



The inclusion of international migrants in Brazilian healthcare system policies: the case of Haitians in the state of Amazonas

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Abstract

A wave of Haitian immigration into Brazil began in February 2010 through three northern border states: Acre, Rondônia, and Amazonas. Focusing on the state of Amazonas, the article uses an ethnographic approach to explore the social networks involved in this immigrant issue and examines how Brazil's Sistema Único de Saúde (SUS) responded to the demands placed by this unexpected contingent of new users vis-à-vis the system's guiding constitutional principles, particularly equity. A picture is painted of some aspects of the most critical immigration period (March 2010-March 2012) and of the public healthcare system's reception of these Haitian newcomers.

Keywords: Sistema Único de Saúde (SUS); international migration; Haiti; Amazonas; universal access.

More than two decades after establishment of Brazil's Unified Health System (Sistema Único de Saúde, SUS), there are still challenges to enforcing the system's guiding constitutional principles of universal access, integrality, and equity. Major obstacles include: the inequalities that reinforce skewed income distribution patterns among Brazilian states and municipalities, the concentration of services in major cities, and the loss of resources that occurs when funds are misused, either because of corruption or of mismanagement (the latter a product of both unskilled managers and bureaucratic overload). If these principles are to be effectively enforced, we must recognize that some social groups come up against more barriers than others in accessing health services. Authors like Coimbra and Santos (2000) have laid bare the deep ties between health indicators like morbimortality and the variables of ethnicity and race (understood here not in the biological but in the social sense), factors underlying social and public health exclusion.

International immigrants constitute one of the groups whose access to health services in Brazil is guaranteed under the Constitution but is nevertheless hampered by a series of structural factors. In social and economic terms, immigrants are generally more vulnerable, especially as newcomers; they more readily agree to work unhealthy jobs, at lower wages, and to reside in precarious dwellings. This boosts the risk of malnutrition, occupational illness, and infectious diseases like tuberculosis, hepatitis, and HIV, as well as psychosocial disorders stemming from social changes and familial separation, such as depression, alcoholism, and drug abuse (Carballo, Nerukar, 2001; Ramos, 2009). Article 5 of the Brazilian Constitution provides for legal equality between Brazilians and foreign residents of Brazil, thereby assuring that immigrants also have access to the benefits of public health policies. However, many factors interfere during the long journey that separates an individual from receipt of healthcare services, as shown by Waldman (2011), who noted that Bolivian migrants in São Paulo use available health services much less often than the rest of the population. Cultural and linguistic differences can be a source of stigmatization in host countries and the social vulnerability derived from an indeterminate citizenship status acts as a barrier when accessing the healthcare system. Likewise hampering integration is the fact that healthcare systems differ across countries, so a migrant faces new, unfamiliar rules and routines (Castañeda, 2010).

This article explores how the SUS responded to the demands placed by an unexpected contingent of new users vis-à-vis the principles underpinning the system, especially that of equity. My focus is on the wave of Haitian immigration into Brazil that began in February 2010 through three northern states: Acre, Rondônia, and Amazonas. Spotlighting Amazonas, I describe some aspects of the most critical period of immigration (March 2010-March 2012) and the SUS's reception of some 6,000 people who fled social disruption in their own country and arrived in Brazil between January 2010 and June 2012.

As newly arrived black immigrants who did not have a permanent residence visa and who spoke a foreign language (French and/or Creole), these Haitians constituted a particularly challenging social group for the SUS. Added to all other related factors were the problems inherent to the public health system in the Amazon region, including an uncoordinated disarray of actors, a dearth of resources at healthcare facilities in border regions, and a lack of efficacious health surveillance policies in the same regions (Silva Neto, 2010); further, providers at times displayed discriminatory or contemptuous attitudes towards the new users.

Subject approach

My methodology was guided primarily by the ethnographic method and its key tools, like participant observation, which is based on the idea that interactions between researchers and research subjects can capture the latter's subjectivity. In the field of health policy, this is extremely useful when exploring the complexity of social orders, something document analysis alone would fail to reveal. Participant observation makes researchers part of the daily lives of the human groups they intend to study and helps "links facts to their representations and to the contradictions between laws and their implementation, through the very contradictions experienced during the group's daily lives" (Minayo, 2001, p.146). Social network methodology was also used to reach the key actors. In the words of Bott (1976, p.299-302; emphasis in original):

A network is defined as all or some social units (individuals or groups) with whom a given individual or group has contact ... a personal network in which a focal node (ego) is in direct or indirect contact (through his or her interrelationships) with every other person inside the network. ... Generally speaking, the people indicated by the 'ego' suggest that others be sought out or make reference to important subjects within the sector, and in this way new 'informants' are steadily added.

