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Cholera and humiliation in the Dominican Republic: A qualitative study of stigma and psychosocial stress among Haitian migrants

By

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Degree to be awarded: MPH

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B.S., University of Georgia, 2004

B.S.N., Emory University, 2011

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An abstract of

A thesis submitted to the Faculty of the
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2013

## Abstract

Cholera and humiliation in the Dominican Republic: A qualitative study of stigma and psychosocial stress among Haitian migrants

By

Hunter Keys

Cholera is not only a crippling enteric infection that can lead to death, but it can stigmatize those it most afflicts–namely, the poor and socially marginalized. The island of Hispaniola, which Haiti and the Dominican Republic share, is still experiencing an outbreak of epidemic cholera that started in late 2010. Haitian migrants, long a subordinate and stigmatized class in Dominican society, play an important role in the epidemic because their circular migration links poor communities in both countries. To date, little is known about cholera-related stigma or its effects on psychosocial health of Haitian migrants. This qualitative study used focus group data collected among Haitian migrant and Dominican community members in urban and rural areas of Duarte Province, Dominican Republic in summer 2012. A total of eight focus groups, stratified by nationality, sex, and urban-rural setting, were held with a total of 47 participants (23 Haitians, 24 Dominicans). Theoretical frameworks of stigma's moral experience and the psychosocial stress model informed thematic analysis of focus group transcripts. Both Haitians and Dominicans expressed fear of cholera and used a rich dichotomy of cleanliness and dirtiness to characterize it. However, accounts diverged when Dominicans blamed the "lower culture" of their Haitian neighbors for the epidemic's spread. In contrast, Haitian migrants cited structural hardships and feelings of unimportance, vulnerability, and powerlessness in the face of the epidemic. Haitian migrants, already cast as morally inferior by an anti-Haitian ideology, became labeled as cholera-carriers. By examining local, subjective points of view held by both the stigmatized and the dominant population, this study uncovered how cholera-related stigma impinges directly on psychosocial health of Haitian migrants and threatens what matters most to them. Public health interventions to address stigma are outlined.

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# CHAPTER I: LITERATURE REVIEW

## *Cholera and Hispaniola epidemic*

Cholera is a significant public health burden. Every year, an estimated 3 to 5 million cases and 100,000 to 120,000 deaths occur worldwide, but due to weak surveillance and case reporting those figures represent only a fraction of actual numbers (Ali et al., 2012). Epidemics occur when the pathogen *Vibrio cholerae* is introduced into settings that lack improved water and sanitation. Most human-to-human spread occurs via fecally contaminated water (Weil, Ivers, & Harris, 2012). After ingestion, profuse diarrhea leads to rapid dehydration and then death (Harris, LaRocque, Qadri, Ryan, & Calderwood, 2012). With prompt medical care, however, death can be averted with restoration of fluids and electrolytes (Sack, Sack, Nair, & Siddique, 2004).

There have been seven global pandemics of cholera (Lee, 2001). Cholera was first introduced to the Western Hemisphere in the early-mid $19^{th}$ century (Barua, 1992) and later the Caribbean island of Hispaniola during the fourth pandemic of 1863-1879 (Jenson & Szabo, 2011). Cholera did not re-emerge in the Americas until early 1991, when it rapidly spread throughout Latin America but spared Hispaniola (Seas et al., 2000).

In October 2010, just ten months after the earthquake that struck Port-au-Prince, epidemic cholera emerged in Haiti (Ministère de la Santé Publique et de la Population (MSPP), 2010). The epidemic quickly spread throughout the country, reaching a case fatality rate of 6% (Barzilay et al., 2013). Haiti has long faced severe shortcomings in water and sanitation. Prior to the earthquake, 63% of the nation's 10 million people had access to safe water, while only 17% had access to improved sanitation (UNICEF, 2013b). Haiti was one of the few countries in the world where coverage for sanitation actually *declined* during the Millennium Development Goals campaign (WHO/UNICEF JMP, 2013). Factors that

contributed to cholera's rapid spread in Haiti include severe inadequacies in water and sanitation, the devastation of the earthquake and impact on already limited resources, above average rainfall, and government incapacity to respond to the crisis (Etienne et al., 2013).

Less than one month after the epidemic began in Haiti, cases were reported in the neighboring Dominican Republic (Tappero & Tauxe, 2011). Sharing the island of Hispaniola, the two countries diverge widely in water and sanitation coverage. In contrast to Haiti, over 80% of the population in the Dominican Republic has access to improved water and sanitation (UNICEF, 2013a). The epidemic in the Dominican Republic peaked mid-way through 2011. By the end of the year, over 20,000 suspected cases and 371 deaths were reported in the country (Ministerio de Salud Pública, 2012), while in Haiti, over half a million cases and over 7,000 deaths were recorded (PAHO, 2013). Cholera incidence in the Dominican Republic remains high in poor regions along the border and in rural communities with limited water, sanitation, and healthcare. As of September 2013, 29,057 cases and 443 deaths from cholera have been reported in the Dominican Republic (PAHO, 2013).

*Social context of cholera*

To date, much attention has focused on the epidemiology and transmission of cholera on Hispaniola, with the goal of developing effective public health interventions (Etienne et al., 2013; Grandesso et al., 2013; Jackson et al., 2013; Periago et al., 2012; Poirier, Izurieta, Malavade, & McDonald, 2012). These studies often implicate knowledge, attitudes, and practices (KAP) at the individual or household levels, where knowledge of cholera transmission, perceived importance of prevention, and actual implementation of healthy behaviors confer protection or risk. While these findings are essential for cholera

interventions, emphasis on the individual or household can potentially overlook the social and community context in which people live.

Local understandings of disease shape prevention and treatment-seeking behavior as well as social constructions of stigma and blame (Hruschka & Hadley, 2008; Weiss, 2008). For example, understandings of cholera differ between urban and rural areas in Eastern Africa, where communities conceptualize risk, prevention, and sources of care differently (Schaetti et al., 2013). In Venezuela and Brazil, public discourse linking cholera to poverty led to further stigma of marginalized groups (Briggs, 2001; Nations & Monte, 1996). Public health indicators such as morbidity and mortality, characterization and distribution of pathogens, classic epidemiologic risk factors, and economic costs may not always be understood as top priorities in communities where cholera takes hold. Thus, in addition to epidemiologic studies, consideration of the social context of cholera is essential to guide the public health response (Nyambedha et al., 2013).

Cholera is "the disease *par excellence* of social inequality" (Briggs, 2001, p. 676). Thriving in areas of social and material deprivation–where safe water, basic sanitation, and primary health services are lacking–cholera strikes the poorest members of society hardest, evident, for example, in its concentrated prevalence within low and middle-income countries (Ali et al., 2012). Furthermore, since the first outbreaks in Europe to the present day, cholera is a particularly feared pathogen, for both the epidemic pace at which it moves and the way in which it claims its victims (Schulze & Angermeyer, 2003).

Like other diseases, cholera takes on meaning within the social context where it occurs. The writer and cultural critic Susan Sontag (1990) commented that, "Nothing is more punitive than to give a disease meaning" (p. 58). A disease that arouses fear and uncertainty in society takes on moral signification, such that the disease itself becomes a metaphor for

what is considered dirty, degrading, deviant, or wrong (Nations & Monte, 1996). Cholera may not only cause disease but also serve as a social marker, demarcating the rich from the poor, the clean from the dirty, and the educated from the ignorant. As such, in settings where the socially disenfranchised already bear labels of inferiority, cholera, through its preference for the poor, can lead to further stigma and social exclusion (Briggs, 2005).

*Haitian migration to Dominican Republic*

Haitian migrants to the Dominican Republic are an important population in the ongoing epidemic. Originally recruited to work on Dominican sugar plantations in the early 20th century (Martinez, 1999), many now work in other sectors, including rice, construction, and informal services (Ministerio de Trabajo, 2011). Most migrate on the periphery of development, moving between impoverished sending communities in Haiti and typically poor receiving communities of the Dominican Republic (Martinez, 1995). Their circular migration pattern between both countries has made them the focus of Dominican cholera campaigns (Ministerio de Salud Pública, 2012).

At present, there is no official estimate of the Haitian and Haitian-descended population in the country, but it is thought to be between 500,000 and 1.5 million, the vast majority undocumented (Canales, Vargas Becerra, & Montiel Armas, 2009; Ferguson, 2006). A legacy of *anti-haitianismo*, or anti-Haitianism, plays a major role in their marginalized social status. The ideology construes Haitians as more African, less civilized, and bent on conquest (Tavernier, 2008). The roots of anti-Haitianism go back to European colonialism, when wealthy elites sought to exploit and control poor black and mulatto classes (Sagas & Inoa, 2003). In this way, anti-Haitianism constructs a Dominican identity *vis-à-vis* Haiti (Howard, 2007), an "othering process" that bestows Dominicans with greater moral worth

(Bartlett, Jayaram, & Bonhomme, 2011). During the Trujillo dictatorship (1930-1961), anti-Haitianism was an official state practice that provided fodder for the massacre of thousands of Haitians and Dominico-Haitians in 1937 (Turits, 2002).

While overt anti-Haitianism no longer operates at the institutional level that it once did, Haitian migrants and their descendants are routinely denied citizenship, legal protection, and access to healthcare and education (United Nations, 2008). Migrant communities lack basic sanitation, water, and healthcare (Simmons, 2010). In addition to structural hardships, many Haitian migrants suffer poor mental health and functional difficulty associated with perceived discrimination (Keys, Kaiser, Foster, Burgos, & Kohrt, Under review). Haitian migrants reference *imilyasyon*, or humiliation in Haitian Kreyòl, to describe such negative life experiences as having limited work opportunities, feeling belittled or unimportant in the eyes of Dominicans, and internalizing anti-Haitian attitudes and beliefs (Keys et al., Under review). Thus, *imilyasyon* is a locally meaningful construct that reveals important social dimensions of the lived experience of Haitian migrants.

*Discrimination, stigma, and psychosocial stress*

Discrimination and stigma bear important health consequences (Link & Phelan, 2006; Pascoe & Smart Richman, 2009). Discrimination operates through institutional, personally-mediated, and internalized pathways (Jones, 2000). *Institutional* discrimination restricts socioeconomic mobility by, for example, limiting employment and educational opportunities (Williams & Mohammed, 2009). *Personally-mediated* discrimination occurs through everyday interactions between people–the “local prejudices” that blind members of the dominant group from scrutinizing broader social determinants of health (Holmes, 2011). *Internalized* discrimination occurs when members of the minority group accept negative

attitudes and beliefs about themselves (Williams & Williams-Morris, 2000). Thus, discrimination is systemically and culturally rooted and ultimately contributes to poor health among those it is directed against.

