” (Howard 2001: 17).⁵ Because it is not easy to differentiate between race, ethnicity, and nationality Dominican identity is often defined as “that which is not Haitian.” A black Dominican will not racially identify as black, but as Dominican, in order to distinguish himself/herself from black Haitians.

Dominican society, in addition to being segregated by race, is also stratified by class. According to Lowenthal, in almost all Caribbean societies, “race and color are shorthand designations of class, but they often overwhelm all other connotations” (1972: 134). In his study of the relationship between class and race in the Dominican Republic, Howard found race to be an indicator of socioeconomic status. Typically, light-skinned Dominicans were linked to the upper class, with dark-skinned Dominicans being linked to the lower class. Howard thus argues that having a “*blanco/a* phenotype probably means that the individual already occupies a privileged position in society” (2001: 68). Furthermore, in addition to the racialized class structure in the Dominican Republic, Sagás argues that race and racial ideology also influence class position within a given class group. Haitians and Dominicans for example, who are both members of the lower class, hold different socioeconomic standings within the lower class. Put another way, poor Haitians are still viewed as inferior to poor Dominicans. According to Sagás, the socioeconomic and racial position of Haitians within the Dominican lower class is a by-product of anti-Haitian ideology.

In his research on the division of labor in the Dominican Republic, Gregory found that Haitians occupy the lowest sectors of the job market. They are predominantly found in the

⁵ According to Howard, Dominicans use the term *la raza* (race) (as opposed to *etnicidad* or *nacionalidad*) when talking about race, ethnicity, or nationhood (2001).

informal sector, and in the industries associated with being “criminalized or racialized” such as the “slavelike cane cutter” industry (Gregory 2007: 207). Similar to Howard and Gregory, my findings confirm the conclusion that Haitians in the Dominican Republic are at the bottom of the socioeconomic ladder. The Human Rights Watch also found this to be the case. “Most Haitians [in the Dominican Republic] are poorer than the poorest Dominican. They have terrible houses, and are easily identifiable by their way of living” (2002: 3). This is especially so in Elias Piña, the poorest province in the Dominican Republic (Demographic Health Survey 2007). In examining the division of labor in Elias Piña, Dominicans overwhelmingly held the majority of jobs in the formal sector such as small business owners, while Haitians occupied the informal sector working as manual laborers in Dominican homes, and businesses. All the Haitian women I interviewed, if currently working, were currently or previously employed as “domestics” in Dominican households.

Because “race and ethnicity are not terms that have fixed referents” (Wade 1997: 5) and are “highly specific to person and place” (Howard 2001: 3), the character of race and ethnic relations in the Dominican Republic cannot be generalized to other countries. In the Dominican Republic, racial, ethnic, and national identification involve discourse about origin and the “transmission of essences across generations” (Wade 1997: 21). Differentiations among the three concepts are not straightforward. Due to the complexity and multivalence of racial/ethnic identification, *antihaitianismo* is the focal point of Dominican identity. Furthermore, race and class interconnect in the Dominican Republic and cannot be treated as two distinct sets of relations. Race and ethnicity influence class position in an essential way in Dominican society. “Class formation itself is predicted upon race structuration, whereby race and class are separate

but connected sets of relations in which antagonism is a primary driving force” (Howard 2001: 57).

CHAPTER 4 METHODOLOGY: THE SUCCESSES AND FAILURES OF GROUNDED RESEARCH

In her work on global health policies, Whiteford argues that global health programs, by ignoring the needs and wants of minority populations, actually increase the social and physical suffering for the most disadvantaged individuals of which racial and ethnic minority women are a large majority (2000). Before global health programs can be adapted to meet the needs of the local populations they aim to serve, research examining the experiences and perceptions of these populations in relation to the availability and quality of health care needs to be conducted. In the social sciences, qualitative research methods are considered the most appropriate approach for collecting data on people's life experiences and everyday behaviors (Silverman 2000). Considering the aim of my study—to understand the experiences of Haitian women in accessing and receiving maternal health care in the Dominican Republic—a qualitative research design was appropriate. Furthermore, considering the importance of race and skin color in the Dominican Republic, a qualitative approach allows for a deeper analysis of the multi-faceted and complicated issues related to race relations and health care in the Dominican Republic compared to what would be provided by a statistical and deductive approach. This chapter explains the concept of grounded theory and summarizes my experience using grounded theory and ethnographic observation to collect and analyze the data.

Grounded Theory As a Research Method

Grounded theory is the most commonly used inductive research method in the social sciences (Bernard and Ryan 2010). Grounded theory methodology is a set of techniques analysts use to identify common “patterns of behavior” that emerge from a set of observations or texts. “As the title implies, the aim [in one form or another] is to discover theories- causal explanations—grounded in empirical data, about how things work” (Bernard and Ryan 2010:

267). I find Charmaz's definition in *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis* to be particularly clear: "Stated simply, grounded theory methods consist of systematic, yet flexible guidelines for collecting and analyzing qualitative data to construct theories 'grounded' in the data themselves. The guidelines offer a set of general principles and heuristic devices rather than formulaic rules. Thus, data form the foundation of our theory and our analysis of these data generates the concepts we construct" (2006: 3).

In the "grounded" method, the researcher uses the results of early interviews to draw preliminary conclusions that, in turn, influence the direction of the conversation in subsequent interviews (Bernard 2000: 443). As the researcher analyzes the interviews, she identifies common concepts that repeatedly appear in the interviews, ultimately linking related ideas into substantive theories. This process of categorizing the data by themes is called coding. "Coding means that we attach labels to segments of data that depict what each segment is about. Coding distills data, sorts them, and gives us a handle for making comparisons with other segments of data" (Charmaz 2006: 3). Throughout the coding process, the researcher constantly analyzes and compares the codes, abstracting concepts from the data. Subsequently, the researcher is then able to develop general theories from the categories derived from the coded data (Charmaz 2006). Ultimately, grounded theory methodology allows the researcher to understand what is happening at the "ground level," from the perspective of the population being studied.

My Experience with Grounded Theory: Trials and Tribulations

My study took place over a six-week period during the summer of 2010. During this time, I conducted 31 in-depth interviews with Haitian women, Dominican women, and health care personnel. Interviewees were between the ages of 18-56. Seventeen interviews were conducted with Haitian women, all of whom lived in Elias Piña except for two women who lived in Belladère, but routinely crossed the border to Elias Piña. Of the seventeen women, five (two of

the five were the women living in Belladère) were displaced by the Haitian earthquake on January 12th, and had only been in Elias Piña (or Belladère) since mid-February. The other twelve Haitian women had lived in Elias Piña for a minimum of four years, with the average of 7-10 years. All twelve women left Haiti in “search of a better life,” and at one point or another since living in Elias Piña, all were employed as domestic servants in a Dominican household. Six of the seventeen Haitian women interviewed had some schooling; and of those six, only two finished high school. At the time of the interviews, fifteen of the seventeen women were not working. Of the two who worked, one sold food in the market every Monday and Friday. The other worked as a domestic servant. Given their dire economic situation, public health care was the only health care option for all the women. Nearly all the women reported having to pay for medicines even when the hospital was stocked with the medicine they needed. Technically speaking, all fifteen Haitian women living in Elias Piña were illegal immigrants.

Thirteen interviews were conducted with Dominican women. Five of them worked in the medical field—one was a psychiatrist, two were general practitioners, one was a nurse, and one was a director of an NGO. I also interviewed one male doctor who worked in the intensive care unit at various hospitals in Santo Domingo and in Elias Piña. In addition to the five who were employed in the medical field, six of the remaining eight women also held jobs—two ran their own *colmados* (small stores that sell your basic necessities such as water, crackers, soda, and oil), one was a teacher, one worked as an administrative assistant in a medical clinic. Another worked as a money-lender. Only two of the thirteen Dominican women interviewed were unemployed at the time of the interviewees. All except for one woman completed high school, and six of the thirteen had attended the university. All the employed women reported having

seguro de salud, a form of health insurance provided by the state that reduces the cost of prescriptions and private health care.

My initial point of contact with the border community Elias Piña was through the help of a women's health organization called *La Colectiva Mujer y Salud*. Prior to beginning my fieldwork, Sergia Galvan, the director of *La Colectiva*, arranged for me to stay with Teodora, *La Colectiva's* psychologist, in Elias Piña. *La Colectiva* is a free clinic, which provides primary health care services to Haitian and Dominican women and children. In addition to Teodora, the Elias Piña clinic has four other full-time female staff members: a general physician, a nurse, a lab technician, and a lab assistant. I spent the majority of my first week getting to know *La Colectiva's* staff, observing patient/staff interactions, and meeting women to interview.

