



Published in final edited form as:

*Stud Ethn Natl.* 2008 September ; 8(2): 248–266. doi:10.1111/j.1754-9469.2008.00014.x.

## Invisible Americans: Migration, Transnationalism, and the Politics of Difference in HIV/AIDS Research

**Thurka Sangaramoorthy, MPH, Ph.D. Candidate**

University of California, San Francisco & 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.

---

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 indicated his disturbance of a colleague's relational stance between treating Haitians and treating non-human animals, he also categorised 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, 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 (U.S.). 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 U.S., statistics estimate that the epidemic is rapidly increasing amongst those who had been previously and still are obscured: Black men and women. Although we've been long 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 demonstrate how official and non-official discourses of HIV/AIDS comes 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<sup>1</sup>**

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

---

<sup>1</sup>Themes in the anthropology of migration and displacement greatly overlap, but are presented as somewhat disparate for the purposes of the paper.

virus depict a need to locate its birthplace. When the Centres for Disease Control and Prevention (CDC) and Canadian public health officials announced in 1982 that a few Haitians 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 there 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 on 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 stigmatization (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 labor demand (*ie.* urban areas) to areas of labor supply (*ie.* 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 those 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 categorization on the Haitian diaspora in the U.S.

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.<sup>2</sup> 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 & Dunn 1996). Although citizenship is conventionally understood within the legal framework of modern democratic nation-states (Castles & 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.*

---

<sup>2</sup>See Kearney (1995) for a more comprehensive review of the anthropology of globalization and transnationalism.

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 & Novas 2004).

Thus far, projects in migration and HIV/AIDS have largely failed to build upon these tenets of transnationalism and citizenship<sup>3</sup>. 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 generalizing 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 sensitise 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 essentializations, 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 U.S.

In order to do better, anthropology must reconceptualise the field of HIV/AIDS in the U.S. in an era of transnational migration and citizenship. We must not only trace how certain

---

<sup>3</sup>For exceptions, please see Mishra *et al.* 1996, Weatherby *et al.* 1997

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 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 do 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 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 concentrated 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 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 around 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. 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 often travel and have multiple partners living in both Haiti and the U.S. Others point out that the structure of institutional health interventions is itself a massive barrier to Haitians in Miami. 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 are 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 speaking privately of improvising their own modes of conduct in order to both help their clients and to avoid being found of professional wrong-doing. This is in line with much research in the U.S. has criticised 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 1995; 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.

### **Contagious Others: Risk, Culture, and Responsible Citizens**

Like the physician in the introductory vignette, many providers reiterate that everyone is at risk, many expressed that 'culture' or '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 healthcare 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 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, essentializations, and explanatory power.

Haitian clients and community organizations 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. Haitians in Miami in particular 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 either through counseling, street outreach, or in classes in a variety of settings. 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 informants utilised the words ‘virus’ and ‘chronic disease’ when asked to describe HIV. It was simply not a retrovirus, a collection of symptoms, or even a catastrophic biomedical and social epidemic, but something experienced, a way of being, and a consequence of certain behaviours and actions. Others questioned what was generally taught about HIV: whether it was really transmitted through needles or sex, or whether vaccines were not being found because people were making too much money off of it.

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. 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, or even bypassing medical institutions in the US altogether to go to Haiti to get services and treatments. Many of those who were HIV positive repeatedly expressed that their needs for HIV/AIDS prevention programmes, whether through educational classes or counseling 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-socialization 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. For many informants, their 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.' 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 re-appropriation of the effects of these classifications and struggles in daily life.

Furthermore, many felt that they as Haitians are still seen as 'boat people,' as uneducated, or as carriers of disease like HIV/AIDS. 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 economical 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 an unit to elect Haitian candidates or gaining better access to political, economic, and health benefits. The politics of blame and marginalization 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 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 organizing protests, demonstrations, and voting drives, initiatives that were part and parcel 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 positive and negative, to be the 'drivers' of their medical care, to 'be empowered,' and to see new 'opportunities' being presented by being HIV positive, civic advocacy leaders in the Haitian community

also held ideal visions of their constituents which 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 can only be transcended through education, equality and modernization. These activists have much in common with those who are not as hopeful for a brighter future, those who continually point to the stunted realization of political and economic gains for Haitians in Miami, and even those who emphasise that Haitians are a 'naturally' un-political and a contentious community, drawing similarities to their naturalization as diseased, poor, and suffering. Both camps position Haitians as a collectivity invariably caught between a 'natural' proclivity for non-participation and 'cultural' baggage of strife and self-contempt.

