LAPLACE, DANIELLE THÉRÈSE, M.A. Foreign Bodies: Public Health and the Regulation of Racialized Threats to Empire and the Citizen Body (2019)
Directed by Dr. Danielle Bouchard. 116 pp.

Who can truly be American? In the United States, the storybook citizen is conceived as a young, white, able-bodied, heterosexual, productive male. The menace of racialized contagion is integral to preserving this fiction and a prominent co-author of this work is the public health sector. Contagion is often articulated as a threat to the empire and to the citizenry and, invested with institutional authority, public health delineates which bodies are "fit" to constitute the body politic. Despite claims of universality, public health policies, recommendations and regulations are informed by historically-specific sociocultural beliefs about race, class, gender and sexuality. This thesis investigates how public health informs the constitution of and responses to racialized contagion. I argue that, in the American context, such formulations can be traced to the late nineteenth century when public health was bolstered by the American Civil War and came to prominence in a society being dynamically reshaped by emancipation, immigration and urbanization. For this project, I conduct a discourse analysis of historically-specific accounts of disease, specifically leprosy (and to a lesser extent syphilis) related to nineteenth century Chinese immigrants and Haitians as a “risk group” for HIV/AIDS at the close of the twentieth century to examine the ways in which public health discourses that serve to exclude certain populations from the body politic (do not) persist. Through doing so, I intend to determine whether there is a pattern to the logics of racialized exclusion that has existed in public health since its inception. In short, do the contours of

whiteness always require the construction of a diseased brown boogeyman and, if so, how is this danger constructed in the American context.

FOREIGN BODIES: PUBLIC HEALTH AND THE REGULATION OF RACIALIZED THREATS TO EMPIRE AND THE CITIZEN BODY

by

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A Thesis Submitted to
the Faculty of The Graduate School at
The University of North Carolina at Greensboro
in Partial Fulfillment
of the Requirements for the Degree
Master of Arts

Greensboro
2019

Approved by

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Date of Acceptance by Committee

April 9, 2019
Date of Final Oral Examination

ACKNOWLEDGEMENTS

I would like to wholeheartedly thank my committee chair, Dr. Danielle Bouchard, for her guidance throughout this project. Her careful insight, patience and encouragement helped make completing this work academically and personally fulfilling. I now await my future academic endeavors with great enthusiasm.

I extend my thanks to my committee members, Dr. Sarah Jane Cervenak, Dr. Tara T. Green and Dr. Mark Rifkin for recognizing the potential in this project and for attesting to the academic rigor of this work. I must also express my gratitude for the wonderful Jenny Dale whose research expertise facilitated the sourcing of such extensive and rich material for this project.

Finally, I would like to thank my family, particularly my partner, Jason Benner, for their patience and understanding throughout this process. Their unwavering support and interest in my academic and professional goals has been a tremendous aid, especially during times when I have felt overwhelmed. Thanks to them, I have been able so persevere towards success.

TABLE OF CONTENTS

Page

LIST OF FIGURES

Page

CHAPTER I

INTRODUCTION

Déjà Vu

In December 2018, the longest government shutdown in American history followed President Donald Trump's refusal to sign a congressional spending bill. Despite the President's insistence that his campaign promise of a wall on the United States-Mexican border was vital for protecting American citizens from drugs, terrorists and criminal undocumented migrants, Congress disagreed. The President, however, eventually signed a spending bill in February 2019 but subsequently declared a "national emergency" to finance his dubious project (Cook & Orr, 2019; Kumar, 2019; Morin, 2019).

Trump's apparent distaste for non-white immigration to the United States became contentious with the announcement of his candidacy in June 2015. The official declaration of his presidential run included the gripe that, "When Mexico sends its people, they're not sending their best...They're bringing drugs. They're bringing crime. They're rapists. And some, I assume, are good people" (The Washington Post, 2015). His unashamed branding of most Mexicans as criminals followed years of "birtherism" accusations launched against his predecessor, Barack Obama, and this fixation on the (in)appropriateness of black and brown bodies for American life has unsurprisingly followed him into the White House (Montanaro, 2016). Aside from several iterations of

the commonly termed “Muslim Ban,” his administration’s ill-conceived and poorly executed “zero tolerance” policy of May and June, 2018 instigated the traumatic separation of over 2,300 children from their parents, and the backlash from this debacle compelled the President to sign an Executive Order in mid-June reversing *his own* administration’s family separation policy (Domonoske & Gonzales, 2018; Gerstein & Hesson, 2018; Jenkins, 2018; Kopan, 2018; Lind, 2017).

“Why,” complained the President, “are we having all these people from shithole countries come here?” Reportedly posed in January 2018, this incendiary question came up during bipartisan negotiations seeking protections for immigrants from several countries. The impoverished Caribbean nation of Haiti was one of them (Dawsey, 2018). Previously singled out by the Trump administration, the government made the alarming announcement in late 2017 to rescind the Temporary Protected Status (TPS) granted to Haitians affected by the calamitous earthquake in 2010 (Cohn, Passell & Bialik, 2019; Fadel, 2017). Furthermore (though officially denied by the White House), according to *The New York Times*, President Trump also made disparaging remarks towards Haitians in June 2017 declaring that “they [Haitians] all have AIDS” (Shear & Davis, 2017).

Accompanying President Trump’s outburst about migrants from so-called “shithole” countries was an indication of his immigration preferences. According to the Commander-in-Chief, “we [the United States] should have more people from Norway” (Aizenman, 2018). One could argue that Trump’s praise for the Scandinavian state simply reflected his meeting with the Norwegian Prime Minister earlier that week (Dawsey, 2018). His views, however, echo conservative sentiments from the turn of the

twentieth century when the hierarchy of white ethnicities positioned persons from Anglo or Nordic stock as ideal immigrants to the United States (Aizenman, 2018; Baynton, 2016).

If we return to President Trump's conflation of Haitians with Acquired Immune Deficiency Syndrome (AIDS), we find that, rather than being a uniquely bizarre assertion, this unwarranted relationship was established in 1982 by the Centers for Disease Control (CDC). Amidst the initial panic surrounding the AIDS pandemic, the CDC identified Haitians as members of the "four-H Club" at risk of the human immunodeficiency virus (HIV) (alongside homosexuals, hemophiliacs and heroin users) (Katz, 2018). This designation prompted the Food and Drug Administration (FDA) to recommend a ban on post-1977 Haitian immigrants from donating blood in 1983. Despite the CDC's removal of Haitians as an "at risk" group in 1985, their communities continued to be associated with AIDS (New York Times, 1985). Worryingly, these presumptions about race and disease do not merely appear to be the rantings of an uncouth President or the errors of a bygone era but rather a mainstay within American public health. During 2014-2016 West African Ebola outbreak, President Obama implemented travel restrictions from Sierra Leone, Guinea and Liberia despite none of these nations having direct flights to the United States, the existence of exit screenings from these countries and travelers' already having to pass through other (primarily European) countries (Roberts, 2014). Several states such as New York and New Jersey, also imposed a quarantine for returning persons previously in direct contact with Ebola patients, with "home quarantine" proposed as an option, leaving many perplexed about its

efficacy if family members within the home could still be exposed to the virus (Yan & Botelho, 2014). All of these decisions, however, were expressly made for preserving the health of the public from infectious disease.

It is also worrying that the fears of racialized contagion by AIDS-infected Haitian bodies at the end of the millennium are reminiscent of those expressed one hundred years prior. During the late 1800s, anti-Chinese rhetoric, for example, was replete with fears of "Chinese Leprosy" and of syphilitic Chinese prostitutes who carried virulent strains of venereal disease (Lee, E., 2003; McClain, 1994; Shah, 2001). Bad "Mongolian" blood was a threat to the healthy, white body politic and discriminatory measures ordered by city Boards of Health, including Cubic Air Ordinances and the closure of Chinese laundries sought to protect the general public from its dangers while laws such as the Page Act (1875) and the Chinese Exclusion Act (1882) restricted immigration and assimilation (Deconde, 1992; Metzger and Masequesmay, 2009; Shah, 2001).

Who can truly be American? "The storybook citizen exudes intelligence, independence and the ability to contribute to national well-being through hard work, political participation and bravery..." (Carey, 2009, p. 1). Birthed in the Age of Reason, the "good" citizen is rational, autonomous, competent and morally upright (Carey, 2009; Erevelles, 2011; Goodley, 2014). This "heroic subject of modernity" embodies the logocentric, Eurocentric and phallocentric ideals of the "West" (Goodley, 2017). Positioned at the apex of human development, the citizen advances "civilization" (Eng, 2011; Schloesser, 2001). *He* is conceived as the norm, yet this model of the young, white,

able-bodied, heterosexual, productive male is a fiction that has always discounted demographic actualities (Carey, 2009; Goodley, 2014).

The menace of racialized contagion is integral to preserving this fiction and a prominent co-author of this work is the public health sector. Contagion is often articulated as a threat to the empire and to the citizenry and, invested with institutional authority, public health delineates which bodies are "fit" to constitute the body politic (Ahuja, 2016; Molina, 2006). If the building of civilization and empire, however, is the business of straight, white men then, " 'The body' is not just any body...On the contrary, the enclosed body is a recognizable synecdoche for male bodies in a society where bodily impenetrability, [and] integrity, has been systematically enlisted to signify "male"… (Cummings, 1991, 76). This body of civilization requires protection from the risky black and brown bodies of Third World peoples, of homosexuals, of drug users, of prostitutes, and of promiscuous women that would prey upon it and destroy it (Ahuja, 2016; Cummings, 1991).

Despite claims of universality, public health policies, recommendations and regulations are informed by historically-specific sociocultural beliefs about race, class, gender and sexuality. Moreover, public health discourses are routinely appropriated by other powerful institutions (both governmental and non-governmental) to support and advance their own assertions about which groups should (not) be afforded social membership and/or legal citizenship (Molina, 2006). These discourses, therefore, inform not only the racialization of both white and non-white populations but also the *otherization* of those racialized as non-white. Furthermore, public health discourses

which circulate fears of racialized contamination and decay serve the pedagogical function of teaching the "mainstream" how to perceive, treat and talk about already marginalized populations while positioning the state as the protector from these infectious bodies (Ahuja, 2016; Molina, 2006; Trauner, 1978).

Is it happenstance that approximately one hundred years apart Chinese and Haitian immigrants were maligned as carriers of dreaded diseases or is there utility to this formulation? According to Susan Sontag (1989), "xenophobic propaganda has always depicted immigrants as bearers of disease" (p. 62) but to what end? Within American society, it appears that the constant threat of fungible diseased brown bodies is crucial to the perpetual (re)construction of whiteness. First, it creates a "preoccupying distinction" between the supposed carriers of disease and the "general public" (Sontag, 1989, p. 27). Second, it rallies disparate white ethnic groups within the United States under the banner of the" general public." Third, as diseased brown bodies from *elsewhere* are positioned as dangerous, populations within the United States excluded from the "general public" but faced with these external threats are compelled to be invested in its (the general public's) defense. Finally, as these foreign bodies threaten the mythical citizen of civilization, *his* protection is an "emergency in which no sacrifice is excessive" (Sontag, 1989, p. 11).

In this project, I seek to investigate how public health informs the constitution of and responses to racialized contagion. I argue that, in the American context, such formulations can be traced to the late nineteenth when public health was bolstered by the American Civil War and came to prominence in a society being dynamically reshaped by emancipation, immigration and urbanization. Through comparing the racialization of

Chinese immigrants during the late 1800s and Haitian immigrants one hundred years later, I will examine the ways in which public health discourses that served to exclude certain populations from the body politic (do not) persist. In doing so, I intend to elucidate and hopefully disrupt how these discourses operate in (re)making the ever-shifting boundaries "whiteness," in service of white supremacy, and in upholding the idealized "citizen." Making this trouble is necessary, as it begs the question, how can we address discriminatory health policy when safeguarding whiteness is a normative (and therefore neutral and "invisible") objective within American institutions? Shock is a common reaction to the blatant racism of yesteryear often prompting expressions of gratitude for contemporary society. Time and again, however, the scientific "objectivity" that informs health and medicine is found to be infected with prejudice despite assurances that the faults of the past have been rectified and claims of advancement. What do these seemingly distinct cases tell us about the logics ingrained in American public health that the same mistakes are repeated? What is the human cost of this repetition?

For this project, I will conduct a discourse analysis of historically-specific accounts of disease leprosy (and to a lesser extent syphilis) related to nineteenth century Chinese immigrants and Haitians as a "risk group" for HIV/AIDS at the close of the twentieth century. While newspaper articles are the primary texts examined in this work, public health -related reports also feature to highlight the interplay between societal beliefs and official policies and to demonstrate how discriminatory "knowledge" is created, disseminated and reaffirmed. In other words, how discourse is generated and how ideas become "fact." Through doing so, I hope to determine whether there is a

pattern to the logics of racialized exclusion that has existed in public health since its inception. In short, do the contours of whiteness always require the construction of a diseased brown boogeyman and, if so, how is this danger constructed in the American context?

"Excess" constitutes a major discursive trope for examining this threat and is featured prominently throughout the main chapters of this work. It not only serves the obvious function of conceptualizing anxieties about the spread of infectious disease but also fears of failed colonization, dangerous sexuality, bodily (and by extension national) degeneration and of being overrun by the undisciplined bodies charged with precipitating these outcomes, all of which feature in this analysis of public health. Primarily through historically-specific press, I identify, trace and critique the ways in which this trope of "excess" features and functions in public health discourse as the popularity and accessibility of newspapers means that they are a rich resource for investigating common understandings of disease and common interpretations of public health pronouncements. My manner of identifying and interpreting "excess," in these accounts, particularly its relationship to imperialism and (neo)colonialism, is primarily informed by, and expands upon the works of Anne McClintock (1995) and Achille Mbembe (2003).

According to Anne McClintock (1995) "boundary order" paranoia features prominently in Western male imperial discourse with explorers dreading engulfment on the edges of the "known world" when entering lands not yet subjected to Western male exploration, domination, and reconfiguration (p. 22, 23, 24). "The feminizing of terra incognita" (with women signifying sexual aberration and excess) "was from the outset, a

strategy of violent containment" (McClintock, 1995, p. 24). Integral to this brutal domestication of liminal excess was the competing deployment of an excess of gender hierarchy, with Western patriarchal norms and later sexual differentiation constituting markers of civilization (McClintock, 1995, p.24; Schuller, 2018, p. 12). During the late nineteenth century, at the height of Western imperialism and when the Chinese were commonly blamed for proliferating leprosy and syphilis, sex difference emerged to stabilize "civilization," considered dangerously prone to disruption and deterioration. Kyla Schuller (2018) maintains that "impressibility" or the state of being receptive to affects became understood as a feature of "civilized" societies in contrast to "primitive" ones whose people had exhausted their capacity for impressibility (and therefore remained numb to advancement) but who could nonetheless throw off affects. Sex difference was employed to address this troubling malleability of civilization with the feminine deemed precariously impressible while rational masculinity was far less susceptible to affects (p. 7, 13, 16). However, as inherently more sensitive, degeneration became a prime concern for "civilization" which could be undone by consorting with unimpressible, atavistic black and brown peoples, whose bodies, like the lands they hailed from, signified excess. Safeguarding civilization from these "invaders" flouting the established "boundary order" involved addressing contagion whether through protecting the white populace from rampant infectious disease or from deleterious racial contamination in the form of miscegenation. The latter, in particular, demonstrated anxieties surrounding dangerous female sexuality with sexual aberration, excess and (white women's) heightened impressibility considered properties of the vessels

responsible for passing along racial and cultural traits, and for white, Western societies, civilization itself (McClintock, 1995, 24, 47; Schuller, 2018, 13).

How does public health relate to excess? As strategy for the management of life, public health has evident biopolitical objectives and practices for managing (i.e. stopping the spread of) contagion (however "contagion" is conceived). Necropolitics, as articulated by Achille Mbembe (2003), is useful for this work as it explores public health's function as a regulatory mechanism for race, its military history, its role in (neo)colonialism and, by extension, its role in determining what constitutes an emergency and whose death is (un)acceptable and necessary (or tragic). By comparing Chinese immigrants during the late 1800s and Haitian immigrants one hundred years later, we can examine the use and utility of these tropes of excess within American public health across time. We can critique the origins of longstanding discriminatory discourses within public health and the function their persistence serves in the "naturalization" of societal inequities and in engendering "permissible" violence. We can challenge guise of "objectivity" that protects public health from confronting its troubling past, present and, if left unchanged, future.

The following section delves into relevant literature for this thesis. Read together, these works provide the historical and theoretical grounding for the project and forward the analytics of excess. The major works I consider are as follows: *Chasing Dirt: The American Pursuit of Cleanliness* (Hoy, 1996) situates the significance of the Civil War to the American public health movement, identified prevailing (miasmas) and burgeoning (germ theory) nineteenth century conceptualizations of disease, and describes how health

and cleanliness became intimately tied to notions of "Americanness;" *Illness as Metaphor* (Sontag, 1978) and *AIDS and its Metaphors* (Sontag, 1989) expands on militarized discourses of disease control and other common metaphors (particularly of exotification and primitivism) that both express and inform racialized understandings of contagion and which participate in delineating the "general public" from those posing a danger to its health and wellness; *AIDS and Accusation: Haiti and the Geography of Blame* (Farmer, 2006), is a brief introduction to how public health participated in Haitian marginalization during the early years of the HIV/AIDS pandemic and designated "at risk" for the disease as well as the ramifications of this label; *Contagious Divides: Epidemics and Race and San Francisco's Chinatown* both provides a historical overview of Chinese immigration to the American West Coast and illustrates the role and practices of public health and other sectors invested with institutional authority in regulating race.

Overview of the Literature

A history of health.

Suellen Hoy's *Chasing Dirt: The American Pursuit of Cleanliness* (1996) traces the United States' 19th century transition from a predominantly rural society where "...the great majority felt no urgency about cleaning up, "(p. 3) to an urbanizing nation in which cleanliness became a moral and patriotic concern, a sign of "Americanness," and a mark of civilization (p. 87). She attributes dramatic shifts in the perception and practice of public health in the United States to the American Civil War (1861-1865). Although the conflict did not alter commonly-held assumptions about the transmission of disease, it

facilitated the proliferation of basic principles of hygiene and sanitation and enabled health experts to develop and practice new statistical methods (Hoy 1996; Kramer 1948).

Prior to the widespread adoption of germ theory in the late 1800s, diseases were commonly attributed to "miasmas." As the nation urbanized during the early 19th century, sanitary reformers and city-dwellers gradually concluded that ridding cities of these disease- causing, noxious atmospheres through improving personal and public hygiene was integral to precluding epidemics (Hoy, 1996; Sontag, 1989; Kramer, 1948). Public health efforts, however, remained sporadic and were largely treated with indifference or contempt, commonly interpreted as interfering with private rights or as unnecessary, expensive measures that would undermine the profitability of tenements (Hoy, 1996). For the upper middle class, cleanliness was primarily a quality that distinguished them from the rural poor rather than a safeguard against disease and, "The majority of people continued living obliviously to the need or nicety of cleanliness" (Hoy, 1996, p. 7). Despite the lukewarm (or occasionally hostile) sentiments towards public health, the first annual National Quarantine and Sanitary Convention was held in 1857. These efforts, however, were interrupted by the Civil War (Blake, 1948; Hoy, 1996; Kramer 1948).

