Harm Reduction, Biopower, and Micropolitical Resistance at the Syringe Exchange Program of Prevention Point Philadelphia

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Disciplines
Anthropology

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HARM REDUCTION, BIOPOWER, AND MICROPOLITICAL RESISTANCE AT THE SYRINGE EXCHANGE PROGRAM OF PREVENTION POINT PHILADELPHIA

By

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In

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Abstract

My thesis is an ethnography of the harm reduction staff of the syringe exchange program (SEP) of Prevention Point Philadelphia (PPP) during a period of six months between 2011 and 2012. Using interviews, participant observation, and secondary research, the thesis examines how the political dimensions of a now institutionally recognized, albeit controversial public health strategy have adapted to new structural constraints by contextualizing the movement’s trajectory through the perspective of individuals involved in the organization. Profiling the current staff of the SEP facilitates an exploration of the radical political heritage of harm reduction internationally, nationally, and in Philadelphia. The incorporation of harm reduction into a neoliberal public health framework resulted in an uneasy and ongoing transition characterized by a tension between principles and practices that site workers embody. I draw on Foucault’s concept of biopower as a means of critiquing the disciplinary effects of institutionalized harm reduction practices, while using Mbembe’s concept of necropolitics to theorize the precarious state of PPP. I suggest that a return to the radical politics of its genesis provides an avenue of resistance to the more repressive consequences of a biopolitical and necropolitical public health system.
Introduction

Although many consider harm reduction simply “a public health movement” (Bourgois and Schonberg 2009:106), in the following pages I will contend that, at my field site of the Syringe Exchange Program (SEP) of Prevention Point Philadelphia (PPP), workers actually consider harm reduction a much broader and farther-reaching methodology for social transformation that strives to attend to the cracks left by traditional public health interventions. In practice, harm reduction itself straddles the margins between public health and social justice, making its ongoing transition from underground acts of nonviolent civil disobedience into a set of institutionalized, State-sanctioned and regulated public health programs a constant source of tension for workers, participants, and activists. It is necessary to first trace a genealogy of harm reduction practices both internationally and domestically in order to grasp how the many different notions of harm reduction interact across history, political-economic context, and objective. I will then place harm reduction in direct conversation with public health, comparing and contrasting their modalities, practices, and objectives, and use the concept of medicalization to further delineate the two movements. Next, I will overview PPP in general and the SEP more specifically, paying special attention to the daily realities, local and personal histories, and political-economic context of the organization. Finally, I will analyze my ethnographic findings in the context of several social theories and conclude by presenting a prognosis and proposal for the next phase of PPP’s transition.

Background to the Research Problem

Given its radical political heritage and persistent connection to the Philadelphia AIDS Coalition To Unleash Power (ACT UP Philadelphia), PPP’s SEP as a state-
sanctioned and regulated program could be said to exist in a constant liminal space, attempting to balance the radical goals and methods of its underground genesis with the restrictions imposed upon it by its legalized status. My ethnographic data has shown that this liminal state produces a series of superficially contradictory situations wherein workers of the SEP act as agents of state disciplinary power while simultaneously resisting the repressive aspects of state power levied against the organization itself. In order to further elaborate this paradox, I will draw from the Foucauldian concept of biopower, paying particular attention to its two poles of anatamo-politics and biopolitics, and explain how they interact in harm reduction as public health practice. I will also review Foucauldian critiques of the governmentality of institutionalized harm reduction and contextualize them across different geographic and political-economic contexts and with my field notes to weigh their relevance to the SEP of PPP. I will use Mbembe’s concept of necropolitics as a means of re-theorizing the precarious survival of harm reduction work under state management, and finally reference the concept of praxis of to examine acts of micropolitical resistance among the SEP workers.

**Research Design and Methodology**

Nadja Eisenberg-Guyot, a former student at the University of Pennsylvania, served as my initial entrée into PPP’s SEP. In true post-millennial fashion, after I posted an article about the success of Chicago Recovery Alliance’s needle distribution program on Facebook and wondered aloud where in Philadelphia I could volunteer at a similar organization, Nadja, who previously worked as coordinator for the SEP, put me in touch with Emily. Emily was the SEP coordinator for seven months of my volunteer position before leaving in September 2011 to work for the Philadelphia Department of Public
Health’s program on adult vaccinations. I contacted Emily in early October 2010 and by February 2011 I met her and Gus at the Wednesday mobile SEP site at 13th and Washington, in South Philadelphia. After filling out a waiver necessary for anybody working near sharps, a potential health risk due to infection from needle-stick injuries, I was ready to start volunteering.

From February 2011 through the present I have volunteered weekly at two separate SEP sites, Thursday and Friday, for a total of two to five hours per week. The Thursday site is located in a van parked at 12 and Indiana in North Philadelphia and is therefore a mobile site, while the Friday site is located in the drop-in center of PPP’s offices at 2nd and Lehigh Avenues. By May 2011, I felt acquainted enough with the SEP’s protocols and variety of syringes offered that I began to carefully observe the dynamics of staff and client interactions, engaging in weekly informal interviews with SEP workers to gauge where I could locate potential research interests. From the summer through the winter of 2011, I paired my immersion as a volunteer in syringe exchange work with a process of participant observation, writing weekly field notes documenting my observations of work at the SEP. I typically wrote field notes either on a computer immediately following the SEP site, or I jotted notes down onto my mobile phone using a note-taking application, and then elaborated those notes on a computer following the site. PPP generally has frequent turnover, a fact made clear to me by the somewhat sudden departure of Emily, the several case managers who came and left over the course of nine months, as well as the organization’s general inability to keep an Executive Director for more than five years (DeMarco 2012). After a few months of consistent volunteering, I realized my constant weekly presence was appreciated enough that I was seen as a
volunteer first and researcher second, so when the time came for me to engage in formal interviews with workers at PPP, everyone I talked to felt comfortable enough with me to speak as honestly and candidly as I could have hoped.

PPP is a small organization, and the SEP runs much more efficiently with volunteer support, whether from outside volunteers such as myself, or from participants within the program. There are currently 15 fulltime staff members, and among those only three consistently work at the SEP, although anyone available will chip in if needed. Therefore, the sample size of my research is understandably small, with just four individuals forming the core characters of my participant observation fieldwork, although I did also speak with several people who are not explicitly SEP workers, but involved in ACT UP Philadelphia.

I’ve collected several hours of formal interviews with PPP staff. For these interviews, I met my subjects at a mutual public location or their homes. I used a set of questions to guide the conversation, but was careful not to ask leading questions and simply took my cue about what to ask next based on the subjects’ responses. I recorded the interviews both on my mobile phone and also transcribed answers onto my laptop word processor.

In order to officially begin formal interviews with SEP workers, I completed an IRB process with the University of Pennsylvania’s Human Subjects Electronic Research Application under Dr. Philippe Bourgois’ project. After several revisions, they granted me an IRB fairly late in the spring of 2012. Because my project does not focus on “clients” (which I consider a neoliberal term reflecting the consumerist discourse of health service work that does not match the actual intentions of harm reduction) but on
staff, I was exempted from an informed consent requirement, as observing staff dynamics and interviewing staff formally and informally poses minimal risk. IRB itself is rigidly structured process, such that my “research objectives” could not be articulated within its clearly delineated distinction between “clients” and “staff” of the SEP. In fact, many SEP workers are also participants in the program, either as active or former drug users who are quite intimately connected with the social networks of injection drug users (IDUs) they serve. However, the IRB forced me to excise interview questions to staff about current or former drug use on the grounds that they were not part of my research objectives, since I agreed to only profile staff, which the IRB falsely assumed would not have personal histories of drug use. This suggests an inability of institutional discourses to understand the blurring of lines between staff and client that is the mutual, horizontal nature of harm reduction itself. Therefore, throughout the thesis I neglect the term “client” in favor of the term “participant” to refer to those who participate in the SEP, whether acquiring syringes or helping to dispense them, and will use “staff” or “workers” to explicitly define those whom PPP employs.
Results

I. HARM REDUCTION

A. International History

Harm reduction is generally understood as a movement of public health practices dedicated to reducing the harm of substance use on individuals and communities. This is a deliberately vague statement that needs to be historically embedded to reveal its true dimensions. Virginia Berridge claims that “harm reduction” had been a focus of drug control policies in UK since at least the nineteenth century, but its conception had shifted from one where lay people and medical professionals allied with the state attempted to reduce harm to individual consumers or addicts, to a wider notion of reducing the harm of the “drug epidemic” of the 1960s on society at large (Berridge 1999:36). Clearly a phrase such as harm reduction depends upon how harm is conceived and prioritized, and where such harm is located. Before the harm reduction movement of the 1980s, “harm” could be considered that of addiction, first threatening individual users, and then threatening society as an epidemic. Perhaps due to the social upheaval generated by liberation movements of the 1960s, many in power were especially attuned to the possible threats that drug use posed to social stability, following the countercultural embrace of psychedelic drugs such as lysergic acid diethylamide (LSD) and marijosea, such that the drug use in and of itself constituted a harm to be reduced. In the UK, however, Berridge contends that this discourse of “harm reduction” went out of favor in national drug policies of the 1970s and 1980s, only to be revived in a new conception by the AIDS crisis of the mid-1980s. This was not the case throughout Europe, however, from which
organizations such as PPP derive the contemporary notion of harm reduction coupled with a re-conception of the harm it strives to reduce.

The Netherlands of the 1970s was the testing ground for this new conception of harm regarding substance use. Now considered a relatively liberal nation with regard to drugs and sex, throughout the 1960s Holland consistently dealt harsh sentences to those in possession of drugs, even prison terms of one year or greater for marijosea possession (van de Wijngaart 1991). However, these repressive policies did little to discourage the widespread questioning of the social order characterized in part by experimentation with hallucinogenic drugs in the 1960s. By 1972, as heroin became widely available throughout the Netherlands, policymakers of the Narcotics Working Party began to re-think drug policy, concluding that its “basic premises…should be congruent with the extent of the risks involved in drug use” (Marlatt 1998:32). Correspondingly, the Dutch government revised their Dutch Opium Act in 1976 by distinguishing drugs of “unacceptable risk” such as heroin, cocaine, amphetamines, and LSD, and drugs with lower risk, including marijosea and hashish, in part so as to separate the market spheres for each class of drug. Although injectable drugs such as heroin and cocaine were considered “unacceptable risks” in 1976, this legal distinction sowed the initial seeds of a harm reduction model. Dutch sociologist E. M. Engelsman considers the distinction “very pragmatic,” as it strove to “avoid a situation in which consumers of cannabis suffer more damage from the criminal proceedings than from the use of the drug itself” (Engelsman 1989:213). It essentially laid the groundwork for a new conception of harm regarding drugs, one that considered drug use a matter of health rather than criminalization and policing. Therefore, if the harms of drug use on individuals and communities were to be
reduced, discourses of health, not justice, would be most suited to achieve this. As a result, in 1981 the State Secretary for Health and Environmental Protection issued a publication that first introduced the term “harm reduction.” Engelsman reviews how the trend included “forms of aid which are not primarily intended to end addiction as such, but to improve the addicts’ physical and social well-being and to help them function in society,” such that the approach was also termed “secondary and tertiary prevention” (Engelsman 1989:216). However, the government did not simply arrive at this pragmatic and humane solution of its own accord.

A drug users’ union called Junkiebond (Junkie League) was established in Rotterdam in 1980 as a means to “combat the deterioration of the user…to improve the housing and general situation of the addict” (van de Wijngaart 1991:39). This union regularly consulted government officials about methadone distribution, law enforcement procedures and legal policies, housing issues, and sterile syringe availability as a means of combating the risk of Hepatitis B infection. Due to the direct input of drug users, in 1984 Amsterdam developed the first needle exchange program (NEP), in which the Municipal Health Service delivered sterile syringes directly to Junkiebond offices for distribution and collection of needles. The exchange program was extremely successful, with the number of needles exchanged spiking from 100,000 per year to 720,000 within the first four years of the program, due in no small part to the burgeoning AIDS crisis and commensurate risk for HIV infection (Marlatt 1998:33). By focusing efforts away from the criminalization of drug use and onto aid, the government turned to a medical model of addiction that accepted addiction as a fact of life for many users and one that must be treated not only with an eye towards abstinence, but also towards the acceptance of drug
users as a part of society that must also be cared for if an ultimate goal of abstinence were to be attained.

If the Dutch approach to harm reduction attempted to reduce criminalization and stigmatization of drug users by listening to them and humanely focusing aid on their health and social well-being in the form of NEPs, then the initial U.K. approach to harm reduction mobilized an explicit medicalization of drug usage. Medicalization is a discursive process that redefines non-medical issues as medical problems, often using the rhetoric of “disorder” to include sleeping problems, behavioral conditions, or substance dependencies (Conrad 2007:5, Williams and Calnan 1996). Concerning drug use, medicalization repositions “deviant” behaviors such as habitual opiate usage and addiction away from moral judgment and transforms them into medical maladies to be treated (Conrad and Schneider 1992).

In the 1920s, several pioneering British physicians recommended the prescription of drugs to addicts as a means to reduce the harm of their use. While the practice fell out of favor around the U.K., the Merseyside Health Authority continued the policy in its service to the people of Liverpool throughout the twentieth century, and by 1990 sponsored the first international conference on harm reduction (Marlatt 1998:37). The Merseyside approach is generally considered a success, as in 1991 the area claimed the second lowest rate of HIV infection amongst IDUs of all English regions while simultaneously registering a decrease in crime rates, the only police force in the UK to do so (Marlatt 1998:40).

In 1994, Switzerland also attempted a heroin prescription or maintenance program and released its generally positive findings a year later. Interestingly, the Social Welfare
Department in Zurich claimed, “heroin prescription is less a medical program than it is a social-psychological approach to a complex personal and social problem,” and that “heroin per se causes very few, if any, problems when it is used in a controlled fashion and administered in hygienic conditions, with clients controlling their dose” (Nadelmann 1995:12). This passage implies that Switzerland conceives of harm reduction, as represented by maintenance programs, less as a medicalization of drug use than as part of a broader social critique. If heroin causes few problems when used in a hygienic, controlled fashion, then the real harm must be located in the unhygienic, uncontrolled situations users find themselves in. Even so, the policy of heroin maintenance still does little to change the root cause of these unhygienic and uncontrolled situations.

