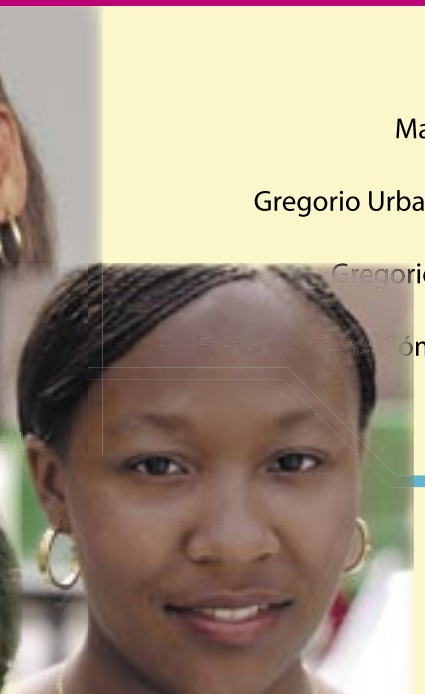


CON UN PIE EN DOS ISLAS:

The Sexual and Reproductive Health of Dominican Women in Santo Domingo and New York City



- Mama Tingo 1
- Gregorio Urbano Gilbert
- Gregorio Luperón
- Gregorio Gómez
- Hermanas Mirabal
- Máximo Gómez
- Los Tainos
- Pedro Livio Cedeño
- Peña Battle
- Juan Pablo Duarte
- Prof. Juan Bosch
- Cassandra Damirón
- Joaquín Balaguer
- Pro de los Heroes 1

SANTO DOMINGO

ACKNOWLEDGEMENTS

This research was funded by a board-designated grant from Margaret Sanger Center International at Planned Parenthood of New York City and by support from the M·A·C AIDS Fund.

CONTRIBUTING AUTHORS

Haydeé Morales, MA – Vice President of Education, Training, and Margaret Sanger Center International, Planned Parenthood of New York City

Vicki Breitbart, EdD, – Vice President of Planning, Research, and Evaluation, Planned Parenthood of New York City

Bethania Betances, MA – HIV/AIDS Technical Advisor, United Nations Population Fund – Dominican Republic

Mishka Vertin, MPH – Research Assistant, Planned Parenthood of New York City

Yvonne García – Research Assistant, Planned Parenthood of New York City

Jaweer Brown, MPH – Director of International Programs, Latin America/Caribbean for Margaret Sanger Center International, Planned Parenthood of New York City

Yaneris Gonzalez – Country Program Coordinator, Dominican Republic for Margaret Sanger Center International, Planned Parenthood of New York City

PUBLISHED BY

Margaret Sanger Center International
Department of Education and Training and International Programs
Planned Parenthood of New York City
26 Bleecker Street
New York, NY 10012 USA

Margaret Sanger Center International
Calle Padre Billini
464 Zona Colonial
Santo Domingo, Dominican Republic

Contact: jaweer.brown@ppnyc.org

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www.plannedparenthood.org/nyc/files/NYC/Dominican_Women.pdf

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COMMUNITY PARTNERS

We are grateful for the contributions of the following individuals who provided their feedback and support for this report:

