PATRONATO DE LUCHA CONTRA EL SIDA (PLUS), INC.

MIGRATORY ROUTES FROM HAITI TO DOMINICAN REPUBLIC: IMPLICATIONS FOR HIV/AIDS AND HUMAN RIGHTS OF INFECTED PEOPLE

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We will learn a lot about the nature of our
society in the way we respond to the illness.

A. Brandt in *AIDS*: The Burdens of History (1988)

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Introduction

This study is part of a series of case studies on human rights and HIV/AIDS, which was carried out simultaneously in Argentina, Ecuador, Mexico, the Dominican Republic and Venezuela by the Latin American and Caribbean Council of AIDS Service Organizations (LACCASO), with the support of the Joint Program of the United Nations on HIV/AIDS (UNAIDS).

This study should be seen as an exploratory step towards a deeper study about the complex and longstanding problem between two nations, which requires to be re-defined in the light of the new events related to the HIV/AIDS pandemic. This study aims at providing new and culturally appropriate alternative answers to meet the challenge HIV/AIDS creates in the Caribbean, North America and Europe.

The study analyzes the possible relation between migratory flows from Haiti to the Dominican Republic and the transmission of the HIV/AIDS, as well as the implications for immigrants' human rights. The study aims at identifying possible areas of intervention and research in order to increase the participation of the population and their organizations in HIV/AIDS prevention and care actions. Time and budget reasons prevent us from considering another important issue: human rights of non-infected Haitians and Dominican-Haitian people ("Arrayanos") in terms of collective stigmatization. It is important to note that when the epidemic started in the United States in the 80's,, Haiti had already been considered as an "international pariah for AIDS" (Chaze, 1983).

The purpose of a broader study will be to better understand how the pieces of what seems to be a complex geopolitical, historical, ethnic, cultural and economic puzzle are articulated, and to propose actions to reduce the impact of the HIV/AIDS epidemic among immigrants, including an active participation of the main actors involved in it.

Objectives

The objectives of the study are:

1. To gather and analyze written evidence on the situation of HIV/AIDS in Haiti and the Dominican sugar agricultural colonies (*bateyes*), its relationship with the Haitian immigration and the human rights of Haitian immigrants living with HIV/AIDS in the Dominican Republic.

2. To collect information from experts about traditional and new migratory routes and strategies.

3. To analyze the possible relationship between migratory routes and relevant social-economic factors, with HIV transmission among Haitian, Arrayano and Dominican immigrants and residents .

4. To gather information about human rights of Haitian immigrants living with HIV/AIDS.

Migration and Health

Throughout the centuries, the relationship between migration and health status of migrants has been one of the most controversial and exciting topics. Spruit (1986) identified the main problems related to immigrants' health in host countries, as follows:

1) the social-economic situation compared to the host population;
2) different perceptions of health and illness concepts;
3) difficulties in education and lack of resources;
4) medical impotence to deal with certain illnesses.

Certain studies about how migrants perceive their health problems show barriers to medical care, such as lack of confidence in medical staff, serious diseases, patients moving from services, and financial problems, among others. Recently, the idea that those problems might be solved with the help of religious or traditional quacks has been widely spread.

In order to make medical staff accept different cultural beliefs as regards healthcare, Farmer (1992) proposes the development of a new method called "hermeneutics of generosity" which may contribute to set the basis of a new way to deal with the epidemiology. In that sense, traditional medicine might change according to the new historical and social context. Therefore, Farmer could take his Haitian informants seriously when they said that AIDS "is not simple" and that "one can pass the disease to another person intentionally". After analyzing critically the popular and fantastic sayings about Haiti, such as the magic and mysterious "black box" where HIV/AIDS pandemic was generated, and after investigating the cultural, economic and political sources of their testimonies, Farmer's hermeneutics justifies, localizes and reinforces the need of a new Epidemiology that later on will be known as Pandemiology.

Colledge, van Geuns and Svensson (1986) consider that migrants have something to say in the research agenda. De Jong (1986) believes that immigrants deserve special treatment in healthcare policies when their health problems are more serious than those of the native groups. The voices of Haitian immigrants and the people who live and work with them were taken into account for this study, probably for the first time in the Dominican Republic, in an attempt to better understand their perception of HIV/AIDS.

Migrant Women and Children

There are certain doubts about immigrant women's and children's capacity to understand and learn the culture and language, but it will be necessary to study

deeply the influence of isolation that many immigrant women experience, particularly those who do not work outside the house.

Migration studies classify women and children in terms of their general vulnerability, mainly associated with the lack of knowledge of the language. Nejmi (1986) identifies three levels of risk among migrant women. The most vulnerable group is that of women who do not speak the language of the host country and children who were born in their mother's country. There is another group of women who have a basic knowledge of the language, and children who were born in the host country and therefore able to speak the language. Finally, there is a group of native women or women who arrived at an early age who therefore speak the language, and children who were born from mixed unions and brought up to speak the language.

Most HIV infected women in the world live in poor countries and communities, since poverty and gender inequality increase their risk. Farmer (1996) found that "serial monogamy" is a common practice among poor Haitian women. "Those are weak monogamous relationships that normally result in the birth of a child but that would not last for more than one year. Once such relationship breaks down, women have a stronger need for a reliable partner. Such instability worsens their economic situation and may bring higher risks of being infected with HIV or other STD (Farmer, 1996). In many cases, infected widows need to find a new partner to survive, and put their new husbands under high risk of HIV infection.

International Migration and HIV/AIDS: Recent Studies

Some recent studies about the relationship between migration and the risk of acquiring and transmitting HIV in different societies emphasize the risk factors and the need of HIV counsel and control of other STDs. Adrien et al (1998), found that unsafe sex of Haitians going back to Haiti from Canada could constitute a risk factor for HIV infection. In Zimbabwe, Gregson et al (1998) reported that the level of awareness among migrant men was quite high (42%) as a result of being single and having contact with the media and access to medical services. In Holland, Fennema et al (1997) found that more than 75% of HIV positive heterosexual men and women were foreigners. In Italy, Suligoi et al (1997) emphasized the need to increase information about STD's risk factors among migrants. In the Russian Federation, Tichonova et al. (1997) confirmed that STD infections increased the possibilities of HIV transmission.

Historical Relationship between both Countries

The Hispaniola Island is shared by two countries, the Dominican Republic and the Republic of Haiti. Together with Tierra del Fuego, San Martín, Ireland and New Guinea, this is one of the five cases in the world where an island is shared by two countries (Vega, 1988). Both societies had developed different but linked ethnic, cultural, political and historical characteristics since the 17th century. However, due to the fact that they share the same geographic and ecological characteristics, their

destinies seem to be joint together. Dominicans and Haitians are sons of masters and slaves. Our mothers were cross Tainas, our fathers Caribbeans, Europeans, Africans, Asians and Americans. In spite of this diversity, or in fact because of it, “for being and not being the other one”, the Escindida Island, today threatened by the regional HIV/AIDS subpandemic, has served as the imperial border for racism in America.

The Dominican-Haitian Border

According to Frank Moya Pons (1991), in the 17th and 18th centuries, the Aranjuez, Basilea and Risswick treaties were signed between Spain and France, setting territorial borders for the two colonies which shared the Island. In 1795, the Spanish part was given to France, as a result of the French revolution in 1789 and the Haitian revolution in 1791. In 1794 Toussaint Louverture occupied former Spanish lands. This was never recognized by Santo Domingo’ Spanish authorities after the so-called “re-conquest” in 1809. In 1822 the Haitian government occupied again the Western part, and those territories were incorporated to Haiti. This measure was ignored in 1844 after the foundation of the new Dominican Republic. During several years of war between both countries, Dominicans continued claiming their sovereignty over the territory they considered had been occupied by the Haitians. In 1861 the Dominican territory was annexed to Spain. After the Restoration War, the Dominican Republic was separated from Spain, and the border was set up just as the Haitian government had defined it between 1822 and 1844.

In 1867, the Dominican Republic signed the first Peace and Friendship, Trade and Sailing Agreement with Haiti. Both governments signed new treaties in 1874, 1880, 1884, 1895, 1899 and 1900. There were more treaties in 1911, 1929 and 1935. The latter set forth the building of an international highway which would be used, in some parts, as border between both countries. In 1937, Rafael L. Trujillo’s government put an end to the occupation of the lands and villages near Barahona, Azua, Jimaní, San Juan de la Maguana, Dajabón and Mao, resulting in the killing of 10.000-20.000 Haitian merchants, farmers and employees.

The Dominican Sugar Industry: Sugar Plantations

According to the Indies chronicles of the 16th century, the word “*batey*” was used by the indigenous *taínos* of the Island to refer to the squares where ball games and ceremonial and social activities used to take place. The word “*batey*” remained in the Spanish language, meaning mainly the place where workers from sugar plantations and their families live (Ramírez, 1992).