Australia was the first nation to formally introduce harm reduction into its national drug policy, as Australian Minister for Health Services Peter Staples called a harm reduction approach “realistic” at the third international conference on harm reduction (Marlatt 1998:45). Since then, Australia has become a bastion of institutionalized harm reduction practices, research, and criticism. In 1993, the Canadian Centre on Substance Abuse outlined its particular model of harm reduction as one which “established a hierarchy of goals, with the more immediate and realistic ones to be achieved as the first steps toward risk-free use, or, if appropriate, abstinence” (Marlatt 1998:43). Here, harm reduction is less a clearly delineated ideology than a framework that offers a “pragmatic means by which consequences [of drug use] can be objectively evaluated (Marlatt 1998:43). This quote suggests that the Canadian model of harm reduction is simply an apolitical set of good public health practices that can be applied for the best possible outcome to users and society.
In reality, however, it is the political activism of drug users that directly resulted in the establishment of many of Canada’s most innovative harm reduction programs, foremost among them InSite in Vancouver, North America’s only state-sanctioned safer injection site. For years, the Downtown Eastside (DTES) neighborhood of Vancouver, British Columbia has experienced an epidemic of infectious disease and drug overdoses among the community of IDUs. A rundown neighborhood of cheap single room occupancy hotels (SROs), public drug trafficking, consumption, and sex work, the DTES has rates of HIV infection equivalent to that of Botswana in 2008, with 30% of residents positive for the virus, and nearly 70% positive for Hepatitis C virus (Condon 1998). A Vancouver Injection Drug User Study revealed that 95% of its subjects were positive for Hepatitis C (Drug War Chronicle 303). An average of nearly 300 illicit drug-related overdoses occurred each year throughout the 1990s. By 1997, the Vancouver/Richmond Health Board declared a public health emergency in the area (Kerr et al. 2001). Due primarily to government inaction in the face of increasing infection rates and drug overdoses, that same year a group of drug users joined together to create the Vancouver Area Network of Drug Users, or VANDU, an organization similar to the Dutch Junkiebond in both philosophy and intent.

VANDU promotes a philosophy of “user involvement and empowerment” with a mission to “improve the quality of life of people who use drugs by providing user-based peer education and support” (Kerr et al. 2001). Their initial objectives included breaking down social stigma associated with drug use, advocating for drug policy changes, and developing a mutual aid network of drug users. Several of the core members had participated in groups such as Political Response Group and IV Feed, the latter of which
ran an illegal, underground safer injection site about year before VANDU’s founding. In their first few years, VANDU members launched a series of highly visible protests to call attention to preventable deaths and ran a gamut of educational and outreach programs, including nightly alley patrols, syringe recovery from SROs, peer advocacy, and a hospital program connecting VANDU members with hospitalized drug users for support. One of their most profound victories from the city was the installation of portable after-hours toilets at the central intersection of Main and Hastings, where they currently also operate a needle exchange open past the hours of the other exchanges in the DTES (Kerr et al. 2001). After a police crackdown in April of 2003, VANDU members opened their own unsanctioned safer injection site, unwilling to wait for bureaucratic requirements and state funding entanglements. Two years later, InSite opened its doors, displaying a clean, state-sanctioned facility operated by the Vancouver Coastal Health Authority with 12 injection seats, staffed by 16 registered nurses, four alcohol and drug counselors, and peer staff, equipped to handle almost 800 injections per day (Drug War Chronicle 303). However, VANDU remained critical of the “hyper-medicalized” nature of the site and ongoing police intimidation, with Executive Director Anne Livingston citing restrictive bureaucratic guidelines that could “cause this place to fail.” (Drug War Chronicle 303). Although police created a four-block radius around the site where those in possession of heroin or cocaine would not be arrested, selling of drugs still remained illegal, which Livingston and others considered a “conflict of interest” if the police were truly invested in the success of the facility.

In many ways, the site was a huge victory for Canadian harm reduction at an institutional level, but it is precisely the location of that victory which makes it an
incomplete one. From the perspective of VANDU, as long as selling and buying drugs is still illegal, drug users are still at risk of the harm imposed by police intimidation and violence. The institutional restrictions imposed on InSite also make it unable to fulfill a mission of harm reduction with integrity, and VANDU has since been picking up the slack. For example, within the first two years of the site’s opening, 40% of users at the site reported needing injection assistance, and a study showed those who need assistance are twice as likely to contract HIV (Drug War Chronicle 402). Many who needed assistance, young people in particular, were forced into the alleyways outside of the facility to pay others for help injecting. In response, VANDU took direct action and created an injection support team to directly assist those who cannot use the site’s facilities, refusing to wait for Health Canada to revise its restrictive policies (Drug War Chronicle 402).

After reviewing a brief international history of the development and implementation of harm reduction, it’s clear that the history and term is quite uneven. Many different social and political actors stake claims to it in specific ways to suit their own intentions, motivations, and discourses. Harm reduction means different things to lawmakers, medical professionals, and those working with drug users on the ground every day. To make sense of these discrepancies, it’s necessary to consider the history of harm reduction as composed of two parallel yet converging trajectories: an institutional history of harm reduction, or its incorporation as government-supported public health practice, and a social history of harm reduction, or its development as a social movement ultimately inextricable from the eventual implementation of harm reduction practices in health programs outside the US. In nations such as Holland and Canada, government
harm reduction programs were created as a result of activism and in several cases, underground direct action from drug user unions, as drug users organized themselves into an identity group deserving rights and political representation similar to racial and ethnic groups from the Civil Rights Movement onwards. However, when the government responded to their activism, they did so in a way which ultimately reinforced the regulations of the state and thus, in many ways institutionalized harm reduction facilities became extensions of state authority over life, while drug users’ unions such as VANDU continued to fight against the state for a more comprehensive and effective implementation of harm reduction ideology. Moving forward, it is important to continue noticing how the tensions between the ideology and specific practices of harm reduction are acted out across history and at my field site of PPP’s SEP.

B. US History

In the US, the history of harm reduction follows a similar trajectory of activism compelling reluctant government support, but the historical moment of the AIDS epidemic lent a different quality to the nature of activism in the US, and as a result has perhaps complicated the translation of some of the more radical beliefs of harm reduction ideology into public health practice. Whereas internationally much of the activism directed at governments grew from drug user unions claiming rights as an autonomous identity group, in the US, “the community of IV drug users has had little or no impact on the provision of services for addicts” (Marlatt 1996:787). Instead, calls for harm reduction programs such as NEPs grew out of a broader coalition of AIDS activists petitioning the state for a “right to life,” therefore invoking a notion of biological citizenship that at once required and mobilized an extant discourse of biopower in order
to articulate demands to the general public, while in practice also resisting traditional arrangements of medical authority (McLean 2011:76). Foucault describes the concept of biopower as a novel form of state power over life developed in West since the classical age. In contrast to earlier forms of sovereign power invested in maintaining power over the national body through coercion and subtraction, biopower is diffuse and capillary, focusing instead on the optimization of life by disciplining, ordering, and regulating individual and population bodies to become productive subjects of state power through the development of many disciplines, including most relevantly, public health (Foucault 1990[1978]).

Decades before harm reduction developed as an international movement, Michael Cetewayo Tabor, a Black Panther from Harlem, New York City, published a document entitled *Capitalism Plus Dope Equals Genocide* (Tabor 1970), and within its pages levied a systemic critique of the roots of drug use in the inner cities of the US that could be said to foreshadow harm reduction ideology. In an effort to trace not only a social history, but also indeed an explicitly radical heritage of harm reduction theory, I consider this a proto-harm reduction document, albeit one that deserves firm contextualization for its time period and political moment. The Black Panther Party was a revolutionary leftist political organization founded by Huey P. Newton and Bobby Seale in Oakland, California in 1966. Marxist-Leninism and later Maoism influenced their politics greatly, and their documents, including the seminal Ten Point Program, reflect an informed political-economic critique of capitalism’s interaction with a white supremacist state and their detrimental effects on the condition of US black people, particularly in urban areas.
Throughout the document, Tabor makes a number of provocative and extremely prescient claims, even noting that the method of supply reduction that characterizes the strategy of the War On Drugs (begun by Nixon the very next year) will not work because “dope dealers and addicts would simply find another drug to take its place” (Tabor 1970:3). Indeed just fifteen years later, crack, a smokeable rock form of cocaine exploded in inner cities across the US, not without controversy as to its origins in contemporaneous Latin American conflicts. Most importantly, however, Tabor characterizes drug addiction as a “plague” of the “colonized ghettos” of America, and rightly points out that the government’s growing interest in drug addiction is proportional to its increasing proximity to White American communities (Tabor 1970:1). He quickly dismisses traditional drug prevention and rehabilitation programs not only as “bourgeois, Freudian,” but because they “deliberately negate or at best deal flippantly with the socio-economic origin of drug addiction,” therefore locating the root of addictive drug behaviors in the political economic situation governing the oppressed state of inner city Black ghettos. Mirroring the trajectory of harm reduction philosophy, he maintains that drug addiction is actually “a social phenomenon that grows organically from the social system,” (Tabor 1970:4). However, he consistently uses the metaphor of “plague” to refer to heroin, drug addiction and drug dealing, thereby mobilizing the rhetoric of illness to conflate a substance, its users, and its dealers as a consequence of psychic and economic survival under a sick and racist capitalist system. This repeated reference to the plague metaphor is a reflection of how illness rhetoric is firmly entrenched and indeed constitutive of our national identity. Years later, Susan Sontag discussed how the metaphor of plague is historically used as a means of stigmatizing chronically
marginalized social groups (who to this day are often referred to as “vectors of disease” in public health discourses), therefore justifying either military action or government inaction. In the case of the AIDS epidemic, the metaphor of plague was used in the US to root the origins of the disease in “the ‘dark continent’” and then moralistically qualify its domestic victims as deviants that illness has judged (Sontag 2001:139).

In Tabor’s text, the rhetoric of plague is deliberately complicated in an explicitly Marxist critique, rooting conditions of squalor, drug abuse among them, in class antagonisms. Where Sontag exposes the historical dimensions of plague metaphors, Tabor paradoxically both resists the typical narrative trajectory of plagues by placing the origin of heroin abuse outside the Black ghettos, yet still requires a rhetoric of illness to articulate his critique in the first place, unable to break out of a discourse of biopower. Rhetoric deployed by AIDS activist group ACT UP later mirrored this paradox, relying on a biopolitical discourse to locate their critique of medicine in medical authority as well as capitalist and State power.

Regardless, Tabor delivers a potent analysis of how structural violence compels marginalized groups to partake in habits that may be physically and emotionally detrimental and serve to further marginalize their social status. Anthropologists such as Paul Farmer describe the concept of structural violence as the “infrastructural expression of the process of oppression” (Farmer 2004:288), and Tabor believes that while heroin use helps to make Black youths “oblivious to the squalor, to the abject poverty, disease and degradation that engulfs them in their daily existence (Tabor 1970:6), if the socioeconomic conditions of drug use do not disappear, the usage becomes addiction and soon the “young victim” has become a “full-time, chartered member of the Cloud 9
Society,” his “decimated…filthy…unwashed…foul” (1970:7) appearance embodying the characteristics of structural violence that compelled his demise. Structural violence has an insidious nature, Farmer claims, because it not only contributes to the suffering of the poor, but because the wealthy desire to ignore it, both in the Third World and even in their home country, and therefore attempt to silence suffering as a means of “hiding the reality of the poor majorities” (Farmer 2004:288). In the US, this process of silencing the plight of the poor occurs in the inner cities with the expansion of what Wacquant terms the “new ‘peculiar institutions,’” both ghettos and now prisons (Wacquant 2004). Tabor wrote before the rapid expansion in incarceration that in many ways characterizes modern Black urban existence, as Black men currently make up nearly 40.2 percent of all US prisoners while only making up 13.6 percent of the US population (Alexander 2010). This expansion is mostly due to the War on Drugs, Alexander claims, a war waged “almost exclusively in poor communities of color” (Price 2011), lending the timing and tone of Tabor’s essay an almost prophetic quality. Currently, while black men make up “13 percent of drug users, they constitute 62.7 percent of all drug offenders imprisoned” (Greig and Kershner 2002:364). As Wacquant explains, the twin phenomena of ghetto and prison are not that different, but in fact interrelated and mutually reinforcing strategies of containing and therefore silencing the true socioeconomic degradation of inner city Blacks. By the end of the seventies, he claims, racist and classist backlash against earlier social movements relied on a carceral logic to solve the “‘breakdown’ of social order in the ‘inner city,’” such as the drug use that Tabor decries. Eventually, the “black ghetto, converted into an instrument of naked exclusion by the concurrent retrenchment of wage labor and social protection, and further destabilized by the increasing penetration of the penal arm of the state, became bound to the jail and prison system by a triple relationship of functional equivalency, structural
homology, and cultural syncretism, such that they now constitute a single
*carceral continuum* which entraps a redundant population of younger black men
(and increasingly women) who circulate in closed circuit between its two poles in
a self-perpetuating cycle of social and legal marginality with devastating personal
and social consequences.” [Wacquant 2004:322]

The prison has thus become an extension of the inner city ghettos, and the War on Drugs
the main factor facilitating people’s movements between the two poles.

In the US, harm reduction necessitated a unifying metaphor and moment of
emergency to get off the ground, and the AIDS epidemic provided the requisite context.
AIDS was initially and now famously associated with the “5 H’s”: homosexuals, hookers,
heroin users, hemophiliacs, and Haitians (Siplon 1999:578). Granted, this was a
stigmatizing and scientifically inaccurate understanding of the dimensions of the virus,
but one that ultimately linked each of these groups by their collective social marginality
and correspondent risk for infection. Therefore, health became a rallying point through
which people could build intersectional coalitions across experience, race, sexuality,
nationality, and class to create a movement for social justice. In this moment of attention
to the health of the socially outcast, the harm reduction movement found its activist legs
in the US.