Bethania Betances, *Fondo de Población de las Naciones Unidas (UNFPA)*

Sarita M. Brand, *Fundación de Desarrollo Loma y Salud (FUNDELOSA)*

Hilda Díaz, *Morris Heights Health Center*

Anabel Ferreira Quiros, *Mujeres en Desarrollo Dominicano (MUDE)*

Cristina Francisco, *Alianza Discapacidad – VIH/SIDA*

Felipa García, *Alianza Solidaria para la Lucha contra el VIH/SIDA (ASOLSIDA)*

Iluminada González, *Dirección de Niñez, Adolescencia y Familia (DINAF)*

Esteban Gutierrez, *Fundación de Desarrollo Loma y Salud (FUNDELOSA)*

Rosa Lavergne, *Dominican Women's Development Center*

Jane Lima-Negrón, *School-Based Health Center*

Gabriella Marquez, *School-Based Health Center*

Dayanara Marte, *Casa Atabex Aché*

Emma Peña, *St. Barnabas Hospital*

Porfirio Pimentel, *Centro de Luz (CELUZ)*

Luisa K. Reyes Sánchez, *Red de Personas que Viven con VIH (REDOVIH+)*

Rosa Milagros Rojas, *Nucleo de Apoyo a la Mujer (NAM)*

Cristina Sánchez, *TU, MUJER, Inc.*

Yorky I. Sánchez, *El Movimiento de Mujeres Unidas (MODEMU)*

Aricela Santana, *Centro de Promoción y Solidaridad Humana, Inc. (CEPROSH)*

Data and opinions presented in this report may differ from those of the organizations listed. The organizations' names are included for identification purposes only.

Background

As increasing numbers of immigrants coming to the United States from the global south are women, it becomes vitally important that the sexual and reproductive health organizations serving them be aware of the socio-cultural context within which these women form their ideas and practices regarding sexual and reproductive health. Dominican women are diverse in their reproductive health needs. It is helpful, therefore, to be aware of their experiences, desires, and modes of communication and information sharing. Yet to date, there has been almost no research documenting the ways in which movement between the Dominican Republic (DR) and the United States affects the sexual and reproductive health of Dominican women.



During the 1990s, more Dominicans entered the United States than any other group in the Western Hemisphere except for Mexicans. By the end of the decade, Dominicans were the second largest Hispanic group in New York City, after Puerto Ricans.

To respond to this need for research, Margaret Sanger Center International – the international arm of Planned Parenthood of New York City – conducted four focus groups with women in the Dominican Republic and in New York. In this report, we describe some of the cultural constructs that emerged as key to understanding how Dominican women think, feel, talk about, and act on their sexual and reproductive health. Our aim is to contribute toward building a new language and framework for sexual and reproductive health that is specific to Dominican women. Through this effort, we hope to construct a more nuanced understanding of the health issues that are priorities for Dominican women and, ultimately, improve the sexual and reproductive education and health care that Dominican women receive, both in New York and in the Dominican Republic.

Literature Review

Before we share our own findings, it is useful to review what existing research indicates about Dominican women’s experiences related to migration and health.

Migration

The movement across borders is complex – even when bodies do not move back and forth, information, beliefs, and resources do. Much of the recent epidemiological literature that examines the relationship between migration and HIV treats Latinos and/or migrants as a monolith. Yet for Latino migrants originating in the Caribbean, their transnationalism, reasons for migration, and integration into the US upon arrival are distinct from the better known agriculturally related migration patterns from Central and Latin America. For example, 34% of Dominicans in New York are not citizens, compared to 54% of Mexicans in New York. In contrast to other foreign-born populations, a greater proportion of Dominican women come to the US than Dominican men (58% women vs. 41% men).¹

During the 1990s, more Dominicans entered the United States than any other group in the Western Hemisphere except for Mexicans. Between 1990 and 1994, Dominicans accounted for one of every five immigrants to New York. By the late 1990s, in New York City, Dominicans were the second largest Hispanic group, after Puerto Ricans.¹

Access to Health Care

Various studies conclude that, as a whole, Latinas in the US underutilize health care services, citing lack of medical insurance, language, lack of transportation, negative beliefs about the health care system, use of folk remedies, and immigration status as barriers.^{3,6,8,9} Many Dominican women in the island republic seek health care in relation to motherhood even though they face sub-standard services.⁷ The DR boasts relatively high percentages of ante-natal coverage (99%),¹⁰ institutional birth deliveries (97%),⁷ contraceptive prevalence (61%),¹⁰ and sterilization (40.9%).⁷ Perhaps paradoxically though, the island still has high rates of maternal mortality (150 per 100,000 live births)¹⁰ – suggesting grievous flaws in the delivery of care during birth.⁷



In the Dominican Republic, maternal mortality rates are relatively high (some estimate 150 maternal deaths per 100,000 live births) even though the country has achieved comparatively high reproductive health indicators in other areas:

- ◆ ***61% of women use some form of contraception***
- ◆ ***99% of mothers seek ante-natal care during pregnancy***
- ◆ ***97% of births are delivered in an institutional setting***