In "Effect of the Civil War on the Public Health Movement" (1948), Howard Kramer states that while, "The outbreak of the Civil War brought to a temporary halt the fight for civil sanitary reform. The public health movement, however, did not mark time, for it was placed on a military footing" (p. 450). For the first time, sanitarians had popular support for their health measures and the war provided public health reformers

with the occasion to test and apply their principles on hygiene (Hoy, 1996; Kramer, 1948).

Health experts sought to avoid the tragedies of the Crimean War (1853-1856) where diseases contracted in hospitals were responsible for an estimated three-fourths of all British casualties. In 1861, President Lincoln formed the United States Sanitary Commission by Executive Order. Its objective: "...to contribute to the army's fighting effectiveness by reducing the incidence of illness as well as the number of deaths caused by preventable disease" (Hoy, 1996, p. 37). The Commission aimed to convince both soldiers and the public that unsanitary conditions, rather than the direct violence of combat, was the most fearsome enemy in war. Indeed, many of the strategies for the biopolitical management of populations (such as the collection of vital statistics) later employed by the public health sector were devised and practiced during the Civil War (Hoy. 1996, p. 42). While these lessons from the war would later be widely applied, at its inception, the Sanitary Commission had to prove its efficacy and it was originally formed without the authority to enforce its recommendations. However, its gradual success in reducing soldiers' mortality from disease as the conflict progressed bolstered its popularity (Kramer, 1948). During the Civil War, sanitarians "...effectively directed the attention and enthusiasm of large section of the American people to support their cause" (Hoy, 1996, p. 58) and the appreciation for cleanliness mushroomed. Following hostilities, mortality in the regular army was reduced to one-third of its prewar levels, soldiers brought home with them the basic hygienic principles instilled by the Commission as did the many women who were "wild to become Florence Nightingales,"

and served as nurses, and many doctors trained during the war would later advance civil health reforms (Kramer, 1948, p. 451).

While the Civil War was over, the fight against disease continued. Rapid urbanization during the mid - to -late 19th century meant the ongoing threat of epidemics and, to preserve the health and welfare of the country, sanitarians urged Americans to make "warfare against uncleanliness" (Hoy, 1996, p. 79). Although it was a civil conflict that brought principles of hygiene and sanitation to the fore, with the incorporation of cleanliness as a core American virtue, it was the "confrontation with racial and cultural 'outsiders' that made personal cleanliness a path to citizenship" (Hoy, 1996, p. 87). (How) could the newly emancipated African-American population and the millions of immigrants from Asia and Southern and Eastern Europe achieve the now "normal" American standard of cleanliness? If they could not, what would that mean for the spread of dreaded diseases?

Metaphors and meaning.

According to Katherine Cummings, "Narratives are technologies for making meaning. They impose sense on subjects and events by emplotting them in purposeful sequences; and they re-present material phenomena in metaphors, which are historically specific and ideologically loaded" (1991, p. 71). That public health in the United States is linked to the context of war is paramount to understanding the common contemporary discourses about infectious disease. In both *Illness as Metaphor* (1978) and *AIDS and Its Metaphors* (1989), Susan Sontag strives towards an elucidation of and liberation from the dangerous metaphors associated with illness (1978, p. 4). She insists that although "one

cannot think without metaphors...that does not mean there aren't some metaphors we might as well abstain from or retire" (1989, p. 5) as punitive or sentimental fantasies (1978, p.3).

"Efforts to reduce mortality from a given disease are called a fight, a struggle, a war" (Sontag, 1989, p. 10). Sontag situates the proliferation of military metaphors in the 1880s, with the rise of germ theory informing fears of invading bacteria (Sontag, 1978, p. 64-65). While Robert Koch's identification of *bacillus anthracis* as the cause of anthrax and his development of the solid culture method in 1881 served to establish bacteriology, if we consider Hoy's account of the centrality of the Civil War to the proliferation of ideas about disease, sanitation and cleanliness, one could argue that American efforts to prevent disease were already widely understood as warfare well before the 1880s (Blake, 1948). With the rise of germ theory, however, came an identifiable "enemy" on which society could wage "war." (Sontag, 1978, p. 66). "It was when the invader was seen ...as the microorganism that causes illness that... military metaphors took on new credibility and precision" (Sontag, 1989, p. 9). The shift away from miasmas towards germ theory, however, was gradual with the latter explanation for disease only becoming widely adopted during the early twentieth century (Hoy, 1996, p. 85-86, 107). A hodge-podge of beliefs and approaches, therefore, characterized public health throughout the latter decades of the 1800s, a time when considerable immigration from Asia (prior to 1882) and Southern and Eastern Europe, and the newly emancipated Black population caused great anxiety among American-born Whites (Baynton, 2016).

Miasma theory predominated during the 1870s at the height of anti-Chinese sentiment. The routine exotification of dreaded diseases coupled with the widespread belief that filth caused disease not only "proved" the absence of the essential American virtue of cleanliness among the Chinese but also established their "alien" diseases as a danger to the body politic (Sontag, 1989, p. 50). As aforementioned, however, the "body of civilization" is not just any body and preserving *his* impenetrability and integrity is equated with the security and prosperity of the nation. According to Sontag (1989), this fortress metaphor for the body is an image that features catastrophe as illness lays siege and threatens to (or succeeds in) breaching the defenses of the body-fortress. This metaphor is distressing at it emphasizes the frailty and vulnerability of the body (and by extension, the nation) (p.8). As protecting this body is paramount, epidemic diseases presumed to originate from elsewhere routinely elicit calls to ban foreigners and immigrants even if common illnesses prove deadlier (Sontag, 1989, p. 50, 62).

While known diseases attributed to the influx of unassimilable Chinese immigrants during the 1800s, could be identified as alien "enemies," against which to wage war, what of diseases "whose causality is murky, and for which treatment is ineffectual?" (Sontag, 1978, p. 58). During the early stages of the AIDS pandemic, the illness confounded the medical community. Even after the identification of the Human Immunodeficiency Virus (HIV) in 1983, the debate continued between contagionists and anti-contagionists as to the cause of AIDS. While the former insisted that HIV led to AIDS, the latter attributed the disease to lifestyle characteristics and squalid conditions (Beck, 2007, p. 6-7). However, just as the identification of bacteria bolstered germ theory

and the proliferation of military metaphors, the identification of the HIV virus engendered descriptions of "high-tech warfare" against an alien invader that destroys immunological defenses and takes over the body (Sontag, 1989, p. 18, 19).

While the Chinese were accused of harboring and spreading a myriad of diseases during the late 1800s, who was held "responsible" for AIDS? According to Sontag,

> AIDS is understood in a premodern way, as a disease incurred by people both as individuals and as members of a 'risk group' - that neutral sounding, bureaucratic category which also revives the archaic idea of tainted community that illness has judged (1989, p. 46).

How are bodies judged "at risk?" How is this judgement confirmed and disseminated? According to Neel Ahuja, "fears of contagion visually and narratively circulate through the media in ways that contain risks to empire" (2016, p. 9). Reporting on the judgements handed down by the sectors invested with institutional authority (and therefore, credibility) forwards not only discourses of blame but also feature the efforts (whether successful or unsuccessful) of out would-be saviors striving to thwart these risks.

Wrongly at risk.

In *AIDS and Accusation: Haiti and the Geography of Blame* (2006), Paul Farmer undertakes a medical anthropological analysis of the HIV/AIDS pandemic, elucidating the accusations and counter-accusations for the illness articulated by the United States and Haiti. Farmer not only engages in ethnographic work in Haiti (1983-1990) but complements his time in the field with historical, epidemiologic, and political-economic analyses (p. 4, 5, 13). Blame is about discourse and the purported Haitian origins of

AIDS in the United States follows the common script of the exotification of dreaded diseases.

Most Haitian AIDS patients during the early 1980s left public health officials flummoxed. They denied engaging in homosexual activity, intravenous drug use or having had blood transfusions which were considered the primary means of transmission. Farmer (2006) states that,

> In order to accurately assess risk among Haitian immigrants, a sound knowledge of the size of this population was necessary. However, no such data were available. Instead of acknowledging its inability to make an assessment of risk, the official—and spuriously low—figure of 200,000 recent Haitian entrants was initially used as the denominator. The resulting conceptual round-up officially brought all Haitians together in a "risk group" (p. 251).

"In contrast to the CDC's rigid limitations on the disease framework," (Cohen, 1999, p. 139) this haphazard classification meant that Haitians, the only group marked hereditarily by ethno-cultural features, were grouped with other populations (save hemophiliacs) that shared sociologically acquired characteristics. The result of this classification was the implication that Haiti was a naturally diseased place and Haitians were a hereditarily diseased people who had to be surveilled and isolated for the protection of the American population (Cohen, 1999; Farmer 1992; Fouron 2013).

The systemic misreading of epidemiologic and ethnographic data cast Haiti as the possible origin of the syndrome in the United States. For example, in 1982, a physician with the U.S. National Cancer Institute stated, "we suspect that this may be an epidemic Haitian virus that was brought back to the homosexual population in the United States"

(Farmer 2006, p. 30). The illness was also exotified and attributed to "voodoo," with this supposition appearing not only in the media but also in medical journals such as *Annals of Internal Medicine* where, in 1983, a Massachusetts Institute of Technology -affiliated physician wrote " 'It seems reasonable to consider voodoo practices as a cause of the syndrome'" (as cited in Farmer, 2006, p. 2). Much of this "misreading" conforms to what Sontag (1989) calls "the classic script for plague [where] AIDS is thought to have started in the 'dark continent' then spread to Haiti, then to the United States...It is understood as a tropical disease: another infestation from the so-called Third World" (p. 51-52). To counter this narrative of AIDS as a "primitive" illness brought by their ragged, illiterate, superstitious and disease ridden countrymen, Haitian officials, physicians and commentators in both the United States and Haiti charged the United States with transmitting the syndrome to the country though international homosexual sex work and attributing its spread to bisexuality and contaminated blood supplies (Farmer, 2006, p. 4, 5). Within the United States, however, the institutional authority and credibility of the CDC prevailed with *The New York Times* alone publishing twenty-one stories on AIDS among Haitians between 1983 and 1985 (Cohen, 1999, p. 165). As a result of being labelled a "tainted community that illness has judged," Haitian populations within the United States experienced a wave of discrimination (Farmer, 2006, p.4; Sontag, 1989, p. 46). Although the CDC removed Haitians as a high-risk group in 1985, "After all the wild theories of voodoo rites and genetic predisposition were aired and dispelled…the public perception of the problem... remained the same—that if Haitians have AIDS, it is very simply because they are Haitians" (Farmer 2006, p. 256).

Though no longer designated “at risk,” Haitian bodies were still considered risky. While the idea of public health as integral to the security of the body politic proliferated during the late nineteenth century, the prevailing precedent set by *Jacobson v. Massachusetts* in 1905 (just as germ theory began to firmly overtake miasma theory) made disease control an issue of national defense. In 1902, Jacobson, a Swedish immigrant, was fined after refusing mandatory vaccinations in Cambridge, MA. While his complaint reached the Supreme Court, the majority opinion stated, “Upon the principle of self-defense, of paramount necessity, a community has the right to protect itself against an epidemic of disease which threatens the safety of its members (as cited in Ahuja, 2016, p. 2). That public health “be afforded police powers to impose emergency solutions—including ones that may harm individuals” (Justice John Harlan as cited in Ahuja, 2016, p.2) makes explicit its ties to war “defined as an emergency in which no sacrifice is excessive” (Sontag, 1989, p. 11). In the American context, it is, therefore, understandable that Congress mandated the establishment of the US military HIV research program in 1986 (Gossett, 2014, p. 37). Furthermore, that detention of 269 HIV-positive Haitian refugees from 1991-1994 in what Neel Ahuja calls “the world’s first HIV concentration camp” (2016, p. 170) at Guantanamo Bay occurred under the guise of humanitarianism underscores the violence of the research and treatment of “diseased” bodies that threaten the body politic (Gossett, 2016, p. 37).

Regulating race.

In 1876, San Francisco’s newly appointed Health Officer, Dr. John Meares, attributed a recent outbreak of smallpox to Chinese residents and their "willful and

diabolical disregard for *our* [emphasis added] sanitary laws" (as cited in Shah, 2001, p. 7). Three years later, Dr. Walter Lindley, the Chief Health Officer for Los Angeles, termed the city's Chinatown a "rotten spot" that pollutes the air and water, insisting that "for the preservation of the lives of *our* [emphasis added] own families [it behooves] us to put it [Chinatown] in the very best sanitary condition" (as cited in Molina, 20016, p. 16). These statements emphasize the function of public health as a means of achieving security, a function that would be more formally established in the twentieth century. Importantly, they underscore the function of disease in determining "us" versus "them."

In *Contagious Divides: Epidemics and Race and San Francisco's Chinatown* (2001), Nayan Shah investigates how "public health served as one of the most agile and expansive regulatory mechanisms in nineteenth century American cities" (p. 3). Exploring its role in processes of inclusion and exclusion, Shah argues that public health transformed from a regulatory system in the nineteenth century to an entitlement system in the twentieth century in which race did not "disappear" but was remade from a difference that threatens to one capable of being reconciled with societal norms (Shah, 2001, p. 6-7). I contend, however, that many of these regulatory features remain within public health.

For the Los Angeles and San Francisco public health boards, the Chinese were a diseased race, the cause of every major epidemic, and indiscriminate spreaders of leprosy, syphilis, smallpox and plague to white Americans (Molina 2006; Trauner 1978; Shah 2001). Chinatowns constituted exotic, spatio-temporal anomalies. They were sites of filth and primitivism inhabited by alien outsiders with heathen beliefs, an ancient

culture and an impenetrable language, and places where disease incubated and then spread via miasmas (Molina, 2006).

According to Shah, "public-health knowledge of dens [and] density... cast Chinatown as a deviant transplantation of the traditional East in the modern Western city… [and its] inhabitants...a race or culture apart and unaffected by the forces of modernity" (2001, 43). How was this "knowledge" created? The public health tactics of surveillance, documentation and quarantine applied by San Francisco's increasingly powerful board of health point to the wide dissemination of strategies for biopolitical management stemming from the Civil War (Shah 2001, p. 4). Public health officials then circulated their racial concerns in official reports, internal memos, correspondence with other health and government officials and the press (Molina, 2006).

If the Chinese and their respective Chinatowns were a threat to the healthy white population why, for example, was there a thirty-year lag between Lindley's declaration of putting Los Angeles' Chinatown "in the very best sanitary condition" and the extension of the city's sewer system to run through it (as cited in Molina, 20016, p.16)? Could it be that the city *needed* a "deviant" population? If cleanliness was a core marker of American civilization then Chinese "filth" served to divide the civilized from those lacking in capacity for civilization (Shah, 2001, p. 8). According to Shah, "the health discourses and policy concerning the problematic 'Chinese'...revealed how whiteness and white identity is performed" (2001, p.11).

Organization of Chapters

To reiterate, for this project, I seek to investigate how public health informs the constitution of and responses to racialized contagion for the sake of safeguarding whiteness and of the predominance of the fictional "ideal" citizen arguing that, in the American context, such formulations can be traced to the late nineteenth when public health was bolstered by the American Civil War and came to prominence in a society being dynamically reshaped by emancipation, immigration and urbanization. This work involves the extensive analysis of press from the respective eras investigated with supplementary content drawn from official reports and documents. Doing so demonstrates that the discourses generated around Chinese and Haitian immigrants were not "fringe" discussions but were exemplary of mainstream understandings of disease and its relationship to non-white peoples. In Chapter 2 *Leprous Heathens: Representations of Disease Amongst Chinese Populations in the late 1800s*, I will discuss the rise of anti-Chinese sentiment in the nineteenth century, investigating the concerted efforts between public health and other authorities and institutions (particularly those concerned with colonial expansion and municipal management) to cast the Chinese as deviant and dangerous carriers of leprosy (and syphilis) and to secure the "general public" from this their "threatening" bodies. This chapter also features an in-depth treatment of the Civil War, examining how biopolitical strategies for military success became incorporated into municipal management and how (post)wartime health discourses invested American public health with a militaristic character from its inception. Third, I will compare representations of Chinese populations with those of

Haitians in *Ferrying AIDS: Representations of Haitians During the HIV/AIDS pandemic of the late 1900s.* In this chapter, I will discuss the United States persistent (neo)colonial investments in Haiti and the political utility (an inconvenience) of Haitians during the Cold War and at the dawn of the HIV/AIDS pandemic. I will also address how public health designated Haitians "at risk" and the lengths taken to delineate the "general public" from the dangers of identified "deviant" populations. Finally, in the conclusion *Public Health Fighting for the Sake of the Citizen*, I will consider whether the claims of this project hold true by examining where the two cases align and there they differ. Furthermore, I expand on how diseased brown bodies feature in anxieties about whiteness coming not only from "primitive" land and peoples but other white, Western civilizations. I end by investigating the ingrained militarism of American public health and how this determines access to care. We will now begin by exploring public health's role in the racialization of Chinese immigrants and in delineating the contours of whiteness and citizenship.

CHAPTER II

LEPROUS HEATHENS: REPRESENTATIONS OF DISEASE AMONGST CHINESE POPULATIONS DURING THE LATE 1800s

> Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That from and after the expiration of ninety days next after the passage of this act, and until the expiration of ten years next after the passage of this act, the coming of Chinese laborers to the United States be, and the same is hereby suspended; and during such suspension, it shall not be lawful for any Chinese laborer to come or, having so come after the expiration of said ninety days, to remain within the United States[1]

At the acme of nineteenth century anti-Chinese hostility, an unidentified physician, writing for the Pacific Medical and Surgical Journal in 1876 glibly remarked, that "The Chinese were the focus of Caucasian animosities…a destructive earthquake would probably be charged to their account" (as cited in Trauner, 1978, p. 73). This observation came less than a decade after the Burlingame Treaty (1868) established equal trade and migration arrangements between China and the United States (Daniels, 2006, p. 92). However, by 1882, the Chinese Exclusion Act (renewed in 1884, 1888 and 1892) would place a ten-year suspension on the immigration of Chinese laborers and would remain in effect until 1943. This act was the first of its kind; a law that restricted a group of immigrants to the United States based on their race, nationality and class (DeConde, 1992; Lee, E., 2003; Ling, 1998; Metzger & Masequesmay, 2009).

[1] From: *An Act to Execute Certain Treaty Stipulations Relating to Chinese*. (1882) National Archives, Retrieved from https://www.archives.gov/historical-docs/todays-doc/index.html?dod-date=506

Unsurprisingly, underpinning this unique targeting of Chinese peoples were widely held beliefs insisting upon their genetic inferiority and their incapability to assimilate into American society (Lee, E., 2003). With the completion of the transcontinental railroad in 1869, anti-Chinese vitriol flourished amidst the economic strife and tensions caused by thousands of men entering the California labor market (Daniels, 2006, p. 92). Not only did "cheap" Chinese labor threaten the prospects of white working-class men but their presumably tainted blood, carrying more virulent strains of diseases, was a danger to the healthy white population while their "heathen" beliefs rendered them morally suspect (Lee, E., 2003: Jun, 2011) Their presence was nothing short of an invasion.