While discrimination and stigma are often used interchangeably, important distinctions should be made. In contrast to discrimination, which tends to encompass group-level processes and experiences (Phelan, Link, & Dovidio, 2008), stigma spoils the identity of an individual, reducing a whole person to a discounted one (Goffman, 1963). Stigma is generated through a process of differentiation, stereotyping, and categorical separation of the dominant "us" from the non-dominant "them" (Link & Phelan, 2001). Disease-related stigma incurs a "hidden burden" of social rejection, disgrace, or shame, making it difficult to capture in epidemiologic data (Weiss, 2008). In response, ethnographic and qualitative methods can be helpful for discerning the "local worlds" of the stigmatized and stigmatizers, where requirements for moral standing are defined, sought after, and lost (Kleinman & Hall-Clifford, 2009; Yang et al., 2007).

Psychosocial stress is a major consequence of discrimination and stigma and has been posited as a link between adverse social and physical environments (Gee & Payne-Sturges, 2004). At the individual level, the stress response consists of biological mechanisms such as increased arousal, tachycardia, elevated blood pressure, and metabolic and hormonal effects that suppress the immune system. Over-activation of these systems leads to organ damage via allostatic load (McEwen, 1998). Social conditions in the community, such as discrimination, fear, and poverty increase the stress response among individuals (MacIntyre, Ellaway, & Cummins, 2002; Payne-Sturges et al., 2006).

Scambler (1998) identified how stigmatized persons may *anticipate* negative life experiences as well as *internalize* negative societal beliefs, pathways that impinge on

psychosocial health. A chronically over-activated stress response from anticipating and internalizing negative experiences can impair social relationships, increase depressive and anxiety symptoms, damage self-esteem, and leave one more susceptible to other diseases (Meyer, 2010; Meyer, Schwartz, & Frost, 2008; Schomerus & Angermeyer, 2008).

*Cholera, stigma, and psychosocial health of Haitian migrants*

Haitian migrants in the Dominican Republic have often figured into narratives of blame, especially during times of political crisis (Martinez, 2003). The onset of cholera in the country was no exception. Concurrent with cholera's emergence in the Dominican Republic, forced expulsions of Haitian migrants quickened in pace (Amnesty International, 2011; see "Urgen parar deportaciones," 2011). Thus, the epidemic was more than a public health dilemma; it assumed complex social and political undertones.

This study explored the psychosocial experience of Haitian migrants in the Dominican Republic during the Hispaniola cholera epidemic. To complement efforts that have focused on the epidemiology of cholera on the island, this paper examines cholera's social context and how cholera figures into stigmatizing practices. The goal is to advance the use of qualitative methods to understand the role of stigma, infectious disease, and psychosocial stress in low-resource settings. This study's practical application is to inform public health strategies put forward in the multi-agency Call to Action Plan for the cholera epidemic on the island (PAHO/UNICEF/CDC, 2012). Ultimately, the study's findings can help reduce the "hidden burden" of stigma that Haitian migrants have long confronted.

# CHAPTER II: MANUSCRIPT

## Introduction

Cholera's recent emergence on the Caribbean island of Hispaniola, which Haiti and the Dominican Republic share, refocused attention on longstanding water and sanitation disparities found there. Just ten months after the earthquake that struck Port-au-Prince, cholera was introduced to Haiti and quickly spread throughout the country, reaching the Dominican Republic a short time later (Tappero & Tauxe, 2011). In response, a multi-agency Call to Action Plan was put forward by the Pan-American Health Organization (PAHO) and other partners to promote prevention and control strategies, with the ultimate aim of eliminating cholera from the island (PAHO/UNICEF/CDC, 2012).

Critical to the Call to Action Plan has been an understanding of the epidemiology and transmission of cholera on Hispaniola, which has generated a rich literature (eg., Etienne et al., 2013; Grandesso et al., 2013; Jackson et al., 2013; Periago et al., 2012; Poirier et al., 2012). However, focusing on discrete risk factors can potentially overlook the social context in which people live (Nguyen & Peschard, 2003), where local understandings of disease shape social constructions of stigma and blame (Hruschka & Hadley, 2008; Weiss, 2008). At present, little is known about the role of cholera-related stigma in the ongoing epidemic. Since community engagement is central to the Call to Action Plan, such studies are increasingly needed.

A special issue of *Social Science and Medicine* (Vol. 67, Issue 3) explored the links among health, stigma, prejudice, and discrimination. This issue brought together health and social science perspectives to evaluate theoretical approaches to stigma (Pescosolido, Martin, Lang, & Olafsdottir, 2008; Phelan et al., 2008); reveal public policies that contribute to

stigma and mediate its effects on health (Link, Castille, & Stuber, 2008); describe pathways through which discrimination drives health outcomes (Williams et al., 2008); and articulate public health and ethical implications (Bayer, 2008; Dovidio et al., 2008).

Another important contribution of this issue was emphasis on stigma's cultural and social aspects, particularly how stigma is a *moral process*. Yang and Kleinman (2008) argue that stigma is embedded in local worlds, where the stigmatized and the stigmatizers are interconnected in a web of social relationships. The term *local world* incorporates some domain of daily life, such as a social network, work place, or neighborhood. There, something fundamentally is "at stake" (Yang et al., 2007, p. 1528)–jobs, social status, relationships, life chances, or money, for example. In essence, stigma diminishes the social status of those whom it afflicts and threatens attainment of what matters most to them (Link & Phelan, 2001; Yang & Kleinman, 2008). Efforts to reduce stigma must therefore begin with an understanding of the moral processes that drive it (Kleinman & Hall-Clifford, 2009).

Like other diseases, cholera takes on meaning in the social context where it occurs. The writer and cultural critic Susan Sontag (1990) commented that, "Nothing is more punitive than to give a disease meaning" (p. 58). By arousing fear and uncertainty in society, cholera becomes a metaphor for what is considered dirty, degrading, deviant, or wrong (Nations & Monte, 1996). Consequently, cholera may not only cause disease but also serve as a social marker, demarcating the rich from the poor, the clean from the dirty, and the educated from the ignorant. As such, in settings where the poor already bear labels of inferiority, cholera can lead to further stigma and social exclusion (Briggs, 2005), a process that has yet to be formally studied in the epidemic on Hispaniola.

*Haitian migration to the Dominican Republic*

Haitian migrants to the Dominican Republic are a largely unrecognized population. At present, no official estimate of the Haitian and Haitian-descended population in the country exists, but it is thought to be between 500,000 and 1.5 million, the vast majority undocumented (Canales et al., 2009). Most migrate on the periphery of development, moving between impoverished sending communities in Haiti and typically poor receiving communities in the Dominican Republic (Martinez, 1995). Their circular migration pattern between both countries has made them the focus of Dominican cholera campaigns (Ministerio de Salud Pública, 2012).

Increased attention on Haitian migrants since cholera's onset contrasts sharply with their history as a long ignored and invisible population. A legacy of *anti-haitianismo*, or anti-Haitianism, plays a major role in their marginalized status. The ideology construes Haitians as more African, less civilized, and bent on conquest (Sagas, 2000). The roots of anti-Haitianism go back to European colonialism, when wealthy elites sought to exploit and control poor black and mulatto classes (Sagas & Inoa, 2003). During the Trujillo dictatorship (1930-1961), anti-Haitianism was an official state practice that constructed a nationalist identity morally superior to Haiti's, providing fodder for the massacre of thousands of Haitians and Dominico-Haitians along the border region in 1937 (Turits, 2002).

Haitian migrants and their descendants are routinely denied citizenship, legal protection, and access to healthcare and education (United Nations, 2008). Migrant communities lack basic sanitation, water, and healthcare (Simmons, 2010). In addition to structural hardships, many Haitian migrants suffer poor psychosocial health associated with perceived discrimination and *imilyasyon*, or humiliation (Keys et al., Under review). For Haitian migrants, humiliation includes having limited work opportunities, feeling belittled or

unimportant in the eyes of Dominicans, and internalizing anti-Haitian attitudes and beliefs. Prior to this study, we are not aware of any formal investigation of cholera-related stigma and psychosocial stress among Haitian migrants in this context.

*Cholera, stigma, and psychosocial stress*

Haitian migrants to the Dominican Republic have often figured into narratives of blame, especially during times of political crisis (Martinez, 2003). The onset of cholera in the country was no exception. Concurrent with cholera's emergence in the Dominican Republic, forced expulsions of Haitian migrants quickened in pace (Amnesty International, 2011; see "Urgen parar deportaciones," 2011). Thus, the epidemic was more than a public health crisis; it assumed complex social and political undertones.

Disease-related stigma incurs a "hidden burden" of social rejection, disgrace, or shame (Weiss, 2008). Goffman's (1963) classic formulation of stigma centered on social processes that contribute to "spoiled identity." Stigma is generated through a process of differentiation, stereotyping, and categorical separation of the dominant "us" from the non-dominant "them" (Link & Phelan, 2001). The process is dependent on and helps consolidate social, political, and economic power held by the dominant group (Phelan et al., 2008).

Stigma is felt by those it is directed against, and a key consequence is increased psychosocial stress (Link & Phelan, 2006). Chronic stress impairs social relationships, increases depressive and anxiety symptoms, damages self-esteem, and leaves one more susceptible to other diseases (Meyer, 2010; Meyer et al., 2008). Scambler's (1998) "hidden distress" model outlines stigma's anticipated and internalized pathways. Chronic stress arises from *anticipating* stigma, or feeling that one will be stigmatized, as well as from *internalizing* stigma, or accepting the negative beliefs of the stigmatizing society (Weiss, 2008).

Ethnographic methods can ascertain how adverse social judgments are made and experienced in different cultural settings (Kleinman & Hall-Clifford, 2009; Weiss, 2001; Yang et al., 2007). In-depth, qualitative approaches are particularly useful since stigma is bound to cultural meanings of disease, socially acceptable norms of behavior, and shared understandings of a disease threat (Weiss, 2008). Also, focusing on the lived experience of those who stigmatize and those who are stigmatized can elucidate moral codes that drive stigmatizing practices (Kleinman, Das, & Lock, 1997; Yang et al., 2007) and thereby inform disease- and culture-specific interventions (Weiss, Ramakrishna, & Somma, 2006).

