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CULTURE CARE MEANINGS, BELIEFS AND PRACTICES OF RURAL DOMINICANS IN
A RURAL VILLAGE OF THE DOMINICAN REPUBLIC: AN ETHNONURSING STUDY
CONCEPTUALIZED WITHIN THE CULTURE CARE THEORY

by

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Submitted to the Doctoral Program Faculty
of the School of Nursing in partial fulfillment
of the requirements for
the degree of
Doctor of Philosophy in Nursing

Duquesne University

2006



**DUQUESNE
UNIVERSITY**
SCHOOL OF NURSING

PHD PROGRAM

APPROVAL OF FINAL DEFENSE OF DISSERTATION

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DATE OF ADMISSION: Fall 2001

DISSERTATION TITLE: CULTURE CARE MEANINGS, BELIEFS AND PRACTICES OF DOMINICANS IN A RURAL VILLAGE OF THE DOMINICAN REPUBLIC: AN ETHNONURSING STUDY CONCEPTUALIZED WITHIN THE CULTURE CARE THEORY

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CULTURE CARE MEANINGS, BELIEFS AND PRACTICES OF RURAL DOMINICANS IN
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The purpose of this ethnonursing study was to discover, describe and analyze the meanings, beliefs and practices of care for Dominican people living in a rural village of the Dominican Republic. Leininger's Culture Care Diversity and Universality Theory and ethnonursing method was utilized as an organizing framework for studying the domain of inquiry. Interviews were conducted with nineteen general informants and ten key informants, all of whom were rural Dominicans living in the village of Villegas 60 miles northwest of Santo Domingo. Exhaustive analysis of audio-taped interviews revealed eighteen categories and nine patterns from which three main themes emerged. The themes were (a) family presence is essential for meaningful care experiences and care practices for rural Dominicans, (b) respect and attention are central to the meaning of care and care practices for rural Dominicans, and (c) rural Dominicans value and utilize both generic (folk) and professional care practices. These findings also detailed what rural Dominicans and Dominican immigrants may value and expect from caregivers in the professional caring relationship. Implications and recommendations for nursing theory, practice, education, policy and research are described.

Dissertation Advisor: Rick Zoucha DNSc, APRN-BC, CTN

DEDICATION

This dissertation is dedicated to my husband, Dr. Philip Schumacher who encouraged and supported me throughout five long years of doctoral education. He picked me up and brushed me off, pointing me on the right track each time I was overcome with self-doubt. In addition to his own work, he selflessly took on household responsibilities and our two small children numerous times when “mommy needed to write.” He is my stabilizing force, my rock, and my very best friend.

I also dedicate this dissertation to my parents, Dr. Thomas and Lynne Kandler and Carl Hill. Tom modeled for me the importance of doctoral education and was there to encourage me, listen to my woes and give confidence to me in the process joys. My mom Lynne, the world’s most caring nurse, modeled for me the altruistic role and represented everything I have ever aspired to be in the profession. My dad Carl, always showed me larger aspirations and dreams. He encouraged the determination in my personality and never stopped offering his praise.

Finally, this dissertation is dedicated to my dearest and best comrade and friend, Kerry Risco. She saw the visions of my education long before I did and advocated and supported me personally and professionally throughout the last ten years. She has been at my side, day and night, and constantly supported and encouraged me.

In loving memory of my grandmother, Monica Hill, who was a nurse that lived nursing both professionally and personally. Her love for the lost and downtrodden inspired me to focus on reaching out to the underserved and seek things that truly matter.

ACKNOWLEDGEMENTS

Many individuals have helped me and contributed to the completion of this study. I am indebted to Dr. Rick Zoucha, chair of my dissertation committee, who assisted my growth in coursework and helped me to fully understand the value of qualitative research, the ethnonursing method and the voices of the rural Dominican people.

I also thank Dr. Carl Ross and Dr. Larry Purnell, the committee members, for demonstrating the feasibility of conducting international research at the doctoral level. They each offered wisdom and support to enrich the study and encouraged my future research endeavors with the Dominican culture.

Additionally, I could never articulate a satisfactory thank you to the Dominican people of this study and interpreters, Diane Sabado and Brenda Jimenez. Their willingness to share their hearts and time provided incredible insights and rich personal understanding of rural lifeways in the Dominican Republic. They are an inspiration for my future research endeavors and personal desires to improve care globally.

Finally, I would like to express my appreciation the Transcultural Nursing Society for awarding me the 2006 research/scholarship award which offered assistance toward the expenses of this study.

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CHAPTER I

INTRODUCTION

Introduction

Nursing research has expanded in the area of transcultural nursing. Knowledge has been needed to gain understanding of different cultures' care beliefs and practices in order to assist caregivers to provide care that is culturally congruent. People around the globe have been more connected to each other than ever before, and a nurse communicating with persons from different cultures has been commonplace. As a result, it has become increasingly important for nurses to possess "an appreciation for and understanding of the culturally relevant views of health, illness, and the experiences of care for individuals" (Zoucha, 1998, p.34).

After an extensive review of the literature using ProQuest, PubMed, Ovid, Social Science Index, ProQuest Digital Dissertations, Academic Search Premier, and InfoTrac OneFile, only one study was found examining the health beliefs of rural Dominicans (Babington, Kelley, Patsdaughter, Soderberg & Kelley, 1999). More studies have been needed to expand nursing knowledge of this culture's beliefs and practices to facilitate culturally competent care. After an extensive review, it appeared that this proposed study would be one of the first transcultural nursing studies designed within the qualitative ethnonursing paradigm to discover the meanings, beliefs and practices of care from the perspective of Dominicans living in a rural village in the Dominican Republic (DR).

Domain of Inquiry

Leininger and McFarland defined the *domain of inquiry* as "a succinct tailor-made statement focused directly and specifically on culture care and health phenomenon" (Leininger and McFarland, 2002, p. 92). The domain of inquiry (DOI) for this proposed transcultural

ethnonursing study was the culture care meanings, beliefs and practices of Dominicans within the context of one rural village of the Dominican Republic. This domain of inquiry was important because of the increasing numbers of Dominicans receiving care in the Dominican Republic and Dominican immigrants receiving care in the United States and other countries. Nurses and other health caregivers must understand Dominican beliefs and practices in order to provide care that is meaningful and congruent with his or her beliefs in the Dominican cultural context.

Purpose and Goal

The purpose of this study was to discover, describe and analyze the meanings, beliefs and practices of care for Dominican people living in a rural village of the DR within the environmental context of their familiar homes and community. This study proposed that care meanings, beliefs, and practices for Dominicans are influenced by shared cultural values, beliefs and practices. The goal of this study was to identify generic (folk) and professional care practices that promote health and beneficial lifeways for rural Dominicans. It was proposed that results from this study would assist caregivers to plan and implement nursing decisions and actions that promote culturally congruent care for Dominican people.

Rationale

The United States has been experiencing a rapid increase in the number of Hispanics immigrating and living in the country. This Hispanic foreign born population in the US reported in the 2000 US Census encompassed individuals from Mexico, Puerto Rico, Dominican Republic, Cuba, Central and South America. Between 1990 and 2000, the number of foreign born from the Dominican Republic in the United States increased by 98%. The 1990 Census Bureau reported 347, 858 foreign born Dominicans living in the US (US Census Bureau,

September 14th, 2005). At the time of this study, there were over 687,000 foreign born from the Dominican Republic residing in the United States (US Census Bureau, 2000, September 15th, 2005). Projections stated that by the year 2050 the Hispanic population of the United States would exceed 102 million and will constitute 24% of the total US population (US Census Bureau, 2004). This had major implications for future health care trends and caregivers. Dominicans immigrating to the US bring beliefs and values regarding health and well being from the Dominican Republic. Therefore, it was imperative to discover and increase knowledge regarding their beliefs and practices from within the context of the Dominican Republic. Increased knowledge regarding culturally specific health care needs for the Dominican population was considered to be imperative to avoid culture conflict and culturally incongruent care for this growing population.

Healthy People 2010 (HP2010), a national health promotion and disease prevention initiative created by the US Department of Health and Human Services (DHHS), outlined the nation's health goals for the decade 2000-2010. HP2010 focused on two major themes (a) increasing the quality and years of healthy life, and (b) eliminating ethnic and racial health disparities in health status (DHHS, 2000). To address ethnic and racial health disparities, it was considered no longer acceptable for health caregivers to deliver health care solely from a national or local point of view. This made it imperative that caregivers became familiar with what is going on globally. Participating in international caregiving opportunities and research increases knowledge of global trends in cultural beliefs and health care. Research conducted in the original cultural setting leads to cultural discovery that minimizes the possible effects of acculturation seen in research conducted with immigrant populations. In other words, by conducting research in the original cultural context of a culture group, purer insights into the

health beliefs and practices of a specific culture group would be discovered. As the United States was becoming increasingly diverse, the next generation of nurses and other health care givers were challenged to expand their knowledge of the different racial and ethnic populations and healthcare inequities facing the US, and to develop new skills to take care of these individuals effectively with cultural competency. With the projected increase in Dominicans immigrating to the US, research on Dominican health beliefs within their original cultural context was considered to be crucial.

This proposed study expanded upon the discovery initiated in a mini study (Schumacher, 2005) which was designed within the qualitative ethnonursing method to begin to discover the meanings, beliefs, and practices of care from the perspective of Dominicans living in a rural village of the Dominican Republic.

Research Questions

The DOI was investigated through an open-ended discovery process. Research questions were developed and refined as a general guide for the inquiry regarding culture care meanings, beliefs and practices of Dominican people. The research questions guiding this proposed study were:

1. What are the meanings, beliefs and practices of professional and generic/folk care for Dominicans in their natural or familiar home and community context?
2. In what ways do technological, religious, philosophical, kinship and social, cultural, political and legal, economic, and educational factors influence care meanings, beliefs and practices of Dominicans?
3. What are the specific professional nursing care actions and decisions that enhance or hinder health and well being of rural Dominicans?

4. In what ways can the three modes of the Culture Care Theory- culture care preservation/maintenance, accommodation/negotiation, and repatterning/restructuring be used to plan nursing care that is culturally congruent for rural Dominicans?

Significance for Nursing

After eight short-term trips to provide primary care to rural Dominicans in the DR, the researcher had become concerned about the outcomes of care and whether or not care given was congruent and beneficial for rural Dominicans. Striking cultural differences existed between professional care practices and the Dominican's generic folk care practices. After several weeks of observing these differences throughout the course of the separate trips over a period of eight years, the researcher had begun to question the beliefs and values regarding professional care practices and whether the professional care practices were being maintained in these Dominican villages over the past few decades. The researcher pondered about what are the professional and generic/folk care meanings, beliefs and practices of these people in the environmental context of their rural villages? After reviewing the literature, it became clear more research is necessary in order to understand answers to the researcher's questions.

Culture care beliefs, values, and practices influence the health and well being of all people from different cultures. Understanding the diversities and universalities of a culture and the influences each has on health and caregiving perceptions and practices was viewed as essential. Cultural aspects of care relevant to diverse people needed to be identified in order to develop culturally congruent modes of care. Research and discovery about Hispanics in general was growing. However, because of the diversity of the Hispanic culture, countries of origin, genetics and acculturation, the National Heart, Lung, and Blood Institute, National Institutes of Health (NIH) and DHHS recommended research within specific culture groups (2003).

Research specific to Dominicans was lacking and more studies of Hispanic health needed to be conducted with specific Hispanic groups including Dominicans in order to consider the differences and similarities that exist among the multicultural Hispanic culture.

With globalization, health care was influenced by multiple factors and involved many healthcare disciplines. Holistic caring, the very essence of nursing, emphasized the importance of caring for the whole person rather than the separate physiologic systems. Transcultural nursing research could potentially lead other disciplines to obtain more holistic knowledge and provide culturally competent care for diverse and similar cultures worldwide. This study offered knowledge of care and health phenomena rather than simple descriptive anthropological or historical facts. If the discipline of nursing was to move forward in providing culturally competent care and forming a knowledge base from which other disciplines can benefit, knowledge of specific cultures, discovered using the ethnonursing method and the culture care theory, was imperative. The ethnonursing method, used by a knowledgeable and skilled researcher, could obtain a holistic view of specific culture care and related phenomena. This research could also lead to identification of culture specific care actions from which all disciplines could draw upon to enable caregivers to provide culturally competent care. In other words, the findings of this study could be used by nursing and other disciplines interested in culturally based care outcomes.

As globalization increased in the 21st century, there was an increased focus upon improving the public health and education regarding health and wellbeing, illness, disease, and injury prevention in the Dominican Republic (Macfarlane, Racelis & Florence, 2000). As a result, there was lesser focus on preserving effective generic or folk methods currently used to enhance wellness and treat illness in the Dominican culture. Healthcare professionals who are

culturally unaware were considered to be particularly vulnerable to ignoring or discovering generic folk practices. As a result, cultural imposition could lead to cultural conflict between the Dominican people and professional caregivers with whom they interact. Also, economic difficulties within the DR could have led Dominicans to seek professional care largely in order to obtain objects of monetary value that may be given as gifts as incentive for treatment of illness. Such items could potentially be sold in order to buy food, tools, or even generic treatment regimens.

Research regarding the differences and similarities in tradition, lifestyle, and cultural care practices between Dominicans and the more developed world could contribute to the knowledge base of transcultural care. With increased knowledge of Dominican generic care meanings, expressions and experiences, sensitivity to cultural universalities and diversities between the Dominican and American culture care could be acknowledged. Research based knowledge of folk/generic care could be combined with professional care, and decisions and actions to provide culturally competent care to Dominican people could be implemented.

Research expanding the knowledge of Dominican and generic care meanings, expressions and experiences was considered significant for nursing education. Transcultural nursing research, reported in nursing literature, was of known value for dissemination of cultural care discoveries. Transcultural nursing research could be used by nursing education to teach culturally specific care values for Dominican people and positively influence the development of culturally congruent care. This study potentially contributed to nursing education's ability to influence culturally congruent care for Dominicans people.

Oriental Definitions

The following definitions were used to give direction to this study:

Concept	Definition
Care meanings, beliefs and practices	Assistive, supportive or facilitative actions, interpretations and gestures by members of a specific culture toward each other or toward outsiders, and as manifested in speech or recurrent action patterns and experiences of informants (derived from Luna, 1989, p. 17)
Cultural Congruent Care	Those cognitively based assistive, supportive, facilitative, or enabling acts or decisions that are made to fit with the cultural values, beliefs, and lifeways of Dominican people in order to provide or support meaningful, beneficial, and satisfying health care, or well being services (derived from Leininger, 1991, p. 49)
Cultural Context	The totality of a particular situation, event, or designated lifeway that gives meaning to the people involved because of the inherent values, symbols, language, expressions, social structure, physical environment, and other factors known and recognized in the setting or situation (Leininger, 1988, p. 27)
Culture Care	The subjectively and objectively learned and transmitted values, beliefs, and patterned lifeways that assist, support, facilitate, or enable another individual or group to maintain their well being and health, and to improve their human condition and lifeway, or to deal with illness, handicap, or death in a long-term care institution (derived from Leininger, 1991, p. 46)
Dominican	An individual who self-identifies with the Dominican culture
Emic view	The “inside view” using language and actions of the people of a particular group or culture (Leininger & McFarland, 2002, p. 48)
Etic view	The external, more universal and generalized view (Leininger & McFarland, 2002, p.48.)
Home/Community Environmental Context	The physical or spatial environment of cultural representatives and/or the familiar community environment which informants identify with, feel at home with, where the language of the country is spoken, cultural symbols are evident, and the nature of kinship and social organization reflects characteristics of the social structure of their native or familiar country (derived from Luna, 1989, p.18)
Social Structure	The major interdependent structural and functional elements of many systems, such as the religious, kinship, political, economical, educational, technological and cultural values of a particular culture screened through linguistic and environmental contexts (Leininger, 1985, p. 209).
Worldview	The ways people view or look at their world (or their universe) to form a picture or value stance as their perspective of life (Leininger & McFarland, 2002, p. 83)
Professional Care	Care based on formally taught scientific knowledge and skills, as it is practiced by trained professionals, such as nurses (Leininger, 1991).

Generic Care	Care that is based on traditional knowledge, beliefs, experiences and skills, and is practiced in families and communities (Leininger, 1991).
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Assumptions

The major assumptions for this study were derived from the assumptions of the Culture Care Theory. They related to the purpose and conceptualizations of the study and were the following:

1. The meanings and experiences of human care become understandable when viewed within cultural context.
2. Care meanings and experiences within a cultural context can contribute nursing knowledge and understanding about health and well being.
3. Care meanings and experiences tend to be embedded in social structure and worldview and need to be identified with reference to naturalistic environmental context.
4. Culturally congruent care practices, based upon knowledge of the culture, provide meaningful and satisfactory nursing care to clients of specific cultures including Dominicans.

Summary

Research based knowledge was needed in the area of transcultural nursing and for the Dominican culture obtained from within the Dominican culture. This study began the discovery of meanings, beliefs and practices of care for Dominicans in a rural village in the DR. This study was significant for nursing because its findings could be used to educate caregivers about providing culturally congruent care to the Dominicans in the DR and Dominican immigrants to enhance their health, well-being, and satisfying lifeways. This study could lead to further study focusing on nursing care decision and actions that are culturally congruent for Dominican

people. This study increased the body of nursing knowledge related to transcultural nursing, and specific knowledge related to the Dominican heritage within the Hispanic culture group.

CHAPTER II

REVIEW OF LITERATURE

Ethnohistory of the Dominican Culture

The Dominican Republic (DR) occupies the eastern two-thirds of the Caribbean island of Hispaniola, which is located west of Puerto Rico. The country's only boarder is with Haiti. The DR is a mountainous tropical country of 18,045 square miles, about the size of Vermont and New Hampshire combined. Its Spanish-speaking population of approximately nine million at the time of this study was 95% Roman Catholic and consisted of three predominant ethnic groups which included white (16%), black (11%), and mixed ethnicity (73%). About half of the Dominicans lived in rural areas (CIA-The World Factbook, 2005).

The DR has had a history of changing rulership, with Spain, France, Haiti, and the US taking their turns at ruling the territory amid attempts at independence and self-rule. The island was originally inhabited by Arawak Indians, called Tainos, until the Europeans arrived in 1492. The European's relations with the Taino, whom they ruthlessly maltreated, deteriorated from the beginning. Christopher Columbus ruled the first colony of Santo Domingo establishing Spanish sovereignty. He attempted, unsuccessfully, to put an end to the more serious abuses to which the Taino had been subjected, but the Taino almost completely died off by 1548. The Roman Catholic Church was the primary agent in spreading Spanish culture in the colony. The need for a new labor force to meet the growing demands of sugarcane cultivation prompted the importation of African slaves beginning in 1503. By 1520, black African labor was used almost exclusively. Large numbers of colonists left for Mexico and Peru where gold and silver were discovered to be in great wealth. As a result, new immigrants from Spain largely bypassed Santo Domingo for the greater wealth west of the island. The population of Santo Domingo

dwindled, agriculture languished, and Spain soon became preoccupied with its richer and vaster mainland colonies (US Library of Congress, 2001).

The French buccaneers colonized the western portion of the island (Haiti) and moved into the Santo Domingo colony. Although the French and Spanish shared the island of Hispaniola, religious, cultural and economic differences contributed to instability. The French Haitians had primary rule over Santo Domingo until 1844 when rebels, led by Juan Pablo Duarte, overthrew the French rule. Leaders between 1844 and 1864 were self-serving and dictatorial leadership prevailed. Eventually, the republic was released from annexation from Spain in 1865. Divisive, chaotic contest for power dominated the land until the United States' occupation which lasted from 1916-1924. The U.S. occupation attempted to facilitate progression to stable democratic rule.

Rafael Trujillo took leadership by unethical manipulation and ruled for 31 years even though his presidential posts were from 1930-1938 and 1942-1952. Trujillo surpassed previous rulers in efficiency, rapacity, and utter ruthlessness (US Library of Congress, 2001).

Additionally, the US Library of Congress documented in general, that the quality of life improved for the average Dominican under Trujillo. Poverty persisted, but the economy expanded, the foreign debt disappeared, the currency remained stable, and the middle class expanded. Public works projects enhanced the road system and improved port facilities, airports, and public buildings were constructed, the public education system grew, and illiteracy declined. After his assassination in 1961, instability led to a second US occupation in 1965 (US Library of Congress, 2001). Though democratic rule was established in 1966, the DR has struggled up to the present time to establish political, economic and social stability.

Foreign Relations and Economics

The DR has had a close relationship with the US and with other states of the inter-American system. It has accredited diplomatic missions in most Western Hemisphere countries and in principal European capitals. Its relationship with Haiti, its closest neighbor, has never been extensive, but the Dominican government has regularly sought international support for Haiti. There was a sizeable Haitian migrant community in the DR which formed the largest foreign minority group. The country was a member of the UN and related agencies including the World Bank and International Labor Organizations (US Department of State, 2005).

The DR, a middle-income developing country, depended on agriculture, trade and services, especially tourism. Although the country has long been viewed primarily as an exporter of sugar, coffee, and tobacco, in recent years, the service sector has overtaken agriculture as the economy's largest employer (CIA-The World Factbook, 2005). The rural villages were traditionally supported by agriculture. The decline in sugar exportation and government policies increasing urbanization decreased agricultural activity, resulting in depressed production and rural poverty. Consequently, health and income disparities were noted to be greater in rural areas compared to urban areas.

After a decade of little to no economic growth in the 1980s, the Dominican Republic's economy boomed. Tourism led the country's earning, followed by telecommunications, and free-trade-zone manufacturing. Agriculture remained a major part of the economy. The DR continued to go through difficult economic times due to bank frauds discovered in 2003 in which losses totaled more than 20% of its gross domestic product. Three areas that required the government's immediate attention were the fiscal imbalances, dealing with the rise in Central Bank Dept, and widespread intermittent electricity blackouts. Health disparities remained

difficult to eliminate unless these economic issues were addressed by the Dominican government (US Department of State, 2005).

Technology

Rural Dominican people had few, if any, technological commodities in their homes. In an assessment of 102 countries' global computer usage, the Dominican Republic fell 70th of 102 in computer ownership, and 70th in computing power (Huang, 2000). More recent analysis reported this profile is changing. According to Miniwatts International, Ltd. (2005), the Dominican Republic had 800,000 internet users, a population penetration rate of 8.9%, a user growth of 1,354.5% from 2000-2005. While wealthier and urban segments of the population and leading Dominican companies had shown rapid adoption and active use of new technologies, much of the country was still not reaping the benefits of computers, the Internet, or even basic telephony. Formal initiatives (public and private) to extend the Internet and networks to the rural and poor segments of the Dominican Republic were still in relatively incipient stages (Kirkman, Gonzalez, Lopes, Putnam & Ragatz, 2002).

Poverty affected the expansion of technology in the Dominican Republic. Computers and other technologies were expensive, and their prices remained out of reach for much of the population. The views of the poor toward internet and technology were conflicting. Some who struggled to afford food, clothing, and shelter saw no relevance of computers in their lives, while others perceived technology as their greatest hope of getting ahead (Kirkman et al., 2002).

Electricity issues in the Dominican Republic impeded technological developments. An obvious feature of most technological items, including appliances along with computers, was that they needed electricity to function. The problems and challenges in the energy sector of the Dominican Republic were a major impediment to technological development. Power outages

rendered most technology useless and rural areas could not accept much of the cost burden to support backup generators and batteries needed in an outage (Kirkman et al., 2002). Importantly, in May 2005, the World Bank approved a \$150 million loan for the Dominican Republic to support the government in providing efficient, reliable, universal, and sustainable electricity service to its citizens. This Power Sector Reform Loan helped stabilize power supply and prevent power outages caused by the large financial deficit of the Dominican sector of the World Bank. The program sought to improve the quality of service and help the poor and enhanced access to social services like hospitals and schools (The World Bank Group, 2005).

In summary, the Dominican Republic had limited use of technology, especially in rural areas. Poverty and problems with electricity contributed to low technology usage rates. A recent loan by the World Bank likely affected Dominicans' experiences with technology. Conflicting views regarding technology and its influence upon the culture from the rural poor population have been reported. More study was needed to examine the emic view of technology and its relationship to the Dominican cultural lifeways.

Education

Formal education in the Dominican Republic included six years of primary, six years of secondary, and higher education levels. The primary six years are compulsory, but only 35-40% of rural schools offered all six grades (US Library of Congress, 2001). More recent documentation by the United Nations Educational, Scientific and Cultural Organization (UNESCO) in 2000 stated the average years of schooling of adults in the DR was 4.9 years (Nationmaster, 2005). UNESCO statistics reported secondary enrolment to be 40.2% in 2000, and tertiary 22.9% from 1993-1997 (Nationmaster, 2005). The reported total population literacy is 84.7% (CIA-The World Factbook, 2005).

Basic education was crucial for sustained economic development and for reducing poverty, preserving the environment, and promoting equality. The DR's literacy rate of 84 percent was considered relatively high. However, the country was faced with major educational problems including scarce classroom materials, poorly trained and paid teachers, and overcrowded classrooms. For every 100 children entering primary school, only 58 finished fifth grade and only 22 completed high school in 13 years or less. Individuals over age 25 averaged only five years of schooling (Population Reference Bureau, 2005). Lack of teachers, supplies, well-maintained facilities and low pay contributed to the lack of education in rural areas of the Dominican Republic. Increase in enrollment had occurred in higher education, but only from areas where secondary enrollment has also increased (US Library of Congress, 2001).

Religion

Roman Catholicism was the official religion of the DR. The US Department of State International Religious Freedom Report stated:

The population is 68.1 percent nominally Roman Catholic and 11 percent Protestant Christian, inclusive of evangelicals, Jehovah's Witnesses, Mormons, and traditional Protestants. In the same study, 20.1 percent of the sample said they had no religion. However, evangelical Christians claim 20 to 25 percent of the population, while the Catholic Church claims 87 percent (2003).

Historically, Protestants first came as migrants from North America in the 1820s. By the 1920s, various Protestant groups and North American Evangelical groups had increased influence. The main Evangelical groups included the Seventh Day Adventists, the Dominican Evangelical Church, and the Assemblies of God. Protestant groups expanded in the 1960s and 1970s, mainly in the rural areas. Pentecostals also had considerable influence in some regions.

With minor exceptions, the relationship between Protestants and the Roman Catholic majority were cordial. Most Haitian immigrants and their descendants adhered to voodoo, and practiced it in secret because the government and the general population regarded the folk religion as pagan and African (US Library of Congress, 2001).

Political Factors

Dominican politics were most notoriously known for the “era of Trujillo”. Rafael Trujillo, the fascist dictator, ruled the country like a feudal lord for thirty-one years. He held the office of president from 1930 to 1938 and again from 1942 to 1952. During the interim periods, he exercised absolute power. The establishment of state monopolies over all major enterprises in the country brought riches to the Trujillos and their cronies through the manipulation of prices and inventories as well as the outright embezzlement of funds. In October 1937, Trujillo ordered the massacre of Haitians living in the Dominican Republic in retaliation for the discovery and execution by the Haitian government of his most valued covert agents in that country. The Dominican army slaughtered as many as 20,000 largely unarmed men, women, and children. On May 30, 1961, Trujillo was assassinated (US Library of Congress, 2001).

At the time of this study, the Dominican Republic was a representative democracy whose national powers were divided among independent executive, legislative, and judicial branches. The president appointed the cabinet, executed laws passed by the legislative branch, and was commander in chief of the armed forces. The Dominican Republic’s multi-party political system held national elections every four years. Leading parties included the PRSC linked to the International Christian Democratic movement, the PRD, affiliated with the Socialist International movement, and the Dominican Liberation Party (PLD). Until 1994, the voter lists had many irregularities and political corruption dominated the Dominican political system. The parties

signed a Pact for Democracy and set a new and fair election in 1996. In 2000, the PRSC candidate, Hipolito Mejia, was elected president in a free and fair election. Mejia entered office with four priorities. The priorities were education reform, economic development, increased agricultural production, and poverty alleviation. Mejia also championed the cause of Central American and Caribbean economic integration and migration, particularly as it relates to Haiti (Wikipedia, 2005).

In 2004, the PLD candidate, Leonel Fernandez Reyna, defeated Mejia and at the time of this study, was the current president of the DR. The PRD, historically, was more radical and more anti-United States. Its original program called for the establishment of a “revolutionary dictatorship” and for close relations with Cuba and the Soviet Union in the 1980s. A more stable two-party system, consisting of the left-of-center PRD and the right-of-center PRSC was thought to be evolving in the 1980s, but a two-and-a-half party system, with the PLD joining these other two existed today. The consolidation of a stable, functioning party system could not be taken for granted in the DR (US Library of Congress, 2001).