Reproductive Health

Studies of reproductive health highlight the various social factors (the social construction of motherhood, economic in/dependence, and acculturation) that influence differences in contraceptive use and age of first pregnancy and motherhood between Latinas in the US and in Latin America.^{3,4,5,6} On the one hand, studies posit that economic dependency and a high social value placed on motherhood explain high fertility rates in Latina communities in the US. But others have linked increased acculturation with higher levels of contraceptive use and more education about sexual health issues.⁴ At the same time, the literature points to the fragility of condom use within conjugal partnerships¹⁵ confounded by power dynamics,^{16,17} limited male involvement, and perceptions of fidelity.^{18,3,4}

According to the 2000 US Census, Dominican immigrant women in the United States had an average fertility rate of 2.5.^{2,3} However, specific rates of abortion, HIV prevalence, and contraceptive use among Dominicans in New York are not known.

HIV/AIDS

Recent research suggests that the movement of people is linked with the spread of HIV in Latin America.¹¹ The Caribbean region ranks second only to sub-Saharan Africa as the fastest growing part of the world with new HIV infections.¹² In this region, the Dominican Republic is second only to Haiti for HIV incidence.¹³ According to the government of the DR, prevalence is increasing at a faster rate among women than men, and HIV/AIDS is currently the leading cause of death for women of reproductive age. UNAIDS estimates that more than 70% of new HIV transmissions in the Dominican Republic occur through heterosexual sex.¹⁴

In New York, the exact number of Dominicans living with HIV/AIDS is unknown. But in 2004 Dominican immigrants ranked the highest in new cases of HIV infection among immigrant groups in Manhattan.¹⁹ Separated from their conjugal partners over extended periods of time, immigrants may have unprotected sex with both casual and primary partners, thereby increasing the risk of HIV transmission.

The sexual lives of Dominican women are enacted at the nexus of migration, economics, and access to reproductive health care. The paucity of literature on the interaction among factors

in this nexus points to the need to understand further how Dominican women – in both the US and the DR – contemplate, discuss, and realize their sexual decisions and behaviors.

Methodology

DOMINICAN REPUBLIC FOCUS GROUPS:

- ◆ *Two groups, total of 20 women*
- ◆ *Women lived in Santo Domingo*
- ◆ *Aged 22-44 (average 37 years old)*
- ◆ *Had children, ranging from 3 to 26 years old (average 14 years old)*
- ◆ *Participants attended or completed high school, but did not get further education*

NEW YORK FOCUS GROUPS:

- ◆ *Two groups, total of 12 women*
- ◆ *Women lived in New York City, having moved there after age 18*
- ◆ *Length of time in US ranged from 4 months to 23 years*
- ◆ *Aged 34-41 (average 39 years old)*
- ◆ *Had children, ranging from 6 to 20 years old (average 13 years old)*

This qualitative study is based on “grounded theory,” meaning that to gain more information specific to Dominican women, we turned to the women themselves in both the Dominican Republic and in New York City. Rather than seeking to test hypotheses, we sought to gain insight into the ways that Dominican women describe and experience their sexual realities.

Our first step was to conduct focus groups with women who reside in Santo Domingo, DR, and with Dominican women who have immigrated to New York City. There were two groups in each locale, for a total of 32 women. Participants were between 22 and 44 years of age, lived in either Santo Domingo or New York, had at least one child, had no more than a high school education, and had at least monthly contact with someone from the alternate city who was not their child but with whom they had an emotional or economic relationship. The women in New York City had lived in the US for between four months and 23 years and had moved to the US after 18 years of age.

Participants were recruited by key informants and from community organizations serving low-income women. They were not known to be clients of Planned Parenthood of New York City or the Margaret Sanger Center International. Participants received a stipend for their participation in focus group discussions. To protect confidentiality, participants were encouraged to exclude any identifying information and were asked to refrain from discussing the contributions of fellow participants outside of the focus group discussion. The discussions were recorded, transcribed, translated, and then analyzed for themes regarding sexual and reproductive health beliefs and practices.