According to Ferrán (1985) there are two basic types of sugar *bateyes*: the central *batey* and the agricultural *batey* (peripheral).

The central *batey* is located near the factory, where its inhabitants usually work, specially in grist activities. It is usually semi-urban or simply urban, and staff management of the sugar plantation is normally located in the central *batey*.

The agricultural *batey* is a rural community whose inhabitants work mainly in sowing, cutting, loading and transporting sugar cane in sugar plantations.

A particular characteristic of the agricultural *bateyes* is their inhabitants' ethnic composition, strongly determined by the presence of immigrants whose work is usually cheaper than the natives', specially Haitians'. Workers have been imported by the sugar industry since the end of last century in order to keep salaries low and diminish production costs (Ferrán, 1985). Since the last quarter of the last century, when the sugar industry began flourishing, several dozens of sugar plantations were established, many of which were later on closed when the profitability of the sugar cane production started to diminish by the end of the 20th century. Until the end of the 80's, when two state-owned central *bateyes* were closed, there were 16 sugar plantations (Ferrán, 1985).

At present, ten plantations belong to the Dominican State, as an anachronic inheritance of Rafael L. Trujillo's state dictatorship (1930-61). However, a few sugar plantations are private. The Sugar State Council runs this consortium which includes a population of more than 180,000 people living in 203 *bateyes* that keep their functional structure. The *bateyes*, following the distribution of the cane fields in the country, go up to the National District and the San Cristobal province, in the South; San Pedro de Marcorís, La Romana, El Seibo, La Altagracia, and Hato Mayor, in the East; Barahona and Bahoruco, in the Southwest; and Valverde and Puerto Plata, in the Northwest (SCS, 1999).

It is important to mention that the word *bateyes* is not necessarily related to the sugar industry. The word is also used to refer to marginal urban neighborhoods with Dominican-Haitian and Haitian population. Moya Pons (1999) explains how the occupation of lands around the sugar plantations has given shape to important towns. He says "A phenomenon that should be studied: the change of these growing towns from sugar centers to cultural centers, where migrants, instead of looking for a job in the sugar industry, come with the hope of finding a familiar community where they will find less discrimination".

Legal Status of Haitian Immigrants

The illegal status of Haitian immigrants is the starting point for the high levels of exploitation suffered by thousands of them who work in sugar cane plantations, the building industry and other crop fields such as coffee, cocoa and rice. Often Haitians arrive illegally in the country and when sugar crop season finishes, they remain in other areas of the country. Illegal Haitian immigrants have not legal protection whatsoever, not even in the Labor Law (Cedeño, 1991; Veras, 1986).

According to the Dominican Republic Constitution, any child who is born in Dominican territory is entitled to Dominican nationality by virtue of the *Jus Soli* principle, which contradicts the Haitian Constitution which is ruled by the *Jus sanguini* principle: any child will have the nationality of his parents regardless of his birthplace. This divergence caused a double-nationality or lack-of-nationality conflict. Sons of Haitian immigrants and Dominican women, have no papers at all. Reliable sources state that no birth certificate has been issued for a long time for any Haitian descendents born in the Dominican Republic. This affects the child's opportunity to go to school, where a birth certificate is required for enrollment.

Since 1940 to 1952 Haitian immigrants used to work illegally in the country. In 1952 an agreement governing the hiring of services of Haitian seasonal workers, in Haiti, to work in the Dominican Republic was entered into. This agreement was approved together with a work contract form which had to be signed by the employer and the employee. In 1959 and 1966 similar agreements were signed: at the moment there is no consensus on whether these agreements are still in force or not.

Anti-Haitianism

The anti-Haitianism expressed by large sectors of Dominican society is a complex phenomenon originated in the ethnic and economic formation of the parallel Spanish and French colonies in Santo Domingo Island; in the historical fight for their independence; in the conflicts caused by the setting of borders between both territories; and in the economic pressures generated by immigration. According to Vega (1988), the Dominican anti-Haitianism of the 19th century, was based on the Haitian ambition to control the Eastern part of the Island". However, we should try not to blame the Haitian people for anti-Haitianism.

It is important to mention that the main actors of the Dominican history were known by their strong rejection towards Haitian occupation of the Eastern part of the Island during the last century. It seems that ruling classes make a great effort to keep that rejection towards the "blackness" of Haitian people, defending the "Spanish condition" of Dominican people. This kind of anti-Haitianism that, according to Vega (1988) is self-defined as a deliberate effort to confront the crossbreeding, the "Spanish condition", and the catholicity of the Dominicans with the Africanism and "blackness" of the Haitians, also reveals the racial prejudice against their own black Dominicans who have existed since the foundation of the colony. However, towards the end of the third decade of the 20th century, perhaps as a reflection of the Nazism, a "Trujillist anti-Haitianism" grew based on the physical presence of Haitians in the country and on the danger they represented for the national culture. Vega said that, after the killing, Trujillo made anti-Haitianism an official policy, probably as a factor of cohesion through the manipulation of terror.

Magic-religious Beliefs

The language seems to be the first obstacle for the new immigrants, who usually speak only "*kreyole*" as opposed to the Dominicans who only speak Dominican Spanish. An obstacle they should overcome in order to reduce their marginality in every-day life in the *bateyes*. However, after a period of adaptation, men seem to learn the Dominican language quicker than women, probably for being in permanent contact with it due to the fact that they spend more time outside their homes and for having more interaction with the host population. The linguistic barrier seems to be less problematic than the cultural barrier, particularly that related to magic-religious beliefs between immigrants and the Dominican power sectors that work in the *bateyes* (guards, army, police, priests, and health and educational staff). Presumably, linguistic differences have a higher importance in the work relationship while the cultural ones are more important in the interacting relationship with health staff.

Farmer (1992) shows how magic-religious beliefs of the rural Haitian culture imply a different epistemology to the one of western biomedicine. This requires the reconciliation of both positions, avoiding the "exoticism" and "satanism" of the cultural practices in the voodoo rites by the host culture. Although Farmer tries to keep himself away from it, he offers examples of common beliefs existing in the folkloric AIDS theory in Haiti, such as a voodoo tradition originated in the dahomeyan exorcist practice that requires to "dance the corpse of the one who died of AIDS, inside his coffin". This practice brings about a conflict among sectors that consider it offensive. This separation ritual is called "*mampoté*" or "*mampoteo*" (from "*mampostear*", to wall up a corpse in a tomb with concrete) and is carried out by Haitians and Arrayanos in the *bateyes* of the Dominican Republic, in an attempt to revert the pain and be solidary with those who have suffered a lot. Thus, people who die of AIDS in the *bateyes* tend to be *"mampoteados*" (Darío Solano, personal communication).

Human Rights: Status of the Population

The Dominican Republic has ratified the main agreements and treaties of the United Nations Member States. This forces the country to observe, among others, the Universal Declaration of Human Rights, the Supplementary Convention about Abolition of Slavery, the International Convention on the Elimination of every way of Racial Discrimination, the Convention on Women's Rights, and the Organization of Work. The Dominican Constitution also provides for different civil and political rights.

However, the country has historically ignored people's rights. Consequently, human rights committees visited the country several times, once in 1976. As a result of those visits, economic sanctions were imposed after determining that the working conditions of Haitian workers constituted slavery practices.

As regards people living with HIV/AIDS (PLWAS), their rights as citizens are set forth in the country's legislation, specifically, in the Law 55-93 on AIDS and its internal regulations. The law provides regulations on diagnosis, prevention, rights

and duties of infected and not-infected citizens, and sanctions for those who ignore the rights and guarantees prescribed therein (Raful, 1995). López Severino (1999) says that the counsel process is not regulated and many times has depended on the work of a few non-governmental organizations. Law number 55-93 establishes counsel, but makes a distinction between counsel given before and after HIV tests.

Cáceres et al. (1998) found, after a survey, that most PLWAS in the country remain anonymous due to the social and labour implications that openly assuming their condition may represent. The existing help groups are located in Santo Domingo, limiting the participation of the migrants living in the *bateyes*. In many cases, relatives of these people try to hide their condition, others on a smaller scale, get support from their social environment. De Moya (1998b) shows that many infected people, their relatives and neighbors, were unable to think of or even pronounce the word "AIDS" without an intense emotional reaction, suggesting the ominous character the word has acquired.

Caceres et al. (1999) assure that access to private health services is related to people's economic situation. At a public level they suffer from lack of diagnosis elements, means of protection and medication. There are also problems with health staff's willingness to assist infected people. The identification, stigmatization and discrimination of HIV positive people in the health sector still remain, as well as mandatory HIV tests. Guyanes (1999) states that the public health system has no anti-retroviral medication available. The laboratory controls for the appropriate use of these therapies are not available at the moment in the country, and an adequate training of the health staff for the follow up of patients on treatment is not enough.

