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Perspectives of Health Care Providers in the Dominican Republic towards Pregnant Haitian Women

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The Intersection of Culture and Medicine: Perspectives of Dominican Health Care Providers Towards Pregnant Haitian Women

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Acknowledgments

I always seemed to be interested in culture and health. But I did not know how the two concepts could intersect with each other. During my senior year in high school in the Dominican Republic, a teacher, Gennifer Kully, gifted me with one of the greatest books I have ever read, *Mountains Beyond Mountains* by Tracy Kidder who describes the life of the medical anthropologist Paul Farmer, *a man who would cure the world.* After reading this book and the many things Paul aimed to do as physician and an anthropologist, I realized that I wanted to do something similar in life. For that reason, when admitted to Western Michigan University, I decided to pursue my undergraduate studies in Anthropology while also being interested in Public Health.

During my freshman year, I learned a lot about the many different ways of life and cultures that exist around the world. Still, I was amazed and curious to understand how that was. For that reason, in the Summer of 2017, the same time I joined the *Lee Honors College,* I traveled to Peru for a month to learn about a new culture and to also learn basic research skills about different social issues that are going on in southern part of Peru. Then, for my sophomore year, after realizing that doing research was something I really enjoyed, and that I wanted to better understand how human societies function, I decided to combine my first major with Sociology. It was then, as a sociology student, that during my Junior year I had the great opportunity to take a class titled *Behavior and Meaning.* I decided to take this course not only because I was interested in learning more about how people learn culture but because I wanted to meet its instructor, Dr. Ann Miles. She is a cultural anthropologist and a professor at WMU, and since the moment I learned about her and the work she does, I, somehow, could reflect the future version of myself in her. Hence, since the moment we met, I knew I wanted to work with her for

the completion of what you are about to read, my honor thesis. My deepest appreciation is for her, Dr. Ann Miles, who has helped and supported me in all the steps that this project has entitled from its beginning to its very end, and who always pushed myself to critical thinking. It has been my pleasure being your student.

As ever, I am and will always be more than thankful to be an honors student. Endless thanks to every staff member and instructor who supported me in different ways and allowed me to be part of the amazing and distinctive educational opportunities that this honors college provides. Two of these great opportunities has been being awarded with *The Carl and Winifred Lee Endowed Research Travel Scholarship* to complete this research study in the Dominican Republic, along with closely working as a Peer Mentor for the honors community. Being part of the Lee Honors College has been my home away from home and the best decision I have ever taken as a student during my time at WMU.

I am also thankful for my parents and my sisters who always gave me support to embark in this journey far away from them. Also, to all my friends, and my boyfriend, thanks for always believing in me more than I believed in myself to complete this honor thesis. Last but not least, I'm thankful for each person, including head of hospitals, doctors, nurses, and receptionists who agreed to be part of this project. Without their help, this couldn't be possible.

Finally, this project isn't only intended to fulfill a requirement for the honors college. Instead, its purpose has been to better understand how culture and medicine intersect as I have always been curious of while also interpreting their intersection in my own community.

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Abstract

Due to the lack of basic health care in Haiti, many Haitian women cross the border looking for a better public health service in the Dominican Republic. However, differences in cultural and medical practices exist between both countries. Thus, for my thesis, I intend to study and explain the challenges that Dominican health care providers feel might impede their abilities to provide adequate health care to pregnant Haitian patients and how they respond to and manage those challenges that they face.

Keywords: culture, birth, body, health.

Introduction

Haiti and the Dominican Republic share the island of La Hispaniola, which after Cuba, is the largest in the Caribbean. Haiti occupies the western third of the island and the Dominican Republic occupies the eastern part. However, "the peoples on either side of the island rarely mix thanks to decades of political tensions and mutual fears fed by a history of wars, massacres, and other atrocities" (Alami, 2018, pg. 2). This sociocultural, political and economic situation between the two countries has only intensified due to manipulated racialized fears that Dominicans tend to have towards Haitians. This anti-Haitian sentiment in the form of discrimination can be experienced in many scenarios of daily life in the Dominican Republic. For example, in public markets, government offices, and in public health care centers, where Haitians can be restricted from services because of the mistrust of the Dominican people. Regardless of the long, complex relationship based on cultural and ethnic differences between the two nations, many Haitians still prefer to cross the border to go to the Dominican Republic, seeking a better life. This includes looking for better public services. This is the case for many pregnant Haitian women who are seeking better public health care, not only for themselves but also for their babies and thus, they cross the border.

Many of the patients giving birth in public health centers across the Dominican Republic are Haitian women. According to interviews conducted by Gilger & Mento (2017), the director of the Hospital General Melenciano expressed how he has watched for years many Haitian women coming to the hospital and leaving with newborns as they cross the border to go to Jimani's public hospital. This is the closest hospital to the border, where there is better service than in Haiti. Gilger & Mento (2017) refer to them as "overwhelming the system" because for example, "of the 40 or more birth deliveries performed in this hospital every month, about 30 are

Haitian births" (pg. 5). He also described how many pregnant Haitian women arrive to the hospital in labor, with many health complications, and without any type of prior medical and prenatal care. The major reason for this is because access to basic health care services in Haiti is very limited, as public hospitals lack of resources for procedures and many pregnant Haitian women cannot afford to pay for appropriate health care. Hence, they look for better medical assistance and more affordable medications during childbirth, in the Dominican Republic, in spite of the racism that they might face there.

Based on the nature of this problem, the purpose of this thesis is to understand how the public health system in the Dominican Republic manages pregnant Haitian patients who cross the border to give birth, and the challenges that Dominican health care professionals face while providing health care to those pregnant Haitian women. I will also explore how culture intersect with medical practices when health care providers and their patients are influenced by different cultures as differences in health practices and procedures preferences and perceptions might result from both the practitioner and the patient. The goal of this project is to identify factors that Dominican health care providers feel might impede their abilities to provide adequate health care to pregnant Haitian women. These factors might include *language, culture and race*. While there is some literature about pregnant Haitian women crossing the border for better health care, my concern in this project is to understand how Dominican health care providers perceive the challenges that they face while they provide health services to their Haitian patients and how it may differ from their Dominican patients.

Description of Study

Design

To better understand the challenges that Dominican health care providers face while giving health services to pregnant Haitian patients, this project was designed as a qualitative research study based on semi-structured interviews. These interviews were conducted with doctors, nurses, and receptionists in two public health care centers in the Dominican Republic. The purpose of these interviews was to elicit and perceive these informants' perceptions of their experiences while they provide services to pregnant Haitian women during childbirth, and how they respond to and manage those challenges that they face. This includes the service given to them from the moment a Haitian woman visits and does check-in in the hospital for prenatal care until the time comes to deliver their babies.

Settings

In order to conduct the interviews with doctors, nurses and receptionists in the two public health centers about their experiences and challenges while serving pregnant Haitian patients with different cultural backgrounds, I traveled to the north side of the Dominican Republic, my home country. Prior to my departure in June 2019, I obtained approval from the Human Subject Institutional Review Board and conducted literature reviews about the nature of the problem regarding why many Haitian women decide to cross the border to give birth on the other side of the island.

As a local in the area, I had contact with doctors and hospital administrators who work in the public health sector and who helped me gain permission to conduct the interviews in the two major hospitals of La Provincia Hermanas Mirabal, Salcedo. During the first week of my data collection, I met with the head of the hospitals to explain more about my study and its

procedures. While explaining what the study was about and its purpose, I was asked which university I was coming from. At this moment, the dynamic of the process changed as they were impressed by the fact that I was coming from the United States to do the study and that I am pursing my undergraduate studies overseas. Hence, I could see how for them I was not just a student trying to get data for my honors thesis but someone who accorded respect, and anything I needed for my interviews was at my disposal right away. Based on the many questions they asked me regarding how I was able to attend an university outside of the DR, I understood that their admiration towards me was probably coming from the fact that in a rural community like Salcedo, very few students have the opportunity of going abroad. However, even though this facilitated the process of getting into the field to conduct the interviews quicker and easier, I wondered if local students, attending a national university, are given the same prestige I receive to collect data for their own thesis projects. After three days of meetings with the head of each hospital, I was introduced to the personnel in charge of childbirth and maternal care in both hospitals.