This qualitative study explored perceptions of cholera among Haitian migrants and Dominicans, local formulations and experiences of cholera-related stigma, and effects on psychosocial health of Haitian migrants. To complement efforts that have focused on the epidemiology of cholera on the island, this paper examines cholera's social context and how cholera figures into stigmatizing practices. The goal is to advance the use of qualitative methods to understand the role of stigma, infectious disease, and psychosocial stress in low-resource settings and contribute to theoretical approaches that underscore stigma's moral experience in local worlds (Kleinman & Hall-Clifford, 2009; Yang & Kleinman, 2008; Yang et al., 2007). This study's practical application is to inform public health strategies put forward in the multi-agency Call to Action Plan for the cholera epidemic on the island (PAHO/UNICEF/CDC, 2012). Ultimately, the study's findings can help reduce the "hidden burden" of stigma that Haitian migrants in the Dominican Republic have long confronted.

## Methods

### *Project Background*

We used mixed-methods to explore prevalence of cholera-related risk factors in Haitian migrant communities as well as local explanations for cholera's spread, prevention, and transmission. The details of the quantitative portion of the project have been reported elsewhere (Lund, 2013). A research partnership between Emory University, the Universidad Autónoma de Santo Domingo (UASD), and a public teaching hospital, the Hospital San Vicente de Paúl, facilitated the study.

*Setting and research team*

Data were collected from June 17 to August 12, 2012 in Duarte Province, Cibao Valley, Dominican Republic. In 2008, Duarte Province had a population of 310,357 (SESPAS, 2008), mostly concentrated in urban and peri-urban areas (Figure 1). Lying approximately two hours from the capitol, Santo Domingo, San Francisco de Macorís is the largest city in the province. Smaller communities are found on the outskirts of San Francisco and throughout the province, where production of rice and cacao is common and where many Haitian migrants live and work. At the time of our study, 25,062 cumulative cholera cases and 401 deaths from cholera had been reported nationwide. Of those, 252 cases and six deaths were reported for Duarte Province (PAHO, 2013).

**Figure 1**: Map of Dominican Republic with study site circled; image from Google Earth

The study was conducted in two communities, one rural and one urban. The rural community, Las Placetas[1], was located in a rice-producing region of the province, approximately 12km from San Francisco de Macorís. The urban community, Esperanza, was

[1] Names of communities have been changed

a small *barrio* within the city of San Francisco de Macorís. At the time of our study, it was unknown if any of the 252 cumulative cholera cases for the province had been reported from these two communities (Dominguez, 2012).

Las Placetas and Epseranza were selected for several reasons. First, both communities were home to Haitian migrants and Dominicans living in close proximity to each other. This feature was important given our interest in Haitian-Dominican social interactions and local constructions of stigma since the advent of cholera. Second, results from a previous study demonstrated relatively higher levels of psychosocial stress and perceived discrimination among migrants in each of these two communities compared to others in the province (Keys et al., Under review), making them ideal for in-depth, qualitative investigation. Third, we felt that pairing urban and rural communities would provide a more holistic picture of local understandings of cholera and Haitian-Dominican social relations. Also, including rural and urban communities would reveal potential context-specific differences between the two geographic settings, a finding noted in other studies (Nyambedha et al., 2013; Schaetti et al., 2013). Finally, key contacts in these two communities facilitate trust among community members.

Bilingual (Kreyòl-Spanish) Haitian and Dominican research assistants (RAs) were trained in all data collection procedures. The study was declared exempt by Emory University Institutional Review Board and approved by the Ethics Committee of Hospital San Vicente de Paúl. All study participants gave verbal informed consent in the language of their choice.

*Focus group data collection*

We used focus groups to collect data. Focus groups are helpful for ascertaining subjective understandings of illness, risk, and normative behaviors (Kitzinger, 2013). Their

structure and informality allow for multiple lines of communication, placing participants in the role of experts on their everyday lives and social interactions (Hollander, 2004; Schulze & Angermeyer, 2003). Furthermore, the group setting can stimulate conversation about often difficult subjects, including stigma. These features made focus groups relevant for our goals of exploring perceptions of cholera and descriptions of Haitian-Dominican social interactions.

In total, we conducted eight focus groups among Haitian migrants and Dominicans. In each community, we held four focus groups stratified by nationality and sex (Tables 1 and 2). No randomization procedures were used. Instead, RAs networked with community contacts to identify and recruit focus group participants. In total, 23 Haitians and 24 Dominicans participated in focus groups. Each focus group ranged from five to seven participants. Ages ranged from 18-73; average age was 36. Haitian participants self-identified as having been born in Haiti. Enrollment was based on the participant's insight into community-level understandings of cholera as well as social interactions between Haitians and Dominicans. No compensation was provided.

**Table 1**: Haitian focus group participants

**Table 2**: Dominican focus group participants

Prior to field activities, we developed separate focus group discussion guides for Haitians and Dominicans. Discussion guide questions were open-ended and based on literature review of the recent cholera epidemic, public health response, history of anti-Haitianism, and findings from previous fieldwork. Haitian and Dominican RAs first piloted

the discussion guides to assess comprehensibility and acceptability by participants and relevance of responses to the research goals.

Haitian focus groups were moderated by a Haitian RA, and Dominican focus groups were moderated by a Dominican RA. Focus groups were approximately one to two hours in duration and audio recorded. Then, RAs transcribed the audio files verbatim in the original language (Spanish or Haitian Kreyòl) with the assistance of notes taken by another RA during the focus group session. Following transcription, files were translated into de-identified English documents by bilingual, native and/or advanced speakers of Haitian Kreyòl and Spanish.

*Data analysis*

Multiple, preliminary readings of focus group transcripts were undertaken, referring back to the original Kreyòl or Spanish for needed clarification. After several readings and discussions, the team developed a codebook comprising deductive and inductive codes. Deductive codes were based on literature review of the public health response to cholera, psychosocial stress, and stigma. These codes captured key constructs such as cholera prevention and transmission, local characterizations of cholera and populations whom it afflicts, perceived unimportance or mistreatment, and perceptions of Haitians held by Dominicans and vice versa. Inductive codes were based on *in vivo* language that resurfaced within and across texts. Among migrants, these included *mikwob* (microbe/germ), *vale* (self-worth), *oblije* (obligation), and *imilyasyon* (humiliation). Among Dominicans, they included *limpieza* (cleanliness) and *contaminación* (contamination).

The codebook and focus group transcripts were uploaded into MaxqDA software for coding, retrieval, and analysis of text segments (VERBI, 1989-2010). During the coding

process, memos tracked important concepts and analytic lines that emerged within and across texts. The memos and corresponding text segments were then retrieved and reviewed in focused readings and discussions with members of the team, allowing consolidation of key concepts and ideas, addition of more codes as needed to parent codes, and assessment for general patterns in the data. To evaluate consistency of those patterns, comparisons were made across important categories, such as urban and rural settings, Haitian and Dominican social groups, and men and women. Themes emerged from these comparisons and again evaluated and compared in order to establish points of convergence or divergence. Analysis of texts followed an interpretative path to determine if key themes in the data could explain larger phenomena (Sandelowski & Barroso, 2003).

## Findings

In Las Placetas and Esperanza, cholera held special meaning among community members. Group discussions were often highly animated, in which participants expressed their dread at cholera's reach across the island. Cholera supported certain dichotomous categories–clean and dirty, rich and poor, those who practice good hygiene and those who do not. Finally, for Dominicans, the health of the community seemed under threat by Haitian migrants, whose cramped living quarters, use of irrigation canals for household needs, and lack of sanitation were evidence of a "lower culture" conducive to cholera's spread. For their part, Haitian participants described feeling blamed for cholera, explained how their identity had become linked to the epidemic, and felt powerless in the face of structural and interpersonal hardships. In short, notions of inferiority and danger contributed to cholera's moral experience and consequently exacerbated psychosocial health of migrants.

*"Like a river whose source is unknown" – Cholera and fear*

Morbidity and mortality from cholera were far less at the study sites than in Haiti, where cumulative attack rates reached 5-6% (Barzilay et al., 2013). Nonetheless, while few people in Esperanza or Las Placetas had actually succumbed to cholera, many people still feared it: "No one can escape cholera," said one Haitian man in Esperanza, "No one knows when he will get infected" (H21). Cholera was understood to be devastating for both those who fell ill and the communities where they lived. In accounts of Haitians, cholera was said to "ravage" [*fe ravaj*] (H02, H07) and "advance upon us" [*avanse sou nou*] (H20). One Dominican woman insisted that "No one wants it to come!" (D09), because, as another cried, "It kills you quickly!" (D02). Powerlessness in understanding cholera's origin contributed to a collective sense of fear among Haitians: "Despite the fact that we've heard about it, it is like a river whose source is unknown to us. We are just seeing it pass by" (Haitian man, Esperanza, H20). In Esperanza, a Dominican woman exclaimed that should cholera arrive, "We'd all die! Imagine one person with cholera, no, a group, a whole community, imagine!" (D12).

This dual emphasis on cholera's lethality and its imagined impact was common among both Haitians and Dominicans. Cholera, a disease that "ravages," "advances," and "kills quickly," was reason for great concern in Las Placetas and Esperanza.

*Mikwob and limpieza – Cholera and the importance of hygiene*

Haitians and Dominicans in the rural community of Las Placetas were, in some way, connected to the local production of rice. The community's poorest members live in typically single-room houses, made from wooden slats or cement blocks and lacking a concrete floor. These houses are mostly concentrated along the side of the rice canal that passes through the

village. It is not uncommon to see trash clogging drainage outlets or see latrines hanging off the backs of houses and emptying directly into the water (Figure 2).

**Figure 2** – photo of rural canal in Las Placetas

The canal in Las Placetas carried important significance in focus groups. For both Haitians and Dominicans, it was considered dirty, polluted, or dangerous. One Dominican woman said that, "Everything goes in there, dirty diapers, everything [...] You can catch [cholera] almost immediately" (D02). Haitian women in the same community agreed that *mikwob* (germs or microbes) found in canal water were hazardous. The canal was said to threaten other populated areas as well: "All of that contamination goes to _ [a nearby town] and gets distributed," said one Dominican man in Las Placetas (D17).