Instead of dispelling these unfounded fears, the burgeoning public health sector emerged as a tool of empire and participated in their proliferation (Moran, 2007, p. 3). For example, in San Francisco, local physician Dr. Mary Sawtelle warned in 1880 that "every ship from China brings hundreds of these syphilitic and leprous heathens" (as cited in Shah 2001, 88). Indeed "the combination of Christian missionary ventures, scientific medicine and U.S. imperial activities in the late 1800s helped produce an image of leprosy as a foreign menace that posed a physical danger to Americans" (Moran, 2007, p. 5). Unfortunately, such xenophobic rhetoric from "experts" like Dr. Sawtelle, came to inform discriminatory municipal, state, federal and international practices, policies and laws enacted to protect the white populace from the purported Chinese threat. These efforts to purge the Chinese from American shores (whether through laws or violence) flourished at a precarious time of colonial expansion in the American West which saw the mass murder and displacement of Native Americans, the implementation of western

versions of southern Black codes, and the proliferation of postbellum anti-miscegenation laws all for the sake of securing white settlement and white racial purity from the Atlantic to the Pacific (Pfaezler, 2007, p. xxi, 110).

This chapter investigates how "contagious" Chinese migrants constituted a threat to empire and to colonial expansion, and to the bodies charged with advancing the American state: young, heterosexual, able-bodied white men. It describes the urgency with which Chinese bodies were distinguished from those of other peoples (both white and non-white) and the emergency strategies deployed to contain or eliminate this exceptional threat. It also emphasizes the necessity of the Chinese presence not only as a source of much needed labor for successful Western expansion and prosperity but also for the solidification of "Americanness," a category that wholly excluded the Chinese. Leprosy never became a pandemic. How much then, was the disease a placeholder, a fixation betraying the vulnerability of the still fragile American state and the fiction of the "ideal" citizen body when such bodies were (and remain) scarce? We will begin with an investigation into the quarrels surrounding Chinese working-class labor and how public health featured in these discussions.

Shrewd Labor

Prior to the Mexican-American War (1846-1848), there was little Chinese immigration to the United States. Following the American victory and the acquisition of territory that would become California, Arizona, Nevada, Utah, Wyoming and Colorado, the few Chinese students and international tradespeople residing in the United States were soon joined by their laboring countrymen seeking riches in California's gold fields

and working on the transcontinental railroad (Daniels, 2006, p. 91; McClain, 1994, p. 1-2). Between 1860 and 1880, the Chinese population grew from approximately 35,000 to over 100,000 with over 70 percent living in California. Although their conspicuous differences made them immediate targets for discrimination and violence, the increasing scarcity of railroad work during the late 1800s was accompanied by heightened anti-Chinese sentiments and recurring anti-Asian discourses in American political and social life as nativist discourses railed against the Chinese as economic competitors (Daniels, 2006, p. 91; DeConde, 1992; Metzger & Masequesmay, 2009; Molina 2006; Shah 2003).

That these beliefs were mainstream and directly informed governance is demonstrated in an account of a San Francisco Congressional Labor Committee meeting (San Francisco Chronicle, 1879). Attendees included, Thomas B. Shannon, Collector of Customs, Loring Pickering, a well-known journalist, J.F. Schaeffer, a clothing merchant and Dr. C.C. O'Donnell, not only a physician but one of the organizers of the local Workingmen's Party and a man who would run for mayor of San Francisco three times. While Shannon declared that "The Chinese make a constant drain upon the capital of the state" and that there was "bitter feeling against the Chinese entertained by the white laboring classes," Pickering found that "The Chinese were eminently a shrewd people" who kept "the price of their labor just under that of white labor" (ibid). Two years later, Dr. John Foye, a physician at the San Francisco smallpox hospital and lazar house (a leprosarium) would briefly reference "The Six Chinese Companies being too keenly awake to their own interest in importing unproductive labor" in his larger account of leprosy in California to the President of the American Dermatological Association, Dr.

James Nevins Hyde (The New York Times, 1881). So pressing was the "problem" of cheap Chinese labor that, regardless of occupation, professionals reiterated this "fact."

The driving of out of Chinese communities during the mid -to -late nineteenth century exemplifies the dire ramifications of such pervasive anti-Chinese racism. "...white miners led the first purges of the Chinese, sparking a wave of violence that raged over the next four decades- north to Tacoma, south to Los Angeles, east to Wyoming and Colorado" (Pfaelzer, 2007, p. xx). It was not only working-class whites, whether unemployed and seeking work in newly acquired territories in the West or tradesmen such as boot cutters and cigar rollers competing with Chinese labor, that organized and participated in the purges but also mayors, governors, ranchers and other elites who, despite benefiting from cheap labor, would use such violence to mark their common whiteness (ibid).

For Mbembe (2003), such extraordinary racist violence is inherent in the politics of race for "in the economy of biopower, the function of racism is to regulate the distribution of death and to make possible the murderous functions of the state" (p. 17). In the late 1800s, the need and desire for cheap, male Chinese labor was juxtaposed against the evident dangers posed by their presence on American soil leading to a series of laws aimed at disrupting and destroying Chinese communities while preserving a Chinese labor force as well as laws protecting white workers. Attuned to grievances of the volatile white populace on the West Coast, in 1862, Congress passed "An Act to Protect Free White Labor Against Competition With Chinese Coolie Labor, and to

Discourage the Immigration of the Chinese into the State of California"[2] which, for example, levied "the Chinese Police Tax" on adults "of the Mongolian race" working in mines or seeking to operate businesses. The Page Law (1875), however, while effectively barring the immigration of Chinese women, still permitted the entry of Chinese male laborers. By restricting the entry of Chinese women, the government hoped to curtail the establishment of permanent Chinese communities while taking advantage of Chinese labor but, without families in the United States, immoral Chinese "bachelors" continued agitating whites, working longer hours and earning more income to save, invest or send home (Pfaezler, 2007, p. 105, 106). While Chinese labor was necessary, violent purges, discriminatory laws, enforced segregation and deportation, kept their communities in a state of injury with appeals of exemption and emergency justifying this discrimination based on the fiction of the Chinese as deleterious to whiteness. The Chinese posed an economic danger through their cheap labor and a mortal danger through their diseased bodies, and the state largely tolerated (and often sanctioned) the elimination of this threat (Mbembe, 2003, p. 16, 21) For example, in 1878 "...Workingmen's Party sympathizers drove disfigured Chinese men, alleged lepers, around San Francisco to display the physical manifestations of the disease" (Shah, 2001, p.99-100) while "the notion of the impure Chinese bodies infecting the young white manhood of the United States" (Pfaezler, p. 92) led to the 1876 burning of Chinatown in the small settlement of Antioch,

[2] From: *An Act to Protect Free White Labor Against Competition with Chinese Coolie Labor, and to Discourage the Immigration of the Chinese into the State of California*, (1862) Retrieved from http://library.uwb.edu/Static/USimmigration/12%20stat%20340.pdf

California after a local doctor accused Chinese prostitutes of infecting seven young men with syphilis (Pfaezler, 2007, p. 89).

Leprosy (and syphilis, often confused with leprosy) was by no means an unknown disease. How then did the condition become fixed to Chinese bodies in the late 1800s? The following section explores the "tropicalization" of leprosy and how Euro-American colonial expansion into Hawai`i informed racialized disease management strategies that would be disseminated worldwide.

A Threat from the East

In California, it was common for the general public and for the public health boards of major cities such as Los Angeles and San Francisco to mark the Chinese as the cause of every major outbreak of disease and as indiscriminate spreaders of syphilis, smallpox, plague and specifically, Hansen's disease (Molina 2006; Trauner 1978; Shah 2001). Historically called "leprosy," Hansen's disease was likely brought to the Americas by early European colonizers (Gaudet, 2004, p. 11, 13). The disease, named after the Norwegian physician Gerhard Henrik Armauer Hansen (1841 - 1912) who, in 1873, first identified *Mycrobacterium leprae* as its cause, affects the sensory nerves and the skin and, although once widely feared, is one of the least infectious diseases with approximately 95 percent of people possessing a natural immunity. Its more widely known name "leprosy" is derived from the Latin *leprosus* meaning "defilement" and the first notes of this old disease can be traced to ancient Egypt and Rome (Gaudet, 2004, p. 14,15; Grzybowski, Kluxen & Potarak, 2014, p. 296, 297; Leung, 2009, p. 2). With its long incubation period (up to twenty years in some cases) and risks of severe nerve

damage, physical deformity and disfiguration if left untreated, leprosy has been one of the most stigmatized diseases in human history with isolation of those afflicted being common practice prior to the development of drug therapy in the 1940s (Gaudet, 2004, p.12, 15).

During the late nineteenth century, Western doctors "...were [still] arguing among themselves whether the disease was contagious or hereditary, if it was a miasmic disease or a problem of bad blood" (Leung, 2009, p. 132). These seemingly disparate notions were all used to create a "preoccupying distinction" between the supposed carriers of leprosy and the "general public" (Sontag, 1989, p. 27). According to Leung (2009) "China lay at the center of controversies over the perceived leprosy pandemic of the late nineteenth century, as the Chinese diaspora was widely believed to be the source of its global spread" (p.2).

American and European imperial activities in the Hawaiian Islands were integral in generating this panic and in constructing Hawai`i as a "a positive model for understanding and managing leprosy" (Moran, 2007, p. 32). Despite being extant in Europe, at the height of Western imperialism during the late 1800s, leprosy became categorized as a "tropical disease" of great concern for "tropical" (or more accurately "colonial") medical experts who often combined tropes of filth, contagion, animality and sin in descriptions of the disease and those afflicted (Ahuja, 2016, p. 31; Gussow, 1989, p. 111-112; Moran 2007, p. 27). Whether introduced to the Hawaiian Islands in the 1830s by U.S. or European traders, or later by Chinese plantation laborers, the latter were commonly blamed for the proliferation of the disease which, in the colonial imaginary,

was the property of strange black, brown and yellow peoples in lands now under the imperial rule of Western states (Ahuja, 2016, p. 33, 35; Gussow, 1989, p. 125; Moran, 2007, 112).

Leprosy came to international public notice during the 1860s with reports of its spread throughout Hawai`i. On the islands, attitudes and policies towards leprosy stemmed from Western imperialism and racist fears of the "yellow peril" bringing the threat of pandemicity (which never came to fruition) to every land where the Chinese emigrated (Gussow, 1989, p. 115, 123, 126). This "common knowledge" of Chinese origin and proliferation of Hansen's disease was reiterated by those in the medical field. In a 1873 letter to the editor for the *San Francisco Chronicle,* David J. Lee (M.D) insisted that "It is well-known that wherever the Chinese are found among the islands of the East Coast of Asia, there leprosy prevails" while the writer of an 1884 *New York Times feature* of Dr. C.C. O'Donnell and his questionable work with Hansen's disease among the Chinese, imparted that "the disease of leprosy is more common among them [the Chinese] than eastern people generally." This belief was echoed by those in other writings such as in the works of the popular nineteenth century travel writer, Charles Warren Stoddard (1843-1909), who in 1879 insisted that "it [leprosy] has followed the Chinese to every land they have colonized" and that " ...400,000,000 Mongolians inherit scrofulous tendencies [with] the leprous seed seem[ing] to germinate spontaneously." Leprosy was feared as the only disease which "inferior" peoples could infect those of the "civilized" West (Gussow, 1989, p. 85, 112, 115, 123) and "the risky touch of the so-called leper suggested the endangerment of able-bodied whiteness in the face of

expanding networks of transoceanic trade and sovereignty" (Ahuja, 2016, p. 33). The imperial project benefited from the Hawaiians' perceived ambivalence towards leprosy. In a state of suspended development, non-whites "were assigned the conditions of unimpressibility or…incapable of being affected" (Schuller, 2018, p. 8). This numbness to the forces of "civilization," however, precipitated advancements in technologies for colonial control with European and American authorities desperate to mold (or protect white people and business from rigid) natives and "savages." In the minds of Western public health professionals, "civilized" societies possessed a healthy fear of the disease thus intervention and acquisition were appropriate endeavors for "saving" the natives and for safeguarding the white settler population (Moran, 2007, p. 29).

Mbembe (2003) describes colonial occupation as,

> a matter of seizing, delimiting, and asserting control over a physical geographical area — of writing on the ground a new set of social and spatial relations. The writing of new spatial relations (territorialization) [is], ultimately, tantamount to the production of boundaries and hierarchies, zones and enclaves; the subversion of existing property arrangements; the classification of people according to different categories; resource extraction; and, finally, the manufacturing of a large reservoir of cultural imaginaries. Imaginaries [give] meaning to the enactment of differential rights to different categories of people for different purposes within the same space; in brief, the exercise of sovereignty (p., 25-26).

The cultural imaginary produced around leprosy in colonial Hawai`i was exported globally. Western involvement in Hawai`i followed typical patterns of commercial and territorial colonial expansion and, under pressure from the U.S and Europe, Lot Kamehameha, the ruler of the Kingdom of Hawai`i, signed a law in 1865 denying lepers rights to movement, property, marriage and legal standing, and enforcing segregation

within hospitals. Eventually, a leper colony was established on the island of Molokai in 1866 (Ahuja, 2016, p. 33; Gussow, 1989, p. 85, 86).

The "treatment" for leprosy effectively became banishment and Molokai "became the Western model for controlling the disease worldwide" (Gussow, 1989, p. 85). Police officers, medical practitioners, private citizens and native tax assessors were mandated to report suspected cases of leprosy and, with the addition of a travelling physician by the Board of Health in 1870, even lepers in the most remote areas of the islands were at risk of apprehension and deportation (Gusssow, 1989, p. 97, 99). Hawaiians, accustomed to handling the disease within their communities, were loath to send friends and relatives to Molokai and, although most resistance was passive, there were episodes of violence against these roundups. Occasionally, unafflicted spouses and partners of those destined for Molokai would voluntarily accompany their loved ones, living with them and caring for them on the island. With increased colonial control came more systematic methods for identifying and banishing those with leprosy as European and American settlers and businessmen not only feared the spread of the disease among the white population but that the "lazy," "indolent," and "immoral" natives, with their resistance to deportation and their susceptibility to Hansen's disease (after the Chinese, Japanese and Indians), jeopardized the health of the plantation workforce and led to the association of Hawaiian goods with leprosy (Ahuja, 2016, p. 35; Gussow, 1989, p.97, 99, 102; Moran, 2007, p. 51, 53).

Unsurprisingly, the intense spatial quarantine mandated by law was not equally enforced among all populations. First, in the West generally, "European" leprosy was

considered distinct from" tropical" leprosy with medical experts advising that white lepers not be housed with afflicted non-whites. Additionally, in Hawai`i specifically, the colonial government often permitted non-natives to seek treatment in their home countries. So, for example, of the 789 people sent to Molokai between 1888-1890, 778 were Hawaiian (Ahuja, 2016, p. 34; Moran, 2007, p. 28, 75).

After tales and reports of rampant leprosy in Hawai`i, it is no wonder that Chinese immigrants to the mainland were erroneously accused of introducing the Hansen's disease to the United States and harboring it within their communities. Dr. John Foye, in his 1881 reply to Dr. Hyde, confidently claimed that "all the subjects of the disease [in San Francisco] with one exception have been Mongolian" (The New York Times, 1881) Similarly, in 1891, *The New York Times* reported that a city Sanitary Inspector, Dillingham, had identified leprosy in a Chinese laundry worker, Chin Hop Sing. In addition to tracing the movements of Sing through the United States, the article also featured the opinions of one Dr. Henry G. Piffard who "said that leprosy was certainly communicable by contact but that he did not know of a case originating in this country…" In an urgent appeal to "protect the industrious of this country from the...hideous and loathsome disease known as leprosy which has been hitherto unknown in our land" the Women's Industrial League, adopted resolutions that were sent to the President and other members of government in 1885 declaring "that the good of the public and the health of the country demand that the Chinese laundries shall go" (The New York Times, 1885).

In the Western imaginary, leprosy posed a direct threat to the imperial project and was contrary to civilization. Interestingly, the Chinese, as harbingers of Hansen's disease, sparked fears of being overrun by primitive and barbaric peoples bringing leprosy "to every land they have colonized" (Stoddard, 1879). For McClintock (1995), this fear of "excess" features prominently in Western imperialism with the absence of borders and boundaries in "virgin" lands provoking both excitement and anxiety leaving European colonizers "suspended between a fantasy of conquest and a dread of engulfment…" (p. 25). Colonization by uncivilized, leprous, racial inferiors would expose the relatively young American state as a pretender to the title of "great power" on par with sovereign Western European countries with global empires. Failure to successfully colonize its Western lands (and beyond) would also deny the United States true "great power" status (Mbembe, 2003, p. 23, 24). Fears of leprosy, a debilitating and disabling condition characterized by bodily deterioration, encapsulated this liminal uncertainty surrounding American dominance and might.

The Hawaiian Islands served the pedagogical function of both informing global disease management strategies for leprosy and promoting notions of "predispositions" towards the illness. That the Chinese were peculiarly susceptible caused anxieties not only abroad but at home. How to treat this foreign "invasion?" We will now explore how the Civil War precipitated innovations in and beliefs about sanitation, public health and "Americanness' and how leprosy became a spatialized as well as a racialized illness within the contiguous United States.

Containing Catastrophe

On the mainland, the question became how to thwart the spread of Hansen's disease. As aforementioned, during the late nineteenth century, both germ theory and miasma theory were proffered as explanations for disease transmission with concerns about stench and sanitation largely linked to the latter theory's hypothesis that noxious air spread infection. As early as 1854, *The Daily Alta California* railed against "filthy localities like the Chinese quarter [as] cholera delights in filth, in decaying garbage...and filthy bodies: particularly when all of these are united in crowded localities" (as cited in Shah 2001, p. 21). To pressure municipal authorities to address the "Chinese question," an 1870 deputation to the San Francisco Board of Health, by the "Anti-Coolie" Association insisted that "No language can adequately describe the crowded filthy abominable condition of Chinese life in our midst" (San Francisco Chronicle, 1870). Institutional fear-mongering, bolstered the validity of these claims. For example, in 1879, Los Angeles Public Health Officer, Dr. Walter Lindley, described the city's Chinatown as a "laboratory of infection" insisting that for "preservation of the lives of our own families [it behooves us] to put it [Chinatown] in the very best sanitary condition."

The American Civil War (1861-65) had much to do with the push for sanitation during the late 1800s with the conflict drastically altering state and municipal health management and standards for patient care. By the end of 1861, the Union Army had grown from 16,000 to 670,000 with the challenges of caring for such a large number of men readily apparent (Humphreys, 2013, p.107). At the First Battle of Bull Run (1861), wounded men lay on the field for up to five days, revealing the Medical Department's

shortcomings as, before the war, there were only 113 doctors in the Union army which, by 1861, needed approximately 1,400 medical men. At the end of the conflict, there were 12,00 doctors in the Union Army and 3,000 in the Confederate Army, many of these men recruited as recent graduates or young inexperienced doctors with the war serving as their major training ground (Humphreys, 2013, p. 105; Kramer, 1948, p.452; Reilly, 2016, p. 139).