Participants

The study was comprised of a sample of 13 participants including six nurses, four doctors, and three receptionists. During my first visit to each hospital, to recruit the participants, the head of the hospital introduced me to doctors, nurses and receptionists in the maternity unit who might be interested in being interviewed. Using a script, I approached the participants, introduced myself and explained the purpose of my study and the eligibility requirements to participate in the interviews. Then, I asked them if they were interested in participating in the study. Once they agreed to be interviewed, a time and date was scheduled according to the schedule of the participant. In one hospital, I was able to conduct four interviews in one day.

This included two doctors, one nurse and one receptionist. In the second hospital, I was able to conduct the rest of the interviews in two days with two doctors, five nurses and two receptionists.

For doctors, the interviews were conducted during the morning because that was the time that they had available for office consults with their patients in those hospitals. Half of the interviews with the nurses were done in the morning and the remaining half in the afternoon due to the constant service they need to provide to their patients. The interviews with the receptionists were conducted in the afternoon as in the morning their time is very limited because of all the patient's visits to the hospital.

Nine of the thirteen interviews were recorded with the participant's consent, as four of the participants did not want to be recorded. The informed consent occurred in person, at the time and place of the interviews. The participants read the consent form, and then I read and emphasized important points including stressing confidentiality, asking if I could record the interview, and noting that the participant may choose to end the interview at any time. Then, the participants signed the consent form. The consent form given to respondents was in Spanish as all of them were native Spanish speakers.

There were no known possible physical, psychological, social or economic risks for participation in this study. The only risk the participants were subjected to was the loss of time during the interview process. There was little to no potential for disclosure of sensitive information as interviews were anonymous.

Data Collection and Analysis

The interviews consisted primarily of nine open-ended questions that asked for in-depth information regarding health care providers' experiences and the problems they might encounter while serving pregnant Haitian women. These nine questions were essential to my study because

I considered that all the participants would be able to answer them in their own way, with their own personal stories in detail. Because of this, based on what each of the participants described to me regarding their own experiences and challenges while providing service to pregnant Haitian women, many other questions emerged. Additionally, all the interviews were conducted in Spanish, and notes were taken in both Spanish and English. See Appendix A for the nine essential questions and the examples of the questions that emerged.

Data was transcribed and analyzed after my return to Michigan, in July 2019. I listened to interviews directly afterwards and then transcribed them in Spanish along with the notes I took during the interviews. I analyzed my data by looking for patterns in each of the participant's responses that could help me to determine common substantive themes and the main challenges that doctors, nurses and receptionists face when they are providing health care services to pregnant Haitian women. This also includes how they feel about it, how they manage each situation, and how those challenges might differ between doctors, nurses, and receptionists. Then, I concluded my analysis by answering each of the nine essential questions of my study with an overall, general response with examples from each of the participant's descriptions.

Contextual Part of the Thesis

To be able to understand the situation and the origin of the problem, for this project I argue that it is very important to understand the sociocultural and political relationship between Haiti and the Dominican Republic. Thus, the first section of my thesis includes an explanation of the long-standing racial dynamics and the historical background between the countries, which dates back to the colonial period. In this section, my goal is to introduce the current, complex relationship that exists between the nations even when they share the same island.

For the second part of my thesis I explore literature on childbirth in rural Haiti and the limitations of Haiti's public health system to provide basic health care to pregnant Haitian women in rural areas.

I contextualize my research in two ways. First, I discuss the term *culture*, and how peoples' bodies are social instruments reflected as a symbol related to culture, society, and power. This includes an explanation of how the body is perceived and experienced individually and socially and how assumptions about the body influence the ways that health care is planned and provided. Second, I refer to birth as a cultural event that differs from culture to culture, but also how it may differ within a culture by social class. In this part, I also discuss medicalized birth and how medical interventions have shaped the nature of birth as childbirth practices have become increasingly influenced by medical technology. Last, I discuss my findings, the significance of this project in regard to how culture and medicine intersect and why being culturally competent in the health field is very important as well as the limitations of my study.

Background History Between Haiti and the Dominican Republic

Examination of the colonial period helps explain how the island of la Hispaniola came to produce two very different countries along with the current historical and social realities of each of these nations. Thus, in this section of my thesis, I aim to explain how the history of each country and the history of their interactions with each other has contributed to deeply-set, long-standing racial conflicts between what we call today Haiti and the Dominican Republic.

First of all, according to Lacer (2005), "the division of the island into Haiti and the Dominican Republic is a perfect example of how colonialism and the plantation system shaped the geography, demography and psychology of the New World; shaping it in ways that eventually led to perpetual friction, including the Haitian-Dominican conflict of today" (pg. 3). Everything began in 1492 when Christopher Columbus and the Spanish empire discovered the island which he named as La Hispaniola, that was inhabited by its native people, the Taino indigenous group. It was on la Hispaniola that the first European gold mine and sugar plantation systems were created. To mine this gold and grow the crops, the Spanish seized the women and forced the men to work in the mountains because the Spanish refused to do the difficult labor. "When harsh treatment and epidemic diseases decimated the Indian labor force, the Spanish imported African slaves to replace the Indians" (Winn, 2006, pg. 41), as they believed Africans would be more capable of performing the hard, physical work. As years went by, the native inhabitants of the Taino group were wiped out of the island as waves of epidemic diseases such as smallpox and plague reduced the indigenous population.

Later, the French empire arrived in the island. Due to the European struggle for control of the New World during the 17th century, France and Spain began to fight to get control of the entire island of La Hispaniola. After resolving their dispute, they decided to split the island into

two colonies. The outcome of this was its current political division. On the eastern side of the island was Santo Domingo, present-day Dominican Republic, primarily populated by white and mulatto Spanish speaking Roman Catholics. This colony continued to force labor from African slaves that were brought to the Caribbean to work in the sugar plantations decades before. However, as Spanish conquerors were in the search of new land and different resources, they were not very focused on the colony of Santo Domingo. As a consequence, the colony's economic activity grew very slowly with little economic impact for Spain. Then, in order to help Santo Domingo become a more profitable colony, the Spanish facilitated trade with other colonies, which "as a result of the stimulus provided by the trade reforms, the population of the colony also grew" (Haggerty, 1989, parra. 19) composed of mixed races with Spanish landowners, black and mestizo freedman, and the remaining African slaves. This then resulted in the diverse population that still characterizes the Dominican Republic.

The French stayed with the western third of the island and named it Saint-Domingue, present-day Haiti. At the time, Saint-Domingue was the world's richest colony in the New World because its land was rich and fertile. France, like Spain, saw this as an economic profit for them, and thus followed the plantation system of the Atlantic slave trade, that involved the transportation of slaves from Africa to the Caribbean. However, the numbers of slaves brought to the colony of Saint-Domingue was higher than in any other colony, and thus Saint-Domingue became mostly populated by black African slaves whose primarily language was Creole and who were influenced by West African and Catholic religions. Due to how many slaves were brought to this colony to work in the plantations, Saint-Domingue became to be the center of the slave trade and the biggest agricultural producer among the other colonies in the Caribbean. With time, due to the brutal work experienced by slaves throughout a forced-labor system, slavery, this

French colony also became the center for the abuse of slaves leading to the decline of its population as many slaves died from diseases. At the same time, because its land was overworked e, their resources declined. Thus, due to land exploitation, its land was no longer available to produce in the same way it used to.