In 1986, Jon Stuen Parker, a student at Yale University’s School of Public Health
and former IDU, founded the National AIDS Brigade in response to a professor’s
comment that HIV prevention efforts should not focus on IDUs as they would not change
their behavior. Parker began meeting with IDUs around the Northeast US to discuss HIV
transmission, and after one IDU brought a few sterile syringes to a meeting in Boston,
Parker began to distribute and eventually exchange syringes on the streets of New Haven
(Lane et al. 2000:52). These early harm reduction efforts clearly embodied a Do-It-
Yourself (DIY) ethic, as all were established and run by activists without official sanction. Moreover, many early and illegal SEPs were established as deliberate acts of “direct action public health and civil disobedience” (Grieg and Kershner 2002:364) in order to publicly challenge prescription laws which required a doctor’s prescription to carry syringes, and therefore call attention to the explosion of the AIDS epidemic among the IDU population. As a result, many early activists were arrested for distributing injection equipment on the streets; Parker alone claimed 27 arrests in seven states by 1993 (Lane et al. 2000:52). Government health officials quickly began to take notice, and in 1988, activist David Purchase tried a different strategy, first informing the mayor and public officials of his intentions to set up a SEP in Tacoma, Washington that summer. Although initially privately funded, by January 1989, just four months later, the program received funding through the country health department and has since expanded into the Point Defiance AIDS project run under a contract with the Tacoma/Pierce County Department of Health (Peterson et al. 1998:224, Lane et al. 2000:52). San Francisco saw its own underground SEP, Prevention Point, emerge in late 1988 as the result of activist organizing, which used teams of stationary and mobile volunteers to reach a broader base (Lane et al. 2000:54). By 1993, there were at least 37 SEPs operating throughout the US (Late et al. 2000:53). Early studies of SEP effectiveness revealed that worldwide, cities with SEPs actively decreased rates of seroconversion by 6 percent annually, while cities without SEPs suffered 6 percent increases per year (Peterson et al. 1998:226). Domestically, the New Haven SEP reduced new HIV infections among IDUs by an estimated 33 percent within its first three years (Peterson et al. 1998:227), while mere participation in SEPs was estimated to reduce the risk of new HIV infection by 50
percent, as these programs also serve to promote safer sex behaviors, and motivation to reduce other risky behaviors among IDUs (Peterson et al. 1998:228).

New York City’s history of SEPs typifies their complicated relationship to state power. On November 7, 1988, the New York Health Department opened the city’s first SEP, temporarily legalizing the practice, but adding restrictions contradictory to harm reduction principles. The state only accepted users into the program if they were on a waiting list for drug treatment, and only gave them one syringe to exchange. Moreover, the SEP was located in the Health Department headquarters, distant from neighborhoods with high drug use but quite close to the police department and court buildings. Within a year, new Mayor David Dinkins, responding to community opposition primarily among African Americans, shut down the program. Activist groups immediately filled the void, Parker’s National AIDS Brigade and ACT UP chief among them. Over the next two years, these groups began distributing syringes in the Lower East Side and meeting with community groups to collectively lobby the city to change its policy regarding syringe exchange. As a result of linking their efforts to drug treatment and other social services, the mayor shifted his position to support pilot SEPs in 1991 (Lane et al. 2000:54). From 1989 onwards, ACT UP established many underground SEPs in other US cities along the northeast corridor and across the country (Tempalski 2007:421, Lane et al. 2000:57). In Seattle, ACT UP organizers informed the city’s Health Department of their intentions to establish an SEP and their desire for the Health Department to take it over; six weeks later, the Health Department did just that (Peterson et al. 1998:224, Lane et al. 2000:55). This relatively quick transition from underground acts of civil disobedience to aboveground appeals for governmental support and participation signaled a strategic shift
that represents the ongoing complexity of SEP programs’ relationship to state authorities to this day.

It would be difficult to understate ACT UP’s relevance and support for the burgeoning harm reduction movement, but it’s important to unpack exactly why and how the group was so well positioned to make an impact, and discuss the theoretical consequences of its strategy to promote harm reduction at a national level. ACT UP was founded in 1987 in response to an increasing number of HIV infected individuals who could not find treatment or support and consistently faced social stigma. The group contained members from other AIDS organizations such as Gay Men’s Health Crisis, the People With AIDS (PWA) Coalition, and the Lavender Hill Mob, a confrontational direct action oriented group that had demonstrated against the NIH, FDA, CDC and St. Patrick’s Cathedral (Elbaz 1995:48). The group was initially composed of predominantly white gay men, but distinguished by its “heterogeneous socioeconomic composition” (Elbaz 1995:51). Its political perspectives and methodology came from a variety of sources, including the gay and lesbian movement and the feminist health movements of the 1970s and 1980s. Gay and lesbian activists in the US have a long tradition of challenging medical authority. The founder of the Gay Activist Alliance (GAA), an offshoot of the Gay Liberation Front (GLF) created in the aftermath of the 1969 Stonewall riots resisting police harassment of queer and trans people, joined ACT UP early on. His experience in the campaign for the removal of homosexuality from the Diagnostic and Statistical Manual of Mental Disorders in 1973 lent ACT UP an informed and historical critique of the medical establishment. Many women in ACT UP were active in the feminist health movement, which developed parallel to the gay and lesbian
movement. In 1969, 40 women from the Women’s Liberation Union in Chicago organized an underground health care system called the Jane Collective, which arranged for safe and illegal abortions. Throughout the 1970s, these women autonomously developed a notion of self-help and critique of the medical establishment that later characterized ACT UP programs, with their stated goal of “‘replacing the traditional disease model taught in medical school with a health-oriented one’” (Elbaz 1995:49-50). Furthermore, the feminist model of an organizing collective was a deliberate rejection of a hierarchical “male model” that led to individuals struggling for power and control over others. Instead, feminist collective models in the health, environmental, peace, and anti-nuclear movements used a consensus decision-making process among their members in a deliberately anti-hierarchical framework (Elbaz 1995:51). ACT UP’s structure exemplifies its anarchist methodology: the group has no single leader and each member is a volunteer who works in whatever capacity they can, with many different committees focusing on different aspects, such as Issues, Actions, Fundraising, Outreach, Media, Coordinating, Treatment & Data, Majority Action Committee, Women’s Caucus, and Housing Committee (Brier 2009:161-2). In short, ACT UP drew from a broad base of experiences and identities to create an intersectional movement focused on a coalition politics of health.

On a theoretical level, Michel Foucault and Thomas Kuhn influenced ACT UP’s critique of the medical establishment and the historical relativism of the supposedly universal scientific discourse (Elbaz 1995:56-7). In addition, ACT UP activists contextualized their postmodern discursive critiques within a more traditional challenge to both the state and the economy, noting that biomedical research is embedded in a
capitalistic structure that works in concert with the state and private industry. By taking on biomedical science, activists were able to level a “multilayered and multifrontal analysis” that resisted the state, capitalism, medical authority, and the interactions between the three (Elbaz 1995:46). As Audre Lorde once famously stated, “there is no single issue struggle because we do not live single issue lives,” so ACT UP as a movement simply chose the issue of HIV/AIDS “as a prism through which to challenge society as a whole” (Elbaz 1995:69), since they could not locate the problem within one institution, but rather a network of State, capitalist, and normative discourses that had contributed to AIDS’ path of destruction.

If ACT UP did not ultimately dismantle capitalism or State power, it did put a significant dent in the power of medical authority to define people’s experience of health (or, more appropriately, illness). As a result of their actions, clinical trials were restructured to give more power and information to their volunteers (Siplon 1999:579) and activists began challenging a medical model by directly dictating the policy changes the AIDS epidemic required through their actions, foremost among them syringe exchange (Shepard 2007:175-6). In a 1992 ACT UP pamphlet, George Carter indicts the CDC for refusing to include common maladies that affect IDUs such as endocarditis and kidney and liver dysfunction in the list of opportunistic infections that compose an AIDS diagnosis, claiming that “IDUs may have been some of the first people to have died of AIDS up to thirty years ago from what was known as ‘junky pneumonia’ and another ailment referred to as the ‘dwindles’ – a fatal wasting disease, not dissimilar from those seen today in PWAs” (Carter 1992:5). He goes on to eviscerate the CDC definition’s focus on “groups as opposed to modes of transmission,” deliberately comparing the
clinical question “are you gay or bisexual?” to the alternative “have you engaged in anal sex?”; “have you shared needles?” (Carter 1992:6) Since IDUs are characterized mostly by their behaviors (injecting drugs) and, at least in the US, not their identity as injection drug users, Carter’s critique of the CDC should be praised for its attention to one of the more marginalized and ignored groups of individuals at risk for HIV infection. Therefore, Carter’s attention to behaviors over identity groups is indicative of intersectional activism that draws lines of coalition across divisive identity politics.

ACT UP’s support of needle exchange is elsewhere characterized as a direct action tactic, their “longest running civil disobedience” (Shepard 2007:176), but in the tradition of Gandhian nonviolence, civil disobedience is merely a theatrical means of calling attention to laws that should be changed for the benefit of society as a whole, or for the enhancement of life, as Foucault might say. Thus, Carter focuses less on the underground success of ACT UP’s needle exchange than civil disobedience as a means to change state policy, using rhetorical appeals to treatment and health to support the practice of needle exchange. He describes how a “coalition of 34 different AIDS and other service organizations have called upon the NYC Department of Health to demand a change in the law,” and even the “conservative New York Times ran an editorial calling for city-sanctioned needle exchange” (Carter 1992:13). He justifies the arrest of seven ACT UP needle exchangers by mentioning how they were found not guilty “with testimony from health and public officials on their side,” paradoxically relying on the discursive authority of medical and State power (Carter 1992:13). Sure enough, by 1990 New York legalized syringe exchange programs “that were monitored by the state Department of Health” (Shepard 2007:176).
There is an apparent contradiction between theory and practice within ACT UP’s public strategy to promote syringe exchange in the US that differs from that of international movements begun by drug users themselves. Most importantly, this contradiction diluted the radical political aims of some segments of the US harm reduction movement in an effort at pragmatically achieving change quickly, as could be expected in any health emergency. Since ACT UP filtered its intersectional politics through the lens of HIV/AIDS, it relied on an appeal to the power of scientific discourse to create a coalition at all, thereby maintaining their critique of current medical authority and practice firmly within a discursive regime of biopower. Many of ACT UP’s members drew on a radical political heritage that criticized state power and capitalism, so by organizing on the basis of health, they directly indicted the state for failing in its ability to protect and support the health of all of its citizens and thus the health of the national body. One the one hand, this could be seen as having a subversive effect, by claiming the right of marginalized social groups such as drug users, sex workers, and queer and trans people to be recognized as active participants in the body of the nation state. Indeed, underground harm reduction programs such as illegal syringe exchanges crystallized an empowering sense of agency among marginalized groups acting to protect their own health when their government would not do it for them. On the other hand, by organizing harm reduction activism solely around a notion of health and biological citizenship and not as autonomous drug users with the right to make choices about what to put in their bodies regardless of how they relate to health of their bodies and thus to the national body, ACT UP harm reduction efforts had a politically subjectifying effect. Using a Foucauldian definition, this subjectification was twofold. Not only were activists created
as subjects in their own right, with the agency to protect themselves from an epidemic, but they were also necessarily politically constituted primarily as subjects of the state and its public health policies, and therefore subject to state power and influence. As a result, when harm reduction practices became institutionalized (rather quickly), national public health discourses continued to associate these marginalized groups with illness as mere “vectors of disease,” and not as fountains of knowledge and methods of disease prevention, and thus manipulated an organic, underground, grassroots solution into a governmental means of managing queer, trans, and drug using bodies, therefore extending state power. This Foucauldian twist of fate meant that in their efforts to expedite the institutional public health embrace of harm reduction strategies, AIDS activists in the US watered down their politics, making “harm reduction” as a term mutually illegible to people from both public health and activist circles. The transition from underground to legal syringe exchange programs typifies the tension between principles and practices of harm reduction. Harm reduction, as it stands currently, represents both principles that mirror a more radical and far-reaching social justice movement and practices that have found favor with even the most entrenched public health policy-makers. Therefore, it is necessary to outline how the differences between principles and practices are operationalized, both across history and within the field site of PPP’s SEP.

C. Principles and Practices

In an attempt to search for a single unifying definition of harm reduction, I quickly understood that this is not only a futile task, but one which masks the complexity of the proliferation of different, and often contradictory, discourses of harm reduction. I
believe these contradictions can be slightly demystified by roughly dividing examples of harm reduction into two categories, those of principles and practices. That said, this division is rough indeed, as many current “best practices” of harm reduction began as examples of putting principles into action, and many of harm reduction’s loftier principles have not yet found articulation as practices in the movement. Moreover, there is significant intermingling between the two categories, as activist harm reduction workers often promote the same practices that governments and public health policy makers do, even if they vary in tone and rhetoric. Regardless, it is important to chart the ongoing transition from harm reduction as an underground movement into its current institutionalization as Harm Reduction practices in order to witness how “harm reduction” is deployed in different discourses to support different ideologies.

Perhaps in an effort to push back against the State’s institutionalization of harm reduction practices and to broaden the focus of the movement, in October 1993, a group of syringe exchange and drug policy activists and AIDS service providers formed a Harm Reduction Working Group traversing color, gender, sexuality, and class lines. This think-tank established a collective vision of harm reduction as a social movement that would transcend HIV prevention by providing a critical analysis of and response to the multiple harms of drug use, sales, and policy, especially the harms faced by the already socially vulnerable, people of color in particular. The vision used a rights discourse to admonish current drug policy for denying people their human rights, while acknowledging the real harms associated with drug use. Most importantly, the Working Group launched a potent critique of the War on Drugs, not only for failing to reduce the supply and demand of drugs, but for actually increasing the medical harms associated with their use. It define
the War on Drugs as a critical component of a neoliberal strategy that “pathologized drug users as the cause of social problems” while recognizing that the “social and economic policies in the 80s had created the conditions for an explosion of drug-related harm in the inner city,” proving Tabor even more prophetic (Greig and Kershner 2002:364). This critique of neoliberalism is twofold, censuring both its policies and its power as a predominating logic governing Western society, a now hegemonic discourse of social interaction. David Harvey reviews how from the late 1970s onwards, neoliberal economic policies materialized free market ideals of individual freedom by forcibly extending the rights of the market. The function of the neoliberal state is to deregulate industries, privatize social services, and otherwise disappear from most aspects of social life. The state’s new role is not to guarantee social welfare, but rather to create an institutional framework that actively enables the welfare of free market actors by intervening only so far as to secure private property rights and maintain or even create new markets amenable to the interests of US capital (Harvey 2005). Over the last few decades, neoliberalism’s hyper-individualist discourse has dealt a hegemonic, atomizing blow to social relations by displacing responsibility for structural problems onto individuals, such that the most innovative solutions developed by fields such as education (charter schools) and public health (bleach) are both market-based and individualizing; in essence, neoliberal solutions to neoliberal problems (Bourdieu 1998:98).

Aware of these developments, the Working Group formed the Harm Reduction Coalition, now with offices in New York City and Oakland, in order to “challenge social, cultural, and economic structures” (Greig and Kershner 2002:365). Their conferences have since discussed “radical social change” in the form of universal health care,
decriminalization of drugs, and drug user organizing (Grieg and Kershner 2002:365).