The Civil War saw the establishment of the first large general hospitals in major American cities (Reilly, 2016, p. 139). During the antebellum period, the sick remained at home and were primarily cared for by the women in their families while the few existing hospitals either operated as asylums or served the poor or unfortunate travelers (Humphreys, 2013, p. 20, 43). By the end of the war, there were approximately four hundred hospitals, as the conflict precipitated the proliferation of institutions which, for the first time, would serve large numbers of affluent patients demanding proper care and respect but also served to keep the wounded under military discipline (Humphreys, 2013, p. 23, 44; Reilley, 2016, p. 139).

In the field, the expected yet devastating effects of disease within the camps compelled sanitarians, physicians and others to tackle infection. Deadly and debilitating outbreaks were no longer solely the misfortune of city slum-dwellers but could threaten the war effort as soldiers lived in close quarters in “unhygienic camaraderie” (Humphreys, 2013, p. 78). Although twice as many soldiers died from disease than in combat during the Civil War, this was a drastic improvement to previous conflicts such as the Mexican-American War when there were at least seven deaths from disease to

every death in battle (Reilly, 2016, p. 138). The Medical Reform Act (1862) would create a corps of medical inspectors to investigate and report on the conditions of camps and hospitals while the Civil War Military Draft Act (1863) established fines and prison sentences for the improper screening of recruits (Humphreys, 2013, p. 107; Reilly, 2016, p. 139).

The efforts of the U.S. Sanitary Commission (a precursor to the Red Cross) were integral in improving health outcomes. The Commission not only performed sanitary inspections but had pedagogical objectives, developing, procedural manuals, proposals to improve the Medical Department, suggestions about camp drainage and sewerage, and creating statistical forms for recording food supplies, personal hygiene and other sanitary matters (Hoy, 1996, p. 42). Of the many pamphlets distributed to thousands of troops (which were often reprinted in newspapers), one for example, advised the individual soldier on health habits such as tent hygiene and vaccination, while others educated officers and surgeons on basic disease prevention and treatment. The Commission also reprinted camping suggestions from its British counterpart that advised on the placement of latrines, drainage, and water supply. Finally, collecting statistics about camp sanitary conditions and medical care, became standard practice as the Commission devised a questionnaire that would eventually include 180 items (Humphreys, 2013, p. 126, 127). The ordinary military camp had a population density comparable to major cities such as London and Philadelphia and the war was the first time that the Federal government, through the army's medical staff, created records for morbidity and mortality on a large scale (Kramer, 1948, p. 454; Humphreys, 2013, p. 272). Following the war,

> As urban areas began to collect vital statistics in earnest ...medical veterans took up a now-familiar task. And for municipal leaders who had served as officers and who likewise had to keep count of their men, supplies and arms, the paperwork for vital statistics may have seemed both routine and straightforward. The war had taught all of them about the bureaucratic machinery of keeping count as a means of discovering the state of affairs and as a basis for taking action to deal with problems (Humphreys, 2013, p. 273).

The thousands of camp physicians trained during the war would leave the battlefield educated in the basics of community health, expecting new standards of patient care, and possessing knowledge relevant for crafting public health legislation (Humphreys, 2013, p. 271-72). Furthermore, as Hoy (1996) stated, soldiers and nurses educated on principles of hygiene would return home with new standards of sanitation as a marker of "Americanness."

The most apparent link between the Civil War and public health reform involved the work of Elisha Harris and the establishment of New York's Metropolitan Board of Health in 1866 (Humphreys, 2013, p. 271; Leavitt & Numbers, 1997, p. 435). A long-time, passionate sanitarian, prior to the war, Harris was the quarantine physician on Staten Island from 1855 to 1860 and helped organize the first national quarantine conferences during the 1850s. In the early 1860s, Harris not only became one of the governing members of the U.S. Sanitary Commission but also the official secretary of the New York Council of Hygiene and Public Health (Breiger, 1997, p. 442; Humphreys, 2013, p. 104). As a member of the U.S. Sanitary Commission, Harris developed a pamphlet about the importance and use of disinfectants and participated in the investigation of outbreaks such as the 1865 emergence of scurvy among African-

American troops in Texas. As a member of the Council of Hygiene, Harris edited the 360-page Report (providing the 143-page introduction) of the extensive sanitary survey conducted in New York in 1864 (Brieger, 1997, p. 443; Humphreys, 2013, p. 271). For the survey, the city was divided into thirty-one districts with each district assigned an inspector (a physician). Most inspectors described their findings in terms of cleanliness and filth. The wider report also contained "graphic, statistical, and descriptive information on population number and size of tenements houses, prevailing diseases, schools, churches, stores, slaughterhouses, factories, brothels, drinking establishments, sewerage, streets and topography" (Breiger, 1997, p. 443). With the results of "the most complete sanitary survey ever made," Joseph M. Smith, the President of the Council of Hygiene and Public Health, would appear before the New York State legislature in early 1865 to agitate for the creation of a well-organized health board (Breiger, 1997, p. 442, 443). Smith's testimony and suggestion, however, still received pushback until the threat of "Asiatic" cholera later that year would inspire more urgent criticisms and calls for action in papers such as the *Nation* which "claimed that New York was nearly as filthy as the Asiatic towns from which the cholera came" (Breiger, 1997, p.444, 445). In February 1866 the state finally passed "An Act to Create a Metropolitan Sanitary District and Board of Health therein for the Preservation of Life and Health to Prevent the Spread of Disease" which became a model for municipalities and states nationwide (Breiger, 1997, p. 445, 446). After this victory, Harris would bring his experiences and expertise to the national stage, helping to organize the American Public Health Association in 1872 and serving at its President in 1878 (Humprheys, 2013, p. 271).

Following the Civil War, there were four government-sponsored investigations between 1869 and 1885 into the conditions of San Francisco's Chinatown which molded public understanding of the location as a site of dirt, disease and inhuman habitation, and a threat to white citizenry. Sanitary inspectors' and physicians' descriptions emphasized the area's sickening filth with accusations of the Chinese displaying a "willful and diabolical disregard for…sanitary laws" (Shah, 2001, p. 18, 20, 35). Both San Francisco and Los Angeles city officials frequently vacillated between talks of razing their respective Chinatowns or containing their dangers (Molina, 2006; Shah, 2001). While the elimination of all dirt, disease and contagion was not possible, restricting these issues to one area of the city seemed feasible and rational (Molina 2006, p. 17).

According to Nayan Shah (2001),

> the Chinese were characterized repeatedly in terms of "excess" - of their number, of their living densities, of the diseases they spawned and of the waste they produced [and] the danger of excess lay in its perceived capacity to expand across class and racial differences and spatial boundaries carrying lethal contagion (p. 22).

Chinatown was a colonial space; a location where the foreign, premodern "Oriental" lived anachronistically within a society of precarious modernity as the conquest of the American West was still underway (Jun, 2011, p. 295). The numerous incursions into San Francisco's Chinatown demonstrate the colonial compulsion to penetrate such "foreign" spaces of excess and monstrosity (McClintock, 1995, p 22, 23). Containing its dangerous effluvia was paramount and the colonial situation permitted aggressive measures that

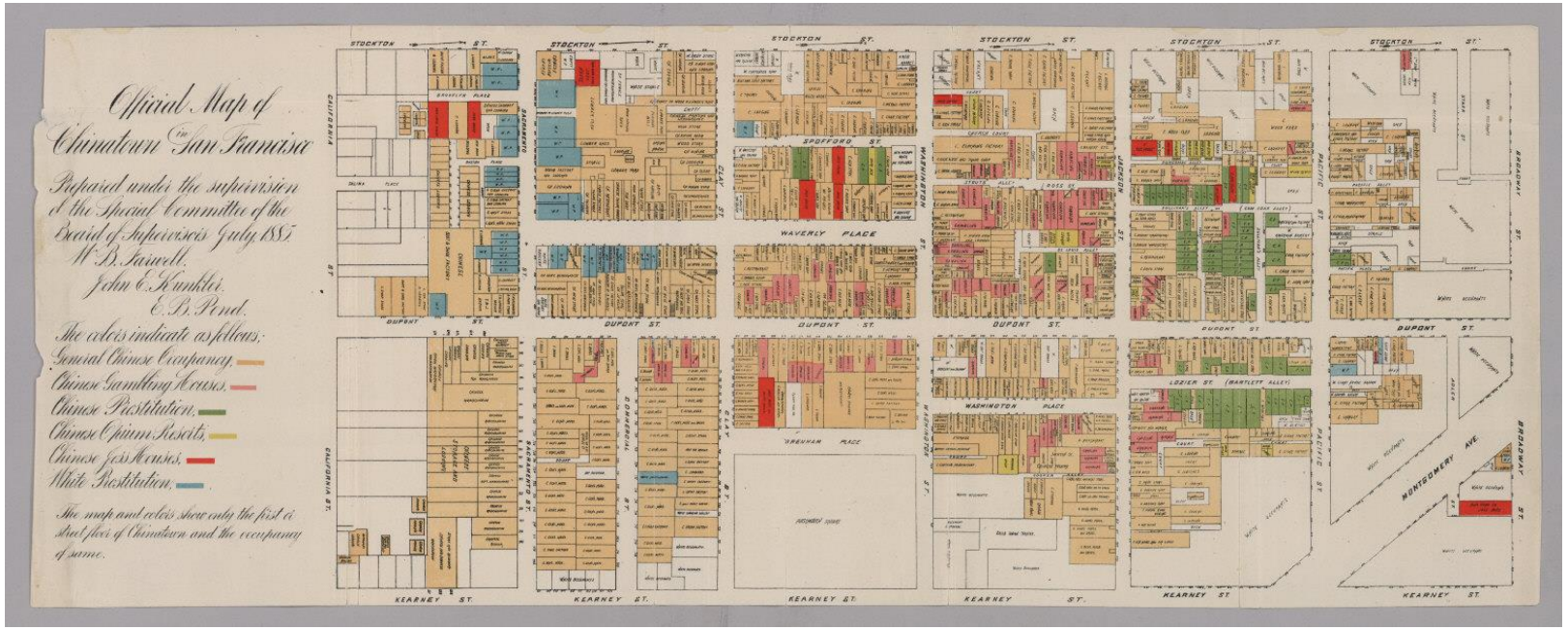
would not be allowed or suggested for European spaces or peoples (Mbembe, 2003, p. 24).

According to McClintock (1995), imperial anxieties about boundary loss were attended to by an excess of boundary order (p. 26). Fears of Chinese excess run amok compelled numerous cities in California, to introduce various laws and ordinances to spatially restrict and delineate the Chinese threat. Throughout the state, zoning ordinances limited where the Chinese could live and do business (Bernstein, 1999). San Francisco introduced a Sidewalk Ordinance (1870) banning the carrying of loads (such as laundry and vegetables) on poles (a common practice among the Chinese) and a Laundry Ordinance (1873) which taxed laundries without vehicles or that used horse-drawn vehicles (the mayor would eventually veto this ordinance). Accompanying these restrictions were Cubic Air Ordinances in both San Francisco and Los Angeles which sought to preclude the spread of disease caused by tight living quarters, but which were disproportionately enforced within Chinese communities thus affecting their domestic arrangements (Molina, 2006, p. 18, 27, 201). Municipal efforts also targeted vice. In San Francisco, for example, the visibility of Chinese prostitutes on major thoroughfares linking residential and commercial districts resulted in aggressive efforts to drive prostitutes from high traffic streets. By 1865 the city and brothel owners had reached an agreement to move Chinese prostitution to the alleyways (Shah, 2001).

Just as the New York Council of Hygiene report mapped that city's tenements, brothels and sewerage, municipal authorities in San Francisco went to great lengths to devise a detailed map of Chinatown. Figure 1 (Official Map of Chinatown in San

Francisco) is featured in the 1885 report by the Special Committee of the Board of Supervisors of San Francisco on the conditions of the Chinese quarter. One of the explicit purposes of the report was to prove that the Chinese "presence on our shores results alone in sowing the seeds of immorality, vice and disease among our people and plunges a large mass of the laboring classes into poverty and misery" (Farwell, 1885, p. 4). The map indicates the location of "Chinese Gambling Houses," "Chinese Opium Resorts," "Chinese Joss Houses," (places of worship), "Chinese Prostitution," "White Prostitution," and places designated as "General Chinese Occupancy" which includes both lodging and businesses. Interestingly, white businesses and residences are also identified but are devoid of color. Even within Chinatown, there was a clear distinction between locations of white sex work and those of Chinese vices (brothels, gambling and drug use). According to McClintock (1995), while "the map is a technology of knowledge that professes to capture the truth about a place in pure scientific form," it is also a "liminal thing, associated with thresholds and marginal zones burdened with dangerous powers' (p. 28). By mapping Chinatown, inspectors created knowledge of the threats existing within this self-contained, alien society that, without consistent and proper management of its borders, would, by virtue of their excessive nature, spill into white communities (Shah, 2001, p. 18).

Figure 1. Official Map of Chinatown in San Francisco[1]



[1] David Rumsey Map Collection. From https://www.davidrumsey.com/luna/servlet/detail/RUMSEY~8~1~215016~5501920:Official-Map-of-Chinatown-in-San-Fr

While discourses surrounding the Chinese served to instill fear in the general public, who constituted "the general public?" How did the treatment of the Chinese contribute to the coalescence of different white ethnic groups under this banner and convince non-white peoples to be invested in its protection? Next, we will consider how public health operated to distinguish the Chinese from other populations with precarious relationships to "Americanness" further positioning them as incapable of truly being American.

Into the Fold; Ousted

During the late nineteenth and early twentieth centuries "race" was understood more expansively as it is today, as both a biological concept with scholars invested in identifying and ranking variations in humankind, and also encompassing what we would contemporarily consider "ethnicity" and even nationality (Baynton, 2016, p. 9; Metzger & Masequesmay, 2009). Although in Western societies, whiteness has historically had the privilege of being both hypervisible (through its dominance) and invisible, (perceived as the norm from which minoritized racial groups deviate), at the turn of the twentieth century, there was a perceived threat to Anglo-Protestant dominance in the United States not only from non-white populations but from those "lower" in the hierarchy of white "races." While persons of Anglo-Saxon or Nordic origin were ideal immigrants to the country, those of Eastern European, Southern European and Irish descent were less desirable (Baynton, 2016, p. 9; Seidman, 2013). The latter in particular, were charged with failing to meet American standards of whiteness for various reasons including their Catholic faith undermining the nation's Protestant character and generating suspicions

about their political allegiance to the Pope, their deviance from American standard of middle-class patriarchal domesticity, their association drunkenness, fighting and riots, and their labor in roles commonly relegated to free Blacks (Duffy, 2013, p. 56, 57, 61).

During the late nineteenth century, contradictory discourses around "incurable" Chinese diseases abounded. For the most part, the Chinese were thought to spread such virulent strains of diseases that segregation within hospitals was a must. In San Francisco's Smallpox Hospital, for example, while all others, including foreigners, were admitted, Chinese suffers of smallpox and leprosy were sent to its "outhouse" (Shah, 2001, p. 70). As aforementioned, "European" leprosy was considered distinct from "tropical" leprosy making racial segregation a common practice. To address this discrimination, since the 1850s, wealthy Chinese California had proposed building a Chinese hospital outside of city limits. Their requests, however, were repeatedly denied based on objections to primitive Chinese medicine and the ingrained belief that the hospital would eventually constitute a nuisance that spread infection (Shah, 2001, p. 24, 71). Other discourses, however, while emphasizing the Chinese association to diseases such as leprosy, downplayed the risk of contagion, at least to the white population. In "A New Danger: Leprosy in San Francisco" (1873), David J. Lee (M.D) insisted that "Leprosy is not an acute form of disease, [it] never becomes an epidemic" but observed a case of leprosy in "a native Californian of Mexican or Indian descent- the very class most likely to contract the disease from Chinese women." Later, in 1881, Dr. John Foye would claim "I have seen none [lepers] out of the Chinese quarter. It is less general than is commonly believed" (The New York Times, 1881). While these statements "naturalized"

and spatially restricted the disease to the Chinese and their communities, the first designates non-whites as those most susceptible to an illness that these doctors deemed difficult to catch. Given the tenuous relationship of the Irish to whiteness in the late nineteenth century, it is unsurprising then that in "Leprosy in Gotham: One of the Beauties of Cheap Chinese Labor" a reporter in New York would specify that "he saw two children of Irish-Chinese birth suffering from the same disease [leprosy]" (San Francisco Chronicle, 1877). Economics, immigration (both Irish and Chinese), miscegenation, and disease and debility all coalesce in the discursive production of the racialized "other" and therefore in the production of whiteness.

Although the Irish were loathed, as "free white labor," they were eligible for citizenship and, despite the distrust of Catholicism, their Christian faith distinguished them from "pagans." One of the most controversial medical figures regarding the "Chinese question" during the late nineteenth century, Dr. C.C. O'Donnell, was notorious for his harsh anti-Chinese stance. An 1884 *New York Times* feature of his work on leprosy attributed his attitude to his ethnic background stating that "As an Irishman, he [O'Donnell] felt that the 'heathen Chinee' were but a sort of cattle that could be put to no better service than as subjects of scientific experiment" and that while some considered the doctor a "charlatan," others found that "in many white men's cases [he] proved himself a good physician." According to Jennifer Duffy (2013) "As newcomers in a relatively young, heterogeneous nation structured according to race-based resources, the Irish [such as O' Donnell] had to make a very firm and public commitment to white racial homogeneity in the United States" (p. 61).

Religion served as a major marker of difference between the Chinese and other peoples within the United States with leprosy commonly associated with Chinese heathenism. “Fear of leprosy was an unquestioned physical reality in Western culture” (Gaudet, 2004, p. 11) informed by Judeo-Christian understandings of the disease that labelled the afflicted “unclean” and, during medieval times, ordered that they be segregated from the general populace. Many religiously-based medieval beliefs and practices persisted into the nineteenth and twentieth centuries (Gaudet, 2004, p. 11; Leung, 2009, p. 2). Travel writer Charles Warren Stoddard referenced this biblical association when he warned in 1879 that the Chinese bring “…with [them] to these shores the seal of a dishonor that probably dates from the fall of man” and “they foster this crowing evil [leprosy] in their flesh.” An earlier 1873 article in the *San Francisco Chronicle*, “The Chinese Horror,” opened with the dire prediction that “One of the possible evils of Chinese immigration is the introduction to this country of that fearful scourge of nations, the leprosy.” While both pieces reiterate the “Chinese origin” myth, the latter proceeds to distance leprosy from Western Christian populations by asserting “it existed among the Eastern nations from the earliest historic times [and] the Jews brought the affliction with them into Palestine.” Municipal management was in no way immune to religious bias. In his 1879 address, health officer Dr. Walter Lindley called Chinatown “the crying sanitary evil of Los Angeles” (Torres-Rouff, 2006, p. 132) while as another stated objective of the 1885 San Francisco Board of Supervisors report was to prove ‘that the Chinese at home are a race unfit in every aspect of life to mingle with and exist among a Christian community” (Farwell, 1885, p.4).