In 1804, with little resources and their land destroyed, through the Haitian Revolution, a slave rebellion, Saint-Domingue became independent from France. The colony of Saint-Domingue was declared as a free republic under the name of Haiti, becoming the first independent nation in Latin America and the first black-led republic in the world. However, this triumph not only cost Haiti destruction of its land and a decline in its economy, but it also provoked mixed reactions in the world, and because it was a black-led nation, it was very marginalized. For example, in order to recognize them as an independent nation, France made Haiti pay 150 million gold francs in reparations because of the loss of money and trade from their independence. From 1804 until 1862, the United States refused to acknowledge Haiti as an independent nation because "their interests were closely tied to Saint Domingue's plantation system and thus, the Haitian revolution had the potential to produce reactions against antislavery advocates in the US, not only by slaves, but also by white abolitionists as well" (Matthewson, 1982, pg. 149). In other words, the Unites States feared and understood that recognizing Haiti as a black free republic that abolished slavery would influence their slaves to act against slavery as well.

Haiti was devastated from years of wars and land exploitation, and with no international recognition as an independent nation, Haiti was unable to create, for example, trade or international relations with other nations. For this reason, after Santo Domingo became independent from Spain in 1821, Haitians invaded Santo Domingo in 1822. Their purpose was to

look for a way to unify the island and create economic wealth for Haiti because they needed to pay reparations to France. However, after more than 20 years of this unification, the people of Santo Domingo fought to become independent throughout the Dominican War of Independence. It was then, in 1844, that Santo Domingo became independent from the Haiti under the name of the Dominican Republic.

In 1916, the United States invaded Haiti and the Dominican Republic. This was supposed to be a "U.S humanitarian intervention" (Farmer, 2006, pg.18) as their goal was to help to restore control over the political and economic instability that was happening in the island. However, "Haitians have somewhat different memories of this American solicitude because of the sharp exploitation of the peasantry, and the internal conflicts much intensified by the extreme racism of the occupying forces" (Farmer, 2006, pg.19). In other words, the US invasion also contributed to Haiti's endless fight to restore themselves from the aftermath of decades of slavery. In fact, during this time, the United States owned sugar-cane companies close to the Dominican-Haitian border and imported Haitian workers to the Dominican Republic because their labor costs were low. Haitian laborers were actively encouraged to work in the sugar cane industries in the DR and big waves of Haitian migration to the Dominican Republic started taking place since the US invasion. After eight years of annexing the countries, in 1924, the U.S left the island.

In 1930, the Dominican Republic was ruled under the dictatorship of Rafael Leonidas Trujillo. As years went by, due to the labor migration of Haitians in the DR, many Haitians found themselves in Dominican territory, and the Dominican people feared that Haitians would invade the country again. Because of this, Trujillo ordered the killing of those who seemed to be "black enough" to be Haitian. This is best known as the *Parsley Massacre*. According to Fontus (1989), in 1937 "the Dominican military sought out and killed dark-skinned people, regardless of

age or sex, who could not pronounce the world *perejil* (parsley), a particularly difficult word for non-native Spanish speakers to pronounce" (pg. 8). The number of deaths after this massacre is still unknown but it's estimated that more than 20,000 Haitians were killed (Davis, 2012). Since this event, Haitians have historically been constructed by Dominicans as "the national and racialized other" (Guthrie, 2017, pg. 3).

Despite this event, a large number of Haitians, especially workers, continued to migrate and live in DR in search of work over several generations. Thus, by 1952, "a bilateral agreement between the DR and the Haitian government was arranged to formalize the migration of cane cutters as seasonal workers in the Dominican Republic" (Martin et al, 2002, pg. 11). With time, fewer workers were required to work in the sugar cane industries but, other Dominican industries started employing more Haitian workers because of their inexpensive labor and the fewer legal protections that they were granted. Those job opportunities mainly include, even nowadays, working in construction sites and in Dominican households as domestic workers.

For decades, Haitian descendants living in DR have faced many problems to become eligible for citizenship rights. According to Schaaf (2009) "the two governments have been unable to agree upon a legal framework to address the nationality of these descendants" (pg. 16), even when they speak Spanish, identify themselves as Dominican and consider themselves part of the Dominican culture. Everything got worse when in 2010 the high court in the Dominican Republic ruled that everyone born in DR was a Dominican citizen only if at least one of their parents was Dominican. However, in 2013, the Dominican Republic constitution stated that this new definition would be applied retroactively, all the way back to 1929. This means that any citizen who had been born in DR to undocumented parents would have their citizenship revoked, and thus thousands of Haitians were effectively stateless in the DR. This affected those Haitians

whose parents were recruited to work on sugarcane plantations and continue to live in DR over generations.

At the time, internationally, this new law passed by the Dominican Constitutional Court was categorized as an act of discrimination and racism because it has restricted people of Haitian descent in the DR from getting their "access to health care, education and employment opportunities" (Schaaf, 2009, pg. 16). Due to international pressure, a law was passed that gave a year for people who were affected by this new regulation to apply for a special registration of their nationality documents if they could prove that they were born in the country. As nowadays, only those who were able to provide documentation that shows that they were born in Dominican territory have been able to stay in the country legally, while many other have faced deportations back to Haiti.

Childbirth in Rural Haiti

Childbirth practices in Haiti are rooted in local beliefs and cultural traditions. However, childbirth practices are also affected by the economic conditions and limitations of the public health system that exists in the country. According to Melhado (2007), "in Haiti, the poorest country in the Western Hemisphere, political instability and economic decline have led to reductions in maternal health services throughout the country, especially in rural Haiti" (pg. 38). Hence, giving birth in Haiti can be very risky for women and their babies who live in rural areas, as both suffer by far the highest maternal and infant mortality rate in the Western Hemisphere. According to the World Health Organization, in 2017, the maternal mortality rate in Haiti was 480 deaths per 100,000 live births (2019, pg.1), and the infant mortality rate was 50 deaths per 1,000 live births. (UNICEF, 2019). Compared with the Dominican Republic, for example, in 2017, the maternal mortality rate was 95 death per 100,000 live births, according to the World Health Organization (2019, pg.1). Hence, looking for better health outcomes during childbirth, many pregnant Haitian women cross the border to the Dominican Republic seeking for better health services.

The heart of this issue lies in the many factors that impede Haiti's health care system's ability to provide adequate health care services to pregnant Haitian women, mainly in the rural areas. These factors include extreme poverty, hunger and malnutrition, political corruption and economic instability, unsafe national roads, lack of good resources, and very importantly, natural disasters. At the same time, pregnant Haitian women in rural Haiti confront bigger challenges than those living closer to the city. They either do not have access to basic health care facilities or cannot afford to pay for the medical procedures. Hence, childbirth is a serious public health problem in Haiti. Even though programs run by nongovernmental organizations have helped

with the situation, pregnant women in Haiti rarely deliver with the help of a trained medical personnel. Instead, “approximately 85% of rural Haitian births happen at home, attended by family members or traditional birth attendants, and only 15% of births are attended by a certified midwife, a doctor or a nurse” (Priest, 2012, pg. 5).