Their early meetings distilled their core principles of harm reduction as both “a set of practical strategies and ideas” and a “movement for social justice” (Harm Reduction Coalition 2004). Their original seven principles demonstrate a resistance to drug user criminalization and also pose a critique of the force of medicalization, juxtaposing the principles with how some practices of Harm Reduction are operationalized. They include,

“accept[ing]…that drug use is part of our world,” “ensuri[ing] that drug users have a real voice in the creation of programs and policies designed to serve them,” “understanding drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors,” “establishing quality of individual and community life and well-being – not necessarily cessation of all drug use,” “recogniz[ing] that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people’s vulnerability to and capacity for effectively dealing with drug related harm,” and “call[ing] for the non-judgmental, non-coercive provisions of services and resources to people who use drugs.” [Marlatt 1998:7]

These six principles alone suggest a more systemic analysis of the complexity of drug use and harm in a neoliberal political economy. They articulate a need to attend to pre-existing social inequalities as a means of mitigating “vulnerability to…drug related harm,” avoiding the more commonly used “risk” term as a means of reframing where harm is located. Moreover, these principles seem to resist a medicalizing discourse. Whereas medicalization turns problems into black and white issues, symptoms that can be diagnosed and cured, here drug use is a “complex, multi-faceted…continuum of behaviors” which cannot be treated with a one-size fits all strategy. Furthermore, medicalization is a unidirectional process that often devalues the agency and experience of patients, but here harm reduction resists that directionality by “ensuring that drug users have a real voice in the creation of programs and policies designed to serve them.” Here, harm reduction is shown to operate, in principle, on a more mutual basis than medicine,
allowing participants to articulate their needs as part of a reciprocal process of understanding. The call for “non-judgmental, non-coercive provision of services” stands in opposition to medicalization that, by virtue of its discursive power, defines and thus judges those who are abusers as pathological, and consequently, forces the standard medical treatment upon those individuals.

A resistance to medicalization finds its clearest articulation in the underground activities of early syringe exchange programs. Drug users did not always run early needle exchanges in the US, and therefore the exchanges “expected drug users to be active participants in the definition and provision of services,” directly “challenging dominant medical models of service-provider-as-authority” (Wieloch 2002:48). Not only did exchanges contest the abstinence-focused medical model of drug abuse treatment, but also for many, their genesis as radical actions transcended an appeal to medicine by demanding access to housing, manifesting the structural critique outlined by the Harm Reduction Coalition. Indeed, for community-based organizations and grassroots activist groups, syringe exchange is merely a means to an end, as “harm” is analyzed as a “by-product of social, economic, racial, or political inequality,” constructing harm reduction as avowedly “ideological and oppositional” (Roe 2005:245).

Harm reduction principles articulate a pragmatic and humanistic view of drug use that attempts to minimize the harms associated with it in a compassionate, culturally competent, and thus more effective fashion (Riley and O’Hare 2000:6-7). Alan Marlatt lays out an even more teleological differentiation between the assumptions of reduction strategies. He claims that criminalization policies, such as the War on Drugs, prohibition, and punishment (of dealers and users) are characteristics of a “supply reduction” logic
based on the assumption that drug use is a moral wrong. The disease model assumes drug addiction is a “biological/genetic disease that requires treatment and rehabilitation,” in an effort at “demand reduction” (Marlatt 1996:785). This still focuses primarily on the individual user as a site of pathology or harm by locating the solution for drug-based harm in altering individual consumption, not social structures. One could even claim that substitution and maintenance therapies, which predated the modern harm reduction movement by several decades, are more indicative of this “demand reduction” approach bolstered by medicalization than harm reduction. Indeed a medicalization policy for “psychoactive drugs of abuse” in the US would be contingent upon the “patient be[ing] willing to play the role of good patient as defined within the sick role” (Levine 1991:638). Perhaps proximity to the process of medicalization is why maintenance therapies have remained a more prominent aspect of public health policies much longer than have syringe exchange programs.

Harm reduction principles are radical in the etymological sense of the word (radical deriving from the Latin radix, meaning root). The root of the problem of drug use is not morally or biologically determined, but rather a shifting target, adjustable for how it affects the lives of each individual user at each moment of their life. Furthermore, the harmful effects of drug use are located along a continuum, so the most realistic approach at confronting those effects is a “step-down” approach that, as is a mantra of harm reduction, “meets people where they’re at” (Marlatt 1998:51). Correspondingly, harm reduction practitioners promote “low-threshold” access to services, abandoning abstinence requirements as a precondition for receiving treatment, as these ultimately serve as barriers for those who, for example, may need housing but cannot stop using
drugs at the moment (Marlatt 1998:52). Once their most immediate needs are met, drug users can begin to assess what step they want to take next in their lives, thus valuing the rights and dignity of each individual (Lenton and Single 1998:218).

The rights of drug users is another principle that harm reduction promotes, however it is less highlighted, perhaps as a means of avoiding criticisms that the movement actively condones drug use and is simply reminiscent of the 1960s era of social upheaval that was, for some, characterized and catalyzed by drug use. Indeed, some suggest harm reduction principles should stay explicitly neutral regarding legalization and decriminalization (Lenton and Single 1998:218). Nevertheless, many consider harm reduction as distinct from abstinence. Lenton and Single propose a “socio-empirical” definition of harm reduction that only considers interventions proper harm reduction if the “primary goal is the reduction of drug related harm rather than drug use per se” and if they include “strategies to reduce the harm for those who continue to use drugs” (Lenton 1998:216). While this may seem obvious, hidden in these claims is an implicit acknowledgment of the “archaeological and anthropological research [that] has shown that human beings have a craving for psychoactive substances. This craving extends to all societies, and goes back to prehistoric times” (Benavie 2009:113).

However, drugs have and continue to assume different places of significance across cultures, and in the US and most of the Western world this generally has been determined by their legal status and relation to market forces (Courtwright 2001:190-3). In an effort to theorize the continued illegality of some drugs amidst the post-World War II legal regulation of many formerly illicit pleasures, Race suggests that legalization is merely the state’s effort to “gear its legal apparatus to a consumer economy” (Race 2009:59).
Somewhat ironically, given the association of marijosea and LSD to the countercultural movements of the 1960s, Race believes that as the act of consumption alone “established itself as the constitutive center of social life,” drug use became recreational and a sign of “excessive conformity to contemporary consumer culture (Race 2009:59-64). Therefore, the state’s position on illegal drugs merely “defines legitimate modes of consumer citizenship” (Race 2009:62). Increasingly, as I’ve noted, this juridical stance is exercised through the prism of medicine, as previously moral or criminal issues are reconfigured as “social problems inspiring therapeutic…attention” (Race 2009:60).

A combination of human rights and public health is a neat way to encapsulate harm reduction principles, if working within an admittedly narrow and contemporary model of public health characterized by a focus on the social determinants of health (Krieger 2001). Krieger argues for a new understanding of a social production of disease marked by inequalities, informed by public health research showing that “19th century declines in mortality in the UK and US [were] due chiefly to improved nutrition, not medical intervention” (Krieger 2001:671). She aims to locate how health fits into an overall political economy, for example, considering redistributive policies to reduce poverty as “healthy public policies” (Krieger 2001:670). From this perspective, human rights and public health are both essential components to harm reduction, and scholars have struggled with how they interact and which should be prioritized. Burris attempts to use harm reduction to synthesize the two aspects, explaining that the rights that matter to him are the “right to the conditions in which healthy choices…are not just possible but hard to avoid. A decent job, a decent place to live, a say in how things are done” create the social conditions that “make health an easy choice” (Burris 2004:244). The principles
of harm reduction thus far emphasize how harm is socially enhanced, if not created, instead of a purely medical phenomenon. Correspondingly, attempts to shift the paradigm of harm reduction in order to incorporate this sociopolitical reading have suggested moving from a notion of risk to a notion of vulnerability. Ezard (2001) lays out a nested distinction between harm, risk, and vulnerability. If harm is the negative consequence of drug use, almost always associated with HIV/HCV transmission, then risk is the likelihood of that harm occurring. Vulnerability, however, looks deeper at the roots behind both, defined as “predisposition to risk of drug-related harms” (Ezard 2001:210-3). While interventions can confront harm, risk, and vulnerability on an individual, community and social level, in practice, harm and risk reduction interventions focus on behavioral modifications that by their individualizing nature risk fragmenting already marginalized communities. In contrast, incorporating an attention to the vulnerability factors undergirding one’s risk-taking behavior necessitates a societal and structural analysis and response, even to individual vulnerabilities such as low self-esteem (Ezard 2001:214). Including vulnerability as an essential component to a harm reduction paradigm will ensure that structural-level analyses are discussed even in the context of designing new behavioral health interventions, and push public health to consider posing interventions more broadly.

Harm reduction principles are explicitly political, involving critiques of structural violence, neoliberalism, and medicalization. However, to be legitimated as public health practice, these activism-rooted oppositional principles were co-opted and misappropriated to survive under the realities of a neoliberal political economy and serve the needs and ideologies of a governmental public health discourse. Nowhere is this
phenomenon more evident than in the case of underground syringe exchanges transitioning to legal organizations. In their underground phase, syringe exchangers established a trust and rapport with the IDU community precisely because of their outlaw status. One staff member of San Francisco’s Prevention Point noted,

“the clients observed us taking a risk of arrest, which in the [drug-using] community has tremendous meaning…they perceived that we were more like them. They were carrying heroin in their pockets, they were illegal; we were carrying needles, we were illegal. And there was a reduction in the social distance.” [Lane et al. 2000:57]

In New York City, the underground exchanges required flexible structures that evolved autonomously as a means of avoiding police harassment and official bureaucracies. As a result, the first exchangers adapted their efforts to meet the clandestine world of IDU communities, creating a sense of mutual identification that bridged the gap between the two. As the gap closed, exchangers began to adopt some of the worldview of IDUs as a persecuted minority. This resulted in the organic development of innovative practices that responded to the realities of life as an IDU, such as “secondary distribution of syringes and mobility of exchange sites” and spontaneous, flexible, consensus-based decision making models, often influenced by ACT UP (Henman et al. 1998:1218).

This is not to wholly romanticize the state of underground syringe exchanges. Before legalization, syringe exchanges in New York City relied on private donations and funding from ACT UP. The monthly budget of both the two SEPs (in the Lower East Side and Bronx-Harlem) was less than $2,600 a month, but after legalization the American Foundation for AIDS Research contributed $70,000 a year to each program (Kochems et al. 1996:474). However, with this additional funding came additional restrictions. Although the underground exchanges were “self-regulating” in that their
ability to distribute sterile syringes depended on the available supply, once legalized, the state imposed caps on the numbers of syringes distributed, fearing both an expansion of the secondary distribution networks formed in the underground phase and backlash from accusations of increased drug use (Kochems et al. 1996:477). In addition, the state now required exchanges to officially register participants with ID cards, on the one hand a potential protection from police harassment, and on the other, an administrative burden that increased the time required for each exchange, lengthening lines and heightening anxiety among an already stressed community of IDUs. Increased bureaucratization required SEPs to (self)-impose regulatory tasks – added paperwork, reporting, time sheets, scheduled hours, which workers saw as a “necessary evil” of regulation that many resisted (Kochems et al. 1996:481). This new bureaucratic reality also altered the structure of SEPs, such that many now operate on a hierarchical three-tier model with a board of directors, salaried staff, and group of volunteers - a far cry from the more egalitarian, consensus-based model of their underground phase. This served as another temporal and logistical barrier to consulting with users and responding quickly and effectively to their needs. Furthermore, new requirements about referrals diverted human and financial resources into not only HIV prevention education, but often also into drug treatment, testing, and case management. Although many early SEP workers “did not see their role as encouraging enrollment in methadone or detoxification treatment programs,” the New York State Department of Health required direct provision of referral to drug treatment (Kochems et al. 1996:482, Henman et al. 1998). Moreover, although legalization generally protects participants and workers from prosecution, it by no means eliminates the threat of police harassment. In fact, the ongoing War on Drugs, as
reinforced by local law enforcement, “may prevent [future] SEPs from being established. Thus, local activists often find it easier to implement underground SEPs than to fight difficult institutionalized policies” (Tempalski 2007:425).

Certainly legalization enables SEPs to expand availability and resources to match their intention of reaching more IDUs. However, “in acquiring official status, SEPs have shed their spontaneous and autonomous, even sometimes overtly anarchist character, and come to resemble other ‘street-oriented’ nonprofit organizations” (Henman et al. 1998:1223). Legalization also institutes new demands, restrictions, and bureaucracies that can divert attention and funds from the initial emergency task – getting syringes into pockets. Thus, legalization can manifest a widening of the social distance between SEP workers and participants (Lane et al. 2000:64). This imposed distance between SEP workers and participants is a predominant characteristic distinguishing harm reduction principles from Harm Reduction practices.

Institutionalized Harm Reduction is now deployed to support a plethora of public health practices, and in the process, manipulates the rhetoric of “agency” and “empowerment” to reinforce a neoliberal logic that displaces structural responsibility for health onto individuals, while also relying on medicalization and an extension of state power. A cursory glance through the Drug War Facts book, published by Common Sense for Drug Policy, reveals an explicit appeal to neoliberal cost saving measures. For example, on one page, “the estimated cost of treating an HIV positive person is at least $195,188” (Holtgrave and Pinkerton 1997:54-62) is juxtaposed with the reality that, through 2005, “241,364 cases of AIDS were reported to have been transmitted through injection drug use (Centers for Disease Control 2005), suggesting that syringe exchanges
are “common sense” not because they support rights or even health, but because they save money. In fact, a study about Prevention Point Philadelphia advocates an expansion of the SEP program on the basis of its projected favorable cost-effectiveness ratio alone. The author demonstrates how, by adding 2-3 new sites in populations of high density AIDS cases and increasing client base by 28%, the “estimated cost per case of HIV averted would be $2800” (Harris 2006:157), without offering advice on how the organization itself could afford such an expansion. Clearly preventing HIV transmission among IDUs saves the state money in the long run. Additionally, Common Sense for Drug Policy cites studies by the CDC and the Surgeon General who describe Harm Reduction programs as a means to an end to drug use entirely, citing how SEPs “also provide other public health services, such as HIV testing, risk-reduction education, and referrals for substance-abuse treatment” (Satcher 2000). Granted, this book is intended to reach a wide audience, including policymakers, but it is important to note how Harm Reduction practices are now cited for their ability to function in accordance within both a neoliberal and medicalized framework.