Kinship and Social Factors

The family was the fundamental social unit in the Dominican Republic. People emphasize trust, assistance and solidarity between kin. Family loyalty was important and taught early in childhood, and people looked to family and kin both for social identity and assistance. A needy relative might receive a loan of a piece of land, some wage labor, or a gift of food. Another type of assistance was a form of adoption, in which poorer families may give a child to a more affluent relative to raise. The adopting family was expected to care for the child and provide proper upbringing. Children were frequently valued little better than unpaid domestic

help. Implicitly, an adoption arrangement implied that the child's biological family, too, would receive financial assistance from the adopting family (US Library of Congress, 2001).

Civil, religious and free unions were accepted and no shame accrued to men who fathered many children and maintained several women. Public disapproval followed if a man failed to assume the role of “head of the family”, keeping with the Latin-Caribbean doctrine of “machisimo.” However, when a man was absent, unassertive or had limited economic assets, a woman assumed the role of head of the family (US Library of Congress, 2001). The number of women who partnered with more than one man was unknown.

Cultural Values and Lifeways

Cultural influences were primarily Native American Indian, Spanish, French, and African in the Dominican Republic. The Taino Indians, a subgroup of the Arawakans from South America, inhabited Hispanola prior to European occupation. Contemporary Dominican society and culture were overwhelmingly Spanish in origin. Taino influence was minimal. African influence had been largely ignored, but it was noted in the presence of African influence in popular dance and music. There was a preference in Dominican society for light skin and "white" racial features. However, blackness did not restrict a person to a lower status position. Upward societal mobility was possible for the dark-skinned person who manages to acquire education or wealth. Dominicans traditionally preferred to think of themselves as descendants of the island's Indians and the Spanish, ignoring their African heritage. Thus, phenotypical African characteristics were often ignored. Emigration to the United States brought a new level of racial consciousness to the republic. However, when those who have emigrated returned to the republic, many had experienced both racial prejudice and the black pride movement in North

America. Family and kinship remained central to the Dominican values and lifeways (US Library of Congress, 2001).

Folk Practices

In the Dominican Republic, individuals sought generic or folk treatments for wellness and illness that were consistent with their cultural and social beliefs. In a mini study leading to this study, Schumacher (2005) was presented with more than 20 different plants and recipes that villagers stated were actively used in the village for maintenance of health or treatment of illness. Examples of natural medicine included use of *calabaza* leaves for toothaches and swelling, ingesting maguey juice for the flu and eating *guayaba* for nausea. Herbalists and/or witch doctors who have Haitian heritage were in nearly every village, and it was common to see greater reliance on natural medicines further away from industrialized city centers (Weeks, Ferbel, Liss, Rosario & Ramirez, 1994).

Summary. The Dominican Republic had a multi-cultural ethnic heritage including Spanish, French, Haitian and native Taino influences. Although the country had diplomatic relations with the US, Europe, and the Western World, the DR had an extensive history of political and economic instability. Though the DR was primarily influenced by Roman Catholic and evangelical Christian religions, Haitian voodoo and African religious ceremonies were practiced, particularly in rural areas. Medicinal folk practices were used in current times. The family remained the fundamental social unit in the DR and included extended family and civil free unions. Political and economic instability influenced health and social disparities, especially in rural areas. Men led households with fluid boundaries, and gender roles and spirituality were evolving and changing. Research was needed to understand the present day meanings, beliefs,

and practices of care for this culture group in order to provide care that was culturally congruent to Dominicans in the DR and to Dominicans who immigrated to other countries.

Care

Caring was a core value of the nursing profession, examined thoroughly over the years by nursing theorists and researchers. Nightingale (1859) wrote that nursing's most important work is caring, Watson (1985) centralized caring in nursing as a "moral commitment", and Leininger (2002) described caring as the "essence of nursing." More recently, Boykin and Schoenhofer offered a rebirth of caring as a component of nursing and characterized caring as a process, moment to moment, constantly unfolding and manifest in all persons (2001). Many nursing curricula throughout the world emphasized the central concept of caring to nursing education, research, and practice, and supported that caring is central to nursing science historically and in the future.

In her foundational study of the Gadsup people of New Guinea, Leininger was the first researcher to discover care and caring behaviors within a cultural context (1966). She stated care has not been fully known and valued in nursing, and with persistence and enthusiasm challenged nurses to revisit the concept over the years. Leininger's Theory of Culture Care Diversity and Universality was the major theory of nursing focusing specifically on investigating the differences and similarities of care among diverse and similar cultures in the world. Asserting that care is "the essence of nursing and the central, dominant, and unifying focus of nursing", Leininger promoted the discovery of meanings, expressions and forms of human care or caring within cultural contexts (2001, p. 35).

Culture

Across many disciplines inside and outside of health care, the emphasis of culture and its relationship to research views and outcomes was exploding. At the time of this study, a universally accepted theory or definition for culture did not exist. Leininger, a nurse anthropologist, conceptualized culture for nursing from her anthropology roots. For Leininger, culture was “the lifeways of an individual or group with reference to values, beliefs, norms, patterns, and practices that are learned, shared and transmitted inter-generationally” (1997, p. 38). Kleinman, Eisenberg & Good (1978) asserted that culture organizes our cognitions, emotions and behaviors in both subtle and obvious ways that may be beyond our awareness. With these characteristics, culture unavoidably impacted on the ways in which people interpreted and viewed care, health and illness.

Cross-cultural or transcultural transactions occur when two or more of the participants are culturally different. Leininger defined transcultural nursing as “a legitimate and formal area of study, research, and practice focused on culturally based care beliefs, values, and practices to help cultures or subcultures maintain or regain their health (well-being) and face disabilities or death in culturally congruent and beneficial caring ways” (1999, p. 9). In the practice of transcultural nursing, care was provided in the context of culture.

Culture-Care

The concepts of culture and care conceptualized the construct “culture care.” Leininger defined culture care as “the culturally derived, assistive, supportive, or facilitative acts toward or for another individual or group with evident or anticipated needs which guide nursing decisions and actions, and are held to be beneficial to the health or the well being of people, or to face disabilities, death, or other human conditions” (Leininger & McFarland, 2002, p. 83). To

provide culturally congruent care, the central goal of the Culture Care Theory, was to provide care that was meaningful and fit with cultural beliefs and lifeways (Leininger, 1999, p. 9). In other words, the goal of the theory was to provide “culture care” that is harmonious and compatible with one’s culture.

In any culture, including the rural Dominican culture, culturally congruent care could not be provided without knowledge of the appropriate culture care. No studies were identified examining facets of culture care for the rural Dominicans.

Studies of Dominican People

A search of nursing literature revealed only 3 recent studies conducted within the Dominican Republic related to Dominican health status, care beliefs and practices. The majority of studies were conducted with Dominican immigrants in the United States. Carman and Scott (2004) conducted an exploratory descriptive study to establish baseline information regarding the health and care status of children in 2 communities of the DR. In this study, 1500 pediatric Dominican health records were reviewed examining demographics, chief complaints, diagnoses and treatments. Their analyses suggested that there are many unmet primary health needs. The most frequent health problems were upper respiratory infections, parasitic infections, and the majority of patients presented with multiple complaints (Carman & Scott, 2004). Their results asserted that living conditions and the lack of primary care continued to underpin the majority of health issues in the villages studied.

Holt’s qualitative ethnonursing study explored the meaning of hope to Dominican people (2000). Using Leininger’s ethnonursing theory and method, Holt spent five weeks immersed in the Dominican culture and from the data developed a definition of hope and its attributes for the culture. According to this study, “hope is an essential but dynamic life force that grows out of

faith in God, is supported by relationships, resources and work, and results in the energy necessary to work for a desired future. Hope gives meaning and happiness.” This ethnonursing founded definition demonstrated the integration of cultural influences such as spirituality, kinship, and other factors upon the concept of hope.

The assertion was made that health disparities remained a current problem in the Dominican Republic and that cultural context influenced health and well being. Babington et al. (1999) began the exploration of cultural context in examining the health beliefs of rural Dominicans. Through focus groups in seven different northern Dominican rural villages, they discovered health beliefs fell into two major categories, physical and spiritual/mystical. Physical means of health maintenance revolved around hygiene, activity and diet. Spiritual/mystical practices included a blend of traditional Catholic and folk beliefs. This groundbreaking study was a cornerstone in discovery of rural Dominicans’ concept of health. Research was needed to obtain the Dominican emic/insider view regarding care and care practices that facilitate their perception of health and well-being. Research cited in this review was conducted in northern Dominican regions, therefore research was also needed within southern villages in the Dominican Republic.

Studies of Dominican Immigrants

Many studies conducted with Dominican immigrants in the U.S. supported that it is crucial to understand the Dominican culture and health beliefs and practices in order to promote their well-being. The literature supported that the value system of Dominican people is transferred after immigration. Ruiz (1990) explained Dominican immigrants bring with them a whole value system and belief system concerning health, illness, and disease prevention. This belief system is largely based upon folk care and practices. Through a better understanding of

that belief system, the caregiver could offer more meaningful and culturally sensitive care to the Dominican immigrant population.

Shedlin and Shulman (2004) conducted a qualitative study involving 57 Mexican, Dominican, and Central American immigrants living with AIDS in the New York City area. This study explored the perceptions, beliefs, experiences and knowledge of HIV care issues for the informants. The results indicated the key elements for providing services to this population are those that built upon on cultural norms. Suarez, Raffaelli and O'Leary examined the beliefs regarding and use of folk healing practices by HIV-infected Hispanics, including Dominicans, who were receiving care in a clinic in New Jersey. Interviews conducted with 76 informants revealed the majority of respondents believed in good and evil spirits, and 86 percent believed spirits had a causal role in their HIV infection, either alone or in conjunction with the AIDS virus. Two thirds of the respondents engaged in folk healing spiritualism, and 78 percent stated they hoped to affect a cure by engaging in folk healing (1996). Results of these studies supported the conclusion that to be effective in reaching and providing services to these immigrant groups, it is crucial to understand the environment from which they come.

Understanding the Dominican belief system required understanding of Dominican folk care and practices. Folk practices were those which used the culturally known herbs and remedies either self-administered or obtained through a folk healer for curing sickness and illness (Hufford, 1997; Leinigner, 1991b). Zapata and Shippee-Rice (1999), in a qualitative study, described Latinos' use of folk medicine and the values associated with it in the context of main stream health care. Interviews with three Latino women and three Latino men from Columbia, Guatemala and the Dominican Republic revealed that Latinos value their cultural folk medicine and folk healers. Though the informants did not rely exclusively on folk medicine and

all used mainstream healthcare providers, the perceived use of medicines that were not natural contributed to reasons for not using mainstream providers. Findings from this study suggested folk medicine continues to be practiced by Latino immigrants, despite years of residence in the United States. This study supported the necessity to understand Dominican care values, beliefs and practices in order to provide culturally congruent care to Dominicans residing in the Dominican Republic and Dominican immigrants.

Other studies have concluded that folk practices are actively used in the Dominican immigrant culture. One pilot study examined the use of complementary and alternative medicine of 50 Dominican immigrants in a NY emergency department (Allen, Cushman, Morris, Feldman, Wade, McMahon, Moses & Kroneberg, 2000). The study found that almost half of the patients used complementary and alternative medicines in the past year for a complaint and suggested that understanding and inquiry regarding alternative and folk medicines was needed when caring for Dominicans. Another on-going study investigated Dominican healing systems and the herbal treatments prescribed for women's conditions by healers in New York City (Ososki, Lohr, Reiff, Balick, Kronenberg, Fugh-Berman, O'Connor, 2002). They discovered 19 plant species actively being prescribed by Dominican healers. Bearison, Minian, and Granowetter described beliefs about asthma and asthma treatment in a Dominican American community to determine how alternative belief systems affect adherence with medical regimens (2002). This study found reliance on home remedies for asthma prevention and treatment. Like the previous studies, the authors of this study suggested more research was needed to explore Dominican folk beliefs and find ways of coordinating them into treatment. Other data supported the conclusion that to be effective in providing care services to Dominican groups, it was crucial to understand cultural

norms, folk practices and the environment from which they come (Duggleby, 2003; Pearce, 1998; Melillo, Williamson, Houde, Futrell, Read & Campasano, 2001).

The Dominican belief system also incorporated kinship with care beliefs and practices. Caregivers needed to explore and understand the relationship between kinship and care beliefs and practices for Latinos in order to provide care that is culturally congruent. One recent study examined cultural factors related to physical activity among Latina immigrants (Evenson, Sarmiento, Macon, Tawney & Ammerman, 2002). First generation immigrants from Mexico, El Salvador, Columbia, Honduras and the Dominican Republic were interviewed in focus groups regarding barriers to physical activity. The study identified one factor inhibiting activity was support from informants' families. Furthermore, the women informants suggested programs needed for promoting their physical activity are those which involve the family. More studies were needed examining the Dominican perspective of kinship involvement in care practices.

Summary

More nursing studies of the Dominican people living within the DR were needed to expand the cultural knowledge base for this population and to assist caregivers to practice culturally appropriate care for those living within the Dominican Republic and those who have immigrated. This study would lead to increased knowledge of Dominican's care meanings, beliefs and practices and facilitate the providing culturally congruent care to Dominicans.

Guiding Framework

The concepts of care and caring have been described as both models and theories. Transcultural nursing care focuses on the study and analysis of cultural values, beliefs, and practices, and their influence in shaping nursing beliefs and practices with respect to health and wellbeing, illness and injury prevention. Giger and Davidhizar's Model of Transcultural

Nursing, the Campinha-Bacote Model of Cultural Competence, Leininger's Theory of Culture Care Diversity and Universality, and Purnell's Model of Transcultural Health Care were reviewed for guidance of this study. Leininger's theory was used to guide this study because of its congruence with the ethnonursing methodology, and its ability to steer the research questions developed from the researcher's emersion experience prior to conducting this research.

The central purpose of Leininger's Theory of Culture Care is to "discover, document, interpret, explain, and even predict some of the multiple factors influencing care from an *emic* (inside the culture) and *etic* (outside the culture) view as related to culturally based care" (Leininger & McFarland, 2002, p. 76). Leininger developed the ethnonursing research method to establish a naturalistic and largely *emic* open inquiry discovery method to explicate and study nursing phenomena related to the theory of Culture Care Diversity and Universality (Leininger, 2001, p.74). The theory and ethnonursing method provided an open discovery, inductively derived approach to explicate, detail, and get meanings of a culture's care patterns, expressions and practices from the people's emic viewpoint. Dr. Madeleine Leininger's Theory of Culture Care could most accurately guide in the discovery process for this domain of inquiry because it explicated care from a cultural and holistic comprehensive perspective.

In the mid 1950s, Leininger discovered the need to address the fact that culture was a critical and major missing dimension of care (Leininger & McFarland, 2002, p. 21). Over the past 5 decades, her initial period of discovery evolved into the development of a comprehensive theoretical and methodological foundation, guiding nursing research that seeks to acquire knowledge to care for people of diverse backgrounds. In her transcultural experiences and numerous research studies of different cultures, Leininger found cultural values, politics, technology and other areas have not always been rigorously studied or were not valued in

relation to nursing care, and yet were probably the most significant in assisting people to face death, illness or disabilities (1997). She strongly supported and reinforced that nursing must use a broader and in-depth perspective to discover care and to obtain data to develop culturally congruent nursing care practices. She suggested study of the particulars of a culture and the Theory of Culture Care provided assumption and tenets to guide researchers in a comprehensive way.

The Theory of Culture Care Diversity and Universality and ethnonursing research method involved discovery of phenomena through qualitative interviewing and data analysis. Leininger developed the *Sunrise Model Enabler* (Appendix A) as a cognitive research guide to assist the researcher to tease out culture care phenomena from a holistic perspective of multiple factors that can potentially influence care and well-being of people (Leininger & McFarland, 2002). Through interviews with informants, the researcher explores, generally, all dimensions in the model which included technological, educational, religious and philosophical, economic, political & legal, kinship and social factors, as well as cultural values beliefs and lifeways, within the context of the DOI. The detailed holistic approach with the Culture Care Theory depicted in the Sunrise Enabler assisted the researcher to systematically and rigorously discover culture care meanings, beliefs and practices of informants within their rural environmental context.

From informants' responses, discovered phenomena were examined in order to predict nursing judgments, decision or actions to provide culturally congruent care that is beneficial, satisfying, and meaningful to a culture group. Leininger envisions three major modalities to guide nursing care decisions and actions. The three modes are (a) *cultural care preservations and/or maintenance*, (b) *cultural care accommodation and/or negotiation*, and (c) *cultural care repatterning or restructuring* (Leininger, 2001, p. 42). The first mode, culture care preservation

and/or maintenance referred to those assistive, supportive, facilitative or enabling professional actions and decisions that help people to *retain or maintain meaningful care values and lifeways to recover from illness, or deal with handicaps or dying*. The second mode, culture care accommodation and/or negotiation refers to those assistive, supportive, facilitative, or enabling creative professional actions and decisions that help people *adapt to or negotiate with others for meaningful, beneficial, and congruent health outcomes*. The third mode, culture care repatterning or restructuring, referred to the assistive, supportive, facilitative, or enabling professional actions and decisions that help clients to *reorder, change, or modify their lifeway for new, different and beneficial health care outcomes* (Leininger & McFarland, 2002). The nurse grounded in culture care knowledge plans and make decisions with clients with respect to these three modes of action in accord with the care data obtained from informants' interview responses.

The ethnonursing research method focused the research on nursing phenomena concerned primarily with humanistic and scientific aspects of human care, well being, and health in different environmental and cultural contexts (Leininger, 2001). Therefore, the method was designed to discover how people know and experience areas of nursing phenomena from a transnational context and perspective. The ethnonursing researcher's task was to learn about nursing phenomena and factors influencing care and health from the viewpoints and daily lived experiences of the informants. Leininger developed several *enablers* to assist the researcher in use of the ethnonursing method. The *Sunrise Model Enabler* provided a cognitive visualization aid to see the totality of the phenomena or dimension under study (Leininger & McFarland, 2002). The *Stranger to Trusted Friend Enabler* (Appendix B) helped the nurse researcher to learn much about his/her own attitudes, behaviors and expectations when utilizing the

ethnonursing method. The goal with this guide was to become a “trusted friend” to facilitate honest, credible, and in-depth data from informants (Leininger & McFarland, 2002). This is different from the quantitative researcher who generally avoided relational contact with subjects. The *Observation-Participation-Reflection Enabler* (Appendix C) was an essential guide to enable the researcher to enter and remain with informants in the familiar or natural context while observing and doing the study (Leininger & McFarland, 2002). While using this enabler, the researcher remained alert to the Culture Care Theory tenets and observed the whole or total situation. A daily journal or field log is used to record what one observed, heard, and experienced with this enabler (Leininger & McFarland, 2002). The ethnonursing method and enablers assisted the nurse researcher to capture meaningful and in-depth overt and covert discoveries related to transcultural nursing phenomena.

This study proposed that culture care meanings, beliefs and practices of the Dominican people are rooted in not one, but multiple factors of the Sunrise Enabler. With the tenets of the Culture Care Theory, ethnonursing method and research enablers guiding the research process, a global perspective of the culture care meanings, expressions and experiences of the Dominican people and possible influences upon health and illness could be discovered. The Culture Care Diversity and Universality Theory and ethnonursing method enabled discovery of new knowledge in relation to cultural and social structure factors of economics, religion, and other domains related to Dominican lifeways.

CHAPTER III

STUDY DESIGN

The ethnonursing research method, which was developed by Dr. Maedeline Leininger was used in this study. Leininger formulated the qualitative ethnonursing method in order to generate substantive and in-depth transcultural nursing knowledge. The researcher participated in multiple endeavors to provide care to Dominicans over the past decade and long desired to discover the care practices that may hinder or enhance health for the Dominican culture group. The researcher chose this method because it is philosophically driven by theory, it allowed the discovery of phenomena from the insider's, or emic viewpoint and it enabled the comparison and contrast with the outsider's or etic perspective. The ethnonursing research method would assist the researcher to obtain meaningful, accurate, and credible data which reflect the cultural lifeways and insights about care, health, and well being of rural Dominicans (Leininger, 1997).

Mini Study leading to Proposed Study

The author conducted a mini study that sought to begin to identify, describe and analyze the meanings, beliefs and practices of care for Dominican people living in a rural village of the DR within the environmental context of their familiar homes and communities (Schumacher, 2005). In addition, the mini study set out to refine the research questions, methodology and semi-structured interview guide and assist the researcher in understanding the Dominican emic view for progression to a larger ethnonursing study. In the mini study, 5 Dominican key informants and 12 general informants were interviewed in a rural village setting in the DR. Informant's responses were analyzed and began the discovery for this proposed study. From the 17 informants, the mini study findings included the discovery of three emerging but not well-defined themes:

1. In promoting care, Dominicans involve kinship in care practices
2. The values of respect, attention, and relationship are central to the meaning of care for Dominican people
3. Dominicans use folk and professional caregivers and care practices in promoting health and well-being

According to Leininger and McFarland, the mini, or smaller study, helps the researcher to gain skills in doing a larger study (2002). The mini study not only helped the researcher gain skills, but also assisted the identification of successes and refinements needed in the methodology and semi-structured interview guide to be used in a study. From the mini study, it was discovered that the informed consent process worked very well. The verbal explanation was needed as many informants were illiterate. Signatures were easily obtained along with marks from those who did not read or write. Interviewing in the home and familiar context was also successful. The informants live in a fluid environment, but interviewing in a place of one's own choosing was facilitative to the discovery process.

Based on the findings and evaluation of the mini study methodology, several suggestions for change in the interview guide were generated. The suggested changes in the interview guide are summarized in Appendix D.

The mini study also assisted with the development of research questions for this study. During the interview process of the mini study, it became clear that the word "meanings" may need to be eliminated from the interview guide. The terminology "beliefs" and "practices" were seemingly understood. The interpreter verbalized numerous times with multiple individuals that the informant "does not understand the question" when using *meanings* of care, or what care *means* to the informant. After reading and re-listening to the interviews, the author did not feel

there was understanding of questions regarding *meanings* of care, but questions pertaining to the beliefs and practices that are related to culturally congruent care were comprehended.

The mini study results suggested the possible need to add a question to the interview guide regarding natural remedies used in folk practices of care. The informants shared numerous examples of plants and herbs that are used to create remedies for various conditions. Suggested questions were: *What are the natural remedies used in folk care? How and for what are they created and used in the Dominican culture?*

Finally, the mini study assisted the researcher in establishing rapport and trusting relationship with individuals in Villegas, a rural village of the Dominican Republic. The results of the mini study initiated the author's exploration of nursing decisions that promote health and beneficial lifeways for rural Dominicans. This study assisted the researcher to better understand the phenomena discovered in the mini-study, and explore nursing care actions and decisions that enhance or hinder health and well being for rural Dominicans.

Entry Into the Field

The researcher visited the rural villages of the Dominican Republic on numerous occasions and participated in many field observations. She had traveled with 2 US physicians who have lived in Santo Domingo for over 10 years. They visited the villages daily and one, Diane Sabado, functioned as one interpreter for this study. The other interpreter was a Dominican born university student. The Stranger-Friend Enabler (Appendix B) was used to assess the researcher's relationship with the informants.

Methodology

Using the ethnonursing research method, the researcher conducted interviews with volunteering participants to obtain nursing knowledge within the context of an individual's

culture. A semi-structured open-ended inquiry guide directed the interviews (Appendix E). To begin an interview, a description of the purpose of the study was given to the informants. The researcher provided an opportunity for informants to ask questions and clarify concerns related to the study. If a participant agreed to participate in the study, a consent form was provided in Spanish (Appendix F). The informants were asked to read and sign the consent form. If an informant was unable to read or write, a verbal explanation (Appendix G) was read in Spanish to the informant and he/she was asked to place a mark of distinction in ink on the consent form rather than a full name signature. Informants were also assured of confidentiality of all information prior to beginning an interview. The interview was guided by the top portion of Leininger's Sunrise Model (Appendix A). The researcher began by eliciting demographic information and general information related to Dominican cultural lifeways. The informant responses guided the interview content, as the researcher examined responses in relation to the facets of the Sunrise Model. The researcher reviewed the Sunrise Model's concurrently during the interview to assure elicitation of thick meaningful data about each facet.

In the ethnonursing research method, data are extracted from interviews to formulate themes. The researcher validated and refined thematic extractions and inferences about culturally congruent care modes of actions through follow-up interviews with participants. 1 or 2 follow up interviews were conducted with key informants. In this study, the researcher conducted interviews with villagers in the village of Villegas, Dominican Republic. Through interviews, field notes, and review of taped recordings, the researcher discovered, described and analyzed the meanings, beliefs and practices of care for rural Dominicans, and identified care practices that may hinder or enhance health and well being for this cultural group.

Participant Observations

Phase I of Leininger's research process (Appendix C) is primarily observation. The focus at this stage is upon obtaining a broad view of the situation without actually taking part in activities or events. In Phase II, the observation is still the major focus along with minor participation and interaction with the people. During Phase III, the researcher becomes a major active participant in order to learn by direct involvement. Finally, in Phase IV, reflective observation is carried out by the researcher to determine the actual or potential impact upon the people or the situation. The reflective phase allows the researcher to step back and evaluate the impact of his/her presence (Leininger, 1985).

In a 10 day field experience in 2004, the researcher focused upon Phase I and II of the research process. In this study, Phase II, observation-participation, and Phase III were continued from the mini study conducted in the natural environment setting of informants, their home village. Additionally, the researcher continued Phase III, active participation, and focused on Phase IV of the process. The researcher visited and interacted with families and assisted with any daily activities permissible to the informants. Interviews of key and general informants were completed for this study during this phase over the period of 21 days. Participation involved interaction with informants, but most of all, continued learning from informants. Each day, a field journal with the researcher's documented reflection of her presence on the participants and settings was kept. This phase continued with subsequent visits to the village for validation and clarification of findings with informants through rechecking and confirming data until saturation in regard to the DOI was reached.

Ethnonursing Interviewing

This study focused on documenting and analyzing meanings, expressions and experiences of care in naturalistic contexts, and discovering the care practices that hinder or enhance health and well being for rural Dominicans. Therefore, in-depth interviewing constituted an important part of the ethnonursing research process. Because ethnonursing interviewing is different from interviewing with survey or quantitative types of research, an unstructured format was used as a general guide to open inquiry. A semi-structured and open-ended inquiry guide (Appendix E) was used to gain information from the informants regarding their culture care meanings, beliefs and practices, and culturally congruent healthcare practices. The inquiry guide included ethnodemographic data as well as dimensions of cultural context. The questions were not read verbatim, but served as a guide for the researcher. The interview guide was revised based on the findings of the mini study leading to this study. As this study unfolded, the informant guided the direction of the interview. Throughout the process, the researcher clarified core meanings and experiences of the informants to establish credibility and accuracy of data.

Setting

The setting for the mini study and this proposed study was a rural village, Villegas, approximately 60 miles northwest of Santo Domingo. The village was nestled in a mountain range and was accessed by one narrow gravel road. The majority of the informants lived within a one mile radius of the “village center” where a community “center” or hut existed. Some villagers lived along the road on the way to the city center, but all informants were within one mile walking distance. The closest neighboring village was approximately eight miles from the village. Villegas was comprised of low income, Spanish speaking Dominican families. A few families had a motor vehicle and several families owned mo-ped motorcycles. Transportation by

horse and donkey was also present in the village to navigate narrow roads in the mountain range. The closest churches, a Pentecostal Christian Church and Catholic church, were between the village and the neighboring village, approximately 0.4 miles away. The closest school, which was public, was beside the churches. Some, but not all of the villagers attended church and school. Some of the villagers were employed outside the village and generated family income. Other villagers maintained small agricultural plots of land. The closest public and private hospitals and professional health care facilities were near Santo Domingo, 50 miles from the village. Another smaller public hospital was 10 miles away in San Cristobal. Several neighboring *brujas* or witch doctors were located in Villegas and nearby villages within a 20 mile radius. Interviews were conducted in a private place of choosing of each person's home or nearby home.

Selection of Informants

Informants were recruited from the village through an individual verbal invitation by the researcher to participate in an interview. Key informants from the mini study leading to this proposed study were re-interviewed in order to substantiate the findings. The additional volunteer convenience sample of new general and key informants were chosen using the snowball method.

For this proposed study, the ethnonursing method was chosen because it used naturalistic inquiry within the qualitative paradigm to uncover the emic (insider's) view as well as the etic (outsider's) view of culture care phenomena. This research method was best for comprehensive inquiry that examines care phenomena within all the facets of the theory. Leininger suggested that key informants and general informants be selected to obtain in-depth knowledge and in order to fully understand the phenomena under study (2001). Key informants are held to "reflect the

norms, values, beliefs and general lifeways of the culture” and in contrast, general informants are “not as fully knowledgeable about the domain of inquiry” but are “used to reflect on how similar or different their ideas are from key informants” (Leininger, 2001, p. 110). Leininger suggests, for a study, as a general rule, 12-15 key informants are needed. For this study, 10 key informants were recruited for 2-3 in-depth interviews. According to Leininger, approximately twice the number of general informants to key informants are needed for a study (2001, p. 110). In this study, 19 general informants were recruited. In this study, saturation was reached with the number of informants. General informants were interviewed for 45 minutes to 1 hour or until saturation was reached. After the first several interviews, key informants were selected based on their increased knowledge related to the richness of information pertaining to the DOI and ability to provide confirmation of the data.

