
Thurka Sangaramoorthy, University of Maryland - College Park
Invisible Americans: Migration, Transnationalism, and the Politics of Difference in HIV/AIDS Research

Thurka Sangaramoorthy
University of California, San Francisco and Berkeley

Abstract

Using the scholarship on transnationalism and citizenship, this paper examines the politics of difference in HIV/AIDS prevention programmes in the United States and their impact on Haitian migrants and immigrants. It finds that there is a tremendous amount of complex movement of knowledge production and expertise among various constituents who work in the field of HIV/AIDS, and these individuals circulate ideas and technologies of HIV/AIDS across different fields in multiple ways. Through these circulations, information about HIV/AIDS becomes entangled in the debates about relevant knowledge bases, and as a result, questions over culture and modernity. This paper traces how such discourses become framed under the rubric of risk and difference and operate at the level of situated experience. Through ethnographic fieldwork observations and interviews, this paper argues that notions of individual responsibility in HIV/AIDS risk management often become inseparable from notions of racial, ethnic and immigrant identity.

Introduction

On a hot blistering day in February 2006, Dr Peters, a prominent physician who heads one of the only Haitian clinics for HIV-positive Haitians in the United States explained to me why he started the clinic a few years ago. He told me:
One of the reasons that I started the Haitian clinic was that these people are very poorly treated. In fact once a prominent medical colleague said that it was impossible to treat, that it was almost like practicing veterinary medicine. It was such a lousy terrible remark. I was horrified to hear that and that day, I said I was going to start a clinic. The reason that he said that was because whatever you say they don’t understand and whatever they say you don’t understand (Peters 2006).

When I asked about working with his Haitian medical clients, he continued on:

One thing is that the Haitian people are very subdued, and they are not very vocal so if they don’t understand something, they may not say ‘Look Doc, I don’t understand.’ And they misunderstand instructions little bit more than others. Like when the pharmacies make mistakes, even if they know, they don’t challenge the authorities very much. They are very subdued. And they are very secretive. They don’t want people to know. For example, I have some Haitian patients at the hospital, when I tell them to come to the Haitian clinic, they say ‘No, I don’t want to be mixed up with Haitians.’ The Haitians, they don’t want to mix with Haitians so that each other will know that they have HIV. And other thing is poverty. Most of them are unemployed. A fair amount are illegal and some of them don’t know how to access services (Peters 2006).

Although this physician clearly indicates his disturbance at a colleague’s relational stance between treating Haitians and treating non-human animals, he also categorises his Haitian clients as beyond achieving total comprehension and compatibility in clinical encounters. The parallel to veterinary medicine is not just about language barriers or mistranslations, but also rooted in racial imaginaries of medical and social primitivism (cf. Farmer 1990, 1992), as if Haitians were somehow more ‘naturally’ not suited for human medical interventions and technologies. This vignette is just one example of the ways in which notions of individual responsibility and suffering in HIV/AIDS prevention and self-management of risk often become inseparable from notions of racial, ethnic, and immigrant identity.
HIV/AIDS has become a crucial component of the debates surrounding health disparities in the United States (USA). This is because in the past decade, while HIV/AIDS infection rates and the national consciousness of the epidemic appear to be on an overall decline in the USA, statistics estimate that the epidemic is rapidly increasing among those who had been previously and still are obscured: Black men and women. Although we’ve long been flooded with numbers that dictate that African-Americans have been disproportionately affected by the pandemic, it is only very recently that sustained attention has turned to the impact of HIV/AIDS in Black and African-American communities. However, the needs of immigrant communities, especially those diverse groups subsumed under the generic ‘Black/African-American’ census and epidemiological categories, have yet to be addressed.

This paper demonstrates how official and non-official discourses of HIV/AIDS come to be disseminated, understood, appropriated, and contested by both service providers and the Haitian migrants and immigrants they serve. In particular, it explores how these Haitian clients continually orient themselves to various institutions or diseases, negotiate resources, and vie to live both inside and outside the public health and political systems. In doing so, this paper integrates concepts of interconnection and circulation found in transnational studies with the emergent forms of individual subjectivity and social identity found in the scholarship on citizenship. By investigating the ways in which local politics of disease connect with broader logics of power and practice, this paper holds the potential to highlight not only the role of institutional forces in mediating citizenship structured by racial and ethnic boundaries, but also the emergence and presence of novel identity formations and subjectivities.

