

Introduction

When I was an ethnographer for a federally funded study on HIV risk and needle use, I met Dave Wood, a middle-aged, slightly built African American heroin user who spent many of his days circulating through a neighborhood shopping plaza where people would arrive to get their morning coffee at McDonald's, pick up a loaf of bread at Sav-A-Lot, or buy and sell drugs in the parking lot. Dwayne Rogers, the outreach worker who was my partner on the study, introduced me to Wood. They had known each other for many years, starting from Rogers's own drug-using days when he spent time in that parking lot trying to hustle enough money for a fix. As a person in recovery and outreach worker for the project, Rogers served as a critical liaison between me and the people I was interested in recruiting as participants. In our first interview, Wood, like many people, worked hard to avoid being identified with a stigmatized group like injection drug users (IDUs), articulating a view of drug users that is clearly informed both by popular stereotypes and by the knowledge effects of the sort of research we were engaged in. Wood commented:

See, you have different levels of people who use drugs. Like, . . . the guys I hang out with aren't the ones who are out on the street, the kind of people that you know, that you see always trying to scrape up ten dollars—you know, the kind of people you probably have interviewed, I should have put it that way. You know, you got people out there every day, they struggling

to survive and they look all greasy [*narrows his eyes*]. . . . People like that, they gotta be out there every day to get their twenty dollars for their drugs. See, I don't have to do that.

Wood's description of "the kind of people that [we] know" as state-funded ethnographers points to the complex processes involved in the production of difference through community health research. Wood's assertion that he was not among those who scrambled to get money to support a habit was particularly ironic, because over the course of many months I saw Wood engaged in exactly such activities in the Sav-A-Lot parking lot. One of his hustles might involve taking fifteen dollars from another user to buy her a bag of heroin for ten dollars and keeping five dollars as a "finder's fee," or he might do an in-depth interview with an ethnographer studying HIV risk in urban injection drug-using populations, receiving a twenty-dollar stipend for his participation. Wood's view of "the kind of people [we] know" and his effort to differentiate himself from them reveal more than the easily understood desire to distance oneself from an oft-disparaged group. His assertions also hint at the new subject-positions that are created for both researchers and participants as service delivery and disease surveillance converge in federally sponsored drug research.

Thornton,¹ where this fieldwork took place, is one of many deindustrialized New England towns and cities bypassed by the booming economy of the 1990s, whose fortunes have continued to decline since the departure of manufacturing jobs beginning in the 1970s. With the abandonment of the inner city, low-income and minority Thornton residents have experienced increasing poverty and health inequalities as indexed by an expanding HIV epidemic, especially among IDUs. African American and Latino community-based organizations have worked to politicize health inequalities such as disproportionate infant mortality or HIV rates in minority communities, drawing together diverse stakeholders under the banner of community health. This book tracks the history of several of these interventions to investigate community health as a key site in which public and scholarly ideas about racial and economic difference are elaborated. As advanced liberal government increasingly depends on the emergence and identification of populations as its mode of governing (Dean 1999), community health research plays a critical role in constituting those populations frequently deemed a "problem" for governing: the poor, minorities, and those who are socially or sexually marginalized. The case studies presented here show how community health research contributes

1. This is a pseudonym, as are all names of people, organizations, and places presented as part of the ethnographic data. I consider questions of anonymization at greater length later in this chapter.

to governance projects such as HIV prevention programs and shapes how people understand, participate in, and resist them.

In U.S. inner cities like the Thornton neighborhoods where this work is based, decisions about the health of the community have become a key if underrecognized battleground where state agencies try to manage unruly populations, and where members of marginalized groups stake claims for their health (see Biehl 2007). This book opens to analysis those bodies of knowledge that are produced and disseminated in decisions about how best to ensure the health and welfare of the community. Researchers and service providers in public health, social medicine, and primary health care have together produced the field of “community health,” where minority and urban health issues are articulated in a context overdetermined by structural forces including deindustrialization, an expanding service economy, and increasing inequality. Further, neoliberal transformations in government displace responsibility for public health and welfare from public to private organizations. These developments have wide-ranging effects, including the constitution of new populations of “at-risk” or excluded citizen-subjects. Political theorist Nikolas Rose suggests, “[Neoliberalism] involves new conceptions of those who are to be governed, and of the proper relations between the governors and the governed. It puts new questions into play about the kinds of people we are, the kinds of problems we face, the kinds of relations of truth and power through which we are governed and through which we should govern ourselves” (Rose 1999, 188). Drawing on ethnographic research conducted between 1998 and 2004, this book places community health, a critically understudied area, at the center of analyses of contemporary transformations in governing.