Other criteria for selection of key informants included:

1. Self-reported that they identify with the Dominican culture
2. Were willing to share information and knowledge related to the DOI
3. Agreed to be interviewed 2-3 times by the researcher for 1 to 2 hours
4. Were over the age of 18 and may be male or female

General informants from the village were selected to enrich the information received by the key informants. The 19 general informants were selected based on the following criteria:

1. Self reported that they identify with the Dominican culture
2. Were willing to share information and knowledge in relation to the DOI though not fully knowledgeable about the DOI as the key informants
3. Agreed to be interviewed 1 time by the researcher for 45 minutes to 1 hours
4. Were over the age of 18 and may be male or female

One 45 minute to 1 hour interview was conducted with each general informant. A minimum of 2- 1 to 2 hour interviews were conducted with each key informant. In the first interview, the guide was used to explore and identify care meanings, beliefs and practices. Data from the first interviews guided the researcher to identification of key informants. In the second or third interview with key informants, the researcher verified the information extrapolated in the first interview and explored and validated care practices that may hinder or enhance health and well being for Dominicans. Second or third interviews were also conducted in order to assure the data were valid and to offer further opportunity for the informant to add information.

Human Subjects and Ethical Considerations

To protect the rights and welfare of individuals, informants were given a verbal explanation of the research study with the purpose and plans of the study. The explanation, in Spanish, included provisions for anonymity and the right to withdraw from the study at any time. Anonymity of informants was maintained by the use of a coding system which avoided the use of names in the process of recording and computerizing field data. A separate notebook was used to document the names of informants. Informants were told that names would not be used in the recording of field notes or in the write-up of the research study.

A written consent form was offered in Spanish (Appendix F). In Dominican villages, many individuals are unable to read or write. If a participant was unable to read or write, a written form entitled "Verbal explanation" (Appendix G) was carefully read and translated. The identification code was placed on the explanation form along with a place for a witness to sign indicating verbal consent to participate was obtained. Permission to tape record the interviews was sought along with permission to jot down notes during the interview process. The intended purpose and usage of notes and recordings was explained.

Interviews were conducted in the home of the participant or a private place of their choosing. By conducting interviews within the home, privacy was preserved. The researcher asked permission to speak to the informant alone in an area within or nearby the home which was chosen by the informant where a private interview could be conducted for 1-1 ½ hours. An interpreter translated the interviews. Each interpreter signed a confidentiality agreement (Appendix H) and did not have access to names or transcriptions.

Throughout the data collection period, the investigator was alert to offensive or sensitive cultural data or uncomfortable topics and those areas were not pursued unless the informants were ready and willing to share ideas with the researcher and through the interpreter. Participants were allowed to withdraw at anytime during the study.

Method of Data Analysis

Data obtained through the interviews were transcribed verbatim from Spanish to English and back-translated to Spanish within seven days with the assistance of a computer and qualitative data management software NUD*IST In Vivo version 6.0. Each interview was transcribed and typed by the researcher after interviews were completed. The qualitative data entries included verbatim informant and observational data as well as researcher dialogue, theoretical speculations, feelings, and detailed observations of the informants' environmental context. Each field of data was dated, numbered, given an informant code, and a code to identify where the data collection took place. This allowed the researcher the possibility of going back to the original field notes and checking the data. Once data were entered, each sentence was coded reflecting categories and domains from the Culture Care Theory. Additional unique codes were added as the study progressed. Coding and data management was assisted using NUD*IST In Vivo software version 6.0.

Informants' responses and other data were analyzed using Leininger's Phases of Ethnographic and Ethnonursing Data Analysis (Leininger, 2001). In the ethnonursing research method, it is the data which drives the direction of the analysis. Data analysis, which was initiated in the mini study analysis, continued from the very beginning of the research process of the mini study and continued to the end of this study. The researcher continually reviewed analysis of the mini study data, and analyzed the fieldwork data from each day to know what to look for on the next day with new informants. During the first phase of analysis, raw data were collected and documented using a field journal, tape recorder, and computer. This phase began in the mini study and was continued in this study. Informant data, observation-participation-reflection experiences, and the researcher's thoughts and theoretical speculations were some of the major sources of data in the first phase. In the second phase, descriptors were identified from the field data and studied within context. Identification of descriptors began in the mini study and was expanded and enriched in this study. In the third phase, recurrent patterns were formulated from the descriptors while retaining their contextual meanings. Patterns identified in the mini study were reconfirmed and expanded in this study. In the fourth phase, which began in the mini study and continued in this study, themes were abstracted from the patterns and theoretical formulations related to the Culture Care Theory.

Substantiation of the Research

Evaluating the quality and rigor of inquiry is important in any research study. The purpose of ethnonursing research is to discover the nature, essence, attributes, meanings, characteristics and understandings of a particular phenomenon under study (Leininger, 2001). Leininger offered six criteria for substantiation of ethnonursing research: *credibility*, *confirmability*, *meaning-in-context*, *recurrent patterning*, and *saturation* (Leininger, 2001).

Credibility refers to the “truth, accuracy, or believability of findings that have been mutually established between the researcher and the informants as accurate, believable, and credible of their experiences and knowledge of phenomena” (Leininger, 2001, p. 112).

Credibility is essential in qualitative research. The meanings, beliefs and practices of rural Dominicans was substantiated through the researcher’s observations and with documentation of meanings-in-contexts of situations and events. Through direct observations and participation in the informant’s cultural environment, the researcher compared and contrasted emic and etic data to uncover diversities and similarities between them. The researcher confirmed interpretations with informants in order to obtain credible data.

Confirmability means “reaffirming what the researcher has heard, seen, or experienced with respect to the phenomena under study. Confirmability reflects evidence of the informants restating or reaffirming ideas or instances that have occurred over time in familiar and natural living contexts” (Leininger, 2001, p. 113). Lincoln and Guba (1985) suggested that maintaining all records obtained through the research process serves as another method of establishing confirmability. Leininger advocated “confirmed informant” checks with direct people feedback as a way to establish confirmability (2001, p. 113). For this study, the researcher maintained field notes from mini study interviews and continued to maintain notes from this proposed data collection period. She reflected upon the data collected and discussed it with the informants during subsequent interviews to confirm or clarify her interpretation of the findings.

Meaning-in-context means that the data become understandable with relevant meanings to the informants within their familiar and natural living and environmental context. This criterion focuses on the significance of interpretations and understanding of the actions, symbols, events, or communications within total contexts of occurrences (Leininger, 2001, p.113). To be

able to meet this criterion, the researcher had to understand the situations and activities described and transfer them to a wider context (Leininger, 1991). Her formal knowledge and experience with the culture aided the researcher in finding meaning in context. The researcher met and interviewed people in different environments and situations, and aimed at getting wide knowledge of the community. The researcher explored the research as a whole to explicate the meaning of data from the rural Dominican perspective and the impact on the DOI. The use of the Spanish language would make the data more vivid, but the English language probably did not restrict the finding of meaning-in-context data. When writing the research report, as special effort was made to keep the information given by the informants unchanged.

Recurrent patterning refers to repeated instances, sequence of events, experiences, or lifeways that tend to reoccur over a period of time in designated ways. Repeated experiences, expressions, events, or activities that reflect identifiable sequenced patterns of behavior over time are used to substantiate this criterion (Leininger, 2001, p.113). In order to meet this criterion, the researcher interviewed different people in different situations and environments. By doing so, she gained information about different aspects of phenomena. Repeated experiences and expressions were obtained.

According to Leininger, *saturation* refers to the “taking in” of occurrences or meanings in a very full, comprehensive, and exhaustive way. Saturation is achieved when there is a redundancy of information in which the researcher gets the same or similar information, and the informants contend “there is no more to offer as they have said or shared everything” (2001, p. 114). The researcher collected and examined the data to determine if information was becoming redundant. She continued data collection until the key informants did not produce any new information.

The final criterion for evaluating quality and rigor in this research study is *transferability*. *Transferability* refers to whether or not the findings of the study will have similar meanings and relevance in another similar situation or context (Leininger, 1991). While the goal of qualitative research is not intended to produce generalizations, but to obtain in-depth knowledge, this criterion looks for any general similarities of findings under similar environmental conditions or contexts (Leininger, 2001). The data in this study were collected in a poor rural Dominican village. However, the interpretations of care meanings, beliefs and practices, based on the lay interpretations of care, could be transferred to some other Dominican cultural contexts, but not all Dominican circumstances. The interpretations could likely be transferred to other rural villages, but could not be transferred to urban or suburban Dominican contexts, because of the differences in economic, educational, technological and other factors.

SUMMARY

This study proposed to discover the meanings, expressions and experiences of care for rural Dominicans living in the Dominican Republic. This study enriched the discovery of a mini study conducted by the author in the village. It also revealed care practices and modes of action that are considered to be culturally congruent for Dominican people. The selected informants were predicted to reveal unknown dimensions related to care experiences. This study was conceptualized within the framework of Leininger's Culture Care Theory and ethnonursing method which guided the researcher to obtain valid and rich data. The findings of this study added to transcultural nursing knowledge related to the Dominican culture and the meanings of care for Dominicans. It also led to nursing care decisions and actions that are culturally congruent for the Dominican culture group.

CHAPTER IV

RESULTS AND FINDINGS

This chapter presents data generated from interviews with key and general informants. The findings in this section were derived from the emic or insider's view as well as from the etic or the outsider's (researcher's) views and observations in the environmental context in which the study took place. All data presented were direct quotes from informants after transcription and translation from Spanish to English.

The data were analyzed using Leininger's phases of ethnonursing analysis for qualitative data (Appendix I). Data obtained through the interviews were transcribed verbatim from Spanish to English and back-translated to Spanish. The software program NUD*IST In Vivo version 6.0 assisted with data management. Data analysis was initiated in the mini study and continued until the end of this study. From the data, descriptors or categories were identified and recurrent patterns were formulated from the descriptors while retaining their contextual meanings. Themes were abstracted from the patterns and theoretical formulations related to the Culture Care Theory. Data are presented in accordance to method of analysis. The descriptors or categories will be presented, followed by the patterns and themes.

A total of 10 key informants (see Table 1) and 19 general informants (see Table 2) were interviewed for this study which is congruent with the ethnonursing methodology. Interviews were conducted until saturation was reached. Sixteen informants were female and 13 were male. Interviews were conducted in the places identified as comfortable and chosen by each informant. All of the informants identified themselves as Dominican and resided within the community of Villegas 10 miles north of San Cristobal, Dominican Republic. Both informants that reported

their income to be “unknown” were in local community political positions and stated they did not want to share the information.

Table 1- Demographic Characteristics of Key Informants

ID#	AGE/ GENDER	MARITAL STATUS	CHILDREN	RELIGION	INCOME PESOS/MONTH (USD equivalent)
M-1	40F	S	2	Catholic	6000 (\$180)
F-1	40M	M 1 D 1	2	None	20,000 (\$600)
AL-1	27F	M 1	2	Pentecostal	0
J-1	20F	S	0	None	0
B-1	34F	M/ CP	4 (1 deceased)	None	9,000 (\$270)
G-1	30F	M/ CU	3	Catholic	7200 (\$216)
JD-1	25F	S	0	None	11,500 (\$345)
MR-1	64M	M/ CU and 2 other women	9	None	2000 (\$60)
FP-1	64F	Widowed 15 years	4 (1 deceased)	Catholic	0
AA-1	22M	S	0	None	9,000 (\$270)

M=Married D= Divorced CU=Civil Union CP= Court Papers S=Single

Table 2- Demographic Characteristics of General Informants

ID#	AGE/ GENDER	MARITAL STATUS	CHILDREN	RELIGION	INCOME PESOS/MONTH (USD equivalent)
ME-1	50F	M	2	Pentecostal	0
I-2	70F	Widowed	7	Pentecostal	0
R-1	50M	M/CU	7	Catholic	2500 (\$75)
Y-1	19F	S	0	Pentecostal	0
A-1	36M	M/CP (separated)	2	None	25,000 (\$750)
C-1	60M	M	2	Pentecostal	Unknown
W-1	26F	S	0	Pentecostal	0
MA-1	55M	M	3	Pentecostal	10,000 (\$300)
FR-1	37M	M/CU	4	None	90,000 (\$2700)
EL-1	31M	M/CU	3	None	6000 (\$180)
WI-1	23M	M/CU	2	Catholic	6000 (\$180)
IS-1	32F	M/ 2 nd CU	4	Catholic	5000 (\$150)
SJ-1	36M	M/CU	4	None	Unknown
ET-1	24M	D	0	Pentecostal	12,500 (\$375)

IC-1	65M	M	2 (1 deceased)	Evangelical	6,000 (\$180)
EC-1	30F	M	0	Evangelical	0
U-1	65F	S 1 split CU	9	None	0
MAR -1	26F	2 split CU	2	None	0
LU-1	29F	4 split CU	2	None	20,000 (\$600)

M=Married D= Divorced CU=Civil Union CP= Court Papers S=Single

Presentation of the Categories

This section represents the second phase of data analysis, *identification and categorization of descriptors and components* (Appendix I). The researcher created *Free Nodes* in *QSR N6* qualitative data management software. Eighteen *free nodes* were identified reflecting the categories and domains from the Culture Care Theory and the research questions for the study. All imported data were reviewed and coded. Coded data were classified according to the domain of inquiry and the research questions. Emic descriptors were studied within context for similarities and differences.

The 12 categories identified from the data analysis were *Worldview of Rural Dominicans, Respect, Destiny, Meaning and Expressions of Care, Role of Women, Role of Men, Machisimo/Machista, Professional Health Services/Systems, Folk Care and Practices, Professional Caregivers and Care, Noncaring Experiences in Professional Care, and Environmental Context and Concerns*. In addition to these categories, data were gathered to gain understanding of the context of rural Dominicans' lives guided by the domains of the Sunrise Model (Appendix A). The worldview or context of living for rural Dominicans was explored through meanings related to the Sunrise Model (Appendix A) and included *technological factors, religious and philosophical factor, kinship and social factors, political and legal factors, economic factors, and educational factors*. The following discussion will first explicate the

culture care worldview of rural Dominicans as generated by these domains of the Culture Care Theory. A full description of the findings in each of the categories and support from informant responses will follow.

Culture Care Worldview according to the Culture Care Theory

The context of rural Dominicans' lives was explored according to the theoretical framework of Leininger's Culture Care Theory. The Sunrise Model (Appendix A) depicts cultural and social structure dimensions which guide the discovery process of a society's culture care worldview. The following discussion will first present the theoretical domains and informant responses explicating them in order to provide contextual orientation to the culture care worldview of rural Dominicans. The findings in each of the 12 categories and support from informants' responses will follow this contextual presentation.

Kinship and Social Factors

"In the family there is unity. We all help each other. There is confidence and belief in one another. In the Dominican family, we can count on one another," affirmed key informant #M-1. Kinship or the relationships between members of the same family was a deeply embedded social foundation for societal functioning in rural Dominican Republic. The family structure was tight and it was the norm for couples in marriage or civil unions to live with the husband's family or on his property. Nearly all properties in this village possessed four or five households of related families. General informant #W-1 affirmed that 15 people live on his father's property. He mentioned that all the families eat together and share household and childrearing responsibilities. The circumstances were identical for every informant who participated in this study. When asked if this close proximity resulted in family disputes or

privacy issues, all 29 informants unanimously stated “no.” Communal living was clearly the norm supported by the informant responses and the researcher’s observations.

Kinship and Community. Loose property boundaries existed between families, but relational boundaries did not. Nearly all informants described close relationships with neighbors and villagers. Kinship was extended not only to blood family members and extended family, but also to neighbors. This may be, in part, due to the fact that most people in Villegas are blood related in some way even though distant. General informant #R-1 stated:

Most of the community here is one large family. They are all mostly related to each other which makes us family in blood, but we are also family as neighbors. A man in this village is primarily responsible to his family first, he must be a friend to his neighbors, and if your neighbor needs something, he should give it and try to live in peace amongst everyone. A woman must be someone who takes care of this town, and all the people in it helping to meet each other in need. You will find that is what we believe.

Key informant #MR-2 said:

Most of the community is one large family. They are all related in some way even if distant. {a small 15 month old boy runs across the yard to his lap. #MR-2 smiles and lovingly caresses and hugs him. When asked if this is one of his 15 grandchildren he says no, but the child belongs to a neighbor but practically spends the entire day down here with him}

Key informant #J-2 added:

The family is central, but in our case, it is not only the nuclear family. In our community, the family includes cousins, grandparents, great-grandparents, aunts, uncles, and sometimes a close neighbor. They are all part of our daily lives. They are all consulted

when we are going to make decisions. You always think of them and talk to them if you are going to make any decisions.

General informant #EL-1 stated, "If I am well and my neighbor up the street is ill, I would give something to my neighbor and sacrifice something to assist him even though he may not be in my family. That is how we are here." General informant #I-1 offered, "If I am sick and in bed, my neighbor will come and clean my house for me and care for me when my family cannot be here." General informant #FR-1 affirmed, "It is the primary responsibility of the family and children to care for someone in wellness or illness. If there are no children available, then we look for a neighbor." When general informant #IC-1 was asked if there existed boundaries or fences between people, he replied:

No, I do not understand that concept? We have never had a fence between homes of family or neighbors in this culture. If someone put up a fence, we would break it down! We would never use that here. Everyone is good here, we are neighbors, one big family. When my daughter died, the entire village came to my home to pay respects. There were 400 or 500 people here, many I did not know, including you. It is an honorable thing to have neighbors fellowship with you because they are your neighbors and we are one family whether we know each other or not. This is how we are.

The circumstances of the researcher supported #IC-1's statement. The researcher was asked to join the funeral gathering with the village for #IC-1's daughter. She hesitated, fearing her presence would be intrusive as she was a true stranger having never met the family. Upon arrival, she was taken straight to the mother and grandmother of the deceased and both grieving women immediately embraced her tightly, tearfully crying and repeating the words, "...thank you sister for coming today, your visit brings me peace even though my cup is empty."

Kinship and Health and Wellbeing. The concept of health was related to kinship. Key informant AL-1 explained:

I was born here and my family is all the way back to my grandparents. A person in good physical or mental health can give proper attention to their family. For this culture, a person is unhealthy if unable to give proper attention to the family. This is why good physical health is important, so we can fulfill responsibility to family.

General informant #SJ-1 offered:

The family should be with you in the hospital when you are sick. This is very important. There is mutual trust among family members. Let me tell you something, when the family is there, you feel better, you feel relief and you get better faster. When they are not there, you get sick and die quickly.

General informant #ET-1 stated:

It is very important to support my family and give them support when they are sick. But, I am not a doctor and I do not know how to heal him. I can only support him emotionally. Some people have a very serious illness. When you realize you are ill, you fall emotionally, if you have somebody with you who tells you that you are going to get better, even if you do not have faith that you will get better, it motivates you. The mind can help you get up and move and get on with your life and family members are key to helping family get well.

Key informant, #F-1 reflected on a previous hospitalization. He described the role of the family in illness as did other informants:

My family was there and everything was taken care of. My family's only function was to sit at my side. This helped me to get well. They were there the entire time. Some were

there while others were not, but there was always someone with me. They stayed all night long.

General informant #I-1 offered:

When I was in the hospital, my family tended to me. They were with me the entire time I was ill. My family washed me and helped me go to the bathroom. They made sure medicines were purchased and given to me. This is the family's responsibility when someone is ill. In this country, you must depend on your family to care for you and help you get well because there is a lack of resources. If you do not have family, a neighbor will help you get well.

General informant #IS-1 stated:

Yes, it is very important to have your family to get well when you are sick. They spoil you and give you strength to go on when you are there for childbirth and also in illness. It is very important! If your family were not there, you would feel sad and have less strength to go on. For example when they are not there, you feel depressed, and when they leave the room, you do not feel their support.

Key informant #B-1 said:

The family is central in hospitals and clinics when you are ill. They are there to make sure you are comfortable. The family is needed there to make sure that you really feel taken care of and you really feel taken care of when your family is there with you! The family is number one there!

Educational Factors

The educational level of the informants varied (Appendix J). The majority of key informants completed elementary school. One key informant was in her third of four years of

university studying to become a school teacher. Another key informant completed four years of university and was an elementary school teacher at the school in Villegas. One key informant completed four years of medical school, and another completed one year of hospital based nurses training after high school. The general informant who had university education completed two years of police academy training. The general informant with trade training completed one year of cosmetology after high school. Four informants were unable to read or write.

Completing high school and attaining trade or university education was supported by villagers and was seen as key to improving lifeways for rural Dominicans in Villegas. Key informant #MR-1 described his desire for his children to be educated. He said, "I want my children to know what is right and what is wrong and to have respect. It is also important that they study. I want them to be professionals because that is the future." Key informant A-1 said, "I am studying. I want to be a professional. I can improve myself and my life if I am educated. I will study 1 of 2 things...either psychology or maybe become a nurse." General informant #FR-1 stated, "It is important that my woman maintain the house and study at the same time."

General informant #U-1 had 9 children with trade or university educations. She said:

It is important for poor Dominicans to get an education. The only way out of poverty is through education and getting a good job. My children take good care of me and they can get me what I need because I encouraged them to go to school after high school. I raised them to be professionals. There are more and more young people getting an education then when I was young. There are more women getting educated and supporting their children. This community is beginning to understand that education is important, but I have known this for years.

Political and Legal Factors

Despite numerous political signs posted on doorways and trees in the village, villagers in Villegas denied extensive political involvement. General informant #C-1 stated he was a government appointed liaison between the current political party and the village. He explained his function was to bring village concerns to a regional council who later reports to country-wide government officials in Santo Domingo. General informant #SJ-1 identified himself as the deputy mayor for the village. He was appointed by the current political party to “oversee and report on community functions.” Interestingly, each of these men explained that talking about politics to me would not be appropriate and they could only share a description of their position. All other informants expressed distrust and corruption in the Dominican political system and its effect upon care. General informant #ET-1 spoke about the politicians:

They lie a lot. They lie a lot to get you in and once they get you where they want you to be, they forget everyone who voted for them and only think of themselves. Even those from this community who are poor, if they get a position in the government and they get money, they forget the people who were their neighbors before they were in a politically advantageous position.

Key informant #JD-1 stated:

Politicians only come for votes. That is not improving here. Politics in this country is not doing what it should to assist the hospitals and get clean water and help rural communities. Once they get their job, they forget about everything.

General informant #MR-1 equated politicians to *machistas* (men having more than one woman and/or more than one family):

There is no trust for politicians in this culture. Politics means empty promises here. Politicians are like men, we lie to women just to get them to go to us, so that is how politicians are. Ninety-five percent of men are machistas, and 100% of politicians are machistas!

Key informant #MR-1 spoke of the current elections coming in eight weeks:

Everyone is in it for their own convenience. In Villegas, tomorrow or next week, you will find two or three politicians who are promising water. They give you lots of water for today to get your votes. Everyone feels good for a day or two, but then the people are forgotten after the May elections. Four years of their power, getting money for their pockets! There is no caring for the suffering. This is why I asked you earlier if you are only going to Villegas because there are more towns with even poorer people with the same problems.

Key informant #B-1 described political influences on health care:

Health care is very bad. In public health care, they do not have anything we need to be taken care of. If we need anything like medication or something they should give to us, a poor man will have to sell his only cow in order to buy the things he needs. This should be given to us by the government or public health system. Sometimes, the priority is not human life, but rather it is your relationship with the party in power and the government. For example, I am sick and I go to the hospital and I am not part of that political party, they will not take care of me as good as if I were part of the current party. Right now it is good to be part of the PLD party.

Politics in the DR was most notoriously known for the dictatorship of Trujillo described in chapter II. Though Trujillo is notoriously known for torture and dominance, older villagers

spoke of him as a hero claiming less hardship during the era and preferred governance. Key informant #FP-1 said:

In Trujillo's time, you got sick and you would get any medicine you needed. The roads were fixed. Yes, he was a dictator, but as long as you obeyed his rules and did not rebel, you at least got what you needed. Now, with this government, there are no medicines. If I go to the hospital to give birth and I do not have any money, they would throw you out to the street after Trujillo left.

Key informant #B-1 said:

Some older people would say that when Trujillo was in power, there were no bums in the street and there was much less crime. From what I hear, he was a dictator, but the infrastructure of the government and the towns, he built it and it was good then. He practically treated his government like family. He put everyone he was related to in the government.

Key informant #MR-1 spoke about Trujillo:

I remember very little about Trujillo. I was only 20 years old when he died. I remember some but not many stories because I was young. We did not have freedom like we have now. He was from San Cristobal right here! I used to live next to his house! He was very respected and feared. Health care was better then and there was less crime.

General informant #U-1 added:

Trujillo died in 1961. He was a good man. You did not see so much crime as you do now. Some people call him a dictator, but I think he was a good man. Dominicans think all politicians are bad people, but there was no crime when he was the leader.

Economic Factors

The informants' monthly income ranged from \$60-\$2700 and the majority of incomes ranged from \$150-\$350 (see Table 1). The informant's occupations were agriculture, consultant, domestic, electrician, high school and university student, market sales, nurse (auxiliary/one year training), police officer, physician, political leader, school teacher, security guard, sodderer, and witch. Most villagers lived day to day and were unable to save money for future purposes. General informant #A-1 offered, "Things are hard, and I do not have any money now. My family ate today. I did not make any money today, so I will have to find work tomorrow." Key informant #M-1 and general informants #MW-1 and #WI-1 said they cannot save any portion of income and money is spent first on food then school expenses for children.

Rural Dominicans described economic causes for hardship and crime. Key informant #M-1 stated, "Everything is so expensive. Things are hard. These are very difficult times. Our burden is economic. It is hard to live in my culture for economic reasons." Key informant #AA-1 said, "...this is a wonderful country, everything is tranquil and it is a great place to be. The only thing is that it costs too much money and the economic situation makes life hard." Key informant #FP-1 stated:

Well, sister, I was born here and look at the age I am. I have always lived here and I do not know anything else. Sometimes it is very hard for those of us who do not have money. But for those who do, everything is comfortable.

Key informant #F-1 said:

Yesterday, I forgot to tell you, it is true that this is a good place to live, but you need to have money to live well. When a person has money, he lives fine here. It is a free country where you can go to the beach when you want, go out to the river and do things

with your family, but you have to have money to do these things. We do not have money so we have hardship.

Key informant #F-1 addressed economic factors and increasing crime:

As the economy gets worse in this country, the people are beginning to fear for their own safety. They need to be more careful when they go out at night and are afraid of being attacked or robbed in their homes. Much of this is because of the economic fall in this country.

The economic hardship contributed to suspicion and distrust of the government and political systems. General informant #A-1 explained, "Anyone here who might have money, it is because they got it corruptly through politics because normal people here do not have money. Politics is the way to trick and betray people to get more money." General informant #EL-1 added:

We have heard that the government gives money to the public hospitals to help people who cannot pay for prescriptions and extra expenses. So, we expect when we go to the hospital, if we do not have it, there is a fund that is supposed to be taking care of our needs. We never see that. You see, the government public hospitals get a sum of money from the government budget to run like a private hospital, but they do not because someone is taking all the money. We believe the government is paying for services for us and we are not receiving it. When we go and we need something and they cannot give it, we feel cheated. Another thing...when you have a paying job that is legal and you are on the books somewhere, they take out a social security. But, the government has always been under funded and they have never been able to pay social security. You work, they take it, but then they never have anything to pay you.

For rural Dominicans, poverty directly affected the quality of care accessed and received. General informant #C-1 said, "...the public system has nothing to work with, and in the private system the doctors have the money to get the things they need. The poor people do not have the money to get that." General informant #EL-1 said, "Here in the hospitals they do nothing for you. You only get help if someone in your family is nice enough to lend you the money." Key informant #FP-1 stated, "Doctors do not spend time sitting down and telling you what you have and this is what you need to do. Because I am poor, they pay no attention to me." Key informant #B-1 said, "...we did not get as good of care as we deserved because we were poor. The treatment is different for people who have more money." General informant #ET-1 described the effect of poverty on health care:

First of all, public health care is very bad and uncomfortable here. The people in Villegas are seen as badly dressed and poor and only first aid is given because the doctors and nurses are obliged to do that, but they do not give you the best care that you deserve. If I go to a hospital and my nail hurts, and I go in a great big car and am well dressed, they pay attention to me like I am a life or death emergency.

Key informant #AL-1 described economic affects on health care in one experience:

I went to the public hospital gynecologist, and she asked me what was wrong. I told her what was wrong and she put me on the table and did a PAP (Papanicolaou Smear). When the results came back, she knew I had a very serious infection and she also knows that I am poor, so she does not even bother telling me what is indicated because she assumes I cannot pay for it.