Haitian Immigration and Human Rights

Patterson (1987) assures that Haiti is one of the "peripheric units" of what he denominates "Western Atlantic system". One of the most important processes in this system , he says, is migration, which applies to Haiti as well as to the Dominican Republic. Farmer (1992) insists that Haitian economy cannot be understood without taking into account the relationship it has with other countries and the role of migration. In the last one hundred years, he says, Haitians have worked in sugar cane and other crop fields in numerous countries in the Caribbean.

This migration originated the formation of important communities in Cuba, the Bahamas, and especially in the Dominican Republic. (Plant, 1987). A United Nations Committee of Economic, Social and Cultural Rights (1998) estimated that near half a million Haitians live in the Dominican Republic, only 25.000 of them have papers. Farmer (1992) says that in 1980 the Dominican government estimated that 90 per cent of the agricultural workers in sugar plantations were Haitian.

Some years before, a survey carried out by Hernández (1973) found out that there was an illegal traffic of workers through the border. The authorities and sugar

companies representatives were aware of this traffic. Back in the *bateyes*, workers lived in a sort of big hut with no ventilation, illumination, amenities, communal equipment or adequate sanitary, diet and dress conditions. Military Dominican authorities carried out raids (the "*recolecta*") aiming at relocating Haitians who were working temporarily in the cities, as an explicit way of showing their illegal condition after the sugar cane season had finished; 60% of the Haitian immigrants had not returned to their country. According to this study, the Haitian participation in the Dominican economy had shown a displacement pattern that included the gradual occupation of lands in the borders for agricultural and cattle use, farming activities in sugar plantations and the moving towards urban regions (street vendors, temporary workers, workers in coffee and rice harvest).

During the last few years, an unknown number of Haitian immigrants have been able to generate income in the informal economy, probably just to survive, particularly working in the private building industry, public works (roads and residence), and as small merchants, craftsmen, painters, prostitutes, and hairdressers for tourists, among others. Jonsson (1998) assures that these people "have escaped from Haitian poverty and tyranny but have fallen in the exploitation of badly-paid jobs and illegality". He highlights that Haitian migration continues and creates tension between the two countries. However, many people say that Haitians do the work that Dominicans do not want to do (the worst paid jobs), i.e. to cut cane and to work in the building industry.

The members of the United Nations Committee of Economic, Social and Cultural Rights (1998), after a special mission to the Island, identified the following main problems:

1. Cane cutters suffer from abuses by migration and military authorities; children and women have no legal existence (p. 15), inherited from the illegal condition of their parents.

2. The discrimination consists of racism, chauvinism and class prejudices about Haitian immigrants and black Dominican who share Haitian ancestors or traditions (p.17). This discrimination is shown in the intent to abolish cultural Afro-American practices or practices identified with Africa (p.29).

This Committee asked the Dominican government to abolish the "regulations that seem to violate the economic, social and cultural rights of immigrants and their families" prescribed in the 1996 Immigration Bill, specially article 6 that considers immigrants under the non-resident and illegal immigrants as foreigners in transit. Moreover, the Committee showed its concern on the increase of "sexual tourism" in the areas of AIDS spreading and propagation.

The HIV/AIDS pandemic in Hispaniola Island.
Demographic, Economic, Healthcare and Educational Situation in Haiti and Dominican Republic.

Table 1 shows a comparison between key aspects of the social, economic, healthcare and educational situation in both countries based on recent data provided by the United Nations. One can note that all indicators show important differences in favor of the Dominican Republic. This table allows us to better understand the direction of the migratory flow from Haiti to Dominican Republic acting as expulsion and attraction elements from one country to the other.

Table 1. Comparison of some demographic, economic, healthcare and educational indicators between Haiti and Dominican Republic.

	Haiti	**Dominican Republic**
Area	27,750 km2	48,000 km2
Population (millions)	7.4	8
Annual per capita income (U$S)	250	1,460
Index of human poverty	46.2	18.3
Social-economic ranking among 175 countries	156	87
Life expectancy at birth (years)	54	71
Mortality of children under 5 years old (every 1,000 born alive)	124	44
Maternal mortality (100,000 born alive)	1,000	110
HIV Infection rate (%)	5.17	1.89
Population with access to healthcare (%)	60	78
Population with access to drinkable water (%)	28	65
Adult illiteracy rate (%)	55	18

Source: UNDP Human Development Report 1997 and UNAIDS Epidemiological Fact Sheet on HIV/AIDS and STD. June 1998

A recent report by the World Lutheran Federation indicates that 95 per cent of the Haitian forests have been deforest, 60 per cent of the population is unemployed or underemployed and that the policy of privatization of all public services and institutions is causing the dismissal of thousands of workers. About 15,000 Haitians were deported from Dominican Republic in February and March 1997, "some of them have certificates of residence, which makes the situation in Haiti even worse and shows the great institutional discrimination against Haitian immigrants that exists in the Dominican Republic." (Jonsson, 1998).

This report also corroborates the extreme and dramatic political and economic situation that Haiti is going through, which could continue to force the low income population out of the country, either by sea to the United States or by land to the Dominican Republic, being the latter more likely to be chosen since it implies lower costs and greater chances of success in crossing the border, even when this implies not only arriving in a poorer country but also finding more competitiveness due to the limited opportunities for the immigration community.

This report concludes that the destiny of the Haitians in this country: "continuously fluctuates between improvement and impairment... Repression and physical abuse have continued. As the production of sugar cane diminishes, less Haitians have the opportunity to find a job in that sector. Many have found a job in the growing

building industry, but they have to compete with a large number of new immigrants coming from Haiti".

This competitiveness among Haitians for a place in the Dominican informal economy is a new ingredient for the crisis.

The HIV/AIDS Epidemic in Haiti

According to Farmer (1992), AIDS pandemic in the Caribbean is made up of multiple HIV sub-epidemics, derived from the larger pandemic in North America. He assures that the epidemiological research has shown that the virus came to Haiti, the Dominican Republic, Jamaica, Trinidad y Tobago and the Bahamas from the United States, probably through tourism and the homecoming migrants from abroad. In his opinion, well-sustained explanations should be given in order to reveal the trans-national link many times avoided in re-counts based on national reports.

The first cases of AIDS in Hispaniola Island took place between the end of the 70's (Pape, 1983) and the beginning of the 80's (Guerrero et al., 1985). Koenig et al. (1987) and Farmer (1992) identify sexual tourism as the most probable introductory route for HIV/AIDS into the Dominican Republic and Haiti, due to sexual contact among male homosexual tourists and Dominican and Haitian males who sell sex to men. Moya and Garcia (1999) also mention organized homosexual tours with common destinations between Santo Domingo and Puerto Principe for middle-aged American and European tourists during the boom of the 80's. This seems to be one of the oldest HIV/AIDS vectors in the Island.

Some studies of HIV seroprevalence carried out between 1987 and 1993 allow us to partially know the magnitude of the local epidemic during that period. In Table 2 we can see data from selected studies, published by PAHO/WHO in 1996, which suggest the display of a mature epidemic. Two studies on prostitutes give evidence that these had reached very high rates of seroprevalence (over 60%) at least in some towns. Low-income groups (1989) and female patients from STD clinics, until 1993, surpassed the 10% of infection, being almost three times higher (28%) in men with STD. Parturient women below 25 years old (1991-1992) and pregnant ones, in at least two sentinel sitles, (1992-93) have overcome the critic level of 5% that suggests a concentrated epidemic. Blood donors (1992) were close to this level. The PAHO/WHO report shows no indication on the existence of seroprevalence studies after 1993.

Table 2. Selected seroprevalence studies carried out in Haiti (1987-1993).

Group	Source	Year	Seropositivity Rate %
Sex workers	Gheiskio	1987 1990	61.0 72.0

Low income groups	Citu Soleil	1989	10.3
Parturient women 14.19 / 20.24 / 25-49 years old	IHE	1991-92	6.0 7.0 4.6
Blood donors	HAS/HSCL	1992 1992	2.2, 3.0-5.0
Pregnant women in Sentinel sites	IHE	1992-93	7.5-9.6, 5.5-6.1,1.8-2.9
Male/ Female patients with STD	Gheiskio	Not reported	28.0 14.0

Source: "Sanitary Situation Analysis. Haiti 1996". PAHO/WHO. June 1996

Two qualitative studies about the situation in Haiti have been published during the few last years. Ulin, Cayemittes and Metellus (1993) studied the role of female Haitians in their country regarding sexual decision making. The results show that there was very little awareness of vertical transmission; women with no means to earn their living were less respected and had little influence on decisions related to their homes and sexual life. Their interest to keep their male partners leads many women to forgive or ignore her partner's infidelity. Some women advise others to abstain from having sex with a promiscuous man and even to abandon him in case he cannot be convinced of being faithful to her.