We readily acknowledge that this study has certain limitations. The women in the focus groups were recruited via availability sampling. They were similar to one another in their socio-economic status and they were known to Dominican-serving organizations. The nature of the sampling process and of qualitative data does not allow us to generalize to a broader population. Nonetheless, the findings offer insights into these women’s beliefs, values, and practices, which we hope will inform future research about the needs and experiences that are unique to this population.

In the second phase of the project, we invited community leaders from Dominican-serving organizations to react to our preliminary analysis and offer concrete recommendations for future programming. We held meetings that provided a forum for the community leaders to voice their response to our findings and their concerns in general. The recommendations that emerged from these meetings are presented at the end of this report.

Findings

Con un pie en dos islas – With a foot in two islands

Not surprisingly, the focus groups indicated that Dominican women in the US maintain strong ties with one another and with their family members and friends on the island. All of the women report weekly contact between New York and the Dominican Republic, including those who have been here for many years.

Between the two countries, women described regular communication, on a weekly – sometimes daily – basis, and an ongoing exchange of money and goods. Most of this communication takes place via increasingly accessible technological means including cell phones, calling cards, and Internet access. Many women on the island receive packages from New York that contain clothes, vitamins, electronics (even televisions and refrigerators), food, and medications (diet pills and over-the-counter drugs). In return, they send packages that contain food that the Dominicans in New York miss or cannot easily obtain, like *arepa* – a sweet – or sometimes *brugalita* – a small bottle of rum. Several of the women travel to the Dominican Republic regularly. One woman talked about going to the DR twice a year “because [with] two children living there [I have] to take care of them.”

Notwithstanding the close contact, the women noted marked differences between the Dominican Republic and New York City. Women in New York City described a “mixed bag”: feeling camaraderie within New York communities with a high percentage of Dominicans and feeling loneliness or longing for the strong community ties of the Dominican Republic. Women spoke of experiencing racism and discrimination at work or in the health care system, largely related to language barriers, even though most of these women had been in the United States for a long time. To some extent, such struggle was understood as part of the migration process itself. As one woman in Santo Domingo expressed it,

I see [Dominicans in New York] as fighters, as women who leave their country to improve the quality of life of their families. It is not easy to go to a foreign country to work to support your family. For me, a woman who leaves her country to go to foreign country is a fighter.

This sense of struggle was not unique to descriptions of living in New York. While women in New York City spoke of the stress related to isolation and the strain of a “hard” New York life, in the Dominican Republic women discussed stress related to the lack of work and financial constraints. They spoke repeatedly about being troubled with headaches. One woman noted with a touch of humor:

My dear, next time you should ask who does NOT suffer from headaches, because this is a country of headaches, heavy traffic jams, problems, you get a headache from everything. You go to the grocery store and you find those high prices so you get a headache, and you come back and find another thing and you get a headache again...this is a country of headaches!



“...if you ask him for protection, then there are doubts. He tells me to use it with other men.”

“Todos somos doctores” – “We are all doctors”

Women in the study expressed misgivings about the health care system in both locations and described a norm of self-medicating or seeking the advice of friends and family before that of health care professionals. They spoke of using various herbal and home remedies like *malta morena* (a kind of malt drink) and medications available through unofficial channels in Santo Domingo or New York (including Cytotec used to induce abortions).

There's a pill. I don't remember the name, but you can get it at the drugstore....

Rather than turning immediately to doctors, women continually seek advice from a broad network of *farmacias*, *botanicas*, relatives, and friends. The recommended remedies were integral in treating their families' health concerns.

Most people are like that, if you have a headache, you buy an aspirin. That's how it is here. Most of the people medicate themselves. We are all doctors; we ask someone what is good to treat this or that.

This is not to say that Dominican women *never* seek formal medical care. Participants in New York City talked about receiving regular health check-ups at clinics and obtaining health information from the Internet, health care providers, community organizations, and television.