Key informant #F-1 explained:

Most doctors work in public and private hospitals. In the public hospital, there is so many poor people who the doctors do not have time and could never give the same care. When they come to the public hospital, they come late and leave early because they do not want to keep their paying private patients waiting. If you had a little bit of money, you could go and see that same doctor in a private clinic and he would treat you differently.

After being treated in a private clinic, general informant #MR-1 said, “They examined me. They treated me well because it was a private clinic. There is better attention because you pay! You are only treated well if you pay.”

The economic difficulties drive the emigration movement to countries of opportunity. The villagers described education to be a means to improve economic difficulties. General informant #EL-1 said, “I want to leave this country and look for something better. Many here feel this way. You only live happily here with money.” General informant #A-1 stated:

The woman who I am with begged me to get married. But, because she has family in the United States, there is a possibility that she may have a chance to go there or marry someone there. If she is free to marry someone else, she can give a life of opportunity to my daughters. We choose to live freely for an economic benefit in the future.

In regard to education’s perceived effect upon economic opportunity, general informant #A-1 said, “I hope we continue to move forward and not go back economically. I hope that each generation will continue to be more educated and move forward.” Key informant #AL-1 stated, “For me, I take a lot of pride in this community, but I know that for me to better myself and my economic situation, I need to better myself, my education, and move out into the Capital or United States.”

Religious and Philosophical Factors

Six informants claimed a Catholic religion, 10 claimed Pentecostal or evangelical, and 13 identified themselves as having no religion (see Table 1). The literature described the Dominican culture to be predominantly Catholic. Interestingly, many informants identified themselves to be Catholic but denied ever being in a church. It was possible a Dominican would state he is Catholic without identifying with the global Catholic beliefs, teachings and practices. General informant #U-1 stated, “We were born with the Catholic religion, but I do not have a religion or attend any church.” General informant #EC-1 said, “...almost everyone says here that they are Catholic whether they go to church or not.” Conversely, “practicing” Catholics who attended church regularly also exist in Villegas. Key informant #MR-2 stated, “All types of religions are here. There are some who say they are Catholic and there are some who are Catholic. Most healers are associated with the Catholic religion.” Key informant #G-1 described a Catholic practice for healing:

Oh yes, people are healed by their faith many times here! They make a promise and go to Higüey walking there as a promise for something for an ill person. There are ceremonies that are Catholic. During Passover, there is also a faith walk.

Key informant #FP-1, who identified herself to be Catholic and a healer described when she was given the power of healing:

The Lord taught me. I was sleeping and in my dream, I was going to a church in a nearby village in my dream. I ran into a small girl dressed in white and I did not see her hands, only her face. She grabbed me by my thumbs and I was afraid. She told me not to be afraid and not to tremble. I came to show you one thing, but do not be afraid of it. I was afraid anyway. She said come with me and I said walk in front of me. She grabbed me

by my thumbs and she said I came to show you some prayers. She showed me a prayer and said this prayer is for this illness and we kept on walking. She showed me another prayer and said this prayer is for this other illness and all the prayers she showed me she showed me what each prayer was for. At the end, when we were done, she said, you do not know me. I said no I do not. And she said look me in the eyes, and trembling, I looked at her in my dream, and she said look at me and I was very afraid. She said do not be afraid, I am Mary, the mother of our Lord, and I came to show you how to save the children. A lot of people have criticized me, but if someone comes to me with a problem, I am not going to let a child die because the Lord would be mad at me if I did. I think the Lord is grateful someone gets better after what I fix for them. I let them go without their pain. The scripture say we should give food to those who are hungry and water to those who are thirsty.

Pentecostal or evangelical informants described the meaning of their faith and a reliance on God for health and illness. General informant #I-2 said, "I put the Lord first before anything with plants and some things from pharmacies. Many times my prayer and God have given me my medicine or what I needed without going to the doctor." General informant #IC-1, a professing evangelical man whose daughter died only four days prior to the interview said, "...she died because God allowed her to die and anything done differently would not have mattered." General informant #ME-1 described her evangelical faith:

I have always heard that a water well cannot give 2 different waters. It is either salty or it is not. I think those people who are not one or the other, they are lost. They do not profess any significant commitment to the Lord. A Christian can be either evangelical or Catholic, but there are those who claim to be Catholic who do not believe, and to me,

they are lost. Just like my friend who lost his daughter (informant #IC-1), the bible tells us that there are things that we do not understand today but we will tomorrow. Your eyes get opened up later when this happens.

During the data collection period, a concept or phrase was learned called *synchrotismo religioso*. The researcher was unable to identify literature regarding this terminology. Three informants, university students, explained to the researcher that this term is used in Dominican education in order to teach students about the religion of the DR. Each of these informants identified *synchrotismo religioso* as the religion of the Dominican Republic. The informants explained the term means *to take a piece of many different religions and make one's own religion*. *Synchrotismo religioso* was present in the village of Villegas. General informant #W-1 said, "Of course, some people believe in everything. They are religious and believe in pieces of all different religions. There are many here who mix them." Key informant #B-1 stated, "There are some people here who mix everything from different religions. There are people who believe in anything and everything here." Key informant #G-1 described a spiritual party one village woman holds every year on the 3rd of May. She said:

There is a fiesta there. She is not Catholic, but she has an altar at the party. She cooks and has a party in the name of several Catholic saints. Everybody goes, they eat, drink rum and beer with loud music and fortune telling. There is drinking to Catholic saints, but this is not associated with the church.

Key informant #J-2 explained:

Almost everyone here has some form of religion. Some are Catholic, Pentecostal, Adventist and some with a mixture of that and traditional spiritual beliefs. In my case, I go to both the Catholic and evangelical churches. I visit each one so I can take the best

from each, but I am not a member at either one. You see, this is part of the idiosyncrasy of this culture. Some beliefs come from our interaction with Africans and Haitians.

Most healers are a mixture of religious and African influence and home remedies. There are different people, each with their own mixture of beliefs. We get the Christian influence from Europeans, the witchcraft from Africans and all is a mixture here. But, for the most part, witches are associated with evil spiritual influences.

Crosses of wood as statues in front of homes were not uncommonly seen. Over half of the homes have a cross in the front yard area. The crosses resembled tombstone marker crosses seen in the United States (see appendix K). Key informant #FP-1 had a cross in her yard. When asked about the significance, she said, "It signifies my Catholic faith and the death of Jesus on the cross. I am reminded of salvation when I look at it. It means my house is marked for the Lord!" General informant # U-1 who claimed no religion, had an identical cross in front of her home. When asked of its significance, she replied, "It possesses the power to keep evil spirits away. Everything exists here! This keeps the evil out of my home." Each home had the same cross but with different significance and meaning.

Technological Factors

Technology developments in rural Dominican Republic related to communication, transportation and electricity. Communication developments in rural areas involved the use of cellular phones. Of the 29 informants, three had cellular phones. No other informants had phone communications. Transportation developments related to increased use of motorbikes and cars. All informants unanimously reported motorcycles causing many problems with accidents. The village was filled with numerous motorbikes with up to seven people riding on one machine. There were fewer than ten cars in the village. Motor vehicle accidents were so prominent that

there was one 400 bed public hospital in the Capital that only accepted victims of motor vehicle accidents.

As mentioned in Chapter II, electricity dilemmas were countrywide. In rural areas, electricity was unregulated with many unprotected wires. Informants described technological factors related to health. Twenty of 29 informants reported to have electricity in the home. Electricity was primarily used for radios and lights. It was not uncommon to see an occasional refrigerator, television, or yard based electric washing machine (see Appendix L). The people of Villegas were concerned about the dangers of electricity and increased use of motorbikes. Key informant #AA-1 said, "Electricity is a major problem with accidents. There are many injuries here with motorcycles and many safety risks." General informant #ET-1, an electrician described the risks with unprotected and unregulated electricity use in the rural areas of the DR:

Electricity is very bad! It is a threat to our health and well being as it stands right now. Yes, it is good to have refrigeration for medicines or food, but there is more danger than benefit. I know electricity. I do not go and put it on any wire. I used to do that, but now I know what danger is in it. I know the theory now and know the industrial electricity, residential and many types. Some people do it with any wire and do not know the risks or dangers with it. Some people hook in not knowing what can happen. In time there are risks because it was not properly installed. High voltage can cause death and does cause many deaths here. They need to protect the way it comes into the house. I could have 50,000 volts in my hand because I know how to do it, and I am not at risk. But, some people with 110 volts in their hand die because they do not know the theory.

Key informant MR-1 explained why people tap into lines without protection:

Here you can walk in darkness and food gets spoiled if you do not have electricity. There are many electrocutions. We pay for electricity but still have to go without it for a period of time every day. It has killed lots of people! People without electricians connect to the power lines. They are desperate because they do not have electricity. They call the company who does not come, so they connect themselves.

Several informants shared a recent tragic death related to electricity in Villegas. General informant #U-1 said, “There are many electricity accidents. You have to be careful with kids who might get shocked or electrocuted by wires. Children die from this. I do not let my grandchildren near electrical wires.” General informant #SJ-1 explained, “There are large problems here with electricity. There have been lots of victims. There have been deaths. Fewer than 6 weeks ago, a young girl was electrocuted from touching her television antennae and she died.” Key informant #B-1 added:

Electricity is a killer here. Because of poor organization of wires, a month ago, a little girl was killed here. This was not the first time that it happened. There are many issues. People do not get electricians to fix things in their homes. Some home just tap into the electricity. When the little girl touched the TV antennae, she died. The lack of electricity can also affect the health of our people. For example, another woman was in San Cristobal giving birth. The public hospital lost electricity and because there is not generator there, the birth is in the dark and candles have to be used.

Phase II Categories

The 12 categories identified from the data analysis included *Worldview of Rural Dominicans, Respect, Destiny, Meaning and Expressions of Care, Role of Women, Role of Men, Machisimo/Machista, Professional Health Services/Systems, Folk Care and Practices,*

Professional Caregivers and Care, Noncaring Experiences in Professional Care, and Environmental Context and concerns. A full description of findings in each of these categories and support from informant responses will follow.

Worldview of Rural Dominicans

The rural Dominican worldview was rooted in *familism* or a strong attachment and identification with family members. The rural Dominican's frame of reference for caring, care beliefs and practices, daily functioning and decision-making was embedded in nuclear and extended family relationships. Key informant #FP-1 stated:

Family is everything. It is the most important and central thing to this culture. When the family is together and very close, this is beautiful! Life is lived for the family and it is a blessing when the whole family is together. We make decisions by consulting family members, close and extended. Family is the basis of our society. Family is central to everything all over this country.

Family relationships were characterized by male leadership, interdependence and loyalty within family units. There was a family hierarchical structure which included the concept of "machisimo." Rural Dominicans tended to remain in close proximity to extended families in the village. The family unit consisted of extended family and also "non-blood relatives" or close neighbors. General informant #IC-1 described what constitutes family in the village:

We are all good here! If you need anything, you can just go to your family. Everybody is present and very close. Family is most important here. The neighbors are your family, too. They all help each other, they all help me here. We are all family. That is how it is everywhere. Everyone is related by blood or no-blood here as family.

The *familism* paradigm was shifting in the rural Dominican population in regard to male leadership. There were Christian men denouncing the concept of “machisimo.” General informant #ME-1 stated:

Machistas are very common here. Most men have more than one family. Most have two and even three. But there are many men in the church who have only one wife as God intended it. Having only one wife or no wife is what God wants and what is right.

Due to economic opportunities in the largely “westernized” capital city of Santo Domingo, younger villagers were seeking education and employment in the city and assimilating with more Western ideology. Some rural women were seeking employment and education and verbalized less submissiveness and an increase in power and decision-making. Key informant #J-1 described how the roles for women have changed in the village:

People have become conscious of education and opportunity in the Capital and the US. When I was a little girl, I remember things used to work in a different way. Women had less freedom than they do now. Women did not make decisions and had only domestic opportunities. People have been learning that education will bring economic opportunity and women have begun, and I say only just begun, to gain independence. It is changing some.

During the time of this study, both the traditional worldview and values and westernized values regarding male dominance and the societal role of women and education were present in the southern rural Dominican community.

Spirituality was also central to the Dominican worldview. Thirteen individuals identified having no religion, but all 29 informants verbalized belief in spirits and supernatural powers for

healing, relationships and daily events. General informant U-1 described spirituality in the village of Villegas:

We were born with the Catholic religion. If you asked most people here what their religion is, they would tell you Catholic. There are also a few evangelicals. Those who state Catholic only say that because we are born with it and most have never been to a Catholic church. It is the belief here, apart from the evangelicals, that everything exists! All spiritual realms exist and we believe in many spiritual influences apart from religion.

The aspects of family and kinship, religion and spirituality will be described in further detail later in this chapter.

Respect

The concept of respect was central to the value and belief system of rural Dominicans. Respect was mentioned 81 different times throughout the interviews. It was important to show respect to a spouse, the elderly, the wealthy, and community leaders. Key informant #AL-1 stated, “respect is everything, without respect there would be nothing.” She later described showing respect to someone as “doing things the way they would be best for both people involved and not just myself.” General informant #C-1 described respect in spousal relationships, “I suffered a lot because of my father having many women. I love my children and it helps me to be responsible and respect my wife because nobody respected my mother.” General informant #A-1 stated, “...it is important for a wife to show respect for her husband by being quiet about what goes on in the home.” General informant #ET-1 was the only divorced informant. In regard to respect in marriage, he offered:

It is very important, respect! For example, in my case, you should respect everyone and anyone no matter what their age. When you feel that you deserve respect and they do not

respect you, you are hurt very deeply. I got married, and my wife and I are separated, because of respect problems. I am a Christian, she is not. I deserve respect. If you cross that line or rules in society, then you are not showing respect.

It was essential to show respect for the elderly. Key informant #F-1 shared, "I respect anyone older than me. It does not matter if they are family members or not. My parents raised me to have respect for others who are older than me and it does not matter who they are."

General informant EC-1 said, "We like to care for our elderly. We care for the elderly in our families and we treat them better than anyone else. We show them respect." Key informant #JD-1 was asked to validate respect being a central concept to the value system of the rural Dominican culture. She stated:

Respect is most important to be show to the elderly. They are good. They give counsel and it is almost always respected and obeyed. We would never challenge the counsel of an elderly person because this would be the ultimate disrespect...I am very rigid that children learn to respect their elders! This is all elders in our culture, not only the ones in the family. I want them to respect all older than them from the time they are young. You will find that this is the belief of all people here.

The Dominican informants shared a common belief that respecting those with money in the village or outside the village is important in the possibility of needing some financial help from them in the future. The villagers described circumstances of individuals in the community who are respected because they have money and have helped people when they were in need. General informant #A-1 confirmed, "You give respect to the ones who have money because they can help out the ones who do not."

Finally, respect was noted to be associated with community leaders. The informants from Villegas identified three families who were known to be community leaders. Only one of these families was politically associated. The informants described the families as leaders because they assisted others in solving disputes and offered financial assistance to neighbors in need. General informant #A-1 was identified as one of the community leaders. He affirmed, “I am always the one trying to help others make peace, and for this I am respected.” General informant #W-1 spoke about one of the respected families. He added, “They are respected because they help the community, they are very serious, they have never had a problem, they have always worked, and none of them are delinquents.”

Destiny

Many Dominican informants described living lives according to destiny. For rural Dominicans, destiny is the belief that events are determined by an impersonal fate and cannot be changed by human beings. In the village of Villegas, several informants claimed to live their lives according to their destiny. This was not true for all informants. Other informants reported that the fatalistic view is decreasing as more people are becoming educated and making active decisions about life circumstances. The majority of data supporting the existence of living according to destiny in the village were regarding the issue of men having many women. Many women stayed in spousal relationships with men who have multiple women even though they are hurt and disapprove. Several informants related this to economic dependency rather than fatalistic reasoning. When asked if some women stay in households which are abusive and a man has several other women, key informant #G-1 stated, “...that depends on the level of education she has, if she makes a change in her circumstances. Some women stay because they think it is out of their control.” Key informant #JD-1 stated:

We have a word, conformity. People here are very conforming. This is how it is here. Many people conform because they think their lives are lived according to destiny. Some people are optimistic and fight for what they believe in and some other people believe in the word of God and their hope is set in that. There is still very much conformity to the way things are here today, though. There is the biggest change for women. Before, a man could have five or six women and battered them and she would accept it. He, the man, had the right to be on the street, but today a battered woman had an option to talk to the police.

Key informant #J-1 stated:

Ninety percent of men have two or three partners in this village. The women who accept this, it is because they have become used to it. They have seen it going on for a long time and they do not like it but do not think they can do anything about it. They have apathy and feel it is out of their control.

A male key informant #MR-1 spoke to the issue, “Many men have two and three women here. If he wants another he just takes her. Women know that and they just accept it here. There is nothing they can do about it. That is just how it is.”

Fatalistic or deterministic thought was reported by religious informants. One Catholic key informant, #FP-1 related her health status to destiny from God. She had been recently ill with typhoid fever three times and despite being aware of available treatments, she did not seek care because her recovery is “up to God and nothing can supersede that power.” General informant #IC-1, a Pentecostal, suffered the death of his 23-year-old daughter during the data collection. She was previously healthy and hospitalized for facial edema for 27 days. On the 27th day, she died in the hospital of unknown causes. In discussion of his daughter’s recent

death, he tearfully explained, "...we showed her all our care and all our love. We told her not to be afraid. She parted because it was God's purpose. If that is God's purpose, nothing can be done in any treatment to change that."

Meaning and Expressions of Care

Nearly all informants described *showing respect* to be the best way to express care to rural Dominican. When asked for the best way to show rural Dominicans one cares for them, nearly all informants, key and general, replied, "by showing them respect." It was noteworthy the numerous times the word *respeto* was stated throughout the interviews. There was a strong connection between the concepts of *respect* and *care* expressed by informants. This section will highlight the ways respect and expressions of care are best shown to rural Dominicans from their *emic* perspective.

The meaning and expressions of care for rural Dominicans revolves around the concepts of relationship and service. Numerous informants described care to be expressed or understood through spending time with an individual and establishing a relationship. Key informant #F-1 said, "When people sit and talk with you, that is a way someone would show that they care for you" and later affirmed, "you have given me nothing, but I feel we have built a relationship and I care about you." General informant #IS-1 expressed to the researcher, "...you talking with me makes me feel good and like you care for me" and key informant #MR-1 said, "...by just sitting here with me and by visiting me here, you show me that you care something about my country and Villegas." Key informant #AL-1 described a woman who is considered to be a leader within the village:

It is clear to the rest of us that she cares for people in Villegas. She works to establish a relationship with people here. We know she cares for us, her neighbors, because she

visits in our homes and spends time and has relationship with people. The relationship is most valuable to us. There is confidence in her and she is a caring person.

General informant #C-1 stated, “people who care for me sit down and talk to me personally. They sit down and listen to me.” Later in the interview, he reiterated:

When someone comes into this community like this to just sit and talk and listen to the people, it means so much! Some days I wake up and I do not know what purpose I have. I just sit in a chair. But, knowing you were coming to ask these questions made me very excited and something to look forward to for today, and then I can know, by what you are doing, coming into my poor community and just sitting among the people and listening, establishing a relationship with me, you care about me and my community.

General informant #ET-1 responded similarly:

It is good that some people are interested in knowing how we live because that makes us feel cared for and that we are not forgotten. This lets us know that some people care about us. Many people come and go, but they do not spend time with us, get to know us as you have done. It is very important that people like you come here because they only come to the beaches and resorts and do not see how people really live.

General informant SJ-1 described the way families shows family members that they care about them when they are sick and in the hospital. He acknowledged:

Family members show they care for others in the hospital or when they are sick by sharing their pain and letting them know they are there for them by sitting with them and listening to their cries of pain. You let the sick person know that if they need you, you are there and you really are. By someone being with a sick person and staying with them that means you care for them.

Other expressions and meanings of care were related to acts of service or helping someone in need through service. General informant #I-1 offered, "When I am sick in bed, my neighbor will come and clean my house for me. That shows me that she cares for me." Key informant #J-1 said care is expressed through "lending a helping hand to someone when they need it." Key informant #B-1 described care expressions through service:

To show you I care for you, you could stay at my house. We will cook for you. We will sit and talk with you and tend to what you need in any way we can. If you are in need, we could cover your need and show you we care for you.

General informant #C-1 described an expression of care for a nearby poorer village:

I can recognize when I see someone treat someone well or do something for them, I see that as showing that they care for them. There is a very poor community down below. Even though we are poor too, we take food there because even though we do not see them as family, we still show them we care for them.

Key informant F-1 added:

When someone does something for you, you feel cared for. I know that my sister-in-law cares about me because when I am away for work and I return home, she goes to my house and asks for me. She may make something outside of the normal every day food and bring it to me and this demonstrates she cared for me. Also, when someone gets sick, and they do not have the money to get medicine from a prescription, if you have the money and give it to them and go fill the prescription, this would also be a demonstration of caring.

General informant #SJ-1 described his ways for caring for his elderly mother. He said, "I take care of her. I go and buy her things and I go see her five or six times each day. I try to buy her

everything she needs and do the household services.” He later described a previous mayor to be caring because of the things he did for the village in getting roads paved and more water supply. He stated the mayor was perceived as caring for the services he performed.

Role of Women

Women were primarily housekeepers and tended to household needs in rural Dominican culture. By 9AM each morning, women retrieved water almost one mile outside the village for cleaning their homes. Cooking for the evening meal took place after cleaning. Children attended school in the morning, afternoon or evening session for four hours. With recent developing educational opportunities, many young women finished high school and remained at home to commute to university classes. Women shared responsibilities caring for elderly and children to complete educational programs. The role of women is changing from the past with more women working outside the home. General informant #I-1 described the change in the role of women by her statement, “women are primarily responsible for attending to their home, husband and children, and grandchildren. But, now they can go to school and work outside the home so things are different then when I was a young woman.” A male general informant #MA-1 described the role of women in the culture when he said, “Some women are dedicated to tending their homes. Others have to go to work outside the home. Others are professionals, and others work in family homes.” Women in Villegas verbalized sacrifice and hardship with maintaining household responsibilities along with employment or higher education.

#AL-1, a 27-year-old female key informant described the current role for women in the culture:

A woman has many functions. In this community, there are women who need to work in different places. Some may work in the Capital city and some have to leave outside the

city to New York or Spain. From up here, in this small village, women have gone to these places to work and earn money. There are women who have become professionals, teachers and nurses. Some also end up dancing in bars. But, there are also women who do not go to school and only look to have a man and a house. Women work because it is a way out. Women also do all the domestic work in homes. For women who are employed it is difficult to manage all of this and also complete the role of a mother. The mother sends the children to school, shows them love, and meets the needs of the children. Myself and my friends, other women who desire to be professional and also have children, we want to better ourselves and reach higher for our children.

Another 34 year old female key informant, #B-1 stated:

In my father's time, the women used to sit and listen to everything the man said. This is what women lived to achieve. This is because women could only stay at home and they had no choice. The man was the only one who worked. Now that women work and can provide for their families, they do not stand for being mistreated because they can fight for their rights.

Key informant #G-1 described the difficulty of maintaining domestic and educational or employment responsibilities:

My sister stays home with my children so I can go to school and when I am finished I can help her also. Right now, women are starting to get an education, some of them here. The women have to work twice as hard because when they get home they have to cook, they have to iron, they have to clean and take care of the children. The woman works two jobs and the man works only one. It is a burden for women here. The women in this village try to help each other. Women have friendship and help each other.

Role of Men

Men in Villegas primarily worked outside the home and village. The men who worked in agriculture may work in the village or by selling harvest items outside the village. Men departed for employment activities before 8AM and most return by 3PM each day. All male informants denied possessing domestic or child care responsibilities. Male informants claimed role responsibilities of leadership and providing financially for their households. Female informants also described the male as head of the family unit except for single mother households. Men described women as caregivers for children, but it was commonplace to see men carrying children, delivering them to evening school, and holding and playing with small children while sitting in chairs around households. Key informant #F-1 denied male care responsibilities for children in the village but he stated, "I feed them and listen to them when they are hungry. I take the children to school on the motorbike and go pick them up on the motorbike."

Male leadership was predominant in marriage and households. General informant #C-1 described, "Even though men and women have different roles, men are the head. The woman is a head of the household in a few cases when a man has left or if a man does not stand up and does his responsibility of providing for his family." General informant #MA-1 said, "I am the head...the man is always the head in a unified front with his wife," and another general informant EL#-1 stated, "My woman and I try to agree and make decisions together. I throw it out there, and she gives a response, but if she does not agree, I decide anyway because I am the head." General informant #R-1 described the role of men to, "lead his family first, be a friend to his neighbors and be a faithful person." Female informant #Y-1 confirmed, "The role of the man in this village is to be the leader of his house and take care of his family." A 70-year-old

widow, general informant #I-1 stated her eldest son is the leader of her household and he makes all home decisions for her after the death of her husband.

Men and women claimed financial responsibilities in the role of men in the rural Dominican culture. Key informant #J-2 offered, "...yes, there are many homes in which the woman is doing the man's responsibility and is providing financially and supporting the whole family." Key informant #B-1 said, "Though it is rare, sometimes a woman will go to another man because her man does not want to support the family financially, so she will go to another who will support her and her children." Key informant #AA-1 described the role of men in the village to "be a socialite, not be delinquent and to attend and provide financially for his family." General informant #C-1 stated, "Men first need to know God. Second, be responsible and earn money to take care of his family, and thirdly, be humanitarian and globally aware to wherever there is a need" and general informant #EL-1 affirmed, "I am responsible to earn money to maintain my wife and children. I am responsible for my woman and children and my parents."

Some male informants perceived the changing role of women in the culture to be a positive change, while some perceive it negatively. General informant #EL-1 expressed his disliking to women's roles outside the home. He stated, "The wife or woman is the one who helps out at home. She works at home. She should have no other role" and Key informant #F-1 said, "Women should take care of the home and maintain the home. This is how we see it but there are many men and women who do not see it that way...other men even make their woman work outside the home to get more money." Key informant #MR-1 verbalized no purpose for women outside the home and said, "...no, I cannot believe there would be any reason for a woman to work outside the home." General informant #R-1 concluded:

A woman is responsible to complete the commitment to her husband, her home and her

children only. She is to take care of her children, give them their education, not to the school...meaning their primary education of how to behave and act. She is responsible to her husband to maintain his clothes, make sure he has food and give him sex.

Conversely, #FR-1 offered, “My woman is to maintain the house and go to school and study at the same time. Her studies will provide opportunities for our children in the future.” General informant W-1 added:

A woman who is completing a good social role in her town is a woman who is respected, attends to her home and her children. She can work or go to school if it does not bring conflict to the care she is responsible for to her children and her husband. Women who put work or school over their children bring more damage. But, a woman does not need to remain in her home as a slave to the domestic things. She can work and study and have opportunity to finish her studies. Sometimes, in this village, the man puts the entire burden on the woman in the household. Men are prideful and the majority of men do not like their woman working outside the home.

Machisimo/Machista

“Machisimo” is a noun of Spanish origin identified with predominantly Hispanic culture and refers to a prominently or exhibited or excessive masculinity (Wikipedia, 2006). The derivative *machista* comes from the Spanish word *macho* meaning “male” or “manly”. Depending on the country, *machistas*, or males demonstrating *machisimo*, are viewed with either respect or disdain. In the Dominican Republic, some men are referred to as *machistas* and were not associated with honor. They were viewed with disdain.

Machisimo was prominent in rural Villegas. Key informant #B-1 stated, “Machisimo is all over this village and other villages in this country. There have men who have two and three

women.” Key informant #FP-1 acknowledged, “Machistas have two or three women, these men are not responsible.” Key informant #G-1 said, “Machismo is when men can have other women but women cannot have other men. It is prominent here. There is an attempt to move away from it, and it is decreasing, but ninety-nine percent of men are still machistas.” Key informant #J-1 added, “...machismo means violence as well. Men put their will up violently against women. It is very common here. Most men have more than one family and many have two and even three.” Key informant #MR-2 described a machista as “a man who believes himself to be superior to another. He has two, three, and four women.” General informant #SJ-1 described a machista:

A machista is a man who says you have to do everything that I say. You cannot make any decisions without me. There are many here. A woman cannot ever go to another man but the man can have as many women as he wants. This is true of most men in this country.”

Key informant #JD-1 described machismo:

Machismo is like this...what I say, that is what you do because I am the man! He makes the decisions based on what he wants and violently enforces it because he is bigger. Ninety-nine percent of Dominican men are machistas! They do not understand that the world is moving forward, with all the technology the world is moving forward and they do not understand that. Here it is a way of life. Trujillo was a machista! He was an ogre. He wanted all three sisters; he was very machismo! Lots of men are machistas. They believe that you cannot contradict them in anything you say. They get mad if you do and there is less hitting of women, but it still happens.