**AIDS Crossing Borders: The Role of Migration in HIV/AIDS Research**

Anthropological approaches have been arguably crucial to the expansion of discourses away from and beyond the search for the origin of HIV/AIDS. Early discussions surrounding the virus depict a need to locate its birthplace. When the Centers for Disease Control and Prevention (CDC) and Canadian public health officials announced in 1982 that a few Haitian immigrants had contracted opportunistic infections, the press as well as noted researchers inferred that poverty and voodoo were somehow risk factors (Sebatier 1988; Farmer 1990). In fact, when Haitians denied that they engaged in homosexual or drug activities, it was predicted that heterosexual transmission was a more ‘primitive’ or ‘atavistic’ stage of
the development of HIV/AIDS (Gilman 1988: 102). Thus, many claimed that Haiti was the source of the disease since mainly heterosexuals were found to have HIV/AIDS (Gilman 1988). Anthropologists were among the first to denounce such rationales (cf. Gilman 1988; Farmer 1990; Farmer and Kim 1991; Nachman 1993). These critiques still hold relevance as scientific studies continue to locate the origin of the epidemic in Africa and Haiti (cf. Hutchinson 2001, Gilbert et al. 2007).

These engagements prove to be especially important to the formulation of the dominant tendencies in the current study of migration and displacement in relation to HIV/AIDS. Migration and HIV/AIDS, on their own, are incredibly complex and pressing issues. Surprisingly, studies integrating migration and HIV/AIDS are incredibly scarce. The published literature over the last three decades has been overwhelmingly epidemiological, with much focus directed toward migration as the way in which disease is spread and migrants as vectors of disease transmission (Quinn 1994; Haour-Knipe and Rector 1996). Others have been mainly oriented toward policy and legal issues related to containment (Kuntz 1990; Fairchild and Tynan 1994; Goodwin-Gill 1996). Many scholars of displacement, however, have been silent on issues that bridge migration and HIV/AIDS because of the fear of having their arguments misinterpreted and, worse, influence policies related to mass testing, deportation, and further stigmatisation (Decosas et al. 1995). As a result, the relationship between migration and HIV/AIDS has been downplayed or entirely ignored.

The HIV/AIDS pandemic, however, illuminates more so than any other disease that migration is not only a key factor in the practices that facilitate transmission, but also a result of complex political, social, and economic issues. Of the few studies that have examined the relationships between migration and HIV/AIDS, almost all argue that migration facilitates other infectious diseases only insofar as it results in a greater mixing of people and increases the possibilities of introduction of disease into a new territory or group (Carballo and Siem 1996; Haour-Knipe and Rector 1996; Caldwell et al. 1997). Haour-Knipe and Rector (1996) reason that it is imperative to incorporate studies of migration with HIV/AIDS research because migrants are particularly affected by social and health inequalities, disparities in HIV/AIDS prevention efforts, political and economic oppression, and difficulties in accessing health and social service programmes. They also stress the importance of understanding that ‘migration’ and ‘migrants’ are blanket terms that incorporate a variety of people and movements, all of which require particular attention and analysis.
Given the variety of points of analyses, the scholarship of migration and displacement is incredibly diverse. There is no overall encompassing theory of migration (Portes 1997). One such early perspective still utilised today by many policy studies of HIV/AIDS perceives migrants as reacting to ‘push factors’ within their communities of origin and ‘pull factors’ in host communities. For instance, much of the early and current policy and epidemiological work in HIV/AIDS in sub-Saharan Africa presuppose that HIV/AIDS diffused from areas of labour demand (i.e. urban areas) to areas of labour supply (i.e. rural districts) (Quinn 1994; Caldwell et al. 1997). In these analyses, host and home communities are seen as politically, socially, and spatially divergent, which, in turn, obscures the fact that behaviour found in urban centres often reflects that found in rural areas (Carael 1997; Dyson 2003). Another related perspective on migration is framed in terms of a world systems theory about unequal relations between ‘centre’ or ‘core’ and ‘peripheral’ countries, in which colonialism and development lead to the extraction of value from the periphery by the core, ultimately inducing resource depletion of the former. This conceptual framework attends to national attempts of managing migrant flows and foreign capital as it relates to the social and political body of the nation. Migration, in such studies, becomes a wholly exploitative process through which certain areas and their inhabitants prosper while others languish.