The World Health Organization (WHO) defines traditional birth attendant (TBA) as “a person who assists the mother during childbirth and initially acquired her skills by delivering babies herself or through apprenticeship to other TBAs” (1992, p. 18). In Haiti and many places around the world, TBAs are considered very important members of their communities because they provide knowledge regarding childbirth that is followed and based on their cultural traditions. Allman (1986) describes the roles that TBAs assume in their communities as caregivers and providers of information to pregnant women regarding care and nutrition for their newborns and themselves. For example, she explains how “TBAs are expected to perform safe deliveries, with proper hygiene and procedures to follow during and after the labor; they should also be able to help women detect widespread health problems” (pg. 41). However, many researchers and organizations have attributed TBAs weaknesses to their lack of proper medical knowledge and training. This may put at risk the lives of many mothers who seek their help during childbirth, and the delivery of their babies. For this reason, the role of TBAs has been debated for many decades because they are great caregivers with uncomplicated births, but they might not be professionally trained when complications are present.

In Haiti, TBAs have worked separately from the formal healthcare system. However, the World Health Organization and other NGOs along with the Haitian government have made efforts to train TBAs in order to improve both their medical skills, and the survival chances of pregnant Haitian women and their children. Byrne et al (2011) explains that “the effectiveness of

TBA referrals to health facilities is dependent on the healthcare system's ability to support an increase in services provided and the supervision needed to support TBAs integration" (2011, pg. 129). However, this is a challenge in Haiti, as the health care system lacks resources to provide assistance to TBAs in rural areas in order to guarantee more safety and fewer obstetric complications for their patients, and thus, reduce both maternal and infant mortality rates.

Pregnant Haitian women in rural Haiti face bigger challenges during childbirth. For example, in rural areas and cities outside the capitol, Port-au-Principe, unpaved roads and lack of nearby health infrastructures make it harder for Haitian women to travel to the hospitals for prenatal visits and delivery care. In a study by Gage and Guirlène Calixte (2006) it was found that in rural Haiti "the physical accessibility of health facilities is strongly associated with women's use of delivery care" (pg. 245). To illustrate this, Fondwa is a rural community located in the mountains of southwestern Haiti, where people live with very limited resources including electricity or running water. According to Priest (2012), no health care facility operates permanently in this community. In fact, he described how since the earthquake in 2010, an NGO set up a trailer that provides basic healthcare services, but it is only staffed by one nurse and one physician, and no obstetric health care is given. Thus, pregnant Haitian women in need of maternal and urgent care in Fondwa have to travel by bus for 45 minutes to get to the hospital. However, as vehicles are very rare in the area, it can take much longer than that because in many cases people have to walk or be carried out to get out of the community. Because of these difficulties, as in many other rural areas in Haiti, births in Fondwa occur at home and are attended by TBAs or family members.

In Haiti, small health care centers with limited resources and provisions are located in villages and small communities, and larger and better-equipped hospitals and other health

facilities are located in bigger cities like Port-au-Principe. Unfortunately, these small or low-level facilities may not provide, as in Fondwa's case, safe delivery services as most of the health care centers are in the capitol. For this reason, many pregnant Haitian women who live in the rural areas, give birth at home. In some cases, according to MacDonald et al. (2018), "if it's necessary, when a woman giving birth at home presents difficulty with the delivery of the baby, they might have access to emergency obstetric care, which is considered the most important strategy for reducing maternal deaths in Haiti" (pg. 12). Yet, even those health centers in the urban areas sometimes also lack the basic supplies needed and there is not enough staff in relation to how many people visit these hospitals every day. Thus, sometimes homebirths are the only option that many pregnant Haitian women have to delivery their babies, but in cases where no complications are present, they are the safer and more pleasant that delivering at the hospital.

Another limitation of Haiti's health care system is the poor quality of care. The World Bank Group in a report made in 2017 refers to how in Haiti only 62% of pregnant women receive adequate medical examinations during pregnancy (pg. 4). Also, the efficiency of the health care providers is very low as three out ten of health facilitators tend to forget to ask their patients about any risk factors related to childbirth that they might have experienced before. At the same time, as the health care system in Haiti is more focused on curative health care, "only 20% of the medical consultations with pregnant women" (Cavagnero et al., 2017, pg. 4) are based on preventive care. In comparison, in the Dominican Republic required special diets and pregnancy checks are very important and strictly followed to guarantee healthier outcomes. At the same time, health facilities in Haiti lack of a management system that allows them to collect, monitor and evaluate data regarding women's visits, the service they receive and the performance of the health center.

Because health facilities lack of resources and staff in both urban and rural areas, TBAs are untrained, there is very limited access to health care centers, and there are many pregnant Haitian women unable to afford maternity care, their maternal health is at risk. This results in fatal consequences for both mothers and their children. Everything became worse after the earthquake in 2010 as Haiti's economy started to decline even more, and the health sector was the most affected. Many health facilities like public hospitals and prenatal centers collapsed and were destroyed. Since then, little has been done to rebuild and arrange better health care centers in the country. Even though the government has increased spending in their health system since then, it has not been enough to cover the decrease in health assistance. Instead, it has decreased even more. According to a report by the World Bank, in Haiti "at $13 per capita a year, public spending on health is below the average for low-income countries, and more than half of all health spending is allocated to curative rather than preventive care: Haiti has many under-equipped hospitals, and only 0.3 dispensaries per 10,000 people" (Cavagnero et al., 2017, pg. 7).

Although the lack of resources and professionalism in Haiti are major limitations to guarantee safer childbirth practices, "studies and projects to train TBAs in better methods of delivery and reduction of health complications, have led to some important improvements in the conditions that mothers and their infants now face in rural areas" (Wiegert, 2011, pg. 46). This has allowed pregnant Haitian women to learn more about pregnancy and childbirth education and becoming aware of breastfeeding information and maternal postpartum issues. Hence, realizing the limitations they face in Haiti, pregnant Haitian women cross the border to Dominican Republic, seeking adequate and more affordable, sometimes free, maternal health care.

Theoretical Orientation

Culture and the Body

According to Mahler (2012), culture is the process of learning "the behaviors and beliefs of a particular social, ethnic, or aged group" (pg. 5). Culture is learned through interacting with other people as we acquire the cultural practices, patterns, ideas, beliefs, and so on from the people who transmit them to us. For this reason, culture is "patterned" as Mahler (2012) refers to it because throughout the course of our lives, as we socialize with people, we continue to practice the cultural abilities we have learned. In anthropology, "culture is defined as the sum total of ways of living, built up by a group of human beings and transmitted from one generation to another" (Mahler, 2012, pg.5). Hence, culture is about "doing" and not "having" because we learn our ways of life in early childhood, as we act and think very much like those who teach us culture. People learn and adapt values, norms, ideologies and traditions of a particular culture or society throughout the process of socialization. Therefore, humans are made of social interactions as integrated members of social groups or communities. Since social interactions are part of the exchanges of symbols, people give meaning to every action or object that they perceive and interpret in their own cultural terms.

This is the case for the human body, an inseparable part of every human being. No human activity can be imagined without it, and it can be understood as "an embodiment of social and cultural norms" (Soukup & Dvořáková, 2016, pg. 514). This means that humans understand their bodies and its functions according to the social norms that they learn through social interactions and the cultural expectations set up in their society. It was not until the 20th century that social researchers began to study the body as an integral part of society and culture. Before that, the body was studied as part of nature but separated from culture. This is what many researchers

have referred to as the Cartesian Mode or Dualism, which separates mind, body and society and perceives the human body as a machine. However, Scheper-Hughes & Lock (1987) stated that the mind and the body are inseparable. In their work, they refer to the "*mindful body*", as a way to define the body in medical anthropology differently than the prior Western assumptions of the Cartesian Dualism. Hence, they deconstruct the body by examining it through three different perspectives, *the individual body-self, the social body,* and *the body politic.*

These "*Three Bodies,"* as they named them, "represent three separate and related units of analysis of the body and three different theoretical approaches and justifications" (pg. 8) to better understand cultural sources and the meaning of health. The first body is *the individual body-self,* which refers to how people experience and understand their own bodies, what happens to them and how they are attached to the mind. In other words, it refers to the lived experiences of the body-self as a solo individual. The *social body* is a natural symbol for understanding the meanings that people attribute to their body's experiences in relation to the cultural beliefs, traditions, social norms and values that they follow within their society, along with the environment they live in. Third, *the body politic* refers to how the body is understood as a result of the regulations, surveillance and power that social and political institutions use to control communities based on what they believe to be the perfect and correct body.