Salud Reproductiva y Sexual – Reproductive and Sexual Health

The women in the study described their use of a variety of contraceptives, most frequently the pill, injections (Depo-Provera), Norplant, and intrauterine devices (IUDs). Only one woman mentioned her partner's vasectomy and one other mentioned sterilization. While there was a general acceptance of contraception, women cited financial barriers and partners' perceptions as impediments to its use. As one woman in Santo Domingo said, “After five years, I needed to replace my IUD, but I did not have money to have it removed.”

In both locations, woman discussed how condom use within a conjugal or primary partnership could be seen as a symbol of infidelity. When they ask partners to use condoms, it is commonly interpreted by the man as a declaration of infidelity on the part of the woman or an accusation of infidelity committed by the man. Therefore, women commonly reserve condoms for use only with their casual partners. As one woman put it,

You use a condom when you are not with your husband, when it is something informal. If I have my husband, I don't use a condom. I use another method to avoid pregnancy.

Given the barriers they sometimes encountered in using both condoms and hormonal methods of contraception, it is not surprising that the women described their pregnancies as typically unplanned. At the same time, the women expressed a high regard for motherhood and positive attitudes toward having children.



“If a woman doesn't want to have more children, she protects herself without telling her man. She takes the pill or has Norplant inserted or she gets a shot to avoid having children.”

My first child was planned and we had a girl right after that. She was welcome because she was a girl, but I was not ready for that pregnancy.

That pregnancies came unplanned was not unique to one location. However, participants in the Dominican Republic perceived that there were more opportunities for support and government assistance for their counterparts living in New York City.

Women who have children [in New York City] get assistance from the government, I've heard many women say....

Generally, women seemed to see inducing the termination of pregnancy, or abortions, as a part of the reality of their lives, whether they lived in the Dominican Republic where abortion is illegal (at the time of this publication) or in New York where it is legal. A woman in the DR described her experience:

I did it and my mother didn't find out until much later.... You can take it but if you have missed more than one period, you always need to go to the hospital. I took three pills and a cousin of mine who is in the military took me to the Central Hospital and they cleaned me out. My mother didn't know what I was up to, she only knew that I went with my cousin. I got cleaned out and I told my mother much later.

In both locations, women mentioned a range of abortifacients. In the Dominican Republic, women discussed inducing abortions with herbal remedies like “avocado leaves,” a “bottle prepared by women,” “a lot of potions,” “pine wood,” “oak bark,” or “the peel of the mamon fruit,” and drugs such as “a black pill” and “Citoten,” comparable to the US medication Cytotec.

I had an abortion. I went to a clinic and I had an abortion for three thousand pesos, but it was quite an experience.... I do not recommend it to any woman, because it was a very unpleasant experience. First I took Citoten and it didn't work, so I went to a clinic.

Women in the New York focus groups added herbal remedies like the aforementioned *malta morena* (two spoonfuls of salt added to a German malt drink with nutmeg) and “a very bitter kind of leaf or some pills.” Most agreed that one could obtain through unofficial channels “a pill or something you put in [your] cervix to induce an abortion.”

Violencia – Violence

Women in both groups spoke not only of the presence of violence in their intimate relationships, but also of having little recourse against such violence. One woman in the DR said, “There are women who get used to it and we get beaten even to have sex.”

Some of the women attributed the violence to alcohol abuse by men:

[In NYC] the thing is that people there drink less Brugal [rum]. I think that alcohol has a lot to do with it. If a woman is not prepared for that, for having a hard time when her man is drinking, she'll get beaten. That's why people say that when a man drinks Brugal, he either fights or wants sex, so it is better to have sex instead of being beaten. And when a woman has an alcoholic partner, imagine that situation every day with a man who is always drinking.



“If you have a problem with your wife, it is better to talk about it, to dialogue, to discuss it in a friendly manner. There's no need to get violent. It is better to talk, discuss, and reach an agreement.”

Several participants spoke of how their precarious finances and those of their male partners were sources of tension in their relationships. Women with male partners who worked outside of the DR depended upon the money these men sent to them and they felt they had to adhere to strict behavioral standards in order to keep the remittances coming.

I run the house, take care of the kids. Men say that they are supposedly working for us, that they are in the cold weather because of us. The Dominican man thinks that no one can touch his woman, because then, he won't give you anything, he won't send anything to us or [his] kids, because he has his pride.