In a public health textbook entry about Harm Reduction, Nodine (2006) conflates many different programs under the grand rubric of Harm Reduction, including needle exchange programs, methadone, decriminalization of drugs, moderation management for alcohol abuse, potential reduced exposure products for tobacco consumption such as heated or noncombustible tobacco, sex education and condom distribution in schools, and even weight management as an alternative to dieting for obese patients. From her public health perspective, Harm Reduction is an innovative strategy to manage “risky behaviors” of all sorts (Nodine 2006), not one that addresses the structural cause of many
negative health outcomes of these behaviors. Indeed, the public health discipline has now taken a hold of the harm reduction movement and revised its more radical aims to serve its own purposes. Fischer praises the effect of Harm Reduction policies in Germany, in particular as they have started to “tackle the problems and risks related to the drugs consumed – the ‘agent’ exercising its critical effects on the ‘host’ within a given ‘environment’” (Fischer 1995:402). This statement neatly encapsulates the public health perspective that the drug users themselves are the ultimate agents of change relating to harm, locating harm individually, and not politically or structurally. In fact, he goes on to explain how methadone substitution was developed as a means to avoid the risks of consuming black market drugs, pointedly avoiding a discussion on decriminalization or legalization of heroin and cocaine entirely. For Fischer (1995), Harm Reduction is an ideal strategy to actually reduce crime, noting how “Hamburg police report that general crime incidents and categories in which drug users have been identified as main suspects have dropped almost dramatically between 1992 and 1994” (Fischer 1995:405). This statement praises Harm Reduction practices for their ability to effectively manage and decrease criminality among drug users, but does not call for an examination of how criminalization of drug users continues to increase the harm they are faced with. In fact, Fischer manipulates the principles of harm reduction even further by mentioning that “the number of newly registered heroin users in Frankfurt has also declined significantly from 903 in 1992 to 557 in 1993” (Fischer 1995:405), praising its ability to ultimately end drug use in society at large, rather than accepting that drug use is a fact of life, and that abstinence is not equivalent to the principles of harm reduction.
Even when abstinence is understood as distinct from harm reduction, Harm Reduction interventions are called upon as last-ditch strategy to enhance a patient’s “self-efficacy.” In one such article, a nurse recounts how her use of a harm reduction intervention to an alcoholic HIV positive woman was successful because the step approach enabled the woman to add rum to her dietary supplement, thereby gaining enough weight to maintain a course of antiretrovirals (ARVs). One throwaway clause in the article, “even though her husband had been abusive,” describes an exogenous factor that might compel the patient to keep drinking, but in the field of nursing, Harm Reduction is applied only as a means of “promot[ing] behavior change that improves health” (Schmidt and Williams 1999:70). This articulation of Harm Reduction in a medical context demonstrates its compatibility with medical interventions, rather than autonomy from medicine all together. In fact, some now claim the medicalization of female circumcision can be implemented “as a harm-reduction strategy,” explicitly linking Harm Reduction practices to the forces of medicalization (Shell-Duncan 2001).

Most critics of Harm Reduction note how its acceptance as public health practice has included an over-emphasis on technologies of agency that reinforce a socially atomizing neoliberal logic while also legitimizing and extending the reach of the state as a new form of (self)-regulation and governmentality. Miller (2001) references Foucault’s concept of “surveillance medicine” first outlined in Discipline and Punish (Foucault 1995[1977]), wherein surveillance characterized a shift from sovereign to disciplinary power as a means of regulating individuals and populations. The medical framework became a model for this surveillance as a system that fostered self-discipline, in that individuals “gazed upon themselves” (Miller 2001:171). Thus, many public health
programs focus on health as an individual responsibility, with messages such as “Stop Smoking,” “Exercise,” and “Have Safe Sex;” thus Harm Reduction practices must also fit neatly within that rubric. By emphasizing technologies of agency, such as using bleach before injecting, Harm Reduction practices aim to make target or at-risk populations productive, “capable as individuals and communities, of managing their own risk” (Roe 2005, Dean 1999). Here, the state doesn’t actually have to address the social causes of risk, as the focus is solely on individual consequences and threats to society. Campbell and Shaw (2008) provide a lengthy description of how these technologies of agency are internalized and ritualized as responses to ethnographic inquiries. IDUs, now accustomed to being subjects of ethnographic research on HIV transmission, have been conditioned after many years to associate ethnographers with the norms of Harm Reduction discourse. Correspondingly, they repeat as mantras, “‘I always use bleach’ and ‘I never share needles’ – even while failing to use bleach or using their partner’s needle before an ethnographer’s eyes” (Campbell and Shaw 2008:696). These repetitions are perhaps a way to dismiss the morals of public health, or merely to shield users from further scrutiny. Additionally, Fraser’s review of health promotion materials on safe injection techniques for Hepatitis C prevention reveals a call to “Use new equipment every time – It’s your life!” creating an unrealistic ideal situation where a drug user must simply choose to take responsibility for protecting and managing his or her life, “despite very real material constraints” (Fraser 2004:202). In other materials, this responsibility expands to the entire community of IDUs, as materials instruct users to “actively encourage your friends to do the same!” (Fraser 2004:204). Roe emphasizes how specific interventions merely design productive techniques that effectively “elicit compliance
through self-regulation” rather than coercive power, evidence of an overall shift in the management of society. These techniques achieve a socially stabilizing effect, by helping to save money on HIV treatment and law enforcement (Roe 2005:246). Therefore, they are evidence of a governmentality that characterizes many neoliberal states, which have bestowed their powers for direct intervention onto an array of private service providers, locating power “in the social rather than in overtly governmental institutions” (Roe 2005:246).

Outside of the US, scholars cite how supervised injection sites (SISs) are also forms of governmentality with their increased “socio-spatial” regulation, since they contain users within one specific site. This accomplishes the work of governmentality in two ways: getting users off the streets to purify the city and thereby present it as an attractive consumption space, and regulating their use within the site as a public health measure (Fischer et al. 2004). Once within the sites, users are subjected to an intricate set of values, norms, and practices that draw boundaries of good citizenship by “mobilizing an elaborate new moral code of what defines a responsible, well-behaved and safe drug user” (Fischer et al. 2004:362). In the process, the SIS makes drug users into citizen-subjects, by first “embedding a pattern of norms” and then “securing through surveillance” (Fischer et al. 2004:362). Even the promotion of heroin overdose prevention through the administration of Naloxone (Narcan) can exemplify neoliberal governmentality. Harm Reduction messages conceive of a drug user as an autonomous agent free to choose to change risky behavior. If the user fails to regulate his or her intoxicated body, this failure of self-discipline labels him or her a chaotic subject, when in fact these messages are not embedded in the everyday reality of a chaotic marginality.
that many drug users on the street reckon with, facing isolation and violence that often accompanies homelessness or survival-based sex work (Moore 2004:1554).

As public health increasingly embraces Harm Reduction strategies, it does so to support its own discourses of agency and empowerment. By insisting upon a government of the self as a means of managing risk, common Harm Reduction practices suggest users enact technologies of the self, such as hygienic injecting skills or administering Narcan to friends, to become rational, empowered, and responsible consumers of risk. This discourse of empowerment characterizes the autonomous, individualized neoliberal subject who has the right as a consumer to make choices that manage his or her risk.

Neoliberalism has become a hegemonic discourse, even in the harm reduction movement. Between 1996 and 2004, the Harm Reduction Coalition added one principle to its original list of seven, now eight. It states that harm reduction, “Affirms drug users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use” (Harm Reduction Coalition 2004). Their deliberate use of “agency” and “empowerment” suggest that neoliberalism is, at the moment, here to stay. Therefore, it’s important to witness how users themselves internalize and interact with this rhetoric.

Moore and Fraser (2006) demonstrate that users have indeed taken on these terms as constitutive of their subject position, and suggest that adopting a neoliberal viewpoint may productively endow users with a sense of resilience that enables them to counter marginalization and stigma (Moore and Fraser 2006:3039). However, as previously stated, these neoliberalized subjects do not exist in a vacuum of sociopolitical power dynamics, so if we must refer to this discourse of agency, we would do better to
“decenter” the neoliberal subject. In an effort to reformulate agency in a fashion more responsive to the reality of users’ lives, Moore and Fraser suggest we ought to reposition subjectivity to “acknowledge irrationality, desire, fragmentation, and multiplicity” promoting a “view of agency as dispersed or intersubjective” (Moore and Fraser 2006:3041), and re-conceptualize responsibility as “distributed and shared, rather than located in the autonomous (neoliberal) subject” (Moore and Fraser 2006:3041). If Harm Reduction practices adopt this more robust and complex notion of subjectivity, perhaps the harm reduction movement can both mobilize and subvert neoliberal discourses of agency and empowerment to locate responsibility for disease prevention not simply within the individual drug using subject, but within the interlocking network of social, criminal, medical, juridical, and political forces from which the HIV crisis stems.

D. Rethinking Harm Reduction

“When people close doors, we jump out of windows” – Jose D.

History and theory serve little purpose if they are not grounded in the lived experience of those who are a part of their development. Thus, it is useful to discuss how SEP workers on the ground at PPP view harm reduction. Site workers are politically informed, if not outright activists, and collectively embody this tension in transition from “ideology to logistics” (Henman et al. 1998) and therefore their statements problematize my simplistic separation between principles and practices since the two aspects of harm reduction adjust to the many circumstances they encounter.

Gus was the first SEP worker I met who is still working at PPP. We met on a cold Wednesday at the mobile site at 13th and Washington. The area was very quiet, and the site was extremely slow. The van was parked right next a row of beautiful, almost-new
low income houses, representing the demographic shifts in the neighborhoods since these sites were first established in 1992. These demographic shifts probably accounted for why the site itself was so slow, or perhaps it was just the fact that few drug users are ready to exchange needles from 10:30am-1:00pm on a Wednesday. Regardless, I stepped into the van and within five minutes, a cop car drove past. Gus said, frustrated and through his teeth to Emily, “That’s the second time that cop has driven by here. What the hell?” Instantly, I understood that SEP site workers were aware of the precarious position, not of their jobs that are chartered by the city, but of their participants, who are at constant threat of police intimidation and violence, regardless of the cards PPP gives them that allows them to be protected from a paraphernalia charge within the City of Philadelphia alone. The cards do not, however, protect users from police violence, or excessive searches. As Luke later pointed out to me, “finding syringes on someone, legal or not, is going to give a cop all the more reason to look through all your stuff and search you more” (Dunn 2012).

For our formal interview, I met Gus at a coffee house in West Philadelphia. Although I prefer to meet people on their own turfs, he lives around the neighborhood and the coffee house was right outside a bus stop that was on his route. We sat down at a table and began talking. Although I attempted to record him, the coffee house was noisy enough that I decided to take notes on my computer instead.

Like all the SEP workers, Gus is aware of the myriad social and political inequalities in this nation, and has worked with drug users for a long time. Raised in Detroit, he is a tall, large white man in his mid-40s. His mother worked at a methadone clinic in the 1980s in Detroit, so he saw the first wave of HIV going through a third
perspective. His mother worked at a program for pregnant users, many of whom were sex workers, and so aside from men who have sex with men (MSM), he was exposed to the entire spectrum of infection’s victims early on. After moving to Chicago to pursue a BA in German, after which he completed graduate studies in German and Linguistics, he heard of harm reduction work through a friend who had used needle exchange services in San Francisco. She told him they were effective and that she got a lot out of them, and eventually she stopped using. She also sent him a bibliography of materials on harm reduction; since he was in academia, working at the University of Chicago library at the time, this method worked for him. He contacted his local exchange, the Chicago Recovery Alliance, and began to volunteer. The longer he was there, the more involved he got. Before long, they hired him (Grannan 2011).

Gus’s origin story and relation to harm reduction is an anomaly from some workers at PPP, as he is not from the Philadelphia area (or even the Northeast), and is not himself an injection drug user. Moreover, he comes from an academic background, so his approach to harm reduction began and in many ways still persists at an academic, theoretical level. When I asked him to help me define harm reduction, he used personal anecdotes to reinforce many of the same ideas I’ve gleaned about harm reduction from my research into its principles. It is not public health, is autonomous from medicine, and it resists criminalization by maintaining a heavy critique of state power; it is also avowedly compassionate and always a bottom-up approach that values the dignity and choices of each individual participant. However, that is not to suggest that it is an extremely cut and dry ideology, as the tension of his position reveals.
The easiest phrase Gus repeated to describe what harm reduction “is” to me was simply, “meeting people where they’re at,” a phrase often repeated by harm reduction workers nationwide. He himself called it a “mantra” that he keeps in mind when he’s doing his job, as it can extend to most situations, physical and emotional, which a harm reduction worker will encounter when with a participant. “It’s not the job of someone who’s using to get to me at a place I determine at a time I determine in a way I determine; ideally, I would be able to go anywhere anytime I want to and do harm reduction work. The only thing that should be driving it should be the needs of the IDU.” However, given his position as part of PPP, Gus is very aware that the mantra that represents the principles of harm reduction is in fact compromised by the Harm Reduction practices PPP is required to exercise. Each day, one site is available for approximately 2 hours at various parts in the city that are often inaccessible or not as high-density drug using areas as they were twenty years ago. Confronted with an inability to spatially “meet people where they’re at,” as Gus understands the restrictions imposed upon his work, he has found ways to focus on how that mantra applies to every interaction with IDUs. While he believes in the basic human quality of trying to take care of yourself, more importantly he believes in every human’s ability to “pursue your own health goals” even if not apparent to a casual observer. He gave me the example of a transwoman who desires to get hormones instead of ARVs. For him, harm reduction puts the participant’s ordering of their needs ahead of a larger policy goal, and this is a big change from most HIV programs in general. Now there is a big wave of “treatment at prevention,” but for many, the temptation to talk someone into treatment puts their injection or gender identification
needs under HIV, and doesn’t value the person’s autonomy in their own health decision-making ability.

“If a person says to me, ‘It’s more important to continue to access hormones than treatment,’” but if they were in a place where treatment was directly medically indicated, I would probably try to advocate for treatment, but respect their desire and make sure they get the needles. They would have to be in awfully bad shape to start advocating for ARVs. It’s not that I’m going to ignore treatment, but [in harm reduction] you allow the person to prioritize their own health needs; respect the person’s arrangement of needs over whatever preconceptions you bring to the table” [Grannan 2011].

This logic clearly runs counter to public health practices, which would prioritize treating an infection above respecting someone’s gender identity and autonomy in health decision-making.