As growing criticisms of the structural reductionism of ‘centre’ versus ‘periphery’ theories surfaced, scholarship focusing on subjective experiences of those displaced and victimised came to the fore under the rubric of diaspora studies. Once conceptualised as a forced or sentimental displacement from homeland, diaspora has attained new epistemological and political resonances (Braziel and Mannur 2003). Diasporic citizens experience multiple identities that are often expressed and experienced in hybridised forms rather than essentialised native identities (Clifford 1994; Laguerre 1998). The works of Farmer and Kim (1991) and Steven Nachman (1993) best illustrate interconnections between HIV/AIDS and diaspora, and in particular, the effects of HIV/AIDS risk group categorisation on the Haitian diaspora in the USA.

Another major approach toward studying migration, transnationalism, turns its attention toward the complex partnerships and tensions between states, global capital, and migrating populations, a focus that was often lacking in diaspora studies and world systems theory.² Scholars of transnationalism pay particular attention to the ways in which cultural flows, social imaginaries, and political-economic structures shape and influence the movement of people, ideas, and objects. Transnational
communities are viewed, thus, as dense networks across political borders created by immigrants in the quest for economic advancement and social and political recognition. Although the notion of transnationality is utilised in a multitude of different ways, many anthropologists denote it in terms of connection, flexibility, and multiplicity across borders intensified under late capitalism (Basch et al. 1992; Laguerre 1998; Ong 1999).

Literature on transnationalism also encompasses the recently emerging field of the anthropology of citizenship (Hann and Dunn 1996). Although citizenship is conventionally understood within the legal framework of modern democratic nation-states (Castles and Davidson 2000), analyses of transnationalism expand contexts of citizenship outside of the juridical sphere. They explore how, in addition to nation-states, various global institutions construct citizenship by employing various policies and practices which shape people’s behaviour in everyday life in relation to certain objectives (Rose 1999; Ong 2003; cf. Foucault et al. 2000). The anthropology of citizenship also describes counter-strategies that enable individuals to evade interventions by authoritative institutions. This is made possible by a neo-liberal ethos that has enabled the states and institutions to solve problems in the era of welfare policies through efficient management and the adoption of moral values and practices (Rose 1999; Strathern 2000). This ethical demand hinders the state and institutions from exploiting citizens as mere objects. Citizens are also motivated to protect themselves from potential violation by self-management and acquiring knowledge; this, in turn, enables citizens to negotiate with authorities and claim their rights (Petryna 2002; Rose and Novas 2004).

Thus far, projects on migration and HIV/AIDS have largely failed to build upon these tenets of transnationalism and citizenship. However, much of their data and conclusions suggest that a transnational framework would prove beneficial in developing effective policy and programmes for migrant populations (cf. Ferreira-Pinto et al. 1996; Farmer and Kim 1991). Some working in HIV/AIDS prevention acknowledge that traditional programmes advocating safe sex and clean needles will not and do not work for populations on the move, and have designed innovative alternatives that are themselves transnational with varied rates of success (Brussa 1996). Others declare the usefulness of integrating ‘what’s at stake’ for members of the community – in this case, HIV transmission and racism – instead of cognitive behavioural approaches which repeatedly have shown no relations between the degree of knowledge about HIV and the adoption of preventive measures (Farmer and Kim 1991: 217).
Furthermore, in much of the recent literature on migration and HIV/AIDS, there seems to be a slow but pervasive move away from generalising HIV/AIDS prevention and intervention efforts for migrant and minority populations, and more attention focused on developing programmes that are more population and culture specific. Many institutions have adopted or are adopting ‘culturally sensitive’ and ‘culturally competent’ approaches which are designed with well-meaning intentions: to sensitisie health providers to the special needs and vulnerabilities of different populations. However, the conceptual framework for these approaches often produces defined sets of values, principles, and behaviours which then translate ‘culture’ into a blueprint (Hunt and Arar 2001). Cultural knowledge becomes a reified thing, to be acquired and institutionalised, to ensure patient cooperation, to facilitate diagnosis, and ultimately to buttress dominant biomedical paradigms. In order to counter such essentialisations, many anthropologists have called upon health care providers and programmes to be flexible and appropriately responsive to a variety of issues including culture (Hunt and Arar 2001; Ong 2003). But these changes are rarely implemented given institutional, time, and other pragmatic limitations of many HIV/AIDS clinical and public health settings as well as social and economic restrictions faced by patients. As a result, it has become exceedingly easy to offer solutions that do not transcend well to migrants and immigrants living in the USA.