As localities assume more and more responsibility for ensuring the public health, identity politics play an increasing yet largely unexamined role in public attitudes and policies. At the same time, the notion of “community” expands its previous meanings of territory and identity to become a central construct in governing (Creed 2006a). My analysis focuses not so much on the motives or understandings of individuals in government but rather on the disciplinary forms of knowledge and practice through which government is carried out—“the bodies of knowledge, belief, and opinion in which we are immersed” (Dean 1999, 16). In particular, I am concerned with the field of public health as an assemblage (Collier and Ong 2005) dedicated to the maintenance and promotion of a healthy population. Governing a healthy population takes place through a range of practices, including biomedical care, individual behaviors, and collective action. As a hybrid field combining elements of public health, medicine, and social medicine, community health brings to bear a special concern for the well-being of urban, poor, and minority populations. Community health research such as the HIV transmission study in which Dave Wood



Alleys shelter injection drug users from prying eyes. (*Photograph courtesy of Amanda Quinby.*)

participated helps designate those marginalized populations, identities, and subject-positions occupied by their members.

Focusing on struggles over community health and health care in an age of neoliberalism, the three case studies presented in the two parts that follow examine the relationship between governing and the formation of politicized identities in the United States. Centered on the needs, demands, and concerns of the poor and marginalized, community health practitioners and researchers often find themselves engaged in highly politically and ethically charged activities, such as documenting the struggles of a woman addicted to heroin to locate a drug treatment program willing to accept her public health insurance as well as someone to care for her children while she detoxes. Struggles and debates over community health are shaped by larger contestations among individuals, organizations, and state actors over the meanings of cultural difference, morality, and justice. As groups lobby for more resources dedicated to African American health issues, for example, or debate the best way to prevent HIV in their communities, they take part in contestation over the art and practice of government.

This book presents a series of case studies—including a community health outreach program for women on welfare, online developments in

culturally appropriate health care, and community debates over HIV prevention programs for IDUs—to analyze struggles around community health, governance, citizenship, and identity formation. In three related research projects conducted over six years, diverse actors make claims on the state as they strive to implement their visions of the social good and how the “conduct of conduct” (Foucault 1991) should be managed. Each study investigates the way that subject-positions are articulated through the structures, discourses, and practices of community health. I show practical examples of how community and cultural difference have come to function as new terrains of government, topographies that are traversed by variously positioned actors whose agendas often seem to head in different directions. This chapter briefly explores the political and epistemological challenges in conducting engaged, ethnographic community health research. I then outline how I came to be involved in each of the three projects, before giving an overview of the arguments presented in the chapters that follow.

The Politics of Ethnographic Knowledge and Practice

Activists must operate in an always uncomfortable space marked out on the one side by their will to bring about social justice and on the other side by their knowledge of their distance from those they support. —Andrew Metcalfe, “Living in a Clinic”

Ethical questions about the anthropologist’s role, her relationships with her subjects, and shared social or political concerns are raised in particularly vivid terms by the experience of doing research in nonprofit settings, which often call for some form of pragmatic support or involvement by an ethnographer (Lyon-Callo 2004; D. Davis 2006; Hemment 2007). Research in impoverished settings in the United States frequently brings the ethnographer into contact with other disciplines such as health care, social work, or the law in ways that complicate the meaning of ethnographic fieldwork (O’Neil, Reading, and Leader 1998; Bourgois 1995). The possibility of ongoing working or personal relationships following fieldwork introduces opportunities for reciprocation and obligation in the ethnographer-subject relationship (Brettell 1993; Benjamin 1999; Weston 1991). For example, on the basis of participatory action research she undertook with a feminist group in Russia, Julie Hemment (2007) argues that ethnographic engagement not only deepens one’s understanding of the exigencies that shape action but demands reflexivity as well. Like Hemment, I shared critiques of oppression and marginalization and goals of empowerment with the program staff I studied. In some instances this pushed me to take on more responsibility than was feasible, or effective.