Before I came to Elias Piña, I naively assumed, along with many other foreigners, that Haitians and Dominicans were primarily distinguishable by skin color. As soon as I arrived in Elias Piña, I realized that Haitians and Dominicans are of all shades, and cannot be divided into distinct phenotypical groups (Howard 2001). I did encounter a few Dominicans who identified Haitians as being *mas negro* (blacker) than the darkest Dominican, yet the majority of the people with whom I spoke acknowledged that Haitians and Dominicans come in all colors, and thus, used other characteristics (in addition to skin color) to differentiate the two nationalities. When I asked Dominicans how they could tell who was Haitian and who was Dominican I was told: "Haitians are not as clean or as put together as Dominicans. Usually, their skin is darker and rougher, but not always. They don't dress well. Haitian women wear their hair in braids, and they do not have nice womanly features like Dominican women. Also, Dominicans are happier people, have good relations with each other, and always greet each other whereas Haitians are

more reserved and are not personable. Haitians cannot speak Spanish like Dominicans even if they have lived here for along time. That is how you can tell the difference.”

The attributes that Dominicans in Elias Piña routinely invoke as a means to identify who is Haitian are clearly embedded in the cultural/ethnic stereotyping described in earlier chapters, and were singularly unhelpful to me in the field. To the extent that there are differences between the two groups, it was not until the very end of my stay that I learned to distinguish between Haitians and Dominicans without falling into the very anti-Haitianism that I sought to avoid. Initially my strategy was to simply wait until I heard Haitian Creole being spoken.

During my initial interaction with the female patients, I explained my purpose for being in Elias Piña. This often lead to a short conversation, and usually ended in my asking the women for their information so I could stop by their house later that day or the following morning to conduct an interview. It was only after I made the error of trying to hold an interview with a Haitian woman in the physician’s office at *La Colectiva* that I decided to conduct all subsequent interviews at the women’s house.

Around my fourth day in Elias Piña, as I was sitting in the waiting area at the clinic, Teodora introduced me to a young Haitian woman who had brought her sick son in for a check-up. As I was quietly chatting to the woman in Haitian Creole, Nillian, the clinic’s doctor, told me to use her office to interview the woman. I was hesitant to accept this offer because I could tell that the Haitian woman was not completely comfortable in the clinic. Nillian insisted and before I knew what was happening she was shuffled us into her office. As I pulled out my notebook, pencil, and recorder, I noticed that Teodora’s twelve year-old Dominican daughter was also in the room. Instead of asking her to leave, I began the interview with Amelia (the Haitian woman). As I asked Amelia to tell me about her situation and how long she had been living in Elias Piña, I

saw her glance over her shoulder at Teodora's daughter who was playing on the computer. She looked back at me, glanced at her feet, and then quietly started telling me how she had come to Elias Piña eight-years-ago to work as a domestic servant. Every few seconds while she was talking, I caught her looking over at Teodora's daughter. Knowing that I had made a mistake by not asking the daughter to leave the room, I asked Amelia if she would be more comfortable talking at her house. She took a deep breath, smiled for the first time, and responded loudly in Haitian Creole, "Wi, wi. Ou ka vini denmen!" (Yes, yes. You can come over tomorrow!). After this experience with Amelia, I decided that interviews needed to be conducted in an environment where the interviewee felt comfortable and their responses less influenced by their surrounding environment, and ultimately more accurate.

In addition to spending time at the clinic, I also observed events that took place in the public hospital. On most days, I spent a couple hours either in the morning or afternoon, sitting in the maternity ward talking to the female patients who had just given birth or who were waiting to do so. Subsequently, this also led to interviews.

Interviewing, Data Collection and Analysis

During my first set of interviews, I took an ethnographic interview approach, starting with broad, general questions. As Bernard and Ryan explain, "The idea is to get people on a topic and get out of the way, letting them provide the information they think is important" (2010: 29). Once the women started talking, I followed Bernard and Ryan's advice and kept questioning to a minimum, interjecting only to re-direct the conversation or to probe for more detailed information. As I became more "grounded" with the interviewing process and more familiar with the data I was collecting, I adapted the interviews to address particular issues or questions. Interviews with medical personnel were slightly more direct as I wanted to understand how they

viewed the Dominican health system. Additionally, I also wanted to understand how the Dominican health system functioned, which required a more structured interview format

During all interviews I took as detailed notes as possible. When the interviewee allowed it, I used a digital voice recorder.¹ Not only did I write down what was being said, but I also took notice of the physical and non-verbal reactions of the interviewee. As soon as finished an interview, I wrote down everything that occurred throughout the interviewing process.² I also carried a separate notebook to record observations and reflections about what I saw and heard.

According to Corbin and Strauss, the process of analyzing data should begin as soon as the first data are collected. “In order to not miss anything that may be salient the investigator must analyze the first bits of data for cues. All seemingly relevant issues must be incorporated into the next set of interviews and observations” (1990: 6). Analyzing the data from the start and allowing earlier results of earlier interviews to inform later ones is the basis of the grounded theory methodology. “The research *process* itself guides the researcher toward examining all the possible rewarding avenues to understanding” (Corbin and Strauss 1990: 6).

Following Corbin and Strauss, every evening when I returned from the field, I re-read and analyzed both my interview notes and observation notes in order to prepare for the next set of interviews.³ I made a running list of common themes that appeared in the interviews. Additionally, I created a separate list of the contradictory data, noting the issues that I did not understand or issues that I needed to further explore. The third list consisted of observations

¹ See Chapter 7 for further information on problems with using a digital voice recorder.

² Most interviews lasted one hour on average.

³ Ideally I would have liked to transcribe the recorded interviews as I analyzed the information written in my notebooks, but due to the shortage of electricity in Elias Piña, I had to wait until I was in Santo Domingo. It was for this reason that around the third week of my research I went to Santo Domingo to transcribe my first set of interviews.

associated with qualitative work. I paid special attention to the potential ways in which the project findings might be influenced by the fact that I was a white, educated and foreign woman. I found myself especially being conscious of this when I observed the maternity ward at the hospital, taking note of how my presence might alter patient/doctor relations.⁴

When I returned from the field, I transcribed the remaining interviews, typed all field notes and started ‘coding’ my data. I began by reading and re-reading through my data, eventually jotting down recurring words, phrases and themes. I proceeded to take the text apart line by line, using different colored highlighters to group blocks of text with similar themes. Next, I cut and pasted all the text highlighted in blue, for example, into a new document. I did the same for the text highlighted yellow, green, orange, etc. Heeding Corbin and Strauss’s advice, I then used the words that people said to name the themes (Bernard 2000: 445). I identified nineteen themes, which I grouped into five major categories (Table 4-1). Finally, by linking the set of coded themes together, I derived several theories and conclusions about race, ethnicity, and maternal health care in the Dominican Republic.

⁴ The section on research concerns and limitations in Chapter 7 further addresses the ethical issues associated with participant observation.

Table 4-1. Coded Themes and Constructed Groups from Analysis of Interviews

Coded Themes (19)	Constructed Groups (5)
Dominican Health Care System Rosa Duarte Hospital Haitian Health Care System Hospital in Belladère	Cost, Availability, Resources
Unequal Treatment Observation of Unequal Treatment Equal Treatment	Race and Ethnicity as Barriers to Care in DR
Racism Exists Equal Treatment Contradictions Personal Observations	Dominican Perception's of Race
Level of Acculturation Spanish Dominican Family Adaptability of Identity	Language and Familial Ties
Desire to Return Home Desire to be White Economic Disadvantages Nwa, Blan, Negro, Blanco	National Identity and Skin Color

CHAPTER 5 RESEARCH SETTING: SPACE, RACE, AND CLASS

The broader social, economic, and racial forces at play in the Dominican Republic are pertinent to understanding Haitian women's relationship to the Dominican health care system. This chapter situates Haitians as ethnic and racial minorities within the larger social, economic, and racial structuring of Elias Piña. I first introduce the spatial organization of Elias Piña and then depict the spatial organization by describing how I tracked down Lillin, a Haitian interviewee.¹ Second, I discuss the political and racial border dynamics in Elias Piña followed by the third section that examines the Dominican health care system and Elias Piña's public hospital. These observations portray the subordinate position of Haitians in Dominican society, setting the context for understanding how Haitian women experience race and ethnicity within the Dominican health care system.

Elias Piña: Spatial Organization

Elias Piña is spatially organized by race, ethnicity, and class. The town's spatial organization shows the economic and racial/ethnic divide between Haitians and Dominicans. There are Haitian neighborhoods and there are Dominican neighborhoods. Dominican neighborhoods are close to the center of town and are economically more developed compared to the Haitian neighborhoods. The spatial organization illustrates the subordinate position of Haitians.

I met Lillin as she was leaving the Rosa Duarte public hospital with her one-year-old daughter.² Lillin spoke in Creole with another Haitian woman, discussing the events that occurred at the hospital earlier in the day. I approached the two women and introduced myself in

¹ Interviewee's names have not been changed.

² Rosa Duarte is the name of the public hospital in Elias Piña.

Haitian Creole. Because Dominicans do not speak Creole in Elias Piña, the women were impressed and amused with my mediocre, American accented Creole. Lillin eagerly agreed to be interviewed and told me to stop by her house the following afternoon.