In order to do better, anthropology must reconceptualise the field of HIV/AIDS in the USA in an era of transnational migration and citizenship. We must not only trace how certain knowledge about HIV/AIDS or identity comes to constitute notions of citizenship and culture, we also have to explore how such knowledge is circulated. This paper examines the circuits through which particular kinds of discourses about HIV/AIDS and subjectivity move and transform. Scholarship on transnationalism and citizenship is fundamental to this project, for it elucidates the ways in which the representations and rationalities of HIV/AIDS move, are taken up, and are transformed by various institutions and people in Miami. In turn, this paper on HIV/AIDS prevention and transnational Haitian communities in Miami builds upon and contributes to scholarship that does not divorce local micropolitics of disease from broader logics of power and practice.

**HIV/AIDS at the Margins: Plagues and Problems**

The CDC has recently issued a ‘heightened’ national response to reduce the high rates of HIV/AIDS among the African-American population, because
even though the 2000 Census predicted that African-Americans account for about thirteen per cent of the total population, over fifty per cent of all new HIV/AIDS cases, almost two-thirds of women with HIV/AIDS, and a majority of children living with HIV/AIDS are African-American (CDC 2002; KFF 2003). In Florida, the impact of HIV/AIDS on the Black/African-American population is startling. Blacks account for almost half of existing HIV/AIDS cases and fifty-six per cent of all new cases (CDC 2002; KFF 2003). The annual case rate of HIV/AIDS for Blacks in Florida (142.7 per 100,000) is twice that for Blacks across the nation (77.4 per 100,000) (KFF 2003), and HIV/AIDS is the leading cause of death for Black males and females living in Florida (Florida DOH 2003).

Over the years, there has been a strong push in HIV/AIDS prevention to decouple stigma from the disease, by bringing attention to notions of universal risk. And as a result of scientific findings of the limitations of behavioural interventions that concentrate solely on education or individual psychology, HIV/AIDS programmes have increasingly focused on broader sociocultural, political, and structural forces that frame the concept of group-level risk (Herdt et al. 1991; Parker 2001). The development of ‘community-level’ prevention programmes has been a key component of these responses, especially in collectivities deemed as being at ‘high risk’ (CDC 2002). These groupings exemplify the multiple ways in which the notion of risk is translated in HIV/AIDS prevention. For instance, certain groupings centre on common ‘behaviours’ that put them ‘at risk’ such as ‘MSM’ (men who have sex with men), ‘IDU’ (intravenous drug users), and more recently ‘heterosexuals;’ others reflect racial and ethnic makeup, gender, and age. Regardless of the divisions, like many public health prevention programmes, it is often ‘communities’ instead of autonomous individuals that have become the targets of HIV/AIDS programmes and messages. Increasingly, in the realm of public health, the concept of community is used widely and often without serious inquiry (cf. Williams 2002). In HIV/AIDS prevention in particular, community has become a core component of both the generation and dissemination of knowledge about HIV/AIDS as well as in the production of expertise of affiliated participants. Therefore, it is critical that the complexity and flexibility of the term be demonstrated in order to better understand the relationships between various constituents, practices, and objectives.

In Miami, Florida, where a myriad of transnational communities are being heavily impacted by the HIV/AIDS epidemic, many physicians, counselors, and activists working with Haitians often speak of the difficulties in translating dominant frameworks of HIV/AIDS prevention to their clients
who travel frequently and have multiple partners living in both Haiti and the USA (Martin et al. 1995; Page and Marcelin 1999; Williams and Jackson. 2000; Marcelin and Marcelin 2001; Marcelin et al. 2006). Others point out that the structure of institutional health interventions is itself a massive barrier to Haitians in Miami (Quam 1990; Singer 1994; Farmer et al. 1996; Singer 1998). For example, a physician, who works at a Haitian health clinic in Miami, told me:

First of all most of them come illiterate, they don’t read and then they are Black. They also have FEAR of deportation. Most of them don’t have any legal status so they don’t have any papers. Here in the States we know everything is about filling out papers and providing a lot of information like social security numbers. So there are a lot of requirements to be part of health care that they don’t have or even if they do have, they don’t want to provide it because of fear of deportation (Eloise 2006).