Fieldwork is the practice of turning colors, chameleon-like, to suit one’s environment, so the self that is extended bears only a certain resemblance

to other selves that are performed in other parts of daily life. The critical junctures that arise from becoming vulnerable through interactions with others reveal in stark contrast the contradictions and occasional alliances between research goals, reciprocity, and obligation. Forming relationships with people with whom we do research implicates us in their goals and agendas. This was nowhere more evident than in the phrase Nikki Sparrow, my closest coworker at Thornton Community Health Center (TCHC) during my dissertation research, would use when she wanted my help with something: “Let me borrow your brain.” John Caughey recommends, “I suggest that in studying any aspect of the culture we are personally involved in we should make explicit, systematic, rigorous use of our experiences” (1986, 242). I try to do the same here.

In her well-known essay “How Methodology Bleeds into Daily Life,” Rayna Rapp observes that “working ‘at home’ has methodological, ethical, and interpretive consequences that would have been hard to foresee from the places I was initially trained to explore as an anthropologist” (1999, 16). Since then, our thoughts about what constitutes “home” have changed dramatically (B. Williams 1995; diLeonardo 2006) as the possible sites of home expand and as more and more anthropologists situate their work in the United States. Many politically engaged anthropologists (e.g., Lyon-Callos and Hyatt 2003) conduct ethnography in nonprofit and community-based organizations with which we share political, social, or economic goals.² We support the aims of such groups at the same time that they form our ethnographic subjects of study. As allies, and as ethnographers committed to the idea of “giving back,” we commit our passion, time, energy, and expertise to supporting the aims such groups were established to meet, while remaining attentive to the unique epistemological privileges and costs of this engagement (Hemment 2007; Lassiter 2005).

I conducted most of the ethnographic fieldwork presented in these case studies in Thornton, a small New England rust-belt city whose population in the 2000 census was at least 21 percent African American and 27 percent Hispanic (predominantly Puerto Rican). In 1999, almost one-quarter of its residents lived below the federal poverty level. The burdens of poverty are not equally distributed, however: more than five times as many Latinos (42 percent) and three times as many African Americans (27 percent) as whites (8.2 percent) lived in poverty in 1999 (Harvard School of Public Health 2009). My research was concentrated in three neighborhoods that make up Thornton’s “inner city.” These neighborhoods—Williamsburg,

2. A large literature in anthropological methods and ethics proposes and critiques various engaged approaches to ethnographic research, including participatory, action, public, and radical anthropology (Polgar 1979; D. Davis 2006; Forman 1995; Lyon-Callos 2004; Singer 1993, 1994b). These and many other authors outline a diversity of ways to support the liberatory aims of people we study.

Brighton Square, and Nobb Hill—share high levels of unemployment, poverty, segregation, an expansion of the informal economy, and the retrenchment of public services, a combination of factors Allen Feldman (2001) terms “advanced marginality.”³

The Williamsburg area is the historical center of Thornton’s African American community, a tight-knit neighborhood that is home to a politically powerful African American middle class, several mosques, a sizable Caribbean population, and a small historic home district. In the early twentieth century, Brighton Square metamorphosed from an Italian American immigrant neighborhood to a working- to middle-class African American neighborhood. Many of these African American families were relocated in the 1960s when urban renewal brought freeways directly through their previously prosperous neighborhood. As part of this demographic transition, more recently arrived Puerto Ricans from New York, New Haven, or other, poorer sections of Thornton moved into the vacated housing, taking advantage of cheap rents and higher-quality housing stock. In contrast to Nobb Hill’s very transient Puerto Rican population, Latinos in Brighton Square remained and built a number of stable and successful community organizations.

Nobb Hill, a neighborhood completing its conversion from Italian American to Puerto Rican residents, is home to TCHC, a federally funded clinic that sponsored the Community Health Advocate (CHA) program discussed in Chapters 2 and 3. The patient population at TCHC was nearly evenly divided among African Americans, Latinos (over 85 percent of whom were Puerto Rican), and Russian and Vietnamese immigrants at the time of my research. The health center offered bilingual practitioners and a full complement of medical translators. All signs in the health center were posted in at least four languages: English, Spanish, Russian, and Vietnamese. A disproportionately large (relative to population) percentage of patients were Russian and Vietnamese because Thornton was a refugee resettlement area and TCHC had a contract with the state to provide refugee health assessments.