Popular accounts by early Christian missionaries in China helped establish and proliferate the "common-knowledge" of China as a diseased place (Gussow, 1989, p. 123). Missionaries "inherited the earlier negative views of the traders and diplomats, which had already prepared the ground for a missionary denunciation of the Chinese. That denunciation was total …" (Gussow, 1989, p. 118). Transmitted in print and from the pulpit, extensive missionary reports focused on paganism, criticized the moral and intellectual characteristics and development of Chinese peoples, and suggested that "uncivilized" populations suffered outbreaks of supposedly extinct diseases such as leprosy thus reinforcing calls for segregation (Gussow, 1989, p. 118; Moran 2007, p. 21).

While non-white peoples generally were considered "dirty" and therefore, more likely to harbor disease, Christianity served to distinguish "believers" from "heathen" peoples further from the ideals of white citizenship. Indeed, in his 1877 testimony to the Senate, Reverend Blakeslee argued against Chinese immigration stating, "Slavery compelled the heathen to give up idolatry…The Chinese have no such compulsion and they do not do it…Slavery took the heathens by force and made them Americans…" (as cited in Jun, 2011, p. 293). In her analysis of Orientalism in the nineteenth century African-American press, Helen Jun emphasizes the role of religion in negotiations of citizenship. Although not monolithic, according to Jun (2011), "As a cultural institution, the black press played a highly significant role in defining black national identity, and nineteenth-century black newspapers were particularly invested in narratives of racial uplift and development" (p. 300). Most stories about Chinese immigrants in African-American papers resembled their mainstream counterparts' sensationalist accounts of

Chinatown ghettos as grotesque sites of immorality, filth and premodern alien difference with concerns about Chinese immigration in lockstep with the general increase in anti-Chinese sentiments during the late nineteenth century (Jun, 2011, p. 298, 306, 309). To counter the standard discourses of the formerly enslaved and their descendants as immoral, violent, savages, the African-American press encouraged values of temperance, chastity, patriarchal domesticity and ideologies of Christian morality juxtaposed with Chinese heathenism and underdevelopment to demonstrate African-American compatibility with modern Western civilization and to prove their entitlement to citizenship (Jun, 2011, p. 301, 302, 303). While most African-American papers did not oppose limiting Chinese immigration, many objected strongly to the Chinese Exclusion Act (1882) recognizing the inherent danger of such restrictive laws based on race. The passing of the Act, however, did not end Orientalist discourses in the African-American press (Jun, 2011, p. 308).

The Chinese were not simply characterized as benign pagans but as intentionally "diabolical." The 1879 meeting of the San Francisco Congressional Labor Committee emphasized the routine association of the Chines with "evil." While Shannon (Collector of Customs) "considered the presence of the Chinese here an unmitigated evil," Schaffer (a clothing merchant) testified about the "evil effect of the large Chinese immigration" and Pickering (a journalist) "thought that if the evil was not soon checked Chinese-made shoes would soon flood the eastern market" (San Francisco Chronicle, 1879). These economic fears were accompanied by Dr. O'Donnell's account of Chinese prostitution and his "loathsome picture of the horrors of leprosy." Susan Sontag (1978) asserts that

"feeling about evil are projected onto a disease (p.58) with leprosy, as noted, associated with filth and sin (Moran, 2007, p. 5). During the eighteenth and nineteenth centuries, diseases came to be viewed as not only divine punishment but as a sign of evil deserving of punishment (Sontag, 1978, p. 82).

During the nineteenth century, deportation served as a fitting punishment for contracting leprosy as the government tried desperately to both contain the evils of Hansen's disease within Chinatown and rid it from American shores. Deportation was not a common disease management strategy in the United States but was a tactic reserved only for leprosy and applied predominantly towards the Chinese within whom the disease was thought to emerge spontaneously (Trauner, 1978, p. 75). Dr. Foye, in his 1881 communication to Dr. Hyde, insisted that "the fact is a significant one that on the 2nd of June, every known leper in the city [San Francisco] was shipped for China, and before the end of the year, 14 new cases have accumulated upon our hands" (The New York Times, 1881). That leprosy could spring forth at any time necessitated routine investigations into Chinatown to identify and detain the afflicted. From 1871 to 1890, of the 128 lepers incarcerated at the Twenty-Sixth Street Lazaretto, 115 were "Mongolian" of which 83 were eventually deported to China (Trauner, 1978, p. 75). As the deportations solidified the link between Chinese immigrants and leprosy in wider, quarantine measures were enforced for ships docking in San Francisco from Asia mandating that cases of myriad diseases be reported upon arrival (Shah, 2001, p. 99; Trauner, 1978, p. 75).

The heathen Chinese's "bad blood" meant that leprosy could emerge spontaneously. Of the utmost importance was, therefore, halting the spread of this infection on American shores through curtailing the reproduction of Chinese communities and Chinese bodies. Finally, we will investigate how public health operated to educate the American society about the "deviant" gender and sexuality of Chinese immigrants, and laws aimed at protecting "us" from "them."

Of Bodies, Material and Political

The broad acceptance of deportation as a disease management strategy points to the widespread notion of the Chinese as a transient population in America. Jean Pfaezler (2007) surmises that the gender disparity within Chinese communities bolstered this belief as,

> The low number of Chinese women probably made the Chinese communities in America particularly vulnerable to persecution. Chinese women would have foretold family, civilization, and permanence, and their very presence would have stood as a barrier to the idea that the Chinese had come to the United States as "sojourners" - temporary and enduringly foreign (p.10).

In 1855, only 2 percent of the Chinese population in America were women. While this grew to 4 percent in 1875, the passing of legislation such as the Page Law (1875) acted effectively as a purge of the Chinese female population, and, by 1880, there were more than 75,000 Chinese men to fewer than 4,000 Chinese women in the United States with 2,000 Chinese women versus 20,000 Chinese men residing in San Francisco alone (Pfaezler, 2007, p. 101, 105; Shah, 2001). The Page Law, and its Californian predecessor, the 1870 "Act to Prevent the Kidnapping and Importation of Mongolian,

Chinese, and Japanese Females, for Criminal or Demoralizing Purposes" prohibited East Asian women from immigrating to America for the purposes of prostitution (Ling 1998, Shah 2001). These laws stifled the arrival of Chinese women, as despite their scarcity, and that "prostitutes came from all racial and ethnic backgrounds...Chinese prostitution was always a special topic of concern to Caucasian California. Caucasians often acted and spoke in fact as if the problem were peculiar to the Chinese" (McClain 1994, p. 56). Lack of finances, restrictions and active discouragement from Chinese society, and harrowing tales of kidnapped and enslaved Chinese women already limited the number of Chinese women departing for the United States, and strict immigration policies meant to address the peculiarly Chinese issue of prostitution (and which effectively cast all Chinese women as destined for brothels) further skewed the gender ratio (Ling, 1998). In the 1879 Congressional Labor Committee meeting in San Francisco, Dr. O'Donnell would charge, "99 of every 100 of them [Chinese women]" in the city with being prostitutes (San Francisco Chronicle, 1879).

If female signifies "excess," it is no wonder then that the small number of Chinese women in the United States nonetheless constituted an active threat of contamination whether by encouraging the permanence of an alien community in the United States, infecting the white populace with disease, or causing racial degeneracy through miscegenation. Chinese prostitutes were believed to carry more virulent strains of venereal disease and medieval understandings of leprosy as a sexually transmitted disease associated with evil and defilement persisted into the nineteenth century as did the idea of the transmutation of different diseases (Humphreys, 2013, p. 80; Lee, E., 200; Moran

2007, p. 5; Sontag, 1978, p. 58). "The Chinese Horror" (1873), for example, claimed that "leprosy is of syphilitic origin" and means of transmission included "from parent to child... from the tainted to the pure blooded, by sexual intercourse, by inoculation from handling the same instruments, and eating the same food." Health Officer, John Meares, similarly asserted in 1876 that, "the so-called leprosy…is simply the result of generations of syphilis, transmitted from one generation to another" (as cited in Shah 2001, 101). In fact, "It was not uncommon for physicians to have difficulty in differentiating leprosy from syphilis (Gussow, 1989, p. 95).

Prostitution marked the aberrant sexuality of Chinese women as did their supposed perverse proclivity for sex with (pre)adolescent boys (Lee, E., 2003; Shah, 2003). In their 1870 deputation to the San Francisco Board of Health, the city's "Anti-Coolie" Association called "the attention of [the] honorable Board to the shocking conditions of the living and lodging of the Chinese inhabitants in this city" where within "subterranean caverns...worn out Chinese prostitutes are taken down to be doctored for the foulest diseases" (San Francisco Chronicle, 1870). These women having "already attracted swarms of American boys of ten to fifteen years of age to their deadly contact. Those lads, the most of them, [having] caught deadly diseases...a semi-leprosy not to be eradicated by any medical skill" (ibid). At the end of the decade, Dr. O'Donnell's contribution to the aforementioned Congressional Labor Committee meeting would echo this "fact" as "several cases of leprosy ...existing in white boys under twenty years of age had been brought to his notice professionally, and upon inquiry he learned that the diseases had been contracted in the dens of Chinese prostitution" (San Francisco

Chronicle, 1870). Characterized as powerful, manipulative and mercenary, Chinese women would lure their passive white male victims and infect them (Shah 2001, p. 87). It mattered not if a medical examination of these "female slaves" as O'Donnell called them, "should fail to light any trace of the disease in a woman, if the poison is in her blood - either by acquisition or congenital, as it very often is-she will communicate the infection"(1884). These contaminated young men would then disseminate the disease to unsuspecting white women (Shah, 2001, p. 87).

Indiscriminate, insatiable, and irresistible, Chinese women captivated "swarms" of American boys while, with Chinese men, they lay in "beastly promiscuousness" within their underground dens (Shah, 2001, p. 35). It is not only that the Chinese were regularly likened to animals but that their animality was infectious and threatened the regression of the white populace. "In health reports, and journalistic reports of health inspections, Chinese were likened to a wide away of animals including rats, hogs, and cattle" (Shah, 2001, p. 27). While Dr. O'Donnell concluded that Chinese were "cattle" for "scientific experimentation," according to the writer of his 1884 *New York Times* feature, the doctor's "peculiar fascination" with them compelled him "to hunt them with the excited untiring eagerness of a hog rooting for truffles." This intense desire for Chinese bodies (sexual or non-sexual) had the alarming consequence of devolution, potentially unleashing the latent animality in "civilized" peoples.

Ingrained in this overwhelming desire for consort with the Chinese was the thrill of crossing boundaries. In 1884, O'Donnell invited the *New York Times* reporter on a "leper hunt," instructing the writer how to spot leprosy, modes of disease transmission,

the navigation of cramped boarding houses, and the demeanor and comportment of Chinese men and women. This pedagogical article, replete not only with medical and technical descriptions but also declarations of shock and disgust, taught readers how to identify leprosy among the Chinese and an "appropriate" loathing of their presence. It also presented them as passive in the face of superior Western medicine (and white Western men); described as "obedient" and "submitting without a word," suspected Chinese lepers were readily available for the doctor's investigations.

O'Donnell also references his personal knowledge of leprosy being "given to adventurous white men" by Chinese prostitutes. If Chinese women were notorious for their debilitating diseases, what would inspire white men to undertake such a risky venture? The temptation of invading a colonial space like Chinatown was not limited to crossing spatial thresholds but included sexual congress with Chinese women. If bodily impenetrability (and the "right" to penetrate others) signifies maleness then penetrability is a quality of its binary, female "other" (Cummings, 1991, p. 74) According to McClintock (1995), "women served as the boundary markers of imperialism" (p. 22). It was this colonial lust, the ramifications of sexual excess, and the desire to dominate that led infuriated whites to raze Antioch's Chinatown in 1876.

While sexual (and gender) aberration was considered a female property, Chinese men were also considered improperly (and dangerously) gendered. "Although half of the Chinese men who immigrated to the United States were married, cartoons in popular magazines and in trade cards alluded to their homosexuality, suggesting that Chinese men disregarded marriage, family and respectable womanhood" (Pfaezler, 2007, p. 103).

Their perversity was also marked by their performance of feminized labor. As work on railroads and within mines disappeared, Chinese men carved an economic niche for themselves working in laundries, restaurants, and tailor's shops or as domestic servants ("houseboys" and nurses) in white households as they were barred from other forms of employment such as on public works projects, within certain factories and other jobs involving skilled and semi-skilled labor (Bernstein, 1999, p. 222, 223; Eng, 2001; Lee, E., 2003; McClain, 1994; Shah, 2003). In an 1873 article simply titled "Leprosy," the *San Francisco Chronicle* expressed horror that despite the risk of infection "people in San Francisco... keep male Chinese for care of children, to wash and dress and care for their little ones...to wash clothes [and] to cook our victuals."

Finally, the mingling of races constituted an alarming threat to white purity. During the eighteenth and nineteenth centuries, there was increasing panic about degeneracy, whether physical, moral or mental. Degeneracy was thought to emerge from many sources, including diseases and, since these defects were considered hereditary and could be passed along and mutate across generations, preventing it was considered an important function of public health (Baynton, 2016; Carlson, 2001, p. 23, 40). The presence and popularity of Chinese opium dens had an unacceptable consequence; the congress of smokers regardless of race, status, faith or occupation. Respectable white men and women fell into disrepute through their addiction and risked contracting syphilis and other diseases through sharing pipes with Chinese drug users. Opium promoted sickening physical intimacy between men of different races and dangerous sexual intimacy between addicted white women prostituting themselves to Chinese den

operators. (Shah, 2001, p. 93, 94, 95). These relations ran counter to an explicit objective of the 1885 San Francisco Board of Supervisors report which aimed to "prove that their [Chinese] race characteristics are so utterly at variance with those of the Caucasian type that assimilation with that race is impossible" (Farwell, 1885, p. 4). Since women were "the central transmitter[s] of racial and…cultural contagion," race-mixing and mixed-raced progeny were causes of great concern (McClintock, 1995, p. 47). The deployment of sex difference meant that overly impressible white women, already prone to aberration and excess (as women), were particularly susceptible to Chinese affects and, therefore to rapid degeneration (McClintock, 1995, p. 8, 24; Schuller, 2018, p. 16). While white women who lay with Chinese men were commonly framed as "fallen," Chinese women posed the active threat to "civilization" and to the moral and physical purity of the nation as they infected the white populace with horrid diseases through their mercenary prostitution while miscegenation would dilute and poison the Anglo-Saxon population with their bad "Mongolian" blood (Lee, E., 2003; Ling, 1998; Pfaezler, 2007, p. 97; Shah, 2003).

Anti-miscegenation laws passed between 1861 and 1913 in states such as California, Arizona, Nevada and Utah sought to construct, confirm and preserve the predominance of whiteness in the American West, criminalizing and voiding marriage between people of color and whites. The Page Law, however, specifically targeted the Chinese, preventing both Chinese men and women with white citizen spouses or free white immigrant spouses (who could become citizens), such as the Irish or Germans, from eventually acquiring citizenship themselves (Pfaezler, 2007, p.110-111). The

adoption of the Fifteenth Amendment (1870) granting the vote to formerly enslaved men and their descendants, and the Chinese Exclusion Act (1882) severely restricting immigration and confirming that no state or federal court could naturalize Chinese persons, further distinguished the Chinese as wholly outside the possibility of becoming American (ibid). Although horribly treated and with their whiteness considered suspect, the Irish were nonetheless white according to the American government and could acquire citizenship. While the Fifteenth Amendment did little in reality to improve the lives of African-Americans, it still defined affiliation to the United States. The Chinese, however, were completely incompatible with "Americanness."

That Chinese immigrants were subjected to such obvious and violent racism (and that public health was an active participant) appears heinous today. However, nineteenth century American society was generating, interpreting, disseminating and reaffirming commonly held "truths" about race characteristic of the era. Although, one hundred years later, it would be in exceedingly terrible form to identify a people as dangerous and diseased because of their race, did the logics of racialization employed by American public health disappear? What does the seemingly nonsensical designation of Haitians as "at risk" of HIV/AIDS tell us about persistent tropes of threatening contagion, strategies for managing disease, whiteness and civilization. The following chapter investigates the logics that proliferated during the fear and confusion surrounding the then unknown and fatal illness during a time when the Cold War rendered American civilization under constant threat. In the hysteria, did public health fall back in the discriminatory roots from which it had supposedly outgrown.

CHAPTER III

FERRYING AIDS: REPRESENTATIONS OF HAITIANS DURING THE HIV/AIDS PANDEMIC OF THE LATE 1900s

> AIDS is no Andromeda Strain: The epidemic will doubtless peak at some time of its own accord. But any comfortable supposition that it will stay confined to particular groups is misplaced. Perhaps the Haitians, who say they are neither homosexual nor drug users, exemplify how AIDS may spread to the general population.[1]

By the time AIDS-related deaths peaked in 2004 at 2.1 million worldwide, assumptions that confined HIV/AIDS to particular "risk groups" would seem wholly naive in retrospect (Boseley, 2010). Deaths from the pandemic since its outset exceed 25 million and, in 2017, there were approximately 36.9 million people living with HIV (Bell *et al.,* 2011, p. 101; UNAIDS). In the United States, while over 1.1 million people are currently living with HIV, between 2010-2015, the number of new infections declined by 8 percent. This overall decline, however, was not universal; during this same time period, new infections increased among African-American and Hispanic/Latino gay and bisexual men (hiv.gov).

Who is "at risk?" In the early days of the pandemic, the Centers for Disease Control (CDC) attempted to answer this question by designating homosexuals, hemophiliacs, heroin users (i.e. intravenous drug users) and Haitians as "risk groups" for contracting AIDS in 1982. The pervasive reiteration of the "Four-H Club" in medical

[1] From: The Scourge of a New Disease, *The New York Times,* May 15, 1983.

publications and the news media caused more “mainstream” members of American society to consider the disease a feature of these marginalized populations (Bell *et al.*, 2011, p. 92). While their supposedly “deviant” behaviors and lack of “personal responsibility” placed homosexuals and heroin users “at risk,” and unfortunate circumstance could result in those with the disabling condition of hemophilia receiving a transfusion with infected blood, what made Haitians predisposed to AIDS? An inability to provide adequate reasoning first led, New York City in 1983, and later the CDC in 1985, to drop Haitians as specified “risk group.” However, as Girard Jean-Juste, Director of Miami's Haitian Refugee Center, told *The San Diego Union-Tribune*, “Once you pluck a chicken, you cannot put the feathers back” (Kurlansky, 1985). The association with AIDS persisted and anti-Haitian discrimination continued.

While the United States had been involved in Haitian affairs since the beginning of the twentieth century, considerable Haitian migration to the US only began during the 1950s and 1960s following the establishment of the U.S-supported, Duvalier dictatorship. Haitians refugees were denied political refugee status (Fouron 2013; Pierre-Louis 2011). Already facing numerous barriers and forms discrimination that hampered their prospects in America, Haitian communities were then labelled “at risk” of contracting AIDS by the nation’s public health institutions leaving the community incensed. Guy Durant, a member of the Haitian Coalition on AIDS, lamented “Very soon, this place [Little Haiti] will be walled off like a ghetto, or we will be required to wear bells like the lepers” (Schwed, 1985). Indeed, the resulting stigma from this association was so severe that, in

1985, a teenager of Haitian descent killed himself after his friends and girlfriend discovered his ethnicity (ibid).

