



Published in final edited form as:

Nurs Inq. 2010 December ; 17(4): 309–316. doi:10.1111/j.1440-1800.2010.00514.x.

Team Process in Community-Based Participatory Research on Maternity Care in the Dominican Republic

Jennifer Foster,

Emory University - Nursing, 1520 Clifton Road Atlanta Georgia 30322, United States

Fidela Chiang,

Emory University - Nursing, Atlanta, Georgia, United States

Rebecca Carbley Hillard,

Emory University - Nursing, Atlanta, Georgia, United States

Priscilla Hall, and

Emory University - Nursing, Atlanta, Georgia, United States

Annemarie Heath

Proyecto ADAMES, Amherst, Massachusetts, United States

Jennifer Foster: jennifer.foster@emory.edu

Introduction

In her article, *Lessons from a postcolonial-feminist perspective: Suffering and a path to healing*, Joan Anderson theorizes that we in nursing must work "... towards a new political consciousness, so that we can address the structural inequities that have been brought about by histories of colonization and ongoing neocolonial practices. It is also to take seriously that suffering, health and well-being are woven into the fabric of the socio-historical-political context, and as health professionals we have a moral responsibility to be mindful of this context" (Anderson 2004, 238).

One of the most marked health inequities is the global disparity in maternal mortality. The comparative likelihood that a woman will die in childbirth is a dramatic: in 2010, the lifetime risk of death for women during childbirth in Ireland is 1:47,600; in Niger, it is 1:7. (Save the Children 2010). Ninety-nine percent of maternal mortality occurs in the developing world (WHO 2005), and most of these developing nations have colonial histories and legacies that persist. Addressing maternal health is a priority not only for mothers' sake, but also for advancing human welfare, equity and poverty reduction. When mothers die, the economies of families, communities, and even nations unravels (Sachs 2005). Targeting research to the most vulnerable populations and during their most vulnerable period in a productive lifespan is essential if substantial progress is to be made in achieving the World Health Organization's Millennium Development Goals 4 and 5, which pertain to maternal and child health (WHO 2010).

Nurse researchers who strive to produce knowledge to deconstruct the structural inequalities between medical institutions and communities and to affect positive social change for health are well oriented to conduct community-based participatory research (CBPR). Community-based participatory research (CBPR), like other forms of participatory oriented research (action research, participatory action research, cooperative inquiry, and other terms), demonstrates a commitment to the explicit recognition and sharing of power and engagement with community partners to the benefit of the communities involved (Israel et al. 2005). Community-based participatory research is defined by the US Agency for

Healthcare Research and Quality, as a “collaborative research approach designed to ensure and establish structures for participation by communities affected by the issue being studied, representatives of organizations, and researchers in *all* aspects of the research process to improve health and well-being through taking action, including social change (Viswanathan et al. 2004, 3), (emphasis added).

Nursing research using the CBPR approach includes a wide spectrum of health concerns. Community involvement in the consent process for research, as well as the design of health screening tools is important to communities’ agreement to participate and contributes to more accurate assessment about health needs in the community (Lutz, Kneipp and Means 2009). Community partners have also built capacity among researchers about the culture of pregnancy and infant care among African-Americans (Savage et al. 2006).

Holkup et al.’s piloting of an elder-focused, family-centered nursing intervention of elder mistreatment has received acceptance and appreciation by the participating Native American community because of the embedded valuation and incorporation of native traditions (Holkup et al. 2007).

Community-based participatory research with Latino populations has helped build researcher capacity to co-create culturally responsive research questions (Foster and Stanek 2007; McQuiston et al. 2005); and health education (Kim et al. 2005). Community-based participatory research has also augmented participation in HIV vaccine trials (Nyamathi et al. 2004).

In global maternal health, Karmaliani and colleagues have used CBPR approach to address depression in Pakistani mothers (Karmaliani et al. 2009). To our knowledge, nursing studies using the CBPR approach to focus on the quality of maternal-newborn health services have not been undertaken in the social context of the developing world.

In this article, we highlight the processes, rather than the findings, of a CBPR project in the Dominican Republic (DR). A detailed report of the findings is reported elsewhere (Foster et al. 2010). Here we wish to illuminate the ways that the process of research systematically constructed an effective nurse-community team. This research project was a direct result of a partnership built over time with US midwives and Dominican nurses that began in 2003. To understand the CBPR approach for maternal-newborn health in the DR, acquaintance with the country’s social and economic context and the history of the nursing partnership are relevant.