Similar findings arose in Esperanza, the urban community. Canals in this *barrio* were essentially open sewers, draining rainwater, run-off, and debris (Figure 5). Like some residents in Las Placetas, people in Esperanza also lived in close proximity to the canal, using its water for household functions. Again, both Haitians and Dominicans in this community said the canal water was unhealthy. Unlike Haitian participants, however, Dominicans explicitly linked the poor, who relied on canals for basic needs, with greater vulnerability to cholera:

> Moderator: Is there a part of this community where it's easier for someone to get cholera?
>
> D20: In some, there are a lot, down there, there is a neighborhood there.
>
> Moderator: Why there?
>
> D21: There is a lot of bacteria, too much bacteria.

D24: In the poorest places that are close to there.

D23: And there, there is no sewer system.

Finally, just as in Las Placetas, the urban canals in Esperanza joined other communities, putting other people at risk as well:

> I don't know if you have smelled it, but there is a damned canal close to _ [nearby village] where all the houses are close to [each other], and there the contamination […] runs through the whole village, from one extreme to the other, and the people who live close are more prone to the contamination (Dominican woman, Esperanza, D09).

**Figure 3** – photo of urban canal in Esperanza

Thus, Haitians and Dominicans in both urban and rural areas associated the canals with contamination, bacteria or *mikwob*, and the potential for cholera to spread beyond their communities. Those in direct contact with the canal water–namely, the poor–were deemed more vulnerable to cholera.

The descriptive language of bacteria, dirtiness, and contamination contrasted sharply with language of cleanliness and hygiene. To prevent cholera, Dominicans emphasized *limpieza*–cleanliness–while Haitians referenced the Kreyòl equivalent *pwopte*:

> [Since] it is from a *mikwob*, we must keep our places clean, the water we drink must be clean [*pwop*] (Haitian man, Esperanza, H22).
>
> If a person does not want to be infected with cholera he should live in a clean way [*yon fason ki pwop*] (Haitian woman, Esperanza, H10).
>
> Because this has a lot to do with contamination [people] have to wash their hands, [so that] this bacteria doesn't stick, through cleaning above all else (Dominican woman, Esperanza, D12).

As these quotes suggest, the importance of cleanliness appeared to hinge largely on individual behavior. As one Haitian man in Las Placetas said, “Cholera comes because you have to invite it to come” (H13).

While cholera was said to disproportionately affect poor people near the canals, some Dominicans argued that socioeconomic status did not preclude the poor from taking preventive measures. In Las Placetas, the following dialogue took place among women:

> D03: Even with a half bar of soap, you bathe well, and wash your hands well, you don’t have to be rich to do this.
>
> D04: […] Imagine how among poor people and rich people, there is a lot of difference […] but if I put myself up to it, even if it’s a half bar of soap, to buy it and wash my hands, to bathe well, to have good hygiene, to put bleach [in the water], I won’t contract cholera.

A Dominican man in the same community also emphasized personal hygiene, referencing local cholera campaigns: “According to the *charlas* [health education presentations], it’s mostly because of a lack of hygiene that causes someone to be infected” (D14). In sum, cholera conjured ideas of contamination, dirtiness, and bacteria among both Haitians and Dominicans. In response, individuals needed to follow basic hygienic principles, evoked in *pwopte* and *limpieza*, principles that both Haitians and Dominicans suggested depend largely on individual behavior.

*“They brought this illness here” – Cholera and blame*

The temporal and spatial distribution of cholera on the island figured into ways participants differentiated the two countries. Because the cholera outbreak began in Haiti, where it took a greater toll, Haiti itself was synonymous with filth, dirtiness, and contamination in narratives of both Haitians and Dominicans. Across urban and rural settings,

multiple Haitian participants described Haiti as "dirtier than [the Dominican Republic]" (H01, H10, H14, H15). "[People] don't litter here like in Haiti, where they'll throw trash anywhere, and things are covered in flies […] The more garbage that is thrown [in Haiti] can attract *miwkob*," said one Haitian woman in Las Placetas (H02). In accounts of Haitian participants, domesticated animals were often linked to the spread of *mikwob*: "What happens in Haiti, you come upon someone making food, [and] the food isn't covered, and animals are nearby, you'll see a pile of garbage […] animals will be standing there spreading *mikwob*" (H04).

Haiti's widespread lack of safe water and medical care were commonly referenced in accounts of Haitian participants. "The water condition here is not the same as in Haiti," said one Haitian man in Esperanza. "In Haiti, people drink water that comes from the ground, which can get someone infected" (H23). Lack of primary medical care further differentiated Haiti from the Dominican Republic. One Haitian woman stated simply, "There are too many *mikwob* in Haiti, and here there are more doctors" (H04). The imagery in these accounts linking trash, animals, and lack of basic services in Haiti contrasted with depictions of the Dominican Republic as cleaner and more developed.

Dominicans also linked ideas of contamination to Haiti, yet their explanations revealed an important nuance not shared among Haitians. For Dominicans, cholera's spread depended less on structural determinants and more on behavior. The following exchange took place among Dominican men in Esperanza:

> Moderator: Do you all think the problem of cholera is different in Haiti than in the Dominican Republic?
>
> D22: It's more common, in Haiti, more common.
>
> Moderator: More common?

> D22: Of course!
>
> Moderator: What else are the differences in this problem, the problem of cholera in Haiti and here in the Dominican Republic?
>
> D24: Well, over there people die of cholera more than here, I think.
>
> Moderator: Why?
>
> D22: Over there, they live underneath trash, they do their necessities, they do everything, and that's why they get sick, and besides, they don't have hygiene.

The last statement in this exchange is noteworthy. While both Haitians and Dominicans agreed that "more people die of cholera" in Haiti than in the Dominican Republic, Dominicans argued that cholera's devastation arose out of how Haitians live–that is, "underneath trash," where they "do their necessities." Dominican participants explained that Haitians "have less hygiene" (D03, D04), "don't have hygiene" (D20, D22), or "take less care of themselves" (D15). In these examples, the role of hygiene in cholera's spread carried special significance not shared by Haitians. Within Dominican focus groups, a logic circulated among participants that held behavioral practices among Haitians as the main reason for cholera's toll in Haiti.

It may come as no surprise, then, that Haitian migrants, having left a country that "is more contaminated than the Dominican Republic" (Dominican man, Las Placetas, D15) and who essentially "take less care of themselves" (D15) were responsible for cholera's arrival in the country. "Who has brought cholera? Think about it, the Haitians brought it, because this illness wasn't here [before]" (Dominican man, Las Placetas, D19). Assigning responsibility to Haitians was cross-cutting in Dominican focus groups, at times in very blunt terms: "We are lucky we haven't gotten sick from cholera, with so many Haitians here" (Dominican man, Las Placetas, D15). In Las Placetas, Dominican women connected poor hygiene among Haitians to cholera in the area:

> D03: Well, some of them have less hygiene.
>
> D04: And some have the least! […] It's easier for them because they have less hygiene, they use the canal water more easily than we do, and they don't have a lot of precautions in this, a lot of care.
>
> D05: They brought, because they brought this illness here, because here there is cholera in many sectors.

In the same conversation, one of the participants recalled how clean the canal used to be: "This was beautiful blue water, but now it's not, it's no more, it's microbial, they do everything in that canal (Dominican woman, Las Placetas, D05). The arrival of Haitians brought with it contamination of what was once clean; Haitians were responsible for what had now become "microbial."

In the same rural community, Haitian participants communicated feelings of blame: "When a Haitian comes from Haiti, they say you've brought this illness with you, and they don't want you around them" (Haitian woman, Las Placetas, H02). At the border, "If [border officials] see you've lost weight, they won't let you come in […] They say he just had cholera" (Haitian man, Las Placetas, H14). Labeled as carriers of the disease, Haitians found it necessary to take certain measures to avoid scaring off would-be Dominican customers in street markets, illustrating how the epidemic's temporality figured into their social interactions with Dominicans:

> Sometimes, before they buy something from a Haitian, they will ask, 'How long have you been here?' If you were here before cholera hit Haiti, they will buy your merchandise. But if the time you give them is short, and you were in Haiti during the time cholera hit, you will not sell anything, and they will be afraid of you. (Haitian woman, Esperanza, H06)

The perspective of a Dominican man in Las Placetas supported this view: "When they come from [Haiti], they bring the disease, the majority, [but] those who were already here at the

very least organize themselves to clean everything, to prevent it" (D18). It seemed that more time in the Dominican Republic bestowed migrants with the know-how and capacity for self-care that more recent arrivals lack.

In sum, reasons for cholera's emergence and spread on the island converged upon notions of hygiene and cleanliness. For both Haitians and Dominicans, Haiti was viewed as a dirty and unhealthy place, where cholera could be acquired and transmitted easily. However, accounts among Haitians and Dominicans diverged when they explained why cholera continued to spread to the Dominican Republic. Haitians emphasized trash, *mikwob*, contaminated water, and lack of medical care. Dominicans cited hygiene practices among Haitians, contending that cholera's prominence in the country was due less to structural determinants and more to behavioral customs of Haitians themselves. In this way, Haitians *as a group* became connected to notions of dirtiness and contamination. In response, Haitians described ways in which they adapted to this labeling, including concealing their length of time in the country for fear of driving away potential business.

*"We have no other water to use" – Cholera and structural violence*

Dominican participants further elaborated upon a general lack of hygiene among Haitians when describing their living conditions. Haitians were said to live in cramped quarters that lacked basic sanitation: "Well, some live in a rented house, some in houses that are in the middle of construction, where there isn't any way for them to […] do the necessary physiological things" (Dominican man, Esperanza, D23). Disgusted at the lack of sanitation among his Haitian neighbors, a Dominican man in Las Placetas took matters into his own hands: "I loaned them this latrine at my house that I don't use. I have to loan it, and not to the whole world, not to all the Haitians, but they loan it to friends [because] there are too many"

(D15). “They arrive at a house that is in the middle of construction,” said one Dominican man in Esperanza, “and there they keep coming until about twenty, all or nothing, which can be seen by everyone” (D13).

These references to “the outside,” the open-air community, where Haitians “can be seen by everyone,” were another common finding among Dominicans. Personal observations supported the view that Haitians–and Haitian women in particular–not only lack hygiene but also modesty. The following exchange took place among Dominican men in Las Placetas:

> D15: In the dormitory where they sleep, [if] you go when they are asleep, you count, and see if there are not more than 30 sleeping there like you would see in a pigpen, lying there all together. There, everything that they do goes towards the canal. I can even go with you all and you can see that we aren’t lying. There are Haitian women [who go to the bathroom], it doesn’t matter if they see me or not.
>
> D14: Yes, what I can say is, that I agree with all he is saying, this is a reality.
>
> D16: They live however, the women don’t care about going out naked in the street […] yes, they have a much lower culture [*una cultura completamente mas baja*], yes.