### Claims of Culture and Disease

Even though many providers and officials said that everyone was at equal risk of contracting HIV/AIDS, they often equated this risk with particular lifestyle choices most often 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 naturalize 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 powerful and self-sustaining conceptualization in the field of HIV/AIDS prevention in Miami. It allows for new ways of acting upon targeted individuals and groups that obscures 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 miseries, 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.

## References

- Basch, Linda G., et al. *Toward a Transnational Perspective on Migration: Race, Class, Ethnicity, and Nationalism Reconsidered*. New York: New York Academy of Sciences; 1992.
- Brazier, Jana Evans, Mannur, Anita, editors. *Theorizing Diaspora: A Reader*. Malden, MA: Blackwell Publishing Ltd; 2003.
- Briggs, Charles, Mantini-Briggs, Clara. *Stories in the Time of Cholera: Racial Profiling during a Medical Nightmare*. Berkeley: University of California Press; 2003.
- Caldwell, John C., et al. *Mobility, Migration, Sex, STDs, and AIDS: An Essay on Sub-Saharan Africa with Other Parallels*. In: Herdt, G., editor. *Sexual Cultures and Migration in the Era of AIDS*. Oxford: Clarendon Press; 1997.
- Carael, Michel. *Urban-Rural Differentials in HIV/STDs and Sexual Behavior*. In: Herdt, G., editor. *Sexual Cultures and Migration in the Era of AIDS*. Oxford: Clarendon Press; 1997.
- Carballo, Manuel, Siem, Harold. *Migration, Migration Policy, and AIDS*. In: Haour-Knipe, M., Rector, Richard, editors. *Crossing Borders: Migration, Ethnicity, and AIDS*. London: Taylor and Francis; 1996.
- Castles, Stephen, Davidson, Alastair, editors. *Citizenship and Migration: Globalization and the Politics of Belonging*. London: Routledge; 2000.
- Centres for Disease Control and Prevention (CDC). *HIV/AIDS surveillance report*. CDC. 2002; 14:1–40.
- Clifford, James. *Diasporas*. *Cultural Anthropology*. 1994; 9(3):302–38.
- Decosas J, et al. *Migration and AIDS*. *Lancet*. 1995; 346:826–28. [PubMed: 7674750]
- Dessus, Julie. Interview by author. Miami: Mar 22. 2006
- Dyson, Tim. *HIV/AIDS and Urbanization*. *Population and Development Review*. 2003; 29(3):427–442.
- Eloise, Marie. Interview by author. Miami: 2006 May 18.
- Fairchild, Amy L., Tynan, Eileen A. *Policies of Containment: Immigration in the Era of AIDS*. *American Journal of Public Health*. 1994; 84(12):2011–2022. [PubMed: 7998650]
- Fanon, Franz. *Black Skin, White Masks*. Markham, Charles Lam, translator. New York: Grove Press; 1967.
- Farmer, Paul. *AIDS and Accusation: Haiti, Haitians, and the Geography of Blame*. In: Feldman, Douglas, editor. *Culture and AIDS*. New York: Praeger Publishers; 1990.
- Farmer, Paul, Kim, Jim Yong. *Anthropology, Accountability, and the Prevention of AIDS*. *The Journal of Sex Research*. 1991; 28(2):203–221.
- Ferreira-Pinto, et al. *Mexican Men, Female Sex Workers and HIV/AIDS at the U.S.-Mexico Border*. In: Mishra, SI, Conner, Ross F., Raul Magana, J., editors. *AIDS Crossing Borders: The Spread of HIV Among Migrant Latinos*. Boulder, CO: Westview Press; 1996.
- Florida Department of Health (Florida DOH). *United States and Florida HIV/AIDS Fact Sheet*. Florida Department of Health, Bureau of HIV/AIDS; 2003 Dec 31.
- Foucault, Michel, et al. *Power: Essential Works of Foucault, 1954–1984, Volume III*. New York: New Press; 2000.
- Gilman, Sander. *AIDS and Syphilis: The Iconography of Disease*. In: Crimp, D., editor. *AIDS: Cultural Analysis/Cultural Activism*. Cambridge, MA: MIT Press; 1988.
- Gilbert M, Thomas P, et al. *The emergence of HIV/AIDS in the Americas and beyond*. *Proceedings of the National Academy of Sciences*. 2007; 104:18566–18570.