“Once I fell in love with an artist, a guy who liked to travel, and for a while I didn’t ask for permission to go out. So my mother said ‘Do you think you’re in New York?’ because I went out and called her later to say that I was not going to sleep at home.”

The women reported that quarrels over money frequently erupted into violence. Although both groups spoke of violence in their relationships, there was a sense in both groups that the laws of New York protect women from violence inflicted by their partners: “Women are not mistreated [in New York City]. There, there are laws.”

Orientación Sexual – Sexual Orientation

When women in the groups were asked about sexual orientation and the existence and degree of acceptance of homosexuality in the DR, they agreed that people in NYC are more liberated in their views. Those on the island report more judgement and social stigma. They said that homosexuality is judged to be not normal, due to the culture of “talking” in close-knit Dominican communities. Some suggested that “It’s uglier [in Santo Domingo]” because “there is more criticism.”

...the difference is that here it is not yet seen as normal.... In NY they live as a couple, but in neighborhoods [here] it is not normal. But in high-class neighborhoods, in other neighborhoods [in NYC], I saw couples of men-and-men and women-and-women living in studios.

When asked if there is more or less homosexuality in the DR or NY, they believed that it was probably the same, but it was more hidden in the DR due to the culture of neighbors and relatives talking.

...I say that it is the same. In [Santo Domingo] you do it less openly than [in NYC] where there is more freedom. A man there can walk holding hands with another man and nobody cares. Here you walk holding hands with another woman and right away people say “But what about this girl? Is she going nuts?” Here they restrain themselves from doing certain things. Maybe here you get that kind of satisfaction, but they restrain themselves more. Here this is big, here this is ugly, baby. And I’m seeing this, because now there are more girls who are like that.

Influencia – Influence

Women in both focus group discussions talked at length about how they perceived their counterparts on the other island. However, a central aim of the study was to understand how the movement between the two islands influenced women’s lives. We sought to discover: what perceptions were packed, shipped, and received in the packages, boxes, or calls going back and forth?



“Here [in New York], the system is different. The system does not help to give our children the education we want for them. We are not talking about hitting them, but here the system does not help much. It contributes to the children’s lack of respect here.”

Generally, women spoke about greater freedoms, with less social vigilance and control, in New York compared to more social cohesion and respect for family and social ties in the Dominican Republic. There was a sense in the groups that Dominican women who live in New York are more “liberated” and experience much more freedom. The groups also described how their actions are shaped and limited by the vigilance of family and friends who criticize and talk disparagingly about any behavior outside the scope of traditional female gender roles.

I would say that [in New York] women have more freedom; [in Santo Domingo] women don’t dare to do certain things. [In New York] Dominican women can live in an apartment with a man and not get criticized. [In the Dominican Republic] if you live with a man, people are always watching who comes in and who goes out. If a friend of yours sleeps at your house, he surely has to be your boyfriend; he can’t be a friend just like in the US without any commitment involved. In this sense, there is more freedom there than here.

While there was a sense that economically the situation was better for women in NYC, that did not replace the need for community. Women nostalgically recalled the sense of community and social cohesion in the DR. As one woman put it,

...I think that there [in the Dominican Republic], with the economic conditions, there is more quality of life.... I had a better quality of life [in the DR] because I spent more time with my family, there are more outdoor activities there than here [in New York], [and] this has changed completely.

In the same light, women reported that their stays in New York brought a general loss of respect for family and social ties. One woman said:

In my opinion, I think that in Santo Domingo we learn to respect our parents. For example, children here [in New York] argue among themselves and they don’t care if they say bad words in front of their mother. In Santo Domingo children are very respectful to their parents.

Participants lamented that family ties seemed to be stronger in the Dominican Republic where it was “easier to maintain a relationship” between families and children. Women in New York City talked about strong protective cultural factors that they wanted to maintain. While these women felt that there is a greater sense of freedom surrounding sexuality in the US, “It is still the same [Dominican] culture – there are still taboos.”