Thus, the behavioral and social customs of Haitians were considered animal-like, comparable to pigsties, contaminating the canal and necessitating intervention. In this exchange as well, others are encouraged to visit these living quarters, so that, “You can see that we aren’t lying,” emphasizing observation to validate one’s perceptions, while the other man affirms, “This is a reality.” Thus, the final comment, that “They have a much lower culture,” gains empirical weight through the privilege granted by first-hand observation.

What would compel Haitians to live this way? While seemingly intrinsic behavioral and cultural practices were one reason, another important explanation arose among Dominicans. The economic opportunity found in the Dominican Republic was said to be a powerful motivator of migration from Haiti:

> D23: There is a lot of work passing through here, and here they feel better.
>
> Moderator: And you, what do you think?
>
> D24: The same thing, that there is more work and they can make more money here […] They live better.

Despite the deplorable conditions in which many Haitians live in the Dominican Republic, they were still figured to be better off than in Haiti.

Meanwhile, Haitian participants went at length to explain how their lives were not always better after arrival. While many agreed with Dominicans that finding work was a major impetus for migration, Haitians painted a different portrait of their life. One Haitian woman in Las Placetas said, "Sometimes we suffer from hunger because there are times with no work, maybe three months without work, when we're suffering from hunger" (H02). Largely undocumented, Haitian participants had few work options available. What work there was entailed certain risks. Notably, one Haitian man in Las Placetas incorporated stoop labor in rice fields, application of pesticides, and harmful *mikwob* into a vivid metaphor:

> We do the work of germs [*se travay mikwob nou fe*]. It's God watching over us, because the type of awful work we do, sometimes you have to get into the mud there, there are horrible products, horrible animals dying […] you put down poison and bad rats die in the same place where the rice is planted. It's truly germ's work [*travay mikwob*] what we do, watched over by God. (H12)

Haitians were acutely aware of disparities in access to safe water in their host communities. While Dominicans inferred that their Haitian neighbors used the canal water out of ignorance, or because of a "much lower culture," Haitians explained that there was little choice but to use the canals: "The reason we use the canal is because there is no other water around here; only the Dominicans get the tap water in their homes" (Haitian man, Las Placetas, H15).

In sum, local explanations of why Haitians lived in certain conditions and engaged in certain practices diverged sharply between Haitians themselves and Dominican participants. First, Dominicans, emphasizing Haiti's longstanding poverty, reasoned that migrants found a better life in the Dominican Republic. A perceived challenge for Dominican communities was managing the consequences of poor hygiene among Haitians, evident when they convert living areas into "pigpens," defecate in the open where "everybody can see," and further contaminate the surrounding environment. For their part, Haitians explained that life in the Dominican Republic was not always improved. Lack of work and arduous occupational conditions made circumstances difficult. Compounding this, communities were starkly divided between households with and without access to safe water. For most Haitians, there was simply no other choice but to use the canal.

Structural determinants of cholera were therefore conceptualized differently between groups. Cholera seemed to reinforce the idea of Haitians as a poor and backwards lot lacking basic self-care–even dependent on Dominican neighbors to take care of them. At the same time, cholera further exacerbated the lived experience of many Haitian migrants. Limited work options, lack of sanitation and safe water, and feeling blamed by Dominicans for cholera's emergence in the country bore consequences for their psychosocial health, examined in further detail below.

*Stigma, identity, and feelings of worthlessness*

Cholera figured directly into the identity of Haitian migrants. If cholera, a disease to be feared, was spread from ignorance or unrefined behavior, then Haitians were also to be feared, or else cast to the same level as the *mikwob* that fester in rice fields or lurk in trash piles, waiting to be kicked up and passed along by animals. This last comparison is important,

since transmission of germs by animals–whether from flies that sat on uncovered food or from cows or mules that kicked through trash–was an explanation advanced by Haitians, not Dominicans. And yet, the language of many Dominican participants conveyed a perception that Haitians were, to some degree, much like animals. Haitian living areas resembled "pigpens" (Dominican man, Las Placetas, D15); they bathed where one woman "wouldn't even wash my feet" (Dominican woman, Las Placetas, D05). "If they prohibit bringing Haitians," figured one man (as if Haitians are "brought" to his country as any other commodity), "you'd have to grow grass for the animals" (Dominican man, Las Placetas, D15). Haitians were said to be slower, but still menacing:

> D19: It's easier to work with a herd of cattle than those people.
>
> D15: […] In order to lead Haitians, you must be strong and fearless [lit. "to have blood," *hay que tener sangre*].
>
> D13: Yeah, you have to be patient to lead Haitians.

To ease the process of paying Haitian workers on his rice farm, one man explained his method:

> I give them numbers, 'Number one! If you lose this number, you won't get paid! Number two! If you lose this number, no pay!' Just like that, and I don't have to remember any names […] because they all look alike. (Dominican man, Las Placetas, D15)

Dehumanizing practices directed towards Haitians were embodied in their self-concept as people–as "faceless," anonymous, like animals. A Haitian rice farm laborer who was living in the same community as the Dominican man quoted above remarked: "[Dominicans] take us for the faceless [*yo pran nou pou san vizaj*]. They see us as dogs […] they are always saying you look like an animal" (Haitian man, Las Placetas, H14). When

coupled to feelings of blame for an epidemic that Haitians themselves associated with trash, *mikwob*, and animals, chronic, interpersonal stressors like these contributed to their devalued identity as a minority population in the country.

Feelings of unimportance compounded self-comparisons to animals. While cholera had generated a massive, nation-wide public health response, some Haitians expressed frustration at feeling left out of those education campaigns: “They give information, but they don’t have meetings to tell us what they will do,” said a woman in Las Placetas (H04). The desire to have meetings was common among Haitians in both urban and rural settings. A man in Esperanza said, “Authorities could at least hold meetings with us in order to know how to act with regard to cholera. Unfortunately we do not have this,” (H18). By overlooking or failing to reach these communities, the public health response to cholera seemed to reinforce feelings of unimportance.

Linked to unimportance was the notion that in the eyes of Dominicans, Haitians *pa gen vale*–have no worth. “Dominicans always think of Haitians as bad things before them. As long as you’re black you have no value [*okenn vale*] to them” (Haitian man, Las Placetas H13). Vulnerability to retaliation was yet another contributor to feelings of worthlessness. In several anecdotes, Haitians said they were often scapegoats for wrongs committed against one Dominican. The common storyline centered on a Dominican who was assaulted, robbed, or killed, possibly by a Haitian. In turn, a band of Dominicans would retaliate against any or all Haitians in that community. On edge for fear of retaliation by Dominicans, Haitians seemed further alienated in the social space they shared with Dominicans after the emergence of cholera. As one man said, “They say our country is condemned with cholera. They won’t even sit next to us because they’re afraid of getting cholera” (Haitian man, Las Placetas, H14). Thus, Dominicans were said to identify Haitians as a diseased population that brought

cholera, while at times Haitians self-identified as worthless, unimportant, and vulnerable to reprisal.

*Stigma, lack of mastery, and humiliation*

A recurrent finding among Haitian participants was feeling *oblije* (lit. "obliged") to endure life's circumstances. *Oblije* communicated an external locus of control, one beyond their capacity as migrants. Lacking control over one's circumstances in Haiti was a common reason for migration: "The reason I [left Haiti] was insecurity […] I was so afraid that I was obliged [*mwen te oblije*] to come here," said one man in Esperanza (H22). "We're obliged to be here. If our country offered us opportunity, we would not leave," said another man (Esperanza, H23). In the few work opportunities they found, however, Haitians were underpaid: "[A Dominican employer] might pay the Dominican 500 pesos, but the Haitian 400 pesos. The fact is, Haitians work harder. But you're obliged [*ou oblije*] because you have to live" (H18). Contrary to assertions by Dominicans, who considered Haitians to have a preference for canal water, one Haitian man explained that "The canal water is not good for us [but] we have to use it [*nou oblije itilize'l*] because there is no other water" (H14). Thus, *oblije* arose in accounts of migrating from Haiti, working in menial jobs, using canal water for household needs, and even feeling resigned to accept humiliation:

> We always find some Dominicans who humiliate us, but we have to look past it because we are not in our country. Even if the Dominicans embarrass us, you must make yourself small before them [*fo'w toujou mete'w pti devan yo* – a phrase to humble oneself], because you are not in your country when they are humiliating you. You feel like they may hit you, they may do whatever they want to you. Since you're not in your country, you have to be calm and accept humiliation from their hands. (Haitian man, Las Placetas, H15)

For Haitian participants, humiliation was a common experience. Humiliation was said to exist before the onset of cholera, only to became more intense: “When cholera was just affecting Haiti, but hadn’t yet come to the Dominican Republic, the Dominicans here were always humiliating the Haitians,” said a Haitian woman in Las Placetas, “[but] after it finished ravaging Haiti, it came to the Dominican Republic, and they said this illness came along with the Haitians” (H02).

In short, Haitians frequently attributed difficult life circumstances to forces beyond their control. If, as some Dominicans said, Haitians were hardworking, docile, and could be led to work, it may have been due to simply feeling *oblije*–obliged to be humble, to stay calm, to “make yourself small,” in order to avoid confrontation and ensure that whatever income they could earn might come their way. The onset of the cholera epidemic on the island appeared to further reinforce these structural and interpersonal hardships between Haitians and Dominicans, including the experience of *imilyasyon* (humiliation).

**Discussion**

This study explored perceptions of cholera among Haitian migrants and Dominicans in the Dominican Republic, moral dimensions of cholera-related stigma, and effects on psychosocial health of Haitian migrants. The identity of Haitian migrants, long subordinate in Dominican social, cultural, and political life, became bound to cholera, generating feelings of unimportance and worthlessness among Haitians. Additionally, the epidemic contributed to feelings of powerlessness and lack of mastery over life circumstances. The lived experience of Haitian migrants in relation to cholera was a *moral* one, in which Haitians were directly linked to notions of inferiority.