I came to Thornton beginning in 1998, when I was searching for a site for my dissertation fieldwork. I was choosing between two very different community health centers. Both were located in small Massachusetts cities that exemplified conditions of advanced marginalization, but one clinic was decades old while the other, TCHC, was more recently established. One site was ethnically homogenous, while the other served a diverse immigrant population. I was intrigued by the possibilities and challenges inherent in the concept of developing a health center “by and for the community” when “the community” was made up of so many diverse groups,

3. As explored in Part II, these neighborhoods also share a strong association in the local media with drug use, HIV, and minority populations.

and I chose to study TCHC. Because the CHA program, the subject of Chapters 2 and 3, was just getting underway at the time I started my fieldwork, the executive director suggested that I take that program as my particular focus (though he granted me full access to all parts of the clinic except doctor-patient clinical encounters).

Without its own building throughout the duration of my fieldwork, TCHC occupies a series of rented spaces in the Nobb Hill section of Thornton. The clinic is a warren of low-slung, single-story offices on a street that seems to be continually undergoing redevelopment. Administrative; Women, Infants, and Children (WIC); and outreach staff work across the street in an office building that also houses many attorneys-at-law. The pragmatic and symbolic divide between these functions of the organization represented by the busy main street of Thornton loomed large throughout my fieldwork. Clinical staff typically did not socialize with administrative, WIC, or outreach staff, who generally did not understand the work performed by their colleagues across the street. Especially at the beginning of my fieldwork, many habits and systems of work at the clinic were in the process of being developed, and the gaps and affiliations illustrated by this spatial divide proved significant for years to come.

Questions of reciprocity and obligation became increasingly salient as my dissertation fieldwork progressed. Over time my participant-observation research became more and more participatory as I began to assume some of the responsibilities of coordinating the CHA program. I was torn between the desire to provide pragmatic help and the desire to maintain my freedom and some semblance of distance. When the health promotion unit head, Nikki Sparrow, asked me if I would be willing to work for the health center as the part-time coordinator for the CHA program, I realized where my boundaries lay in terms of involvement. While I may have been taking on some parts of the job, to be an actual staff person at the health center would have represented a significant change in my role. Being directly and personally implicated in TCHC's structures of accountability would have dramatically altered my relationships with the lead health educator, health advocates, and other program coordinators, a change I ultimately could not accept. Despite this decision, however, as time passed my field notes increasingly began to open with to-do lists, and "things to do" would crowd the margins. I took on prosaic responsibilities such as providing transportation for CHAs to distant, off-site training. I saw these tasks as opportunities for spending time with participants in different venues—but once I committed to help, it became a responsibility all the same.

In an effort to protect research participants from further public scrutiny, ethnographers often work to conceal the identities and even the locations of the people we write about (Brettell 1993; Apter et al. 2009; A. Stein 2010). When we discussed the politics and possibilities of anonymity for

TCHC in any published work that might result from my research, TCHC's executive director at the time I began my dissertation fieldwork confidently assured me that I was welcome to name the organization, perhaps because he imagined this would lead to greater recognition for its achievements. Despite this, I have elected to change the names of all individuals, organizations, and locations in keeping with anthropological convention. However, unique features of Massachusetts law shaped the parameters of my fieldwork and must therefore be included here. Massachusetts state laws prefigured later federal developments on at least two occasions that are relevant to this story. Massachusetts passed a version of welfare reform several years before the 1996 federal welfare reform law was passed. In contrast, Massachusetts was an anomaly in HIV prevention policy for many years, remaining one of only a handful of states that prohibited the sale of syringes over the counter until 2006. Further, a critical element of the story told in Chapter 6 concerns the Massachusetts law requiring syringe exchange programs (SEPs) to obtain "local approval," pushing responsibility onto localities as a means of protecting state legislators from the wrath of syringe exchange opponents. I proceed with this strategy of anonymization with some uncertainty but with the hope that it offers the best solution to the need to account for relevant context while respecting the privacy of people and organizations who shared their professional and personal lives with me.

"Empowering" Community Health Advocates

The CHA program discussed in Part II was developed as a form of "radical health education" (Minkler 1992; Minkler and Wallerstein 1997) to foster greater self-determination among those who are the "targets" of health and social programs (Gastaldo 1997). Similar to the aims of some activist anthropologists (Lyon-Callo 2004), radical health education seeks to overturn what they see as the oppressive power relations inherent in traditional research in favor of a more committed, cooperative, and participatory approach to public health and research (see, e.g., Harrison 1991; Park 1993; Polgar 1979). Likewise, the cultural competency proponents presented in Chapter 4 see themselves as activists in the movement to bring social justice and antiracist education to the field of health care.