Finding Lillin's house was not an easy task. Similar to other rural towns in developing countries, there are no street names or house numbers for zones outside the "central" part of town. The "central" part of town is defined in relation to the "roundabout," which consists of a cement "park" decorated with benches and mango trees. The town bank, the municipal building, and a number of *colmados*--small stores that sell your basic necessities such as water, crackers, soda, and oil--are located on the circular road that surrounds the central "park." Cement houses varying in quality line the semi-paved streets leading away from the central "park." The majority of these houses are Dominican. Tucked just behind these houses are scattered clusters of small decaying wooden shacks. These shantytown-like "neighborhoods" are over-crowded and littered with garbage, populated by stray dogs, and contaminated by sewage water. These "neighborhoods" are primarily Haitian. Although, technically, Dominicans and Haitians live "next" to one-another, Elias Piña appears to be segregated into distinct racial and economic spaces with Haitians at the bottom of the socioeconomic ladder.

This is not to suggest that Dominicans in Elias Piña are living well. The majority of Dominicans make just enough to get by, living in what I would call "urban" poverty. For example, the Dominican family with whom I stayed lives in a Dominican neighborhood called *Los Mangos*. This neighborhood consists of about ten cement apartment buildings full of cracks and holes. Electricity and running water are intermittent. Apartments are over-crowded with children, and the streets are piled high with garbage waiting to be picked up by the state-run garbage company. Goats, dogs, and cats roam the streets rummaging through the piles of waste

looking for anything edible. The air is stuffy and humid, and at night, mosquitoes, moths, and cockroaches invade the tiny unsanitary apartments. In contrast to the Haitian neighborhoods, the apartments have indoor toilets, bathtubs, discrete bed-rooms with beds, kitchens with gas stoves, sinks and refrigerators, and sitting areas with furniture and televisions.

None of the seventeen Haitian women I interviewed, no matter how long they had lived in Elias Piña, had electricity or running water in their homes. Those who are lucky have access to a small communal latrine used by the neighborhood. At most, the houses have “two” rooms (which is one room divided in two by a piece of cloth) used for sleeping, eating, and cooking. Some houses have mattresses, plastic chairs, and half-functioning gas stoves. Haitians who arrived after the earthquake have even less. I recall one family of eight that slept on flattened cardboard boxes and dirty old rags under a blue tarp.

With my interview notebook and the written “directions” to Lillin’s house in hand, I hopped on the back of a *motoconcho*, the only form of motorized transportation in Elias Piña, and told the *conchero* to drop me at *La Galeria*, Lillin’s neighborhood. When I arrived at *La Galeria*, I was unsure from Lillin’s directions where to go so I stopped at the nearest *colmado* to see if anyone knew where Lillin lived. The short heavy woman running the *colmado* asked in Spanish, “Is she Haitian?” I told her that Lillin was Haitian and had a little daughter who was sick. The woman in the *colmado* took a moment to ponder the name before shaking her head no, followed by a hand gesture directed at her two friends sitting in her front yard. The women made their way to where we were standing and politely greeted me. These women did not know Lillin either, but they kindly introduced me to another Dominican woman down the street who did. She pointed me in the direction of Lillin’s house, which was located down a small dirt road behind a row of crumbling cement houses, half-a-block north of her *colmado*.

I walked down the “road,” which actually was a dirt path littered with broken glass, broken cement blocks, and garbage. The path ended quickly and opened into a space about half the size of a basketball court. What had once been a standing cement house had crumbled to pieces. Rotten mangos covered the semi-flooded, muddy ground, scattered with pieces of rotting wood and wire. It smelled of sewage. Three half-clothed kids between the ages of three and seven played, stopping now and again to examine the rotten mangos on the ground. To the far right of the crumbling cement house, I saw a row of small wooden shacks with tin roofs lined up one after another. As I approached, I found three Haitian women, Lillin being one of them, sitting in dirt-covered red plastic chairs in the front of the first house. Smiling, and somewhat surprised that I showed up, Lillin kissed my check and introduced me to the other women. Lillin was holding her semi-conscious sick daughter over her right shoulder. The whites of the child’s eyes were yellow and her black pupils were glossed over. Beads of sweat dropped off her forehead. She was struggling to breathe and a continuous stream of liquid orange, vomit-like fluid flowed from her tiny mouth. The treatment Lillin’s daughter previously received in the hospital appeared not to have worked. Her daughter was in desperate need of health care. Lillin’s poor and segregated living conditions demonstrate the economic hardships Haitians face daily in Elias Piña.

Haitian-Dominican Border Relations

Crossing the Haitian-Dominican border involved a process that exemplifies the dominate/subordinate relations between Dominicans and Haitians in Elias Piña. Skin color and nationality are critical to the border-crossing experience for most Haitians. The importance of skin color and nationality in the Dominican Republic similarly influence the experiences Haitian women have in the Dominican health care system.

Elias Piña/Belladère is one of the three designated border-crossing points along the Haitian/Dominican border. The current population of Elias Piña is estimated to be 72,000 people. This is likely not an accurate count given the chaotic and disordered border crossing regulations. Although I crossed the border a number of times, I am still confused about how the border-crossing process actually works. In fact, many border residents are unclear themselves about how the border-crossing process works, especially after the earthquake. According to one Dominican border officer, in the immediate aftermath of the Haitian earthquake, movement of goods and people across the border was unrestricted. Working through the paper work and necessary documents to cross the border would have slowed the emergency relief process. Five months after the earthquake, however, it appeared that some border-crossing regulations were being reinstated (at least by the Dominicans).

Based on my limited observations and experiences crossing the border, I have several conclusions about border-crossing politics:

The border is defined by a ten-foot high green metal wall which extends for no more than 100 yards in each direction. During the day part of the wall “retracts,” creating a space of about 50 feet. All border traffic is directed through this small opening which is monitored by Dominican police and border-control. The “legalities” of the border-crossing process seem to be in the hands of the Dominicans. On the Dominican side of the border, there is a customs office run by Dominicans. On the Haitian side of the border the customs office is located in the town Belladère, more than twenty minutes away from the actual crossing point.

Connections are beneficial. According to Dominican and Haitian border residents, bribes happen and are accepted.

Haitians seem to be monitored more closely than Dominican. Haitians have to pass through customs with the appropriate documentation in order to enter Elias Piña. The Dominicans I noticed, such as Teodora (the psychologist of *La Colectiva* with whom I lived) and the other Dominican staff members of *La Colectiva*, did not have to show documentation when crossing the border to Haiti or when they passed the customs office in Belladère.

The lighter skinned people receive less scrutiny from border patrol. In fact, a Dominican man once told me that because of my white skin and American nationality I could cross the border without stopping at customs or showing documentation.

Haitians are permitted to cross the border without documentation on Mondays and Fridays to sell their products in the market. The market sustains the economic livelihood for many border residents. According to Sergia, the director of *La Colectiva*, the market helps reduce the level of poverty for Dominicans in this region: “Dominicans in the area depend on the Haitian market for business. So while they say that the Haitians are unnecessary and not wanted, they are necessary for the economic survival for Dominicans living in this region.”

There is a noticeable difference in infrastructure and development between the two border towns. For the most part, roads in Elias Piña are paved and easy to maneuver. The roads leading to Belladère and the other Haitian border towns are unpaved and full of ditches and rocks. On rainy days, the roads turn to mud; the holes fill with water, making it extremely difficult for vehicles to travel. Government facilities in Elias Piña are semi-well-kept and equipped with electricity and running water, but in Belladère the schools and medical centers have no electricity, insufficient resources, and remain half-built. Belladère’s population continues to increase as Haitians displaced by the earthquake migrate to the border area.

During my fourth week in Elias Piña I witnessed an interesting interaction between Teodora and the Dominican border patrol, which illustrates the Dominican belief that they are superior to Haitians and therefore, should not be subject to the same border crossing policies as Haitians. Usually, Teodora and Meri, who also works for *La Colectiva*, had no trouble crossing the border and never needed documentation. Yet, on this day, documentation was requested. Why they were suddenly required to provide documentation I do not know. I assume it had to do with the reinstatement of border policies that had not been enforced after the earthquake. In order to cross the border, Dominicans were now required, as the Haitians had always been, to present the proper documentation: a Dominican passport and a Haitian visa.³

Teodora was outraged because for the past five months she had been traveling to Haiti twice a week without documentation to conduct workshops with Haitian women displaced by the earthquake (*La Colectiva* had been contracted by a number of international organizations to conduct workshops and provide aid to women and children displaced by the earthquake in Belladère, Lascahobas, and Hinche). According to Teodora, border control had specifically told her she did not need documentation to go to Haiti. But on this morning she could not cross the border because she did not have documentation. Teodora, and a couple of Dominican men, started shouting at the officers, at which point I heard one of the men say: “This is our island. We do not need papers to cross to Haiti. We are Dominicans and this island, this land is Dominican.” Some pushing and shoving followed and before I knew it, Teodora and Meri managed to cross the border and were on their way to Belladère.

³ If this is still the case today I do not know. Additionally, as I previously stated, my understanding of this process is based on what I saw and heard by a few select individuals. My understanding is not a complete explanation of the complicated political border-crossing process.

As I left the border and headed for Rosa Duarte hospital, I reflected on what I had just witnessed. This incident portrayed how Dominicans view themselves superior to Haitians and felt they should not be subject to the same border-crossing policies as Haitians. Even though I knew that not all Dominicans shared the same opinion as these Dominican men, it was clear that these Dominicans valued themselves above Haitians. This dominate/subordinate attitude is reflected in the health care setting as well.