In this study, Haitians and Dominicans in the same communities shared similar beliefs about cholera. Both groups feared the disease, emphasized risks in using contaminated water, underscored hygiene in preventing cholera's transmission, and discussed how the two countries differ markedly in sanitation, access to safe water, and medical care. The narratives diverged between Haitians and Dominicans, however, on underlying determinants of cholera's transmission. While both groups emphasized the role of personal hygiene, Haitians drew explicit links to the structural obstacles they endure as a largely undocumented and marginalized group. Cholera, they explained, arose from *mikwob* encountered in arduous jobs or in polluted canal water. In contrast, Dominican participants assigned responsibility for cholera to Haitians, a process that essentially occurred via three steps: first, cholera was noted to be more prevalent in Haiti; second, Haitians were considered desperate to migrate to the Dominican Republic; third, Haitians were thought of as less hygienic and of a "lower culture," qualities said to predispose them to cholera. Thus, some Dominicans concluded that cholera's emergence in the country was due to Haitians themselves rather than structural problems like lack of safe water and sanitation.

In this way, cholera appeared to reinforce pre-existing stereotypes and stigmatizing beliefs about Haitian migrants, long cast as an ignorant, poor, and inferior class of people by an anti-Haitian ideology (Franco Pichardo, 1997; Howard, 2007; Martinez, 1999; Sagas, 2000). Haitian participants felt blamed for cholera, explained ways in which their identity as a group had become bound to the disease, felt unimportant and worthless in the eyes of their Dominican neighbors, and ignored by the public health response. Finally, feeling *oblije*–obliged–to suffer structural hardships and devaluing attitudes indicated a profound sense of disempowerment, leaving some to feel incapable of preventing cholera.

*Cholera and the moral experience of stigma*

Stigma is "embedded in local moral contexts" (Kleinman & Hall-Clifford, 2009, p. 418), where values and importance are attached to goals and life chances. Within a "local world," stigma simultaneously defends what is important for the dominant population and threatens what is important for the stigmatized (Kleinman & Benson, 2006; Yang et al., 2007). Based on our findings, we propose a model for cholera-related stigma in the Dominican Republic that encompasses the institutional, interpersonal, and individual levels where it is created, enacted, and felt (Figure 4).

**Figure 4**: A model for cholera-related stigma in the Dominican Republic

First, our findings show how cholera-related stigma threatens what is important to Haitian migrants. Contemporary migration from Haiti to the Dominican Republic is largely driven by economic insecurity (Ministerio de Trabajo, 2011). In a community-based household survey done at the same site, the majority of Haitian respondents not only cited an economic motive for migrating but also reported sending financial remittances to Haiti (Keys et al., Under review), demonstrating the importance of economic security and supporting extended family. Furthermore, personal needs like eating and bathing, accessing healthcare, and positively engaging with community members were commonly cited tasks and goals important in everyday life. In a previous study in rural Haiti (Kaiser, Kohrt, Keys, Khoury, & Brewster, 2013), similar activities were cited by Haitians, demonstrating the commonality of these values within this population.

In the Dominican Republic, failure to attain these goals and engagements is rooted in longstanding structural inequalities, comprising what Scambler (1998) calls *enacted stigma*

and occupying the outermost level of our model (Figure 4). "It takes power to stigmatize," write Link and Phelan (2001, p. 375), and unfair institutional practices constitute a primary means of consolidating power. The effect of adverse institutional policies was evident, for example, in accounts of Haitian participants who drew links among hazardous occupational and residential settings, unequal pay, and increased exposure to contaminated water. At the same time, our findings point to a shared public view that cholera denotes dirtiness, irresponsible behavior, and contamination or *mikwob*. By attaching these moral meanings of the disease to those vulnerable to it, cholera-related stigma scapegoats Haitians for the epidemic and thereby normalizes longstanding anti-Haitian institutional practices.

In addition to forms of *enacted* stigma, Haitian participants described experiences of *felt* stigma (Scambler, 1998). In this study, stigma's interpersonal pathways left many Haitian participants with the sense that life was uncertain or dangerous. Traumatic experiences such as being attacked or robbed, hiding from retaliatory mobs, or dealing with border officials who suspect one may be infected with cholera increase anticipatory stress and result in heightened vigilance and anxiety. At the same time, chronic interpersonal stressors, such as feeling devalued by Dominican market-goers, are persistent, negative stress exposures. Felt stigma within this population also led to an adaptive response to deflect the diagnostic label (Scambler, 1998): some Haitian participants concealed their length of time in the country to avoid suspicion of being infected with cholera.

Finally, at the individual level, felt stigma can be *internalized* (Figure 4). By finding work only in *travay mikwob*, living amidst widespread material deprivation, and incurring the everyday burden of humiliation, Haitian participants categorized themselves as lacking *vale*– value or self-worth. This exhibits a form of "self-stigmatization" that generates low self-

esteem, depressive symptoms, and feelings of disempowerment (Weiss, 2008; Williams & Mohammed, 2009).

From another angle, inclusion of Dominicans in this study revealed subjective, relational ways in which the dominant population understood and formulated cholera-related stigma. For Dominicans, cholera had become not just literally but morally contagious (Nations & Monte, 1996; Yang & Kleinman, 2008). At times, Dominican participants looked back nostalgically upon community life, when canal water was clean and Haitian migrants had yet to establish themselves. The presence of Haitians and their "lower culture" had come to threaten such values as modesty and cleanliness, in turn impacting the health and identity of the community. In essence, associating Haitian migrants with cholera aligned with the three functions of stigma proposed by Phelan and colleagues (2008): (1) to exploit or dominate the minority group, (2) to enforce social norms, and (3) to avoid disease.

It is well known that Haitian migrants are an exploited workforce in the Dominican Republic (Corten, Duarte, Soto, & Fridman, 1995; Diaz Santana, 1976; Grasmuck, 1982; LaTortue, 1985; Lozano, 1992; Martinez, 1995, 1999, 2003; Pascual Morán & Figueroa, 2005; Sagas, 2000). Over time, *anti-haitianismo* developed as an ultra-nationalist ideology, justifying an economic system that reaped benefits from Haitian migrant workers while denying them basic social and human rights. Blaming the migrant population for cholera allowed Dominican participants to overlook unfair institutional practices that maintain advantage over migrants as well as ways in which the national government fails to enact much needed sanitation and safe water policies as a whole.

Second, failure to comply with social norms are usually cast in terms of moral character (Goffman, 1963). Those who do not conform to acceptable behavior are blamed for their misfortune (Phelan et al., 2008). This was apparent, for example, when Dominican

participants faulted lack of hygiene among their Haitian neighbors as reason for cholera's foothold in the country. Dominican participants connected social values of individual responsibility to messages found in public health programs. Assigning individual responsibility for cholera and faulting the poor for their vulnerability parallels findings from a study in northeast Brazil (Nations & Monte, 1996). There, public health campaigns against cholera inadvertently linked the urban poor with degrading metaphorical images. Two lurid cultural stereotypes, *pessoa imunda* (filthy person) and *vira lata* (stray mutt dog), surfaced in interviews with poor community members, who expressed resistance to the cholera control campaign and its attachment of moral labels. These findings demonstrate how public health messages can be imbued with moral judgments. By bolstering their arguments with public health messages that emphasized individual agency, Dominican participants referenced a character flaw of Haitian migrants that engendered cholera's spread across the island.

Third, stigma has been conceptualized as a product of our evolutionary past, a function that may have developed to avoid infected members of the population (Kurzban & Leary, 2001). Distinguishable "marks," or alterations in symmetry, lesions or discoloration, diarrhea or vomiting, or behavioral abnormalities exhibited by the infected contribute to a strong affective response among the non-infected (Phelan et al., 2008). In this study, cholera provoked strong emotional responses among both Haitians and Dominicans, who expressed relief that cholera had yet to make a significant impact in their communities and portrayed the danger posed by contamination and *mikwob* in vivid and emotionally charged terms.

In addition to eliciting an emotional response, cholera bore a mark in itself. Recent weight loss or an otherwise thin body habitus were reasons for Dominican officials to turn away Haitians at the border, while in the community, Haitians that bathed in canals were regarded in disdain. These socially constructed biological or behavioral marks of cholera,

applied to the Haitian migrant population at large, only add to the larger array of social and racial marks that devalue the African influence in Dominican society, including such phenotypical features as darker skin tone and hair texture as well as social and cultural traits like language and spiritual traditions (Howard, 2001). For Dominicans, cholera-related stigma thus functioned not only as a pragmatic act of self-preservation, where physical integrity was threatened, but in defense of a Dominican "existential and moral experience" (Yang et al., 2007, p. 1528), one that defines itself as diametrically opposed to all things Haitian (Franco Pichardo, 1997; Sagas, 2000).

*Putting "heads together:" reducing stigma in the Dominican Republic*

This study's findings point to entrenched social, economic, and political inequalities that became all the more pronounced after the arrival of cholera to the island. Reducing cholera-related stigma must be folded into broader efforts that address these inequalities. The Framework Integrating Normative Influences on Stigma (FINIS) can guide effective stigma interventions at institutional, community, and individual levels (Pescosolido et al., 2008).

Foremost, positive change at the institutional level would have the most wide-reaching impact. The FINIS model recognizes how stigma is embedded in a larger socio-cultural context, where organizations, media, and political forces help define what is "other" (Pescosolido et al., 2008). The Dominican national and cultural identity has, since its inception, defined itself largely in opposition to Haiti (Sagas, 2000). Historical and political events, including the inception of institutionalized *anti-haitianismo* under the Trujillo dictatorship and more recent practices like denial of authorized documents and forced expulsions, normalize the expectation that Haitian migrants are inherently *different* from Dominicans and "naturally" have limited access to social power.

From a public health perspective, contextualizing cholera within its social determinants would be a crucial step towards countering such "othering" processes (Viruell-Fuentes, 2007; Viruell-Fuentes, Miranda, & Abdulrahim, 2012). This entails emphasizing cholera's relationship to poverty as much as individual responsibility. Public health messages should address all socioeconomic groups rather than the poor alone (Nations & Monte, 1996). At the same time, social marketing can communicate the effects of stigma, clarify misconceptions about cholera and its supposed link to "cultural differences," and encourage political action on provision of sanitation and safe water to vulnerable communities, all steps aligned with the Call to Action Plan for cholera on the island (PAHO/UNICEF/CDC, 2012). Finally, national media should avoid metaphorical language that compares the epidemic to "a killer" or "an invasion" that "spreads out of control," language used in other disease outbreaks (Wallis & Nerlich, 2005) and which would only feed into anti-Haitian stereotypes.