As childbirth is perceived and experienced differently among different cultures and societies around the world, assumptions of the body of a pregnant woman can also be perceived differently from culture to culture under this idea of the three bodies. This includes how the pregnant women understand their bodies individually in terms of, for example, the new physical and emotional changes that they can experience during pregnancy. At the same time, the body of

the pregnant women can be perceived and understood throughout metaphors of the body given in particular societies. For example, in societies where birth practices are more medicalized, the body of the pregnant women is seen as "a machine". In addition, this medicalization of birth in many societies becomes a particular form of power over the body of the pregnant women as doctors and the health care system are the ones responsible for controlling and regularizing childbirth practices.

Birth as a Cultural Event and Medicalized Birth

According to Jordan (1993), "childbirth is an intimate and complex transaction whose topic is physiological and whose language is cultural and thus, neither of both are available without the other" (pg. 3). In other words, the physiology of birth and its social-interactional context intersect with each other, but they are managed in countless ways. Hence, birth practices have an "universal biological function" (pg. 4), but birth is experienced differently depending on "the specific sociocultural matrix within which it is embedded" (pg. 4). Thus, birth is a powerful social and cultural event and a significant personal experience in women's lives. However, it differs according to their culture and society. This means that women situate their childbirth experiences within the different socio-cultural factors of their lives as there are many choices that women can make during birth that depend on their society's norms, values, and cultural traditions.

Birth practices are different from culture to culture because of the local history, traditional beliefs, family and religion, social systems and structures, social stratification, laws, ecology, and technological development. Thus, these social and cultural features of birth have an important impact on birth practices as each one of them affects the "mother's attitudes towards modes of delivery, their definitions of the different modes of births that exist in their culture, and

the decisions they make in this regard" (Roudsari et al., 2015, pg. 174). For this reason, birth is ritualized differently by every culture. To illustrate this, in the Dominican Republic, after the baby is born, is recommended that the mother do not leave the house for 41 days because they are very likely to contract an infection because their pores are open, and they are also restricted from having baths with cold water during the first month after the delivery. In contrast, in Haiti, "after one-month postpartum, pregnant Haitian women take a cold bath; it enhances healing and tightening of the muscles and bones loosened during delivery" (Colin, 2010, slice 28). At the same time, traditionally, in Haiti, the baby is given a name one month after he/she is born while in Dominican Republic, most of the time, months before the baby is born, family members attribute a name to it based on the gender.

Selin (2009) has studied the different ways that birth is experienced and perceived around the globe. This includes different cultures from the Solomon Islands to Africa, Asia and the American continent. In her work, specifically, she focuses on the notion of power regarding the important decisions taken during childbirth. For example, choosing the place of birth, birth positions, who receives the baby and how the mother has to behave during the delivery. All of these decisions, despite being common in birth and labor practices in every culture, vary from woman to woman based on their socio-cultural environment. Thus, in many cultures, the pregnant woman might make those decisions. In others, women might have less authority over their bodies at the moment of the delivery because doctors, midwifes, traditional birth attendants or family members decide what is more appropriate for them.

To illustrate this, birth for Maya Indians is considered to be an event related to the daily life activities of the pregnant women. It usually takes place at home, at the mother's house, and is managed by family members and midwives, who are very often related to the mother.

Differently, in the DR midwives are not traditional and home births are very rare. Thus, when it comes to giving birth, pregnant women in the DR go to the public hospitals and those who can afford it, go to private clinics. There, pregnant Dominican women are often told that the best way to give birth is through a C-section because they are considered, by doctors, to be less painful, easier and quicker to do, and also a way to make more money out of the patient.

At the same time, birth is also experienced differently based on women's social class in their society. For Dominican pregnant women, even when more than half of them deliver through c-section, those who can, would prefer to pay a private clinic because they understand that there, they might have a more pleasant birthing experience through a c-section than delivering at a public hospital. In the same way, Selin (2009) explains how the socioeconomic status plays a large role in the practice of homebirth in China. She describes the case of the pregnant Chinese women who are most likely to give birth at home because they are "impoverished women who cannot afford even the most basic care; women in extremely rural areas who cannot reach the rural clinics; women attempting to escape the Planned Birth policy; and women from minority groups who have stronger social imperatives to remain close to home and family during birth" (pg. 64). This is very similar to Haitian women who live in rural Haiti and also give birth at home due to very similar limitations as many Chinese women. In contrast, in China, "nearly all middle-class women give birth through C-sections in state-run hospitals, and in the most privileged, private clinics" (Owen & Razak, 2019, para. 2), like in the Dominican Republic.

According to Davis-Floyd & Sargent (1997), "human's actions such as the cultural creation of traditions, customs, and rules construct childbirth practices directly, but the phenomenon of pregnancy and birth as women experience them are very real and are massively

affected by the constant technological, political, and social changes of the postmodern word" (pg. 16). Based on how these actions differ from culture to culture, in many societies, homebirths are seemed more pleasant than the medicalized one, and vice versa. Yet, cultural traditions regarding birth and traditional birth practices have been left behind due to the highly influential and standardized biomedical procedures of western medicine. In other words, birth practices are being controlled by more technological processes, as they are seen to guarantee pregnant women a more modern birth experience. In fact, according to Behruzi (2013), "social scientists have argued that a medicalized birth is determined by embedded cultural ideas in which progress and technological birth practices are defined as a victory of civilized society over the ancient feminine nature of birth" (pg. 2). As a result of this, a woman's birth experience, including labor and delivery, are being considered and managed as a medical problem in many cultures and societies around the world.

For example, in the United States, the great majority of births take place in hospitals and are attended by physicians as birth is predominantly viewed as a medical event. In contrast, in Haiti, as the delivery process is not considered a health problem, during labor pregnant Haitian women tend to be very active either squatting or dancing. Jordan (1993) describes that "the inclusion of pregnancy and childbirth in the medical realm has several consequences, all of which are predicated on the transformation of the pregnant women into a patient" (pg. 43). This refers to how pregnant women are accordingly treated as patients because they are expected to fulfill the role of the "sick person" stated by Parsons (1951) as "they are governed by and being consumers of medicine" (Varul, 2010, pg.77). In this case, during childbirth and labor women in the U.S. and many Westernize cultures are considered relatively helpless; they have become "ill", and thus their normal responsibilities and their social performance "are suspended and

replaced by a set of sick-role specific rights and obligations" (Varul, 2010, pg.7). This includes that they are required to seek technically competent help from medical personnel to treat their condition.

This also relates to what Emily Martin (2001) described about of how women's bodies came to be regarded as machines through the Cartesian dualism, "a metaphor that underlies and accounts for women's willingness to apply technology to birth and to intervene in the process" (pg. 54). In this case, the doctor is the mechanic who manages the women's uterus as a machine and the woman as a laborer, and thus the baby is seen as a product. However, she added that "it seems beyond reproach for doctors to be concerned with the fetal outcome of a birth because what seems significant is that cesarean section, which requires the most management by the doctor and the least labor by the uterus and the woman, is seen as providing the best products"(64). With this, she refers to how doctors have created the attitude that a cesarean delivery implies the perfect product of birth, the perfect baby. Hence, as technology has come to manage birth practices, according to Davis-Floyd & Sargent (1997) it also symbolizes the loss of women's "authoritative knowledge" over their own bodies and the birth process (pg. 63).