Health Care in the Dominican Republic

The Dominican Republic, like most developing countries, provides both public and private health care services. Technically, the public system is obligated to provide “free” health care services to any individual who seeks care independent of their nationality. According to La Foriga et. al, however, who analyzed the Dominican health care system in 2004, services deemed to be “free” fail to incorporate the indirect costs associated with seeking health care such as the cost of transportation to and from the health facility, the cost of medicine, the cost of “specialty” testing such as x-rays and ultra sounds (2004). The burden of these costs makes access to health care extremely difficult, especially for the poorest populations, ultimately resulting in low use of the public health system. For many, the extra costs associated with seeking care are not worth the return—the quality of care is inadequate and, as a result, patients often leave the facility in the same condition as they entered yet find themselves economically worse-off (La Forgia et. al 2004). Despite the overall low use of the public health system by all Dominicans, La Forgia et. al found, the public system was used most by the poor with 62% of the poorest 20% claiming the public hospital as their main form of care compared to only 29% of the richest 20% claiming the public hospital as their main form of care (2004). Ironically, the poor are “forced” to pay more for inadequate health care because they cannot afford private health care.

La Foriga et. al found that most individuals, if they had a choice, prefer to use private care. Given that patients have to pay not only for the indirect costs associated with receiving care, but also for the service itself, the private health care system offers better services, more resources, and better quality of care than the public health care system. In fact, La Forgia et. al discovered that many poor households opted to spend nearly half of their yearly income on private health care services due to the higher quality of care (2004).⁴

Dominican Health Care vs. Haitian Health Care: Physical Description of Hospitals

When I first entered Elias Piña's public hospital I was struck by the disorganization and chaos all around. The hospital, which is surprisingly big, has a shortage of medical supplies, medical personnel, and infrastructure. I spent the majority of my time in the emergency hall and the inpatient care unit, which includes the maternity ward and children's wing. Due to the limited number of doctors, patients are not attended to checked on regularly. In addition to the doctors, five nurses are on call every day. Although the nurses have patients to monitor, they appear to spend much of their time in rocking chairs chatting.

The hospital is spacious, but because of insufficient upkeep a number of rooms have leaky roofs and cracked walls. There are no individual rooms for patients. The children's wing consists of two large rooms, each room with five hospital beds and one bathroom. Every time I visited all the beds were occupied. The rooms also had some white plastic chairs and one small desk-like table piled with folders and medical equipment. Patients are fed a meal of rice and beans once a day. With few windows and no fans or AC, air circulation is limited; each time I entered the hospital, I was engulfed by the odor of sickness and disease.

⁴ The state also provides minimal health coverage for working Dominicans. Dominicans who have this coverage pay less for private health care and get discounts when purchasing medicine at most pharmacies (La Forgia et. 2004)

Although the health care system in the Dominican Republic is not good compared to the U.S health care system, it is far better than the health care system in Haiti. The hospital in the border town Belladère is a third of the size of the hospital in Elias Piña, yet it has three times as many patients. Patients line the hallways waiting for their chance to see the doctor, which can take days. The hospital is constructed so that the hallways are partially outside and some of the rooms are missing doors and walls. Each room is packed with as many metal hospital beds as possible. There are no light fixtures in the rooms and no running water. Given the number of patients in each room, it is hard to know how the medical staff controls the spread of disease. I am not sure how many doctors and nurses work in the hospital. Compared to the hospital in the Elias Piña, not once did I see a nurse who was not attending patients.

According to the hospital's administrator, the hospital in Belladère charges each patient 50 *goud* (equivalent to \$2 US dollars) to cover the cost of all services, including the cost of medicine, labs, and x-rays. Unlike the Dominican Republic, there are a limited number of clinics and hospitals in Haiti. In Elias Piña, for example, there are a number of private as well as public clinics in addition to the public hospital, whereas in Belladère the public hospital is the only health care option.

The border crossing experience as well as the spatial organization of Elias Piña demonstrate the marginal and subordinate position Haitians occupy in Dominican society. Their inferior position influences the quality of health care they can access. Not only are they economically bound to the weak public health care system, but they are also subject to maltreatment by Dominican medical workers.

CHAPTER 6 FINDINGS AND ANALYSIS: DO RACE AND ETHNICITY MATTER?

This chapter draws on the results of my observation and interviews in order to depict Haitian women's perception of the Dominican health care system, specifically in the Dominican border town of Elias Piña, and to examine their opinions about how race and ethnicity influence the health care they receive.¹ The materials in this chapter are organized according to five conceptual categories, noted table 4.1: *Cost and Availability of Services; Race and Ethnicity as Barriers to Care; Dominican Perceptions; Language and Familial Ties; and National Identity and Skin Color*. For purposes of clarity, I present my findings present by nationality.

Haitian Women's Perception of Health Care in the Dominican Republic

Cost of Care and Availability of Services

Most of the Haitian women I interviewed stated that Dominican health care was better than Haitian health care. Interestingly, some of these women had never attended a hospital or clinic in Haiti. Other women, who had used the Haitian system, observed that one of the main differences between the two systems was the cost. They pointed out that health care in Haiti is not free as it is in the Dominican Republic. The women also commented that health care was not easily available in Haiti, and they complained about wait time in Haitian clinics. Common words the women used to describe the Haitian system included: fight, disorganization, costly, understaffed, and lack of medicine.

Maria Elena, a Haitian woman who moved to Elias Piña shortly after the earthquake in Port-au-Prince explained, "There is a difference between health care in Haiti and health care here in the Dominican Republic. Maternal health care in Elias Piña is better than in Haiti. In Haiti,

¹ Although I often refer to the "Dominican health care system" in the broad sense, my findings are limited to the Elias Piña hospital. Given the time constraints of my study, I was not able to observe other public hospitals or private clinics in the country.

you pay more money and wait longer for service.” Adella, who has lived in Elias Piña for six years similarly voiced, “The hospital in Elias Piña is much better than the hospitals in Haiti. There are too many sick people in Haiti and you always have to wait to see a doctor. Then there is the problem of money. On entering the hospital in Haiti you have to pay a fee, but here you don’t.” Wislina, another Haitian woman displaced by the earthquake in Port-au-Prince, explained that even though she lives in Belladère, she prefers to go to Elias Piña for health care. “The Dominican system is better than the Haitian system. The hospital in Belladère doesn’t have enough resources. I have stomach problems and when I went to the hospital in Belladère they told me they didn’t have the equipment for the procedure. So I came here to Elias Piña.”

Women like Rosmara and Adelina had no access to health care when they lived in Haiti. For them, just having access to care made the Dominican system better than the Haitian system no matter the quality of care they received or how they were treated. “In Haiti, we didn’t go to the hospital or doctor. We were all born in my mom’s home. Sometimes midwives came, but there was no medicine for the pain. Here when I have a problem or my children have a problem I can walk to the hospital,” Adelina explained.

It is true that the hospital in Elias Piña is better equipped in terms of space, staff, supplies, and quality of materials than the hospital in Belladère. Yet, as a number of the Haitian women explained, having resources and being well equipped is one thing, but providing quality care and treatment of patients is another. When I asked the Haitian women to talk about quality of care—specifically focusing on race/ethnicity as a barrier to quality of treatment—I elicited interesting and contradictory responses.

Race and Ethnicity as Barriers to Care

Chapter 2 reviewed a number of cases studies that discussed how ethnicity and culture informed minority women’s decision to seek maternal health care. These studies underscore how

use of maternal health services is influenced by minority women's perceptions of the quality of care. In Ghana, for example, ethnic minority women chose not to seek care because of racial mistreatment by health care staff and culturally inappropriate birthing practices at the medical facilities. In contrast to the example from Ghana, I found that despite being subject to racial prejudice in the hospital, Haitian women in Elias Piña still sought care. Furthermore, the women varied in their interpretations of racial prejudice and mistreatment: Some thought they were given poor treatment because of their race and ethnicity; some saw the system as racially discriminatory though they themselves never experienced discrimination; and others did not perceive the system as racially discriminatory.

Unequal treatment

Some of the Haitian women directly addressed the issue of race and ethnicity as determinants to the quality of health care they received in Elias Piña. These women explained that Haitians do not receive the same kind of treatment as Dominicans because they are Haitian and because they are black. For example, Wislina stated, "Yes, there is a difference between Dominican women and Haitian women. Why? Dominican people, for the color of their skin think they are superior, and for that reason, when you go to the hospital here [Elias Piña] you can see that Dominican people receive better treatment than Haitian people." Wislina offered a personal example of racial bias: "I have gone to the hospital here [Elias Piña] two times. In the hospital, they [the medical staff] ignored me and didn't attend me even though I had been waiting the longest. Then they gave me a prescription without telling me what it was and told me to leave. They didn't do this to the Dominicans."