Unlike leprosy with its ancient history, HIV/AIDS emerged swiftly and stealthily; a mass murderer from the "dark continent" that had infiltrated America and mortally wounded thousands before they knew what had struck them. Before the penny had truly dropped about its potential for mass devastation there were on-going debates about the disease's "real" threat to the general populace. This project of delineating the "general" from the "deviant" occurred at a precarious time in U.S. foreign policy with the decades-old Cold War still demanding that the nation display its capitalist might in the face of the ever-present Communist threat. With its support of the Duvalier regime, Haiti was an important pawn in America's strategy of containment (Arthus, 2015).

The vast majority of Haitians are the Black descendants of the formerly enslaved. As the intelligibility of Blackness is New World contexts is intimately tied to the violence of enslavement, it is unsurprising that, in the American imaginary, the routine suffering inflicted upon Haitian migrants during the early days of the HIV/AIDS pandemic was not extraordinary, for, as Sharpe (2010) insists, "the violence of everyday black subjection [even] presented in its most spectacular form does not confirm or confer humanity on the suffering black body" (p. 2).Throughout American history, it is this violence rather that informs not only Black racialization, but also Whiteness. "The power of domination and exclusion is central to the belief in being White," says Ta-Nehisi Coates (2015), "and without it 'White people' would cease to exist for want of reasons" (p. 42). The dead or maimed Black figure, therefore, has immense social utility for formulating parameters of

Whiteness. White physical and affective security being equivalent to Black murder is more than irrational (and deadly) anti-Blackness as the visible, inert Black figure is essential and acceptable for ensuring that "Whiteness" remains safe (i.e. essential to definition of "Whiteness" itself) (Schuller, 2018, p. 2; Sexton, 2016). Although Black, Haitians were still distinct from African-Americans, possessing a triple minority status informed by their race, their foreignness, and their (French) Creole language (Farmer, 2006, p. 178). Their association with "exotic" practices such as voodoo and their portrayal as disingenuous refugees further marked them as suspect outsiders. Finally, their inexplicably AIDS-infected bodies cast them, unlike all others, as dangerously deviant not because of practice or circumstance but in the flesh.

This chapter explores the (neo)colonial relationship between the United States and Haiti emphasizing the latter's significance in the advancement and protection of American civilization. It analyzes the complex dynamics of the threatening "non-enemy" as, while Haiti has consistently been firmly within the United States' sphere of influence, Haitian bodies have nonetheless been formulated as "dangerous." To this end, it focuses on "excess," a major theme that informed American anxieties about its geopolitical strategy of "containment," the rampant spread of disease, unaccountable migration, uncontrollable sexuality and gender transgression. It examines HIV/AIDS narratives as pedagogies disseminating lessons about "deviance", "normality" and "risk." Furthermore, it looks at the ease with which migrant racialized peoples are cast as "disease-carriers." HIV/AIDS was never a disease that only afflicted members of the "Four-H Club." How much, then, did the intense focus on delineating these groups (and

others) from the "general populace" serve to distance or preclude already marginalized populations from the category of the "average" American? We will begin by examining how the U.S.-Haiti relationship is exceptional and how this state of exception manifested during the 1900s.

Tied Together

U.S. involvement in Haiti was a geopolitical mainstay of the twentieth century. After the assassination of the smaller country's sixth President, Jean Vilbrun Guillaume Sam, American forces invaded in 1915 under the pretext of "instability" (Farmer, 2006, p. 177, 178; Jefferies, 2001, p. 72). Rather than being a wholly dubious justification, American imperialism at the turn of the twentieth century relied on notions of civilization and "fitness" for leadership. The United States sought "great power" status during the scramble for empire with presidents such as Theodore Roosevelt (1958-1919) asserting that "civilized" nations had the responsibility of dividing among them the remainder of the unclaimed, "underdeveloped" world, taking land from "lesser" powers that could not maintain order, and even seizing territory from other great powers that proved inept in their management of their colonies (Engel,J., 2008, p. 672, 673). While the latter was deployed as a justification for the Spanish-American War (1898), the Wilson administration's intervention into the world's first independent Black Republic stemmed from the desire to create stability for the prosperity of democracy in a nation characterized by disorder (Anthony, 2008, p. 244; Engel, J., 2008, p. 673). In short, "great powers" (rightly) had imperial interests and, time and again, Haiti had proved incapable of managing its own affairs.

The armed occupation of Haiti persisted until 1934 during which time the American government exercised political and economic control over the country. Having "left" but in no way truly gone, the U.S. would remain involved in Haitian affairs with the Cold War compelling the capitalist superpower to both extend and consolidate its spheres of influence to pressure and contain the communist threat. Within the Caribbean region, this meant propping up the concurrent dictatorships of "Papa Doc" and "Baby Doc" Duvalier (Arthus, 2015, p. 505; Farmer, 2006, p. 178; Jefferies, 2001, p. 72; Pierre-Louis, 2011, p. 56).

François "Papa Doc" Duvalier was elected as Haitian President in 1957 (Arthus, 2015, p. 505). Prior to his sudden death in 1971, his administration "fostered an atmosphere where murder, corruption, intimidation and poverty, were the order of the day" (Jefferies, 2001, p. 72). Early in his tenure, much of the Haitian upper-class left the country under political pressure, resettling in Europe, Canada (predominantly Québec) and the United States following the passage of the Hart-Celler Immigration Act (1965) which abolished the discriminatory quota system that favored immigrants from Northern and Western Europe. Many of these elites took the opportunity to regularize their status and sponsor the migration of close relatives (Fouron, 2013, p. 707; Gjelten, 2015).

Despite the atrocities of the elder Duvalier's regime, successive American presidencies continued their support fearing a Castro-type event in Haiti and as a method of isolating the Cuban leader. With communism as the foremost enemy, Washington sanctioned the ascent of Jean-Claude "Baby Doc" Duvalier as life-president in 1971 (Arthus, 2015, p. 506; Fouron, 2013, p. 707). According to Jean-Jacques Honorat, an

international development consultant during the 1980s, “intellectuals who fled the repressive regime of Papa Doc Duvalier were generally well received... but when the non-qualified, illiterate masses tried to escape the poverty and police harassment in the mid-1970s, the American society tended to reject them” (Howe, 1984). The younger Duvalier continued his father’s legacy of suppression and brutality during the 1970s and 1980s, driving the desperate poor to escape poverty and persecution via flimsy, makeshift boats in the hope of reaching American shores (Fouron, 2013, p. 707; Jefferies, 2001, p. 72). By 1984, there were an estimated 300,000 to half a million Haitians in the New York Metropolitan area alone with Miami constituting another major population center. In 1986, “Little Haiti” was reportedly home to approximately 30, 000 of the 70,000 Haitian refugees residing in Florida. The majority of refugees in the United States were undocumented migrants (Howe, 1984; McCombs, 1986). Strategies employed by the Reagan administration to stem this overwhelming influx of Haitians included detention in centers located in Puerto Rico, New York, and Kentucky, and refoulement (Farmer, 2006, p. 2010; Pierre-Louis, 2011, p. 57). In 1984, Arthur C. Helton, a spokesman for the Lawyer Committee for International Human Rights, charged that “more than 1,000 Haitian refugees have been turned back by Coast Guard vessels intercepting ships from Haiti” (Howe, 1984).

Amidst the suppression and violence visited upon the local population, was a stable (for the most part) tourism industry during the 1970s. Once Haiti’s second largest source of foreign revenue, several news reports covered the devastating effect that the AIDS “risk group” designation had on the industry (Candell, 1985: Kurlansky, 1985;

McLaughlin, 1983; Simons, 1983). Visitors to Haiti reportedly fell from 300, 000 in 1983 to 210,000 in 1984 with the stigma of AIDS assisted by recession and increased political volatility (Candell, 1985; Kurlansky, 1985). In the 1980s, the blame game would charge Haiti with not only sending unworthy refugees but also HIV/AIDS whether in the bodies of these migrants or in the bodies of returning gay tourists.

Eventually, a popular uprising would compel the younger Duvalier to flee Haiti for France in 1986 (Wilkinson, 2014). Subsequent elections in 1987 and 1990, however, were both followed by coups, with the latter displacing President Jean-Bertrand Aristide and instigating a U.S-led military intervention in 1994 to restore him to power in "Operation Uphold Democracy," at title harkening back to the Wilsonian tenet that to ensure that American democracy flourished, the United States had had to actively remake the international system to be more like its own. (Conway, 1998; Engel, J., 2008, p. 675; Kretchick *et al.*,1998). This political instability during the early 1990s, led to fresh waves of desperate Haitian "boat people" setting out for the United States where a approximately 35,000 people we apprehended at sea and either returned to Haiti or transported to and detained at Guantanamo Bay (Ahuja, 2016, p. 169-170). Deemed a "success," "Operation Uphold Democracy" would restore Aristide to power and lead to elections in 1996 which saw the ascendency of President René Garcia Préval (Conway, 1998; Kretchick et al.,1998, xi).

Traditionally, Haiti has been portrayed as the hemisphere's most backward nation—strange, hopelessly diseased and isolated from the "civilized" world (Farmer, 2006, p. 24, 133). The country has long been an exceptional space. As a thriving

independent Black state borne of a successful slave revolt would run counter to the international order (in addition to generating anxieties of the "infectious" nature of slave insurrection), Western nations were invested in rendering the country incapable of "genuine" independence and in reestablishing colonial control and "boundary order" to contain Black excess. The Haitian Revolution (1791-1804) may have freed Haiti from France but the second independent nation in the Western hemisphere was hardly recognized as sovereign, if we take "sovereignty" to signify a state of being unavailable for colonial appropriation (Dalleo, 2013, p. 3, 6). Anomalous, Haiti was not recognized as having created a human world (were its inhabitants even fully human?) and remained a (neo)colonial zone subject to the violence of the state of exception with the reaffirmation of Haitian dependence integral to maintaining the status quo (Mbembe, 2003, p. 23, 24). This Black country could not (be allowed to) achieve civilization on its own, nor could numerous interventions bring civilization to the uncivilizable. At the dawn of the HIV/AIDS pandemic, the United States needed Haiti to contain communist Cuba while, of the five countries in the Caribbean basin with the largest number of AIDS cases (the Dominican Republic, the Bahamas, Trinidad and Tobago, Mexico and Haiti), Haiti was the most fully dependent on U.S. exports (Farmer, 2006, p. 132).

Already having the misfortune of hailing from the poorest nation in the Western Hemisphere, Haitians stood accused of being the source of AIDS in this part of the world. While gay men were (and are) commonly associated with the HIV/AIDS in mainstream discourses, the disease's origins had always been tied to blackness and the tropics. The following section discusses the ramifications of this "tropical" categorization for Haitians

and the interplay between beliefs about the "tropics," "primitivism" and sexual "deviance" and disease.

A Tropical Tragedy

According to Katherine Cummings (1991),

> AIDS narratives might equally be called pedagogies. One of the lessons they teach is the distinction between "us" and "them." This distinction is fundamental in narratives that return to the origin of organisms (subjects, communities, nations) in the attempt to make sense of AIDS (p. 69).

The most oft-cited explanation for human immunodeficiency virus (HIV) is that it spread from chimpanzees infected with its simian counterpart (SIV) during the early twentieth century in central Africa from hunters coming into contact with infected blood (Bell *et al.*, 2011, p. 3,4). Transmitted through blood or bodily fluids, the virus adversely affects the immune system and, if left untreated, can progress to acquired immunodeficiency syndrome (AIDS) where the weakened immune system becomes susceptible to myriad illnesses and struggles to resolve them. An HIV diagnosis is made through testing for the virus' antibodies in the blood (Bell *et al.*, 2011, p. 14. 62, 66, 73).

There is still no conclusive evidence as to the origins of the disease in the U.S. with the first diagnoses in Haiti and America occurring at a similar time (Candell, 1985; Kurlansky, 1985; Simons, 1983). Gay tourism in Haiti was small yet significant. In "Haiti Paying a Heavy Cost for bad rap as Source of AIDS" (1985) Kurlansky notes that "Before being closed by the government in 1983, there were several homosexual clubs in Port-au-Prince [the capital] which advertised in New York City. In 1979 there was even a

gay convention here [Haiti], largely attended by Americans." One theory was that gay American men contracted HIV via sexual intercourse with Haitians and brought the virus back with them to the United States. An opposing argument accused gay American tourists of transmitting the disease to poor Haitians profiting from homosexual prostitution (Candell, 1985; Farmer, 2006, p.30; Kurlansky, 1985; Simons, 1983). A recent study published in *Nature*, however, indicates early strains of HIV among populations in Haiti, the Dominican Republic, Jamaica, Trinidad and Tobago. How the virus reached the Caribbean remains unknown (Akpan, 2016; Worobey *et al.*, 2016).

Unlike leprosy, which was split into "tropical" and "European" varieties for the purposes of distinguishing its brown and black sufferers, HIV/AIDS, with its commonly-accepted African origin, has always been associated with the tropics In 1983, Dr. Caroline MacLeod, Director of the Institute of Tropical Medicine would call it a "tropical disease syndrome" (Stuart, 1983) and, while the HIV/AIDS would eventually become a global pandemic, stressing its tropical link distanced the illness from America and from Americans. Inexplicably, the disease "disproportionately" affected Haitians to such an extent that they were designated a "risk group." Although the Centers for Disease Control (CDC) estimated that Haitians constituted only three percent of cases between 1979 and 1985, from 1982 to 1985, the organization consistently presented AIDS-related statistics about Haitians in its Morbidity and Mortality Weekly Report (Candell, 1985; Gavett, 2012). These cases were perplexing because, as stated in 1983 by Betty Hooper, a spokesperson for the CDC, Haitians "do not admit to homosexuality or intravenous drug use," (Engel, M., 1983) two behaviors which would have placed them in other "risk

groups.” In his study published earlier that year in the New England Journal of Medicine, Dr. Jeffrey Vieira of Brooklyn Hospital similarly stated, “The Haitians we looked at are hard-working, they have one wife, they don't report any drug use or homosexuality” adding “I don't see how they could have picked AIDS up here. I think they brought it with them, but how they got it there I don't know” (Christensen, 1983). Haitians had AIDS because tropical illnesses afflict tropical peoples, no behavioral “deviance” required. The “risk group” label suggested that they were simply predisposed to having this disease in their “bad” blood (Fouron, 2013, p. 712). Despite immediate charges of this designation being “unscientific” and “discriminatory,” the CDC kept Haitians in the “Four-H Club” until 1985 with John Narkunas, a public health advisor with the CDC insisting that Haitians would be considered a “risk group” until proven otherwise (Schwed, 1985).

According to Sontag (1989), “there is a link between imagining disease and imagining foreignness,” (48) with illness associated “with an exotic, often primitive place” (51). During the 1970s and 1980s, Black foreigners fleeing their poverty-stricken country were illegally entering the U.S. in droves with some of their number carrying in their tainted blood a frightening and fatal illness from the tropics. What of other similarly-labelled “risk groups” not distinguished by race and ethnicity? That gay tourists contracted HIV/AIDS in Haiti and brought it back with them to America fits the narrative of the foreign (and tropical) origin of deadly diseases. Furthermore, gay men, with their “perverse” and “excessive” sexuality were already cast as susceptible to numerous, exotic

sexually-transmitted illnesses. In “AIDS: A New Disease’s Deadly Odyssey” (1983), Robin Henig noted,

> Sexually active homosexuals are prone to a host of diseases: syphilis, gonorrhea, genital herpes, hepatitis amebiasis (one of the most common diseases in what doctors call the “gay bowel syndrome”) and infections caused by fungi and protozoa usually seen only in the tropics. Indeed, bizarre infections are so common in the homosexual community that one scientist, presenting a report on these occurrences in 1968, called his talk “Manhattan: The Tropical Isle”

While the gay body’s presumed pathology was tied to the tropics, the “abnormal” gay mind has been linked to atavism. According to Diana Fuss, “psychoanalysis...has long equated ‘the homosexual’ with ‘the primitive’ (as cited in Eng, 2001, p. 6). Eng (2001), traces this tradition through analyzing Sigmund Freud’s works, specifically *Totem and Taboo* and “On Narcissism: An Introduction.” Freud contends that as “the primitive” cannot access the unconscious, he is unable to regulate his sexual perversions. Since “proper” psychic maturation means possessing and unconscious that regulates one’s actions towards a healthy (and necessary) heterosexuality, homosexuality is a pathology that exemplifies stalled development (p.7, 8, 10). Furthermore, read as improperly feminine, gay men were overly impressible and, therefore, acutely receptive to the affects of the “uncivilized” (Schuller, 2018, p. 16). With these supposed predispositions in body, mind and emotion is it a wonder, then, that white homosexual men flouted taboos against interracial sexual congress and were inordinately susceptible to this tropical illness borne by primitive “Third World” peoples?

Departing from the suspect yet ingrained discourses connecting gay men with tropical peoples and diseases, what of enduring and alluring fantasies of colonial domination of "exotic" places? Can the American government's long history of involvement in Haiti be divorced from the nation's past an available location for meeting the wants and needs of gay male tourists? In his analysis of colonialist erotics, Joseph Boone (2001) observes that critiques of Orientalism discount or ignore homosexuality, conforming rather, to heterosexual interpretive frameworks (p. 44). He argues, however, that many accounts of the "sexual promise" of the Orient include witnessing or participating in gay sex, and, while the fantasy of colonial penetration and domination by the "superior" West often presumes a binary, "inferior" female, "that which appears alluringly feminine is not always, or necessarily female" (p. 44, 48-49). Haiti is not the Orient. However, it is a place marked by both extraordinary colonial resistance in the form of the Haitian Revolution (1791-1804) and subsequent (neo)colonial domination. That the country was a popular playground for gay American tourists, even during the repressive Duvalier years, points not only to the ease with which tourists were able to move (or felt they were able to move) in a country with a long history of American (mis)management of but also the availability of the site for (neo)colonial domination, penetration and consumption.

Unlike leprosy, HIV/AIDS became a global pandemic. While "excess," therefore, constitutes a major theme, we will proceed with a specific focus on American responses to Haitian refugees fleeing their country for the United States during and immediately

after the Cold War. Although Haitians were not “enemies” their excess was an emergency that required exceptional measures.

Perilous Porosity

“Infectious diseases to which sexual fault is attached always inspire fears of easy contagion and bizarre fantasies of transmission…” (Sontag, 1989, p. 27). A 1983 article by Marlise Simons for *The New York Times* recorded the frustrations of an American resident of Haiti who was asked his port of embarkation by a customs official at Kennedy Airport in New York, “‘When I said Haiti’ the traveler recalled, ‘the customs lady told me ‘Open your passport. I’m not touching it.’” Some epidemiologists suggested mosquitoes spread AIDS (Gentry, 1988; Kurlansky, 1985; Altman, 1983) others speculated about bloody voodoo practices (Candell, 1985; Christensen, 1983; Doyle, 1986). In the early days of the pandemic, security guards at the National Institutes of Health (NIH) in Bethesda requested a special briefing on infection control, while some hospitals in the area also used differently colored linen for its AIDS patients (Engel, M.,1983). In 1985, Patrick Lennon, the head of Belle Glade General Hospital in Florida lamented that "nurses have refused offers of employment or asked for hazard pay to work in our hospital” (Bowers, 1985).