Men in Villegas had opposing views regarding the acceptance of machismo. Some men, particularly those claiming Christian religion, renounced men having multiple women and violence against women. Other men described being a machista as a way of life without any significant consequences. General informant EL-1 said, "Men are just that way. They should all have at least one woman in the street to be happy." Key informant #MR-1 acknowledged having a wife and other women in the past and most of his adult life. He stated:

Most men are machistas here. Having a sweetheart on the side in this culture has nothing to do with loving the wife you love. I do think it is selfish now that I am older, but it is a way of life. The children from both women get along like brothers and sisters. The man feels good when the women are fighting over him, he feels strong and important!

General informant FR-1 stated:

If your wife is not willing and ready for you and doing what you say, then you just go and find another one. I have one wife, but I have other women when I want some sex. I do not call them regulars. Men have up to three women and I do not have any children with these women because they are for sex.

General informant #EL-1 concurred, "...since I am providing the money, I can have as many women as I want." Additionally, general informant #R-1 said, "I am with other women, but I do not want my wife to know that because it would hurt her feelings. But, she does know about one and this is why we fight, but there is nothing she can do about it." General informant #A-1 explained:

You have to be responsible like me. If you see a woman who you want, when you go to her, you go prepared with stuff to protect yourself. But, there are men who just see a woman, lay her down, who do not care what she has or what she does, and these are the

ones who get caught with kids. Responsible men know how to have lots of women without lots of kids.

Men who opposed machisimo also expressed their views. General informant #SJ-1 stated, "...pigs always look for mud, and when I say this I mean that men with divided houses because of machisimo affiliate with others like themselves." General informant #ET-1 explained the Christian influence:

Because I am a Christian, I have a different view than most men, but there are other men like me here, too. What machistas do in this country is wrong. The Dominican man is very machisimo. They believe that women do not have the same rights that men do. The woman should follow everything the man does in every situation except he can also have more women. I do not believe this is what God intended, so I believe it is wrong.

Women in Villegas openly spoke out against machisimo in the culture and described fear of consequences for engaging in relations with other men. General informant #IS-1 explained:

There are many men here with two families. These machistas do not leave the other woman even when the women fight. The man goes from one house to another...sometimes both in the same week! This is upsetting for women and if a woman did this, she could be killed.

Key informant #J-1 stated:

If it were up to us, men would have only one woman, but it is not up to us. Women fight over the men when they are with two women. He can do it but she cannot. Many women are afraid of being harmed. Women get very hurt and angry here.

Key informant #M-1's husband has other women. She explained, "I do not like that my husband has other women, but he does. Sometimes I fight, but he will not stop. It is very hard for a woman when her husband goes to another."

Consequences of machisimo in rural Dominican Republic were described. Besides broken relationships, there are economic consequences and children experience difficulties. Key informant #JD-1 lived with her mother while her father lived most of her life with another family. She explained:

Machisimo affects the children. They think dad is leaving and he is not going to love me anymore. Their grades are affected. They think they are going to get a divorce if they are married. My father is not good because he is with women all the time and cannot provide for me or my sister due to all of his children.

Key informant #G-1 described problems with machisimo in the culture:

One of the main problems is that the education will not be the same for all of the children involved. If there are three children in one family and three in another family, their education cannot be the same for all of them. The brothers and sisters do not get along well because of this and the communication is not good between them.

Key informant #AL-1 said:

Machisimo is deadly! It is the primary source of conflict here. It is not only the cause of disagreement, but it is the cause of suffering for the whole family. Even if a man were a government official, he would not be able to sustain both families the same way.

Because, to complete your family obligation is not just to provide food. I am a daughter of two families. My father had two families. With my mom, there were six children and the other family had seventeen children. It was very close to my house where my father

stayed with the other woman at the other house. The primary relationship was with the other woman, but both women loved the same man. He was in love with the other woman. Both women agreed because they were both in love with the same man. I would never allow that because I wanted to grow up with a father! As an adult, I do not feel as sad anymore, but I felt sad my whole life as a child because of this. I wonder what I might have reached today had he only one family.

General informant #C-1 was also a child of a two family structure. He added:

For me, machisimo is very bad. A curse! My father had another family, there were eleven by my mother and eight by another woman. My mom had hard work, my father never had a good job and we were such a poor family. For every peso that came into the home we had to split it in half, one for us and one for them, so the family was always struggling. I am the oldest and I had to help my mom a lot because she kept getting pregnant. I could not study because I had to help my mom who was always pregnant. I could not be afforded the opportunity of school. So, I think it is a curse!

Professional Health Services/Systems

The delivery of healthcare systems in the DR was managed by three systems. The first system, the public healthcare system is administered and subsidized by the government and served the majority of the population. There was a large public hospital in San Cristobal 10 miles south of Villegas. The services were free of charge and offered to all people in the country. The second system, the Social Insurance Service (SIS), covered the healthcare needs of workers enrolled in the social security system. This included teachers, road workers, and most individuals employed in schools and hospitals. There were some informants who have SIS insurance and used SIS health services and hospitals in the capital city of Santo Domingo. Third,

the private system, administered by private health insurance schemes served those who could afford to purchase insurance or services. The private systems served the upper, middle, and lower-middle classes. No individuals in Villegas possessed private insurance. Private hospitals required payment before services were delivered for any individuals who did not have private insurance.

In general, villagers were dissatisfied with public health care that is free to them at the point of entry in San Cristobal. Informants described government influences that are corrupt and affect healthcare services and care. Rural Dominicans preferred private care and shared moneys in order to obtain care in the private system. Dominicans sought professional services for traumatic injuries and apparent life or death emergencies. Folk healers and home remedies were used for non-emergent healthcare needs and when professional medical treatment was deemed ineffective. Folk healers and remedies will be discussed in a later section of this chapter.

General informant SJ-1 described the Dominican healthcare system to be “very bad and not functioning well.” General informant #C-1 described the view of the current healthcare system:

The healthcare system is not good here. There are good intentions but the care and services are extremely bad. Many people die for unexplained reasons. The doctors and nurses in the public system have nothing to work with, but in the private system they have money and the things they need. The people in this village do not have the money to pay to private hospitals to get the good care that we need.

Other informants expressed a negative influence and corrupt connection between politics

or political parties and government subsidized healthcare systems. General informant #I-1 stated, “public health care is depended up on how much interest the party in power gives it.”

General informant #R-1 added:

The big public clinic, even in the Capital gave me a very bad experience. My experience confirms to me that politics has destroyed our healthcare system. The political parties, when they are running, will do parties, when they are running, and make promises and take peoples’ voting cards. They make promises to them that they will get good health care if they vote for them. If you vote for them and they get in power, they act like they do not know you and forget their promises to improve the hospital. Politics is based on a lie and what I expected to receive in the hospital did not happen.

Key informant #M-1 explained reasons for avoiding the government public hospitals:

We try to avoid the government system. I would rather have other health care than go to the public hospital if there was a way. If you are not of the political party that is in power, they will not help you. That way they know if you are in that party is because all the people are registered an the people in the clinic know what party you voted for. So, when you go to the clinic, people know that you are not of that party and they give bad care. Political influences have destroyed the public system.

All informants who discussed the differences between private and public healthcare systems described a preference for private systems and better care received in the private system.

Key informant #AL-1 described, “...it is true the private clinics are very good. In the public hospitals the care is very bad” and key informant #B-1 affirmed, “I would say that most people here believe there needs to be more development in public systems. I do not know any person who would say the public system is satisfactory.” General informant #MA-1 said, “You can

always expect a lower grade of care in a public hospital.” Key informant #JD-1 had recently completed medical school training in the private and public sectors. She stated, “There is no lack of resources in private hospitals. I worked in public and private hospitals for three years and say a great difference between them.” She explained her greatest concern, “There is no handwashing in the public system. There is much infection and surgical brushes are shared and re-used before surgeries because there are not enough.” General informant #ET-1 explained his perception of the public health system:

First of all, public health care is very bad and uncomfortable here. The people in Villegas are seen as badly dressed and poor and only first aid is given because the doctors are obliged to do that. They do not give you the best care that you deserve because it is public and we are poor. The treatment is different for people who have more money or are associated with the government party. The girl who died this week in this village (a 23- year-old presumed dead from “swollen face”) was a victim of the public hospital. The doctors did not do the necessary studies to determine her illness so when they finally got to treating her, the only report back was that there was nothing else to do for her and so she died.

Key informant #J-1 described a public hospital scenario:

Some patients in the public hospital in San Cristobal die without ever being examined. In San Cristobal, the care is very bad. They were going to fire some doctors from the hospital there because there was a pregnant woman who was there and crying the whole time because she was in pain and in labor. The doctors said, “When you were making that baby you were crying like this were you.” They were mocking her and made fun of

her. She died in childbirth. That was seven months ago and now her family is here alone.

Informants who experienced care in the private sector described satisfactory and good care. This was evident when #A-1 stated, “it is true private clinics are very good,” general informant #U-1 said, “private hospitals have the best care,” and general informant #W-1 added, “I finally went to a private institution where I was cared for and given what I needed and got better.” General informant #MR-1 said, “They examined me. They treated me well because it was a private clinic.”

Villagers in Villegas described sharing of resource and money to obtain treatment in a private system when possible. Key informant #AL-1 said, “I take a loan from my family if I need it in order to get care in a private hospital,” and key informant #F-1 said, “we start within our family to find the loan for money to get care in a private hospital. Sometimes, when the private care is an emergency, people in the village have to go outside the family to ask for money.” Key informant #B-1, a teacher with SIS insurance, said she usually goes to the SIS hospital for care in the Capital, but the care is almost as poor as the public sector. She said she will try to get money to go to the private hospital whenever she is able. General informant #EL-1 added, “...you can only get the care you need in this country if your family is nice enough to loan you the money to pay a private hospital for care.” Key informant #M-1 concluded:

If I get sick or my kids get sick, I pay for better care in the private hospital when I can. If my mother or grandmother gets sick, all of my brothers and sisters get together and pay the private hospital so they will allow her inside and treat her. We do not take grandma to a free clinic where she would not be respected and treated well. Everyone has to come together and pay.

Folk Care and Practices

Folk care practices were widely used in this area of rural Dominican Republic. Informants described witches or *brujas* in the village, non-witch associated healers, and many home remedies. In this section, folk care practices will first discuss the use of home remedies, then folk beliefs related to nutrition and behavior to maintain lifeways. Next, a discussion of *brujas* and curses and non-witch folk healers will follow. Finally, the rural Dominican's decision to seek folk or professional care will be described.

Home Remedies. Key informant #AA-1 said, "We have many home remedies for fever, headache, colds, stomach problems and lots of teas" and general informant #EC-1 concurred, "the natural remedies we have are better than medicine." Key informant #FP-1 offered:

People say that we have all the medications we just do not know what is in the plants. I have a grandchild who is studying medicine at university. The plant depends on what illness is needed to be treated. If someone has bronchopneumonia, you can take different leaves for it.

General informant #MAR-1 stated:

Home remedies are used much here and people do get better! For strep throat, my mother makes a sebum that you can get at the pharmacy and you can heat it up. It has a seed with it also and for nine days my mother prays and uses this wax and it works. They get better. They go to hospitals and doctors and they do not get better, but with my mother's treatment, in nine days it is gone.

There was a wide variety of plants, fruits and concoctions made in Villegas to treat illness and maintain lifeways. Table 3 summarizes the key and general informants' descriptions of home remedies and folk treatments used in the village.

Table 3- Summary of reported home remedy use in Villegas

Item	Synonym/ description	How used	Treatment
PLANT			
Anamun		Boiled in tea	<i>Allergies or Congestion</i>
Amor Perfecto	“Perfect love”	Boiled in tea	<i>Impotence</i>
Berro Leaf	Watercrest	Boiled with chives and honey to make a syrup and blended with a radish	<i>For colds</i>
Bija		Boiled in tea	<i>Fever reducer</i>
Bruca Prieta		Mash it, gargle the leaf mashes and spit it out	<i>Sore throat</i>
Cayena	Dominican flower	Boiled in tea with lemoncillo and juana la Blanca 3 middle stems of this flower with 1 cooked coconut flower	<i>Cough</i> <i>Cough</i>
Coconut Flower		Cook 1 flower and add 3 middle stems of cayena flower boiled in tea	<i>Cough</i>
Escobita blanca	Broomweed	Pull it out with all its roots, wash it and boil it to make tea	<i>Fever in children and antidiarrheal</i>
Guata Pana	Ginger root	Boil in tea and gargle it	<i>Sore throat</i>
Hair of the Corn		Used in mamajuana	<i>See mamajuana concoction</i>
Honey	Honey	In anything as desired	<i>Improves taste of home remedies</i>
Juana la blanca	Juana the white; AKA “blanki neta”	Boiled in tea Boiled in tea Boiled in tea with lemoncillo and cayena	<i>Antidiarrheal</i> <i>Vaginal infections and irregular menses</i> <i>Cough</i>

		Boiled in tea	<i>Drink it 4 days for a 4 day period, drink it 5 days for a 5 day period (etc)</i>
		Boiled in tea	<i>Kidney pain</i>
Lemoncillo	Lemoncilla	Boiled in tea	<i>Cold and runny nose</i>
		Boiled in tea with juana la Blanca and cayena	<i>Cough</i>
Marbi	Sweet potato root	Used in mamajuana	<i>See mamajuana concoction</i>
Orange Leaves	Orange leaves	Boiled with Guanava in tea	<i>Fever or allergies</i>
Oregano	Oregano	Boiled in tea	<i>Gas and upset stomach, slow digestion, and anti-diarrheal</i>
Peiquito	Small tree; English translation “little dog”	Used in Mamajuana	<i>See mamajuana concoction</i>
Rompe para guey		Take a shower or bathe in it	<i>Removes evil eye curse</i>
Sour Orange Root	Sour Orange Root	Used in mamajuana	<i>See mamajuana concoction</i>
Tuatua	Physic nut plant	Boiled in tea	<i>Children upset stomach</i>
Uka Root		Boiled in tea	<i>Kidney pain</i>
Zebula	Aloe Vera	Leaf drippings	<i>Topical for skin irritations</i>
		Mix with beets, molasses, carrots	<i>Vaginal infections</i>
		Make into ovule for insertion	<i>Vaginal itching and hemorrhoids</i>
		Drink drippings	<i>Helps hepatitis</i>
FRUIT/VEGETABLES/ OTHER			
Ajo	Garlic	Placed inside wounds	<i>Prevents infection</i>
		Placed inside	<i>Matures the abscess</i>

		abscess Wilted leaf	<i>and prevents infection</i> <i>Placed on top of open abscess will mature it</i>
Bicarbonate	Bicarbonate	Mix with oranges and vinegar	<i>Anti-diarrheal</i>
Cebolla	Onion	Mixed with honey and lemon	<i>For colds</i>
Guanabana	AKA “soursop”	Drink the fruit’s juice	<i>Cold and Fever</i>
Lemon	Lemon	Mix with honey and onion With honey	<i>For colds</i> <i>For cough</i>
Mamon	Green or red fruit from tree with white flesh you suck off a large seed	Drink the juice	<i>Antacid</i>
Melaza	Molasses	Mix with aloe vera, beets and carrots	<i>Vaginal infections</i>
Naranjas	Oranges	Mix with bicarb and vinegar	<i>Anti-diarrheal</i>
Papaya	papaya	Eaten	<i>Constipation</i>
Passionfruit	Passionfruit	Boil in tea Eat and digest	<i>For stomach pain or “bad blood”</i> <i>Irregular menses</i>
Remolochas	Beets	Mix with aloe vera, molasses and carrots	<i>Vaginal infections</i>
Vinegre	Vinager	Mix with bicarb and oranges	<i>Anti-diarrheal</i>
CONCOCTIONS-RECIPES-OTHER			
Name	Recipe or description	Uses	
Mamajuana (may also be known as “mara bali”)	90% rum, 8% honey, 2% red wine, wood, leaves, spices, occasionally ginger root: age 6-12 weeks before drinking	<i>Impotence, Aphrodisiac, Clean organs of a woman who gives birth outside of hospital, gonorrhea cure,</i>	
Home mixture	Perfect love, orange, pala de chivo, calbrito, cherry leaves, cherries, and lemons	<i>Cough and Allergies</i>	
Pharmacy mixture	Mandania (chamomile), argosema, lordetido, leaves of oscalita: boil all together	<i>Treatment of sweating hot flashes</i>	
Ensalmar	Healing chant performed by a	<i>Used to cure evil eye or</i>	

	<i>bruja</i> , or a female elder. English translation “to cure by spells, a magician-nun with prayer” (sometimes involves plants)	<i>possible curses</i>
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Home remedies were reported to be passed down from generation to generation, primarily from mothers and grandmothers. When asked if young women were currently learning home remedies in the village, general informant #C-1 stated, “Of course!” and general informant #EC-1 said, “Usually it is the women who learn and make home remedies. They learn from their mothers and grandmothers. They pass it down in knowledge.” General informant #FR-1 said, “Home remedies are best known by the older generations, but they teach their knowledge.” General informant #I-4, a professing Catholic informant stated:

From our ancestors, we learned, and I learned, that there are a lot of plants that are medicinal. The bible says that every leaf in the field has a virtue specifically given to it by God, therefore it has healing benefit.

Key informant #G-1, the village nurse said:

I can make you a tea for vaginal infections, and I have no saints, no altar, and I know this is for infection and that it works because I learned it from my grandmother. Sometimes, your period is late, and you have a headache, and you learn from you grandparents some leaves and some teas and you get your period.

Informants reported sending many plants and fruits to family members in other countries, primarily New York City for home remedies. Key informant #JD-1 said, “there are many plants my family cannot get in the United States. I send medicinal plants to many family members in Miami and also New York. They ask me to bring it to them when I visit.” All informants who

reported taking plants to family in other countries denied clearing the vegetation through customs and immigrations statutes.

Folk beliefs related to nutrition and health maintenance. Many informants described good health to be maintained through exercise and walking. Several informants also stated they stay well from eating more fruits and vegetables. General informant #I-4 said, “natural food from the countryside keep a person healthy. Passionfruit juice and cherries help and guava fruit has lots of vitamins to prevent illness.” General informant #W-1 stated he maintains health by eating a low fat diet and avoiding soft drinks and cigarettes. He also said he drinks lots of water and sugar cane should be avoided in diabetics. When asked how villagers prevent illness and maintain health, key informant #M-1 replied:

People who walk around without shoes can make themselves sick. IF you eat *muncio* which is a little fruit that will make you sick, it will cause death. It gives you mucous in your stomach and you die. You also should not eat cashews if you are in your adolescence and developing because it gives you tuberculosis. Also, worrying can make people nervous, make the blood pressure go up and have a high heart rate. Buying bottled water is very important, and the food we eat, rice and beans, will keep you healthy.

General informant described spiritual causes of illness:

If you go to a *bruja* for a complaint and a few days later your neighbor gets sick, and everyone finds out you went to the witch, they would all think that you brought on your neighbors illness. This is one reason you would not tell anyone that you went there because many neighbors see the witch and are guilty of brining illness to the town.

Witch doctors or brujas. Informants reported the existence of both *brujas* and non-witch healers in the village. General informant #R-1 said, “There are many people in the village who go to witches.” *Brujas* were reported to be Dominican or Haitian and male or female, but primarily female. *Brujas* were associated with curses and future telling and occasionally medicinal remedies for healing. General informant #U-1 stated, “There is witchcraft here and people who work against it. If someone has a curse, some other witch can undo the curse.” Key informant #B-1 confirmed, “There are people here who read cards and read the cups, and do curses. They are witches. The mother of a lady who lives here is a witch and down the hill is another one...but not all village healers are witches.” General informant #FR-1 said, “A witch is a person who can do or remove a curse and sometimes uses medicines for sickness. Sometimes they know which roots will help you get better.” General informant #IS-1 said, “Witches can cure curses and make medicines. They do both. The same person who reads the card and cups also makes teas and herbs for medicine, but they are mostly for curses.” General informant #I-4 described economics leading to treatment with a *bruja*. He said:

People who do not have enough money to go to a clinic can take a urine sample to a witch. He will read it and collect bark and leaves and send you to a pharmacy to buy a packet of other things to make a concoction that will treat the problem. But, I do not go there because witches are people who consult the dead and spirits.

Key informant #G-1 described a local witch. She stated, “There are some things that she can do and can heal. She can cure illnesses that are caused by demons that are spiritual and the doctors cannot help you there.” She described a scenario with a *bruja*:

There are people who have been to all the doctors. One child, with an ulcer in particular, stepped on something and got an ulcer on his foot. His whole body was in pain on that

side that he stepped on. He was in pain for 15 days. They were taking him to the doctor every day for the 15 days. He was admitted to the hospital. They took him out of the hospital and the witch prepared some tea and it was supposed to be a curse that she removed from his back with a salve and when they took him back to the doctor it was gone.

Key informant #M-1 offered:

The witch rubs something on the stomach and on the back. She says a prayer and gives the child who has no appetite something to drink. She does not tell you what she gave to drink, it is a secret so you do not go and make it at home and not come back for healing. Her treatment works because when the children are on their way there they are not hungry, but when they are leaving, they are hungry.

Key informant #B-1 described an experience with a *bruja*:

My first daughter, the one who died, I dressed her really pretty, and when she came home, she had a fever. I took her to a witch doctor and she said it was the evil eye that the baby had suffered from. One leg was shorter than the other after the fever. She was only 7 months old when this happened. She took off her clothes and did something called *ensalmar*, and when she did it the 3rd time, her leg was back to normal. I do not know what it is that she did, but I saw it happen.

Many informants denied believing in curses and Christian informants denounced the power of healing from witches. One informant, #LU-1 claimed to be a *bruja* and reported many women from the churches “sneaking” to her services after dark.

Secret visitation to brujas. Informants described secrecy with visiting a *bruja*. The need to visit in secret was expressed by both Christians who denounced witches and informants

claiming Catholicism and no religion. Key informant #JD-1 added, “The more educated, the more shame in going to a witch. More educated people do not believe in witchcraft.” General informant #A-1 said:

You would go very secretly to the witch. This would always be done in secret. You would not go to the one in your neighborhood, but to someone in another neighborhood where nobody knows you. So, the ones who visit this neighborhood have come from afar so their own neighborhood’s do not know they are there. You could be blamed for illness in your village if people know you go there.

General informant #I-4 described her feelings about *brujas*:

The origin of people going to see the village healer is because they have demonic powers that help them read urine and do things, but I am a Christian, so I would always go to a clinic. In a clinic setting, those people have science and they are trained and it is a good thing. Witches and people like witches in this community are bad. This conviction is for me. But, if my neighbor wants to go to them, it would not matter, I would still be friends with that person and I would not treat them any different. It is a personal choice.

Curses. Key and general informants described circumstances of *brujas* and curses.

General informant #A-1 said, “Witches do curses.” General informant #FR-1 reported people have died because of witch’s curses. Key informant #AL-1 provided an example for using a *bruja* to curse someone:

For example, if we were friends and you did something to me, I would go to a witch and tell the witch that you need to do something so that she dies or so she is in an accident or a family member dies or for something bad to happen to you.

Key informant #J-1 spoke about curses and urban Dominicans:

This is not just in rural areas. There are lots of people from urban areas and the Capital who come to witches way out here. You can see big expensive cars from the city here and they are usually looking for a witch and they go to see them for cures for curses placed on them. It is part of the rural culture and in the city.

Key informant #AA-1 stated, “There are curses here. Religious people do not believe in them and those who are not religious do believe in them.” General informant #I-4, a Pentecostal, was concerned about visitation with a *bruja*. To the researcher, she said:

They wanted to bring you somewhere yesterday and I did not want them to take you to that witch. Because he is a witch, I was worried about you! They only cause curses and we do not want you to be cursed. I am afraid he will do something to you. He is Haitian and we do not want you to be harmed.

General informant #ET-1 shared a circumstance involving a curse:

I met a good student, a woman, two semesters from graduation from teaching. She was pretty and she went to a party and drank a lot of alcohol. She fought with another girl and that girl went to a witch doctor and had her cursed. The first girl became crazy, left her studies and was naked in the street. Her family is very rich and went to all types of doctors to have her healed. They went, finally, to a witch doctor who told them it was a curse on her. They do curses to people and the doctors cannot find what is wrong with them. The second witch cured her. This is black magic, and they do it through the power of Satan.

A known curse in the Hispanic culture was *mal de ojo* or “evil eye.” In Dominican culture, the evil eye belief was that a person can harm you, your children, livestock or

possessions by looking at them with envy. It is not always seen as intentional harm or curse, but also as a consequence of envy. General informant #ET-1 described the evil eye curse:

Certain people can do that. They can tell you that you have really nice hair, for example, and they just want your hair to fall out and for you to have ugly hair. Since they have that relationship with Satan, the persons hair does fall off! You say something nice but your jealousy meant to harm someone.

Key informant #B-1 said:

If you see something and it impresses you in such a way that only with looking at it you can switch something to that. The elderly say that anyone can do this and you do not do this intentionally. Many times you do not notice when you do this. For example, about a week and a half ago, right in that house there, an animal died and it was supposedly because of the evil eye. IT was caused by someone who knows the owner. The person passed by and said that is a pretty pig and later he died. It was someone whom they know...a family member. They were angry at the person for giving the evil eye. An animal at my house, a pig, also died due to the evil eye. Someone was feeding my pig and killed it with the evil eye.

Non-witch folk healers. Non-witch associated folk healers were described by informants.

Key informant #AA-1 stated that some healers are witches and some are not. He described most healers to be unassociated with witchcraft and curses even though *brujas* exist. Key informant #G-2 stated, "...some heal without having an altar or anything and they just know what leaves work for what." Two informants identified themselves as village healers and verbally insisted they were not *brujas*. Key informant #FP-1 described an experience with a folk healer or medicine woman:

The last time that I was sick with typhoid and bronchopneumonia, I did not go to the hospital. I went to a woman who is a doctor and she was really good. She is a friend of mine, and she gave me all the medicines I needed and I did not have to pay. She came to see me at my house. She was a folk doctor who has a clinic outside this village.

Key informant #FP-1 claimed to be a Catholic village healer:

Some people here go to the hospital and pay all that money, and when their money runs out, they come here and their problems are solved. I am 64 years old and I have never visited a witch! I do not read cards or cups. Everything I do is in the name of the Lord. All should be done in Jesus' name. Whenever they bring me somebody, I tell God that these are not my hands, these are your hands.

General informant claimed no religion, denied being a witch and said she practices natural medicine. She stated:

If you come to my home, I will show you many medicinal plants. I can make any of it for stomach pain or abdominal pain. I boil and make teas. Many things I make work well for kids. The meds you buy are made from these plants, all of these plants. My mother and grandmother taught me some, but much more I just learned on my own. I can make it and I give it from my heart...I am different because I can cure evil eye. I use holy water and say a prayer and the person is cured. I do not want you to think I am a witch, though. The truth is, if you have a child and you have evil eye, I cure him and if you want to present the evil eye, I can do that, too. Nobody knows why the girl in the village died this week. The family is evangelical. They do not believe, and everything exists! In my opinion, her problem was spiritual. They went to doctors and they could not find anything wrong. They should have gone to a spiritual healer. I can cure swollen

faces! I have nine children and I pierced their ears forty one days after they were born and that protected them from the evil eye. Nobody could reach them because I protected them.

Decision to seek folk or professional care. Some rural Dominicans sought professional care initially, but if the treatment was ineffective or cause was not identified, they used folk care practices. General informant #A-1 said, “Most people would go to a doctor first, and if they do not find anything significant, then they will try a witch doctor.” General informant # W-1 said, “If you have a cold and the tea did not work, you go to the doctor, and if it does not get better from the clinic treatment, you go back and make a tea.” Key informant #FP-2 added, “...in some cases, first you go to the doctor, the doctor treats you, and if you see no relief, then you work with home remedies. You should stop the doctor’s treatment and not mix them because that could be toxic.” Key informant #G-1 said:

Some go to witch doctors first, and some go to doctors first, and if the doctor does not find anything then they go somewhere else because it is a problem the doctor cannot see. They go to the witch doctor who can heal what cannot be seen.

Professional care was sought after folk care when a villager could not pay for professional treatment. General informant #I-4 said sometimes individuals go to witch doctors because they do not have money to go to a clinic or hospital.

In perceived non-emergency cases, home remedies were the first employed treatment. General informant #I-4 said a tea would always be used for an infection before taking someone to a clinic or doctor. General informant #MA-1 added, “You would not take someone to a clinic for something like a cough or a cold, in this case, you would do a natural remedy or pharmacy remedy first.” General informant #SJ-1 stated, “There are some things that you need to go to a

doctor immediately...emergencies only or trauma.” Key informant # AL-1 concurred, “There are times when you do not have time to wait and must go straight to the hospital like trauma.

This depends on the severity of illness.”

Professional Caregivers and Care

Rural Dominican informants expressed a desire for professional caregivers to meet their care needs. The concept of *attention* and *tending to one's needs* was central to this expressed desire. Key informant #AA-1 summarized:

They need to work on caring better for people and paying attention to them in the public system. They need to have more people there to help the sick and more doctors and nurses working so people can be paid attention to. Doctors need to explain more to people, not write prescriptions and send them on their way. They need to speak to the family members also because the patients may not be well enough to understand the information. We need the doctors and nurses to pay more attention to us.