I first approached the network involved with Haitian immigrants in Manaus in 2011 through the Catholic Church, which has been receiving them ever since the first waves arrived in 2010. Through these contacts, I became part of the network of social actors that addresses the issue of Haitians in Manaus, including therein municipal employees, nongovernmental organizations, and the Catholic Church, along with other religious denominations. In January 2012, I took an eight-day trip to Tabatinga to familiarize myself with the route traveled by Haitians when they enter Brazil through this municipality and to gain an overview of their situation upon arrival. My interactions with newcomers at Divino Espírito Santo parish were important to gaining a clearer understanding of their aspirations and challenges. I visited two healthcare facilities (one in Tabatinga and one in Manaus) as well as the army hospital in Tabatinga (Hospital de Guarnição do Exército). Supplementary interviews were conducted with eight people, including health managers in Manaus and Tabatinga, members of the clergy with ties to the Catholic Church's Pastoral Care for Migrants service, and members and leaders of humanitarian associations involved in assisting Haitians. I also attended two thematic seminars.

Data were further sourced from two questionnaires that profiled the immigrants. Posing basic questions about place of origin, marital status, profession, and so forth, one of these surveys was conducted by the Pastoral Care service (300 questionnaires in all) and the other (around 150 questionnaires) by the project "International migration, demographics, and health: an analysis of the living conditions of Haitians in Manaus," of which the current study is part. Clippings were also compiled from websites and newspapers in the state of Amazonas that carried news on the Haitian issue.

A bibliographic review of the topic of migration and transmigration informed my field observations and enhanced my understanding of the flux of Haitian migration. Nakamura (2011, p.102), referring to the use of the ethnographic method in health research, states that

“the reiteration and constant repositioning of the dialectic movement between field experience and adopted theories are fundamental to the rigor and validity of qualitative studies, which are grounded essentially in the relations established between empirical data and theoretical interpretations.” The effort to register these manifold sources and approaches in the relations between Haitians and the Brazilian healthcare system constitute a “dense description.” In this sense, according to Geertz (1989, p.7):

What the ethnographer is in fact faced with – except when (as, of course, he must do) he is pursuing the more automatized routines of data collection – is a multiplicity of complex conceptual structures, many of them superimposed upon or knotted into one another, which are at once strange, irregular, and inexplicit, and which he must contrive somehow first to grasp and then to render.

This study therefore examines the issue by approaching through a diversified network of actors: Haitian migrants, public health authorities, government agents, members of the media, healthcare providers, and nongovernmental partners. It depicts the views of this network and provides a dense examination of these various perceptions of the issue.

Nation, transnational migration, and health policies

Investigating the relation between migration and health means relying on conceptual tools that can adequately address the profound changes that have taken place in personal and government relations as communications, transportation, and the exchange of information, goods, and people have grown more dynamic in recent decades. The earlier theoretical framework used in earlier decades has fallen ever shorter of the mark in accounting for the complexity of the social processes entailed in new cross-border emigration flows for three reasons: it is grounded in an essentialist, crystallized view of culture; it sees interconnections between immigrants and their native lands as one-way streets (i.e., immigrants undergo change but are unable to influence the people or places that receive them); and it views the “assimilation” of immigrants as cemented and irrevocable.

From a political and geographic perspective, the concept of nation is increasingly meaningless, although it remains strong from an ideological angle. Wimmer and Schiller (2002) caution about contamination from the “methodological nationalism” that runs through many studies on migration, which consider national societies to be naturally given units of study rather than social constructs. What we observe are much broader, deeper phenomena involving the preservation of kinship, economic, religious, and emotional ties between those who migrate and those who remain behind. These have been pointed to as the most visible features of so-called “transnational migration” or “transmigration.” In the view of Glick-Schiller, Bash, Blanc-Szanton (1995, p.48), transmigrants are “immigrants whose daily lives depend on multiple and constant interconnections across international borders and whose public identities are configured in relationship to more than one nation-state.” This concept, which has greater theoretical merit than others that have been applied, will guide this examination of Haitian immigrants, whose lives after crossing the border are characterized by the preservation of kinship, cultural, financial, and emotional ties to their native countries.

As ever greater numbers of people have crossed international borders, a gamut of reactions have been felt in the political and administrative realms of host countries. One constant concern is the extension of basic rights to immigrants, especially the right to health care. Despite advances in the debate over basic human rights, led by supranational agencies like the United Nations (UN), the recent world economic crises and resurgence of far-right ideologies in Europe have made their impact felt through a certain backtracking in social policies and, more specifically, in healthcare policies for immigrants in various spots around the globe. The main target are precisely those who most need assistance: undocumented immigrants – those who have yet to succeed in fulfilling all required steps towards legalizing their status as citizens outside their native countries, requisites that vary from one place to another (Chauvin et al., 2009).