More recently, 107 Haitian homes with at least one PLWAs were found. These homes had suffered changes in their socio-economic and family structures. These changes included:

1) unemployment, increase in requests for loans and sale of assets as illness became more serious;
2) low level in searching for medical care, even when this was available;
3) social responses as denial, ostracism and abandonment among others (Aggleton & Bertozzi, 1997).

The HIV/AIDS epidemic in Dominican *bateyes*.

Table 3 shows data from nine HIV seroprevalence studies carried out in sugar industry populations. These studies have been carried out in different scenarios, such as Customs offices located in the border with Haiti, and in agricultural *bateyes* in Monte Plata, Yamasá, Hina, San Pedro de Marcorís, Hato Mayor and Barahona.

Table 3. HIV seroepidemiological studies in sugar cane plantations ("*bateyes*") in the Dominican Republic (1985-1996).

Author, Year, Place, HIV+/N HIV Prevalence (%)
Guerrero et al., 1985, Customs offices Haiti border 30/1.000 3.0
Martinez et al., 1986, Haitian cane cutters, Monte Plata and San Pedro de Marcorís 15/500 3.0
Acra, 1987 Haitian cane cutters, Hato Mayor, 3/200 1.5
Perez et al., 1987, Haitian cane cutters, *Batey* A. Bass, San Pedro de Marcorís, 4/87 4.6

Melgen et al., 1988 Dominican and Haitian cane cutters, Los Jobillos, Yamasa, 7/186 3.8
Guerrero R. et al., 1991, Haitian cane cutters, Barahona, 6/100 6.0
Capellan, 1992, Men and women in *bateyes* of Haina all of them Dominicans Haitian immigrants (<1 year) Arrayanos Haitian residents (>5 years), 37/397 9.3 4.4 5.0 10.0 15.0
Brewer et al., 1996, Women, *Bateyes* of San Pedro de Marcorís, all of them < 35 years old Dominicans Arrayanos Haitians, 28/492 5.7 8.8 3.6 4.9 7.4
CEA/PAHO/UNAIDS, 1998 Women *Bateyes* of Barahona Dominicans Arrayanos Haitians 4/211 0.14 1.2 13.3

Source: IEPD/Profamilia, AIDS Bibliography (1988-1997) and SSC/PAHO/WHO (1998)

HIV infection rates in different *bateyes* are quite variable, and therefore, difficult to compare. The main identified risk factors for all the members of these communities are: the fact of having suffered from syphilis, and the time they have lived in *bateyes*. In the case of women, the receptive anal sex, professional prostitution, home economic support, and the fact of being under 35 years old, were all causes associated to risk. Half of the HIV positive women had had no more than two sexual partners. (Brewer et al., 1996). Capellan (1992), Brewer et al (1996) and CEA/OPS/UNAIDS (1998) found higher rates among Haitians, followed by Arrayanos and Dominicans. The first two of these three studies concluded that most of the HIV transmission seems to take place in the *bateyes*.

Comparison between epidemics in Haiti and in Dominican *bateyes*.

Seroprevalence studies carried out in Haiti can be compared to those carried out in Dominican *bateyes*. The seroprevalence shown by "low income groups" in Haiti in 1989 (10%) is higher than the one found among male Haitian cane cutters in several Dominican *bateyes* by Guerrero et al. (1985), Martinez et al. (1986), Acra (1987), Perez et al. (1987), Melgen et al. (1988) and Guerrero R. et al. (1991) and similar to the one reported by Capellan (1992). This study and the one carried out by Brewer et al. (1996) found that levels of infections among prostitutes from *bateyes* were more than two times lower (25%) than the ones reported in Haiti (61%-72%). Women studied by Brewer showed HIV rates of 5.7 per cent, slightly superior to the 5.17 per cent estimated by UNAIDS at present for the general Haitian population.

Studies on Knowledge, Beliefs, Attitudes, and Practices related to HIV/AIDS in *Bateyes*.

Few studies on knowledge, beliefs, attitudes and practices related to AIDS have been carried out in *bateyes* of the country. The most complete work is the one carried out by Blandino (1990) who reported that there is an important power structure in these communities with influential informal charismatic leaders who

work with “mysteries” (“chamanica” figures). This author also proved that there were fraternities or “Gagas”, “secret” hierarchic societies of a magic–religious nature which operate openly in Lent. As regards AIDS, Haitian women had less knowledge about the HIV transmission than Dominicans and Arrayanos. 85% of the Haitians were not willing to use condoms when having sexual relations with their spouses, but practically all of them were ready to have an “AIDS Test” if it was for free.

While carrying out a survey on family planning in 27 *bateyes*, Ramirez (1992) found that women who were born in Dominican territory had two times more knowledge about the existence of the condom (63%) than the ones who were born in Haiti (30,4%). A recent study carried out showed that Haitians “chamanes” stressed the fact that they were not able to cure anyone suffering from this disease, and they did not intend people to believe in a possible cure for it, their role was to help infected people to be emotionally stable after visiting them.

HIV Preventive Action Attempts in Dominican *Bateyes*.

Adequate attempts to prevent HIV/AIDS transmission have been carried out by state organizations such as the STD and AIDS Central Program (PROCETS), from the Public Health Secretariat (SEAPAS) (Mañaná & Gamboa, 1990), the Dominican Social Security Institute (DSSI) (Arbaje et al., 1992; Millord et al., 1992ª, 1992b) and the Reproductive Health Program of the Sugar State Council –SSC-. Non governmental organizations have also participated in these attempts, such as Dominican Churches Social Services, and agencies such as Medicus Mundi and HIV/AIDS Prevention Project (PREVIHSA) from the European Union, among others. However, no impact reports or evaluations have been published allowing us to know the specific situation in the *bateyes*. Hospitals belonging to the Dominican Social Security Institute offer general medical care, and the Salvador B. Gautier Hospital offers especial medical care to Haitian workers having insurance in private and state-owned *bateyes*, as well as to their spouses and children. At the beginning of 1999, the P. Juan Montalvo Study Center and the Jesuit Service for Refugees (SJR) published a catalogue containing names of organizations and institutions that give services to Haitians and to Dominicans with Haitian ancestors in the Dominican Republic. The catalogue included 41 non–governmental, 14 ecclesiastical, 7 rural , 6 trade union, and 5 municipal organizations.

METHODOLOGY

This study was done in three main phases:

1) Revision of existing documents showing the relationship between Haitian immigration, HIV/AIDS and human rights of PLWAS.
2) Semi-structured interviews to key informants, authorities and experts on the topics of interest; and

3) Study of eight cases of Haitian immigrants who live with HIV/AIDS in Dominican *bateyes*, based on semi–structured interviews to these people and/or confidants (close relatives and neighbors), who gave their consent.

Two semi–structured interview guides were outlined, one for key informants and the other for Haitian immigrants who live with HIV/AIDS in the sugar colonies ("agricultural *bateyes*"). The key informants' guide consisted of 11 parts about the interviewee's experience and knowledge on the migratory routes from Haiti to Santo Domingo, points of departure, stations and destination, variation and reasons for changes in the traditional migratory routes through time, comparison between the HIV/AIDS situation in Haiti and Santo Domingo, knowledge on violations of the rights of immigrants who live with HIV/AIDS, community support, the role of magic–religious beliefs, health services availability and quality, participation process, and debate on migratory control bills, among others (see Appendix I).

The interview guide for PLWAS and their confidants consisted of 33 questions which covered the following topics: demographic profile, migratory process, lack of legal documentation, human rights status, ways of detecting the infection, condition of spouses and children, knowledge of the disease, symptoms, medical care, social support and relationship with the community, as well as discrimination episodes at working, health and house environments and free transit (Appendix II).

An environment examination guide was also used during the visits to the *bateyes* which help to describe the communities which were under study and illustrate the existence or non–existence of local services. These included register of streets, housing conditions, healthcare facilities, electric power, sewage and garbage disposal facilities, schools, churches, commercial activity in the community, health service, internal community organization, and means of transport (see Appendix III).

A list of possible key informants was made. This list consisted of representatives of the Diplomatic Corps, Amnesty International, International Labor Organization, Upper United Nations Commissioner for Refugees (UUNCF), Organization of American States (OAS), the Latin American College of Social Science (FLACSO), the Foreign Affairs Secretariat, Migrations and Prison Departments, National Committee of Human Rights, Human Rights Commission, Dominican–Haitian Women Movement (MUDHA), Socio–Cultural Movement of Haitian Workers (MOSCTHA), university teachers and journalists.