I told my children that when I was 16, I couldn’t go out or even look out the window. My parents would ask me what I was looking at, if I had a boyfriend, this and that. My daughter is 17 and my son is 14 and he thinks that I’m his friend and that he can talk to me however he wants. I don’t buy that. If I have to spank him in front of someone, no matter who, I do it. Yes, but at school the first thing they teach the children is that they have a right to call the police, even if it involves their father or mother.

Discussion

These focus groups point to a complex and dynamic interplay among factors that affect Dominican women’s reproductive health and welfare. From the discussions, we learned that

it is not simply limited access to quality health care services, or lack of male involvement in contraception, or obstacles to obtaining safe abortions, but rather the sum total of all of these factors that inform how the women make reproductive health decisions.

Women in both groups reflected the research literature in their reluctance to use health care systems in both the Dominican Republic and New York City. Such hesitation is set against a backdrop of self-medication and seeking advice from others in their social network. Being proactive about one's health and/or involving others in health decisions are not *in themselves* problematic. In fact, the model of community health promoters has been lauded and encouraged in public health. However, in a context of unplanned pregnancies and limited access to quality health care, the practice of using herbal remedies (like those to terminate a pregnancy) may become problematic if it puts women at risk for unsafe procedures.

On both islands, women reported limited involvement from their partners in their contraceptive decisions. Dominican women in both the DR and NYC stated that contraceptives are a woman's responsibility and, as such, contraceptive decisions are usually undertaken without their partner's knowledge. On the one hand, using hormonal methods of contraception may require a woman to seek access to a health system or provider that is at times hostile (as was said to be the case in New York, due to language and cultural barriers) or to confront inadequate or low-quality services (as was said to be the case in the Dominican Republic).

On the other hand, our participants reported that condoms remain problematic as an alternative to hormonal methods of contraception. Although many described a tacit understanding that their migrating partners may have other sexual partners, women in primary relationships said that asking for condom use is tantamount to suggesting infidelity. Such decisions reflect the complicated nexus of migration and reproductive health. Women in focus groups in the Dominican Republic mentioned that a woman would not only be perceived as questioning fidelity, but would also jeopardize much needed remittances or financial support, if she suggests condom use. Condoms, therefore, are much more than just a tool to prevent pregnancy or disease. It is through condoms that partners negotiate fidelity, trust, and even economic stability.

Another experience that played a role in the women's relationships and reproductive health decisions was intimate partner violence. Women pointed to a series of structural factors—poverty, lack of job opportunities, weak law enforcement, and alcoholism—that heighten the levels of violence against women. The women's economic vulnerability combined with their vulnerability to violence is cause for great concern. Whereas a childless woman—even one with precarious finances—might be willing to leave an abusive relationship, this decision could be particularly difficult for a woman with children. She might endure being abused in order to maintain the monetary support for her children.

In the face of such challenges, it is not surprising that many of the women said that their pregnancies were welcome, but unplanned. In the Dominican Republic, where abortion is



It is not simply limited access to quality health care services, or lack of male involvement in contraception, or obstacles to obtaining safe abortions, but rather the sum total of all of these factors that inform how the women make reproductive health decisions.

illegal, women have few options other than to go to *farmacias* or *botanicas* for medications or herbal remedies to terminate pregnancies that they cannot contemplate bringing to term.

It is critical to understand how each of these factors is in play at the same time. We must pay attention to the way that these factors, individually and in their multifaceted interplay, can increase women's susceptibility to a score of adverse outcomes such as sexually transmitted infections, HIV, unsafe abortion, violence, and sexual abuse.

Recommendations

In the second phase of our research we turned to the experts in the field to understand, given this information, what can we do?

We hosted two events (one in the Dominican Republic and one in New York City) to bring together community leaders, health care providers, non-governmental organizations, bilateral health and development organizations, AIDS service organizations, and government agencies. The goal of these gatherings was to present our findings and seek input about them, to create a dialogue about the project, and to formulate possible next steps. Some of the invitees expressed their frustrations with processes of research development and resource sharing that they perceived as excluding them. The participants also contributed constructive feedback for future projects and concrete recommendations for practitioners seeking to improve health programming for Dominican women. We compiled recommendations from the two groups, synthesized them, and collated them into the recurrent themes presented below.