Maria Elena and her family were also victims of the January 12th earthquake in Port-au-Prince. Losing everything, Maria Elena, her four children (three are triplets under the age of two), her husband, her mother who lost her hearing during the earthquake, her brother and his

daughter (who also lost her hearing during the earthquake) arrived in Elias Piña shortly before I did. During my six-weeks in Elias Piña I visited Maria Elena and her family on a regular basis. They liked to tell me about the earthquake and how it transformed their lives. In Elias Piña the seven of them share a small shack with no furniture except for one broken mattress that has been stuffed with cardboard and broken springs. They live in a squatter settlement that has one communal latrine and a small wooden hut for bathing. According to Maria Elena, even though she was “allowed” to cross the border to Elias Piña, there has been no help for displaced Haitians. “There is a difference between Haitian women and Dominican women,” she explained. “Dominicans don’t see the value of Haitians. There is no help for getting jobs. No help for my children’s health. The doctors treat Dominican women and their children better than Haitian women and their children.”

Although Wislina and Maria Elena recognized that Dominican women and Haitian women received a different quality of health care in the hospital, they still used the Dominican health care system. “It is clear that Haitians and Dominicans don’t receive the same treatment in the hospital. But, I can see how Haitians, especially the less educated ones, might think they are getting good care simply because they have access to care. Yet, I tell you, there is a difference in treatment between Haitians and Dominicans. I know that I am not treated equal by the doctors, but what other options do I have? At least the hospital has space for me. It is better than in Haiti,” Wislina explained.

Observation of unequal treatment

Other Haitian women stated that while they had never been mistreated in the hospital, they had witnessed or heard about verbal and physical mistreatment of Haitian women. According to Jessica, a nineteen-year old Haitian girl who has lived in Elias Piña since she was seven, “They [the Dominican healthcare workers] treat the Haitians like dogs. They call Haitian patients the

devil. Listen, they have treated me well, but I have seen how they treat other Haitians, bad, very bad. It isn't equal." Similarly, Lillin commented, "In the hospital they know you are Haitian, but they attend you well. I can only speak of my experience though. I have heard of Haitian women having problems and not receiving the same treatment as Dominican women, but in my experience everything was fine."

These observations of racial prejudice and maltreatment of patients did not deter Lillin or Jessica from using the health facilities. Lillin's comment echoes Wislina's: "They treat the Haitians worse than the Dominicans, but they [the Dominican doctors] have to attend everyone. It is better than in Haiti. In Haiti, there are no resources in the health system. What other choice do I have? Yes, I could go back to Haiti, but in Haiti there is nothing. I can't make money in Haiti. In Haiti, it would have taken days for my daughter to see a doctor. Here, she was admitted right away. I am a Haitian fighting here in Elias Piña. I am not in my country and I have to accept the realities of being on Dominican land. I do not think I am less than a Dominican, but they [Dominicans] do not see it this way. It makes me sad. But I have to provide for my children and I can do that better here than in Haiti."

Equal treatment

Other Haitian women believe that the health system treated Dominican and Haitian women equally. Ivòn, for example, has lived in Elias Piña for ten years. Her two daughters were born in the Rosa Duarte Hospital and in her opinion "there is equal treatment in the hospital in Elias Piña for Dominican and Haitian women." Through the course of the interview, however, Ivòn made a number of statements that seemed to contradict her first statement. "Haitians always have to pay more in the hospital. The medicine is not free for Haitians. Sometimes there are people who won't even speak to the Haitians. But this depends on the person. Some treat Haitians good and

others don't. I think it is economic differences that matter." Ivon's perception of health care in Elias Piña is likely influenced by her own economic position in society.

Although Ivon stated that race and ethnicity were not barriers to care, she could not say why Haitians had to pay for medicine and Dominican's didn't. If the system treated Dominicans and Haitians equally, wouldn't the Dominicans have to pay for medicine too? Could it be that Dominicans with insurance do not have to pay for medicine? If so, do uninsured Dominicans have to pay for medicine?

According to several informants, Dominicans without insurance have to pay for medicine just like Haitians. Yet others stated that Haitians do not pay for medicine when it is available in the hospital. Yet a Dominican woman I interviewed described a scenario in which a Dominican nurse provided medicine for her Dominican patients, but told her Haitian patients to buy the medicine even though the medicine was available in the hospital. Although the Dominican woman claimed that it was a racial issue, it was not clear if Haitians did not receive medicine because of their race or because they were not Dominican citizens. Despite inquiries with hospital staff and patients, I was not able to clarify with certainty the hospital's policy on the cost and distribution of medicine.

Rosmara and Adelina also claimed that the hospital treated Dominican and Haitian women equally. Contrary to Ivon, Rosmara and Adelina claimed that Haitians do not pay for medicine. "Yes, Dominicans and Haitians receive care. There is no difference. I don't have to pay, but in Haiti I know people pay to go to the doctor." Although the women perceived the hospital as a place of equity, they did not view the Dominican Republic as such: "Haitians are not treated well in the Dominican Republic. The Dominicans don't see value in Haitians. Here, Haitians and

Dominicans live side-by-side, but Haitians only walk with Haitians and Dominicans only walk with Dominicans.”

My findings suggest that the women perceived the role of race and ethnicity in health care in different ways. All of the women perceived Dominican society, specifically in Elias Piña, as racially prejudice against Haitians, yet they had different perceptions about the role of race and ethnicity within the hospital setting. The findings indicate that the Haitian women who experienced racial mistreatment still used the Dominican system. Given that the Haitian health system is so inadequate, the Haitian women valued the opportunity to receive treatment, even if the care was not equal to that of the Dominican patients. As Wislina put it, what other choice do they have as Haitians? My findings further indicate that some Haitian women viewed Dominican society as racially discriminatory, yet did not perceive the Dominican health system in these terms. I wonder why Rosmara and Adelina saw the treatment of Haitians equal to that of Dominicans in the health care system, but acknowledged that Dominican society more generally did not treat Haitians and Dominicans as equals?

Dominican Women’s Perceptions of Race/Ethnicity and Health Care in Elias Piña

The Dominican women had different perspectives about the position of Haitian women in the Dominican health care system. Similar to the Haitian women, some Dominican women did not perceive the Dominican health system as racially prejudice against Haitians. These women viewed the treatment of Haitians equal to the treatment of Dominicans. In their opinion, race and ethnicity did not influence the quality of care patients received in the Dominican Republic. Other Dominican women experienced the health system as racially prejudice against Haitians. These women witnessed interactions between Haitian women and Dominican health workers that indicated race and ethnicity did influence the quality of care patients received.

Two Dominican women I interviewed asserted that Haitians and Dominicans receive the same quality of health care in the Dominican Republic. “The treatment in the hospital here is equal for all people. We all receive the same attention,” Fransisca stated nonchalantly. Doctor Barbina, who works with blood samples in the hospital’s lab, voiced a similar opinion as Fransisca, “We attend to the Haitians as if they were Dominicans. Our country is equal.”

Yet, as the interview continued, Fransisca and Doctor Barbina spoke about Haitian health practices in a way that revealed their biases and prejudices, “Haitian women don’t take care of themselves like Dominican women. They have like eighty kids and are promiscuous. They don’t use birth control. They dress different and are dirtier,” Fransisca said with Doctor Barbina nodding in agreement. Given that both Fransisca and Doctor Barbina used private clinics instead of the public hospital, I wondered how they knew about Haitian health practices. Furthermore, while Fransisca and Doctor Barbina did not perceive the Dominican health system as racially biased, their comments about Haitian health practices reflect the anti-Haitian ideology embedded in Dominican society.

I interviewed Ana, another Dominican, in the tiny room I shared with Teodora’s daughter. With her dark skin color and short wavy hair Ana is often mistaken as Haitian. Ana had a negative perception of the hospital, claiming that generally most patients are treated poorly. She acknowledged that Haitian women did not receive the same treatment that Dominican women did, but she was uncertain about how much race or racism had to do with their treatment. “The hospital in Elias Piña is *antigenico* (not hygienic). The nurses work at their convenience and the doctors are known for saying bad things about all patients, Dominicans included. It is hard to say if Haitians are treated worse than Dominicans in the hospital. I guess, considering that most Dominicans see Haitians as less and considering that Haitians live under Dominicans, there must

be a racial and economic barrier in the hospital. But, then again, I am not sure. I mean there are a lot of Haitians here and they are always coming so the racism must not be bad.”

Contrary to Fransisca and Doctor Barbina, other Dominican women directly spoke to the racial and ethnic inequities in both the Dominican health system and the country. Alexandria, the youngest and poorest Dominican woman I interviewed was adamant:

The doctors and nurses treat the Haitian women poorly. They give more attention to the Dominican women. They say horrible things to the Haitians. The nurses are more caring with the Dominican women when they give birth. The Dominican women are always given medicine, but the Haitians are not. They are told to buy the medicine. I mean I do not think the doctors or nurses are nice to anyone. Poor Dominicans are treated bad too, but Haitians are treated worse. I have seen Haitian women left outside the hospital because the doctors do not want to treat them. One time, a Haitian woman ended up giving birth on the sidewalk in front of the hospital. The doctors blamed her for not coming earlier to get check-ups. Oh, and I remember the first time I gave birth. I was lying on the bed in the maternity room, and this Haitian woman was behind a curtain giving birth. She was screaming because of the pain, and the doctors...they, they were hitting her and called her the devil. But you know when a Dominican woman gives birth the doctors' hold her hand and give her care. Lots of times the doctors don't even tell the Haitians what kind of medicine they are getting. The doctors just yell at them in Spanish to take the pill.