The FINIS model also suggests that positive change can be brought about through intervention in communities, where the stigmatizers and the stigmatized live in interconnected relationships. One way to reduce the effects of cholera-related stigma is based on the *convite / konbit* systems of social cooperation. When the Dominican Republic was a pastoral colony, the *convite* was a formal gathering of farmers and small landholders who banded together to accomplish tasks (Domínguez, Castillo, & Tejeda, 1978). Related to the Spanish term, the *konbit* is a parallel structure in Haiti central to rural life (Métraux, 1951). Its spirit of solidarity is invoked in the expression *tèt ansanm*, or "heads together." These overlapping customs can provide a framework for "positive contact" events that seek to reduce stigma. Grounded on this shared history, a "heads together" approach could involve community meetings, workshops, and other informal events where mutual cooperation and understanding are goals. Field studies have documented that frequent, positive interactions

between Dominicans and Haitians reduce anti-Haitian sentiments (Howard, 2001; Murphy, 1991). Since feelings of powerlessness are expressed by poor Dominicans in the same communities as this study (Foster et al., 2010), Haitian migrants and their Dominican neighbors may discover that they share similar obstacles and common goals. “Heads together” events can help define those goals and develop constructive ways of accomplishing them. In so doing, trust and social integration among community members can be facilitated.

At the individual level, the FINIS model incorporates important social-psychological features of stigma, such as awareness of a disease threat and ideas of culpability and concealability (Pescosolido et al., 2008). The individual level of FINIS integrates acceptable norms of behavior and describes the felt experience of the stigmatized. In this study, Haitian migrants described both anticipated and internalized experiences of unfair labeling by Dominican authorities and community members. A major consequence was diminished psychosocial health and hope for attaining important goals and expectations. Increased peer support in migrant communities is one individual-level approach to address these needs. Interventions include educating community members about stigma and training community health workers and community leaders to use therapeutic listening and counseling skills (Murray et al., 2011). The circular migration that many Haitian migrants undertake between the two countries poses a challenge to sustained peer-support interventions, however. In response, public health efforts can seek to identify and recruit Haitian “culture brokers” who have resided in migrant communities for longer periods of time. These individuals should be familiar with the cultural background of migrants and availability of resources in the receiving community, including sources of healthcare and advocacy (Kirmayer et al., 2011). Bilingual Kreyòl-Spanish culture brokers can also educate Dominican healthcare personnel

on cultural understandings of disease, treatment-seeking behavior among Haitian migrants, and culturally sensitive ways of providing care.

*Limitations*

While this study sheds new light on the experience of stigma in the Hispaniola cholera epidemic, important limitations should be mentioned. Data were collected in Spanish and Haitian Kreyòl, while analysis was conducted in English. Important subtleties in the original languages may have been lost. Also, this study is short on examples of positive interactions between Haitians and Dominicans, which are just as integral to the two countries' histories (Martinez, 2003). Future studies could identify and characterize these forms of positive interaction in order to inform stigma-reduction interventions, including "heads together" activities introduced here. Finally, more rigorous studies that follow a cultural epidemiology approach could track the experience of *imilyasyon* and stigma longitudinally and thereby contribute to developing effective stigma-reduction interventions (Weiss, 2001). This study's findings should be considered a first, essential step towards a comprehensive understanding of cholera-related stigma and effective ways of reducing its burden.

*Conclusion*

Cholera's emergence on the island of Hispaniola revealed longstanding disparities in water and sanitation and sparked an international public health response. However, just as important to epidemiologic studies of the epidemic is an understanding of cholera's social context. It is there that cholera acquires meaning, both among those who suffer and those who feel threatened. In the Dominican Republic, cholera and its moral labels were attached to Haitian migrants, already beset by a history of anti-Haitianism in the country and whose

accounts conveyed heightened states of psychosocial stress. In short, in its preference for the poor and marginalized, cholera accentuates inequalities and becomes reconfigured into notions of blame and inferiority. Reducing this "hidden burden" of stigma should be integral to the push to mitigate cholera's impact on the island.

## CHAPTER III: PUBLIC HEALTH IMPLICATIONS

This study documents how cholera exacerbates the psychosocial health of Haitian migrants in the Dominican Republic. Both Haitians and Dominicans attached powerful metaphors of cleanliness, hygiene, and individual responsibility to cholera's prevention and transmission. However, Dominican participants often assigned blame for cholera to the presence of Haitian migrants in their communities and reduced structural disparities to cultural differences between themselves and Haitians. Cholera was perceived to be not just literally but morally contagious.

Moral judgments about cholera bolster negative attitudes and beliefs about Haitians and consequently perpetuate stigma. In turn, stigma increases psychosocial stress, delays treatment-seeking, generates resistance to public health campaigns, and exacerbates feelings of disempowerment. Public health agencies therefore have an important stake in reducing stigma of Haitian migrants in order to mitigate the impact of cholera.

The first step in combating stigma should be additional inquiry into the unique social and cultural processes that create it (Kleinman & Hall-Clifford, 2009). Cultural epidemiology combines ethnographic and quantitative methods to understand values, beliefs, norms, and explanatory models of disease among members of a cultural or social group and then seeks to empirically measure their influence on health (Hruschka & Hadley, 2008; Weiss, 2001). Building on this study's findings, future research should examine cholera-related stigma in

more depth by contextualizing it within the history of anti-Haitian stigma in the country and track its effects over time. For example, Haitian migrant labor occupies a central role in the economic development of both countries. As well, historical and political events dating back to the conscription of Haitian *braceros* to work on sugar plantations, the 1937 massacre of Haitians and Dominico-Haitians, and periodic forced expulsions of migrants all influence contemporary Haitian-Dominican social relations. Thus, future research into cholera-related stigma should account for these historical, politico-economic, and social processes to better understand the "local world" of the stigmatized.

Additionally, a research agenda to clarify the effects of stigma and minimize its impact should document its burden on Haitian migrants, including reluctance to disclose fears or worries of having cholera; exclusion from work or social activities; blame and devaluation; diminished self-esteem and mental health; economic and social impact at the household level; and other locally relevant indicators of social exclusion (Weiss et al., 2006). Importantly, these approaches require local validation of features of stigma. For example, concerns about the inability to marry are important to stigma in South Asia but may be less so in other regions (Raguram, Weiss, Channabasavanna, & Devins, 1996). Research in the Dominican Republic should investigate what matters most to Haitian migrants (Yang et al., 2007), and determine how being stigmatized with cholera threatens attainment of life goals. As well, future research into cholera-related stigma should examine effects on help-seeking behavior and treatment adherence; evaluate changes in the magnitude and character of stigma over time in response to public health interventions; and improve knowledge about misconceptions of cholera, its root causes, and ensure that laws and health policies do not inadvertently promote stigma (Weiss & Ramakrishna, 2006).

*Social capital* refers to cohesiveness and trust among community members, leads to positive social engagements, fosters a sense of control over life circumstances, and consequently has strong effects on health (Berkman & Glass, 2000; Marmot, 2006). This study revealed how stigma antagonizes social capital by impeding mutual trust and social cohesion between Haitians and Dominicans. Practical steps to reduce stigma and increase social capital can be taken in communities where Haitians and Dominicans live and work.

One way of doing so is increased positive social contact based on *convite/konbit* forms of social organization, which have long been a part of Dominican and Haitian rural life. In the Dominican Republic, the *convite* was a way for farmers and other small landholders to band together to accomplish tasks, typically celebrated at the end with song and dance (Domínguez et al., 1978). Directly related to the Spanish term, the *konbit* is a parallel structure in Haiti (Métraux, 1951), remains an essential part of rural Haitian life (Pierre, 2005), and is also commonly referred to as *tèt ansanm*, or "heads together." Drawing on this example of shared history and cooperation, community meetings, workshops, leisure activities, and other events can bring together Haitian and Dominican community members from different backgrounds in an informal setting (Walker, Verins, Moodie, & Webster, 2005). Such positive contact is known to be helpful in reducing prejudicial attitudes held by Dominicans (Howard, 2001; Murphy, 1991), but any lasting effect must strive to create sustained and meaningful social ties (Pescosolido et al., 2008). Since feelings of powerlessness are expressed by poor Dominicans in the same communities as this study (Foster et al., 2010), Haitian migrants and their Dominican neighbors may discover that they share similar obstacles and common goals. Community mobilization can help define those goals and develop constructive ways of accomplishing them. In so doing, trust and social integration among community members can be facilitated.

Another community-level approach for reducing stigma is public health education. In other settings, education campaigns have inadvertently linked the poor and socially marginalized to cholera's harmful metaphors, ascribing infection to individual agency while foregoing mention of cholera's relationship to poverty (Briggs, 2005; Nations & Monte, 1996). The importance of framing cholera within its social determinants cannot be underestimated. In the Dominican Republic, public health campaigns should continue to emphasize the importance of personal and household hygiene in preventing transmission of cholera. At the same time, social marketing can communicate the effects of stigma, clarify misconceptions about cholera and its supposed link to "cultural differences," and encourage political action on provision of sanitation and safe water to vulnerable communities. Clear public health messages can explain how biological and behavioral explanations alone do not provide an exhaustive interpretation of the epidemic (Fassin, 2003). In this way, public health campaigns can reach both the stigmatizers as well as the stigmatized.

Training and educating community health workers (CHWs) and community leaders encourages social cohesion and mobilization. CHWs can supplement cholera education strategies with discussions about stigma, its adverse effects on health, and the need to contextualize the cholera epidemic within the broader problems of poverty and social exclusion. Haitian participants in this study readily expressed their interest in having community meetings about cholera. There is great potential to build on these motivations and create more holistic approaches to cholera education campaigns that include stigma reduction as part of cholera prevention.

The emotional impact of cholera-related stigma bears important implications for public health strategies as well. In this study, Haitian migrants described both anticipated and internalized experiences of being unfairly targeted by Dominican authorities and community

members. A final community-level approach to addressing this effect is peer support in migrant communities. Again building on existing networks of CHWs and community leaders, interventions can include educating community members about stigma and using therapeutic listening and counseling skills (Murray et al., 2011). While little research has formally explored the extent of social supports in migrant communities of the Dominican Republic, it can be assumed that such resources are limited. One central challenge to building peer support is the circular migration that many Haitian migrants undertake between the two countries, making social support networks potentially untenable. In response, public health interventions can seek to identify and recruit Haitian "culture brokers" who have resided in or near migrant communities for longer periods of time. These individuals should be familiar with the cultural background of migrants and availability of resources in the receiving community, including sources of healthcare and social advocacy groups (Kirmayer et al., 2011). Bilingual Kreyòl-Spanish culture brokers can also educate Dominican healthcare personnel on cultural understandings of disease, treatment-seeking behavior among Haitian migrants, and culturally sensitive ways of providing care.