Grounding these fears of HIV/AIDS is panic about excess, about “leakage.” With the invasion of the virus, the “impermeable” body is found to be porous and the resulting illness ruins its integrity through causing mutation and decomposition (Cummings, 1991, p. 72-73, Sontag, 1989, p. 41). Alarmingly, the invading virus responsible for these leaky bodies entered the United States through invading brown bodies in leaky boats. An

invasion wholly uncalled for as their nation, though cordoned off as “primitive”, rested within the broader American sphere of influence protected from the nightmares of communism. In addition to HIV/AIDS being cast as a tropical illness, discourses of “containment” (including fears about the breaching of boundaries) also served to delineate “AIDS-carriers” from the general populace.

In 1947, State Department official George Kennan, under the pseudonym “Mr. X” famously wrote in *Foreign Affairs Magazine* that “the main element of any United States policy toward the Soviet Union must be that of a long-term, patient but firm and vigilant containment of Russian expansive tendencies” (as cited in Brown, 2015, p. 34). This strategy of “containment” informed the U.S. position towards the Soviet Union during the Cold War and included competition for influence in the development of poorer nations around the world (Brown, 2015, p. 140). For the United States, Cuba encapsulated this threat of communist excess in the Third World. “US military interventions from 1959 to the end of the Cold War...were caused by the desire to prevent the success and spread of the Cuban Revolution [which] intensified the Cold War in Latin America and the Caribbean…” (McPherson, 2016, p. 148). Indeed, the Cuban Missile Crisis (1962) found the United States and the Soviet Union on the brink of nuclear war with both nations terrified at the possibility of the total annihilation of their respective civilizations (Sherwin, 2012). While President Kennedy was no fan of the elder Duvalier’s methods, his administration sought to maintain friendly relations with the dictator to ensure his allyship against communism instead of antagonizing him and risking American exclusion (Arthus, 2015, p. 505, 507, 508).

Haitian “boat people” fleeing repression during the 1970s and 1980s, therefore, created a geopolitical quagmire for the United States. As America officially backed the Duvalier regime, the government could not very well accept Haitians as political refugees for this would serve both as an admittance of the atrocities taking place under a U.S-supported administration and to undermine American arguments about the righteousness of capitalism vis-à-vis communism (Pierre-Louis, 2011, p. 57). Unlike their Cuban counterparts who immediately received asylum if they made it ashore, the government insisted that these Haitians were economic refugees and, therefore, ineligible for political asylum (Fouron, 2013, p. 708).

That America was in this tricky position was not lost on those championing the Haitian cause during the early 1980s. A 1982 article by the *New York Times* frankly stated that

> the Government's contention is that the Haitians, unlike Poles and Nicaraguans, are not political refugees. In the view of the Federal Immigration and Naturalization Service [INS], the Haitians are fleeing economic repression, which is not a ground for asylum here. Civil libertarians describe this as a way of muting a sensitive foreign policy issue. The Governments of Nicaragua and Poland are not allied with the United States, they point out, while the regime of President for Life Jean-Claude Duvalier of Haiti is. The assertion is that the United States is overlooking repression in Haiti in order to keep the friendship of President Duvalier. It could hardly risk insulting him, the Haitians' lawyers contend, by granting his countrymen political asylum.

Of the 5,487 Haitian claims for political asylum made in 1983, only 1 was granted (Howe, 1984). If not refouled at sea, Haitians that made it ashore were detained with many incarcerated at Krome, a former anti-aircraft missile base-turned-detention center

near the Florida everglades. Despite having an “emergency” capacity of approximately 850, Krome was nonetheless described in 1981 as “bursting with humanity” (Jaynes, 1981). Widely depicted as unworthy “riff-raff,” (McCombs, 1986) (contrary to genuine political asylum-seekers), there was great frustration regarding appropriate courses of action for a people “coming in at a rate of 15,000 a year” (Jaynes, 1981).

In its bid to contain communist excess, the United States unwittingly precipitated the generation of another form of excess that exposed the permeability of its borders. “They're [Haitians] likely to arrive anywhere, from Marathon to West Palm Beach,” said Miami’s INS Assistant District Director for Deportation, Leonard Rowland, “So how do you patrol it?” Accompanying Rowland’s comments to *The Los Angeles Times,* were the opinions of his superior, Director Perry Rivkind, who declared asylum “…ought to be confined to persecuted people, not a whole country who want a better way of life. I often wonder what would happen if 260 million Russians decided they're sick of the Soviet Union and want to come here?" The article, however, emphasized the futility of curtailing the desperate masses willing to pay off smugglers or risk death at sea, as in 1980 and 1981, while “more than 23,000 Haitians were caught at the Florida shore....INS officials believe[d] that 25,000 more may have slipped in unseen” (Bearak, 1985).

Haitians were a people surveilled and detained yet unknown as no solid figures existed for the number of refugees who had managed to illegally infiltrate the country. Inaccurate knowledge of Haitian excess in America, however, according to Farmer (2006), led the CDC to classify them as a “risk group” as prevalence rates within the community were calculated with incorrect data (p. 251). "Most of the data used by the

CDC federal Centers for Disease Control and other health authorities," said Dr. Jean-Claude Compas, Vice President of the Haitian Medical Association Abroad, "were gathered by hospital-based physicians with no knowledge of French or Creole" who "admitted their complete ignorance of the intricacies of Haitian culture" (Wilke, 1983). Wherever Haitians existed, AIDS was speculated. As a "risk group," health professionals and bureaucrats tied the illness to their bodies rather than the general populace, which in the case of AIDS meant "white, heterosexuals who do not inject themselves with drugs or have sexual relations with those who do" (Sontag, 1989, p. 27). Indeed, health authorities during the 1980s were keen to downplay the threat to mainstream America. "We have seen no evidence that it [AIDS] is breaking out from the originally defined high risk groups," said Dr. Edward N. Brandt Jr, Assistant Secretary of Health and Human Services in 1983, "I personally do not think there is any reason for panic among the general population" (Pear, 1983). A *Washington Post* article two years later covering increasing diagnoses outside of the "chief risk groups" maintained nonetheless that "the disease does not yet seem to have spread to the general U.S. population in a significant way. Instead, those most likely to be infectious are still overwhelmingly in the few well-defined risk groups" (Rensberger & Russell, 1985) Even as late at 1988, Floridian Health officials insisted that, although there was a significant uptick in AIDS amongst heterosexuals, "the figures [didn't] mean the virus 'breaking out' into the general population" but rather a "special group -men and women from countries where heterosexual transmission of AIDS is common. In Florida, that mean[t] immigrants from Haiti" (Gentry, 1988).

Accompanying this constant reiteration of HIV/AIDS being restricted to certain bodies was rhetoric that spatialized the illness in relation to these bodies. The "AIDS capital of the United States" was distinguished not only by its high rates of illness but also its significant Haitian population. Belle Glade, Florida, a city in Palm Beach country populated by "Blacks, Haitians and Mexicans" earned this distinction in the mid- 1980s by having approximately 1 AIDS patient per 1,000 residents in a city of 20,000 (Conant & Prout, 1985, p. 37; Newman, 1985). In a 1985 article from the *States News Service*, the head of Belle Glade General Hospital Patrick Lennon linked these cases "to the large population of Haitians migrants who pick winter vegetables or chop sugarcane…the Haitian population in Belle Glade has risen from less than 1 percent to more than 20 percent over the past seven years...." (Bowers, 1984). This tropical link was reiterated that same year by Dr. MacLeod, Director of the Institute of Tropical Medicine in Miami, who, speaking to *The Orlando Sentinel* " said the AIDS cases in Belle Glade may have something to do with the 10,000 Caribbean workers who migrate through the town during the sugar cane harvest, bringing with them a variety of viruses"(Goudreau, 1985). Notably, these assertions were made after the CDC had removed Haitians as a "risk group" for contracting HIV/AIDS. This continued association of Haitians with AIDS in the news media was not uncommon. Although a 1985 *New York Times* article by Jon Nordheimer covering Belle Glade was careful to note that Haitians had officially been removed, it nonetheless insisted that "recent Haitian immigrants continue[d] to run a higher risk of contracting AIDS than the general population." A year later, in his bid to encourage HIV/AIDS testing, AIDS coordinator for the public health service Dr. Walter

Dowdle, defined “homosexual and bisexual men, present or past intravenous drug users, people with signed or symptoms compatible with AIDS… [and] people born in Haiti and countries in Central Africa…” as having an increased risk of infection (Altman, 1986)..

In addition to its disproportionate population of Haitian migrants, Belle Glade was singled-out for its poverty. The aforementioned Nordheimer (1985) article reported that “diseases of overcrowding, poor sanitation and malnutrition [had] long been documented in Belle Glade’s black ghetto, where 5,000 people live in hovels and boarding houses within a 10-square-block area” while Dr. MacLoed insisted that those who contracted HIV/AIDS lived in a “very poor section of town... [with] ...tremendous overcrowding, mosquitoes breeding all year, and a high rodent population.” Of the many theories that abounded about the cause and spread of AIDS, ones that focused on filth harkened back to nineteenth century anti-contagionist beliefs in “miasmas” with the unsanitary lifestyles of the afflicted thought to cause immunosuppression (Beck, 2008, p. 7). The characterization of Belle Glade as a squalid locality inhabited by tropical peoples within Florida’s tropical environment emphasized Belle Glade’s “foreignness” and “primitivism.” Raimondo (2005) argues that mainstream reporting of the city as a Third World anomaly within the First World, where racialized poverty too extreme for American society somehow existed, initially distracted from deeper considerations of the heterosexual virus transmission at a time when HIV/AIDS was termed the “gay plague” (p. 54, 55). The illness, rather, became spatially tied to Belle Glade’s peculiar environment and peoples with perverse heterosexuality in the form of racialized sex work touted as the primary reason for its spread.

The narrative of Haitians as a people intercepted, detained and contained and as AIDS carriers merged with Haitian incarceration at Camp Bulkeley in Guantanamo Bay during the early to mid-1990s. The overwhelming arrival of an unknown number of Haitians during the 1980s constituted a breakdown of boundaries and, according to McClintock (1995) "reinscribing a ritual excess of boundaries [is] accompanied all too often by an excess of military violence" (p. 24). Haitian migrants were refouled at sea and incarcerated at Krome and then, in 1987, the Reagan administration barred the immigration of individuals with HIV/AIDS. Following the resurgence of Haitian refugees after the deposition of Jean-Bertrand Aristide in 1991, approximately 10,000 intercepted Haitians were detained at Guantanamo Bay with those testing positive for HIV separated from all others (Ahuja, 2016; Brier, 2009). "The camp," explained Dorning (1993) for the *Chicago Tribune,* "is at the bottom of a dusty hill where cactus and scrub brush grow...There is a guard tower, with a roof of dried palms. Ninety Marine security police are the guards." Almost one hundred military personnel were posted to monitor the over two hundred HIV-positive detainees and, reminiscent of Molokai's leper colony, their families (spouses and children) in what the American government insisted was a "humanitarian" camp (Ahuja, 2016, p. 170; Dorning, 1993). While Dr. Paul V. Effler, a CDC physician, communicated to Charles McCance, Director of the CDC's division of quarantine that "it defies common sense to cluster such people together in such close quarters and with such crude sanitation" (Cimons & Healey, 1992), "the Bush administration argued that allowing HIV-positive travelers inside the U.S. would spread

the virus and overburden a health-care system that in some cities [were] already ...stretched thin by AIDS" (Dorning, 1993).

In political limbo (acknowledged as having plausible grounds for asylum but unable to enter the U.S. for being HIV-positive) these "stuck" detainees caused an administrative headache. When questioned about the poor sanitary conditions at Camp Bulkeley, "immigration and military officials blamed each other" (Cimons & Healey, 1992). Detainees were housed "roughly 20 to a tent [measuring] about 30 by 30 feet," there were "limited laundry facilities," with meals "eaten in mess halls" and toilets available as "either commercially available portable units leased by the Navy or facilities housed in cinder-block buildings" (ibid). These portable toilets grew, "rank in the hot Caribbean sun." (Dorning, 1993). The incarcerated declared the camp "fit only for animals" (ibid). According to hunger-striker, Yolande Jean,

> There was no privacy. Snakes would come in; we were lying on the ground; and lizards were climbing over us. One of us was bitten by a scorpion...There were spiders. Bees were stinging the children, and there were flies everywhere (as cited in Ahuja, 2016, p. 169).

"The barracks," wrote Dorning (1993), with their walls of plywood and wire mesh, resemble[d] modern chicken coops-clean, well-kept chicken coops." What purpose does this remark on cleanliness serve? Dorning's insistence upon the orderliness of detainees' "chicken coops" reaffirms the association of racial minorities with animality while referencing the United States' superiority as a nation bestowing the gifts of modernity onto "primitive" peoples (if cleanliness is a standard of "Americanness," best mention

that the dehumanizing accommodations are spotless!). The animalization of Black bodies has been a consistent feature of colonial logics (Ahuja, 2016, p. 182). That Haitians would somehow be predisposed to a disease thought to have spread from chimps to humans fit with long-standing racist stereotypes and caricatures bestowing simian features onto people of African descent. Housed as animals in the company of other animals, Haitian hunger-strikers also pressed the question of Haitians' ability for sound human reason. By refusing food in protest of "living conditions... probably better than they were in impoverished Haiti" (Dorning, 1993), detainees irrationally rejected the benevolent "humanitarian" assistance of the American government to their own detriment (Ahuja, 2016).

Who was responsible for the adverse health outcomes stemming from Camp Bulkeley's poor conditions in which Haitians lived in "modern chicken coops" that were nonetheless better than the living conditions in their homeland? The INS insisted that they were "not the inn-keepers" and that to discuss care "you have to talk to the Navy" (Cimons & Healy, 1992). The Navy, however, countered that the American government needed to make a determination on the status of HIV-positive detainees as the base hospital at Guantanamo Bay only served routine medical needs (Cimons & Healey, 1992; Dorning, 1993). "We don't think," insisted INS spokesman Duke Austin in 1993, "there is treatment they [HIV-positive Haitians] need in the United States that is not available there [at Guantanamo Bay]," (Dorning, 1993).

The carceral control and management of these refugees was an extension of the now routine militarized control of Haitian excess (Ahuja, 2016, p, 170) According to

Ahuja (2016), "the association of HIV with Haitian refugee bodies helped to realize the fantasized emergency scenario of military quarantine that is repeatedly envisioned as the last line of defense against globalization's processes of disease emergence" (p. 171). The Haitian body, however, was already an emergency prior to the 1987 ban on HIV-positive migrants. Appeals to exception, differentiating Haitian refugees from their Cuban counterparts, for example, commonplace during the 1970s and 1980s, produced the Haitian body as an inconvenient emergency. Haitians were not "enemies," per se but their excess was problematic, betraying the imperative within the American sphere of influence to maintain the image of capitalism's supposed civilizational superiority over communism and exposing the faults in notions and practices of "humanitarian" detainment (Mbembe, 2003, p. 16). Within (neo)colonial spaces such as Haiti and Guantanamo Bay, such militarized violence is permitted, even towards "non-enemies" as it functions in the service of "civilization," whether to advance the United States vis-à-vis the Soviet Union or to protect the First World peoples from deadly Third World diseases. While Haitians were not a direct threat to American lives, their elimination strengthened American potential to life and security (Mbembe, 2003, p. 17, 24).

While Haitian excess defied American expectations of the smaller country bolstering and protecting the civilization of its larger counterpart, this same unruliness necessitated interventions that reaffirmed the civilizational superiority of the United States with Haiti figured as an ungovernable space in perennial need of assistance. Efforts to quell the increasing panic surrounding HIV/AIDS commonly framed the disease as one afflicting other "unruly" populations as well. Next, we will consider the interplay

between public health (and other bodies invested with institutional authority), the media and disease in constructing and disseminating discourses around "deviance," "innocence" and "fault."

A(n) (Im)Proper Punishment

> "Some people," said Patrick Lennon of Belle Glade General Hospital,
>
> have expressed the feeling that the whole AIDS situation is the work of a just a righteous God who is avenging the deviant life styles of homosexuals and drug addicts…While I am not qualified to comment on the methods used by God, I am qualified to report to you these victims are consuming enormous quantities of expensive health care.

Lennon made these comments in 1985 after requesting over $1 million from a congressional panel for his overburdened facility in "the AIDS Capital of the United States." AIDS, a disease of excess, afflicting populations characterized by excess, was exceeding the resources of the institutions meant to treat it. Much has been said about the federal government's sluggish response to the growing pandemic during the early to mid-1980s. In 1983, Dr. Edward J. Brant Assistant Secretary of Health and Human Services, rejected criticism that the Public Health Service was ignoring the AIDS because of its association with homosexuality. That same year, however, Rep. Henry A. Waxman, Chairman of the House Energy and Commerce health subcommittee charged the Reagan administration with being lackadaisical about a disease once called "gay-related immune deficiency" (G.R.I.D.) accusing its response of being "too little and all but too late…The administration has never asked Congress for money for AIDS and, in fact, has opposed congressional efforts to provide funds to the Centers for Disease Control and the National

Institutes of Health." (Russell, 1983). Two years later, a New York physician called the disease "a 'catastrophe' that will decimate their [gay men's] numbers" (Rensberger & Russell, 1985). However, it was not until 1986 that President Ronald Reagan would even publicly mention the term "AIDS" (Brier, 2009, p. 80). The enduring question was of the illness' risk to the "general population." While some physicians warned that the "virus [was] going to move gradually and steadily to all parts of the population" others argued that "the threat to the heterosexual population [was] being overdramatized for political reasons" (ibid).

The suspect morality of the primary risk groups associated with the disease (homosexuals and heroin users) informed societal beliefs about the appropriate response to the virus. As Sontag (1989) puts it, "the unsafe behavior that produces AIDS is judged to be more than just weakness. It is indulgence, delinquency, addition to chemicals that are illegal, and sex regarded as deviant" (p. 25). Were these stricken populations "worthy" of support and resources? That HIV/AIDS was not initially a pressing priority during the Reagan presidency has been an enduring critique of his administration. By the end of 1985, the Domestic Policy Council, the presidential domestic advisory board, had only discussed the growing pandemic five times with the President attending only one of these meetings (Brier, 2009, p.78-79). Within his administration, there were debates between the New Right, which emphasized personal responsibility and took a moralistic stance against gays, lesbians and drug users, and those advocating that rational medical science dictate the appropriate course of action. Foreign policy was also affected. While the Reagan administration barred the entry of immigrants with AIDS beginning in 1987,

the United States Agency for International Development (USAID) developed a comprehensive AIDS prevention plan more thorough that those used in the U.S (Brier, 2009, p. 79, 80, 81, 82). The State Department, in particular, was wary of immigration restrictions, preferring diplomacy "to win favor among nations who might otherwise align with the Soviet Union...the president overrode State's concern by suggesting that AIDS, like communism, needed to be physically prevented from entering the country (Brier, 2009, p. 81-82).