In the Dominican Republic, the public health system also manages birth as a medical problem rather than a natural phenomenon, and thus the pregnant woman is treated as a patient for her condition. One of the main reasons for this is because nowadays many women deliver through c-sections. This differs from 40-50 years ago when women were more encouraged to deliver by natural modes. However, nowadays, many pregnant Dominican women do not even have an option regarding which mode of delivery they prefer as their doctors decide for them. This decision, in most of the cases, is a C-section procedure. In fact, according to Howard (2018), in 2014, the Dominican Republic was ranked as the country with the highest C-section

rate in the world, with 58.1%. Worldwide, she explains, “the number of births by cesarean section is on the rise, climbing from about 16 million (12.1% of all births) in 2000 to 29.7 million (21.1% of all births) in 2015” (parra. 2). In contrast, childbirth in Haiti is expected to be a happy and celebratory traditional event in women’s lifetime and not a health problem. This is mainly why “many pregnant Haitian women see no need for prenatal care, and some fear and actively avoid modern medicine and hospitals, viewing pregnancy, labor and delivery as normal parts of a woman's life cycle and not as a medical problem” (McHale, 2014, pg. 8). This helps to explain the low rate of c-sections in Haiti, as in 2017 it was 5.4%, according to UNICEF.

Research Findings and Discussion

According to the interviews that I conducted with doctors, nurses and receptionists in two public hospitals in the Dominican Republic, three to four pregnant Haitian women, per day, visit these hospitals for either prenatal care or to deliver their babies. Doctors described that the medical contact they have with pregnant Haitian women is to guide them during the entire pregnancy period by doing monthly check-in and evaluations, track changes, explain the mothers' and the babies' health status, prescribe medications, interpret diagnosis, and provide them with information about diet and delivery instructions. Nurses have very similar medical contact with pregnant Haitian women as they are in charge of providing primary care to patients, recording their medical histories and symptoms, taking test samples, conducting patient observations, and preforming physical exams. The nurses I interviewed were very familiar with the process of birth for pregnant Haitian women because during labor they are the ones allowed to perform dilation checks along with facilitating anything that the pregnant Haitian women might need during labor. "We also collaborate with the examination of the baby along with the pediatricians, making sure that there are no problems with the baby, while also cleaning, measuring and weighting the baby" one nurse explained.

Overall, every doctor, nurse and receptionist described that they have a good relationship with their pregnant Haitian patients but that there were factors that impede them from properly understanding each other. Three doctors explained how for them it is very important to create a doctor-patient connection where both can trust each other. However, due to that many pregnant Haitian women mostly attend their medical consults once or twice before their delivery date, and some of them arrive to the hospital just to give birth, this relationship is not established.

While doctors, nurses, and receptionists recognized that their pregnant Haitian patients are different from their Dominican patients, the health care services are the same for both Haitian and Dominican women, they explained. However, as one nurse described "in many cases because of the limitations that many pregnant Haitian women present, we provide them with the medications prescribed." In other cases, as well, another nurse explained that "if the pregnant Haitian women do not bring with them the necessary items for themselves and the babies at the moment of the delivery, we supply them with newborn clothes, underwear for the women, breast pads and dippers." Thus, as nurses referred to this, maybe better services are provided to pregnant Haitian women. This is because they understand that the health care services in Haiti are very limited, and that it might be the case that those pregnant Haitian women live under extreme poverty and do not even have the resources to buy the medications they need. This are services, as one doctor explained, "that are not given to Dominican pregnant women because as Dominican citizens they qualify for the insurance that pays for the medical prescription given to pregnant women.

They also expressed how they feel about providing care to pregnant Haitian women. The 13 participants described how most of the time they feel "worried" about the language barrier that exists between themselves and their pregnant Haitian patients. At the same time, one receptionist described that she "feels scared about how sometimes pregnant Haitian women do not have the proper or valid documentation to register them for the health services that they need, as this makes it harder to properly fill their record of personal and medical information." This is scary for her because "even when pregnant Haitian women do not have identification with them, the service is not neglected but their information remains missing in their system which can impede to track future visits to the hospital," she described. Doctors, particularly,

besides the language barrier, also feel "*powerless and impotent*" when their patients do not follow the procedures that they mandate.

Although cultural and ethnic differences exist between the Dominican Republic and Haiti, according to the interviews with doctors, receptionists and nurses, the biggest priority for Dominican health care providers in these hospitals is to give adequate healthcare services to all their patients. As one doctor explained to me during our interview, "we provide health care services to everyone, with no distinction between nationality, skin color, race and social class". As a result, health care services to pregnant Haitian women is always provided.

However, there are three main challenges that health care providers in the Dominican Republic face while providing service to pregnant Haitian women. These three main problems are first, *differences in language between the patient and the healthcare provider*, second, *the medical impact on the perceptions in the importance of timeliness and organization and* third, *the medical and cultural impact on not following medical procedures and advise (noncompliance).*

Differences in language is the main challenge that health care providers in the Dominican Republic face while serving pregnant Haitian women. This is because pregnant Haitian women most of the time do not speak Spanish, and the health care providers in these two hospitals, do not know how to speak Creole. Hence, the patients and the doctors experience many difficulties while they try to communicate with each other. This, as described by doctors, nurses and receptionists can result in misunderstanding and misinterpretation of the patient's need and the doctor's medical suggestions. In some cases, many Haitian women visit the hospital with someone, most of the time a family member, who speaks Spanish and helps to explain the mother's medical situation to the doctor. In this case, as the doctors are able to understand their

situation, they explain the medical procedures that the pregnant Haitian woman needs to follow to that person who has accompanied her. However, it is a priority for health care providers in the DR to be able to understand their patient's needs and to provide them with adequate services. Hence, they have found two solutions to approach the language barrier that they experience with their pregnant Haitian patients.

First, when pregnant Haitian women visit the hospital for medical attention, if they do not speak any Spanish and are not accompanied by someone who can translate for them, receptionists, doctors and nurses call in local Haitians who work at the hospitals, know Spanish, and can help as translators. Second, nurses and doctors explained to me how the public health system in DR has been able to develop "an alphabet", as they call it, that describes the most common physical and hormonal changes, symptoms, health problems and complications that pregnant women can experience during pregnancy. This alphabet is written in both, Spanish and Creole and it includes illustrations of each description. With this, pregnant Haitian women can describe how they are feeling every time that they see their doctors for prenatal care, and thus, Dominican health care providers can better understand their needs. The reason why this alphabet was created is due to the high number of pregnant Haitian women visiting public health care centers in DR. This facilitates and overcomes, at some level, the language barriers that impede pregnant Haitian women and Dominican health care providers from communicating effectively and thus provide adequate health services to them.

Language is a fundamental part of our lives and many anthropologists have explained how "culture covers a very wide part of human life and behavior, and language is manifestly a part, probably the most important part, of it." (Robins & Crystal, 2020, pg. 31).

Therefore, in the same way culture is learned throughout our social interactions with members of our society, language is culturally learned as well. In fact, it is one of the most important parts of the process of learning culture because culture is also passed from person to another through language. However, in different cultures around the world, people are able to attribute different meanings and symbols to the same words, objects and actions. For this reason, people from different culture, think differently as well. Hence, language barriers result in miscommunication and misunderstanding because when the time comes to translate from one language to the other, "the meaning of the words as used in the original language are subject to alteration by the meaning of the words used in the translated language" (Wolz, 2014, pg.248). Thus, in the case of pregnant Haitian women and their health care providers, even when translators are available at the hospitals, the translation from one language to the other can influence what the doctors understand about what the pregnant Haitian woman explains and vice versa, "as the perception of the patient's language influences the way they understand the diagnosis or medical procedures that we provide to them", one doctor explained. This also "affects the way that health care is provided and restrict pregnant Haitian from fully engaging in their pregnancy care services", one obstetrician described. This can result in cross cultural and medical disagreements and in mistrust as in some cases, as one doctor explained, "the language limitations that we experience also result in significant challenges for the pregnant women because they might interpret what we explain differently, because, maybe, what we say has a different meaning in Haiti.