I shared many of the goals of the CHA program designers, Mercedes Cota and Niara Kadar, two community health organizers who together facilitated the six-week-long participatory training for new CHAs. They sought to provide resources for low-income African American and Latina women to become agents of change for their communities, using health disparities as the fulcrum with which to mobilize others. Especially at the beginning of my fieldwork, I supported both the aims and the model of the CHA program, which made it even easier to become fully immersed in

its nuts-and-bolts operations. I tried to imagine how my ongoing fieldwork could be used to support the program and advance its aims. Implementing the CHA program brought a plethora of difficulties once the health advocates completed their training and started work at their respective agencies, however, as Viviana's experiences illustrate.

While many women whom we tried to recruit for the program wanted nothing more than regular, middle-class, or professional jobs that paid them a living wage so they could provide for their families, others seemed excited by the opportunity to be a CHA. For many, it was their first chance to relate to others in a supportive pedagogical environment. For instance, on the second or third day of the training, I overheard Viviana repeating to herself, "I love this. I love this," as she sat next to me. Viviana was the only Puerto Rican participant in our class of about twenty African American and Caribbean American participants. As a fully bilingual Spanish speaker, she was a valuable asset to the outreach team for TCHC who would be working in predominantly Puerto Rican neighborhoods. I got to know her well on the thirty-minute drive to and from the training each day. As outsiders together we formed a kind of alliance in the training, either sitting next to each other or else grouped together by other participants. In some ways Viviana relished her difference from the others, expounding at length on Puerto Rican culture and traditions. At other times she asserted a shared identity with other participants as people of color, saying, "I'm Spanish, but I'm black inside." Her efforts in establishing this kind of solidarity were met with bemused acceptance by African American participants. Everyone agreed on her nickname, "the Mayor," because she greeted everybody by name and with a handshake daily. Viviana's early penchant for this kind of participation led to her eventual departure from the program for a better job, because the health center was too disorganized to give her satisfying work and because—since she was no longer a welfare recipient—the part-time work did not pay her a living wage.

At TCHC, Viviana was among the most vocal critics of the health center's failure to provide appropriate accommodations for the CHAs. While she often helped try to smooth over the grumblings of other participants, her eventual defection for a secretarial job in the housing office of her Section 8 building marked both a success of the program (in moving a former welfare recipient into stable, full-time work) and its failure to accommodate and build on Viviana's genuine efforts to help others. She showed a flair for the role of advocate as she accosted people on the street and helped them negotiate the bureaucracies of Medicaid, and I was almost as disappointed as she was by our failure to keep her. Programs such as the CHA program do have an obligation to the people they recruit, an obligation to leave them better off, in some way, than when they began—and yet so many programs (and researchers) fail to meet these obligations, for

many reasons.⁴ Funding for the CHA program ended, some CHAs were hired into other positions at TCHC, and the clinic itself entered a phase of fiscal crisis accompanied by widespread layoffs and reorganization. I still ponder how or whether the research presented here was able to forward the CHA program's aims, though my next two Thornton research studies, focused on HIV risk among IDUs, provided more concrete ways to contribute to policy debates that emerged around community health programs. Concurrently, however, I continued another small research project focused on culturally appropriate health care.

Producing and Addressing Differences in the Clinic

The production, reproduction, and dissemination of new formulations of ethnic and racial identities through discussions in the clinic about how to provide more culturally appropriate health care drove me to seek out other domains in which ethnic and cultural difference is produced in medical encounters. Online efforts to develop culturally appropriate health care respond to the same problems of *difference* and *distance* addressed by the lay health outreach worker program presented in Chapters 2 and 3. I was introduced to the Culture and Health e-mail discussion list, which forms the basis of material analyzed in Chapter 4, when a colleague forwarded me a message from the list. The Culture and Health list unites participants from all over the world to disseminate marginalized forms of expertise that have been mobilized as ethical-political solutions to the "problem" of cultural difference in health care. A moderator screens messages and posts them to the list and subscribes individuals. Reflecting expanding interest in topics of culture and health across public health and the health professions, the number of subscribers to Culture and Health has grown steadily; when I first subscribed in 2003, the list reached about two hundred members, while in 2007 the moderator announced that she had signed up the one thousandth list member, and in 2010 that number was nearing two thousand subscribers. Those who post to the list tend to be health care administrators who have been assigned responsibility for handling issues related to "cultural diversity," such as medical interpreters, or for ensuring compliance with federal regulations. A few nursing academics, medical anthropologists, and cultural competence "experts" who seek to share expertise and market their services also post regularly. I also explored the