I spent three hours in Alexandria's one-room house with her new-born daughter and her Haitian-Dominican husband. Alexandria talked nonstop about Haitian-Dominican relations in Elias Piña. Her perception of race relations in Elias Piña and more specifically in the hospital, confirmed what some of the Haitian women stated.

It makes me sad. I mean we are all meat and bones. The Haitians feel like they are worthless, and what is sad is that they have no other option. They are so poor. The Haitians come looking for a better life, but they don't always find it because of the racism. I think it is worse here in Elias Piña because of the tensions over the border. Here in Elias Piña lives Haiti and the Dominican Republic. Some Dominicans might tell you that Haitians are treated equally, but that is a lie. Dominicans don't like to acknowledge the mistreatment because deep inside they are ashamed. It is not good here for Haitians, but they have to “accept” the abuse because for them it is better economically here than in Haiti.

Sergia Galvan, the director of *La Colectiva*, perceived the Dominican health system in a similar way. During my six-weeks of fieldwork I came to know Sergia well. Sergia founded *La Colectiva* in the late 80s to improve women's health education in resource poor areas. She decided to create an organization focused on health and health care because of the inadequate health system in the Dominican Republic. Sergia provided an insightful explanation of how race functions to the disadvantage of Haitian women in the Dominican health care system.

There is racism in the Dominican Republic against Haitians. There is no question about it, but we still exist together. The Haitians along the border seem to tolerate the racism. What is their other choice? While they 'live' and 'work' together there is an underlying attitude of superiority by Dominicans and the Haitians have accepted this. Look, health care and other social services in the Dominican Republic are racially prejudice. You can see this in how we don't try to understand Haitian culture or language. We reject everything Haitian. Dominicans don't speak Creole. Dominican doctors don't know or care to know how Haitians practice health care. Conflicts can arise when Haitians come to the Elias Piña to give birth. Many Haitians do not have the resources to maintain healthcare practices. They go to the doctor, get consulted, but are not given medicine. It can be difficult for the doctors to treat Haitians when understanding of each other's situation does not exist.

Sergia described racism against Haitians as physical, symbolic, and verbal. She observed that despite the violence, Haitians are more concerned with other issues such as hunger and poverty. "There is a lot of verbal violence against the Haitian patients. But the Haitians 'accept' and learn to live with this violence. For them, it isn't as big of a problem as the other social problems they are confronting such as hunger. The thing is though many Haitians don't realize that race and poverty are connected in Elias Piña. Racism is linked to economic inequity."

My findings suggest that Dominican women perceived the role of race and ethnicity in the health care system in different ways. Some Dominicans recognized the racial tensions that exist between Dominicans and Haitians. Sergia, Alexandria, and Italiana acknowledged the inferior treatment of Haitians both within the health system and in Dominican society as a whole. Additionally, Sergia, Italiana, and Alexandria understood the contribution Haitians make to the

border economy. “Dominicans need the Haitians, but they don’t acknowledge it. The Haitians stimulate the economy of Elias Piña by selling their products in the market. If the market wasn’t there, Dominicans would be living in worse poverty,” Italiana commented. At the same time, other women see no inequalities in Dominican society or its health system. Although women like Fransisca and Doctor Barbina stated women receive the same kind of health care regardless of race or ethnicity, their other comments suggest that they perceived Haitians as inferior to Dominicans. Some Dominicans appear to hold racially biased notions of Haitians.

Language and Familial Ties

Rosa’s interview was key to my understanding of the various ways in which ethnicity and race mattered in the hospital. The day I met Rosa in the hospital, two Haitian children died. I was not in the hospital when this happened, but had spoken to the mother of one of the children earlier the same day. Rosa and her dehydrated one-year-old daughter occupied the same hospital room as one of the Haitian children who died. Rosa taught me that race operated through language and familial ties.

“You know Haitians are looked at as lower beings than Dominicans. They don’t want us here. You know that other Haitian woman you met this morning...well, her baby died this afternoon a few hours after you left. The baby wouldn’t have died if it was Dominican,” Rosa explained. I learned that the baby had been in the hospital for three days. She was being treated for diarrhea, dehydration, and malnutrition. According to Rosa, when the baby died the doctors were not there. The child’s mother, Monica Jan, who did not speak Spanish, went running through the hospital halls screaming for help, but by the time the doctors arrived it was too late.

The doctors don’t check on the patients, especially the Haitian patients. The go away for hours and nobody is here to monitor the children. We never have the same doctor and this creates confusion. The nurses here treat Dominicans and Haitians differently. We have to pay for medicine even when they have it in the hospital. I

can't afford it. Now she can't get better," Rosa said pointing to her one-year-old daughter who lay motionless on the only bed in the room.

But it is even worse for Haitians who do not speak Spanish and who don't have Dominican family. When I first arrived at the hospital with my child for example, the nurses put an IV in her foot. But the IV fell out. The nurse put it back in immediately. They only did this because I can speak Spanish and because I have a Dominican husband. I know this because the same thing happened with Monica Jan's baby, but the nurses didn't put the IV back in when it fell out. She just left and didn't come back for hours. They didn't give her the same attention because they knew Monica Jan was Haitian and didn't speak Spanish or have a Dominican husband.

Rosa's comment about the different degrees of racial and ethnic mistreatment demonstrates that language ability and familial relations, in addition to race and ethnicity, influence the quality of care Haitian women receive in the hospital.

Wislina and Jessica shared somewhat similar views as Rosa about the importance of acculturation. Jessica explained that in addition to her ability to speak Spanish, her light skin also worked to her benefit. Wislina was often mistaken for Dominican. She explained that the Dominican guards rarely checked her passport when she crossed the border. "I am not directly targeted because of my skin color. Knowing Spanish is helpful too, but most Dominicans can tell who is Haitian and who is Dominican by how we speak Spanish. Haitians who only speak Creole are treated worse." Echoing Wislina, Jessica stated, "My one child has a Haitian father and my other child has a Dominican father. This matters in the eyes of Dominicans. The child that has the Dominican father is valued more."

My observation of Haitian-Dominican interactions coincides with Rosa's, Wislina's, and Jessica's perceptions about language ability and familial ties. The degree to which race and ethnicity matter in the health system is partly due to skin color but it also varies by the level of acculturation. Haitian women who speak Spanish and are married to a Dominican are treated better than Haitian women who do not speak Spanish and who are not married to a Dominican.

In the following excerpt, I describe an interaction between a Dominican nurse and a Haitian woman in the maternity ward. This observation indicates that language and acculturation influence the degree to which race and ethnicity matter in the Dominican health system.

I found Jan Kristina sitting alone on a broken hospital bed in the maternity room. Rainwater dripped down the walls and gathered in large puddles on the cracked tiled floor. I was surprised that she was the only woman in the room. Typically when I visited, there were at least three or four women in the maternity ward waiting to see the doctor. I maneuvered my way around the puddles and approached Jan Kristina. In Creole, Jan Kristina explained that the other women had been transferred to another room because of the rainwater. I did not understand why the other women had been transferred, but Jan Kristina had not. Over the course of the next five minutes I learned that Jan Kristina had been sitting alone for over an hour. The nurses had not come back for her. Moreover, Jan Kristina did not understand why she could not leave the hospital. She had now been in the hospital for over twenty-four hours. She came to the hospital because she had fallen and wanted to make sure everything was okay with her pregnancy. Over a day later, after having been seen by a Dominican doctor, Jan Kristina was still not permitted to leave the hospital.

Eventually, the hospital staff moved Jan Kristina to the temporary maternity room. For the next few hours, I watched the Dominican nurses as they entered the room, checked the patient's IVs, and monitored the women. Except for one Dominican woman, all the women in the room were Haitian. Jan Kristina was the only one who did not speak Spanish. Furthermore, Jan Kristina had recently arrived to Elias Piña following the earthquake. Her only acquaintances in Elias Piña were other displaced Haitians. Finally, in her broken Spanish, Jan Kristina attempted to ask a nurse if she could leave. Although she knew that Jan Kristina did not speak or

understand Spanish, the nurse turned to her and harshly stated in clipped Dominican Spanish that Jan Kristina could not leave until the doctor came to release her. The nurse was annoyed with Jan Kristina's lack of understanding and did not bother to address Jan Kristina's concerns.