Even countries known for their humanist stances, like France, have implemented mechanisms that hinder an undocumented individual's access to the public healthcare system, thanks to pressure from far-right political parties (Constant, 2010). In Spain, immigrants have been blamed for the economic crisis and public debt, fostering a climate favorable to enactment of Royal Decree-Law 16 in 2012, which encumbers undocumented immigrants' access to services of medium- and high-complexity and resources like medication and prostheses by forcing them to pay an annual amount into the healthcare system; the law also put a number of other obstacles in place, such as the rule that immigrants are only eligible to join the national health insurance system after working one year on the formal labor market within Spanish territory (España, 24 abr. 2012). In the United States, despite the Affordable Care Act (ACA) pushed through by President Barack Obama in 2011, under which the federal government assumes certain responsibilities for expanding coverage and covering healthcare costs for the uninsured, the country has explicit legal restrictions on immigrant inclusion. Central among these is the Personal Responsibility and Work Opportunity Reconciliation Act, which dates from 1996; this law was not amended by the 2011 healthcare reform precisely because Congress made approval of the ACA contingent on its preservation (Castañeda, 2010, p.9).

Some studies have attempted to demystify the idea that immigrants impose an irremediable burden on the US healthcare system. Okie (2007) has warned that the obstacles put in place to hinder the access of undocumented immigrants can jeopardize the health of the entire population – for example, by decreasing overall vaccine coverage for children and pregnant women.

The debate about extending healthcare services to immigrants (whether documented or not) appears to swing between two poles. At one end, universal health care is considered a right and therefore an object of state intervention under any circumstances, even when foreigners are involved. At the other, guided by the logic of liberalism, the contributive dimension of social policies is prioritized and only those who contribute financially to the state are deemed legal subjects. Kullgren (2003) questions whether it is really advantageous for the state to limit healthcare coverage for immigrants, since this carries an even greater long-term onus in the form of lower primary care indicators and makes it harder to detect and contain exogenous illnesses that might spread among the public at large. In the Amazon – an endemic home to tropical vector-borne diseases like malaria, dengue, and hepatitis and

where Peruvians, Colombians, and Venezuelans constantly cross borders – the inclusion of immigrants is not only desirable but completely necessary and constitutes a key challenge for the health system (Silva Neto, 2010).

Transnational migration from Haiti and the choice of Brazil as a destination

There is extensive scholarship on the various flows of migrants out of Haiti, which can be grouped into three major waves starting in the 20th century. The first ran from the dawn of the century through 1935 and the second, from 1935 to 1965; the third began in 2005 and stepped up pace following the 2010 earthquake (Aglade, cited in Renois, 2010). Certain destinations are given preference in tune with the social context of each era, and some of these flows have been well documented, for example: within the Caribbean (Ferguson, 2003); towards the United States (Stepick, 1998); and towards Cuba. The latter is among the oldest destinations, dating to the expansion of the Caribbean sugar industry initiated in 1913 and fundamental to the construction of the Cuban identity (Couto, 2006).

Migration is a state matter in Haiti, where a specific ministry handles questions regarding expats. Created in 2004, the Ministry of Haitians Living Abroad (*Ministère des Haïtiens Vivant à l'Étranger*) took over the task of raising funds within the transnational Haitian community to help rebuild the country following the 2010 earthquake. In 2010, the minister said that Haitians living abroad were sending some two million dollars a year to assist relatives back home, which, in his words, made the Diaspora “indispensable to the reconstruction of Haiti” (Paraison, cited in Renois, 2010, p.36).

Although a significant number of Haitians immigrated to Brazil starting in 2010, this country is not among those with the greatest Haitian presence. Haitian geographer Georges Anglade (cited in Renois, 2010) compiled estimates on the number of Haitians residing around the world in what he declares to be a diasporic territory outside the borders of the country: Dominican Republic (750,000), Cuba (400,000), France (100,000), United States (2.5 million), Canada (352,000), Bahamas (50,000), Mexico (1,935), Africa (25,000 across a number of countries), Lesser Antilles (200,000), Guayanas (50,000), and Latin America (25,000). The landmark for Haitian immigration to Brazil was the earthquake of January 12, 2010 (7.3 on the Richter scale), which in 35 seconds struck a radius of roughly 25 kilometers in southwestern Haiti. The tremor devastated the country's most densely populated region, where cities like the capital of Port-au-Prince, Petitionville, and Jacmel are home to the majority of government agencies and departments and to universities and public services. It affected about 15% of the population and left a catastrophe in its wake: 220,000 dead, 300,000 wounded, and 1.3 million homeless. The country's already weakened infrastructure was also completely destroyed, aggravating a scenario of social problems that stems from political instability engendered by the US occupation that lasted nearly fifteen years, from 1915 to 1934; a series of coups d'état; natural disasters like hurricanes and earthquakes; and environmental havoc wreaked by predatory crops – combining to lend Haiti its reputation as the poorest country in Latin America (Dupuy, 2005).

Prior to 2010, Brazil did not number among the favorite destinations of Haitians. Brazilians previously knew very little about the country; news through the media was scarce

and superficial, generally reporting on the Brazilian Army's role as leader of the MINUSTAH force since 2004.¹ A survey conducted by the International Organization for Migration (Organização..., 2010) showed that from 1970 to 2000 the number of Haitians in Brazil never exceeded the 1980 figure of 127 – a situation that changed radically in 2010.