Social context of the Dominican Republic

Although the World Bank has reclassified the Dominican Republic from Lower Middle Income Country (LMIC) to Middle Income Country in 2009 (MIC) (World Bank 2010), the country still suffers from marked income inequality. The poorest half of the population receives less than one-fifth of GNP, while the richest 10% enjoys nearly 40% of national income (US Central Intelligence Agency 2010). The Pan American Health Organization’s (PAHO) 2007 health indicators report almost half (49.5%) of the households in the third largest city in the DR, our research site, are poor (PAHO 2007).

Nevertheless, the nation has a well-developed public health infrastructure. The national Secretariat of State for Public Health and Social Welfare (SESPAS) provides and regulates regionally based primary health care centers, municipal hospitals, reference hospitals and specialty hospitals in the capital of Santo Domingo. Approximately 75% of the population uses the public system (Rosa Burgos, personal communication, May 18, 2010). Additionally, 97% of births take place in hospitals (Miller et al. 2003). Public health

infrastructure and institutionalized birth are presumed to be essential to lowering maternal and newborn mortality, yet the Dominican Republic persist with relatively higher than expected levels of maternal and newborn mortality for a MIC (150–160 maternal deaths per 100,000 live births and 22 infant deaths per 1,000 live births) (PAHO 2007).

A study of institutionalized deliveries in the Dominican Republic documented widespread problems in the quality of care including over-medicalization of non-complicated deliveries and inappropriate management of complicated ones. They also noted compassion fatigue, demoralization and overwork among providers (Miller et al. 2003). In this context in 2003, a US midwife delegation was invited by the Dominican nurses in a public regional referral hospital to consult about the doubling of maternal deaths there in a six month period.

As a result of that consultation, US midwifery faculty formed a non-profit, nongovernmental organization, PROYECTO ADAMES, to develop professional capacity among the nurses in the maternity area. Donated funds enabled a series of participatory educational conferences in the core competencies of international midwifery (Fullerton et al. 2003; Foster et al. 2005). Nurses were the focus in that setting because they provided the care and management of the vaginal births; physicians performed all operative deliveries.

The Dominican nurses observed that pregnant women who died would usually come to the hospital seriously ill, which is a challenge to all personnel, even in high resource settings. The nurses in the maternity ward of the hospital wanted to know why women delayed getting care until they were in such a deteriorated state. This query evolved into the research question of the study. The CBPR approach builds a research team comprised of community members as well as academically trained researchers. Both healthcare personnel and community members are stakeholders necessary to answer this question.

The team process and experience of CBPR

Building a cohesive, well functioning research team when team members differ in socioeconomic status and educational preparation is a challenge. Nevertheless, an egalitarian structure and process among team members is essential to resist the status quo in power relations between community and nurses, and between US researchers and Dominican researchers. Prior to the commencement of research training, the nurses involved in the study recruited 5, non-politically elected, volunteer, Spanish literate, community leaders with strong reputations for honesty and commitment to the community. They self-identified as community leaders; we use their term interchangeably with the term community health workers (CHWs). The CHWs came from 4 neighborhoods within the catchment area of the hospital of interest. All were women, except for one male, who recruited the male participants. The specific neighborhoods were selected by the Dominican Area Public Health Director, based on geographical representation and socioeconomic vulnerability.

All members of the research team participated in all steps of the research, ethics training, recruitment, data collection, analysis, and dissemination. One of the challenges in research ethics training involved certifying all the team members online. None of the CHWs had ever used a computer before. Nevertheless, the entire day spent in an internet café with all team members assisting one another resulted in universal success in certification of the research ethics. The online curriculum was provided by Family Health International (Family Health International 2009). This was a source of great pride as individuals, and as a team. We obtained institutional review board approval from both the PI's university Institutional Review Board (IRB), as well as the Dominican hospital's IRB.

Participant recruitment and informed consent

Once the team was ethics certified, recruitment and obtaining participant consent were activities that built team identity. Nurses and CHWs had numerous questions in the field to obtain informed consent. To answer questions rapidly in the field, the Dominicans suggested a floating cell phone service (“servicio flotante,” or, “flota”) so that team members could contact each other to answer questions, receive updates or other vital communication. The flota was a separate cell phone from one’s personal phone, so everyone on the research team carried a cell phone dedicated to the research project. Cell phones are widely used throughout the country, so it was an accepted and familiar technology. Cell phones not only helped solve problems in the field, they were a constant reminder of team inclusion and identity.