A letter explaining the nature of the study and the institution which would carry it was sent to all the candidates who had been invited to participate as key informants. The letter also requested documentation available on the topics described. Eleven interview attempts were carried out without success. Those attempts included an average of five telephone calls and/or pre-arranged visits in order to organize the interview.

Five semi–structured interviews about migration, foreign affairs and human rights were carried out to key informants who worked with immigrant women and Haitian prisoners. The sixth interview was about funeral rites related with AIDS in *bateyes* as a cultural magic–religious expression. These interviews were recorded with the consent of the interviewee, and then edited, summarized and tabulated to be analyzed individually and in groups.

The next stage consisted of interviewing Haitian male and female immigrants either HIV positive or living with AIDS. In order to do this, the authors contacted health staff from the Sugar State Council and from community organizations who had worked together with the authors in preventive actions between 1992 and 1997. They were asked to recruit their own patients who were ready to give their oral consent to participate, anonymously, in the study. The consent included the possible participation of the spouse, their children and other confidants as interpreters, unless the interviewee would consider that this was a violation of his right to privacy and confidentiality. So, doctors, nurses and health promoters were trained to explain the purpose and the objective of the study to the candidates, and to obtain the consent from the patients. In one of the cases in which the patient was in the terminal stage of the illness, his wife and children consented to be interviewed. The selection criteria included the fact of being born in Haiti, being HIV seropositive or living with AIDS, living in *bateyes* colonies.

Finally , four semi–structured interviews to women and four to men were carried out in their homes. These interviews were also recorded with the patients' consent, then edited, summarized and tabulated for analysis . The research team handed in anti–parasite medicine, condoms and educational material to the health promoters in each *batey* which was visited to be distributed among the population.

In order to complete the study of 8 cases, they carried out additional individual interviews to 10 neighbors, an evangelical pastor, a husband, a patient's wife, a sister–in–law, two community leaders, three health promoters, a nurse, three female doctors and two *batey* supervisors. The *bateyes* involved were: Altagracia, Excavación, La Construcción, and Las Pajas, in San Pedro de Macorís; and El Pomito/SCS, Bayaguanita, y Palomara, in the National District.

The analysis strategy included the three phases of the study: first of all they analyzed available documents (laws and treaties, books, university thesis, reports from different organizations, and press cuttings). Secondly, they analyzed the semi-structured interviews to key informants in terms of recurrent subjects and their reciprocal relationship. Finally, they followed the same process with semi–structured interviews to HIV seropositive Haitian immigrants or those living with AIDS and their confidants.

Interviews with Key Informants

In the map we can see the places through which most of the Haitian immigrants intent to cross the border and the destination chosen in the Dominican Republic, according to the five interviews done to key informants.

1. From Dajabon and Jimaní (in the Manzanillo Bay up to Restauración) up to Cibao (Esperanza, Montellano, San Francisco de Marcorís, La Vega), to cultivate sugar and rice, and to Santo Domingo, for the building industry.
2. From Jimaní, Elías Piña and Pedernales up to tomato and melon fields in San Juan de la Maguana, the coffee plantations in Barahona, and the South sugar plantations (Barahona, Haína) and the Southeastern ones (San Pedro de Marcorís, La Romana, Hato Mayor, and Higuey).

The border areas where countries exchange goods in commercial markets (such as Quanaminthe/Juana Mendez, Jimaní/Mal Passe, Dajabón y Pedernales) are "evasion routes" where migratory controls can be easily eluded. Informants indicated that immigrants use the mountains of Sierra de Bahoruco, in the South, to get to Pedernales, slipping through roads and alleys. A not-so-well-known route, identified by one of the informants, is to cross the sea in little motor boats ("*yolas*"), in the South of the Island, landing in the beaches of Pedernales. This traffic seems to depend on the socio-economic and political situation causing the exodus from Haiti, the severity of the migratory controls in the border, and the immigrants' resources to offer bribes. Some immigrants, whose families live near the border, arrive in the country to work in specific agricultural tasks and, regularly, take the money they have earned back to their families.

Each year, almost 10,000 workers enter the country after being legally hired by the State through the Sugar State Council. This implies that all immigrants should undergo medical tests, should be vaccinated against malaria and be given a vaccination card that the Haitian Affairs Office in the Migration Headquarters would take into account in order to provide them with an identification card. The holders of this identification card will be considered as visitors in transit and will be distributed in different *bateyes* to live in small houses or big huts.

Private sugar plantations and individual tenant farmers who own cane fields hire migrant workers through middlemen ("Seekers") directly in Haiti and then take them to agricultural plantations. It is not clear how much of this traffic is legal and how much illegal.

People interviewed agreed that, in general, the magnitude of the AIDS epidemic in Haiti is greater than in the Dominican Republic. They highlighted that Haiti's conditions are unhealthy and that the access to health services is scarce. These two factors are shared by the Dominican *bateyes*, where Dominicans, Arrayanos and Haitians live together.

Participants informed about violations to immigrants' human rights: immigrants are required to pay a bribe in order to cross the border, women are cheated and raped in the border, sexual abuse trials are adjourned, women do not appear in the

payment list of plantations and they are not entitled to accommodation unless they have kids who are able to work in the cane field.

Three informants admitted knowing cases of PLWAS, Haitians and Dominicans, living in *bateyes*. One of the informants emphasized "they only have the right to die, since they have no other rights in their *batey*". They reported different violations to PLWAS' human rights: they were not allowed to move freely (residents prevented them from moving freely within the community), they had to avoid physical contact with others (they were given food from a certain distance), compulsory cleaning (utensils used by PLWAS were washed many times), discrimination (health staff did not provide services or gave excuses for not providing them), and ostracism (HIV positive resident Haitians were deported when trying to renew their permits). The informants also mentioned the scarce access to health and education services.

However, some people interviewed considered that HIV positive people, in a way, consented to being isolated and, in the case of prisoners, being released and then deported, as a way to cope with the pressure exerted by groups and communities.

According to informants, the response of the Haitian population to the HIV/AIDS crisis in the country is conditioned by the rights recognized or denied by the country and its institutions. One of the informants explained that "historically Haitians have never been treated as persons". This adds another element to the stigma of the HIV positive condition, regardless of nationality. Haitians also ignore the right vested in their children to have the nationality of the country where they were born. Moreover, they do not have legal papers, and there are no migration authorities that speak kreyole.

According to the point of view of those interviewed, the main obstacles this people have to face are the language barriers, poor quality of life conditions as healthcare, housing, education, and others, high level of illiteracy, and prostitution as a means to survive.

The interviewees admitted that once they arrive in the country, most of the Haitians seem to have no intention of going back to their own country and they move from one place to another in order to cheat migratory controls and live in other productive areas. They also identify popular religion as a helping element in some cases and as an obstacle in others for AIDS prevention and care. They think people refuse to accept their disease, and believe that they have been "bewitched".

As regards HIV/AIDS preventive actions in the *bateyes* and other places of residence for Haitian people, informants said that employers should show more interest and should include HIV/AIDS prevention and care in their working agendas. They suggested the creation of educational messages in both languages, Spanish and *Kreyole*, delivery of condoms, improvement of living conditions of PLWAs by allocating enough funds and training human resources. Moreover, they

propose the delivery of basic medicine for seropositive people, either Dominican or Haitian.

However, one of the informants said that "The State is not responsible for the healthcare to foreigners, since there is no possibility of affording the high cost this would imply". This person stressed his interest in knowing the real magnitude of Haitian migration as well as the status of HIV epidemic among immigrants.

Representatives of the participating organizations assured that there is little coordination among them regarding human rights activities. Three of them identified these organizations as being interested in reporting irregularities (arrests, deportations, repatriations). Only two of them admitted having carried out joint actions, such as submitting proposals for debate at the National Dialogue (Dialogo Nacional), and reports before the United Nations, Upper Commissioner of Human Rights. Two of the institutions, which are related to the government, are working in the revision or debate process of migratory laws with the purpose of launching a new bill and preparing a common memorandum between both nations, to be discussed during a new meeting between the Presidents of the two States.

Study of PLWAS in Dominican *Bateyes*.

As we already mentioned, eight cases of Haitians (four women and four men) who live with HIV/AIDS in sugar *bateyes* of the National District and San Pedro de Marcorís, were studied. The results of these interviews are shown in Table 4 and attached maps.

Description of the *Bateyes*

The communities which have been visited are agricultural *bateyes* characterized by the absence of basic services: drinkable water, sanitary facilities, electric power, excrement and garbage disposals, rain drainage systems, and health services. Roads are not paved and local transport is scarce. In September 1998 hurricane George practically swept away all the latrines of the *bateyes* of San Pedro de Marcoris. Single-family houses are built of wood with zinc roofs. Walls and roofs of living quarters -"*barracones*"- are made of cement, and occasionally of zinc. Almost all communities have one or two churches, mainly Evangelic and Adventist. The population changes from one *batey* to the other, depending on the number of houses available, individual huts and living quarters. The number of homes varies between 40 and 1,000 in the *bateyes* studied inhabited by Haitians, Arrayanos and Dominicans of different ages.