Finally, "it takes power to stigmatize" (Link & Phelan, 2001, p. 375). Institutional practices that marginalize Haitian migrants, restrict them to communities that lack basic services, and deny them access to healthcare, education, jobs, and citizenship maintain stigma as the status quo. Addressing cholera-related stigma becomes "as much a political project as a health project" (Mittlemark, 2003, p. 10). Public health efforts to reduce the burden of cholera can simultaneously help dismantle anti-Haitian institutional practices. Specific areas of focus for public health policies include water and sanitation, documentation, labor rights, and access to healthcare.

First, public health efforts must continue to press for equitable water and sanitation policies throughout the country. The multi-agency Cholera Elimination Plan (CEP) for Hispaniola has set a 10-year goal for eliminating cholera from the island. Central to this plan are improving access to safe drinking water and improving management of excreta and solid waste in both countries (PAHO/UNICEF/CDC, 2012). Accomplishing these goals will require sustained commitment by the governments of Haiti and the Dominican Republic as well as international agencies, donors, and non-governmental organizations. Based on findings from this study, policymakers should incorporate stigma reduction programs into water and sanitation policies, specifically in strategic themes of health promotion, risk evaluation and monitoring, and surveillance (UNICEF, 2013c).

More broadly, Haiti and the Dominican Republic must create a unified immigration policy, one that not only holds human rights as a core value but scrutinizes the determinants of migration, its beneficial effects for economic and social development, and in turn how migration can be supported and facilitated (Pascual Morán & Figueroa, 2005). Immigration policy must consider the circular migration that most Haitians undertake between the two countries. Haitian migrants could be granted authorized status for a delimited period of employment, with the ability to safely return to their families in Haiti. Furthermore, a bilateral policy would recognize how the economic development of both sending and receiving communities are linked and incentivize employers to pay into social security benefits of their workers (Winter, 2012). The latter point is especially important since most Haitians, being undocumented, do not qualify for government-subsidized health insurance and are often forced to pay out-of-pocket for care (Leventhal, In press). Aside from articulating health benefits, labor contracts should stipulate safe conditions, employment rights, and a minimum wage.

Finally, a rights-based approach to public health interventions ensures that both Haitian migrants and poor Dominicans are not left out of cholera prevention efforts. Anti-Haitian stigma and discriminatory institutional practices jeopardize "the highest attainable standard of physical and mental health," a universal right enshrined in the country's Constitution and a core tenet of the International Covenant on Economic, Social, and Cultural Rights (ICESCR), to which the Dominican Republic is party. The injustice of the situation that many migrants face was not lost on them in this study. Haitian migrants routinely expressed their frustration at having few work opportunities beyond the "stoop labor" in rice fields or street markets. They were angry at living in shacks without sanitation or piped water, while Dominican houses next door were noticeably better off. Feeling blamed for cholera made the situation no less difficult. Public health efforts that work towards correcting unjust social structures like these can help ensure that Haitian migrants and other disadvantaged groups can participate more fully in society and lead healthy and productive lives.

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**Figure 1**: Map of Dominican Republic with study site circled; image from Google Earth

**Figure 2**: Canal in Las Placetas. Photo by lead author, 2012.

**Figure 3**: Canal near Esperanza. Photo by lead author, 2012.

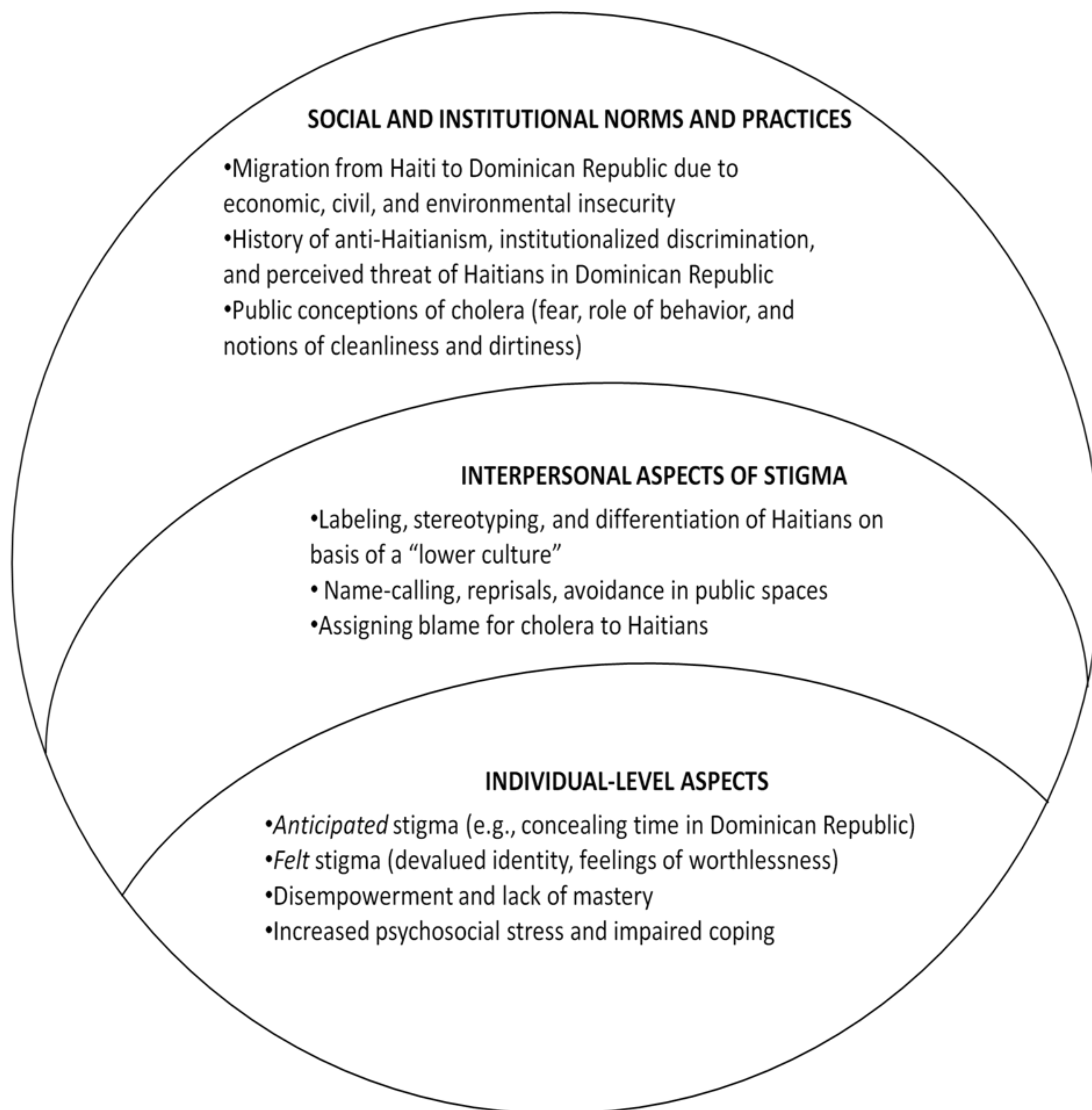


**Figure 4** : A model for cholera-related stigma in the Dominican Republic

| Focus Group ID | Participant ID | Community | Gender | Age |
|---|---|---|---|---|
| 1 | H01 | Las Placetas | F | 33 |
| 1 | H02 | Las Placetas | F | 38 |
| 1 | H03 | Las Placetas | F | 25 |
| 1 | H04 | Las Placetas | F | 28 |
| 1 | H05 | Las Placetas | F | 32 |
| 2 | H06 | Esperanza | F | 19 |
| 2 | H07 | Esperanza | F | 25 |
| 2 | H08 | Esperanza | F | † |
| 2 | H09 | Esperanza | F | † |
| 2 | H10 | Esperanza | F | 23 |
| 2 | H11 | Esperanza | F | 18 |
| 3 | H12 | Las Placetas | M | 37 |
| 3 | H13 | Las Placetas | M | 33 |
| 3 | H14 | Las Placetas | M | 18 |
| 3 | H15 | Las Placetas | M | 27 |
| 3 | H16 | Las Placetas | M | 25 |
| 3 | H17 | Las Placetas | M | 32 |
| 4 | H18 | Esperanza | M | 25 |
| 4 | H19 | Esperanza | M | 26 |
| 4 | H20 | Esperanza | M | † |
| 4 | H21 | Esperanza | M | 34 |
| 4 | H22 | Esperanza | M | † |
| 4 | H23 | Esperanza | M | † |

**Table 1:** Haitian focus group participants (N=23)
† indicates missing information

| Focus Group ID | Participant ID | Community | Gender | Age |
|---|---|---|---|---|
| 5 | D01 | Las Placetas | F | † |
| 5 | D02 | Las Placetas | F | † |
| 5 | D03 | Las Placetas | F | † |
| 5 | D04 | Las Placetas | F | † |
| 5 | D05 | Las Placetas | F | † |
| 5 | D06 | Las Placetas | F | † |
| 6 | D07 | Esperanza | F | 43 |
| 6 | D08 | Esperanza | F | 47 |
| 6 | D09 | Esperanza | F | 54 |
| 6 | D10 | Esperanza | F | 40 |
| 6 | D11 | Esperanza | F | † |
| 6 | D12 | Esperanza | F | † |
| 7 | D13 | Las Placetas | M | 23 |
| 7 | D14 | Las Placetas | M | 73 |
| 7 | D15 | Las Placetas | M | 60 |
| 7 | D16 | Las Placetas | M | 65 |
| 7 | D17 | Las Placetas | M | 50 |
| 7 | D18 | Las Placetas | M | 26 |
| 7 | D19 | Las Placetas | M | 46 |
| 8 | D20 | Esperanza | M | 21 |
| 8 | D21 | Esperanza | M | 48 |
| 8 | D22 | Esperanza | M | 42 |
| 8 | D23 | Esperanza | M | 43 |
| 8 | D24 | Esperanza | M | † |

**Table 2:** Dominican focus group participants (N=24)
† indicates missing information