The Dominicans also suggested the formation of recruitment groups, or “brigaditas,” (little brigades). Each brigadita comprised a CHW, nurse, and US researcher or research assistant. The brigaditas spread out in the selected neighborhoods, systematically knocking on every third house to recruit women for the focus groups and interviews.

At first, the recruitment encounter was met with warmth, friendliness and an invitation to enter the home, sit together, and explain the research. Those eligible were quite agreeable to participate. As soon as presented with the approved informed consent form, however, women hesitated. The recruited neighborhoods were among the most marginalized and impoverished in the city. In that setting, signed documents are usually associated with formal legal proceedings, such as bankruptcy notices, police reports, and other acts of state authority. Women began to voice doubts about the true nature of the research. Written, rather than oral, consent had been part of the research design, because literacy in the Dominican Republic (88%) is high and ability to read and write is assumed (US Central Intelligence Agency 2010).

Women’s hesitation did not relate to illiteracy, rather, it was a pause about presumed trust, another manifestation of the cultural assumptions of unequal power relations in the nation. The Dominican Republic has a long colonial history with post independence authoritarian political regimes, of which the thirty-one year rule of Generalissimo Rafael Trujillo Molina (1930–1961) was the most notorious (Sagás and Orlando 2003). Poverty, relative social position, and the historical distrust of government authority hold explanatory power for such doubts. Interestingly, beyond the detailed explanation of the document, ultimately the required informed consent document was understood as, “una cosa de su cultura” (literally, “a thing from their [US] culture”). Once participants understood the document to be outside of their own cultural experience, but affirmed as trustworthy by leaders within their community, they agreed to participate. The assumed trust of the CHWS helped to build team trust. Attendance at the groups was 83% of those recruited.

Data collection

Initially, the moderation of the 12 focus groups and 12 interviews designed for the study was intended to be a shared enterprise by the research team members. As Yelland and Gifford (1995) have discussed, the perceived identity and self-presentation of the researcher or the facilitator might inhibit access to and/or participation of participants. Our team discussed this issue after the very first focus group. One of the team members observed that a participant looked directly at one of the Dominican nurses during her responses. The team recognized that a participant’s identification of a team member as a nurse from the hospital they were discussing could inhibit, or at least influence, the responses of participants. We decided to minimize the effect of “being known” by having the Dominican nurses and

CHWs still be present, but avoid moderating groups and introduce themselves only by first name.

The US researchers, both “outsiders,” could easily present themselves accurately as ignorant about the Dominican health system. This ignorance could help participants feel comfortable educating the moderator about the system as the participant had experienced it and mitigate the presumed authority of Americans. From then on, the US part of the research team took on the responsibility of moderating the focus groups. Others were present at the focus groups, either assuming other roles, or as observers. All were clear about their roles during the groups, and all participated in the debriefing sessions after the focus groups.

The CHWs also conducted participant observations of 15 women during their prenatal care visits. For reasons of confidentiality and maintaining anonymity in the research process, the CHWs did not accompany the participants into the examination room during their visit with the physician, but they noted laboratory tests and sonograms ordered, as well as patient instructions and education.

Despite a lack of formal education about maternal health, CHWs made critical observations about the prenatal care process and how it affected pregnant women in the community. They made meticulous, insightful comments about wait times, clinic inefficiencies (such as the loss of lab results or difficulty obtaining an ultrasound appointment) and the quality of the physical space, noting whether there were enough chairs to sit on, and the presence of functioning fans in the hot Caribbean climate. The CHWs were crucial insiders to obtaining this kind of information. Their records also document women’s gratitude simply for their role of accompaniment and observation.

Data analysis

Once the data had been collected and transcribed, the team was oriented to data analysis and interpretation, using a simple, descriptive content analysis approach (Sandelowski 2000). Community-based participatory research has been slow to engage the community in data analysis and interpretation because it diverts community expertise, time, and attention to acquiring analytic skills. Cashman and colleagues contend, however, that CBPR partners are uniquely positioned to take lead roles in data analysis and interpretation of findings, and the presence of the community voice expands the academic researchers’ understanding of the issues (Cashman et al. 2008).