Dr Eloise’s story of the disconnectedness of HIV/AIDS programmatic rules and regulations from the reality of her clients’ situations is a familiar one. Many other providers also lament that protocols for HIV/AIDS services fail to take into consideration some of the everyday realities of migrant and immigrant clients with language and literacy barriers, and speak privately of improvising their own modes of conduct in order to help their clients and to avoid being found guilty of professional wrong-doing. This is in line with research that has criticized the ineffective impact of existing HIV/AIDS intervention and prevention programmes, originally designed for white homosexual and bisexual men and intravenous drug users, within Black communities (Singer 1994; Sobo 1998; Levenson 2004). These findings have prompted many health advocates, social scientists, and practitioners to argue for the development of new programmes that address unequal, inadequate, or inaccessible services, educational and employment vacuums, structural underdevelopment and dependency, racism, sexism, and homophobia along with HIV/AIDS prevention (Farmer 1992; Scheper-Hughes 1994; Singer 1994, 1998).

Contagious Others: Risk, Culture, and Responsible Citizens

Like the physician in the introductory vignette, many providers reiterate that everyone is at risk and many express that ‘culture’ or the ‘nature of the Haitian people’ was what put them more at risk. For instance, there was an overwhelming tendency of providers to speak about the enormous lack of
interest or access to health care in the Haitian community while simultaneously portraying the community as one which was ‘suffering’. A health worker said it was important to pay attention to ‘culture’ when working with Haitians because practices like voodoo didn’t really allow for adherence to new medical trends, describing this as a tension between ‘tradition and assimilation’. Many claimed that risk was not related to race or ethnicity, but other proxies such as ‘social environments’, ‘predispositions’, ‘social isolation and discrimination’, or ‘cultural factors’. These discourses of characteristics and actions stemming from cultural influences were often indistinguishable from those that derived from the ‘nature’ of Haitians. The inter-relatedness of the concepts of ‘nature’ and ‘culture’ here result in identical meanings, essentialisations, and explanatory power.

Haitian clients and community organisations are not necessarily passive participants in or recipients of these discourses. They participate fully in the production and maintenance of conceptions of HIV/AIDS, risk and health, as well as identity and community. Although I was warned of the difficulties of getting informants to speak about HIV/AIDS, I encountered very few dilemmas when discussing these issues. All of my informants readily shared their thoughts and stories of HIV/AIDS.

Very few Haitian clients ever utilised the words ‘virus’ and ‘chronic disease’ in describing HIV/AIDS; the vast majority, instead, conceptualised HIV/AIDS in terms of how it spreads from person to person through sex or drugs, or how they would react to it if they had it. Others questioned what was generally taught about HIV; for example, whether it was really transmitted through needles or sex, or whether vaccines were not being found because people were making too much money from AIDS prevention. Some offered explanations that seemed to merge biomedical notions of HIV/AIDS and personal interpretations. For instance, a woman who regularly came to the local Haitian clinic told me:

I remember one time they tell you SIDA is a virus. Everybody has it in their blood but sometimes, it’s not developed and for some people, if you don’t do it, it doesn’t bother you. You don’t have nothing but if you do prostitution, you can develop more. If you are on drugs too (Remy 2006).

She constructs SIDA as a virus, which is the information she has been given by medical staff at the clinic, but she interprets this virus to be endemic to the human body. If someone were to ‘do prostitution’ or be
‘on drugs’, then this virus will develop into the disease; if ‘you don’t do it,’ then it will not develop into symptoms or a disease. SIDA for her, like many other informants, was a biological entity, as well as an outcome of multiple effects and an everyday occurrence of suffering rather than an exceptional event. As Paul Farmer (1992) and Karen McCarthy Brown (1991) have documented, narratives of illness, disease, and suffering often implicate the role of human and spiritual agency in bringing about affliction. But Haitians in Miami have had a long history of being targeted by local and national prevention and research programmes, and almost all of my informants had in some way interfaced with HIV/AIDS programmes through counseling, street outreach, or in classes in a variety of settings. They utilised biomedical models of disease promoted by the official rhetoric of HIV/AIDS prevention, while simultaneously reconfiguring HIV/AIDS through human and spiritual mediations.4

For others, HIV/AIDS represented resources otherwise not available. One of my informants, a middle-aged woman who was suffering from thyroid complications, spoke eloquently about her long battle with health problems, poverty and lack of insurance. She stated:

Maybe if God give me SIDA, I can say that it would be better for me. Because before, I don’t have a house to stay. I don’t have nothing for my two kids. They don’t give me nothing. I say ‘If I have SIDA, they will give me house to stay, they will give me money, they give me that’ (Henri 2006).