A nurse expressed how not being able to speak the same language as her Haitian patients makes her "feel incompetent, in a cultural, medical and personal setting" because, as she described, "I cannot explain by myself the medical treatments that I am going to do to the pregnant woman, neither I am able to start a conversation where I can, at least, ask them how

their day is going to be able to create a small relationship between us." For receptionists, it seems to be less complicated than for doctors and nurses because in this case "translators, including the family members and the local Haitians that work at hospitals, help to facilitate the communication that exists between us, which is mostly based on asking and answering questions about personal information and the service the pregnant Haitian women need," one receptionist explained.

Despite of this challenge that health care providers face with their pregnant Haitian patients, they have been able to create institutional solutions for the problem by first identifying the language barrier and how they affect both the patient and provider performance, along with facilitating translation services. This has helped so much, as all the participants explained, because with both the translators and the alphabet, they are able to understand in a better way how they provide the service that is necessary for each patient.

Second, I refer to *the medical impact on the importance of timelines and organization.* Doctors and nurses described that one of their main challenges is that Haitian women are frequently late for their medical consults and some of them arrive in labor to the hospitals. This a problem for health care practitioners in DR because it has a medical impact on the way they usually provide health services. First, Dominican health care providers are very strict with their day-to-day schedule as a way to guarantee better services to each patient. Hence, the fact that Haitian women arrive late for their prenatal checks and medical examinations, affects the doctor's ability to properly give service to them. For example, one doctor I interviewed described how many pregnant Haitian women "do not show up for their prenatal visits early in the morning. Instead, they arrive one to two hours later than their scheduled time or they might not show-up at all until the next day." Thus, when they do show up, doctors might be with other

patients who were already scheduled for their visits. Doctors explained that in cases like these, they will see the patient after all of their prior consults are done. But this can be affected by their own time limitations as they have to adjust their schedules for the other responsibilities they have as health care providers. For example, all the doctors I interviewed explained that in the mornings they work in the public hospitals, where all the Haitians go, and in the afternoon, they visit the private clinics. Hence, the time they have to provide health services to a Haitian woman who is late for her consult might be very short because they have *el tiempo arriba,* or they are *short of time,* and this impacts the quality of the medical attention that they can provide to their patients.

Similarly, the fact that pregnant Haitian women arrive to the hospitals already in labor and most of the time "almost ready for the baby to come out," as one nurse said, also affects the provider's ability to give adequate health services, This contributes to the "high morbidity rates that pregnant Haitian women present along with the complications that such morbidities can cause during pregnancy", one doctor explained. Hence, in many cases, "many pregnant Haitian women arrive to the hospital to give birth and are not aware of their health complications, which results in difficulties for both the mother and the baby, and also for us to intervene on time before the complication gets worse" one doctor expressed.

Emily Martin (2001) discusses her "*analogy of birth and production"*. With this, she compares the Western birthing process with the industrial processes of production as "women's bodies are subjected to the same kind of controls as workers in the workplace" (pg. 139) because women and their bodies are perceived as a machine that can produce its product, the babies. Industrial workers used to control the machines "be able to control the pace of their work, to keep time for themselves, avoid exhaustion, exercise authority over their work, and to express

their solidarity and hostility to management" (pg. 139). However, I do not only refer to this to how women's body are perceived as a "machine" but also to how Dominican health care providers are the "mechanics" who can manage their time to control the quality of their production, in this case, the quality of giving medical attention to their patients. They can also control how many patients they can give services to in a workday while also being able to have personal time available to rest, and most importantly, to practice power and authority over others, in this case, over their patients. Timeliness is very important to Dominican health care providers so they can accomplish the many responsibilities they have during the day. Thus, having a way to control time, allows them to facilitate and provide more adequate health care services. But, when pregnant Haitian women arrive late to the hospitals for their monthly evaluations, blood tests, or even for labor, Dominican health care providers are impacted by the fact that this can restrict them from assisting with adequate health services as many expressed above.

Some doctors and nurses attribute pregnant Haitian women's lack of ability to be on time to their culture and the practices they follow regarding birth, and because "they have a poor culture of following orders", one obstetrician expressed. Pregnant Haitian women perceive childbirth as a natural process rather than a medical problem. Thus, it might be the case that pregnant Haitian women arrive late to the hospitals as a "self-defense in the hospital" as Martin (2001) refers to indicate how "the methods women have developed are strikingly similar to those that workers have tried in the workplace so they can delay admitting themselves to the hospitals as long as possible because they often understand that this allows a shorter time for their labors to be defined as ineffective and the baby to be extracted" (pg. 141). Hence, arriving at last minute to the hospitals might be a type of resistance for pregnant Haitian women to avoid

doctors have control over their bodies, and thus the pregnant woman is able to control more her birthing process.

Like the *political body* that Scheper-Hughes & Lock (1987) referred to, doctors understand that they and the hospitals are the ones authorized to discuss and determine the important decisions taken during childbirth, and not the birthing woman. However, the pregnant woman is the only one able to control her labor as Martin (2001) described it. But with the regulations that social institutions, the health care centers in this case, impose over them, they can use power over the birthing women and her body to control her , so the doctors, the mechanics, help the machine, the women, to produce her product, the baby. Yet, this is not so easily the case for pregnant Haitian women who resist medical authority.

In consequence, another factor the Dominican healthcare provider feel that impedes them to provide adequate health services to pregnant Haitian patients is the Haitian pregnant women's lack of ability to follow medical instructions. Doctors also attributed this to Haitian women's culture and the traditional practices they follow regarding birth that impede them from understanding the importance of following their doctor's recommendations. I refer to this as *the medical and cultural impact on following medical procedures* They specified two different scenarios when this happens. First, Haitian women do not follow medical instructions in regards of medications, prescriptions, diagnosis and nutritional diets recommended and explained by the Dominican caregivers during their prenatal visits. For example, one doctor described that "pregnant Haitian women do not believe in vaccines, which are necessary for both the baby and the mother, nor the diets that they should follow during their pregnancy." One nurse described that "if they need blood and urine tests or need to be hospitalized due to health complications, they will reject doing it because they do not believe in that."

Second, during labor, the Haitian women do not follow the procedures that Dominican health care practitioners believe to be necessary in order to have a safe delivery. One nurse described that “pregnant Haitian women do not like laying down in the bed.” Instead, “pregnant Haitian women start dancing around like in a circle while also raising and lowering both of their hands”. “In moments of less pain, they do squats because they believe that it helps the baby to come out easier, and when the baby is ready to come out, they start chattering their teethes while also screaming”, another nurse explained. Doctors explained that different than Dominican women, Haitian women do not even allow or request analgesics or any other medications during the delivery of the baby, unless complications are present. In contrast, “the Dominican pregnant women follow all the procedures and believe in what we are capable to do, and that’s the difference between how Haitian patients are different from the Dominican patients” a doctor explained. Hence, pregnant Haitian women “do not follow our regulations because such regulations seem to be different than the medical beliefs they have learned in their own culture”, explained one obstetrician, and this includes that they do not “believe” in medicalized birth.