When Haitians were asked what motivated them to come to Brazil, they generally mentioned a speech given by former President Luis Inácio Lula da Silva when he was in Port-au-Prince in January 2010, shortly after the earthquake. The migrants reported that the former president offered support to the country, which would include shelter to those who migrated to Brazil. In conjunction with contact with Brazilian troops belonging to MINUSTAH, this prompted some of those who wanted to rebuild their lives outside Haiti to see Brazil as a possible destination. Haitians also have a great deal of affection for Brazil, mainly because of soccer, a very popular sport in their homeland. The Haitian migrants also emphasized Brazil's economic success; well informed in this regard, they mentioned the fact that the World Bank ranked Brazil as the eighth largest economy in 2001.

The first waves of immigrants arrived a few weeks after the earthquake. Air travel to São Paulo was only an option for those with a visa in hand when they left Port-au-Prince. For most, the road to Brazil was much longer: after leaving through the Dominican Republic, they would fly to Panama and from there usually continue by land or air to Ecuador and Peru, via the cities of Lima, Quito, and Santa Rosa or Iñapari. This twisted pathway was laid out by a network of “coyotes” that sprouted up in the months following the earthquake in Haiti and arranged the travels in exchange for payments ranging from \$2,500 to \$5,000 – a “package” that included travel, initial housing, and a job, as promised by some. Although this illusion seduced the earliest migrants in 2010, it was soon undone by the harsh reality they encountered. The Haitians reported cases of violence, theft, and rape on their way from Peru to Brazil.

Points of entry into Brazil were concentrated chiefly along the northern border, that is, the towns of Assis Brasil and Brasileia in Acre and Tabatinga in Amazonas. A significant number of those entering through Acre later traveled to Porto Velho, capital of Rondônia, transforming it into another center of Haitian immigration within this region (Pimentel, Cotinguiba, 2012). The presence of the Haitians altered the social setting in border towns and the state capitals of Manaus, Rio Branco, and Porto Velho, where the migrants began circulating in search of local jobs. Most tried to earn money so they could continue on to states in southeastern Brazil, particularly Rio de Janeiro and São Paulo, where they believed they would find more job opportunities. The Haitians like to present themselves as a people accustomed to work; indeed, this seems to be one of their strategies for reducing the bias encountered in migratory destinations. Things have been no different in Brazil, where the migrants often mentioned this characteristic in their discourse.

One of the stigmas attached to the Haitians is that they “spread disease.” This has been recurrent in other destination countries, like the United States, where they were considered a “risk group” during the height of the 1980s Aids epidemic (Santana, Dancy, 2000). Stigmatization of migrant populations is one of the cruelest aspects of modern geopolitics, making it even harder for these groups to attain citizenship status. In Amazonas, the press and even public health authorities proclaimed the Haitians to be “a menace” (Pedrosa, 1

fev. 2012; Rosseto, 8 fev. 2011). Alarming reports like these grew especially after the January 27, 2012, death of the first Haitian identified as a carrier of the Aids virus by the Tropical Medicine Foundation in Manaus (Lima, 26 jan. 2012, p.13).

The first organization to offer these immigrants some form of aid was the Catholic Church, which provided them with meals and lodging through its Pastoral Care for Migrants service and religious orders such as the Scalabrinians. Help came next from a network of small civil society organizations, led by Evangelical churches and ordinary citizens, including the Love Haiti Association (Associação Ama-Haiti), the Jesuit Service, and the Philadelphia Church Ministries International. In the first week of January 2012 alone, 133 newcomers arrived in Tabatinga, an influx that held steady through the end of that year. The response to this unexpected number of immigrants was to cobble together a minimal structure that never gained firmer shape, and the situation subsequently acquired tones of a humanitarian tragedy. Through its Technical Education Center (Centro de Ensino Técnico), the Amazonas state government arranged for immigrants to study Portuguese and computers; classes were held at parishes like the one in the neighborhood of Glória. The Municipal Department for Social Assistance (Secretaria Municipal de Assistência Social) also contributed some mattresses and foodstuff, but never enough.

Pressure was brought on the state government to do more to ameliorate the situation. Given the alleged invitation extended by then-president Da Silva, the governor said the federal government should be responsible for receiving the Haitians and sardonically suggested that they be settled in the housing units reserved for federal civil servants in Brasília (Brasil, 27 jan. 2012). The public balked at the governor's comments, prompting a response from the state itself, which became more pro-active. Amazonas established some services, which began with health assessment campaigns at sites set up to receive new arrivals; there, teams of doctors and nurses examined the immigrants and gave them rapid HIV tests. Still, these initiatives were sporadic and not adequately coordinated.