Questions of health almost always elicited narratives of lack of insurance, money and other resources, as well as struggles with bureaucracy, poverty, and family (cf. Marcelin et al. 2006). Questions of health also showcased the complex ways that informants navigated health care systems, often going from one institution to another to avoid accumulating enough bills to trigger a call from collection agencies, or avoiding certain clinics and hospitals because of a lack of money or dissatisfaction with rude personnel. Some even bypassed medical institutions in the USA altogether to go to Haiti to get services and treatments in order to avoid the prohibitive costs of both Haitian traditional healers and biomedical doctors in Miami. Many of those who were HIV-positive repeatedly expressed that their needs for HIV/AIDS prevention programmes, whether through educational classes or counselling sessions, are drastically different from existing ones. They desired a format that was less ‘educational’ and more reminiscent of a ‘support-group’. They wanted classes that gave them information relating
to their daily lives, on issues not only concerning their health or their illnesses, but also about immigration, poverty, housing, politics, transportation, depression, isolation, religion, family and re-socialisation after an HIV-positive diagnosis. Clients also stated that a lack of participation stemmed from inconvenient timing of classes and office hours, fear of being seen by other Haitians, and an aversion to discussing HIV/AIDS repeatedly. These concerns indicated serious and complex misalignments between the ways in which experts propelled discourses of community, disease and suffering under the guise of prevention and how clients negotiated individual and collective participation and assembly in the name of science and public health.

The topic of HIV/AIDS also elicited formulations of the concept of risk and danger. Many informants’ narratives revealed that they felt that sex was the primary and sometimes only way that people were able to get HIV/AIDS. Many Haitian women spoke of ‘taking precautions’ but these didn’t necessarily mean condoms or what is commonly advocated as safe or safer sex. For instance, Julie Dessus (2006), whom I met when she brought her husband to get tested for HIV, told me ‘I’m not worried because I went to Haiti, and when I came back my daughter told me she saw [my husband] with someone and I told him I’m not going to get sex with you before you get tested.’ For Julie, safer sex equated to the assurance that her husband was not HIV/AIDS positive, validated only through testing; it did not mean rebuking her husband’s sexual indiscretions or using condoms to protect herself, as is currently taught by HIV/AIDS prevention programs. Many others told me about never truly knowing about the actions or statuses of partners, even husbands, hence the futility of ‘being careful’. These formulations of risk, much like those of health providers, are authoritatively rooted in ideas of community and identity as both sites of struggle and classification, and as constant tragedies of rejection and strategic reappropriation of the effects of these classifications and struggles in daily life.

Many felt that they as Haitians are still seen as ‘boat people’, as uneducated, or as carriers of disease like HIV/AIDS (cf. Farmer and Kim 1991; Farmer 1992; Nachman 1993; Stepick et al. 2003). They also strongly expressed this positioning as having been construed at the national level by immigration policies rooted in racial and ethnic prejudice, which then trickled down locally, breeding resentment and envy between various ethnic groups. Although many felt that they as a collectivity are not privy to certain political and economic resources allotted to other immigrant groups, they also cite that this predicament is due to problems within the community itself, such as lack of effective leadership and civic engagement.
which prevents broader movements of economic and political equality. Often people would speak of the notion that ‘Haitians can’t see the bigger picture’, as in voting as a unit to elect Haitian candidates or gaining better access to political, economic, and health benefits. The politics of blame and marginalisation have come to constitute not only political-economic difficulties, but damaged subjectivities as well, as a lack of cohesiveness becomes symbolic of deep rooted self-hatred (cf. Fanon 1967). Similarly, many felt that their lack of community civic engagement or community mindedness was not only due to fears of repercussions such as deportation or even possible violence to family members in Haiti, but also because of perceptions that the community will not offer them anything in return.