General informant #C-1 stated, “We recognize that private doctors are more caring, and we expect this of them, to pay more attention to us,” and general informant #E1-1 said, “When you bring someone to the hospital, you would hope that they would be attended to. Here, there is not attention.” Key informant #F-1 added, “In the public hospital, there is so many people who the doctors do not have time and they cannot give good care and pay attention to people.” General informant #ME-1 stated, “I have seen many die sitting on benches in hospitals waiting and nobody paid attention to them.” General informant #W-1 offered:

They did not ask enough questions and they did not take care of me and give me the attention that I needed. I finally went to a private clinic where I was cared for and given

the attention that I needed and given a prescription that did not make me sick. They paid attention to what I needed at the private clinic and listened to me. They took more time.

General informant #FR-1 articulated the concept of attention associated with professional care:

My wife had babies in the hospital and they do not give care and attend well. They forget about you if you do not have your family there to attend to you. If the family is not there fighting for your rights, they would just forget about you. They would leave you there until you die. They need to pay more attention, for instance, when some people are sick in the hospital, you have to go through the hospital finding the doctors and the nurses to get them to give attention to the one who is sick. The care is very bad in our hospitals because when we are sick nobody pays attention to us.

Informants who had experience in private hospitals with private professional caregivers described good care because they were *tended to* and the caregivers gave *attention*. General informant #C-1 described, "...when I was a child, I broke my leg and went to the private hospital. They attended to people back then. When the dictator was in power, we had really good healthcare." Key informant #F-1 said, "Everything was exactly on time, the medicines that I needed were there and the doctors and nurses paid attention to me" and general informant #FP-1 stated, "I was treated well because they gave me all the studies I needed and paid attention to me." General informant #MR-1 affirmed, "Doctors and nurses who care pay attention to a person in pain and take good care of them. They pay attention to them and give them more time." Key informant #FP-1 described good care given to her daughter before she died in a private hospital:

When my daughter was in the private hospital, the doctors and nurses cared well for her. I cannot complain about the medical care. They paid attention to her. They arrived at

8AM and examined her. They came again at noon and at 4PM and again at 8PM. They did all the lab studies and all the lab tests. They answered to my calling every time I called to them and paid attention to my concerns. This is how the doctors and nurses were very good to us even though she died.

Uncaring Experiences in Professional Care

Informants in Villegas described uncaring experiences in professional care. General informant #C-1 stated six times that doctors and nurses speak badly to patients. General informant #ET-1 described uncaring behavior toward his brother in the emergency room. He said, “The people who were there threw him in the hallway and treated him roughly.” Key informant #MR-1 said, “...they just throw you there and do not care for you. I do not know what they gave me. They did not explain anything to me. Home remedies are better.” General informant #W-1 described treatment after a motorbike accident. He stated, “...when they were cleaning, they were doing it so rough. They could have been gentle and delicate. They could have understood that it was very painful for me.” Key informant #FP-1 described uncaring behavior toward her son with a severe leg fracture:

The doctors do not even talk to you. They just ask you when was the accident and do an x-ray. They do nothing more. They did not examine him or give him pain medicine” [The researcher was shown the x-rays of her son’s leg from the time of injury and 4 weeks prior to the interview. He had a complete tibia/fibula fracture. It remained displaced and was not pinned or re-aligned. He had a cast which was placed 5 months earlier. There was no healing and he could not stand].

Key informant #FP-1 described uncaring behavior from a doctor:

Doctors are disappointing here. I went to the doctor and he wrote me a prescription and he did not talk to me or explain anything to me. He did not examine me. He just gave me the prescription and sent me on my way. We do not even understand the prescription, so we have to take it to someone else, like the pharmacist and it is the pharmacist who tells you what your disease is.

Key informant #AL-1 was studying nursing at university. She decided to study nursing because of her experiences in professional care:

Before, when I was younger, I got sick a lot and I had many bad experiences with the nurses, and bad and good doctors. I want to be a nurse because I want to offer more. A bad nurse would be someone who sees a patient in an emergency and ignores them. This happened to me many times. One time I arrived in pain from an ovarian cyst and nobody asked me what happened. She told me to stand the pain and did not get the doctor quickly. I was in severe pain in the emergency room over one whole day.

Key informant #JD-1 described uncaring circumstances:

Everything is bad about care here! Especially in the public hospitals! All of it! Treatment toward patients is very bad. Doctors and nurses do not take care of patients. There are no medicines. There is not quality and no attention and respect given to patients.

Everybody offers their opinions, but nobody works. They do not check to see if someone needs to be changed or needs anything else to be comfortable. You may have heard about the woman who died in childbirth. The doctors made fun of her in her pain.

General informant #MA-1 described uncaring experiences after childbirth:

They did not allow my family to take care of me in the hospital. Because they would not let my family care for me, I did not get food. The woman doctor was very hard for me

and it was like living something very hard. She did not believe I was in labor and told me over and over that it was in my head.

General informant #MAR-1 described professional uncaring behaviors in a public hospital:

I did not like how I was treated. Nurses were negligent and did not care for me. I got an infection and no antibiotics. I had the infection for two months. I went to the private hospital and my infection was treated after two months and got better. I was treated well there. They should be more aware of patients needs because look what happened to me because of negligence on their part. I gave birth in December. While I am giving birth, the doctors were only paying attention to whether or not they were going to get a double salary from the government. Maybe this is why I did not get any antibiotics.

Environmental Context and Concerns

The informants from Villegas described crime, HIV/AIDS, and polluted water to be the greatest environmental threats to their health and well-being. Key informant #FP-1 said, “There has been a crime wave. But, for us the poor, we sleep safe without being robbed. Nobody kills us for what we have. Murder occurs for crimes of passion.” General informant #IC-1 added, “They are killing people everywhere and I do not know why! I was instructed not to leave the hospital after dark because there is too much robbery. I always waited to leave at daylight.” General informant # SJ-1 stated, “Drugs have increased crime along with lack of discipline and police. You do not know the time of day when you might have money in your pocket and they come and rob you and steal your money. There is more fear today.”

These data were particularly interesting as a murder occurred in the village during data collection. A 33-year-old male was ambushed and shot on his motorbike at 7AM on his way to the markets. He was giving a taxi ride on the back of his motorcycle to another woman from the

village. She was unharmed. Neither the man nor the woman was robbed. It was later discovered he was involved with another man's wife, an alleged crime of passion.

HIV and AIDS are prominent on the island of Hispaniola and in the Dominican Republic. Four homes were identified in Villegas with children as young as 10 years raising younger siblings due to death of their parents from AIDS. Key and general informants discussed the threat of HIV/AIDS in the community. Key informant #B-1 said:

HIV is very common here. Many men are with many women. Many have it and do not know it. There is much separation and men go to many women and infect them.

Promiscuity is a major problem making HIV spread and leaving children to be orphans.

The final environmental concerns expressed by informants related to unclean water supply. Pipelines were placed eight years earlier by a political party, but the work was never finished. Latrine drainage and trash permeates the surrounding earth and water supply. Parasites, typhoid fever, dengue fever, and Giardia occurred commonly in Villegas. General informant #EC-1 said, "I cannot drink the water that is not purified because it will cause disease and parasites." Key informant #FP-1 stated, "The water makes many people sick here." General informant #MAR-1 stated, "We drink the water that we find because it is here, but it makes us sick with diseases and parasites." Key informant #J-1 explained:

There is a girl in the fourth grade here who was very nervous every day. When I asked her why she was so nervous, she said because she is waiting for the truck that sells water because she needs to buy water for her home. Some really young children carry this burden.

Presentation of the Patterns

In phase three of the data analysis, data were scrutinized to discover saturation ideas and recurrent patterns of similar or different meanings, expressions, structural forms, interpretations, or explanations of data related to the domain of inquiry. Data were examined to show patterns with respect to meaning-in-context along with further credibility and confirmation of findings (Appendix I). From the informants' interview responses, the following patterns emerged:

1. A pattern of need for family to be present in order to give care and assistance to the ill.
2. A pattern of absence of family in illness experience inhibiting health and well being
Supporting Categories/Cultural Context for patterns 1& 2: worldview, meanings and expressions of care, uncaring experiences in professional care, and kinship and social factors cultural context
3. A pattern of respect as an essential characteristic in providing and showing care to others
4. A pattern of *paying attention to* as care when a caregiver (professional or kin) is caring for one's emotional or physical needs
5. A pattern of *lack of paying attention to* one's needs perceived as uncaring
6. A pattern of *machisimo* inhibiting respect and attention and resulting in perceived lack of care and threat to health and well being
Supporting Categories/Cultural Context for patterns 3-6: respect, meaning and expression of care, professional caregivers and care, and uncaring experiences in professional care, machisimo/machitas, and environmental context and concerns

7. A pattern of professional care in public and private clinics in promoting health and well being
8. A pattern of folk caregivers and use of folk spiritual practices in order to promote health and well being
9. A pattern of plants, vegetation and home remedies used to promote health and well being

Supporting Categories and Cultural Context for patterns 7-9: professional health services/systems, folk care and practices, professional caregivers and care, and the spiritual and religious cultural context

Phase IV Themes

In the fourth phase of Leininger's Phases of Ethnonursing Analysis for Qualitative Data, the researcher presents major themes abstracted from the categories and patterns (Appendix I). Multiple interviews were conducted with key and general informants. From the culture care worldview contextual analysis and 12 identified Phase II categories from the data, nine patterns and three major themes of culture care meanings, beliefs and practices for promoting health and well being for rural Dominicans were recognized. The remainder of this chapter will present the three major themes and supporting patterns.

Theme One: Family presence is essential for meaningful care experiences and care practices for rural Dominicans

The care patterns that supported this theme were (a) *a pattern of a need for family to be present in order to give care and assistance to the ill* and (b) *a pattern of absence of family in*

illness experience inhibiting health and well being. The kinship and social factors cultural context and categories of *worldview, meanings and expressions of care, and uncaring experiences in professional care* informed the researcher about the care patterns supporting this theme.

Familism or a strong attachment and identification with family members is one of the most pervasive values deeply embedded in Dominican culture. As described in the category *worldview of rural Dominicans*, the family is the frame of reference for daily functioning and decision-making. Individuals within a family have a moral responsibility to aid other members of the family when experiencing life issues, financial problems and poor health conditions. Key informant #FP-1 eloquently described the meaning of family and its central significance to rural Dominican culture and lifeways:

Family is everything. It is the most important and central thing to this culture. When the family is together and very close, this is beautiful! Life is lived for the family and it is a blessing when the whole family is together. We make decisions by consulting family members, close and extended. Family is the basis of our society. Family is central to everything all over this country.

In the cultural context of kinship and social factors, nearly all informants described close relationship with neighbors and villagers. Kinship is extended not only to blood family members and extended family, but also to neighbors. The informants described neighbors caring for the sick and helping the ill maintain their homes and responsibilities when family is not available for assistance. A general informant said, “If you do not have family, a neighbor will help you get well.” As noted in fieldnotes, when two separate funerals occurred in the village during data collection, nearly the entire community visited and expressed care and

concern to the grieving families. This included unknown neighbors and the researcher who was unknown at the time. When the researcher expressed concern of intrusion upon the grieving family, informants explained it would be an offense *not* to attend the funeral gathering due to the kinship felt toward her in the community. The grieving families expressed feelings of comfort from the known and unknown visiting neighbors, including the “unknown” researcher. Family members and visiting neighbors sustained the grieving households through cleaning, cooking and visitation for five to seven days after the funerals. Family and extended community family was an integral part of caring for someone in a grieving process.

Key and general informants clearly articulated the desire for family presence in clinic and hospital settings to promote wellness. One informant said, “The family should be with you in the hospital when you are sick. This is very important...when the family is there, you feel better, you feel relief and you get better faster.” A key informant concurred, “My family was there and everything was taken care of...this helped me to get well,” and another said, “...family members are key to helping family get well.” The importance of family in hospital and clinic settings was richly expressed by key and general informants. Informants even explained the lack of family care and care practices will inhibit healing and well being. One informant stated, “When they are not there, you get sick and die quickly” and another said “If your family were not there, you would feel sad and have less strength to go on.”

In the category *meanings and expressions of care*, informants described sitting and spending time with someone, working to establish a relationship with a person, and performing acts of service to those in need as ways to express care. When a person is ill in the rural Dominican culture, or in need of care, it is important for the family, the central frame of

reference, to express care practices in these ways. One informant articulated the value of family care expressions in a hospital setting:

Family members show they care for others in the hospital or when they are sick by sharing their pain and letting them know they are there for them by sitting with them and listening to their cries of pain. You let the sick person know that if they need you, you are there and you really are. By someone being with a sick person and staying with them that means you care for them.

In the category *uncaring experiences in professional care*, informants described their experiences with uncaring behaviors from professional caregivers. Many informants described uncaring experiences with professional care because the family was not allowed to care for ill family members. All but one description of kin being kept from an ill family member occurred in a private hospital. Interestingly, no informants described uncaring experiences or behaviors from folk caregivers.

Theme Two: Respect and attention are central to the meaning of care and care practices for rural Dominicans

The care patterns that supported this theme were (a) *a pattern of respect as an essential characteristic in providing and showing care to others*, (b) *a pattern of **paying attention to** as care when a caregiver (professional or kin) is caring for one's emotional or physical needs*, (c) *a pattern of **lack of paying attention to** one's needs perceived as uncaring*, and (d) *a pattern of **machisimo** inhibiting respect and attention and resulting in perceived lack of care and threat to health and well being*. Through scrutiny of the categories *respect, meaning and expression of care, professional caregivers and care*, and *uncaring experiences in professional care* the first three patterns supporting this theme were revealed. The fourth pattern of ***machisimo** inhibiting*

respect and attention and resulting in perceived lack of care and threat to health and well being was derived from careful analysis of informants' responses in the categories of *Machisimo/Machitas* and *Environmental Context and Concerns*.

The universal pattern of *respect as an essential characteristics in providing care and showing care to others* was derived directly from the informants' responses related to the value of the concept of respect in Dominican culture. Most informants described *showing respect* to be the best way to express care to rural Dominicans. When asked for the best way to show rural Dominicans one cares for them, nearly all informants, key and general, replied, 'by showing them respect.' Respect (*respeto*) was mentioned 81 different times throughout the interviews and most frequently when discussing *meanings and expressions of care* in Dominican culture. Dominicans expect respect to be expressed based on age, spousal relationships and professional status. Informants described showing respect to be the most important value to be instilled in Dominican children.

Rural Dominicans described not feeling cared for if they are not shown respect. A divorcing general informant described lack of respect to be the cause of his failed marriage. He said, "...when they do not respect you, you are hurt very deeply." A key informant said, "We do not take grandma to a free clinic where she would not be respected and treated well," and another informant described uncaring circumstances when "...there is no attention and respect given to patients." In rural Dominican culture, respect revolves around establishing relationships and serving the needs of those with whom one has relationships.

The universal pattern of *paying attention to as care when a caregiver (professional or kin) is caring for one's emotional or physical needs* was derived directly from informants responses related to giving *attention or tending to one's needs*. In rural Dominican culture, to

give attention or *tend* to someone means to give the person undivided mindfulness or focus of their physical and emotional needs. It required the cognitive process of selectively focusing on the needs or thoughts of an individual. A key informant stated, “For this culture, a person is unhealthy if unable to give proper attention to the family.” The most commonly described act of giving attention was sitting and listening to an individual. A general informant, when describing how her family tended to her needs when she was ill said, “They were there and sat with me at my side. This helped me to get well. They listened to me and shared my pain.” Another informant described tending to someone who is ill by “...sitting to them and listening to their cries of pain.” Informants described feeling *cared for* through the offering of attention through sitting and listening from the researcher. Responses affirming this view included, “just you sitting and talking with me makes me feel good and like you care for me,” and “by sitting here and by visiting me here, you show me that you care something about my country.” Another informant reiterated, “It is good that some people are interested in knowing how we live because that makes us feel care for and not forgotten.” Key informant #C-1 summarized:

When someone comes into this community like this to just sit and talk and listen to the people, it means so much! Some days I wake up and I do not know what purpose I have. I just sit in a chair. But, knowing you were coming to ask these questions made me very excited and something to look forward to for today, and then I can know, by what you are doing, coming into my poor community and just sitting among the people and listening, establishing a relationship with me, you care about me and my community.

In rural Dominican culture, to *give attention* or *tend* to someone also related to perceived needed acts of service. There is a moral obligation to servicing the needs of others in the family and community. A commonly stated phrase, “if your neighbor needs something, you should give

it” affirms this notion. In rural Villegas, when informants were asked the ways care is shown through tending to someone, the most common acts of service described were cooking, cleaning, assisting with child care, and giving or lending money. Many stories were shared of neighbors or family members cooking and cleaning for an ill individual. One informant said, “When I was in the hospital, my family tended to me...they washed me and helped me go to the bathroom.” Care is also expressed through tending the needs of individuals who are not ill. Many informants stated they would show the researcher they cared for her by *tending* to her needs to eat and sleep. This was most clearly articulated by a key informant’s words:

To show you I care for you, you could stay at my house. We will cook for you. We will sit and talk with you and tend to what you need in any way we can. If you are in need, we could cover your need and show you we care for you.

The universal pattern of *lack of paying attention to one’s needs perceived as uncaring*, supports the notion that attention is central to meaning of care for rural Dominicans. Informant descriptions of uncaring professional care and caregivers related strongly to *lack of attention* or *absence of tending* to one’s needs. This universal pattern was also derived directly from the verbatim translations of key and general informants. In analysis of the *professional caregivers and care* and *uncaring experiences in professional care* categories, informants described the rural Dominican desire for professional caregivers to give attention and tend to individual needs. Some of the verbatim translations supporting this assertion were “they need to work on caring better for people and paying attention to them in the public system”, “They need to have more doctors and nurses working so people can be paid attention to”, “we need the doctors and nurses to pay more attention to us”, “when you bring someone to the hospital, you would hope that they would be attended to.” The informants described care to be poor or unsatisfactory due to lack of

attention shown to people. Statements included “The care is very bad in our hospitals because nobody pays attention to us” and “Everything is bad about care here...there is no quality and no attention and respect given to patients.”

The final pattern supporting this theme of *machisimo inhibiting respect and attention and resulting in the perception of lack of care and threat to health and well being* was derived from directly from informant responses related to the machisimo concept and the category of machisimo/machita. The Dominican informants referred to many men as *machistas*. These men are those with more than one family living in relationships with more than one woman. Additionally, the Dominican *machista* is associated with male dominance and female suppression.

All women and some men (mostly evangelical Christian men) in the village describe *machisimo* as destructive to the village. One informant, in regard to *machisimo* stated, “...women get very hurt and angry here.” Informants shared personal circumstances of heartache and lack of opportunity because finances had to be spread between two or more families. Many informants described feeling disrespected as a child and as a spouse by a man split between families. The economic strain of one man supporting two families resulted in lack of time spent with his children and tending to needs and showing care. A key informant described, “Machisimo affects children. They think dad is leaving and he is not going to love me anymore. Their grades are affected...my father is not good because he is with women all the time and cannot provide for me or my sister due to all of his children.” Dominican *machistas* are considered disrespectful to spouses and children and perceive as uncaring.

Theme Three: Rural Dominicans both value and utilize both generic(folk) and professional care practices

The care patterns that supported this theme were (a) *a pattern of professional care in public and private clinics in promoting health and well being*, (b) *a pattern of folk caregiver and use of folk spiritual practices in order to promote health and well being*, and (c) *a pattern of plants, vegetation and home remedies for promoting health and well-being*. Careful review and analysis of the categories *professional health services/systems*, *folk care and practices*, *professional caregivers and care*, and the spiritual and religious factors cultural context informed the researcher about the care patterns supporting this theme.

The pattern of *professional care in public and private clinics to promote health and well-being* was synthesized from descriptors of professional care systems and professional care experiences shared by key and general informants. Public and private professional health care services exist and are utilized by villagers in rural Villegas. From the informants' responses, it is unanimously shared that care in the private institutions is preferred. Private care and clinics are costly and require payment before services. For this reason, private clinics are only used when the financial resources can be obtained for services. In most cases, this circumstance is reserved for trauma and emergency situations. The closest clinics and hospitals to the community are public. Public or government sponsored clinics and hospitals provide free care, but informants prefer the care of private doctors, clinics and hospitals. Public institutions are associated with uncaring practices, understaffing, lack of needed resources, and preventable deaths. Informants described care in private professional settings to promote health and well being. Private clinics were described as "very good" and one informant acknowledged, "I finally went to a private institution where I was cared for and given what I needed and got better."

The majority of professional caregivers and practices are used for trauma and severe illness. The informants described using professional care for surgical interventions, traumatic

injuries, critical illness, childbirth, fractures and burns. Three encounters with the professional care system were noted in the village during data collection. In the first scenario, a woman who died of “swollen face” was critically ill and died in the professional system. The family denied use of folk care practices in her illness because she was “too ill”, but verified use of folk practices in other illnesses to promote health and well being. The second noted instance of use of professional care was with a 26-year-old man with a traumatic leg fracture. A cast was placed for four months without realignment and there was no evidence of healing. He possessed x-rays and stated he was initially given three pain pills from the hospital. Finally, one informant’s wife delivered her second child in the nearby public hospital during the data collection period. Professional care and caregivers are used in rural Dominican Republic to promote health and well being.

The pattern of *folk caregivers and use of folk spiritual practices to promote health and well being* was revealed from key and general informant descriptors and experiences with folk caregivers and folk spiritual practices. Importantly, many informants described less belief in folk care and practices with increased years of education. Despite educational status increasing in rural areas, use of folk caregivers and folk spiritual practice remained actively utilized. For the people of Villegas, it is true healing practices in the culture may involve a professional doctor, but consultations with a *bruja* or possibly a religious healer also occur. In rural Dominican culture, there are other concepts of illness (besides professional evidence based) that are assumed to *not* be recognized by professional caregivers. As a result, rural Dominicans value traditional folk treatments which provide culturally familiar ways to treat conditions of *spiritual-physical* etiologies.

Often ailments or medical problems are thought to be the doings of an evil spirit. A person's poor health is attributed to magical causes such as a curse which has been cast by someone as a result of an interpersonal disagreement. The curse primarily takes place through the actions of a *bruja* which is a Spanish name for *witch*. Informants validated the existence of *brujas* in Villegas, and one informant identified herself as a *bruja*. She was the only informant who refused tape recording of the interview, thus there are no direct quotations from her interview in the discussion related to witch doctors or *brujas* in Chapter IV. *Brujas* are believed to have the power to curse or hex people and also banish evil spirits. The *bruja* informant maintained a hut with an altar, many pictures of saints, tarot cards, various rums, whiskies, and wines and large glass vases filled with water for fortune reading. The hut was located in the extreme outskirts of the community, high on a hill with a treacherous 1-2km walk through rough terrain on a very narrow path to reach its entrance. She described her primary role to call on spirits for curses and reading the future for people. She denied possessing a role for healing the physically ill unless the illness etiology was curse related. She denied use of roots or plants for healing, but other informants described *brujas* who use roots, plants, and concoctions for healing. She stated her primary clients were women. Women come from all churches and all over the community, according to the *bruja*, to seek spells to cure infertility, and to curse other women who are having relations with one's spouse. She stated the church-going women come in secret after dark. She also validated that many wealthy Dominicans visit her from the city to request curses and have curses removed. *Brujas* charge a fee for each consultation.

The most common curse described by the informants was *mal de ojo* or *evil eye*. The evil eye describes a look inspired by jealousy. In Villegas, it is most frequently blamed for death of livestock, infant and toddler illnesses, and bad luck. One informant stated she prevented the

curse in her own children by piercing their ears 40 days after birth and that she herself, could remove the curse of evil eye, but strongly denied being a *bruja*. This is presumed because a *bruja* is perceived negatively and evil by many villagers.

In Villegas, there are religious healers or spiritualists who are not associated with curses. These healers claim Catholicism and renounce *brujas*. It was very important to these healers that the researcher did not associate them with witchcraft or *brujas*. Roman Catholicism has been combined with traditional folk religion in rural Dominican Republic and folk practitioners of this nature are consulted to heal the sick, for spiritual advice, and to prevent calamity. Two informants claimed to have God-inspired spiritual gifts for healing. These women relied on prayer and spiritual rituals for healing. *Ensalmar*, a healing chant, is one method used by elderly women for healing. For those who believe in its power, it is a respected folk practice. Religious healers may work through saints and ask them for special help for people in need. Religious healers combine traditional folk medicine using plants, roots, and objects of nature with spirituality for healing. They are valued in treatment frequently before seeking professional care, and also after professional care treatment are perceived to be ineffective. Religious healers do not charge a fee for a consultation because it is seen, to them, as a way to care for the community and serve God.

The pattern of *plants, vegetation and home remedies for promoting health and well being* was derived from rich and thick descriptions of home remedies currently employed in the rural culture. An extensive variety of home remedies were revealed in the data, nearly all of which are considered traditional practice that is unassociated with professional or spiritual care practices (see Table 3). It was true that spiritualist and some *brujas* may use some of the remedies concomitantly with their treatments, but all home remedies described (except for those for

treating evil eye and bad blood) were validated to be used independently to promote health and wellbeing. Home remedies were also used with professional treatments, but in some cases, home remedies and “pills or medications” are mixed. Some informants stated they do not mix professional medications and home remedies due to fear of toxicity. Often time, if a professional treatment is perceived to be ineffective in two or three days, home remedies frequently replace the professional treatment, and sometimes they are used concomitantly. Many individuals in this rural Dominican community use traditional folk home remedies exclusively. In general, folk healing traditions and home remedies are transmitted and learned primarily through older female kin. Additionally, vegetation is reported to be taken to family in other countries to promote health and well being.

In the rural village of Villegas, use of herbs and other natural things for healing are widely used. Folk remedy ingredients included fruits, spices, roots, leaf and pharmacy concoctions (See Table 3). The majority of remedies are in the form of a tea that is ingested. Ovules for vaginal or rectal insertion were described along with topical preparations. Ailments treated included abscesses, allergies, bad blood, cold symptoms, congestion, constipation, cough, diarrhea, evil eye, fever, gas, gonorrhea, hemorrhoid itching, hepatitis impotence, hot flashes, irregular menses, kidney pain sore throat, nausea and vaginal itching and infections.

In summary, rural Dominicans value *both* folk and professional caregivers and care practices in promoting health and well being. Key and general informants offered rich descriptors of use of professional care and folk care. Decisions regarding which to use depends upon the ailment and one’s individual beliefs. Some Dominicans rely mostly on professional care and others at the other end of the spectrum typically employing folk care. From the analysis, there are also, clearly, individuals at all points in between these two poles.

These themes and patterns were extrapolated from informants' recurrent responses to questions and are supported by data from interviews. The researcher discovered these themes and patterns through analysis of the cultural and social structure dimensions of the theory and the 12 categories described at the beginning of this chapter. The researcher explored and clarified the patterns with key informants during follow up interviews. These patterns and themes were identified through analysis of interview data and reflect the culture care meanings, beliefs, and practices of rural Dominicans involved in this study. Transcribed verbatim excerpts from key and general informants are described offering support. A detailed discussion of the identified patterns and themes will follow.

CHAPTER V

DISCUSSION OF THE FINDINGS

The purpose of this ethnonursing study was to discover, describe and analyze the meanings, beliefs and practices of care for Dominican people living in a rural village of the DR within the environmental context of their familiar homes and community. This study proposed that care meanings, beliefs and practices for Dominicans are influenced by shared cultural, values, beliefs and practices. The goal of this study was to identify generic (folk) and professional care practices that promote health and beneficial lifeways for rural Dominicans. Results from this study will assist caregivers to plan and implement nursing decisions and actions that promote culturally congruent care for Dominican people.

The domain of inquiry for this study was culture care meanings, beliefs and practices of Dominicans within the context of one rural village of the Dominican Republic. Research for this study was conducted with rural Dominican people living in their own homes and community of Villegas, Dominican Republic. Leininger's Culture Care Theory guided the research to provide insights into the culture care meanings, beliefs, and practices of rural Dominicans. The goal of this study was to identify generic (folk) and professional care practices that promote health and beneficial lifeways for rural Dominicans. This goal was important to uncover the culture care practices of this group of people in order to provide culturally congruent nursing care. Culturally congruent care was predicted to facilitate improved health and well being for rural Dominicans.

The ethnonursing method was used to discover the emic views of rural Dominicans related to the domain of inquiry. Etic observations of the researcher also contributed to the finding of the study. The researcher has spent over 10 years participating in numerous short term immersion and caregiving experiences in rural Dominican communities. The time spent in

immersion and research along with the extensive data collected helped to substantiate evidence related to qualitative research criteria of credibility, confirmability, meaning-in-context, recurrent patterning, saturation, and transferability.