Harm reduction is certainly not public health, as Gus told me time and again, but that doesn’t mean harm reduction has an explicitly antagonistic relationship to public health. According to Gus,

“public health had no effective response to the spread of HIV among injectors, drug injectors did. While it can be fruitful to work with public health practitioners, and look at models of disease transmission…some specific people working in public health are awesome, but for the most part public health practitioners can at best measure the effects of harm reduction. As long as drug use holds the place it does in society, it’s going to be hard for a mechanism so intimately tied up with the government to take a leadership role” in the drug using world” [Grannan 2011]

Even around the world, there are problems with governments turning harm reduction strategies into public health policies, he points out, and the many critiques above of institutionalized Harm Reduction speak to this reality. Moreover, Gus says, public health has its own historical problems as a field:

“It’s not a democratic idea in any sense of the world; if you quarantine someone, yeah that ensures life, but not liberty or the pursuit of happiness. And that impulse [to quarantine] is there, even if it’s unusual to happen. The head of health policy in the US is a military officer: the Surgeon General. Only other thing I can think
of where that is also true is the actual military. There is no equivalent to the Secretary of Defense for Health, maybe the HHS” [Grannan 2011].

This pointed political analysis of public health’s proximity to state power is indicative of the tensions between the harm reduction movement and its official, aboveground practices that workers struggle with every day.

The easiest way for workers to overcome this tension is to simply live their politics. One of the central tenets of harm reduction is compassion, and this manifests in many ways. First, Gus cited not putting a prerequisite for obtaining service on a cessation of use or behavioral change, but providing a service regardless of your use status as a harm reduction step. “I don’t care if you’re drunk,” he says, “having a roof over your head will make your life better. Once your life is better, maybe you can make changes.” He admitted that this is not an easy perspective for everyone to understand, but like any job, it is suitable for some and not others.

“Have trouble concentrating? Don’t be an accountant. Risk averse? Don’t be a firefighter, or in finance. Lack empathy? Don’t do harm reduction. You have to have a very strong belief in the basic humanity of all people to do this job, and be willing to change your approach given new research, or the reaction of the person in front of you to your suggestion. There is no flowchart of yes/no to go through this effectively. You must be willing to listen and respect information your interlocutor gives you as valid,” because it represents their experience and at the moment, that is all that matters in your interaction with them.

After talking with Gus I get the feeling that he sees harm reduction as extremely individually centered and therefore empowering. Having reviewed so many critiques of how this individualizing discourse of empowerment is deployed in public health to support a neoliberal agenda, I initially found it hard to reconcile the empowerment promoted by public health authorities worldwide with the empowerment that harm
reduction workers promote in the field. Ultimately, I believe the empowerment of harm reduction workers differs from a public health discourse in its directionality, referring to another central tenet of harm reduction, that it is “bottom-up.” Gus reminded me that the whole movement was started by active users as a way to address problems they saw in ways they knew would accomplish, and that the further a program gets away from the participation of active users, the less effective it is. Everything Gus learned about harm reduction he was taught by active users, typifying this bottom-up approach.

By allowing someone to prioritize their own health needs over larger public health strategies, you empower them in the decisions they are already making, rather than imposing a discourse of empowerment on them to convince them it is right to adopt a sanctioned public health strategy. The bottom-up directionality of “empowerment” rhetoric is thus qualitatively different in harm reduction movement discourses versus public health discourses. Supporting and generating empowerment from below, not coercively imposing a sense of empowerment from above, more correctly summarizes a harm reduction approach. This is due to harm reduction’s awareness that people cannot always make rapid changes in their lives, so a step approach is most realistic. To be compassionate one must work with the victories, however small they are, to get towards making a bigger change.

Therefore, Gus considers his title as harm reduction worker a difficult term, because, “I’m not sure how much harm reduction I do. Certainly disease prevention happens when whoever gets a clean needle uses a clean needle, but it’s not me being somewhere. It’s very centered on the person exposed to the harm. A good syringe access worker gets himself out of the way as much as possible. I supply materials, answer questions if asked, but I’m not reducing harm actively at that moment. It’s in many ways an egoless game. I can reduce harm for myself, but it is harder to reduce harm for other people. You can’t go into every interaction thinking, “I have to act positively to make this person healthier”’” [Grannan 2011].
This statement could seem to reiterate many of the critiques of Harm Reduction imposing a sense of responsibility on individual IDUs to make behavioral changes. However, Gus interestingly juxtaposed harm reduction from disease prevention, explicitly not conflating the two, as would most public health practitioners. When his statement is contextualized in the compassionate and bottom-up framework that Gus reiterated over and over, it seems clear that it is merely a way to also relieve himself of responsibility for individual health, perhaps because he is aware that there are larger forces at play which do more harm to everyone than any one individual behavior. In fact, he sees the bulk of his job as

“ameliorating the negative effects of society’s attitudes toward substance use and users. Part of my job of harm reduction is working to minimize the harm that society directly does. If there were a rogue cop running around Kensington, I would see my job as trying to stop that. It’s about reducing the harm society has, not necessarily the harmful effects of substance use. One of the most harmful substances around is alcohol. Ethically, we can do more to reduce the harmful use of alcohol, it’s very damaging, but that’s not done” [Grannan 2011].

This poses the question, why are some drugs considered more harmful than the others? It probably has to do with the state and market’s control over legitimate modes of consumption and investment in the process of othering those who use institutionally illegitimated substances for pleasure (Courtwright 2001, Race 2009). Overall, Gus contextualized harm reduction work in an explicitly political frame. When I asked him if he feels fulfilled in his position, he nods vigorously and says,

“You can see multifarious positive effects in people’s lives. People take benefits they get out of it in different ways. I’ve seen people make astonishing changes, keep themselves healthy in the face of incredible social oppression. A positive change in someone’s life can be maintaining health with an active habit; I’m completely comfortable seeing that as a positive result of my work” [Grannan 2011, emphasis added].
Here, Gus simply reiterated many of the principles of harm reduction, not only an explicit rejection of abstinence, but a broader frame contextualizing use and illness within social and political oppression. He went on to subvert the public health definition of agency by directly labeling the “agent of harm [is] social norms and values.” It is for this reason that our interview ended on somewhat of a low note. With this broader social perspective in mind, he said, looking down at the table, “Sometimes I wonder if there is any harm reduction in Philadelphia.”

I met with Jose at about 10am one Thursday morning in his house in a “Puerto Rican ghetto” in North Philadelphia, several blocks from the PPP offices. To my surprise, Mike was staying there with Jose, and came downstairs with this dog to smoke a joint before heading out to work. Jose remarked, “We live in a colorful house. Does the smoke bother you?” I said it was fine, and after Jose lit a cigarette, we started talking. Jose is a gay Latino man in his late 50s, or as he says, “I’m a big ol’ fag.” He lost an 18-year partner to AIDS years ago (Otterbein 2011), and has been a core activist with ACT UP Philadelphia almost since the beginning and became involved with PPP about 15 years ago, four or five years after it started. He is from the Philadelphia area, but has lived “all over: Jersey, Ohio, New York,” and although he never tried crack or heroin, he grew up in the “age of disco” and has done drugs on and off his entire life. Furthermore, he has friends who are drug users, and “just because they are on drugs doesn’t mean they should get AIDS. They are my friends, plain and simple.” As with most, his connection to the AIDS epidemic and activism is what got him involved in harm reduction. Jose’s statement about his friends materializes the intersectionality of the harm reduction movement’s aims at the historical moment of the AIDS crisis, extending a coalition of the
condemned to include queers, as well as drug users, sex workers, and the poor, as often those categories were not mutually exclusive. Since he comes from an activist mindset, he is used to spinning Harm Reduction policies to conform to a multiplicity of agendas. When I asked him, “Why harm reduction?” he answered simply, “Because it works. But we have to push it from a cost effective angle. 8 cents a needle, that’s a good policy. Still, we live in the US, people in the middle of nowhere don’t care about drug addicts; they just want us all to die.” Immediately Jose sets up the dichotomy between harm reduction movement principles and Harm Reduction practices that I attempted to outline above. The only way to get “harm reduction” anything to happen in a public forum requires compromising and spinning it to fit whatever political discourse is dominant. In this case, the cost-effective angle fits the anti-welfare, neoliberal discourse of the moment. Referring to this friction between the movement and its practices, Jose says, “Even though you wanna be rad and fierce, you can’t put 4000 people who use our services in jeopardy. If we [PPP] get shut down – boom – no needles. And then we have to go back to people doing out of their cars again.” Sometimes, he suggests, it’s not feasible to equate harm reduction as a movement with the Harm Reduction practices at PPP, because the movement threatens power arrangements. Gus also mentioned this deliberate division saying “there are long term goals, such as trying to challenge societal views of drug use, but I’m not counting on that to change anything tomorrow. It’s fine to have goals but they can’t work to the exclusion of continuing to help people dealing with very short-term needs.” Given the population PPP attends to, the emergency support it needs right now is more important than the repercussions of challenging those in power.
Once he established a firm boundary between his activist work with ACT UP and his work at PPP, Jose explained his jobs. He's currently working on something called Proyecto Sol, which organizes Latinos with HIV in a six-week class called Project Teach. In the course, he teaches people how to live with HIV, how to take their medications, informing them of different infections they’re prone to get, how to treat them, how to talk to their doctor, read their medical labels, all things that were not available to poor people of color for many years. Julie Davids, one of the founders of PPP, wrote the course material and the program has been running since 1995. Although not syringe exchange, this Project Teach class embodies many harm reduction principles, extending nonjudgmental information to marginalized people about how best to navigate the medical system. As Jose is also HIV positive, the class can be seen as a mutual imparting of knowledge in order to empower individuals to navigate and make demands on the medical system more effectively, challenging the power imbalance inherent in the doctor-patient relationship.

Jose’s thoughts on harm reduction in particular ranged from the personal and situational to the broad and political, challenging my assumptions on what really “counts” as harm reduction at all. He started out by impressing upon me that harm reduction is very different for every group of people.

“It’s completely different for Latinos versus African Americans. Because of cultural things, stigma. With Latinos, Catholicism plays a big role: sex outside of marriage, stigmas and taboo, cultural difference, machismo is very prevalent and has a great deal to do with infection rates. With African Americans, guys don’t wanna be seen as gay, they’re sleeping with a man, in love with a gay, but don’t know how to deal with that, so still they’re having unprotected sex with women to avoid that. Now numbers [of infection] in black women are skyrocketing. That won’t change until someone talks to them, on their level. Maybe they don’t need to be having sex behind a bush in the park, but it’s a lot different for each community. With youth culture, too. When you’re young, you feel like you’re
invincible, you have that rebellious side. I think young people who wanna be
doing rad stuff should be doing harm reduction stuff. It should reflect the people
you wanna give harm reduction techniques too. I mean, even though I’ve had sex
more than any of those kids in some STI training combined, you know they’ll
never believe me, but if you talk to them, maybe they would listen” [DeMarco
2012].

Although on the one hand, Jose seemed to reinforce some racist assumptions that
HIV rates are rising because of the backwardness of different cultural groups in the US, I
actually think this statement advocated the need for a more responsive public health
approach to Harm Reduction, one which didn’t promote the same state-sanctioned Harm
Reduction strategies for everyone, but adjusted to specific contexts in an effort to be
more culturally competent. Jose is aware that harm reduction shares many similar aspects
to public health. “People who believes in harm reduction are always white. It’s difficult
for a white person who’s not poz (HIV positive) to tell people, ‘You should be doing
this.’ We need more POC in harm reduction, who understand their own cultures and
communities, and can make it relevant for their own people.” Later, he mentioned how
in one site meeting, Gus had said, “‘POC (people of color) need to be listening to harm
reduction, but I thought, ‘Gee, that’s the wrong attitude. It needs to go the other way, be
bottom-up. The notion that ‘I’m the expert, even though I’m not a part of the community,
don’t look like you, etc…’ that attitude is imposing from above.” This repeated emphasis
on the bottom-up ideals of harm reduction conflicts with a public health attention to the
individual locus of harm. Yet paradoxically, as with Gus, Jose believes harm reduction is
distinct from public health precisely because it is so individualized, and therefore pays
attention to the granularity of each situation:

“public health is just blanketed for hundreds of thousands of people. Harm
reduction is personalized for each individual. It’s also always for marginalized
populations and communities. Public health has a really strict conception of who
and what the public is, and harm reduction treats or deals with people who public health doesn’t consider public. Most of the time, it’s really filling in the cracks that public health leaves open and ignores. It’s getting real raw and specific, talking about sex, telling someone “don’t let them cum in your mouth, this is what you do if...[trails off]. It’s just so different, and it has to happen” [DeMarco 2012].

Even though some of the specific actions he mentioned are behavioral adjustments, the discourse of harm reduction movement constructs the individual as the locus of the solution, not the locus of harm. A larger critique Jose presented suggests that public health as a field evolved to implicitly constitute normative segments of the population as “public” to the exclusion of others. Dean Spade explains this as an effect of “population management power” in the US under governmentality, reading Foucault to unite individualized disciplinary power and broader population-management power. By creating normative ideals for productive citizens on an individual level and then enforcing these standards through generalized policies, these programs target and exclude those who do not fit the norms. It’s not that policies are explicitly racist or sexist, but rather that normative ideas about race and gender become mobilized to support a policy that ultimately accomplishes such a purpose. For example,

“the mythology of Black criminality is produced and used to justify a range of War on Drugs policies, from sentencing enhancements to exclusion from public housing and higher education. Support for these population-level programs is mobilized by the use of racist and sexist images that construct ideas of ‘us’ and ‘them’ – a national population that needs protection and constitutive others who are cast out as threats and drains to that population” [Spade 2011:111-3].

While public health is superficially concerned with protecting everyone in the nation, for those engaged in harm reduction work, which attends to “the cracks” left by broader public health interventions, it’s clear that public health interventions are designed to enforce normative constructions of what constitutes the “public” in public health. When
public health appropriates Harm Reduction, it does so to reinforce among participants the notion that they are merely threats to the public at large, vectors of disease that deserve regulation and surveillance, but are also too unimportant for the neoliberal state to manage directly, therefore individual behavior modifications are the only strategy they are given to regulate themselves, relieving the State of responsibility by displacing it on individuals.

Jose clearly understands how public health interacts with Harm Reduction, and at one point in our conversation decided to abandon the state-sanctioned definition in favor of a much broader and more radical one.

“Harm reduction is a whole lot of things. It has to go deeper than what people conceive of as harm reduction. Being able to initiate conversations – say with the wife of a man who was in prison and may have been having gay sex. She doesn’t know how to have that conversation, protect herself, but talking to her, that’s harm reduction. My kids are hungry, what am I gonna do? That’s harm reduction. It’s turning a trick, not always for drugs, mind you. I’ve seen people exchange sex for Pampers, Alex. It’s helping people with the simplest things in their lives. Much more than condom use, bleaching out a needle. Good harm reduction has to be holistic [draws a circle in the air with his fingers]. You write what you have to to get the money you need, but harm reduction is basically just social justice work. It’s treating people with dignity and respect. I want to give people showers and one hot meal a day. Currently, all we can do is give them needles and condoms” [DeMarco 2012].