Our study aimed to be intentionally attentive to the inclusion of the community in data interpretation. We anticipated that though neither the nurses nor the CHWs had any experience reading and interpreting transcribed text, differences in education level would become more obvious in this phase than any other, and that the social hierarchies that exist in the Dominican Republic might limit the self-confidence of the CHWs to interpret the data. Before analysis began, we met as a team to explicitly acknowledge the hierarchies that exist on our team, as a means to achieve awareness of the social norms in the context. Then we named the valued contribution of each team member’s perspective.

Nevertheless, the first analysis meetings produced vocal nurses and silent CHWs. The nurses, educated at the baccalaureate level or beyond, were much more empowered to engage with qualitative analysis. The PI decided to separate the team into 2 subgroups, CHWs and nurses, to work separately on data analysis at first, so that the CHWs could make decisions on their own, as an autonomous group. Dworski-Riggs and Langhout argue that empowerment is connected to opportunities of stakeholders to make decisions (Dworski-Riggs and Langhout 2010). At the end of each analysis session, CHWs and nurses came together to share their perspectives; this process of sharing was audio-taped and transcribed.

A deep exploration of the analytic differences between nurses and CHWs is beyond the scope of this paper and will be reported in a future article.

Knowledge translation

The team worked as one group to organize the findings and conduct public community meetings (including the study participants themselves) to present back their initial findings. The purpose of these meetings was not to collect new data, but to enhance trustworthiness by member checking, and to give the community first access to the findings of the research.

Another purpose was to invite volunteers to participate with the hospital to plan improvements, and an opportunity to inform the neighborhoods about the research results, before any other public dissemination. An average of 50 people per neighborhood participated in these meetings. They verified that the descriptions CHWs and nurses provided about community perceptions resonated with their experience.

The US researchers had also analyzed the texts from a feminist and critical medical anthropological lens, and they proposed another layer of interpretation which was discussed by the entire team, suggesting a model drawn from the themes identified. They noted that the current social order serves neither the community members nor the health care system. Community members and healthcare providers perpetuate a cycle of blame: Personnel in the health care system blame poor outcomes on the community's ignorance, and the community blames the health care system for disrespect, but is afraid to state their rights and engage in changing it. A culture of blame precludes social change, because it distracts from the development of personal agency to effect change.

One of the most challenging next steps for the research team was to present the research findings to the hospital personnel, because of their fear that the findings of critique would not be well received by authority figures in the hospital. Also, it was very important to the nurse members of the team to avoid delivering a message of blame to their colleagues, especially when they knew the stressful working conditions and lack of resources nurses and doctors in the public system face regularly.

The team chose to report the findings and analysis to the hospital using dramatic techniques, a common mode of popular dissemination (Sullivan and Siqueira 2009). A hospital meeting was called and the findings were presented to approximately 50 nurses and physicians. The nurses, in full white uniform to accentuate their affiliation, presented the reality of working under stressful conditions. The CHWs, facing the nurses, spoke aloud the most moving passages of poor treatment from the text of the focus groups and interviews. They turned to each other, in mock accusatory style, each reiterating, "It's your fault," and then responding to the other's accusation, "No, it's your fault!" about the status of care in the hospital. Then, a CHW staged an interruption, exclaiming, "Wait! There is another way!"

They used this opportunity to invite hospital volunteers to join with community volunteers to work together, to address the concerns about the quality of care in the hospital. From that meeting, 6 hospital volunteers signed up to join with 6 community volunteers as the Grupo de Salud (Health Group). It was the first time in the history of the hospital that the community has joined with health providers to jointly address the quality of care in their institution. The next step of the Grupo de Salud was to conduct a pilot of interprofessional and community communication. Community leaders, nurses and family practice residents will use cell phones to provide continuity of care between prenatal clinic, delivery hospital, and postpartum home visits for 40 women. The original research team will monitor the communication record and evaluate the way the Grupo de Salud functions, as well as the outcomes produced by their team effort. The pilot is initiated at the time of this writing.

Discussion

The deeply embedded patterns of the colonial history and income inequality in the Dominican Republic have perpetuated the dynamic of perception of a powerless community and an authoritative, but mistrusted, state. The intention of this CBPR project has been to actively challenge these historical and cultural patterns, by engaging individual stakeholders in maternal-newborn care to co-produce new knowledge and reflect upon that knowledge together, on a level playing field, in the service of healthcare. Paulo Freire (1971) has theorized that it is this process of reflection which produces a critical consciousness, leading to social change. This process has also enabled all team members to listen, understand, and develop compassion for the perceived other (Said, 1978).