Female Cases

A description of each case is given in Appendix E. The age of female HIV positive cases interviewed ranges from 24 to 45 years. These women do not speak Dominican Spanish, cannot read or write, and before acquiring the illness, "sold things", washed and ironed clothes for a fee, or collected coffee in private plots of

land for a living. They reported having had from 2 to 5 monogamous unions in series, and 3 to 4 kids with different partners. Two women had small kids showing HIV infection signs and symptoms. The husbands of two of them supposedly died from AIDS. One of them knew he had been infected by a previous HIV positive wife. The two infected women immediately got married to another man in the *bateyes*. The other two were also married. Some of them met their partners in Haiti and others in the *batey* where they lived.
Three of these women entered the Dominican Republic from Haiti by land and the other by sea, moving from northern and southern towns to different Dominican communities. They passed through at least two immigration posts before settling where they are at present. All these women have no identification documents. Nevertheless, they said they can go wherever they wish without being asked to present "papers" or being disturbed by migration authorities. However, they tried not to call too much attention in the community. In many cases the women interviewed said that Hurricane George "took their papers away" (see Appendix F).
Three of them said to suffer from fever, diarrhea, parasites, kidney infection, skin problems and "stomachache". In no case was the word AIDS mentioned. Only one, detected during her latest pregnancy eight months ago, said she had no health problems, but recognized that her baby "is always sick". All of them sought medical care. Two of these women have received medical assistance on a temporary basis: during child delivery, and, in the other case, continually during the last few days. Their husbands, children, sisters-in-law, neighbors and religious priests help them. The women interviewed complained that they had not been told to come back to see the doctor, that they received no medicines, and that they had no money to pay for the doctor or medication. They stated that they never had problems with the community or with health or migration authorities. People visit them, feed them whenever they can, and help them with housework. They reported that the health centers they went to take good care of them, sometimes quickly, but apparently they are not properly examined or assisted. These centers have no equipment to make tests or medicines to provide to those in need. Women generally have to move out of their own communities in order to have access to health services.

Male Cases

A description of each individual case is given in Appendix E. The ages of the four men interviewed ranged from 37 to 63 years. Female health promoters and neighbors, with the consent of them all, except one patient who was in his terminal stage, spontaneously helped as interpreters. Men live in agricultural *bateyes*, two of them with their wives and kids. Even though they had been married, two of the men were living on their own, with no couple. In one case the wife had left him and was living with a neighbor, however, she visited him and gave him food. The other was visited by his wife and kids , who lived in another *batey*, once a week
They migrated through the northern and southern frontier, and one of them landed in Perdernales. All of them, except one, lived in migratory stations. One of them said he walked almost the whole country, reporting 15 places of residence (see Appendix F). Three of them came in by themselves and one of them with his wife

and a little son to work in the sugar cane the *bateyes*. None of them have identification papers, even though they have been living in the country for over 10 years. They did not report problems with the authorities for lack of identification papers.
These men claim to suffer from “Amoeba “, “cholerine” and diarrhea. One of them said that his illness was originated by a hit in his head some years ago. In no case was the word AIDS mentioned. Two of them said to have been subject to the HIV test in public hospitals. One is a pensioner. In general, they do not know exactly why or what are they suffering from. One of them said that he lives in the hope that God will take his illness away. None of them continues working with the cane due to their illness, but some sow yucca and sweet potato in small plots of land “for domestic use”.
All of them reported having sought medical care in their own communities and out \of them or through health promoters. One of them is happy for being able to take medicines. Another went to a *batey* nearby for a medical examination, but there were no personnel or medicine available. Their families help them with food. They said that they get on well with other members of the community. In one case, a neighbor said that people try to prevent children from stepping on the saliva of the infected people or seating where they seat. A man had to be moved from his home apparently for conflicts with a neighbor due to his seropositivity.

Human Rights: Situation of Haitian Immigrants Living with HIV/AIDS

Table 4 shows the main considerations regarding the situation of human rights in relation to Haitian HIV Positive Immigrants. This study reveals that the economic, social and cultural treatment historically given by the Dominican State to Haitian immigrants, who are poor and have no identification papers, does not leave much space for additional violations. Nevertheless, new violations occur every day, as shown by the chart.

Human Rights: Situation of PLWAS Haitian Immigrants

Table 4 shows the main considerations regarding the situation of the human rights in Haitian HIV Positive Immigrants. Through this study it has been observed that the economic, social and cultural treatment given by the Dominican State to Haitian immigrants, who are poor and have no identification papers, leaves little space for additional violations. Nevertheless, as shown in the chart, new violations take place every day.

Human Rights	**Situation of Haitian Immigrants who live with HIV/AIDS**
Right to non-discrimination and Equity before the law	Haitian immigrants and their descendants, most of them semi-clandestine and with no identification papers, suffer from continuous

	discrimination in the Dominican Republic. Lack of identification papers helps increase the marginality and vulnerability in the framework of HIV positive situations by keeping infected people away from environments which are favorable for behavioral change and treatment of HIV/AIDS. Any contact with formal authorities (police, military, legal or sanitary) implies a certain deportation risk. That is why HIV positive immigrants and their descendants cannot claim their right to non-discrimination and equity before the law.
Women Human Rights	Sexual and reproductive rights (physical and mental health, education, information) do not comprehend Haitian immigrant women and their descendants. Key informants state that many of them are cheated, bribed or raped when attempting to cross the frontier, or when they are repatriated. HIV screening of pregnant women is not accompanied by education in *Kreyole* helping prevent prenatal transmission. The HIV positive status is not communicated to women, neither is it accompanied by counseling sessions, or controlled on a regular basis.
Children's Human Rights	Children of one or both Haitian parents born in the country are constitutionally Dominican, but they are never given their birth certificate as proof of their nationality. They do not receive information on how to protect themselves from HIV infection or about their illness and how to deal with it, in case they were infected. There is no protection in the case of orphanhood due to HIV or other condition. The right of non-discrimination and privacy of HIV positive children is not addressed. The question of being involved in their growth, or in programs for HIV children is not taken into consideration.

Right to marriage, to form a family and to request protection from the State and the society	No accurate information is provided to women in their productive age about the risk of prenatal transmission.
Right to Privacy	Private life in the *bateyes* is limited, since neighbors have a tendency to share their intimacy. Even when one of the cases reported knowing his/her HIV positive condition, neighbors suspected or were informed about that condition because of the absence at work, the death of the spouse under similar circumstances, or by their own symptoms.
Right to enjoy the benefits of scientific progress and its application	Immigrant population do not receive education about the use of condoms, nor basic prophylactics for pain or antibiotics for the treatment of conditions related to HIV.
Right to Free Transit	Two cases of HIV Haitian immigrants were known, whose right had been infringed: one of them had been forbidden access to a certain community, the other had been subject to the test of HIV antibodies In order to renew his residence permit, and when the test gave a positive result he was deported together with his family; and another one had to change his address due to problems with a neighbor.
Right to a Higher Physical and Mental Health Level	Medical care and services are not ensured. Health services are located far from the agricultural *bateyes*, doctors visit most of them once a month, where they have no equipment or medicines, and pay little care to immigrants. No information, education and support related to HIV/AIDS is provided, they have no access to treatment of STD, to preventive means, nor to HIV screening with counseling. No treatment or drugs are provided to grant sick people a longer life. HIV positive people are discriminated in sanitary centers based on their status and often refused medical care.
Right to Suitable Living Conditions	The rights to food, housing, clothing,

and to Social Security Services	medical care and social services, and the right to social security in case of unemployment, illness, disability, widowhood, ageing, among others are not respected. HIV positive people are not provided with differential treatment, as they should. Two key informants reported that some employers stopped paying their affiliates' monthly contributions to the Social Security.
Right to Work	An HIV positive person or living with AIDS should be allowed to work after knowing his status, as long as he can do his job.
Right to be Free of Cruel, Inhuman and Degrading Treatment or Punishment	Two key informants said that immigrants are cheated and bribed and that women are raped while crossing the border and during repatriation.

Debate and Conclusions

Immigration, HIV/AIDS and Human Rights: Tomorrow is Too Late.

Most of the research performed and the data obtained from case studies support the idea that most of HIV transmission takes place in Dominican *bateyes*, and not as a result of new Haitian immigration. Dozens of new HIV positive cases in the disease stage are being discovered in those communities where absolute poverty prevails. Every day, adults and children die without knowing what were they suffering from and how to lessen the pain caused by the disease.