Doctors Without Borders maintained an emergency office in Amazonas from November 2011 to March 2012 to help strengthen the system. The group sponsored the distribution of hygiene kits to the Haitians in Tabatinga waiting for permission to travel; these included a plastic bucket, mosquito netting, a toothbrush, and personal hygiene products. On occasion, the NGO assisted the state health agencies of Amazonas and Manaus with initiatives to aid the Haitians and trained state and municipal healthcare providers in "Haitian culture," basic vocabulary, and treatment approaches. In early 2012, Primary Health Units (Unidades Básicas de Saúde/UBS) worked to register data on the Haitians. The Catholic Church set up a telephone line, staffed by a Haitian fluent in Portuguese, to help healthcare providers who were encountering problems caring for the Haitians, since the latter spoke mostly Creole and French and knew little Portuguese.

Fearful of social chaos in border towns and caving in to pressure from the media, the federal government closed Brazil's borders to Haitians on January 13, 2012, acting through the National Immigration Council (Conselho Nacional de Imigração). Under normative resolution no. 97, of January 12, 2012 (Brasil, 13 jan. 2012), Brazil began requiring Haitians to obtain a visa in their country of origin, an unprecedented move in the history of the country's international relations. In the days following resolution enactment, cities that

were stopping points on the path to Brazil – like Inãpari, Peru – grew packed with Haitians, and when the new norm went into effect, they had no way of entering the country. On the other hand, certain initiatives facilitated the permanent residence of those who managed to enter the country and represented important landmarks in the revision of Brazilian law on international migration. For example, the 2012 resolution provided for a new category: permanent residence on humanitarian grounds (a measure also adopted by Ecuador). Mexico and Chile – likewise destinations for Haitian immigrants during the same period – took similar steps, such as facilitating family reunification by allowing immigrants to bring their families to their host countries (Loudor, 5 jul. 2012).

Profile of Haitians in the state of Amazonas

Most Haitians who came to Brazil through Amazonas were from cities like Gonaïves, Jacmel, Port-au-Prince, Ganthier, Cap-Haïtien, or Croix-des-Bouquets, and most were men between the ages of 20 and 35. In other words, the profile of the Haitians who arrived in Porto Velho (Pimentel, Cotinguiba, 2012) did not differ from that of other national groups, such as Peruvians (Silva, 2012, p.262). From 2010 to 2012, the majority arrived through Tabatinga, along the border with the Colombian town of Letícia, where migrants stayed until the Brazilian Federal Police issued them a temporary visa allowing them to continue on to Manaus. Not everyone had enough money for the new leg of the journey, so many remained in Tabatinga for months, even after receiving their visas. While the Haitians were concentrated in neighborhoods like Portobrás and Ibirapuera in Tabatinga, their housing was scattered about in Manaus, where they were temporarily lodged in neighborhoods near the São Geraldo Parish church (São Geraldo and Centro) and later moved to rented houses spread across different neighborhoods, especially on the periphery.

The presence of some women was observed, most in the same age bracket as the men, though in substantially smaller proportions. A sample of 307 records on the Haitians who had arrived through mid-2011 and that was made available by the Pastoral Care for Migrants service in Manaus indicated that 86.5% were male and only 13.5% female.

The SUS and Haitians in Manaus

Manaus, capital of Amazonas, has a population of 1,832,423, according to the Brazilian Institute of Geography and Statistics (Instituto Brasileiro de Geografia e Estatística, IBGE). It is the seventh largest city in the country and concentrates most of the state's population, that is, 79.17% of its inhabitants, while only 20.83% reside in rural areas (IBGE, 2013). This is largely attributable to the fast-paced urban expansion that began in 1967, when the federal government created the Free Trade Zone, an industrial park based primarily on fiscal incentives.

Assistance in Manaus follows the SUS model in terms of organization and services and is organized according to level of complexity. Primary care falls to units within the program called Family Health Strategy (Estratégia Saúde da Família, ESF) and to Primary Health Units, while most medium- and high-complexity services, like exams and surgeries, are provided at surgical centers and hospitals. As an organizational model for primary care that prioritizes

prevention and promotes health and integrality, the Family Health Strategy program is the “gateway” to the SUS. ESF units serve a given geographic area, thereby forging ties with that community. The ESF sifts through demand to channel it to other levels of the system. It maintains 175 health posts in Manaus, built in strategic locations and equipped with healthcare teams comprising doctors, nurses, nutritionists, nursing assistants, and community health agents, among other professionals (Oliveira, Gonçalves, Pires, 2011, p.36).

In their discourse, public health authorities in Manaus voiced their greatest concern over the possibility that the presence of contaminated individuals might trigger a cholera (*Vibrio cholerae*) outbreak. Although the Caribbean has seen a number of outbreaks since the nineteenth century, no records indicate that *Vibrio cholerae* ever hit Haiti until 2010 (Jenson, Szabo, 2011), when the country suffered its first outbreak because members of the Nepalese military with the MINUSTAH force brought the infection from their own country and spread the *Vibrio* in one of the main rivers in the department of Artibonite. The situation was aggravated by administrative havoc in the aftermath of the earthquake. The United Nations hid from the public the fact that their troops had spread cholera, until a group of independent epidemiologists held a panel to analyze the situation and issued a report, edited by Craviotto (2010), which gives an account of the epidemic process (Piarroux et al., 2010).