4. In *The Will to Improve*, Tanya Li outlines the often-unintended consequences of improvement programs carried out in colonial and postcolonial circumstances (Li 2007), including the seeding of new "problems" that later serve as justifications for further improvement programs. Kate Crehan (2006) points out the broad similarities between the language used in domestic U.S. urban redevelopment and international development literatures. These broad patterns are explored further in Part I, particularly around themes of empowerment, responsibility, and participation.

online training modules and curricula through which “cultural expertise” is transmitted and shared from trainers and administrators to health care providers themselves. The first time I presented this work as a lecture, audience members urged me to seek out sites where cultural competence trainers, administrators, and other health care workers meet in person, to supplement my analysis of the online posts with observations of face-to-face encounters. So I attended several conferences and training sessions devoted to topics related to culturally appropriate health care.

Around this time, I was invited to contribute a guest lecture on cultural competence to an online gerontology course on health literacy. I hesitated—since much of my work on cultural competence had involved critiquing the oversimplifications and subject-producing effects of cultural competence discourse and interventions, I was not sure it made sense to be actively involved in producing and disseminating such knowledge, even in a seemingly innocuous setting like this. When I discussed the invitation with my partner, she pointed out that this would provide another opportunity for participant-observation research and that I might be able to learn more by taking part in the production and circulation of cultural competence knowledge.

I created PowerPoint slides and a digital audio recording of a lecture that outlined anthropological understandings of culture and explanatory models of illness (including biomedical explanatory models) and presented overviews of several approaches to cultural competence (see Chapter 4). Students were required to write brief essays responding to the assigned readings and my lecture and, in a subsequent online discussion, to apply concepts from the lecture or readings to their own experiences as either employees or students. Many students were enrolled a pharmacy program, bringing several years’ experience working as pharmacy techs in retail pharmacies in Tucson and elsewhere. Their online comments about these experiences etched in sharp relief the inequalities of access that drive cultural competence educators to redouble their efforts. Students described trying to communicate across language gaps using “hand gestures,” “facial expressions,” and “hoping for the best.” Impromptu interpreters that students reported recruiting to help them communicate with their customers included “an employee who may be working in the cosmetics department,” other customers, or a patient’s son or daughter. While members of the Culture and Health list and participants in cultural competence conferences often use similar stories of gaps in care to ground their claims for cultural competence interventions, these vivid cases of substandard access to medication information related by students (who thought they were doing an adequate job of delivering care) nonetheless shocked me, illustrating yet again what poor care passes as sufficient for linguistic minorities in the United States.

Putting together a forty-five-minute lecture, delivered online to students I would never meet, did help me appreciate the frustration that cultural competence trainers frequently vent on the Culture and Health list about the challenge of reducing complex concepts such as cultural difference to sound bites delivered with the intention of improving care. I was concerned about the oversimplifications I presented in my lecture, and yet, as became clearer to me only after the task was completed, the problems I sought to address are real.⁵ This tension between the inadequacy of remedies (which are themselves plagued by a raft of unintended consequences) and the profound gaps in quality of health care for the poor and marginalized animates all the case studies discussed here.

Illicit Drug Use, HIV Prevention, and Marginalization

I returned to Thornton after an absence of about three years as an ethnographer with the Hispanic Health Council in Hartford, Connecticut. Resuming fieldwork in Thornton, as part of a three-city study on HIV risk and injection drug use, I was dismayed to discover that little had changed during my absence. The “roaring Nineties” seemed to have bypassed the city altogether. Abortive redevelopment projects would occasionally install new facades on downtown music venues or restaurants, but a year later the spaces usually stood empty. TCHC struggled with declining Medicaid reimbursements and changes associated with Massachusetts’s own welfare reform and health insurance reform laws (which eliminated the state’s “Free Care” pool, which safety-net health care providers used to reimburse themselves for care they provided to the uninsured). The clinic teetered between the brink of disaster and winning accolades for its innovative health promotion work conducted on shoestring budgets by dedicated staff members. Staff turnover continued apace, such that ten years later almost none of the original staff members I met during my dissertation fieldwork are still employed there.