Nevertheless, community-based participatory research is labor intensive, time-consuming, and complex. What works in one situation may not necessarily work in another. Positive social changes can be neither predicted nor assumed. Moreover, simply creating a platform to work together does not guarantee positive results for improved health care.

In the worldwide movement to improve quality and safety in healthcare, much attention is given to the development of effective teamwork (Weaver 2008). All members on our team acknowledged their team functioned well on this research project. How did this come about? Most of the research to date on teamwork in healthcare has focused on the articulation of the knowledge, skills and attitudes to achieve competency to deliver quality patient care (Cronenwett et. al. 2007) Druskat and Wolff argue, however, that the real source of team success lies in setting the fundamental conditions that allow effective task processes to emerge. These conditions are trust among members, a sense of group identity (a feeling among members that they belong to a unique and worthwhile group), and a sense of group efficacy (the belief that the team can perform well and that group members are more effective working together than apart) (Druskat and Wolff 2001, 82).

We believe this project established these fundamental conditions described by Druskat and Wolff. To summarize, the process of ethics certification at the internet café marathon promoted group efficacy. During recruitment, the team suggested forming cross-cultural, cross-educational brigades and using a cell phone network to troubleshoot the consent process. These activities established both trust and team identity. Team identity was also built during data collection, by clarifying team member roles and involving everyone in debriefing sessions. The team was able to ensure high participation rates and follow up by contacting their community networks. Team analysis built trust and efficacy by their performance in persisting in the tedious work of reading, rereading, coding, and naming the significant messages that emerged from the transcribed data. Efficacy was also established as they conducted presentations about the findings, not only at the local level, but also attending a nursing conference in the capital city of Santo Domingo. Because none of the Dominican nurses or CHWs speaks English, they have not been involved in the writing of publications in English. They will be involved in Spanish publications planned for the future, however.

The team was aware of the global support for their efforts. The WHO Making Pregnancy Safer Initiative calls for activities to strengthen linkages between men, women, families, and communities with the health care system (WHO 2003).

WHO calls for a human rights approach to improve maternal health services: “[A human rights approach] aims to facilitate women, men and communities to advocate to ensure that comprehensive maternal and neonatal care services and information are accessible and available to them... raising awareness of rights can further “empower” women, men and communities to “demand” quality services that meet their needs and the mechanisms to be

put in place that will allow their voices to be heard in the planning, monitoring and evaluation of those services... those users who are more informed about their reproductive rights should have improved interactions with providers” (WHO 2003, 17). Access to research resources and support are also inequitably distributed around the world, which is one of the reasons the WHO encourages North-South collaborations to strengthen nursing and midwifery globally (WHO 2002).

The experience of having a voice, important, valued, and unique, encourages the community to actively ally with the health care team. An alliance is necessary to understand the difficult and complicated issues facing a community’s health care system, and it is even more critical to develop effective strategies to improve it. The explicit involvement of communities to engage with health services is essential to diminish disparities. As nurses, we hold a moral responsibility to partner with communities, as well as to establish the conditions for mutual success.

Acknowledgments

This research is supported by the National Institute for Nursing Research, 1 R21 NR010201-01 A2.

We also enthusiastically thank our research team: Professor Rosa Burgos, Nurses Ramona Caceres, Carmen Tejada; Community Leaders Asela Almonte, Frank Noboa, Lydia Perez, Marilyn Urbaz; Transcriptionist Rosa Maria Nuñez; Bookkeeper Jenny Nuñez. We appreciate the support of the Director of Hospital San Vicente de Paul, Dr. Ambrosio Rosario, as well as the Duarte Area Public Health Director, Dr. Luis Dominguez. We are also grateful to Lic. Rafael Castillo Alvarez of the Centro Universitario del Region del Nordeste We also gratefully acknowledge Dr. Deborah Koniak-Griffin for her helpful advice on this project.