How were populations, charged with harboring a virus as existentially threatening as communism, depicted? Articles covering HIV/AIDS commonly linked homosexuality with promiscuity. "AIDS" wrote Rensberger & Russell (1985) for *The Washington Post*, "was first identified among American homosexual men, whose sexual activities encouraged rapid spread." In a lengthy, 1983 feature, "AIDS: A New Diseases Deadly Odyssey" for *The New York Times*, Robin Henig detailed the outcomes of an early investigation which found that "those [gay men diagnosed with AIDS] studied were sexually promiscuous. Their average number of lifetime sexual contacts was 1,100." Similarly, Mark Schwed, covering a 1985 Haitian study, reported "the preliminary finding is that homosexual promiscuity is the main determining factor in who contracts AIDS."

AIDS, understood as a disease of sexual excess and aberration, was (and arguably still is) viewed as a punishment for those individuals and groups who are overly and improperly sexually active (Sontag, 1989, p.26). If impenetrability constitutes a cultural signifier of "maleness," then the dread of "leakage" and "contamination" caused by

AIDS heightened homophobic anxieties around gay men's improper penetrability. As Cummings (1991) states, this notion of male impenetrability "informs heterosexual readings of gay male sexuality...as a renunciation of the signs and privileges of the masculine role" (p. 74). After the designation of Haitians as a "risk group," community leaders critiqued the American public health apparatus' ignorance of the deeply ingrained cultural taboo against this renunciation. Although Haitian AIDS cases perplexed physicians because patients routinely denied engaging in homosexual intercourse, as Dr. Jean-Claude Desgranges explained, "telling someone they are homosexual, it is like killing the whole family...It is the worst word you can use in Haiti" (Schwed, 1985). "Homosexuality," said Rudolphe Malebrance, member of the Research Group of Immunological Diseases "is extraordinarily taboo in Haiti...there is very little of the 'gay scene' of affluent Western nations. But there is thought to be a great deal of bisexuality, especially among the vast ranks of the impoverished" (Kurlansky, 1985). Many Haitians argued the denials by their countrymen diagnosed with AIDS "stem[med] from cultural differences that ma[de] it extremely shameful to acknowledge homosexuality" (Altman, 1983). Homosexuality, understood as improper penetrability, rendered gay men "not men." Through tying AIDS to homosexual men, the disease became understood as one that did not afflict "real men" and rather a consequence of gay men's deviant, "feminine" sexual practices that rejected "proper" masculinity (Cummings, 1991, p. 74). The supposed cultural "misunderstanding" by American physicians presumes that this homophobic understanding of masculinity and of HIV/AIDS was (and is) not present in the United States. As Puar (2007) observes, part of the victim-blaming discourse

surrounding Iraqi prisoners tormented by American troops at Abu Ghraib centered on the accusation that the sexualized torture only proved so effective because "backwards" and "primitive" societies find homosexuality acutely shameful compared to the liberated West (p. 91). That Haitian men's "irrational" unwillingness to disclose same-sex intercourse confused American doctors, is contradicted by the homophobic vitriol, violence and victim-blaming experienced by gay men with HIV/AIDS.

Despite homosexuality being taboo in Haiti and the country's supposed lack of a "gay scene," homosexual prostitution "had been fairly well-known in the capital city as a way of earning tourist dollars" (Kurlansky, 1985). As aforementioned, during the 1970s, Haiti was a popular vacation spot for gay men with vacationers' interactions with male sex workers in urban areas such Carrefour well-documented (Christensen 1983; The New York Times, 1983b). Until the closing of the country's gay bars in 1983, male prostitution as an economic exchange geared towards foreigners was at least tolerated in Haitian society. Prostitution, as exemplary of sexual excess, was cited not only as the avenue by which AIDS entered the U.S. but also the primary means of heterosexual transmission thus spreading the disease beyond the "Four H-club." "A key link," wrote Renseberger & Russell (1985), covering heterosexual disease transmission, "may be prostitutes, who are often drug abusers and therefore at risk for AIDS." Departing momentarily from sex work, this tie between AIDS and illicit intoxication went beyond intravenous (heroin) drug users. Reminiscent of the late-19th century obsession with Chinese opium dens by municipal authorities, Henig's (1983) aforementioned article reported that the gay men studied "frequented homosexual bars and bathhouses (where a

typical visit may include sex with 15 to 20 deliberately anonymous men). Many of them used ‘poppers,’ inhalant amyl nitrite and butyl nitrite, drugs said to have the effect of enhancing orgasm.” In addition to this merging of intoxication and sexual excess in AIDS discourses was the blending of intoxication with religious excess. In the early days of the pandemic, voodoo’s pagan rituals were speculated to spread HIV/AIDS. "Our theory,” said Dr. Jeffrey Viera of Brooklyn Hospital” is it's [AIDS] transmitted by some unrecognized route. Haitians are connected in some way with voodoo practices involving transmission of blood products, cutting each other with knives," (Christensen, 1983). In 1986, Dr. William Greenfield "wrote a letter to the Journal of the American Medical Association... [arguing] many of the potions and poisons used in voodoo rituals are composed of human parts...and are handled in a way that might facilitate transmission of HIV” (Doyle, 1986). In his discussion of the medical and popular fascination with voodoo as a possible avenue for the proliferation of HIV/AIDS, Farmer (2006) cites the words of Swiss anthropologist, Alfred Métraux who, in 1959, observed that “certain exotic words are charged with evocative power...Voodoo is one. It usually conjures up visions of mysterious deaths, secret rites - or dark saturnalia celebrated by blood-maddened, sex-maddened, god-maddened, negroes” (p. 23).

That drugged-out, AIDS-carrying, sex workers were threat to the heterosexual population served to again confine the disease to certain “deviant” bodies. Returning to Belle Glade, Florida, the city’s female prostitutes were described as “exceptionally industrious” (as cited in Raimondo, 2005, p. 59). In a 1985 interview with *The New York Times*, Dr. Jeffrey Sacks, epidemiologist for Florida stated the “victims with no risk

factors are all men…we're seeing… a number of men who are clearly heterosexual telling us of multiple contacts with prostitutes" (Nordheimer, 1985). Similarly, a year later, the *Los Angeles Times* reported the suspicions of CDC epidemiologist, Ken Castro, that "…the large number of female prostitutes who cater to the male farm laborers in the area may be a good part of the explanation" (Nelson, 1986). In a more general article, "AIDS: A Menace Beyond 'Risk Groups'; Research Raises New Fears About Disease's Scope and Virulence," Rensberger & Russell (1985) reported "nearly one-third of a sample of some 80 male AIDS patients classified as being in the 'no known risk' group admitted to prostitute contact." This heterosexualization of HIV/AIDS was also racialized (as seen in the case of Belle Glade) with press releases and news articles regularly citing Haiti and Central Africa as major locations for the heterosexual transmission of the disease. Avoiding HIV/AIDS meant avoiding this site of illness and death, perversely sexualized black and brown bodies. As Raimondo (2005) astutely observes, "although it is [the] male client that serves as the actual conduit between otherwise distant territories of sex work and the middle-class home... the origin of …HIV…is always the body of the sex worker" (p. 61). "The virus may spread next to other sexually active populations," reported Rensberger & Russell (1985) "such as college students, perhaps infecting, as one researcher put it, 'the Ivy League college girl whose boyfriend has had sex with a prostitute two years earlier.'"

"Innocent" contractors of HIV/AIDS, such as the (presumably white) Ivy League college girl, were cast opposite the irresponsible "deviants" who spread the disease and consigned the undeserving to death. Other unfortunate souls included children born to

drug-addicted mothers (McLauglin, 1985), women infected by bisexual male partners (Patton, 1985) and hemophiliacs, born with the misfortune of a "deviant" body and commonly represented as unlucky members of the "Four-H Club" whose disability rendered them susceptible to the virus. Between 1979-1985, hemophiliacs accounted for 1 percent of AIDS cases with most contracting this illness via blood transfusions (Schwed, 1985). To protect the blood supply, in 1983, the American Red Cross advised gay men, Haitian immigrants, drug users and other "high risk" groups to refrain from donating blood (New York Times, 1983a) while a year later, the U.S Public Health Service recommended that homosexual and bisexual men with multiple partners be barred (Bayer, 1985, p. 3).

> Among those pressing for the ban was the National Hemophilia Foundation, which was alarmed because hemophiliacs were becoming the inadvertent victims of a contaminated blood supply. Resisting this effort was the organized gay community with feared that stigmatization would accompany the assumption that all gays were a potential source of 'bad blood" (ibid).

As Virginia Apuzzo of the National Gay Task Force insisted, "'We should screen blood not people'" (Russell, 1983). It was not until 1985 that a blood screening test for HIV would be approved by the Food and Drug Administration (FDA) with a test detecting both HIV 1 and HIV 2 only made available in 1992 (Herman, 1992). As feared, the stigma of "bad blood" remained firmly attached to certain populations. In 1983, the FDA recommended a ban on post-1977 Haitian immigrants from donating blood and, despite the removal of the "risk group" designation by the CDC and the development blood screening tests, its recommendation remained and was expanded to include all Haitian's

in 1990. Following this declaration, over 50,000 people in New York protested the proposed measure forcing the FDA to reconsider its position (Hilts 1990; Lambert, B., 1990). Today, gay men are still banned from donating blood unless they have been abstinent for at least one year (redcrossblood.org).

HIV/AIDS, of course, was never a disease restricted to particular “risk groups.” This designation, however, and its association with “deviance” rendered those diagnosed with the disease suspect or guilty of having failed to lead a “normal” American life and a threat to those succeeding in doing so. As Black immigrants and refugees, the possibility of “Americanness” was already questionable for Haitians before being branded as “at risk” not because of practice or a diagnosable condition from birth but seemingly because of their blood. “Deviant” populations contracted and spread AIDS ergo Haitians, by default, were “deviant.” “The effects of the stereotyping were devastating: many Haitian immigrants lost their tenuous grips on employment in the United States and were subjected to profiling in schools” (Ahuja, 2016, p. 175). "A people cannot be a risk group" insisted Rudolphe Malebrance, "I think we will carry this burden for a long time” "People won't shake hands with us," lamented Girard Jean-Juste, "They get very cold” (Kurlansky, 1985).

CHAPTER IV

IN CONCLUSION: PUBLIC HEALTH FIGHTING FOR THE SAKE OF THE CITIZEN

If, as Justice John Harlan insisted in 1902, "principle of self-defense" gives a community "the right to protect itself against an epidemic of disease which threatens the safety of its members" then non-members a outsiders, will invariably be cast as the enemy not the microscopic organism or "bad air" thought to produce the illness (Ahuja, 2016, p.2). A disinfected surface is no guarantee that every bacteria and virus has been destroyed and poisonous "miasmas" may still linger in seemingly fresh air. What can be dealt with clearly and forcibly, are bodies. What do these two cases, one hundred years apart, tell us about defending the citizen?

First, many of the logics of racialized contagion are easily transferable. "'Other' subjects are fantasmically intersubstitutable over and beyond their particular modes of address," "writes Cummings (1991), "…always remain[ing] on call, awaiting the moment when the self feels threatened and acts to allay its anxiety by naming, isolating and thus containing the so-called threat…" (p.17). Devastating illnesses (whether actual or imagined) are the property of heathen, tropical peoples and public health must be at the forefront of the citizen's defense. Furthermore, the "reasonable" emergency measures deployed against these "primitive" outsiders are not read as excessively violent. As Susan Sontag (1989) states, Eurocentric assumptions hold that,

> peoples with little reason to expect exemption from misfortune have a lessened capacity to *feel* [emphasis in original text] misfortune. Thus, it is believed that Asians (or the poor, or black, or Africans or Muslims), don't suffer or don't grieve as Europeans (or whites) do (p. 51).

In any case, their exceptional suffering is necessary for both defining the "citizen" and preserving the citizen's life.

As aforementioned, this citizen body is not just any body but that of the young, white, able-bodied, heterosexual productive male both symbolic of, and charged with advancing civilization. This work explicitly investigates the utility of fungible diseased brown bodies for preserving this fiction and the predominance of whiteness. Public health was (and is) not immune to societal beliefs about race, gender, sexuality, class, religion, and immigration/immigrants both incorporating and disseminating these beliefs in their polices, practices and pedagogies, and, invested with institutional authority, participating in the entrenchment of knowledge about which bodies harbor and spread disease versus "the general public." While the racial predisposition of the Chinese to leprosy was nineteenth century "common knowledge", to reassure the American public during the early years of the HIV/AIDS pandemic, public health authorities maintained that the disease was limited to identified "deviant" groups despite evidence to the contrary. Though members of any race could be afflicted with the disabling condition of hemophilia and/or engage in the presumably "immoral" behaviors which, according to public health, heightened susceptibility to HIV/AIDS, the tenuous Haitian connection, through criticized from the beginning, featured in official policies reports and pronouncements for years, with physicians retroactively searching for "deviant"

behaviors (such as adherence to voodoo) to explain the prevalence of the illness among them. The quickness with which Haitians were uncritically identified as a "risk group" coupled with the charge that HIV/AIDS in the United States originated in Haiti demonstrates the ease with which institutions can fall back on established, discriminatory beliefs such as the tropical origin of dangerous diseases naturally harbored by "primitive" peoples.

During the late nineteenth century, as the whiteness of some European peoples remained suspect, policies and laws such segregated medical care, rights of citizenship and anti-miscegenation laws, served to bring these groups into the fold of the "general public." Though, "are the Irish white?" was no longer a question posed one hundred years later, "risk groups" for HIV/AIDS did not conform to standards of hegemonic whiteness. Hemophiliacs were saddled with an unfortunate disability that distinguished them from the ideals of able-bodied citizenship. Contrary to the rational, autonomous and morally upright ideal citizen, intravenous drug users were dependent on illicit substances and could not control their primitive urges for pleasure. Neither could gay men whose "deviant" sexuality spread a deadly disease that they brought with them back to United States following interracial intercourse in Haiti. And, (most) Haitians were neither citizens nor white. As made plain in chapter three, these groups were not considered the "general public." Differences such as immigration status and citizenship, language and religion further differentiated contagious non-white "outsiders" from other racially marginalized groups within the United States.

Finally, the threat of these "outsiders" to the citizen constituted an emergency permitting the sacrifice of the offending bodies through active measures such as quarantine (Hawai`i and Guantanamo Bay) and immigration restrictions (the Chinese Exclusion Act, refoulement and the designation of Haitians as "economic" refugees), and the passive, yet violent, disregard for the ill. With restricted access to health care (for fears of infecting the white populace) nineteenth century Chinese immigrants were left to their own devices. One hundred years later, the Reagan administration faced intense criticism for its delayed response to the HIV/AIDS pandemic. Excluded from the category "general public," protection from these bodies rather than their rehabilitation was the primary concern.

Second, the purported threat of black and brown diseased bodies to American life can serve as a placeholder for American insecurities and anxieties about its membership and position in the pecking order of white, Western nations. The risks to empire were not solely found in diseased brown bodies but came from other countries with claims to "civilization." Given the presumed superiority of Western civilization over all others, the unfinished imperial project during the late 1800s marked the United States as unfit for, or not yet capable of, assuming the "great power" status of its European counterparts. The state of exception precipitated by this urgent matter permitted violence against those accused of hindering progress. By casting the Chinese as major culprits, the state not only created a scapegoat, charging them with potentially deteriorating American civilization through their deteriorating leprous bodies, but also showcased American imperial might through their domination and control. Everywhere the Chinese were found, whether in

Hawai`i or on the mainland, required colonial disease management. Chinatowns became heavily surveilled colonial spaces, both out of place (and time) in the United States and proof of the American ability to contain the threats brought by primitive peoples while the colonial strategies developed in Hawai`i for treating leprosy were disseminated worldwide. The Chinese could ruin American civilization, but their management was also evidence of the United States' capacity to operate as a powerful, Western nation. While HIV/AIDS was not exclusively tied to Haitians, anxieties about their diseased bodies were intertwined with American fears about being superseded or annihilated by the Soviet Union. The exceptional threat to the United States was communist expansion. Though flaunting the cracks in America's sphere of influence, that Haiti and its people were found lacking in their role as buffers still reaffirmed the United States as a civilizing force vis-à-vis an ungovernable nation in constant need of colonial intervention and management. "Haitians fleeing the regime of President Jean-Claude "Baby Doc" Duvalier arrived at the onset of a frightening new disease that was striking down young American men" (Scwhed, 1985). A disease that was seemingly a property of "bad" Haitian blood which first entered the United States within or through contact with Haitian bodies. A disease with the potential to render American male citizen body, and by extension, the nation, vulnerable when the Cold War demanded unquestionable might.

Lastly, American public health as a regulatory mechanism cannot be divorced from its military heritage. The public health movement flourished in the United States after it was placed on military footing (Kramer, 1948, p, 450). Its advancements (the establishment of general hospitals, new biopolitical statistical measurements, improved

urban planning, and new public health policies) were strategies to preserve the lives of millions of fighting men defending America, not from any outside threat, but from itself. The great American implosion that was the Civil War was the deadliest conflict in American history (Lambert,C., 2001). This emergency not only precipitated new public health practices but also established whose health was paramount and promoted health and cleanliness as American standards. Ingrained in public health is this legacy of the urgent defense and care of the white, male citizen soldier thus making addressing disease a(n) (implicitly or explicitly) militaristic endeavor. This work describes numerous ways in which public health informs racialization. In addition to minoritized racial groups being positioned as diseased threats to whiteness, there is also the reservation of care for "us" and not "them." If public health is conceived as a form of defense, then there is no reason for extending "our" means of preserving life to the "enemy," even if such an extension would engender a healthier nation. It was, therefore, not contrary to American public health to deny Chinese migrants access to general hospitals and to bar them from building their own, or to deny ill Haitians in Guantanamo Bay proper hospital care, even if these measures would have improved individual and societal health outcomes (indeed these denials were said to be for the sake of public health). Neither was failing to implement innovations in urban planning for better sanitation which would have undoubtedly improved health and environment. Despite, Los Angeles' Health Officer Walter Lindley, vowing to put that Chinatown nuisance" in the "very best sanitary condition" it took thirty years for the city's sewer to finally extended through the area (as cited in Molina, 20016, p.16). In Florida, "diseases of overcrowding, poor sanitation and

malnutrition [had] long been documented in Belle Glade black ghetto, where 5,000 people live[d] in hovels and boardinghouses…" (Nordheimer, 1985). At Camp Bulkeley, detained Haitians endured awful conditions despite well-established principles of sanitary camp management. It is this denial of proper care and consideration that defines the (presumably dangerous) "other" versus the citizen whose body must be protected and for whom public health must serve.

In December 2018, the President, through his customary method of governing by tweet, "accused Democrats of wanting 'Open Borders for anyone to come in' [which] brings large-scale crime and disease,'" (Da Silva, 2018). The current conservative climate has galvanized many with anti-immigrant stances to adopt such inflammatory rhetoric despite the worrying spread of "eliminated" diseases such as measles being attributed to low vaccination rates in communities within the United States (King, 2019). The "diseased immigrant" narrative has, in fact, been challenged by both John Hopkins University and Columbia University with Dr. Paul Spiegel, Director of the Center for Humanitarian Health at the former, insisting that "There is no evidence to show that migrants are spreading disease" (Fox, 2018). Is this demonstrative of a broader permanent shift in public health or that the artificial fearmongering has not permeated wider society? (How) would this measured take hold up in the face of a broadly perceived existential threat to American civilization? What violences are we currently blind to that will regrettably only be evident in retrospect?

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