Between 2001 and 2003 I worked as an ethnographer based at Thornton Community Health Center and at the Brighton Square Community Health Coalition (a group of health care and other service providers that was also active in the CHA program), where I worked closely with two outreach workers. Though employed by the Hispanic Health Council, I was the Thornton site ethnographer for the Syringe Access project, a study of syringe-related HIV risk funded by the National Institutes of Health. Ethnographers and outreach workers for the Syringe Access study were also

5. As a development worker said to ethnographer Tanya Li after she outlined her critique of development programs in Indonesia, “You may be right, but we still have to do something. We can’t just give up” (Li 2007, 2).

based in each of the two Connecticut research sites, with support and coordination provided by the Hispanic Health Council and investigators at Yale University and the University of Massachusetts. Much of the ethnography presented in Chapter 5 was completed with the support of that project.⁶

As an ethnographer for a study of HIV risk among IDUs, I became better acquainted with the fragile, tenuous connection between primary health care and behavioral and mental health resources for the poor and underserved. Public debates on drug use and HIV, which reached a fever pitch during my 1998 fieldwork with the citywide referendum that defeated syringe exchange, continued as public health advocates pressed for prevention programs while opponents dug in and marshaled their objections (Shaw 2006). AIDS activists had struggled for years to open an SEP to prevent HIV among IDUs in Thornton, where 52 percent of new AIDS cases were attributable to injection drug use in 2001 (MDPH 2001). SEP advocates failed to mobilize the active support of African American voters, many of whom see substance abuse (and HIV infection) as an important index of their community's marginalization (Shaw 2006).

To learn more about why such diverse groups opposed syringe exchange so vehemently, I developed a small study of community attitudes toward syringe exchange, drawing on both household survey and ethnographic methods.⁷ With a team of community interviewers, my collaborators and I completed door-to-door surveys in English and Spanish. I also conducted participant-observation research with syringe exchange organizations in Connecticut, which faced their own budget cuts, local opposition, and other organizational challenges.

I was invited to present findings from this research in public hearings at both the local and state level. Most of the African American and Latino residents we interviewed supported syringe exchange to prevent HIV infection, while opponents were more likely to be white and suburban. This data also supported arguments for neighborhood-based representation on the Thornton City Council instead of the at-large system used for forty years, since the white-majority city council had repeatedly opposed syringe exchange while most residents of Thornton's inner city favored it (see Chapter 6). Research I conducted with harm reduction programs portrayed in Chapters 5 and 6 was based both in Thornton and at several area SEPs, and it continued throughout both the Syringe Access project and the Community Attitudes study. My interviews for that study were completed between 2001 and 2005 with IDUs in Thornton's three "inner city" neighborhoods, as well as with staff from area SEPs.

6. The project was funded by the National Institute on Drug Abuse (R01 DA12569, Merrill Singer, Principal Investigator).

7. The study was funded by the National Institute on Drug Abuse (R03 DA16532, Susan Shaw, Principal Investigator).

Project Overview

This book unites theoretical analyses of the relationship between government and citizens with clinic-based and community studies of on-the-ground struggles over the meaning of cultural difference, ethnicity, and belonging among diverse communities in urban Thornton, Massachusetts. Chapter 1 provides a theoretical overview of the major concepts that run throughout the book. Part I, “Technologies of Citizenship and Difference” (Chapters 2 to 4), explores a range of social, practical, and electronic technologies that mediate subjects’ relationships with health care organizations and the state, including the CHA program, which trained low-income women of color to serve as public health outreach workers, and the emergence of cultural competency programs as ethical-political solutions to the “problem” of cultural difference in health care. CHAs were to serve as bridges between underserved communities and the community health agencies that employed them, engaging residents in a process of community empowerment. Women on welfare who enrolled in this program began a course of self-fashioning that started with participatory education for “empowerment” and closed with the habits and skills necessary for the “world of work” when the program began to receive federal Welfare-to-Work (WtW) funding midway through my fieldwork. Chapter 2, “Community Health Advocates: The Professionalization of ‘Like Helping Like,’” describes a Freirean training for low-income women of color to serve as outreach workers in underserved neighborhoods. I trace the ways in which “community” was mobilized throughout this program and produced as a sign with meanings of nonprofessional authenticity (similar to street credibility), ethnic identity, and contradictory implications of marginalization and belonging. In the CHA program, notions of community are linked to ethnicity through technical and administrative practices, as well as through community organizing efforts that function as practices of identity.