- Goodwin-Gil, Guy S. AIDS and HIV, Migrants, and Refugees: International Legal and Human Rights Dimensions. In: Haour-Knipe, M., Rector, Richard, editors. *Crossing Borders: Migrants, Ethnicity, and AIDS*. London: Taylor and Francis; 1996.
- Hann, Chris, Dunn, Elizabeth, editors. *Civil Society: Challenging Western Models*. London: Routledge; 1996.
- Haour-Knipe, Mary, Rector, Richard, editors. *Crossing Borders: Migration, Ethnicity, and AIDS*. London: Taylor and Francis; 1996.
- Henri, Claire. Interview by author. Miami: 2006 Mar 21.
- Herd, Gilbert, et al. Anthropology, Sexuality, and AIDS: Introduction. *The Journal of Sex Research*. 1991; 28(2):171–187.
- Hunt, Linda M., Arar, Nedat H. An Analytical Framework for Contrasting Patient and Provider Views of the Process of Chronic Disease Management. *Medical Anthropology Quarterly*. 2001; 15(3): 347–367. [PubMed: 11693036]
- Hutchinson, Janis Faye. The Biology and Evolution of HIV. *Annual Review of Anthropology*. 2001; 30:85–108.
- Kaiser Family Foundation (KFF). Key Facts: African-Americans and HIV/AIDS. 2003 Sep.
- Kuntz, D. Contagious Disease and Refugee Protection: AIDS Policy in the United States. The Seminar on Migration Medicine of the International Organization for Migration and the World Health Organization; Geneva, Switzerland. 1990.
- Laguerre, Michel S. *Diasporic Citizenship: Haitian Americans in Transnational America*. New York: St. Martin's Press; 1998.
- Levenson, Jacob. *The Secret Epidemic: The Story of AIDS in Black America*. New York: Pantheon Books; 2004.
- Mishra, Shiraz I., et al., editors. *AIDS Crossing Borders: The Spread of HIV Among Migrant Latinos*. Boulder, CO: Westview Press; 1996.
- Nachman, Steven R. Wasted Lives: Tuberculosis and Other Health Risks of Being Haitian in a U.S. Detention Camp. *Medical Anthropology Quarterly*. 1993; 7(3):227–259.
- Ong, Aihwa. *Flexible Citizenship: The Cultural Logics of Transnationality*. Durham: Duke University Press; 1999.
- Ong, Aihwa. *Buddha is Hiding: Refugees, Citizenship, and the New America*. Berkeley: University of California Press; 2003.
- Parker, Richard. Sexuality, Culture, and Power in HIV/AIDS Research. *Annual Review of Anthropology*. 2001; 30:163–79.
- Patton, Cindy. *Inventing AIDS*. London: Routledge; 1990.
- Peters, Donald. Interview by author. Miami: 2006 Feb 10.
- Quinn, Thomas C. Population Migration and the Spread of Types 1 and 2 Human Immunodeficiency Viruses. *Proceedings of the National Academy of Sciences*. 1994; 91:2407–2414.
- Petryna, Adriana. *Life Exposed: Biological Citizens after Chernobyl*. Princeton, NJ: Princeton University Press; 2002.
- Portes, Alejandro. Immigration Theory for a New Century: Some Problems and Opportunities. *International Migration Review*. 1997; 31(4):799–825. [PubMed: 12293206]
- Rose, Nickolas. *Powers of Freedom: Reframing Political Thought*. Cambridge, UK: Cambridge University Press; 1999.
- Rose, Nickolas, Novas, Carol. Biological Citizenship. In: Ong, A., Collier, Stephen J., editors. *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems*. Malden, MA: Blackwell Publishers; 2004.
- Sebatier, Renee. *Blaming Others: Prejudice, Race, and Worldwide AIDS*. Philadelphia: New Society Publishers; 1988.
- Singer, Merrill. The Politics of AIDS and Medical Anthropology: An Introduction. *Social Science and Medicine*. 1994; 38:1321–1324. [PubMed: 8023183]
- Sobo, Elisa J. Love, Jealousy, and Unsafe Sex among Inner-City Women. In: Singer, M., editor. *The Political Economy of AIDS*. Amityville, NY: Baywood Publishing; 1998.

Strathern, Marilyn. *Audit Cultures: Anthropological Studies in Accountability, Ethics and the Academy*. London: Routledge; 2000.

Weatherby, Norman L., et al. Immigration and HIV Among Migrant Workers in Rural Southern Florida. *Journal of Drug Issues*. 1997; 27(1):155–172.

## Biography

Thurka Sangaramoorthy is a Ph.D. candidate in Medical Anthropology at University of California, San Francisco and Berkeley. She is currently finishing writing her dissertation research 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 theorized and rationalized to matter.