Because of this this, many doctors and nurses feel “*impotent and powerless”* to do their jobs as caregivers because of the intersection of Haitian women’s beliefs of childbirth as a natural process rather than a medicalized event like Dominican health care providers perceive it. This relates to what Davis-Floyd & Sargent (1997) explained about “the roles that technology and social interactions play in the constitution of authoritative knowledge” (pg. 61) during childbirth. They stated that within some groups “differing kinds of knowledge come into conflict; in others, they become a resource for constructing a joint way of seeing the world, a way of defining what shall count as authoritative knowledge” (pg. 60). For Dominican health care practitioners, Dominican women are able to understand childbirth under the social

construction that birth is a medicalized process. Thus, Dominican women understand that having a c-section, being hospitalized and laying down in the bed is "the safer way" to have their babies because that is what the practitioner says. This is based on how the health care system in DR is structured as "*a technomedicine system of health care* that objectifies the patient, mechanizes the body, and exalts practitioner over patient in a status hierarchy that attributes authoritative knowledge only to those who know how to manipulate the technology and decode the information it provides" (Davis-Floyd & Sargent, 1997, pg. 8).

However, laying down in the bed and conducting a c-section is good for the doctor but not necessarily for the birthing women. For this reason, Wendland (2007) explains how "*obstetrical knowledge is socially constructed*". In her work, she provides evidence in regards of how delivering babies throughout c-sections is "influenced to larger discourses about the nature of womanhood and of motherhood" (pg. 227). This includes how women's birthing experiences result in how their bodies are seen as "dangerous sites from which fetuses must be rescued" (pg. 228). Thus, as Haitian women do not lay down in the bed and instead, squat and walk around while in labor, which is actually better for the women, Dominican health care providers feel "powerless and impotent" of performing and working as they usually do. This is related to what Davis-Floyd & Sargent (1997) explained about that "*the power of authoritative knowledge is not that it is correct but that it counts"* (pg. 61), meaning that the knowledge that counts is in regards to the decisions and actions that are taken and by whom are they taken. In this case, as the dynamic of the birthing process changes with Haitian women, Dominican health care providers feel powerless when pregnant Haitian women do not follow their medical instructions and procedures because that questions their authority.

In addition, according to Quevedo (2008), *"*hospitals and communities have become global villages where, daily, many languages, cultures, and customs intersect, clash, merge, and evolve" (pg. 63). Thus, culture and medicine have become two concepts that intersect in so many ways around the world. Culture incorporates a combination of people's beliefs and behaviors that define the values of their communities and social groups. Intersected with medicine or medical practices, it organizes around and influences societies by issues related to health, health care and public health care systems. Nowadays, very different than before, healthcare providers and educators are becoming familiar with the intersection that exists between culture and health because it has led to positive outcomes in terms of creating a more understandable environment for patients and clinicians with different cultural backgrounds. This is the case for Dominican health care providers and pregnant Haitian women who cross the border to Dominican Republic. Understanding how culture and medical practices intersect is a challenge for medical practitioners and health care systems as cultural competency, communication, and trust are necessary for a successful interchange at the moment of serving a patient coming from a different culture. Culture, and the limitations of language barriers, can influence the way that healthcare services are provided, and the way patients understand their practitioners. However, becoming culturally competent which is defined as "*the ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients"* (Georgetown University), helps the provider to better understand the patient's attitudes towards medical practices in its own terms. This way, the professional is able to adapt easier to a more multicultural environment and provide better services to the patients who are mostly immigrant population. In this case, pregnant Haitian women who cross the border to give birth.

For this reason, I suggest that in order for Dominican health care providers better understand the language limitations that exists between their pregnant Haitian patients and themselves and the way they behave (this includes their perception of timelines in regards of arriving to the hospitals just in time for labor along with why they do not follow their medical procedures), they should become *culturally competent.* This will allow them to find better solutions to confront these challenges that they face in their daily routines as health care practitioners. Thus, they will be able to reduce their and the patient's struggle to communicate effectively because of the language barrier, provide better health services by understanding the way the patients understand the process of birth along with promoting trust between their patient-provider relationship besides the cultural and linguistic differences that exists between them.

Limitations of my study

There are two main limitations of my study. First, my study is only based on the perspectives of the Dominican health care providers about how they feel when they are providing health services to pregnant Haitian women, along with the factors that might impede them to provide adequate health care. It does not include the Haitian women's challenges and experiences while visiting public hospitals in the Dominican Republic, and how they feel when they are receiving the health care services from Dominican doctors and nurses. Thus, it does not incorporate how they perceive the way Dominican health providers understand their medical and cultural values, traditions and beliefs about birth as a natural event. Hence, in this case, there is only one side of the story. With this, I am only able to understand what the caregiver's experiences are while providing health care to patients whose cultural background is different than their own and how their Haitian patients might differ from their Dominican patients.

Second, race is another limitation of my study. Due to the historical context between Haiti and the Dominican Republic, deeply-set, long-standing racial conflicts exists between both countries, coming from Dominicans as an anti-Haitian sentiment in form of discrimination towards Haitians. In this study, I wasn't able to see how Dominican health care providers give services to pregnant Haitian women and the way they treat and interact with them. For this reason, as a study based on interviews, I can't tell if there is any form of discrimination towards pregnant Haitian women. People know what to say about race because no one wants to appear to be racists, so it is possible that my respondents may not have been completely forthcoming. Hence, there could be a big difference between what people say and do. In this case, as I didn't do participant observation in these two hospitals, I'm not able to tell if what the Dominican health care providers described to me during the interviews is exactly what they do when they provide health care services to the pregnant Haitian women who visit the hospitals. In the future,

my hope is to continue working on this project incorporating the perspectives of pregnant Haitian women while also doing participant observation in the hospitals to better understand the situation from both sides of the story.

Conclusion

The anthropology of birth and the anthropology of body has been able to understand that birth is more than a process rooted in the biology of the women's body. Instead, birth is also a socially shaped event, influenced by culture and thus practiced and experienced differently from one society to another. So natural and medicalized birthing practices are perceived differently by members of different communities, as in the case of pregnant Haitian women and Dominican health care providers. In this thesis, I have been able to understand the challenges that Dominican health care providers face while serving pregnant Haitian women, and how they feel about it. Most importantly, I have been to understand how the challenges they encounter with their pregnant Haitian patients, whose cultural and medical practices are rooted in a different sociocultural context, influence and affect the way that their healthcare services are planned and provided in the Dominican Republic. This is when culture and medicine intersect, and it becomes very important for practitioners to be culturally competent in order to be able to better understand their patients' needs.

In addition, regardless of the long history of war, cultural and institutional conflicts between the two countries, and how Haitians are perceived as the *racialized other* by many Dominicans, pregnant Haitian women who visit these two-public hospitals of la Provincia Hermanas Mirabal in Dominican Republic, are always provided with health services by Dominican health care providers. Even when difficulties in communication, trust, time and health practices preferences arose between the patients and the practitioners, as one doctor explained, "health services, a human right, can't be denied to any one not matter which country they are, which language they speak, and which cultural practices they follow".

Appendix

The 9 essential questions for the interviews were:

1. How long have you worked in this hospital?
2. What is your job position?
3. Per day, how many pregnant Haitian women visit this hospital?
4. What medical contact do you have with pregnant Haitian patients?
5. How do you feel about providing care service to Haitian women?
6. What problems do you face and encounter with Haitian women?
7. Is the health care service the same for Haitians and Dominicans?
8. What is your overall relationship with Haitian patients?
9. In what ways are your Haitian patients different from Dominican Republic?

Examples of the unstructured questions included:

1. How did you feel when that happened?
2. What was your attitude towards a situation like that one?
3. What do you do in certain moments like the one you just described?
4. Why do you think is that?
5. What makes you feel in such way?

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