I interviewed Jan Kristina later that week. I asked about her experience in the hospital. Did she feel that being Haitian influenced her ability to access quality care in the hospital? "The doctors in Elias Piña treat Haitians the same as Dominicans. We all receive care," she stated. Based on what I had observed I did not perceive this to be the case. Although I do not think any of the women, the Dominican women included, received particularly good care, I observed a difference in treatment between Jan Kristina and the other Haitian women. Jan Kristina's inability to speak Spanish and limited understanding of Dominican culture compared to the other Haitian women in the room (all of whom spoke Spanish and who had lived in Elias Piña for some time) further influenced the quality of care she received. The other Haitian women had acculturated more and in their case, race and ethnicity seemed to be less of a barrier to their care. Yet, compared to the Dominican woman, the Haitian women were not treated with the same respect or concern by the nurses. The nurses attended to the Dominican woman first and communicated with her about her treatment. The nurses answered her questions and checked on her frequently. The Haitian women were attended to afterwards and verbal communication between the medical staff and the women was minimal. The Haitian women rarely asked questions and appeared timid. Based on my observations of the maternity ward, I perceive race and ethnicity as a barrier to quality of care. I also perceive the degree to which race and ethnicity influence quality of treatment in the hospital, varies due to level of acculturation

While other Haitian women and I observed the health care system as racially biased, why did Jan Kristina see it as equal? Rosmara and Adelina also thought Haitians and Dominicans

received the same treatment in the hospital, yet both women did not think Dominican society treated Haitians and Dominicans as equals. One possibility is that Haitian women like Jan Kristina, Rosmara, and Adelina perceive the system as equal because the care they received in the Dominican Republic was so much better than what they would have received in Haiti. Access to care in the Dominican Republic is such an improvement over the care available in Haiti that Jan Kristina, Rosmara, and Adelina did not recognize the difference in treatment between Haitian and Dominican patients.

Initially, I thought I would find a difference in perceptions between Haitian women who had lived in Elias Piña for a long time and Haitian women who had arrived following the earthquake. My findings indicate that women who arrived after the earthquake perceived the role of race differently. Maria Elena and Wislina arrived in Elias Piña following the earthquake. They shared similar opinions of the role of race and ethnicity in the Dominican health care system. Both women perceived the system as racially prejudice against Haitians. Jan Kristina also arrived after the earthquake, but she did not perceive the Dominican health care system as racially prejudice against Haitians. Jan Kristina thought Haitians and Dominicans received equal treatment. The other Haitian women who shared Jan Kristina's opinion had lived in Elias Piña for a minimum of six years. Thus, based on my findings, Haitian women's perception of race and ethnicity in the Dominican health system did not correlate with the amount of time they had spent in Elias Piña.

National Identity and Skin Color

Dominican women repeatedly addressed the issue of skin color and nationality. The terms *negro y blanco* (black and white) are embedded in everyday Dominican speech. Dominican women equated white skin with beauty, success, and superiority. Dark skinned Dominican women wanted to be lighter in order to distinguish themselves from the "black skinned" Haitian.

According to Sergia, “We [Dominicans] have the problem of *blanquear*. We all want to be white. There is a very negative association with *negritude* in the Dominican Republic.

Dominicans think that to be black is to be Haitian. It has to do with the history of the island, the colonization by the French and the influence of America, as well as the government and how people are perceived by the government.” The comments and actions of other Dominican women reflected Sergia’s statement. For instance, the women often said, “The Dominicans are white and the Haitians are black. They are very, very black. They have black, ugly skin. Blacker than the Dominicans.” It seems that Trujillo’s racial discourse and idealization of the “white race” are still critical ideologies in the border region.

Contrary to Dominican women, Haitian women did not associate light skin with superiority. While they did not “desire” to be white, Haitian women talked about the benefits of light skin in the Dominican Republic. Wislina explained that light skin is advantageous when judged solely by skin color. She observed, however, that her light skin color did not change the fact that she was Haitian. Wislina perceived her light skin color as advantageous compared to darker skinned Haitians, but asserted that her light skin color did not make her equal to a Dominican. Wislina’s comment confirms that Haitians inferior position in the Dominican Republic is not just a matter of skin color, but also of ethnicity and nationality.

Fifteen out of the seventeen Haitian women interviewed stated they would like to return to Haiti. When I inquired why they hadn’t returned, the women consistently responded, “I have to feed my children and I can’t do that in Haiti. Although I live in poverty here [Elias Piña], I am able to provide food and shelter for my family. I have more economic opportunities here.” The women who arrived after the earthquake were among those who wanted to return to Haiti. Due to Haiti’s situation, however, the women had no immediate plans to return. Although the women

were proud of their Haitian heritage, they often felt the need to assimilate to Dominican culture. Immigration raids and physical violence against Haitians in Elias Piña were common. To avoid racial conflicts, many Haitian women adapted Dominican mannerisms and downplayed their Haitian heritage.²

Summary

My findings suggest that Haitian women perceived race and ethnicity as barriers to health care in the Dominican Republic in different ways. Women such as Wislina and Maria Elena directly experienced racial discrimination in Elias Piña's public hospital. They discussed how Haitian women were not treated with the same respect or given the same attention by medical staff as Dominican women. Wislina described that she was denied treatment and ignored by the Dominican medical staff because of her race and ethnicity. Jessica also thought Haitian women were given poorer treatment than Dominican women. Although she never personally experienced race or ethnicity as a barrier to quality care, she had witnessed other Haitian women being treated poorly and commented "the medical staff treated Haitians like dogs." Other Haitian women did not view the Dominican hospital as racially biased. Rosmara and Adelina claimed that Haitian and Dominican women received the same quality of treatment as the Dominican women. They did not think race and ethnicity influenced their health care experience.

Literature that discusses the role of race and ethnicity and use of maternal health care argues that ethnic and racial minority women often choose not to seek care when the care is racially discriminatory and culturally inappropriate. Contrary to the literature, my findings indicate that Haitian women, even the women who experienced and perceived the health care

² As a researcher in the Dominican Republic, there are definite advantages to being white and female. Dominican border officials never questioned my reasons for crossing the border. Doctors and nurses permitted me to roam the halls of the hospital while other visitors had to wait for visiting hours. The *Motoconcheros* charged me less and bus drivers gave me first priority in seat choice. On the other hand, my whiteness also drew unwanted attention, especially from Dominican men.

system as racially discriminatory used the hospital in Elias Piña. Even though the Haitian women did not receive the same quality of care as the Dominican women, they valued the opportunity to access “quality” health care whereas in Haiti they did not have access to care. As Wislina put it, “Poor quality care is better than no care. I know I don’t receive what I should because I am Haitian. But it is better in Haiti where there is no care.”

The Haitian women also spoke about life in the Dominican Republic. The women described Dominican society as racist and noted that generally Dominicans did not value Haitians. I wonder why women like Rosmara and Adelina who viewed Dominican society as racially biased also thought that Haitians and Dominicans were treated equally in the hospital. It is plausible that Rosmara and Adelina did not distinguish access to care from quality of care. Although both Dominican and Haitian women had access to health care, I observed that Haitian women did not receive the same quality of care as Dominican women. My findings further indicate that the degree to which race and ethnicity influenced the quality of treatment Haitian women received varied by language ability and familial relations with Dominicans. Haitian women who were less acculturated received worse treatment

The way race operates in the Dominican Republic health care system is not simple. There are definite advantages to having light skin, but as Wislina explained ethnicity and nationality cannot be forgotten. A light skinned Haitian is still Haitian and therefore, inferior to a Dominican. The overlap between race and acculturation were not always easy to differentiate. Skin color and acculturation as well as ethnicity and nationality are all important determinants that affect the health care experience of Haitian women in Elias Piña.

CHAPTER 7

STRATEGIES TO IMPROVE MATERNAL HEALTH OUTCOMES FOR RACIAL AND ETHNIC MINORITIES

The purpose of this study is to understand Haitian women's perceptions of maternal health care in the Dominican Republic. I am particularly interested in their opinions about the role race and ethnicity played when using Dominican health care services.

Ethnic and racial minority women, according to the literature, have less access to health care and use health care services less than non-ethnic minority women (Camacho et. al 2006). The processes by which ethnic and racial minority women decide to seek care depends on various factors in addition to their socioeconomic status such as their position as racial and ethnic minorities in their respective sociocultural settings (Puentes-Markides 1992). Blanchard and Lurie argue that racial and ethnic minorities' decision to seek care highly correlates with the cultural and racial appropriateness of the care provided (2004). Studies indicate that racial discrimination and cultural insensitivity in the health care setting deter minority women from using the available services.

Contrary to the literature, my findings indicate that Haitian women used the Dominican health care system despite racial mistreatment. Because health care in Haiti is not readily available and is costly, Haitian women value the chance to receive care despite poor treatment and racial discrimination. The findings indicate that although Haitian women perceived the Dominican health care system superior to the Haitian health care system, they perceived and experienced race and ethnicity in different ways.

Summary of Findings

Using the principles of grounded theory and participant observation, I conducted open-ended interviews with Haitian and Dominican women in the Dominican border town of Elias Piña. Interviews and observations were analyzed and coded into common themes. Themes were

then grouped into categories, which were linked together to derive several conclusions about how Haitian women perceived health care in the Dominican Republic.