Brazil experienced its most recent cholera outbreak in the 1990s, when an epidemic in Peru jumped the border and hit nearby towns like Tabatinga and Benjamin Constant; it reached Manaus in October 1991 and spread into the rest of the country that same year. Thanks to control efforts, the illness was eradicated and no outbreaks have been recorded since 2000, when a few cases were detected in the Northeast (Hofer, 1993). Since then, only isolated cases of individuals infected in other countries have been detected in Brazil.

The Central State Public Health Laboratory (Laboratório Central de Saúde Pública do Estado, LACEN), which until then conducted bacteriological exams to isolate *Vibrio cholerae* solely in Manaus, expanded the service to reach the Haitians arriving in Tabatinga and thus improve system response time in detecting cases. The cholera issue also played a role in defining the division of responsibilities between the state and municipalities, which followed the SUS organizational model. The state was charged with optimizing the organization of exams and rapid tests, while the municipality of Manaus was assigned to undertake initiatives to incorporate the Haitians into the system at the level of primary care and to foster treatment. One treatment initiative was undertaken at the Heitor Dourado Foundation for Tropical Medicine (Fundação de Medicina Tropical Heitor Dourado), an Amazonas state government agency where people with Aids, malaria, or dengue were sent for hospitalization.

The spread of filariasis was also singled out as a possible risk presented by the Haitians. Endemic in some tropical regions of Asia, Africa, and the Americas, human lymphatic filariasis is a parasitic infection caused by helminths of the species *Wuchereria bancrofti*, *Brugia malayi*, and *Brugia timori*. It represents a serious public health problem in China, India, Indonesia, and certain areas of Africa (Melrose, 2002). In the Americas, the disease is caused specifically by *W. bancrofti*, which was probably introduced by the slave trade during the colonial period, when the mosquito *Culex quinquefasciatus* offered an appropriate vector. Active foci of transmission are found in Haiti, the Dominican Republic, Guyana, and Brazil. Transmission has been halted in Costa Rica, Suriname, and Trinidad Tobago, where

the disease was endemic until some years ago. It is supposed that at least 600,000 of Haiti's estimated eight million inhabitants are infected with *W. bancrofti* (Rochars et al., 2004). In Brazil, a nationwide survey conducted in the 1950s detected autochthonous transmission in 11 cities: Manaus, Belém, São Luís, Recife, Maceio, Salvador, Castro Alves, Florianópolis, São José da Ponta Grossa, Barra de Laguna, and Porto Alegre. Distribution of this parasitosis is urban and sharply localized in Brazil and active transmission has only been detected in one region of Recife, where the disease is being monitored (Rocha, Fontes, 1998; Rawlinson et al., 2014).

Melrose (2002) places those afflicted with filaremia in three categories: endemic normals, who have microfilaria antibodies circulating in their blood but a low level of filaremia; asymptomatic microfilaremic carriers; and chronic carriers, who have filariasis but do not always develop the associated clinical symptoms. The most reliable method for detecting the disease is thus a peripheral blood smear, which checks for the presence of the microorganism in the infected blood. The parasites display "nocturnal periodicity" – that is, a greater concentration circulates in the blood between ten PM and two AM – and therefore some diagnostic tests, like the thick blood smear stained with Giemsa, are done during this time frame. The fact that Primary Health Units are closed during these hours was cited as one of the main barriers to conducting the test on Haitians. LACEN nevertheless collected 585 blood samples, of which 15 tested positive for filariasis (i.e., 2.6% of the total sample). By using exams like the immunochromatographic card test (ICT), samples can be drawn at any time and results obtained within ten minutes; however, since Amazonas had not been the focus of transmission for several years, no ICTs were available there (Arcanjo, 2012).

In addition to the challenge of conducting tests during the key time frame, other bottlenecks to monitoring for filariasis were cited: (1) The language barrier presented an obstacle, since the Haitian newcomers did not speak Portuguese, making it hard to convince them that the test was necessary. Additionally, the needle has a distinct meaning for some Haitians, since it is used in Vodou religious practices; invasive tests like blood draws are therefore an especially sensitive topic (this was reported by missionaries who accompanied Haitians to healthcare facilities). (2) Asymptomatic individuals often refused treatment. Admittedly, this problem does not occur solely with Haitians but also with other people who suffer from illnesses that present no clinical signs and who thus deem treatment unnecessary. (3) Since the disease has been eradicated, there was a dearth of trained technicians qualified to identify the microorganism.