Chapter 3, “Neoliberalism at Work: Contemporary Scenarios of Governmental Reforms in Public Health and Social Work,” outlines the transformations that the CHA program underwent when it received WtW funding to support CHA salaries. Aimed at creating productive citizens, Massachusetts’s welfare reform law specified a new population, the “hardest to serve,” and sought to use community empowerment to move them from dependency to self-sufficiency. The WtW program instituted new governing relationships and disciplinary practices that were designed to transform welfare recipients. Participation in the WtW program made Thornton Community Health Center and its partner agencies subject to the discipline of the state in new ways as well.

These themes of the management of difference through community health are also addressed in the second case study in Part I. Chapter 4,

“Technologies of Culturally Appropriate Health Care,” explores the development and dissemination of cultural expertise to health professionals through online media, drawing on five years of contributions to an e-mail discussion list on culturally appropriate health care and on participant-observation research at conferences and trainings. As minority advocacy groups and others seek to make health care more inclusive, new interventions are being developed to reform health care and expand the regimes of knowledge that are available to health care providers. An emerging “cultural competence” industry generates and distributes specialized social expertise using online media to teach health care providers how best to respond to “cultural difference” in clinical encounters. In many public health and primary care settings, outreach workers are used to reach those whose cultural difference is assumed to keep them *out* of the clinic (making them “hard to serve”), while trainings for physicians are meant to help them deal more effectively with cultural differences in clinical encounters. Both types of programs have the simultaneous effect of *producing* new understandings of difference as they strive to negotiate and resolve it. Further, culturally appropriate health care aims to eliminate health disparities by governing the conduct of both medical professionals and patients.

Part II of the book, “Technologies of Prevention and Boundaries of Citizenship: Drug Use, Research, and Public Health,” explores another dimension of community health: that focused on substance abuse and HIV prevention. Part II features ethnographic research I conducted between 2001 and 2004 with injection drug users (IDUs) to investigate the intersections among community health research and the formation of identities and populations. Chapter 5, “‘I Always Use Bleach’: The Production and Circulation of Risk and Norms in Drug Research,” traces the circulation of “harm reduction” discourse through researchers’ interactions with drug users. Harm reduction is a pragmatic approach designed by drug users themselves aimed at reducing the negative health and social effects of drug use through modest interventions in drug use behaviors (Marlatt 1996). In the wake of the HIV/AIDS epidemic, harm reduction activists focused on reducing the risk of HIV transmission through contaminated injection equipment. Their practices and pedagogy were influenced by findings from sympathetic drug researchers whose work helped shape new norms of drug-using behavior. Carrying out state-funded drug ethnographies places researchers in the position of *representing* to IDUs these principles of HIV risk reduction (for example, “don’t share syringes”), in relation to which drug users locate their own practices to establish themselves as ethical subjects if not citizens.

In Thornton, AIDS activists have struggled for years without success to open a SEP to prevent HIV among IDUs. Syringe exchange, explored in Chapter 6, “Syringe Exchange as a Practice of Governing,” is a hotly contested practice that enacts both the state’s and the public’s ambivalent

relationship with drug use and drug users. Harm reduction practices, like other public health and primary care programs, work to manage populations by serving them through a range of specific accounting practices. Organizations rely on a variety of techniques, from tagged syringes to one-for-one exchanges to mass distribution programs, to regulate the circulation of and access to syringes with a range of effects on staff, users, and public perceptions of the role and purpose of syringe exchange as a technology for HIV prevention.

As with other terrains of social life such as welfare and sexuality, community health is implicated in questions of government in complex ways. Public health institutions seek to redistribute health care and mobilize other techniques of government that engage individual citizens by weaving together concepts of identity and difference into the notion of “community” as a terrain of government. As communities mobilize health statistics to support their political arguments and demands, however, their voices are being articulated in a political environment that is increasingly governed by neoliberal thought—an environment whose dominant rationality relies on the logic of a competitive marketplace in addition to, or perhaps even instead of, claims of justice.