Many, however, felt that the political and economic positioning of Haitians in Miami has improved and is progressively getting better. There has been a growing legion of Haitian activists promoting civic engagement amongst Haitian residents of Miami, by organising protests, demonstrations, and voting drives, initiatives that were part of a larger push for self-advocacy and self-reliance in the realm of health, politics, and economics. These undertakings strongly parallel public health campaigns, such as HIV/AIDS prevention and intervention, that strive to make the individual responsible for his or her own health and well-being, often obscuring broader historical and social frameworks. Much like health care providers who are constantly encouraging their Haitian clients, both HIV positive and negative, to be the ‘drivers’ of their medical care, to ‘be empowered’, and to see new ‘opportunities’ in their HIV/AIDS diagnoses, civic advocacy leaders in the Haitian community also held ideal visions of their constituents that are always already muted by constructions of a particular Haitian identity and collectivity, as steeped in too much culture, too much ignorance, and too much hopelessness, and which can only be transcended through education, equality and modernisation. These activists have much in common with those who are not as hopeful for a brighter future, those who continually point to the stunted realisation of political and economic gains for Haitians in Miami, and even those who emphasise that Haitians are a ‘naturally’ unpolitical and contentious community, drawing similarities to their naturalisation as diseased, poor, and suffering. Both camps position Haitians as a collectivity invariably caught between a ‘natural’ proclivity for non-participation and having too much ‘cultural’ baggage of strife and self-contempt.

**Claims of Culture and Disease**

Even though many providers and officials argue that everyone is at equal risk of contracting HIV/AIDS, they often equate this risk with particular
lifestyle choices associated with culture. Briggs and Mantini-Briggs (2003) argue that such kinds of cultural reasonings serve as key apparatuses in connecting concepts of race and disease. As concepts of multiculturalism, pluralism, and the values of different communities underscore changes to governmental rationalities and as individuals become increasingly understood through their fidelity to particular types of community standards and commitments, issues become problematised through characteristics of communities and their cultures (Rose 1999). Thus, equating drug use and having multiple sex partners with HIV/AIDS risk while simultaneously placing them in the realm of culture serves to naturalise social and structural inequalities. This has the effects that Briggs and Mantini-Briggs describe:

When the concept of culture is used to characterize racialized populations, its capacity to essentialize, exoticize, totalize, and dehistoricize is powerfully unleashed, reducing complex social phenomena to timeless sets of premodern traits that purport to provide a self-evident and exhaustive interpretation applicable to all ‘bearers’. Because cultural and overtly racial discourses are both capable of achieving these effects, even invocations of culture that are anti-racist can racialize populations effectively, and they wield their power without enabling target populations to make the sorts of appeals to liberal sentiment that would be prompted by overt public attributions of biological or intellectual inferiority (2003: 313–14).

It is in this way that culture as risk continues to be a powerful and self-sustaining conceptualisation in the field of HIV/AIDS prevention in Miami. It allows for new ways of acting upon targeted individuals and groups that obscure ideological constructions of racial and ethnic differences on which they are based.

Haitian clients are fully implicated here as well. They continually blur demarcations between individual and collective identities, and official and non-expert translations of risk and disease. They engage or evade various systems of care strategically while the systems of governance and experts generate risk data about the dangers of their particular group. Notions of culture and community, for Haitians in Miami, is both situated and lived through intricate managements of extrication, indifference, and fidelity. It involves a double bind of allegiance, belonging conditionally to a community to which many don’t wish to belong and claiming their loyalty to a culture in Haiti that no longer stands, except for what it carries in term
of misery, poverty and injustice. Finally, in the absence of collective participation due to complex economic, political, and social disenfranchisement and history, community and culture are simultaneously lived as vulnerability and resiliency – implying not necessarily powerlessness but surely unequal power.

Notes
1 Themes in the anthropology of migration and displacement greatly overlap, but are presented as somewhat disparate for the purposes of the paper.
2 See Kearney (1995) for a more comprehensive review of the anthropology of globalisation and transnationalism.
3 For exceptions, please see Mishra et al. 1996; Weatherby et al. 1997.
4 I would like to thank the anonymous reviewer for suggesting the incorporation of how Haitians perceive diseases in general, and in particular, HIV/AIDS.

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**Thurka Sangaramoorthy** is a PhD candidate in Medical Anthropology at the University of California, San Francisco and Berkeley. She is currently writing her dissertation on the notion of race and ethnicity as surrogate markers of risk in HIV/AIDS research. Her research seeks to clarify what is captured by ‘race’ and ‘ethnicity’ in HIV/AIDS research and surveillance data, and to investigate these concepts as representations of risk. In particular, the research explores the impact of race and ethnicity in medicine and public health by focusing on health and social service providers and educators and Haitians and Haitian Americans. Her research builds upon studies that question not whether race and ethnicity matter in determining health and illness, but how they are theorised and rationalised to matter.