Beyond the realm of tropical diseases, another issue that quickly drew the attention of healthcare agents in Manaus was the matter of pregnant Haitians. Although there were fewer women than men, the women enjoyed a different immigration status since they are eligible for a permanent visa if they have Brazilian children. Item I of article 113 of the Foreigner Statute (Estatuto de Estrangeiro; law no.6.815/1980) reduces the minimum residence period for obtaining a permanent visa to four years if an applicant's child has been born in Brazil. Some of the Haitian women who gave birth in Brazil were pregnant upon arrival, while others became pregnant afterward; most of them formed relationships with other Haitians after their arrival. Only rarely do couples travel together. Most men prefer to bring their families over only after they have settled in, while the majority of the women who travel alone are single. In January 2010, six children were born to Haitians at the army hospital in

Tabatinga. While I do not know the exact figure, certainly a larger number of children were born to Haitians in Manaus in 2012. Healthcare agencies quickly became concerned with these pregnant women, who were the first to be encouraged to enroll with the SUS because of their greater vulnerability. While pregnancy may have been a factor that facilitated the women's insertion into the Brazilian healthcare system – since they caught the eye of ESF teams – the language barrier hampered the system's efforts to reach them, as apparent in the account of one somewhat frustrated healthcare provider:

We discovered Haitians in some of the houses in the neighborhood, with pregnant women in two of them. We tried to come up with a way of bringing them into the clinic for prenatal care. We wondered how we might do it, because they don't speak our language, right? The [community] agent and I went there [to see] them one day, to talk to them about the importance of prenatal care ... I asked for their cell phone numbers. We do that here because it's easier for me to make the appointments and then call them back, so they don't forget to go, give them a little push ... It didn't do any good because when we called, they didn't understand what we were saying. Then we went back and found out [the women] had moved. [Haitians] move a lot! Still, we managed to get two of them [to do the tests], but they didn't finish; I don't even know anything more about them (Andréa, 41, ESF nurse).

In Brazil, pregnant women are routinely encouraged to undergo the set of medical procedures known as prenatal care, which includes periodical exams and follow-up during pregnancy; consequently, it seems that women have generally incorporated this idea into their mentality. In Haiti, however, prenatal care is not necessarily routine. As pointed out by Sargent and Larchanché (2011, p.346), one basic issue to keep in mind when discussing the health of migrants – beyond the biological aspects of these migratory flows – is that people do not only move across national borders but also between and across different medical systems.

It is likewise important to bear in mind how healthcare services operate in Haiti. Wamai and Larkin (2011) described these as a veritable “patchwork:” most health services are private; a large contingent of clinics work on their own; and a large number of NGOs and missionary programs provide emergency care. Accordingly, Haitians are not in the habit of going to healthcare services; instead, they only do so when they consider a situation serious.

In Haiti, some diseases are associated with witchcraft and can lead to the carrier's social exclusion. Furthermore, it is commonly believed that medicine cannot treat certain illnesses. Consequently, seeking health care in the form of biomedical intervention is not a regular habit, particularly for people living in rural areas, where such services are especially hard to come by. Vodou, the national religion, also plays a determinant role, since the lack of health care makes spiritual therapists the most accessible – and sometimes the only – resource (Vonarx, 2008). Anyone proposing to work with this population must approach these issues with sensitivity.

The fact that the Haitians represented a novel factor for the Brazilian healthcare system is apparent in how daunting the municipal managers of Manaus found it to assign a specific agency to initiatives aimed at the group. Responsibility for the matter of the Haitians was first assigned to a technical department – the same one that oversees work targeting the indigenous population in Manaus. This department launched some initiatives to encourage

Haitians to join the healthcare system, which included conducting surveys at the river port known as “Manaus moderna” (modern Manaus), where Haitians from Tabatinga disembarked. However, funding constraints blocked the continuity of these activities.

Some barriers can be traced to the ideas and preferences of providers. The providers who coordinate healthcare teams report that Community Healthcare Agents (CHAs) are sometimes reluctant to include Haitians in their pro-health initiatives (a reluctance that can also apply to other users). Although CHAs do not represent a specialized professional contingent (only an elementary education is required for the post), they play a particularly vital role in the system because they are responsible for visiting communities to register people, provide follow-up for pregnant women and children, and guide users on how to receive care. CHA support is essential to the success of any health initiative. Since CHA performance is tied in part to goals in user coverage and follow-up, the agents often refuse to include people residing in rental units, especially in areas that are typically low income. Given high occupancy turnover, the CHAs will sometimes ignore alternative living arrangements like “estâncias” (houses divided into rooms or efficiency apartments, each rented to a different family) because they think long-term follow-up will be impossible. Because of their low cost, these are precisely the most common living arrangements for Haitians. Brodwin (2001) describes Haitians in Guadeloupe who form groups and rent housing together to minimize expenses so they can send money back to their families in Haiti. This same tendency is observed in Manaus, where turnover is very high at shared residences.