Key Elements for Reproductive Health Programs Serving Dominican Women

Access to Quality Health Care

- Draw on existing social networks to expand health services. Develop the community health promoter model to expand access to care.
- In particular, in New York: address issues of language barriers and lack of confidence in the health care system by educating providers about racism and cultural differences.

Gender

- Address gender norms from a holistic approach: in addition to women, include men and youth of both sexes.
- Deconstruct social myths and taboos that impede good health. In particular, demystify the notion that machismo is a cultural fixture.

Intimate Partner Violence

- Expand meanings and cultural understanding of “violence” so that the community goes beyond associating violence with only extreme physical abuse and includes emotional and sexual abuse within the scope of “violence.”
- Empower women within the context of a human rights framework.
- Involve public health sector in supporting and providing services to women survivors of violence.
- Incorporate men, youth, and families in programs to address and prevent intimate partner and intrafamilial violence.

Research

- Collaborate with Dominican-serving organizations to get their input on research design and development.
- Ensure that future research endeavors train community leaders to conduct further research.
- Support and encourage research about Dominican women, with involvement of Dominican women.

Conclusion

In both sites, Dominican women preferred to obtain medical information from one another or men in their lives and to use self-diagnosis and self-medication rather than visit a professional health care provider. Further research is needed to determine how this norm enhances or detracts from their sexual and reproductive health. Although Dominican women are accessing formal health care in emergency or “last resort” situations, we need to address the barriers that prevent them from getting *preventive* health care. To what extent do the racism and lack of cultural sensitivity that these women reported within medical institutions act as a barrier for all Dominican women? Accurate information about birth control and reproductive health services needs to be disseminated more widely. Because Dominican women place trust in their peers, the community health promoter model should be implemented both in the DR and in NYC Dominican neighborhoods, with women teaching other women in their own language and from their own cultural perspective. This can include workshops at community social service and/or health centers as well as the *botanicas* where women say they go for health information. Herbal treatments that are popular, safe, and effective within the community can coexist with primary health care; this largely depends on provider attitudes and receptivity. Health care providers’ attitudes will affect women’s willingness to share information about their self-care and their use of primary care as a complement to herbal treatments.

While it is evident that Dominican women feel a strong sense of community with one another, and rely on their peers for support and information, we discovered that many women turn to men when gathering information related to their health. Programs in both locales should provide the information, resources, and skills-building for women to make their own educated choices regarding their reproductive health, and to share this empowerment with other women. At the same time, the benefits of including Dominican men in education efforts concerning reproductive health are clear.

With the feminization of the pandemic of HIV, it is essential to address the synthesis of factors that increase HIV risk for women. It is no coincidence that the same power dynamics involved in intimate partner violence also increase HIV risk. Survivors of violence, rape, and sexual abuse are at risk for HIV infection, while at the same time poor women living with HIV are more likely to be targets of violence, due to stigma and discrimination. We must work to change the larger structural disparities and inequities that exacerbate the risk of HIV infection for Dominican women in the DR and the US, just as they do for women throughout the world.

Similarly, careful attention should be given to the complex problem of intimate partner violence. Health care providers serving Dominican women on both islands should be trained in detection, referral, and treatment for women survivors of violence. Programs and public education campaigns should be developed to engage women, men, youth, and families in efforts to prevent this kind of violence.

Finally, we must advocate for policies that promote the reproductive rights of women both in the Dominican Republic and in the US. In the DR, policies must increase the availability of birth control methods and education about birth control to lower the incidence of unplanned pregnancy. This is especially crucial in a country where legal abortion is unavailable. In addition, we must support advocacy efforts by Dominican women to ensure equal access to legal and safe abortion. In the US, where Dominican women are legally able to obtain abortion services, there are barriers that deter many women from seeking the services. They turn instead to unsafe, less effective, and/or untested termination methods even when they could be receiving high-quality evidence-based care. The reproductive needs of women in the DR and Dominican women in the US must be more aggressively addressed on both grassroots and policy levels if we are to provide them with the services to which they are entitled.

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