References

- Anderson, Joan M. Lessons from a postcolonial-feminist perspective: Suffering and a path to healing. *Nursing Inquiry*. 2004; 11(4):238–246. [PubMed: 15601412]
- Cashman, Suzanne B.; Adeky, Sarah; Allen, Alex J., III; Corburn, Jason; Israel, Barbara A.; Montañó, Jaime; Rafelito, Alvin; Rhodes, Scott D.; Swanston, Samara; Wallerstein, Nina; Eng, Eugenia. The power and the promise: Working with communities to analyze data, interpret findings, and get to outcomes. *American Journal of Public Health*. 2008; 98(8):1407–1417. [PubMed: 18556617]
- Cronewett, Linda; Sherwood, Gwenn; Barnsteiner, Jane; Disch, Joanne; Johnson, Jean; Mitchell, Pamela; Sullivan, Dori Taylor; Warren, Judith. Quality and safety education for nurses. *Nursing Outlook*. 2007; 55(3):122–131. [PubMed: 17524799]
- Dworski-Riggs, Deanne; Langhout, Regina Day. Elucidating the power in empowerment and the participation in participatory action research: a story about research team and elementary school change. *American Journal of Community Psychology*. 2010; 45(3–4):215–230. [PubMed: 20232244]
- Druskat, Vanessa Urch; Wolff, Steven B. Building the emotional intelligence of groups. *Harvard Business Review*. 2001; 79(3):80–90. 164. [PubMed: 11246926]
- Family Health International. Research ethics training curricula. 22009 [Accessed September 7, 2010]. from: <http://www.fhi.org/en/RH/Training/trainmat/ethicscurr/index.htm>
- Foster, Jenny; Burgos, Rosa; Tejada, Carmen; Caceres, Ramona; Hilliard, Rebecca; Chiang, Fidela; Hall, Priscilla; Urbaz, Marilyn; Perez, Lidia; Noboa, Frank; Almonte, Asela. A community-based participatory research approach to explore perceptions of the quality of maternal-newborn health services in the Dominican Republic. *Midwifery*. 2010; 1016/j.midw.2010.06
- Foster, Jennifer; Regueira, Yadira; Burgos, Rosa; Sanchez, Annmarie Heath. Midwifery curriculum for auxiliary maternity nurses; A case study in the Dominican Republic. *Journal of Midwifery and Womens Health*. 2005; 50(4):e45–9.
- Foster, Jenny; Stanek, Kari. Cross-cultural considerations in the conduct of community-based participatory research. *Family and Community Health*. 2007; 30(1):42–49. [PubMed: 17149031]
- Freire, Paolo. *The Pedagogy of the Oppressed*. New York: Herder & Herder; 1971.