The findings from this study are grounded in extensive evidence and verbatim descriptors, and will center on the patterns and themes discovered in relation to the Culture Care Theory. The verbatim descriptors were presented in Chapter IV in relation to worldview of rural Dominicans, the concepts of respect and destiny, kinship and social factors, meaning and expressions of care, roles of men and women, the concept of machismo, professional health services/systems, folk care and practices, professional caregivers and care, noncaring experiences in professional care, and social structure factors related to the Culture Care Theory. Leininger's Four Phases of Ethnonursing Analysis of Qualitative Data (Leininger, 2001, p. 95), Enablers (Appendix B and C), and interview guide (Appendix D) assisted the researcher to identify and examine data for discovery of recurrent patterns to support the domain of inquiry. Universal or common themes were abstracted from the patterns identified in Chapter IV. The thematic findings were grounded in data obtained through observations and interviews and reflected the perceptions of rural Dominicans in regard to the domain of inquiry.

The three major themes that emerged from the study were *(a) family presence is essential for meaningful care experiences and care practices for rural Dominicans (b) respect and attention are central to the meaning of care and care practices for rural Dominicans (c) rural Dominicans both value and utilize generic (folk) and professional care practices*. In this chapter, each theme will be presented and discussed. The three predicted modes of nursing care actions and decisions related to the Culture Care Theory will be presented as identified to support culturally congruent care for rural Dominicans living in the Dominican Republic.

Theme One: Family presence is essential for meaningful care experiences and care practices for rural Dominicans

The first theme identified was *Family presence is essential for meaningful care experiences and care practices for rural Dominicans*. For rural Dominicans, based on this theme, it is essential, in order for care to be optimal, family must be present. Rural Dominicans clearly articulated the meaning of culturally congruent care to be strongly associated with present family members and kin for a person experiencing illness. The findings of this study supported the current literature reports that family is the fundamental social unit. The family unit included both nuclear and extended family members, as described in chapter II. Rural Dominicans enjoyed large extended family networks and daily visits and exchanges with family members when they live in close proximity to one another. In rural Dominican culture, the concept of family extended to neighbors and friends and all that make up the community of which one is part. The community “family” helped rural Dominicans survive the difficulties that occur throughout life. With the great importance and value of family in the culture, it was natural to understand the desire for family and kinship involvement in care and care practices.

The informants described benefits to kinship presence including improving the achievement of wellness, a sense of “being cared for”, and assurance for obtaining medications and treatments to promote well being. Conversely, the absence of kinship and family for an ill person, or “keeping an ill person’s family away” hindered care that is culturally congruent. With the clearly articulated strong sense of *familism* in Dominican culture, it was imperative that kinship and family were present in care experiences to provide hands on assistance when possible, help in decision-making, and offer emotional and physical support. To inhibit family or kinship presence for an ill rural Dominican, would in turn, inhibit culturally congruent care.

In summary, analysis of informant responses revealed the desire for kinship and family involvement in care. In this study, the family (nuclear, extended, or community) was centrally valued and embedded in rural Dominican lifeways as seen in the literature review. Family and kinship was important for promoting health and well-being. The absence of family influence and presence in care giving settings and practices was detrimental to achieving health and well being for rural Dominicans.

Theme Two: Respect and attention are central to the meaning of care for rural Dominicans

The second identified theme, *Respect and attention are central to the meaning of care for rural Dominicans*, speaks to the relational specifics in caring for rural Dominicans. Dominican informants described showing respect and offering one's attention to be the best way to express care to another individual. From analysis of informant responses, showing respect seemed to include taking someone's thoughts, feelings, needs, wishes and ideas into consideration. Showing respect meant taking all of these seriously and giving the person worth and value. In caregiving circumstances, showing respect seemed to indicate listening to them, explaining information to them, acknowledging them and addressing their individual needs and concerns. The data revealed that this should be done in a way that supports focused listening and undivided attention on the part of the caregiver.

Interestingly, that the Spanish verb *attender* was most frequently used by informants describing meaning and expressions of care. The verb *attender* literally translates to *care for or look after* in English. The only other Spanish verb used to describe meaning and expressions of care was *cuidar* which literally translates in English to *care for or tend to*. Even in analysis of translation of verbiage used, the concepts of *tending* and *attention* were directly associated with

care. When approaching a Dominican with an attitude and actions conveying respect and attention, the person perceives a sense of value and worth and ultimately, “cared for.”

The literature review reported the Latin-Caribbean doctrine of *machismo*. This study confirmed its presence in the DR and that *machistas* are seen as a threat to health and well being. Besides limiting economic opportunities for health and education services, there existed a prominent fear of HIV and sexually transmitted diseases (STDs) among informants due to the nature and practices of Dominican *machistas*. The villagers had already lost many individuals to HIV and described sexually transmitted disease to be a consistent threat to health and illness. One informant, a school teacher, explicated a need for educational programs for students in primary and secondary levels regarding HIV and STD prevention. The island of Hispaniola is documented to have the highest global concentration of HIV, and villagers described a significant fear of transmission from the sexual practices of *machista* men.

In summary, key and general informant responses clearly articulated the importance of the values of respect and attention in meaning and expressions of care for rural Dominicans. Respect was valued highly in the Dominican culture and was an essential characteristic in providing and showing care to others. Offering a focused mind and listening ear to rural Dominicans, and acting in service to a perceived need or tending to one’s needs, was necessary in showing care. Rural Dominicans perceived care as uncaring when caregivers did not incorporate respect and attention into caregiving encounters.

Theme Three: Rural Dominicans both value and utilize generic (folk) and professional care practices.

The third theme, *Rural Dominicans both value and utilize generic (folk) and professional care practices*, reveals the importance of understanding the unique and dynamic practices of

Dominican people to promote health and beneficial lifeways. The data unmistakably confirmed the literature reports that both generic and professional beliefs and practices are valued in rural Dominican culture. There were ambiguous lines between professional, generic, spiritual, and remedy based care practices. Many Dominicans employed a variety of practices that were derived from each of these categories. Weeks, Ferbel, Liss, Rosario & Ramirez (1994) described a common reliance on natural medicines further away from industrialized city centers in the DR. This assertion was supported in the rural Villegas population in this study, approximately 60 miles from the capital city of Santo Domingo. Other Dominicans primarily relied on professional practices, and still others home remedies and spiritual practices. Undoubtedly, both generic and professional practices were respected and were actively impacting care and care experiences for Dominicans living in the DR and also for those who may have emigrated.

Summary

This chapter discussed the findings extrapolated from interviews conducted with key and general informants and the researcher's observation and participation in the social and care related activities with rural people in the village of Villegas, Dominican Republic. Culture care meanings, beliefs and practices were discovered and articulated using verbatim translated quotes of informants. Themes and supporting patterns were presented in relation to emerging categorical phenomena and the facets of the Culture Care Theory. Nine patterns and three major themes of culture care meanings, beliefs and practices for promoting health and well being for rural Dominicans were identified and discussed.

In the remainder of this chapter, the impact these themes have upon culturally congruent care and nursing science will be discussed. All nurses and caregivers, regardless of their geographic location, must be prepared to provide culturally congruent care to clients with diverse

backgrounds. This study's themes provided insight regarding the culture care values for rural Dominicans to assist in developing the foundation for providing culturally congruent care.

Discussion for Culturally Congruent Nursing Care

According to Leininger and McFarland, the researcher is to focus on the three theoretical modes of culture-care actions and divisions that might be appropriate, congruent, satisfying, safe, and beneficial to people being studied (2002). The three nursing modes of action or decision that the nurse researcher examines with informants are (a) *culture care preservation/maintenance* (b) *culture care accommodation/negotiation* and (c) *culture care repatterning/restructuring* (Leininger & McFarland, 2002). The researcher and the informant can decide together the appropriate care actions and decisions that will promote an individual's health and well being.

In accordance with Leininger's Culture Care Theory, this study discovered the culture care meanings, beliefs and practices of rural Dominicans in one village in the Dominican Republic. Leininger proposed that the discovery of universalities and diversities in human care in a specific culture enables nurses to plan and provide culturally congruent care for members of that culture (1991). A discussion for culturally congruent nursing care for Dominicans focused on the three modes of care in the Culture Care Theory will follow.

Culture Care Preservation and Maintenance

Culture care preservation or maintenance refers to those "assistive, supportive, facilitative, or enabling professional actions and decisions that help people of a particular culture to retain and/or maintain meaningful care values and lifeways for their well-being, to recover from illness, or to deal with handicaps or dying" (Leininger & McFarland, 2002, p. 84).

First and foremost, in order to preserve and maintain meaningful care values for Dominican people, nurses and other caregivers need to identify how one's own cultural values,

assumptions, and beliefs affect patient care and decision-making. Culture is the “lens” via which a person views the world and makes sense of what is seen. A caregiver’s own cultural values naturally impact his/her own interpretations and reactions. Cultural values and beliefs are dynamic and ever-changing. There must be a willingness to recognize that cultural diversity exists and modify care giving practices to keep with a person’s unique individual characteristics and cultural background. A conscious willingness to see the world or situation from another’s point of view is the first step in providing culturally congruent care to any culture group including rural Dominicans.

In order to preserve or maintain the cultural care of the rural Dominican patient, nurses and other healthcare providers are encouraged to recognize and maintain the importance of family involvement in various aspects of care. The significance of family involvement in caring for ill individuals was a strong finding in this study. Informants offered rich descriptions of the value of family in hospitalizations and clinic. Informants explained the value of family in illness outside of professional care settings and in grief. The family is central to Dominican way of life in health and illness. The family is culturally necessary to provide direct physical care and be present and physically near a sick person. For an ill rural Dominican, the absence of family inhibits wellness and healing. Nurses can develop a plan that allows for the family to be involved in the care of their loved one. This would preserve the cultural value of family involvement in care.

In order to preserve or maintain cultural care of the rural Dominican patient, nurses and other caregivers are encouraged to facilitate the maintenance of spirituality in health and well being. Spiritual and religious influences play a major role in health and illness for rural Dominicans. The assumption should not be made that a Dominican client is of pure Catholic

theology and tradition. A rural Dominican may desire various spiritual regimens from a collection of spiritual and religious foundations. Importantly, a caregiver should ask each individual Dominican how his/her own spiritual values can be maintained in health and illness because this could vary amongst persons. Faith, church, and “power from spirits” are an influential source of hope and strength in rural Dominican culture, especially in times of sickness. The nurse should facilitate an environment that invites desired folk caregivers and spiritual healing practices.

Culture Care Accommodation/Negotiation

Culture care accommodation and/or negotiation refers to those “assistive, supportive, facilitative, or enabling creative professional actions and decisions that help people of a designated culture (or subculture) to adapt to or to negotiate with others for meaningful, beneficial, and congruent health outcomes” (Leininger & McFarland, 2002, p. 84).

As previously explained, family involvement is necessary to promote health and well being in hospitals and clinics for the rural Dominican population. This effort may require accommodation and negotiation to achieve congruent care outcomes. Nurses and caregivers need to find ways to accommodate the family so they can spend time with an ill loved one. Because the family includes the extended family, it is likely to experience the presence of many individuals with a sick person. Caregivers must recognize the importance of family and accommodate this value in creative and respectful means of negotiation when needed.

In order to assist rural Dominicans to adapt to or negotiate with others for meaningful and congruent health outcomes, nurses and caregivers should show respect through sitting and listening to patients. Informants thoroughly described a desire for caregivers to sit and listen and *spend time* in relationship and communication. Rural Dominicans told stories of lack of care

from lack of time and attention and communication. In order to show respect through sitting and listening to rural Dominicans, more time may need to be planned for nurse-client encounters. In order to provide culturally congruent care, nurses and other caregivers should show respect by asking questions and pursuing a rural Dominican's thoughts and concerns. Affirmation of this assertion was revealed in reflection of the data collection process. Countless times the researcher was told she was expressing care and establishing relationship by inquiring about the informant's thoughts and concerns. Importantly, the nurse should make attempt to notice what seems important to the Dominican patient and offer it comment.

Giving attention to a rural Dominican will assist the individual to adapt or negotiate with others for congruent health outcomes. Every act of paying attention conveys meaning. By offering undivided attention, or selective concentration on a Dominican patient, the meaning of care is perceived. Dominican informants do not wish to be in a caregivers physical presence and *ignored*. The nurse or caregiver providing culturally congruent care to the rural Dominican population should focus deliberate, patient centered, mental and physical concentration directed toward the person in need. In order to offer therapeutic attention to rural Dominicans, sitting and facing a person, looking at him/her and making eye contact, and tuning out unrelated stimuli would be necessary.

Culture Care Repatterning/Restructuring

Culture care repatterning and/or restructuring refers to “the assistive, supportive, facilitative, or enabling professional actions and decisions that help clients reorder, change, or modify their lifeways for new, different and beneficial health outcomes” (Leininger & McFarland, 2002, p.84). Culture Care repatterning and/or restructuring for rural Dominicans relies heavily upon the focus and development of relationship between nurse and client. For this

reason, culture care repatterning and/or restructuring may not be possible without first applying the concepts of culture care accommodation and/or negotiation. Only through the development of relationship can trust be developed and collaboration regarding care occur. By sitting and talking with a Dominican client, showing interest in his/her perspective and offering undivided attention, an environment for negotiation and repatterning can develop. Communication and relationship between a patient and care provider are key to cultural care for Dominicans.

Rural Dominicans have unique generic health beliefs and practices which are employed to varying degrees. Learning about these beliefs and practices and gaining an understanding of them are a vital first step to new and beneficial health outcomes. Rural Dominicans may be reluctant to share their beliefs and practices for fear of judgment; hence building trust through establishing relationship is preliminary. Nurses and caregivers should sit and talk with rural Dominican clients and show interest in their perspective and perceptions of health problems. Dominican clients should be asked what they perceive to be the cause of their problem and what type of treatment is desired. It is possible that some folk practices are harmful and others are helpful. Professional caregivers need to gain knowledge regarding those which are helpful and express value of their usage. The first step in modifying the use of harmful folk practices is to openly offer acceptance, acknowledgement and value of folk practices so caregivers and patients can negotiate professional and folk practices based on a trustworthy collaborative basis.

This research identified a pattern of *machisimo* (men possessing more than one woman or family) to be perceived as lack of care and a threat to health and well being for the rural Dominican population. The informants shared personal circumstances of heartache and lack of opportunity and perceived lack of care by families affected by *machistas'* behaviors. Transcultural nurses involved with the rural Dominican population must continue to investigate

interventions along side the rural Dominican population to repattern *machisimo* and its negative influences upon care and the culture. Caregivers may need to assist and enable rural Dominicans to examine the effects of *machisimo* on health and well being. Interventions may include focus groups and personal supportive actions educating the culture regarding *machisimo*'s discovered effects upon health and perception of care. Accountability groups and support for victims of *machisimo* could be initiated to help the culture establish new and beneficial lifeways in regard to spousal relationships. Efforts should be taken to assure ideas and interventions would be grounded in the unique cultural perspective of the Dominican culture. More research is needed to determine the Dominican perspective in repatterning/restructuring *machisimo* behavior and interventions to combat its consequences.

Many informants described living their lives according to destiny. These types of perceptions may influence decisions regarding achieving and maintaining healthy lifeways in rural Dominican culture. Support groups could be created to facilitate exploration of possibilities to change the village's health or economic situation. Methods for assisting individuals to utilize the family for empowerment can be explored and practiced. Individuals from a Dominican racial and cultural background who have successfully made choices to positively impact their lifeways could be recruited to mentor rural Dominicans who feel helpless or of no control over the future.

Based on the results of this study, professional caregiver repatterning is also necessary. The informants of this study described uncaring experiences in professional care in the Dominican Republic. Nurses and other caregivers were perceived as uncaring if they ignored patients, did not explain medications and treatment, neglected or did not show attention to patients, or showed a general lack of respect. Culture care repatterning requires addressing uncaring actions and making changes that are deliberate and comprehensive. The uncaring

experiences were with Dominican professional caregivers. Nurses from other cultures caring for rural Dominicans must obtain transcultural nursing knowledge in order to care for individuals in this culture group and facilitate caregiver-patient experiences that are perceived as culturally congruent.

Nursing Implications

Implications for Nursing Theory

In this study, Leininger's Culture Care Theory served as a theoretical framework to investigate the culture care meanings, beliefs, and practices of rural Dominicans in one village in Southern Dominican Republic. The goal of this study was to identify generic (folk) and professional care practices that promote health and beneficial lifeways for rural Dominicans. The findings from this study will contribute to the body of nursing knowledge regarding the care of Dominican people. The study's discoveries support the importance of generic and professional care in the promotion of health and well being in Dominican people. Additionally, the findings of this study support Leininger's notion that phenomena of care are embedded in aspects of culture.

Leininger's Culture Care Theory as a theoretical framework assisted the researcher all stages of data collection and analysis. The prescriptive nature of the Sunrise Model (Appendix A) seemed to impart the need to "fit data into boxes or domains" and served challenging in this international research endeavor. For this novice researcher, the preoccupation with "getting enough information regarding each domain" was distracting and at times inhibited the informant-driven interview process. The researcher often wondered, in this study, if a more apt approach would have been to begin an interview and allow domains to emerge from the data. Recognizably, the possibility of "missing rich content" in this process would support the need for

the theory's cultural and social structure dimensions to assist the research process. For this reason, categories were established in this study to enhance the data that emerged from the domains of the Sunrise Model. For this study, the Culture Care Theory and ethnonursing method appropriately uncovered culture care phenomena. In critiquing this process, the researcher discerned that the research questions and DOI guided the study in the context of the Culture Care Theory. It was only through exploring the DOI that the researcher obtained rich and meaningful data. However, in keeping with qualitative research philosophy of understanding the meaning or nature of experiences, the qualitative researcher must be flexible and open to potential new discoveries. This is certainly not a new debate regarding critique of the Culture Care Theory, but one that should be continued in dialogue.

The findings from this study confirm the Culture Care Theory and that meanings and experiences of human care can become understandable when viewed within a cultural context. Rich descriptions of rural Dominican lifeways found in this study can contribute to culturally congruent care practices. In addition to confirming the assertions of the theory, this study develops the theory in regard to considering the religious/philosophical factors that influence care expressions, patterns and practices for rural Dominicans. The literature reports the country to be 95% Catholic, as seen in chapter II. However, the informants in this study and researcher's etic comparison to data reveal an emerging religion termed *synchrotisimo religioso*. A Dominican interpreter, B. Jimenez (personal communication, March 16, 2006) and several informants described Dominican textbooks to state the religion of the Dominican Republic to be taught in the educational system as *synchrotisimo religioso*, or a mixture of many religions to suit an individual's liking. Several informants described Dominican people to state they are Catholic but explained the same people have never been in a Catholic church and/or have never

practiced Roman Catholicism. It was explained to the researcher that this is reported because to state that one is Catholic is customary, but most rural Dominicans visit many churches and take from various religions including protestant, Adventist, Catholic, and traditional African voodoo beliefs. The evidence of *synchrotisimo religioso* as the dominant religion in the DR was supported by the informant's responses in this study. In regard to theoretical application of the Culture Care Theory to cultural study, it may be important to investigate what one reports to be his/her religion and also investigate what is practiced.

The family is the fundamental social unit in the Dominican Republic as described in Chapter II and the results of this study. Family loyalty is important and Dominicans emphasize trust, assistance and solidarity between kin. In addition to Dominicans, the importance of family and kinship in health and caregiving is reported in Hispanic literature (Guarnaccia, Parka, Deschamps, Milstein & Argiles, 1992). Unique to the rural Dominican population from this study is the essential nature of family presence in illness. Unlike other reports of Hispanic cultures, it was noteworthy, in this study, Dominican family presence is essential and the lack of family presence and involvement in caregiving is perceived as a threat to maintaining health and achieving wellness. Further study of the essential nature of family presence is needed in other Dominican populations to develop this importance emerging unique characteristic for Dominican cultural values.

This study does contribute to the body of transcultural nursing knowledge. The findings from this study provide additional knowledge regarding generic and professional care practices of Dominicans, a subgroup of the Hispanic culture. This study resulted in three major themes based on values of care in the Dominican culture. The findings support existing studies which make the assertion that the concepts of family, respect and relationship are central to Hispanic

cultures. Specifically, this study reveals themes for greater understanding of culture care values for Dominicans residing in their home country. To date, few studies have been identified exploring culture care phenomena in rural Dominican Republic. Most contributory, this study revealed specific data pertaining to rural Dominicans' folk practices, expanding the body of transcultural nursing knowledge and foundation for further investigation.

Implications for Nursing Education and Practice

This study's findings have significant implications for nursing education and practice. The knowledge gained from this study regarding the importance of family, respect, and attention in care practices may be incorporated into nursing curricula when addressing care for Dominican people. The publication and dissemination of the themes and recommendations for care will provide nurses and other healthcare providers with knowledge about the culture care beliefs and practices that are specific to people of rural Dominican origin. The findings regarding home remedies and folk care practices will contribute to the growing body of knowledge regarding folk medicinal practices of rural Dominicans in the Dominican Republic and Dominican immigrants.

With knowledge and education of rural Dominican care meanings, beliefs, and practices, nurses and other healthcare providers can incorporate the values into care in order to provide care that is culturally congruent for Dominican people. The findings of this study encourage nurses to involve family in care, treat patients with respect and give focused attention to Dominicans in need. Advanced practice nurses, nursing students or other health caregivers who have never cared for a Dominican client can be oriented to a personal approach and beginning care giving focus through the findings of this study. Knowledge of the folk beliefs and practices by nurses, nurse practitioners, and physicians will assist healthcare providers to accommodate and negotiate culturally congruent care that is beneficial for the health and well being of

Dominicans in the DR and Dominican immigrants. The additional knowledge from the findings of this study will enhance the understanding of culturally sensitive care provisions through the use of Leininger's care modes which include culture care preservation and maintenance, culture care accommodation or negotiation, and culture care repatterning and restructuring.

Implications for Nursing Research and Policy

This study affirms feasibility of conducting international research. For many nurse researchers, the concept of studying cultural phenomena in non-immigrant populations may seem to be an unachievable endeavor. Not only is international research feasible, it is essential for understanding cultural context prior to acculturation of an immigrant population. A researcher who immerses oneself in the home culture of a culture group can gain greater trust and relationships for discovery in subsequent research undertakings.

This research has provided a basis for transcultural studies of Dominican people in their native environment. Further study of transcultural nursing phenomena is needed in other rural areas of the Dominican Republic and also in urban environments. Research conducted with Dominican immigrants can be compared to the findings of Dominicans in their native environment to discover the influences of acculturation on culturally congruent care. Research is also needed exploring the perceptions of care given by short term care giving outreaches from western caregivers, which are an increasing influence in health and well being in rural areas of the DR. A significant finding in this study was the informants in this study extensively use folk practices exclusively and in combination with professional biomedical care and treatments. Further research is needed investigating the health consequences of these therapeutic interventions in both Dominicans in their native environment and Dominican immigrants.

Nurses play an important role in promotion of health and disease prevention as well as the management of illness states. This is reflected in research priorities. Sigma Theta Tau International (STTI), an international honor society for nursing offered recommendations for global nursing research priorities (STTI, 2005). These included eradicating extreme poverty and hunger, achieving universal primary education, promoting gender equality and empowerment of women, reducing child mortality, improving maternal health, combating HIV/AIDS, ensuring environmental sustainability and developing a global partnership for development. This study supports the need for research funding to support these global initiatives in the DR. Specifically in the DR, research funding is needed to promote gender equality, combat HIV and AIDS and achieve universal primary education in rural areas.

Recommendations for Future Research:

The following are research topics to consider for future studies:

1. Investigate the effects of folk care practices and folk remedies on health and illness.
2. Discover the effect of acculturation on care meanings, beliefs, and practices for Dominican immigrants living abroad.
3. Explore the care meanings, beliefs, and practices of Dominicans in other rural and urban geographic areas of the Dominican Republic.
4. Investigate the perceptions of care from western outreach endeavors in the Dominican Republic.
5. Explore home remedies in greater depth, including preparation, administration, frequency and implications for use.
6. Investigate the implications of HIV and AIDS risks in rural Dominican populations.

Culturally Congruent care and Nursing Implications for Dominican Immigrants

Chapter II described the growing Dominican immigrant population in the US. Dominicans immigrating to the US bring beliefs and values regarding health and well being from the Dominican Republic. Therefore, it is imperative to discover and increase knowledge regarding their beliefs and practices from within the context of the Dominican Republic. Increased knowledge regarding culturally specific healthcare needs for the Dominican population is imperative to avoid culture conflict and culturally incongruent care for this growing population. With recognition that acculturation affects immigrant populations, it is important to note that this study does offer valuable general implications for caring for rural Dominicans living abroad.

Family involvement is necessary to promote health and well being in hospitals and clinics for the rural Dominican population. If numerous present family members interfere with professional care, it may be necessary to negotiate time frames for family members to be with loved ones. It may be difficult to establish boundaries with visiting family members and simultaneously acknowledge the cultural importance of their presence. This should be done with respectful communication and explanation. Many western institutions possess visiting boundaries and limits in order to preserve privacy for nearby patients. Measures to preserve privacy and accommodate families need to be pursued. Additionally, the importance of treating rural Dominicans with respect and attention are equally as important for Dominicans living abroad.

In Chapter I, studies of Dominican immigrants revealed plants and vegetation are brought from the Dominican Republic and being used for home remedies abroad. Dominican informants described vegetation for medicinal purposes taken to family members living outside the

Dominican Republic validating home remedy usage with Dominican immigrants. This study offers additional knowledge regarding traditional folk care practices that are specific to immigrants of Dominican heritage. It is imperative that nurses caring for Dominican immigrants become familiar with their spiritual and folk care practices. Nurses must respectfully inquire with each Dominican immigrant client regarding utilization of folk remedies and treatments. With increased knowledge and understanding, the healthcare community can offer acknowledgement and value of folk practices. In addition, patients and caregivers can negotiate professional and folk practices in a trustworthy collaborative effort without patient fear of caregiver judgment.

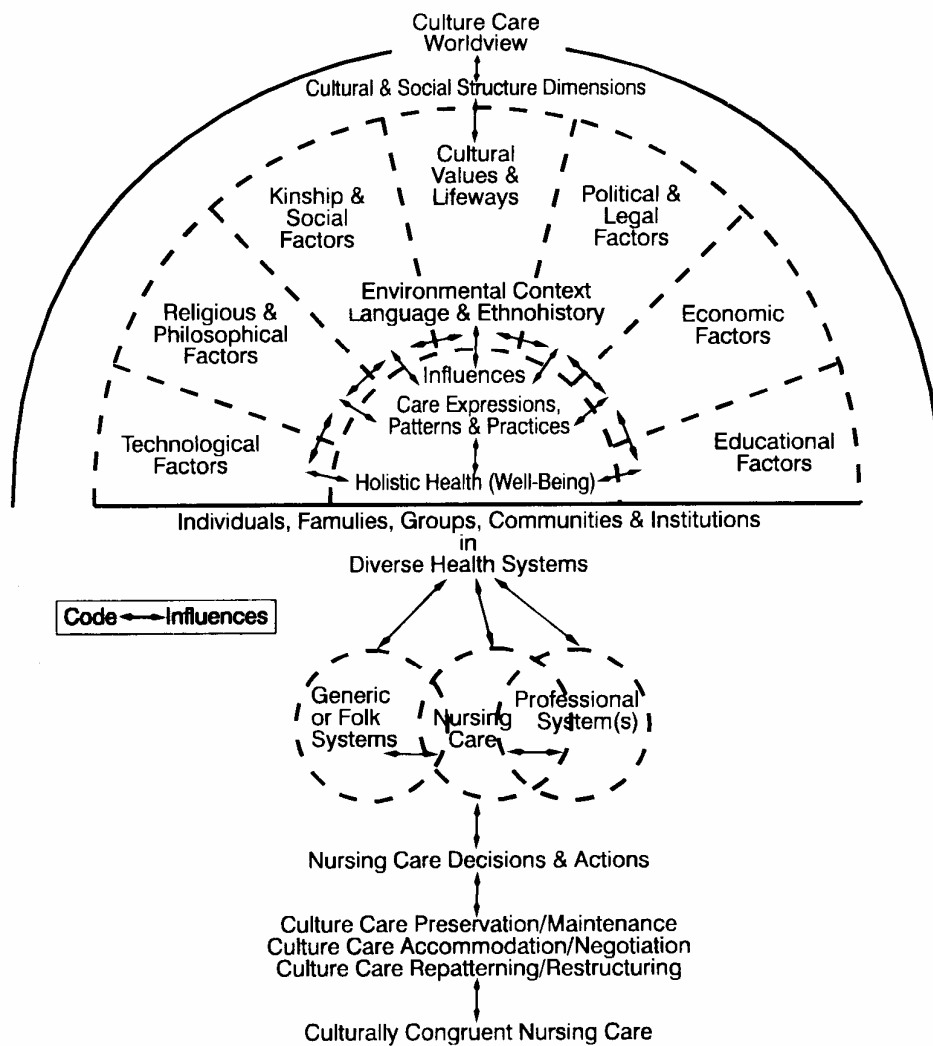
Conclusion

This study investigated the culture care meanings, beliefs and practices of Dominicans in one rural village of the Dominican Republic. This study was conceptualized within Leininger's Culture Care Theory and used the ethnonursing research method to guide its discovery. It was assumed that care meanings and experiences tend to be embedded in social structure and worldview and need to be identified with reference to naturalistic environmental context. In addition to answering the research questions, patterns and themes abstracted from the data were discovered and discussed regarding culturally congruent care for rural Dominicans in their native environment. Implications for nursing research, education and practice, for providing culturally congruent care for rural Dominicans and Dominican immigrants were presented. Strengths and limitations and recommendations for future research were highlighted.