Although a good share of the Haitians in Manaus find jobs in the informal sector, where a number of organized groups are active, formal employment also facilitates Haitian enrollment in the SUS, since immigrants applying at factories in the Manaus Free Trade Zone industrial park are urged to have their required health screening done at a public facility. SUS managers chose to pay little heed to this fact. Instead, they tried to assign the Haitians to specific healthcare facilities by announcing over radio and TV where they should go to register and receive care – an effort that met with little success.

Haitian reluctance to participate in these institutional initiatives stems from their common mistrust of institutional contact, which they avoid out of fear of a potential negative impact on their request for a permanent visa. They even avoid having their picture taken. This behavior seems to tie in with what they have learned through other moving experiences, especially to countries that impose greater restrictions on migrants. An interview taken in the field shows that discretion is an important value for transnational Haitian migrants:

In my family, I've got a male cousin in the United States and an uncle in Canada. ... They told me about there, about how hard it is to get a visa. ... It's easier in Brazil, but we have to be careful to do everything right. It's not good to make yourself too visible. ... If I'm too visible, have my picture taken, everybody will see me, they'll say 'look at that guy.' ... That can get in the way later; they might mark me. You've got to stay low, not draw a lot of attention (Bien-Aimé, 30, originally from Port-au-Prince).

Final considerations

Although the Brazilian Constitution of 1988 achieved historical victories, the universal right to health care that was supposed to eliminate social differences in the name of legal egalitarianism does not appear to have been guaranteed. Gender, ethnicity, color, class, and other specificities still stand as factors that keep a good share of the population from fully exercising basic rights. In the Amazon, where geographic and social issues weigh heavily in access to public services and policies, the principle of SUS equity is challenged by the constant need to tailor approaches and methodologies to ensure universal access while likewise taking regional characteristics into account. Santos et al. (2001) observes that a large share of immigrants in this region are still undocumented and, when it comes to basic human rights, marginalized. The case of the Haitians cannot be considered an isolated fact. When migrants choose this country as a destination, it reflects the role that Brazil has mapped out for itself on the world's new political scenario and comes in response to its much-touted economic prosperity and resultant positive image. In 2012, the Ministry of Labor announced that 30% more work visas had been issued to immigrants the previous year, indicating that the continental leadership role to which Brazil aspires is not cost free and that public power should be prepared for this. In this sense, health plays a fundamental role in calling into question the nationalism and xenophobia that at times pervade the discourse and practice of Brazilian government agents and media and contribute to stigmatizing immigrants.

While the lack of direction and coordination by the actors responsible for enforcing health policies may not have placed any obstacles in the paths of Haitians seeking access to the healthcare system in Amazonas, it kept the system from performing effectively. As we saw earlier, the positive cases detected during the blood draws that were conducted on a small portion of immigrants in 2012, as reported by Arcanjo (2012), show how the government fed alarming news to the media while concomitantly doing little to take more incisive action, for example, by devising protocols for testing new arrivals at the border and providing medical follow-up of any positive cases – options that have also been suggested by Rawlinson (2014, p.3).

The immigrant's health must also be considered not just from the perspective of illness but also from an integral perspective. This has not happened for two reasons. First, the new subjects struggle to deal with a healthcare system that differs from the one in their societies of origin; the Haitians report that in their country of origin users pay for most services and so they have trouble understanding a service where care is universal and preventive in nature. Second, restrictions on healthcare access in the Amazon are not the monopoly of immigrants but a problem shared by the public at large. I saw an example of this during my field work in Tabatinga. Because of government mismanagement, the municipality went through a period of supply problems at public pharmacies, including a shortage of basic medications like acetaminophen, an analgesic often used to bring down fevers. When some immigrants were unable to obtain the drug, they automatically attributed it to their immigrant status rather than to a general shortage.

So long as the system fails to direct its initiatives more efficaciously, local actors will develop their own strategies. As we have seen, pregnancy and formal employment act as inclusion

factors for the immigrants. And because children are the target of specific campaigns like polio immunization and of initiatives by nongovernmental actors, they too have attracted the attention of healthcare agents, who usually insist that parents take their children to public healthcare facilities for follow-up. But much is yet to be done to incorporate immigrants into the SUS.

Some simple actions could have a positive impact on immigrant access to health services, such as sensitivity training in cultural competence for healthcare providers, managers, and other members of the system. In addition, fighting institutional racism, incorporating regional specificities into policymaking, and pursuing strategies that take regional specificities into account are principles that must be followed if all people, without distinction, are to be accorded citizenship and health.

NOTE

¹ MINUSTAH is the acronym for the Mission des Nations Unies pour La Stabilisation en Haiti (United Nations Stabilization Mission in Haiti), a peacekeeping mission created by the UN Security Council on April 30, 2004, to restore order following the deposition of President Jean-Bertrand Aristide; it includes troops from Argentina, Benin, Bolivia, Brazil, Chile, Canada, Croatia, Ecuador, Spain, France, Guatemala, Jordan, Morocco, Nepal, Paraguay, Peru, the Philippines, Sri Lanka, the United States, and Uruguay.

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