Some of the Haitian women viewed the health care system as racially prejudiced against Haitians. These women thought the quality of health care provided to Haitians was not equal to the quality of care provided to Dominicans. They attributed this inequity to their inferior status as racial minorities in the Dominican Republic. Other Haitian women did not share this opinion and felt that Haitian and Dominican women received the same quality of treatment

All the Haitian women perceived Dominican society as racially prejudiced against Haitians. Interestingly, even the Haitian women who felt Haitians and Dominicans received equal care experienced Dominican society as racially biased. It is possible that the Haitian women who thought Haitians and Dominicans were treated equally in the health care system but not in society, had trouble distinguishing between access to care and quality of care. While both Dominicans and Haitians had access to health care, based on my observations, they did not receive the same quality of treatment. Some Haitian women recognized that language ability and Dominican familial ties influenced the degree to which race and ethnicity mattered in the health system. The less acculturated women appeared to receive worse treatment by Dominican health care staff. Skin color was also a factor in how the Haitian women were treated. The Dominican value of light skin was advantageous for light skinned individuals including Haitians. That said, ethnicity and nationality were significant factors as well. Light skinned Haitians because of their Haitian nationality and ethnic background were still treated or perceived to be inferior to Dominicans.

Dominican women's perceptions of the Dominican health care system also varied. Some Dominican women claimed that race and ethnicity did not influence the quality of treatment

Haitian women received. They felt that Haitians and Dominicans received the same kind of health care. Other Dominican women did not share this opinion and acknowledged that race and ethnicity mattered. They perceived the system as racially prejudice against Haitians.

Research Concerns and Limitations

While I tried to remain as unbiased as possible when observing Haitian-Dominican dynamics, it would be inaccurate to assume that my interpretations of what I heard and saw were not influenced by my prior knowledge of Haitian-Dominican relations. The idea of the “naïve” observer who can “put himself or herself aside” from the object or subject being observed is not realistic. According to Keiding, “Observers from the very beginning of their observations, based on a few, and most likely unobserved observation actualize specific expectations about the participants and the interaction. Expectations may, of course, later be proven wrong, but initially they actualize specific horizons of meaning, even in cases in which the observer decides to avoid immediate and spontaneous interpretations. A hardcore ‘open mind approach’ is, from this perspective, nothing but explicit self-blinding.” (2010: 15). Without question, “something,” as Sanjek puts it, “will attract the observer’s attention, produce meaning and frame future observations” (Keiding 2010: 54). A researcher who fails to recognize the role her experiences and expectations play in the process of observation and interpretation is simply leaving “the process of observation as the major unobserved absorber of contingency in data production based on participating observation (Keiding 2010: 79).

While qualitative research is a useful tool for collecting information about people’s lived experiences, it is not without limitations. As a researcher/observer you “can neither observe the unmarked space nor the difference used in the construction of reality” (Keiding 2010: 31). Consequently, observations are never neutral or objective. As Keiding says, “There is no way to escape becoming a participant and, as such, co-producer of the observed phenomenon” (2010: 1).

In my study, I often questioned how my presence, as a white American female researcher, influenced the interviewee's responses as well as the social interactions between the Haitian women, the Dominican women, and myself. Were the women agreeing to be interviewed because they thought that in exchange I, as a wealthy American, could offer them some sort of help?¹ Were the nurses in the hospital changing how they interacted with the women because of my presence? Was I treated differently because of my gender—would a white American male researcher have been received in the same way?

Arguably, a natural bias is likely created by my presence as a white American female researcher given the likelihood that I represent power, wealth, and access to resources in a poverty-stricken society. How the respondents perceive my “background” influence the direction of the bias and this in turn affects my results. If Dominicans, for example, realize that their anti-Haitian attitudes are morally suspect, they might modify how they interact with Haitians when I am present and act on their best behavior. Hence, it is plausible that the racism I observed among Dominicans underestimates the degree of racism that would have occurred if I had not been present. It also possible, however, that Dominicans do not perceive themselves as racist. If this were the case, my presence might still have effect, but not necessarily on their behavior. Additionally, it is also possible that as a woman, conducting research in the context of a fundamentally patriarchal and sexist culture, my subjects, regardless of their moral opinion about race, might dismiss or devalue my authority. A corollary to this observation is that such a tendency would be more pronounced among males rather than females. If this were the case, it would appear that observations of male actors would actually be less biased.

¹ In the Dominican Republic, as in most developing countries, the common belief is that all Americans are rich and educated. Given that the majority of foreigners coming to the Dominican Republic are white, wealthy European and American tourists, it is inevitable that all Americans are stereotyped as being rich.

Speculation also arises with Haitians subjects. If Haitians saw me as a potential source of benefits (which in many cases they did), in the hopes of getting those benefits, they might have exaggerated their claims about Dominican racism, telling me what they thought I wanted to hear. On the other hand, because race plays such a significant role in their everyday lives, they could have “played it safe” and, therefore, underplayed the severity of racism they actually felt. Furthermore, it is likely that the extent to which Haitian women underplayed the racism they felt depended on their status. Within the group of Haitian women I interviewed, some felt more vulnerable in Dominican society than others. This means that the likely tendency for Haitian women to exaggerate the racism they perceive may be less among Haitian women who feel comparatively more vulnerable.

The question then becomes to what magnitude do these biases affect my results? This question is the most difficult to answer given that there is no way to make defensible claims in this regard. Even though it is impossible to measure how biases might have influenced the results, it is important to acknowledge that they exist and are no doubt part of the results.

I was also confronted with the barrier of using a digital voice recorder. In order to ensure accuracy and transparency it was my original intention to record all interviews. However, in many cases, I was unable to use my recorder per request of my informant. For many of the women, especially the Haitian women, this was the first time they had ever heard of—let alone seen—a digital voice recorder. Although I explained the purpose of recording the interview, a number of the women were still uncomfortable with the idea. There were also occasions when I felt it inappropriate to whip out my fancy gadget, which probably cost more than what some of them would make in six months. As a result of my own personnel conflict, and the requests of the women, I only used my recorder for twenty of the thirty-one interviews. Other barriers

include the length of the study, language, and cultural misunderstandings. Since I only had six weeks in the field I was unable to conduct interviews in other regions of the Dominican Republic. My findings cannot be generalized to represent the perspectives of Haitian women living in other regions of the Dominican Republic. Furthermore, at the time of my study, my proficiency in Haitian Creole was far from fluent, and in some instances, I had to resort to speaking Spanish, which could have altered my understanding and the informants' understanding of what was being said.

Significance of Findings and Future Research

As Haiti struggles with the aftermath of last year's earthquake and with the recent cholera outbreak and its political instability, the number of Haitians migrating to the border region is likely to increase. Given the fragmented and overburdened Haitian health care system, Haitians seem to be seeking health care in the Dominican Republic in greater numbers than ever before. The likelihood that this will change in the immediate future is slim. To avoid worse health outcomes, the Dominican health care system needs to improve the quality of care provided to both Dominicans and Haitians. Recognizing the role race and ethnicity play in the Dominican health care system is an important first step to reducing poor health conditions and health inequities in the border region.

My findings illustrate that Haitians use the Dominican health care system even when they experience racial discrimination and low quality care. This indicates that Haitians are in great need of health care and will most likely continue to seek care even when they experience racial/ethnic prejudice. Racial and ethnic barriers prevent Haitians from obtaining adequate health care services such as access to medication. While Haitians might be able to access the health care system, their dire economic situation and racial/ethnic inferiority influences their ability to buy and receive medicine. What good is a consult if the patient is not provided with the

treatment to cure the sickness? Furthermore, health policy makers should not assume, as the findings indicate, that every Haitian (or Dominican for that matter) perceives race in the same way. It is critical that health policy makers understand the multiple ways in which race operates in order to formulate and implement equitable and effective health policies. It is my hope that health professionals use my findings to influence the development of future health care programs in the Dominican Republic.

More research that investigates the role of race and ethnicity in respect to quality health care access along the Haitian-Dominican border should be conducted. First, quantitative data on health care access, use, and outcomes by race/ethnicity and class position is needed for the entire border region. Quantitative data will allow researchers to statistically measure racial and ethnic disparities in relation to health care access and health outcomes. Second, a comprehensive study focusing on the social factors in the Haitian health care system that cause Haitians to seek care in the Dominican Republic is essential to better understand Haitian perceptions of Dominican health care. Third, hospitals and private clinics in other provinces of the Dominican Republic should be examined. The role of race and ethnicity in the health care system is likely to vary depending on geographic region and the quality (public or private) of the health facility. Finally, future research should also analyze the experiences of the Dominican health care providers who primarily serve Haitian patients. Reducing problems associated with cross-cultural miscommunication will likely improve patient-provider relationships, which is important for the provision of good quality care.

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BIOGRAPHICAL SKETCH

Erica Felker-Kantor was born in 1983 in Santa Clara, California. She grew up in Salt Lake City, Utah with her parents and twin brother. Erica attended Boston University where she earned a Bachelor's degree in Latin American Studies and Spanish. During her time at BU, Erica spent one and half years studying and conducting research in Ecuador, Nicaragua, and El Salvador. After graduating from BU in January 2007, Erica worked for Oxfam America and ACCION USA. Following this, she spent two years working for non-profit organizations in Ecuador, Bolivia, and Costa Rica.

In 2009, Erica started graduate school at the University of Florida where she was awarded the Foreign Language Area Studies fellowship in Haitian Creole. During her time at UF, she pursued coursework on the social determinants of global health. Following graduation in May, Erica will return to Haiti to coordinate a health education program. In August 2011, Erica will start a second master's program in global public health at Johns Hopkins. After completing her MPH, Erica would like to work for an international health organization working with Latino and Haitian populations.