The situation of human rights of PLWAS is the consequence of general ignorance of civil human rights of Dominican population, the lack of a migratory policy respectful of human rights, the conflictive historical relations between both nations and the generalized stigmatization of HIV/AIDS. As one of the key informants remarked, the only right that HIV positive people have, either Dominicans or Haitians, is the right to die, without knowing the reason. An important number are mothers who get infected and infect others because of their need to have monogamous relations in series, as a means of survival.

It is important to take into account that Haitians, *Arrayanos* and Dominicans can no longer wait for emergency humanitarian health care and educational action. The mother whose daughter is dying in her arms, hoping that she will be cured cannot wait until tomorrow. For this people, tomorrow is late. The voice of those who suffer have rarely been heard (Farmer,1996); however, we beg that someone listens this time. It is necessary to act in these communities delivering emergency food to improve the situation of PLWAS, as well as antibiotics and basic medicine for lessening the pain. Nevertheless, these ethnic groups have to be represented and

heard, based on their cultural view of the epidemic, without imposing points of somebody else's point of view.

Flexible, Dynamic and Changing Migratory Routes

Migratory routes between Haiti and its destination points in the Dominican Republic are multiple and varied, including new clandestine access routes, such as the sea. Interviews with key informants and case studies show two main migratory routes, one in the south and the other in the north. Migratory flows cross the border mainly through the checking posts and bordering roads of Pedernales, Jimani, Elias Piña and Dajabon. The increase of migratory flows seems to depend on the specific political and economic situation in both countries. Nevertheless, this process looks like a constant osmosis phenomenon by the exceeding Haitian population towards the Dominican territory, as a result of Haitian ecological degradation. This exceeding number of people will continue being assimilated, from a cultural and ethnic viewpoint, by the Dominican population and their descendants, who in a two-generation period, will not be able to distinguish one group from the other. This single-generation Arrayano population will continue increasing since their kids will be Dominicans.

Growth of the Mixed Population in Central and Urban *Bateyes*

The growing shortage of loading capacity of the Haitian territory will continue operating as a cause of exclusion for its population. Even though the Dominican sugar industry has decreased, the construction industry and informal economy in urban centers of the country have grown considerably. This is due mainly to the economic recovery experienced since 1990, the expansion of public works in the cities, the hotel and textile industries development, as well as the reconstruction performed after Hurricane George. These factors attract the exceeding Haitian population towards the Dominican territory. The agricultural *bateyes*, which in the past were the traditional destination of many Haitians and Arrayanos, are being substituted by central *bateyes* and marginal neighborhoods ("urban *bateyes*", as their residents call them), which are the only place where any low-income-family can survive. The growing interaction between these families and their Dominican neighbors should be immediately studied in order to present harmonious cohabitation alternatives and a sustainable development among them.

The Role of Poverty in the Epidemic Facilitation

The aggravation of the pandemic in the *bateyes* occurs mainly due to the residents' poverty and inequality conditions which increase their vulnerability to the infection. Records of syphilis in men and women and sexual work performed by women, anal sex, the fact of being the head of the family, and youth, were identified as individual risk factors of infection. The fact of a woman being head of family requires an structural and deeper analysis beyond the object of the present study. An

epidemiology which lays the "blame" of virus transmission on their own victims, exclusively due to individual behavior, is ignoring social structures like poverty, which may probably be one of the main risk factors, even above the effect of non-documented immigration.
Just like Aggleton and Bertozzi (1997), this research found that the Haitian homes studied, where at least one of the members was infected with HIV, had suffered changes in their social and economic structure as well as in the operation of the family, such as lost of remunerated work, low levels of medical care, ostracism, refusal and partial abandonment. Nevertheless, probably due to poverty conditions, no increase in loans taken or sale of personal belongings was observed. Farmer (1996) says that even when most of the epidemiologists study population groups, they intend to study individual risk factors out of their context, instead of looking at factors pertaining to population in their historical and social context. To acknowledge the role of poverty is to place individual “risk” behaviors within a context in the “pandemiology” we use to describe HIV/AIDS.

“Arrayanization” of the Epidemic

Due to the precarious socioeconomic and cultural situation of the bateyes, Haitians and Arrayanos immigrant who live in these bateyes show higher rates of infection than their Dominican neighbors. PLWAs in the studied group infect their counterparts without wanting or even knowing. In this sense, we can talk of “Arrayanization” of the epidemic in the Dominican Republic. Nevertheless, since we must undo the attempts to blame Haitians for the anti-Haitianism, we also have to avoid the “arrayanization” of the epidemic fault, and the accusing speeches on AIDS, since they always end up looking for “the guilty” instead of preventing new infections.

Possible Implications of HIV Pandemiologic Migration

In general, research indicates that most of HIV transmission occurs in a complex chain in which members of different ethnic groups get infected among themselves. There are several historical alternatives of transmission of the infection that can be stated among the different ethnic groups and gender, but the following seem to be the most likely:

1. HIV positive male foreigners and returning Haitians coming from HIV epicenters in North America could have infected male bisexual Haitians (Farmer,1996) and Dominicans (De Moya, 1999) during homosexual tourism boom in the Caribbean in the late 70’s and early 80’s;

2. HIV positive bisexual men (“hombres corretiaos”, that is sexually experimented) coming from Haiti who sell sex to men, could have infected other foreign and Haitians homosexuals and Haitian and Arrayano women, either sex workers or not

(according to Capellan 1992, Dominican women tend to avoid sexual relations with Haitians) in the early 80's and 90's;

3. Positive bisexual Dominican males who sell sex to men could have infected susceptible male homosexual foreigners and Dominicans, Dominican and Arrayano women, either prostitutes or not in the 80's and 90's, and these could have infected their stable partners (spouses and clients) (possible origin of urban epidemic in the Dominican Republic);

4 Haitians and Arrayano non-sex workers infected by those men could have infected their children by vertical transmission, and also other men (specially Haitians and Arrayano) (probably suffering from syphilis) who later on started going out with them in the *bateyes* (according to Brewer 1996, there are 14 men every each woman in the *bateyes*);

5 Non professional sex workers, some of them Haitians but most of them Arrayano and Dominicans, called "brinca de casa en casa" ("jump from one house to the other") (Guerrero et al.,1985) could have infected their sons by vertical transmission, their spouses and stable partners through sexual intercourses and clients (probably suffering from syphilis) in the *bateyes* where they lived, either by having relative stable partners with single Arrayano and Dominicans, or by having irregular sexual intercourses with them (according to Capellan, 1992, almost half of the male population in the *bateyes* have had sexual intercourses with Haitian women).

6 Haitian, Arrayano and Dominican professional sex workers who work in the *bateyes*, commonly called "jejenes", could have infected their kids, their husbands or stable partners, and clients (probably suffering from syphilis) belonging to the three ethnic groups in irregular sexual relations in their neighborhood (according to Guerrero et al., 1985, many prostitutes emigrate to the "central *bateyes*" of the plantations during sugar cane crop on payment days in order to offer their services to men who have no spouse);

7. Haitian and Arrayano professional sex workers who work in tourist centers and in the port area, usually referred to as " tourist " and "port" sex workers respectively, could have infected "sexual tourists" and foreign merchant marines, mainly European and Afro-Caribbean who seem to prefer black women for sex. Specific cases of HIV positive prostitutes have been reported in Sosúa, Puerto Plata, Santo Domingo, Boca Chica and Las Terrenas, among others;

8. Haitian, Arrayano and Dominican infected men could have infected their stable and occasional partners;

9. Female stable partners of these men could have infected their children.

To conclude, these considerations confirm that there is a close relationship between the epidemics in Haitian territory and in Dominican *bateyes*. Higher rates

of prevalence in Haiti may have to do with the increase of infection rates affecting new immigrants who arrive at the country (see, for instance, HIV rates in Haitian women in Barahona, CEA/OPS/UNAIDS, 1998). Nevertheless, the epidemic status of *bateyes* show that there is a high risk of infection, particularly affecting women and young males and females who arrive at the country, and natives and residents who start their sexual lives. Hence, Haitians who are repatriated every year should have, therefore, a higher level of infection than immigrants who enter the Dominican Republic for the first time.