- Fullerton, Judith; Severino, Richard; Brogan, Kelly; Thompson, Joyce. The International Confederation of Midwives' study of the essential competencies of midwifery practice. *Midwifery*. 2003; 19:179–190.
- Holkup, Patricia A.; Salois, Emily Matt; Tripp-Reimer, Toni; Weinert, Clarann. Drawing on wisdom from the past: an elder abuse intervention with tribal communities. *Gerontologist*. 2007; 47(2): 248–254. [PubMed: 17440130]
- Israel, Barbara A.; Eng, Eugenia; Schulz, Amy J.; Parker, Edith A., editors. *Methods in Community-Based Participatory Research for Health*. San Francisco: Jossey-Bass; 2005.
- Karmaliani, Rozina; McFarlane, Judith; Asad, Nargis; Madhani, Farhana; Hirani, Saima; Shehzad, Shireen; Zaidi, Anita. Applying community-based participatory research methods to improve maternal and child health in Karachi, Pakistan. *Nursing Outlook*. 2009; 57(4):204–209. [PubMed: 19631062]
- Kim, Sue; Flaskerud, Jacquelyn Haak; Koniak-Griffin, Deborah; Dixon, Elizabeth L. Using community-partnered participatory research to address health disparities in a Latino community. *Journal of Professional Nursing*. 2005; 21(4):199–209. [PubMed: 16061166]
- Lutz, Barbara J.; Kneipp, Shawn; Means, Deirdra. Developing a health screening questionnaire for women in welfare transition programs in the United States. *Qualitative Health Research*. 2009; 19(1):105–115. [PubMed: 18997152]
- McQuiston, Chris; Parrado, Emilio A.; Martínez, Amanda Phillips; Uribe, Leonardo. Community-based participatory research with Latino community members: Horizonte Latino. *Journal of Professional Nursing*. 2005; 21(4):210–215. [PubMed: 16061167]
- Miller, Suellen; Cordero, Milton; Coleman, AL.; Figueroa, J.; Brito-Anderson, S.; Dabagh, R.; Calderon, V.; Cáceres, F.; Fernandez, AJ.; Nuñez, M. Quality of care in institutionalized deliveries: the paradox of the Dominican Republic. *International Journal of Gynaecology and Obstetrics*. 2003; 82(1):89–103. [PubMed: 12834953]
- Mosavel, Maghboeba; Simon, Christian; van Stade, Debbie; Buchbinder, Mara. Community-based Participatory Research (CBPR) in South Africa: engaging multiple constituents to shape the research question. *Social Science and Medicine*. 2005; 61:2577–2587. [PubMed: 15955605]
- Nyamathi, Adeline; Koniak-Griffin, Deborah; Tallen, Louise; González-Figueroa, Evelyn; Levson, Lisa; Mosley, Yvonne; Dominick, Ernestina; Anderson, Nancy. Use of community-based participatory research in preparing low income and homeless minority populations for future HIV vaccines. *Journal of Interprofessional Care*. 2004; 18(4):369–380. [PubMed: 15801552]
- Pan American Health Organization. *Health in the Americas: Country Profile, Dominican Republic*. 2007 [Accessed September 6, 2009]. www.paho.org
- Sachs, Jeffrey. *The End of Poverty*. New York: The Penguin Press; 2005.
- Sagás, Ernesto; Inoa, Orlando. *The Dominican People: A Documentary History*. Princeton: Markus Wiener Publishers; 2003.
- Said, Edward. *Orientalism*. New York: Vintage Books; 1978.
- Sandelowski, Margarete. Whatever happened to qualitative description? *Research in Nursing and Health*. 2000; 23(4):334–340. [PubMed: 10940958]
- Savage, Christine L.; Xu, Yin; Lee, Rebecca; Rose, Barbara L.; Kappesser, Mary; Anthony, Jean Spann. A case study in the use of community-based participatory research in public health nursing. *Public Health Nursing*. 2006; 23(5):472–478. [PubMed: 16961566]
- Save the Children. *State of the World's Mothers*. 2010 [Accessed June 19, 2010]. <http://www.savethechildren.org/publications/state-of-the-worlds-mothers-report/state-worlds-mothers-executive-summary-2010.pdf>
- Sullivan, John; Siqueira, C Eduardo. Popular arts and education in community-based participatory research (CBPR): On the subtle craft of developing and enhancing channels for clear conversations among CBPR partners. *New Solutions*. 2009; 19(4):399–406. [PubMed: 20129900]
- United States Central Intelligence Agency. *The World Fact Book*. 2010 [Accessed June 19, 2010]. <https://www.cia.gov/library/publications/the-world-fact-book/index.html>
- Viswanathan, Meera; Ammerman, Alice; Eng, Eugenia; Gartlehner, Gerald; Lohr, Kathleen N.; Griffith, Derek; Rhodes, Scott; Samuel-Hodge, Carmen; Maty, Siobhan; Lux, Linda; Webb, Lucille; Sutton, Sonya F.; Swinson, Tammeka; Jackman, Anne; Whitener, Lynn. Community-

based participatory research: assessing the evidence. Evidence Report/Technology Assessment (Summ). 2004; 99:1–8.

Weaver, Terri. Enhancing multiple disciplinary teamwork. *Nursing Outlook*. 2008; 56(3):108–114.e2. [PubMed: 18501748]

World Bank. Country Snapshot. 2010 [Accessed June 19, 2010]. <http://geo.worldbank.org>

World Health Organization. Strategic Directions for Strengthening Nursing and Midwifery. Geneva: World Health Organization; 2002.

World Health Organization. Working with individuals, families and communities to improve maternal and newborn health. Geneva: World Health Organization; 2003.

World Health Organization. Maternal mortality in 2005: Estimates developed by WHO, UNICEF, UNFPA, WORLD BANK. Geneva: World Health Organization; 2007.

World Health Organization. Millennium Development Goals: progress towards the health-related Millennium Development Goals, Fact Sheet 290. 2010 [Accessed June 22, 2010]. <http://www.who.int/mediacentre/factsheets/fs290/en/index.html>

Yelland, Jane; Gifford, Sandra M. Problems of focus group methods in cross-cultural research: a case study of beliefs about sudden infant death syndrome. *Australian Journal of Public Health*. 1995; 19(3):257–263. [PubMed: 7626676]