If Harm Reduction seems like a mere extension of public health practices to marginalized populations, it’s only because organizations like PPP don’t have enough resources to fulfill the potential that the harm reduction movement still desires.

For others, like Luke, harm reduction has a much more deeply personal and affecting significance that is sometimes even “apolitical.” I met Luke at his house in South Philly on a bright Thursday afternoon. It’s a nice row house that formerly belonged to his mother, but he has to sell it and move to North Philadelphia because, as is all too
common in our neoliberal political economy, the neighborhood is being increasingly
gentrified and has rapidly become too expensive to live in. Attendant to this, I notice a
giant new condominium under construction just a few yards from his house. Inside, the
house is nearly vacant with no lights on, as he is in the process of selling it. Luke is a
white man in his early 40s from Delaware County outside of Philadelphia, but has been in
the city for 20 odd years. Several years ago he moved out of Philadelphia to Prospect
Park. He’d been clean for 7 or more years and worked at a rehabilitation center called
Miramont for that time period, and “besides, I liked Delco, it’s where I grew up, I have
family there.” He first worked at PPP four or five years ago, then went to jail for a little
while and lost his job because of it. When he got out, he worked for Project HOME doing
homeless outreach, and then worked at the Camden, New Jersey exchange before coming
back to work at PPP’s SEP part time. He’d known about PPP for a long time, having used
its services for more than decade. The very first time he went there he had been “living in
a hit house and getting high pretty hard, so I had sores on my back. I was worried about
it, thought I had HIV, so I went PPP to see the doctor.” As an SEP worker, Luke is
invaluable due to his connection to the community of homeless and drug users around the
Kensington area, and it was this level of social embedding that got him the job again,
despite losing out on the coordinator position to someone “with a degree.”

When I asked him if he was a “current or former drug user,” I inadvertently not
only asked the wrong question but also started an entire discussion on the benefits of
harm reduction discourse at an individual level. He responded,

“God, yeah, ‘current drug user’ I guess. But see it’s a funny thing about that
question. I’ve been in and out of programs so much that I’ve been brainwashed.
You know part of the 12 Step program is to self-identify as an addict, and you do
that all the time, constantly, so even if you’re clean for a long time you always
self-identify as an addict. Current or former drug user doesn’t really resonate. Even if I’m not using now, I’m always gonna be like a timebomb, and could be using. That’s how they approach the ‘disease,’ because you’re ‘diseased’ like you always have it. It might be under control now, but you still have it. That’s the way it is with addiction theory. I don’t subscribe to that addiction concept. Maybe because I’ve been de-conditioned from being around harm reduction, but I’ve started to say ‘user’ instead of ‘addict.’ Addict implies sick, diseased. Like clean vs. dirty, stuff that you never really think about. I used to call myself a junkie for a while because it was just natural for me to self-identify that way, until one day Nadja said, ‘It’s weird that you say that, do you think about the toll that it takes on your self-esteem? And I really appreciated that. Harm reduction is good for peeling that onion. Changing how we talk about drug use changes how people view themselves. How healthy is it really to be continually self-identifying as an addict all the time? It’s better to look at drug use as this multifaceted thing that involves society, economics, not just addiction. Like, I’m not some leper” [Dunn 2012].

Although Luke first became acquainted with harm reduction through methadone maintenance and didn’t know about syringe exchange much, the principles he picked up quickly affected his life and self-conception.

“It’s the principles, like rights of users, dignity of the drug user, helping to de-condition me from being brainwashed by my family, society at large for being a really bad person, a sick or dirty person, into realizing that it wasn’t the case. If I’ve gotten anything out of harm reduction, it’s that. We’re more than just drug users or junkies, we’re people and are a part of communities and families” [Dunn 2012.]

More than almost anyone, Luke is aware and verbally critical of the tension between the harm reduction movement and the public health institutionalization of its practices, what he calls the “hijacking of SEPs by the public health world.”

“You wonder sometimes how much you can trust people, you feel that tension. At Prevention Point I’m saying, look plus tens is not enough [referring to the SEP policy that allows workers to give ten extra syringes for any amount under fifty dispensed for an exchange], and I talk to management and I get vacant looks. You wonder where they’re at with stuff. For them, it seems the SEP is just a part of Prevention Point, but where I look at Prevention Point, the other stuff is just an added bonus. The SEP really is Prevention Point, but I don’t know if that’s how it’s looked at anymore. People say that’s what happened when the Ryan White money came in, there was this emphasis on testing. But is testing even harm reduction? Yet resources get focused towards that. There needs to be one place
where people who are still using can feel safe, and with this focus on testing you scare people off. This one girl had been coming for a while and after getting asked about testing, she started avoiding us. She just wanted to be left alone, get syringes, that’s it. You wanna be safe, get clean syringes, but you might stop coming if people keep talking about testing, constantly reminding you about risks. Testing, case management, it’s good to have them but it shouldn’t be bad to think of the SEP as a service unto itself. That’s enough sometimes. It’s great just to get someone coming on a steady basis getting clean syringes, and taking that as a victory. That’s worth a budget and money alone. People will eventually make the decision to do different things. Whether or not we have case management or testing doesn’t affect it, they would do it either way. Besides, a lot of the people who use services often know more about navigating the system better than case managers” [Dunn 2012].

It’s plain to see that this tension between the harm reduction movement and institutionalized Harm Reduction practices is real and experienced most personally by drug users themselves, whether working at PPP or just using its services, since sometimes those lines are not so clear cut. Luke understands why this public health “hijacking” is taking place.

“PPP is mainly funded by the Office of Addiction Services (OAS). That’s why the sites, except Saturday, happen mainly within business hours. The rationale is that OAS wanted PPP to be a gateway into treatment. That’s what their M.O. has been the entire time, what they want to use PPP as. They see the SEP as a way of bringing people in to get them involved in billable services, they’re not just happy that people are coming for syringes at all. That fucked up harm reduction, the intent. It’s not that services are a bad thing, I don’t wanna close doors, just have more doors open. People know how to use the system, they don’t need it shoved down their throats.” [Dunn 2012].

This may be a hasty statement, and it would be imprudent to simply disregard services altogether, and Luke knows this. Later on, he told me that

“PPP is awesome because if you’re in Kensington, stuck down there and been on a run, don’t know what to do, PPP is well positioned to help you with basic issues: getting you an ID, connected with the Behavioral Health Service Initiative (BHSI) or Community Behavioral Health (CBH). It makes a real difference to have someone advocating for you. If people go on their own, they will get shuffled out, but with PPP, they will actually get treated, the agency will work with them and it will be a different experience. They won’t shuffle them through” [Dunn 2012].
PPP still serves a more ideological and principled harm reduction purpose in the way it interacts with other state services such as BHSI or CBH. Like with Jose’s Proyecto Sol, which teaches positive people how to navigate often-inaccessible medical terrain and jargon, PPP acts as advocates on behalf of their participants, using the system to the benefit of its participants if they need it. The means of promoting these services at PPP could be different, but they are a part of the reality of existing as an aboveground service organization, not merely an underground needle exchange. Still, Luke believes PPP could do more to advocate directly for participants who are enmeshed in a system that may not understand them.

“ER visits, I wish we could do more of that, develop a relationship with ERs. Like have one ER that is their go-to for taking people. Because now we’re taking people to ERs and having them be mishandled, judged, and ending up where they don’t the services they need. I know this one dude, his whole leg has been amputated. There’s a communication gap, that’s the problem. He’s aggressive, smells, and gets defensive, maybe he’s mentally ill. They take him at his word and don’t realize where he’s coming from. I’ve watched him for years as his leg gets chopped off one bit at a time. A lot of this is because he doesn’t have access to running water” [Dunn 2012]

Difficulty accessing and maneuvering emergency rooms is an unfortunate reality for many users, and Luke thinks PPP can put its harm reduction principles into practice by doing the work of anthropologists (Bourgois and Schonberg 2009:97-9) and acting as cultural translators when users become patients in medical institutions.

“People are less willing to go to the hospital after one bad experience being treated like shit. But it’s hard to tell medical providers what to do without making them feel inept. We just need to let them know that sometimes you have to learn to filter things differently, and think about what they [patient] need. Typically there will be some disagreement because the person will start med-seeking, and then the whole thing will turn to shit” [Dunn 2012].

If PPP were to intervene, it could challenge medical perceptions of drug users and extend harm reduction’s commitment to “non-judgmental, non-coercive provision of
services” (Marlatt 1998:7). Luke also sees PPP as well positioned to bring to the forefront issues that are at the core of users’ lives but are forgotten by most other agencies, such as homelessness. Currently, the way that homeless are counted is by splitting the city up into segments. Each nonprofit does one section, but Kensington

“just isn’t on the map, people aren’t even counted there. At PPP, I would identify people as chronically homeless, call up the City, tell them about it. I mean, a big reason he’s in and out of ERs is because he doesn’t have access to running water, so his cellulitis is acting up. If we could get him housed, everyone would be doing better. They’d be saving money, and his life would be better. But they would say to me, ‘He hasn’t had enough contacts or shelter stays.’ But people who use are shelter resistant because it doesn’t fit in with the choices they make in their life. Their rules make it hard for someone who uses to stay there. They don’t get credit for being homeless and don’t qualify for these programs” [Dunn 2012]

For Luke, housing is as much harm reduction as syringe exchange, but only if it doesn’t require abstinence before entry, as Gus mentioned earlier. And although Housing First policies that take a low-threshold approach are gaining traction, housing, like SEPs, can get “filtered through other criteria that’s not very harm reductionist. Access is tricky, because services still use coding which neglect people and neighborhoods,” he says. PPP is perfectly poised to get people into houses that need it, and SEP workers like Luke are more determined than your average overburdened and disconnected case manager who does not have such intimate and ongoing experience with the community he or she serves.

Luke’s indispensability to the organization demonstrates that in practice, PPP actually does continue to take its cues from users. Even though he came into this work as a product of the 1980s, “with my head full of ‘BEWARE OF HIV’ messages, I didn’t know anything about Hep C, and so many people like me didn’t know anything either. Harm reduction is falling short with Hep C, so when I got back to PPP I told them we
should get rid of those water bottles, because they were just Hep C waiting to happen.” He was referring to small refillable water bottles with caps that the SEP dispensed in its usual supply bag before around July of 2011. Since then, the SEP has dispensed one-use plastic strips originally used for nebulizers in hospitals, of both sterilized water and saline, the latter of which more closely matches the PH content of one’s blood to help prevent scarring and allow veins to heal faster after injection. PPP continues to ensure that drug users do have a “voice in the programs designed to serve them,” (Marlatt 1998:7), as they actually help design policy. It seems PPP is not just imposing a false sense of empowerment from public health strategies designed above, but actively valuing knowledge generated organically, and thus empowering users less hierarchically.

As Jose and Gus relayed, PPP cannot be as overtly political as the harm reduction movement principles state. However for Luke, sometimes it does feel political.

“Not always, like when I’m dealing with people one on one, a lot of it is really personal, because of my past, it’s almost apolitical. But I do have a lot of resentments. That’s actually a Jon Paul line, something like ‘being a survivor, a battered veteran of the drug war. I have resentments, I have fucking scars, diseases, I’ve been in jail. I’m a casualty of the drug war.’ It’s hard not to see it politically, knowing it’s not necessary and it’s such a fucking failed policy. It’s good to know I’m helping, but sometimes I feel like a MASH unit. This war is still raging on but I’m helping comfort people. Because that war is political, then yeah, by default it makes it political. But here’s the thing. If this wasn’t a job, I would be doing it anyways, helping users. I have to do this to make sense of my life, of the pain and suffering. Otherwise I have years of this shit for what, why?” [Dunn 2012]

It seems that for Luke, the old feminist slogan “The Personal Is Political” is an apt way to describe the intersection of politics with his health and personal life in his work at PPP.
II. PREVENTION POINT PHILADELPHIA

As with other syringe exchanges in the US, ACT UP began running what is now PPP’s SEP underground as an act of civil disobedience and mutual aid to the community of IDUs in North and South Philadelphia. Although, as with most US syringe exchanges, much of this organizing mobilized a discourse of health relevant to the raging AIDS epidemic, in Philadelphia drug users were active participants in the establishment of the underground SEP that would become PPP. Over the past year as I became close with activists and workers involved in PPP, one name consistently popped up: Jon Paul Hammond.

Jon Paul Hammond was a pansexual and openly HIV and HCV positive IDU from Northern Liberties who became involved in ACT UP Philadelphia in 1991 after returning from a brief position as student executive of his alma mater, Friends World College in New York (Colletta 2010). Described as a “force of nature” (Lxbean LiveJournal), he was one of just a few people who, understanding the threat HIV posed, stood up for drug users and called for a syringe exchange (Colletta 2010). Unwilling to wait for bureaucratic legislation in a health emergency, Jon and other ACT UP activists began distributing sterile needles and condoms (perhaps under the name Midnight Cowboys) in mostly North Philadelphia and some parts of South Philadelphia. They relied on active drug users to head up the programs and then followed their leads on what to do, exemplifying the bottom-up approach of most grassroots harm reduction organizations in the US. “You need an entrée into those communities to help it run effectively, and active users were the perfect means” (DeMarco 2012). In its underground phase, the ACT UP outgrowth ran mobile sites out of the back of volunteers’ cars late at
night, distributing needles paid for by ACT UP Philadelphia (and other regional ACT UP groups) and the Friends Neighborhood Guild. Meetings were underground and everything was “real hush hush” (DeMarco 2012). Through private funds and individuals, needles were shipped into the city. It is even suggested that the city itself found ways to get money for needles in the underground era. “No one will ever say that out loud, but at the time, we had a decent mayor” (DeMarco 2012). Ed Rendell, the mayor at the time, “got AIDS all along. Rendell had a gay son with AIDS in the very beginning, so the movement hit home for him” (DeMarco 2012). Regardless, the political unpopularity of syringe exchanges prevented Rendell from just “coming out and sanctioning the exchange to make it law. He had to be forced, through public pressure and demonstrations” (DeMarco 2012).