Recommendations

Organization for Community Democracy

In terms of action, in the *bateyes* where most of the Haitians and Arrayano live, there is no bilingual information, education and communication, neither in their own language, the kreyole, or in Dominican Spanish, to promote social participation. A plan to reduce the levels of marginality of the Haitian groups, particularly in the case of women born in Haiti and their children, should be developed by teaching the language and reading and writing instruction, which could well be done through base community organizations (OCB) in the *bateyes*, especially those formed by people who speak both languages. Most of the existing brochures are only written in Dominican Spanish. Moreover, it must be admitted that illiteracy reaches 55% in Haiti and probably that rate is at least similar or higher in rural *bateyes*. Distribution of information in Kreyole should not only be in the form of literature but also through interactive and non-paternalist radio messages (that is, couples speaking about prevention and care actions), creative ways of expression (for instance, creation and validation of group instruction sessions, role-play, metaphors), health promotion interactive talks in the base community organizations (OCB) (V. 6., prevention of sexual and prenatal transmission, assistance to infected people), and regular counseling in Kreyole by trained health promoters, nurses and/or teachers.

Preventive Actions by Local People

Preventive efforts, specifically distribution of condoms and/or blood tests (like the ELISA test), should take into account that the economy in most of the *bateyes* is extremely precarious. In many agricultural *bateyes*, where the circulating money is little (especially where the bosses are the owners of the only grocery stores, and pay their employees with groceries, instead of cash) it is necessary to deliver condoms free of charge or sell them at a very low price. In those *bateyes* where there are health promoters, *chamanes* and *mayores de gagás*, they may be used to deliver and promote the use of condoms, and should be trained to do so. This should create a link with traditional healers for care and support. Places that do not count with this type of staff will have to hand over or sell condoms in the little “grocery stores” in each *batey*, after providing basic training to their employees.

New Alternatives for Prevention and Care

Another requirement would be the implementation of a campaign in order to promote “the use of condoms”. Even when this study was not aimed at developing a strategy for promoting its use, the rate of infection in the *bateyes* clearly evidences that this type of action is necessary. Moreover, a deeper investigation about other types of high risk sexual intercourses carried out in migrant communities with high rates of syphilis (for instance, lack of sexual education, “alum” vaginal baths taken by many Haitian and Dominican-Haitian women in order to keep the vagina dry and hold it tight, and lack of circumcision in men) (see Halperin, 1998), can help identify the most important and urgent avenues for public health campaigns in the *bateyes*, while the “culture of condoms” is introduced and reinforced. Other subjects, such as personal hygiene, environmental sanitation, nutrition, auto-medication, and the organization and sustainable development of the community, among others, should be included as part of these preventive actions.
It would be useful to promote and spread a cultural resource, such as sowing yucca and sweet potato, and animal fattening (at least chicken) for family consumption. Cultivation can be diversified by sowing corn, peanuts, *guandules*, beans, string beans in order to ensure provision of food for the infected people. This should be done through the interrelation of CEA health programs, OCBs and other communities in the *bateyes*, such as churches, the *gagás* and other cultural resources (see Center of Social Studies, 1999).This may help families support their members and give them preventive education and emotional support in order to help them admitting, instead of denying, the HIV/AIDS existence (see Aggleton and Bertozzi, 1997).

Haitian Culture and Religious Beliefs

It is important to note that the new relationship between Haiti and the Dominican Republic, through exchange programs for young students, improved the traditional accusing ideologies, and allowed both nations to get rid of the prejudicial and stereotyped idea they had of their own cultures. Knowledge and respect for the combined magic-religious practices and beliefs of these human groups should be promoted. Some speeches include anti-Haitian prejudice and voodoo satanization, and they seem to be the basis for treating Haitian population as “non human”. Such ideas seem to be characterized by the fear of a mythology of the “exotic”, represented by ancestral prejudices to “the Haitian”, “the African”, and “the black” rather than by hate and contempt.

Joint International Cooperation

In order to be effective, HIV/AIDS prevention must include access to HIV antibody tests with pre and post test counseling in Kreyole, and intensive treatment of syphilis and tuberculosis, either at a preventive or curative level. It seems hard to believe that if Dominican authorities have not invested on HIV/AIDS prevention and care after its own population, they will be willing to do so for a historically abandoned and stigmatized foreign population, as the Haitian. That is why international resources to reduce the pandemic potential of the Island towards the

Caribbean, North America and Europe are needed urgently. This agrees with Farmer et al's (1996) conclusions stating that what we need is to understand how multiple factors operating at different levels may act to influence the health of the population as regards to HIV.

Thus, it is necessary that an HIV/AIDS joint pandemic intervention be declared a priority of the Caribbean and Central America sub-regions, in Haiti as well as in the Dominican *bateyes* on the basis of a new hermeneutics that goes beyond Farmer's proposal, a hermeneutics of solidarity.

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APPENDIX I

PATRONATO DE LUCHA CONTRA EL SIDA, INC (PLUS)
LATIN AMERICAN AND CARIBBEAN COUNCIL OF AIDS SERVICE ORGANIZATION
(LACCASO)

QUESTION GUIDE FOR SEMI-STRUCTURED INTERVIEWS TO KEY INFORMANTS

I would like, if you agree, to talk a little bit about your experience regarding the Haitian migration and its relationship with HIV/AIDS and the human rights of infected people.
All data and information that you provide is confidential. I ask for your permission to record this interview.
Data of the person interviewed.
Sex, age, studies, profession, institution where he/she works, position.

Questions
1. Which migratory routes do you know from Haiti to Santo Domingo? (origin, stations and destinations).

2. In your opinion, how have traditional migratory routes varied during the last few years? Which might be the reason of those possible changes?

3. In your opinion, how would you compare the AIDS situation in Haiti with the one of Haitian men and women in the *bateyes*?

4. Could you tell me about any case of an Haitian person infected with AIDS who live in the country you may know of?

5. In that case, in what aspects do you think that person was discriminated? (health, work, housing)?

6. How is the Haitian population that lives in the country responding to AIDS?

7. Do you think Haitian popular religiosity could facilitate or obstacle prevention and assistance of AIDS?

8. What do you suggest should be done in order to improve AIDS prevention in the *bateyes* and other Haitian population residential areas?

9. Which support resources should be implemented to assist HIV/AIDS infected people inside and outside the *bateyes*?

10. What is the relationship between you and/or the institution you belong to and the groups that work on Human Rights in the country?

11. At present, are you or the institution you belong to involved in the Migratory Law reform or debate process?

APPENDIX II

PATRONATO DE LUCHA CONTRA EL SIDA, INC. (PLUS)
LATIN AMERICAN AND CARIBBEAN COUNCIL OF AIDS SERVICE ORGANIZATION
(LACCASO)

QUESTIONS GUIDE FOR SEMI-STRUCTURED INTERVIEWS TO PEOPLE WHO LIVE WITH HIV/AIDS

I would like, if you agree, to talk a bit about your experience in the country and the way you have been moving from one place to the other, and whether this is in some way related to the fact that you live with the disease.
All data and information that you provide is confidential. I request your permission to record this interview.

Demographic profile.
Age, sex, studies, marital status, number of sons/daughters, who he/she lives with, where he/she works, economic status, *batey* in which he/she lives.

Detection of the infection
1. How and when did you learn about this disease?
2. Tell me, in your own words, what are you suffering from.
3. What has happened since you learnt you were suffering from this disease?
4. How and when do you think you caught this disease?

Relationship with your Family and Society
1. Have you spoken with somebody about your disease?
2. What did your relatives do when they learn about it?
3. What did you and your family do to discover if they are also infected?
4. Do you have someone, apart from your own family, who can help you?

Migratory Process
1. How many times have you entered the Dominican Republic?
2. When (years)?
3. Through which places have you entered?
4. Could you please tell me, in your own words, how did you arrive at the country?
5. Up to date, could you tell me in which *bateyes* have you been living and when (years)?
6. Why have you moved?

Human Rights Status
Work:
1. Were you working when you were informed you were suffering from this disease?

2. If you did not, when did you stop working and why?
3. If you did, what happened?
4. How do you get money now?

Health

1. Are there any social security consulting room or rural clinic where you live?
2. How far is it?
3. How much do they charge for assistance?
4. What is assistance like in that consulting room or rural clinic?
5. Do you get medicines there?
6. Do you know what type of doctors work there (psychologists, specialists, others)?

Lodging

1. Where do you live (living quarter, house, outdoors)?
2. Did you live there before?
3. Why do you live there now?

Free transit

1. In your own words, could you please tell me which places do you visit?
2. How do people treat you?
3. Do you think people know you are sick?
4. Have you been in trouble with any authority (police, employer, public health, neighbors council)?
5. Could you please tell me what kind of problems?
6. Has this situation affected your family (school, work, other)?

APPENDIX C
OBSERVATIONAL GUIDE

1. Streets: Names, how many, are they paved, drainage system.

2. Schools and/or colleges.

3. Health centers.

4. Churches.

5. Living conditions: approximate number, building material, health care premises, water, lighting, telephone.

6. Means of transport: cars, “motoconcho”, bus, taxi, others.

7. Commercial activity in the area: grocery stores, stores, agricultural product markets, cooked and raw food selling stands.
8. Garbage disposal