Appendix A

Transcultural Nursing: Concepts, Theories, Research and Practices

Figure 3.1
Leninger's Sunrise Model to Depict the Theory of Culture Care Diversity and Universality



From *Culture Care Diversity and Universality: A Theory for Nursing* by M. Leininger, 1991
New York: National League for Nursing. Reprinted by permission.

Appendix B

Chapter 4: Cultural Care Assessment to Guide Nursing Practices

Figure 4.2

Leininger's Stranger to Trusted Friend Enabler Guide*

The purpose of this enabler is to facilitate the researcher (or clinician) to move from mainly a distrusted stranger to a trusted friend in order to obtain authentic, credible and dependable data (or establish favorable relationships as a clinician). The user assesses him or herself by reflecting on the indicators as he/she moves from stranger to friend.

Indicators of Stranger (Largely etic or outsider's views)	Date Noted	Indicators as a Trusted Friend (Largely emic or insider's views)	Date Noted
<p>Informant(s) or people are:</p> <ol style="list-style-type: none"> 1. Active to protect self and others. They are "gate keepers" and guard against outside intrusions. Suspicious and questioning. 2. Actively watch and are attentive to what the researcher does and says. Limited signs of trusting the researcher or stranger. 3. Skeptical about the researcher's motives and work. May question how findings will be used by the researcher or stranger. 4. Reluctant to share cultural secrets and views as private knowledge. Protective of local lifeways, values and beliefs. Dislikes probing by the researcher or stranger. 5. Uncomfortable with becoming a friend or confiding in a stranger. May come late, be absent and withdraw at times from the researcher. 6. Tends to offer inaccurate data. Modifies "truths" to protect self, family, community, and cultural lifeways. Emic values, beliefs, and practices are not shared spontaneously. 		<p>Informant(s) or people are:</p> <ol style="list-style-type: none"> 1. Less active to protect self. More trusting of researchers with "gate keeping" down or less. Less suspicious and less questioning of researcher. 2. Less watchful of the researcher's words and actions. More signs of trusting and accepting a new friend. 3. Less questioning of the researcher's motives, work and behavior. Signs of working with and helping the researcher as a friend. 4. Willing to share cultural secrets and private world information and experiences. Offers most local views, values and interpretations spontaneously or without probes. 5. Signs of being comfortable and enjoying friends and a sharing relationship. Gives presence, on time, and gives evidence of being a genuine friend. 6. Wants research "truths" to be accurate regarding beliefs, people, values and lifeways. Explains and interprets emic ideas so the researcher has accurate data. 	

* Developed and used since 1959 by author.

Adapted from *Culture Care Diversity and Universality: A Theory for Nursing* by M. Leininger, 1991. New York: National League for Nursing. Reprinted by permission.

Appendix C

Leininger's Ethnonursing Observation-Participation-Reflection Enabler				
Phases	1	2	3	4
Focus	Primarily Observation and Active Listening (no active participation)	Primarily Observation with Limited Participation	Primarily Participation with Continued Observations	Primarily Reflection and Reconfirmation of Findings with Informants

Appendix D

Interview Guide Heading or Sunrise Model Facet	Suggested Change to Interview Guide	Rationale for Suggested Change
Ethnodemographics	<ol style="list-style-type: none"> 1. Eliminate pursuit of info for spouse and children 2. Eliminate the pursuit of identification as Dominican 3. Add “or property” to question pursuing who lives in the household 4. Add question: <i>What livestock/animals to you have and own on your property?</i> 	<ol style="list-style-type: none"> 1. It is likely interviews will occur with spouse and children anyway, would be better to ask for clarification of relationships with other informants 2. All people identify themselves as Dominican in this village as stated numerous times. It became offensive to continue asking each informant 3. Questioning who lived in the household was effective, but the “household” often mean the hut on the same property. There were many extended family who were being cared for by an informant and lived in a hut on the same property 4. There were goats, chickens, pigs, donkeys, dogs and cats everywhere. Pursuit of ownership was not included in original interview guide
Cultural Values, Beliefs and Lifeways	<ol style="list-style-type: none"> 1. Eliminate the “typical day and night question” 	<ol style="list-style-type: none"> 1. There was difficulty understanding this question. A view of this content is achieved when talking about

	<ol style="list-style-type: none"> 2. Move the question regarding “what values do you want to pass on to your children” to the kinship sector 	<p>other areas within the interview guide</p> <ol style="list-style-type: none"> 2. The researcher repeatedly forgot to come back to this question and it was well understood. It would be better to place elsewhere to facilitate the answer in context of the phenomena
Worldview/Spiritual/Religion	<ol style="list-style-type: none"> 1. Eliminate questions #1,#2,#8 2. Move the question #5: “what does good health mean to you” to another section of context 3. Add the question: <i>What foods are avoided that are NOT related to religious or spiritual reasons?</i> 4. Add the question: <i>Can you tell me about the ceremonies to the saints that occur in the Dominican culture?</i> 	<ol style="list-style-type: none"> 1. These questions were not understood, repeatedly difficult to explain 2. When the informant discusses health, this flows better with other areas than in the topic of spirituality/ religion 3. Many foods were offered from numerous individuals that were assumed by the researcher to be for spiritual reasons, but proved to be unrelated 4. This topic came up regularly and could be pursued in more depth
Kinship and Gender	<ol style="list-style-type: none"> 1. Eliminate the “family tree question”, #1 	<ol style="list-style-type: none"> 1. This question did not elicit much information, more flow when asking people directly about members of their family

	<p>2. Add question: <i>Can you tell me about male/female relationships, marriage and social unions in your culture?</i></p> <p>3. Add questions: <i>Can you tell me about how men and women perceive the situation of a man having many women in your culture? What are the effects of a man having dual families in your culture?</i></p> <p>4. Add question: <i>How are the elderly respected in your culture?</i></p> <p>5. Add question: <i>What are the views of men and women in your culture about education?</i></p>	<p>2. Numerous responses involved marriage and social unions. It would be beneficial to explore in greater detail</p> <p>3. Responses highlighted information regarding men having 2 families. Questions exploring this in more detail would add richness to the discovery</p> <p>4. The informants repeatedly discusses elderly are valuable and looked to for counsel. A question is needed discovering specific ways in which respect is shown to them</p> <p>5. Informants shared different views regarding education. It was unclear what the gender specific views may be</p>
<p>Meanings and Experiences of Care</p>	<p>1. Eliminate questions #1, #2, #6</p> <p>2. Add questions: <i>Tell me about care that is</i></p>	<p>1. These question are not understood and the information was obtained with using the other listed questions</p> <p>2. Additional questions are needed eliciting</p>

	<p><i>received in the public system in your culture? Can you tell me about care that is received in your private system? I would like to know more about care that is received from brujas, could you share more with me about this? Have you received care from westerners who visit your country, and if so, what were your experiences like? In what ways did westerners care for you that was in line with what you expected? In what ways was care provided that was not meaningful or what you expected?</i></p>	<p>specific information regarding care from specific types of environments. Adding the questions will assist the researcher to pursue this data and allow for better flow in and out of related sections of the interview guide</p>
<p>Professional and Folk Caring Factors</p>	<ol style="list-style-type: none"> 1. Add a note to the researcher in bold: <i>remember to consider when asking about bruja treatment that it is viewed shamefully. This may be best pursued when one on one or in private interview with key informants during subsequent interviews</i> 2. Eliminate question #4 3. Add question: <i>What can you tell me about the care of doctors and nurses? How is the care given by doctors and nurses different?</i> 	<ol style="list-style-type: none"> 1. This will remind the researcher within each interview regarding sensitivity with inquiry 2. “Meaningful” is not understood 3. Care from doctors and nurses was lumped together in many responses with initial discovery of differences in

	<p>4. Eliminate #12</p> <p>5. Inquire deeper and validate about specific plants used medicinally</p>	<p>perceptions of care. Adding the questions will facilitate deeper discovery</p> <p>4. Transportation is discussed in other areas of the guide, seemed redundant when incorporated in this section</p> <p>5. Knowledge regarding folk medicinal practices is tremendous and would assist in knowledge acquisition for a later study</p>
Technological Factors	<p>1. Add question pertaining to World Bank loan and Dominican perceptions of technological development</p>	<p>1. Recent approved \$150 million loan will affect electricity in DR, and the literature reports a conflict in perceptions of technological development by the rural poor</p>
Political Factors	<p>1. Add questions: <i>Can you tell me about the history of politics in your country? How has the government or leaders in the past or current time assisted your people in achieving good health and well-being?</i></p>	<p>1. Two times in the mini study interviewing, a side conversation/debate broke out stating comparisons in health and economics when Trujillo (a former dictator) was in power. There were clear differences in views of the effect of government. Adding these questions facilitates deeper discovery regarding this issue.</p>

Economic Factors	1. Add question: <i>Based on the economic situations that you have described to me, can you tell me about how your economic situation affects care you receive from public, private, or western caregivers?</i>	1. The informants described their economic situations in detail, but the questioning did not elicit how the economic situations influence different care environments. Adding this question will assist deeper exploration.
Environmental Context	No suggested changes to this section of the interview guide	

Appendix E

EHTNONURSING INQUIRY GUIDE FOR DISCOVERING CARE MEANINGS AND EXPERIENCES IN CULTURAL CONTEXT																	
I. Introduction	II. Ethnodemographics																
The purpose of this study with interviews and observations is to learn from you about your family and lifeways in order to plan for and improve nursing care for Dominican people. In this part, I would like to discuss with you or have you describe yourself and your family and then I will talk to you about other aspects of care.	<ol style="list-style-type: none"> 1. Tell me about yourself and your family: 2. What is your: <table border="1" data-bbox="776 449 1312 657"> <thead> <tr> <th></th> <th>Informant</th> </tr> </thead> <tbody> <tr> <td>Age/Sex</td> <td></td> </tr> <tr> <td>Birthplace</td> <td></td> </tr> <tr> <td>Marital stat</td> <td></td> </tr> <tr> <td>Occupation</td> <td></td> </tr> <tr> <td>Education</td> <td></td> </tr> <tr> <td>Income</td> <td></td> </tr> <tr> <td>Religion</td> <td></td> </tr> </tbody> </table> 		Informant	Age/Sex		Birthplace		Marital stat		Occupation		Education		Income		Religion	
	Informant																
Age/Sex																	
Birthplace																	
Marital stat																	
Occupation																	
Education																	
Income																	
Religion																	
III. Cultural Values, Beliefs, Lifeways																	
As a nurse, I am interested in your cultural values and way of living in order to be able to plan healthcare for Dominicans. <ol style="list-style-type: none"> 1. What specific values or beliefs do you possess that you would identify as Dominican? 2. What does good health and well-being mean to you? 	<ol style="list-style-type: none"> 3. How many children have you (your wife) given birth to? Are they all alive and living in the DR? 4. Who lives with you in your household most of the time? Who lives on your family property? 5. What livestock/animals do you have and own on your property? 6. Can you tell me what it is like living in this country? 																
IV. Worldview/Spiritual/Religion	V. Kinship and Gender																
I am interested in knowing more about your spiritual or religious way of living. <ol style="list-style-type: none"> 1. Could you tell me about the relationship between religion and health? Religion and care? 2. What religious rituals or ceremonies to you observe? How often do you observe them? 3. Are there certain beliefs concerning what or who influences illness in your village? 4. Can you tell me how illnesses can be prevented, diagnosed or treated in your culture? <p>I would like to learn more about your religious beliefs and practice and especially as they relate to your general wellness and/or health.</p> <ol style="list-style-type: none"> 1. Tell me about food that you are required to eat? Are there foods you avoid? 2. What foods are avoided that are NOT related to spiritual or religious reasons? 3. Do you observe religious customs or holidays? ____ If yes, which ones and what is the significance? ____ 4. Can you tell me about the ceremonies to the Saints that occur in the Dominican culture? 	I am interested in the structure and composition of your family. <ol style="list-style-type: none"> 1. The major role of the male or husband in your culture is__? Female or wife? 2. How and by whom are family decisions made within your culture? Your family? Who is consulted? 3. Who is the head of your household? 4. In Dominican culture, I understand it is not uncommon for a man to father children apart from his spouse. Can you tell me more about this? 5. Can you tell me about male/female relationships, marriage and social unions in your culture? 6. What is the significance of marriage in this culture? To what degree do separation, divorce or broken homes occur and impact families in your village? 7. Can you tell me about how men and women perceive the situation of a man having many women in your culture? What are the effects of a man having dual families in your culture? 8. To what degree is domestic violence (violence against a spouse and/or children) common within your village and/or community? 9. What else can you tell me about roles of men and women? 10. What are the views of men and women in your culture about education? 11. Are there specific roles for men and women who are elderly? Teenagers? 12. How are the elderly respected in your culture? 13. What values and beliefs related to your culture are most important to you and to pass on to your children? 																

VI. Meaning and Experiences of Care	
<ol style="list-style-type: none"> 1. In your culture, what signs would let you know that someone cares about you? 2. Can you give me some words which describe a caring person? 3. Have you had experiences with people who are non-caring? If someone doesn't care, how would they express themselves? 4. Could you tell me about the Dominican family and their caring ways? What are the strengths of the family? 5. In your culture, what ways to men show care? Women? 6. As you think about care, what do you think contributes to the development of a caring person and/or family or a caring institution, i.e. hospital, school or home? 7. Tell me about care that is received in the public system in your culture? Can you tell me about care that is received in your private system? 8. I would like to know more about care that is received from brujas, could you share more with me about this? 9. Have you received care from westerners who visit your country, and if so, what were your experiences like? In what ways did westerners care for you that was in line with what you expected? In what ways was care provided that was not meaningful or what you expected? 	
VII. Professional and Folk Caring Factors	
Could we talk next about your experiences with different health care systems?	
<p>NOTE: REMEMBER TO CONSIDER WHEN ASKING ABOUT BRUJA TREATMENT THAT IT IS VIEWED AS SHAMEFULLY. THIS MAY BEST BE PURSUED WHEN ONE ON ONE OR IN A PRIVATE INTERVIEW WITH KEY INFORMANTS DURING SUBSEQUENT INTERVIEWS.</p> <ol style="list-style-type: none"> 1. Have you ever been hospitalized or treated in a clinic? For what reasons? What was your experience like? 2. Have you ever received care from a healer, medicine person, wise woman, or witch doctor? In what ways do they show care? 3. In what ways is the care shown by these healers different from care shown by nurses or doctors in the hospital or clinic? 4. In what ways do nurses show care? Can you give examples from your experiences in the hospital or clinic? 5. When a family member is hospitalized, what roles do the family and kin wish to play during the course of treatment or hospitalization? 6. What are your expectations regarding nursing care and/or medical treatment? 7. In the future, if you were in a hospital (or clinic) what things would you like the nurse to do to show care? 8. What systems do you currently use, clinics or folk healers, or both? 9. When do people in your culture choose folk or professional care? 10. What can you tell me about the care of doctors and nurses? How is the care given by a doctor different from nurses in your culture? 11. Could you tell me about the traditional health remedies which you currently use? For what conditions or illnesses are they used? 12. What plants are utilized for prevention of illness and treatment of disease? How are they prepared and used? What can you tell me about natural medicinal remedies used in your culture? 13. Is there anything else you would like for me to know regarding care and folk practices? 	
VIII. Technological Factors	IX. Political Factors
<ol style="list-style-type: none"> 1. Tell me about your ideas of technology and how it influences your way of life? 2. What types of modern technology or treatment care are preferred within your culture? What types are avoided? 3. Are there things that concern you about technology and health care? 4. In what ways do you see technology interfering with human care in the hospital or clinic? 5. What can you tell me about the World Bank loan for increasing electricity stabilization in the DR? How do you feel this will affect your daily living and health and well being? 6. What can you tell me about the use of technology in your culture? How do you feel technology will be developed and what effect will technological development place on your village and country? 	<ol style="list-style-type: none"> 1. Who are the most influential leaders in the community? 2. Are there certain leaders who are known to be caring people? Who are they? 3. How do these leaders show care to the community as a whole? To individuals in the community? 4. What is the attitude toward authority in your culture? 5. Can you tell me about the history of politics in your country? How has the government or leaders in the past or current time assisted you in achieving good health and well-being? 6. How does the political arena in your culture influence care and care practices inside and outside of health care? 7. Are there government clinics in the area? How do you feel about the healthcare system in the DR? What can you tell me about doctors, nurses and medical treatments in your country?
X. Economic Factors	XI. Environmental Context
<ol style="list-style-type: none"> 1. What are the major sources of income for you and your family? 2. What are your major expenses? 3. Are you able to save a portion of your income? 4. Who controls the money in your family? 5. How do you pay for health services? For clinics? 	<ol style="list-style-type: none"> 1. Are you concerned about your environment and how it related to health and illness? 2. Are there any relationships between water and food supply and health and illness? 3. Is there anything you would like me to know about your environment and how it relates to

<p>For folk healers?</p> <p>6. Are you concerned about your economic situation?</p> <p>7. Based on the economic situations that you have described to me, can you tell me about how your economic situation affects care you received from public, private, or western caregivers?</p>	<p>your cultures' illnesses or ability to stay healthy?</p>
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Adapted from:

Luna, L. J. ((1989). Care and cultural context of Lebanese Muslims in an urban U.S. community: An ethnographic/ethnonursing study conceptualized within Leininger's theory. *DAI*. (UMI No. 9022423).

Appendix F



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CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE: Culture Care Meanings, Beliefs and Practices of Dominicans in a Rural Barrio of the Dominican Republic: An Ethnonursing Study Conceptualized within the Culture Care Theory

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(412) 396-6545

SOURCE OF SUPPORT: None

PURPOSE: The purpose of this study is to discover, describe and analyze the meanings, beliefs and practices of care for Dominican people living in a rural barrio of the DR within the environmental context of their familiar homes and communities. Interviews will be conducted one to three times and each interview may last from 45 minutes to 2 hours. These interviews will be tape recorded. During these interviews you will be asked about your cultural beliefs, practices, and nursing care related to the meaning of health, illness, and well being.

RISKS AND BENEFITS: There are no known risks or direct benefits from participating in this study; however, changes may occur in patient care for Dominican people here and in the United States and nursing

education regarding the Dominican care needs after the study is completed.

COMPENSATION: You will not be compensated for participating in this study. However, participation in this study will require no money from you.

CONFIDENTIALITY: Your name will never appear on any survey or research instruments. Verbatim quotations may be used but no name will ever be attached to ensure that confidentiality will be maintained at all times. No identity will be made in the data analysis. All written materials and consent forms will be stored in a locked file in the researcher's home. All information relating to this study will be destroyed upon completion of all activities related to the study. The interpreter hired to assist in translation will be sign a confidentiality agreement and will not have access to your names.

RIGHT TO WITHDRAW: You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time.

SUMMARY OF RESULTS: A summary of the results will be supplied to you, at no cost, upon request.

VOLUNTARY CONSENT: I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reasons. On these terms, I certify that I am willing to participate in this research project.

I understand that should I have any further questions about my participation in this study, I may call Dr. Paul Richer, Chair of the Duquesne University Institutional Review Board. (412-396-6326) or Dr. Rick Zoucha at 412-396-6545 or Gretchen Schumacher at 809-560-5071, and will be given opportunity to discuss, in confidence, any questions with any member of the Institutional Review Board.

Participant's Signature

Date

Researcher's Signature

Date



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CONSENTIMIENTO A TOMAR PARTE EN UN ESTUDIO DE INVESTIGACIÓN

TÍTULO: Significado del Cuidado Personal Como Factor Cultural, Creencias y Practicas de los Dominicanos en Barrios Rurales de la Republica Dominicana: un Estudio de Etnoenfermeria Conceptualizado Referente A la Teoria del Cuidado Personal Como Factor Cultural.

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ORIGEN DE APOYO MONETARIO: Nada

PROPÓSITO: El proposito de este studio es descubrir, describir y analizar los significados, creencias y practicas en el cuidado personal de los dominicanos que viven en los barios rurales de la Republica Dominicana dentro del contexto ambiental de sus hogares y comunidades. Se haran de una a tres entrevistas y cada una puede que dure de 45 minutos a 2 horas. Las entrevistas seran grabadas en cintas de audio. Durante las entrevistas se preguntara acerca de las creencias culturales, practicas y el cuidado de enfermeria relacionado con el significado de salud, enfermedad y bienestar.

RIESGOS Y BENEFICIOS: No hay riesgos conocidos ni beneficios directos por la participacion en este estudio, sin embargo cambios pueda que ocurran en el cuidado de pacientes domini-

canos aca en los Estados Unidos, ademas una vez completado el estudio pueda que cambios ocurran en la educacion de enfermeria mas alla del propio cuidado de los dominicanos

COMPENSACIÓN: No hay compensación por tomar parte en este estudio. Sin embargo, participación en este estudio requerirá nunca de su dinero.

CONFIDENCIALIDAD: Su nombre no parecera en ningun instrumento de encuesta o investigacion. Opiniones textuales pueda que se usen pero el nombre no figurara para garantizar que la confidencialidad sera mantenida en todo momento. No habra identificacion de los datos de analisis. Todo material escrito y consentimientos seran guardados bajo llave en la casa del investigador. Toda la informacion relacionada a este estudio una vez que se haya completado sera destruida. El interprete contratado para asistir en la traduccion firmara un acuerdo de confidencialidad y no tendra acceso a los nombres.

DERECHO A RECOGERSE: No tienes obligación de tomar parte de este estudio. Estás libre a recogerte su consentimiento a tomar parte en cualquier momento. Estás libre negarse a grabación en cinta y todavía tomar parte del estudio.

SUMARIO DE LOS RESULTADOS: Te daré un sumario de los resultados, libre de gastos, a petición.

CONSENTIMIENTO VOLUNTARIO: He leído las declaraciones del aboce y entiendo qué se está solicitando de mí. También entiendo que mi participación es voluntaria y que estoy libre retirar mi consentimiento en cualquier momento, por cualquier razón. En estos términos, certifico que estoy dispuesto a participar en este proyecto de investigación.

También comprendo que si tengo más preguntas sobre mi participación en este estudio, puedo llamar Dr. Paul Richer por 412-396-6326. Dr. Rick Zoucha por 412-396-6545 o Gretchen Schumacher por 809-560-5071, y puedo discutir, en confianza, cualquier pregunta con cada miembro del Junta Directiva de Repaso Institucional.

Nombre

Fecha

Investigadora

Fecha

Appendix G

VERBAL EXPLANATION

I would like to introduce myself. I am Gretchen, a nurse studying at Duquesne University. I am engaged in field research related to the meanings, expressions, and experiences of care of people living in barrios of the Dominican Republic.

The purpose of the research study is to learn about the meanings of care and how care is experienced and expressed by people living in barrios of the DR and also about what practices increase your health and well-being. Although you may not benefit personally from the research study, information obtained will be beneficial and helpful in planning and providing health and nursing care for Dominican people.

Should you agree to participate in the study, 1-3 interviews will be required, each lasting about 1-2 hours, and at a time that is convenient to you. All information is confidential and your identity will not be revealed. Your participation is entirely voluntary and you may feel free to withdraw your consent and discontinue your participation in the project at any time. Any questions will be answered.

I would also like to ask for your permission to record the interviews using a tape recorder. This will allow me to review the information you share with me and prevent me from overlooking important information given by you. If you do not wish to consent to the recording it will not be done. If you give permission to recording of the interview, the tapes will only be listened to by me and the Spanish-English translator.

In the event of any injury resulting from the research, no reimbursement, compensation or free medical care is offered by Duquesne University. In case you have any questions regarding the research study or your rights as a research participant, I can be reached at the home of Francisco and Diane Sabado, (809) 560-5071.

Signature of Witness of Verbal consent: _____

Appendix G (cont)

EXPLICACIÓN VERBAL

Me gustaría introducir yo mismo. Yo soy Gretchen, una enfermera quién estudia a la Universidad Duquesne. Estoy activo en la investigación que concierne los significados, las expresiones, y las experiencias del cuidado de las personas que viviendo en los barrios de la República Dominicana.

El propósito del estudio de investigación es aprender de los significados del cuidado y como el cuidado está experimentado y expresado por la gente que viven en los barrios de la República Dominicana. Aunque no puedes beneficiarte del estudio de investigación, la información que está obteniendo será beneficioso y útil en el planeando y el proveyendo el cuidado de salud y de enfermera por la gente dominicana.

Si convienes en tomar parte en el estudio, 1-3 entrevistas estará requerido, cada que dura 1- 2 horas, y en un momento dado que te convienes. Toda la información es confidencial y su identidad no estará revelando. Su participación es totalmente voluntaria y estás libre retractar su consentimiento y discontinuar su participación en el proyecto en cualquier momento. Cualquiera pregunta estará contestada.

También me gustaría preguntar por su permiso a recordar las entrevistas con un magnetófono. Eso me permitirá revistar la información que compartes conmigo y me impedirá de omitiendo una información importante que has dado. Si no quieres constar, no lo hago. Si me das su permisión a recordar su entrevista, solamente yo y el traductor escucharemos las cintas.

En el caso de que cualquier herida que ocurre a consecuencia de la investigación, nunca reembolso, compensación, o cuidado médico libre ofrecerá por la Universidad Duquesne. Por si tienes cualquier pregunta sobre el estudio de investigación o sus derechos cuando estás un partícipe, puedes te pones en contacto conmigo en el hogar de Francisco y Diane Sabado, (809) 560-5071.

Firma de testiga _____

Appendix H

CONFIDENTIALITY STATEMENT

I understand that as an interpreter for a study being conducted by Gretchen Schumacher of the School of Nursing, Duquesne University, under the supervision of Professor Zoucha, I am privy to confidential information. I agree to keep all data collected during this study confidential and will not reveal it to anyone outside the research team.

Name: _____ Signature: _____

Date: _____ Witness Signature: _____

Appendix I

Leininger's Phases of Ethnonursing Analysis for Qualitative Data*

Fourth Phase

Major Themes, Research Findings, Theoretical Formulations, and Recommendations

This is the highest phase of data analysis, synthesis, and interpretation. It requires synthesis of thinking, configuration analysis, interpreting findings, and creative formulation from data of the previous phases. The researcher's task is to abstract and present major themes, research findings, recommendations, and sometimes theoretical formulations.

Third Phase

Pattern and Contextual Analysis

Data are scrutinized to discover saturation ideas and recurrent patterns of similar or different meanings, expressions, structural forms, interpretations, or explanations of data related to the domain of inquiry. Data are also examined to show patterning with respect to meanings-in-context along with further credibility and confirmation of findings.

Second Phase

Identification and Categorization of Descriptors and Components

Data are coded and classified related to the domain or inquiry and sometimes the questions under study. *Emic* or *etic* descriptors are studied within context and for similarities and differences. Recurrent components are studied for their meanings.

First Phase

Collecting, Describing, and Documenting Raw Data (Use of Field Journal and Computer)

The researcher collects, describes, records, and begins to analyze data related to the purposes, domain of inquiry, or questions under study. This phase includes: recording interview data from *key* and *general* informants; making observations, and having participatory experiences; identifying contextual meanings; making preliminary interpretations; identifying symbols; and recording data related to the phenomenon under study, mainly from an *emic* focus, but attentive to *etic* ideas. Field data from the condensed and full field journal is processed directly into the computer code.

*Leininger, M.M. (1987,1990, and current revisions in 1991).

From: Leininger, M.M. (1991). Culture Care Diversity & Universality: A Theory of Nursing. New York: National League for Nursing Press

Appendix J

Table 4- Summary of Educational Characteristics of Key Informants (10 informants)

Elementary grade completed									High school grade completed				Post High School Education	
None	1	2	3	4	5	6	7	8	9	10	11	12	Trade	Uni
									x					
											x			
											x			
														x
														x
													x	
														x
				x										
			x											
											x			

Table 5- Summary of Educational Characteristics of General Informants (19 informants)

Elementary grade completed									High school grade completed				Post High School Education	
None	1	2	3	4	5	6	7	8	9	10	11	12	Trade	Uni
			x											
x														
x														
												x		
	x								x					
						x								x
									x					
					x									
											x			
				x										
									x					
				x										
													x	
				x										

*Uni=University

Appendix K



Appendix L



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