ACT UP Philadelphia also led aboveground activism to address the rampant AIDS crisis. For years, Jon Paul and other ACT UP activists called attention to the AIDS epidemic and urged political support for harm reduction syringe exchange programs. In one such action, Jon Paul, David Acosta, and Kiyoshi Kuromiya locked themselves in a barbed wire enclosure outside of the US courthouse in Center City Philadelphia to call attention to Camp Bulkeley, the Guantanamo quarantine of HIV positive Haitians (Gossett). In July 1992, Ed Rendell signed the syringe exchange into law by issuing Executive Order 4-92, declaring a public health emergency that legalized the possession of syringes within the City of Philadelphia accompanied with a PPP registration card, protecting users from paraphernalia charges (but not police harassment). Still, Rendell fought with the governor at the time, Robert Casey, who declared that he would arrest
anyone doing needle exchange. Rendell said publicly, “Well then I will be the first one you arrest,” and the program survived (DeMarco 2012).

Throughout the 1990s and the present, ACT UP Philadelphia members played a formative role in developing city, national, and international strategies to combat the HIV epidemic. ACT UP Philadelphia activists started many of the AIDS service organizations in the area. David Acosta founded the Gay and Lesbian Latino AIDS Education Initiative (GALAEI), a multi-service organization bridging the gap between LGBT and AIDS communities, and is now the coordinator for HIV/AIDS prevention programs in the Philadelphia Department of Public Health AIDS Activities Coordinating Office (AACO). Nan Feyler, an ACT UP activist who used to distribute needles out of the back of her car, became the executive director of the AIDS Law Project in 1993 where she served for seven years before becoming Chief of Staff for the Philadelphia Department of Public Health. In 1992 Kiyoshi Kuromiya founded the Critical Path Project, which began as a newsletter that translated complex biomedical information about new HIV drugs for people of color, women, and poor people. This newsletter transformed into the first ever HIV Standard of Care used nationwide. Jane Shull founded Philadelphia FIGHT, which started as just three people doing research in order to get AIDS drugs to people through clinical trials, a true example of activist science (DeMarco 2012). As ARVs became more effective but inaccessible to millions of Third World citizens who needed them because of corporate patents, ACT UP activists paved the way for expanding global access to treatment, founding a group called Health GAP (Global Access Project). “PEPFAR (US President’s Emergency Plan for AIDS Relief) was thought up in West Philadelphia bars by ACT UP activists years ago,” said Jose, who currently sits on the board of Health
GAP (DeMarco 2012, Otterbein 2011). ACT UP’s most recent demonstration on July 9th, 2009 involved twenty-five protesters, including several members of ACT UP Philadelphia, who chained themselves together in the US Capitol Rotunda, demanding an end to the federal funding ban on syringe exchange and increased housing for people with AIDS. On July 10th, the very next day, Obama signed federal funding for syringe exchange back into law. “I don’t want to say that our action had everything to do with that,” Jose asserted, “but you want us to push you, yeah motherfucker, we’ll push you. And it lifted the stigma off of it. Even if it was only for two years” (DeMarco 2012). One sentence buried at the bottom of an immense omnibus spending package in late 2011 reversed the decision. PPP never saw the money anyways, as the State of Pennsylvania prohibits any funds from supporting syringe exchanges (Moraff 2011).

PPP is arguably the most effective HIV/AIDS prevention organization in the entire city, and it is certainly the most underfunded and underappreciated. In 1992, the HIV infection rate among IDUs in Philadelphia was 42%. Between 2004 and 2006, the IDU population was the only high-risk group to experience a drop in HIV infection rate, from 23% to 12%, according to a Philadelphia Department of Public Health epidemiological study (Schwarz et al. 2008). Their funding comes primarily from OAS and AACO, with supplementary grant funding from private foundations including the AIDS Fund, Drug Policy Foundation, and the Tides Foundation. Their current mission is “to reduce the harm associated with substance use and sex industry work by promoting health, empowerment, and safety while advocating for human policies and programs” (Prevention Point Philly) interestingly treading the line between neoliberal public health and harm reduction activism. Their services include not just an SEP, but also the Street
Side Health Project, providing free medical care to participants at both mobile sites and their office at 2nd and Lehigh including the Stabilization, Treatment, and Engagement Program, a low threshold suboxone program presented as an alternative to methadone maintenance treatment; the Trans Health Information Project, one of the first organizations of its kind providing HIV prevention materials and health education for trans and gender-variant individuals in Philadelphia; Comprehensive Risk Counseling Services, essentially case management connecting participants to counseling, social services for food or housing, and medical or legal services; the Jon Paul Hammond Computer Lab, including training in computer basics, online job hunting, resume writing, and online GED preparation; and the Harm Reduction Services Center, a drop-in center offering free HIV/HCV testing, referrals, clothing, and several groups such as the Safety Counts group that provides health education for drug users involved in sex work.

Although PPP has evolved to offer a range of services, its core is the SEP, which operates five mobile sites and two fixed sites during the week throughout the city. The SEP offers a wide array of needles from a 29 gauge to a 13 gauge with removable tip to meet any participant’s injection needs, be it heroin, cocaine, or steroids or hormones. The standard needle is a 27 gauge Terumo, a gauge large enough to inject both heroin and cocaine, the latter of which can easily clog in a smaller gauge. The Terumos are also individually packaged, making them easier to sell on the streets than the higher-quality BD syringes, which maintain a reputation for excellence among older generations of IDUs. Many people sell ten packs of individually packaged sterile syringes from PPP for just one dollar, a practice known as secondary exchange that is mutually beneficial for the seller who makes money from city-funded syringes, and the buyer, who receives
sterile syringes much cheaper than in pharmacies. Indeed for several participants, selling needles from PPP is their “main hustle” (Dunn 2012), and SEP workers are fine with this, because the more needles they distribute, the more they flood the street market of syringes, driving prices down and thus enabling more people to access sterile injection equipment.

Funding and political restrictions limit several dimensions of PPP’s exchange program. Each site operates for only two or three hours, and generally during working hours. The sites have been fixed since 1992, despite geographic and demographic shifts in drug using populations. Moreover, the exchange maintains a less-than-simple system for exchanging needles. Below fifty needles exchanged, the SEP offers an additional ten needles in an attempt to get users to build up their reservoir so they can exchange higher quantities later. This is a sly policy that displaces the responsibility of acquiring enough sterile syringes, oftentimes for entire hit houses or shooting galleries, onto users themselves, but is necessary due to funding restrictions. Above fifty needles, the SEP offers a one-for-one exchange, with a maximum of 600 needles per user per day.

Additionally, the SEP provides a supply bag with a bottle of bleach, three strips of BZK antiseptic wipes to clean off site on the body after injection, alcohol prep pads for pre-injection, strips of sterile water and .45% NaCl saline solution for mixing up shots, metal caps for cooking the shots (although in Philadelphia the heroin is pure enough that many users do not heat their drugs), small and large adhesive bandages, bags of cotton filters for drawing up the solution into the barrel, and antibiotic ointment for abscesses. Wound care kits including two-by-two and four-by-four gauze pads and conforming stretch bandages with tape are also available, and necessary for many users with chronic abscess
wounds. As of July 2011, the SEP also offers “safer smoking kits” for crack users, including a laboratory-grade glass “straight” pipe, balls of “chore” copper wire scrubbers to ignite the rock, wood chopstick pokers, and a rubber spark plug cover as a mouthpiece, intended to prevent the transmission of HCV, which can live on surfaces much longer and spread among crack users with cracked or burnt lips. As these crack kits are relatively new, their budget comes from the syringe budget, and thus PPP can only distribute one per person per week.

Reflecting on Jose’s statement that harm reduction fills in the cracks that public health leaves open, it appears that whatever PPP cannot do aboveground as a city funded public health organization, ACT UP does instead. Often the most effective PPP-supported programs are officially autonomous ACT UP actions, following in the vein of the organization’s direct action genesis. For example, Sam, an ACT UP member and former PPP staff member, created a short-lived drop in center for sex workers known as Women’s Night, but additionally organized ACT UP members to walk up and down Front Street and Kensington Avenues in the middle of the night, physically handing syringes and condoms to sex workers. In the middle of our interview, Jose told me, “it feels weird for me to tell you, ‘Don’t say this is PPP, this is ACT UP, keep them separate,’ but we have to keep the two organizations completely separate, because there are things PPP cannot get caught doing, otherwise it will get shut down.” There are populations that PPP cannot legally reach, such as youth under 18, but one way or another PPP, through ACT UP, finds ways to deliver needles to this institutionally ignored demographic. There are also exchanges in the greater area that PPP supports,
both financially and with actual syringes, but it’s “still underground, it’s really hush hush” (DeMarco 2012).

It seems that for PPP, the transition from underground activism to aboveground public health is both ongoing and perhaps a perpetual state of being, with ACT UP serving as the direct action wing of a chronically and institutionally undermined organization. To further explore the relation between the two, I attended an ACT UP Philadelphia demonstration on March 21\textsuperscript{st} outside Republican Senator Pat Toomey’s office on the National Day of Action on Syringe Exchange to “ask him why he wants people to contract HIV and Hepatitis C.” I arrived at 16\textsuperscript{th} and JFK a few minutes past noon to find three people, a middle-aged white man and two younger black men, one of whom is a HIV tester at PPP, standing on the sidewalk, unsure of where the rest of the group was but fully stocked with press materials. Quickly we realized that the sixty-odd demonstrators had gone to Love Park to rally before marching back the Senator’s office. I ran across the street to catch up with everybody and after a few minutes of chanting, we marched back across the street to the plaza outside the Senator’s office. The crowd was extremely diverse, in age, race, and income. I saw most of the staff of PPP, including the Executive Director, Director of Programs, several case managers and counselors, and Mike, an SEP worker. Mike brought several friends with him, all of who fit comfortably within the description of “crust punk.” Crust punk is musical genre and subculture influenced by anarcho-punk and metal with nihilistic, political leanings, visually characterized by fans that often wear black clothing with studs and spikes, have many tattoos, and decline regularly washing as a social statement. Many in the crowd arrived by taking a bus that left from the PPP offices that morning. The chants and signs reflected
the constant tension between syringe exchange programs as a smart, neoliberal public
health practice and as a moral and human right for drug users [Figure 1]. In the same
round, we shouted, “Clean Needles save lives / Lift the ban now // Clean needles save
money / Lift the ban now,” and “Prevention is a human right / Lift the ban now // Pennies
now or millions later / Life the ban now.” Purely by order, it appears ACT UP prioritizes
the human right of drug users to access syringes safely, but as an organization that must
convince the public to support a health program it consciously mobilizes a neoliberal
discourse of cost-effectiveness in the same breath. After counting, I discovered that the
chants provided were evenly split between those appealing to human rights and a
neoliberal rationality. Two white women from Project SAFE, a sex worker outreach
project, a white doctor from Jefferson who works at PPP, a Latina HIV tester from PPP,
and a white, disabled man and former IDU all gave impassioned defenses of syringe
exchange, many directed at PPP in particular. After a short skit, three demonstrators
walked into the office building in an attempt to speak with Senator Toomey and present
him with two large bills, one totaling the costs of a lifetime’s worth of HIV medication,
and the other totaling the costs of syringe exchange for one year. The demonstrators
managed to make it in the building and to his office, but were refused an audience and
came back down to the plaza. ACT UP had not planned a civil disobedience because
organizers expected a higher turnout of drug users and did not want to put them in a
situation with arrest potential. The demonstration ended formally at 1PM, with the
intention of drawing people on lunch break, and everyone filtered back to the bus or their
offices.
Although small and tame compared to another action in DC that same day in which four demonstrators were arrested, the protest still provided an interesting cross-section of what PPP does well and what it can improve. First and foremost, PPP should be commended for bringing people out to a demonstration in the first place. It expresses a commitment to their mission, “to advocate for humane public policies” (Prevention Point Philly). The intersectional representation in the speeches brought together sex workers, drug users, doctors, positive people, and activists under the banner of improving the health and safety of marginalized people in Philadelphia. Noticeably absent, however, were larger numbers of drug users and homeless people that Jose desired and who would have been present in Vancouver, where the VANDU drug users’ union has had an integral role in pressuring the government to establish harm reduction policies not just on the basis of health, but on the human rights of the community. Although internally the boundaries between PPP practices and ACT UP actions blur, externally PPP is still a public health organization and necessarily operates as an extension of State biopower, which has a disciplining and thus depoliticizing effect on its participants, who are thus less able or willing to bite the hand that feeds them in an age of neoliberal austerity.
III. BIOPOWER

Foucault uses the term biopower, literally “life” and “power,” to refer to a new means of effecting power over bodies in the West since the classical age. Whereas before the sovereign exercised power over life through subtraction, with the sword as symbol of the sovereign’s right to take life or let live, in the modern era, power has since transitioned to serve a more complex and insidious purpose. Subtraction, or deduction, is now but one element of power among many that work to “incite, reinforce, control, monitor, optimize, and organize the forces under it: a power bent on generating forces, making them grow, and ordering them” (Foucault 1990[1978]:136) rather than coercing submission. Together, these constitute a new regime of power with the aim of “fostering life or disallowing it to the point of death” (Foucault 1990[1978]:138). Foucault concretizes this abstract analysis of a power over life by dividing it into two mutually reinforcing and co-developing poles, the first, an anatomo-politics “centered on the body as a machine: its disciplining, the optimization of its capabilities, the extortion of its forces, the parallel increase of its usefulness and its docility, its integration into systems of efficient and economic controls, all this was insured by the procedures of power that characterized the disciplines.” (Foucault 1990[1978]:139). The second is a biopolitics of the population which centered on the “species body, the body imbued with the mechanics of life and serving as the basis of the biological processes: propagation, births and mortality, the level of health, life expectancy and longevity, with all the conditions that can cause these to vary. Their supervision was effected through an entire series of interventions and regulatory controls” (Foucault 1990[1978]:139)

These two poles work together in a new system of biopower with a purpose to “invest life through and through” (139). Foucault cites a vast array of diverse technologies and
disciplines that since the seventeenth century have carried out the role of biopower to manage life and make it productive, including universities, barracks, economic observation and of course, public health.

Biopower isn’t necessarily good or bad, but it has effects on both an individual (species body) and national (population body) level that reflect its ability to create, manage, and optimize a productive citizenry as subjects of the state. Correspondingly, every state policy is designed to serve this purpose. Therefore, biopower could be said to mediate this oft-cited transition from the underground social movement of harm reduction, dedicated purely to saving lives, to its form as institutionalized public health practice, now invested with the responsibility to discipline, render docile, regulate and “surveil” the bodies of IDUs. Scholars have criticized methadone maintenance programs for their ability to discursively and practically “discipline addictions,” transforming addicts into “patients” by providing methadone as a “treatment” under the discourse of Western biomedicine, thereby creating well-disciplined subjects of a system with aims to foster productive citizens and manage the impact of any non-productive citizen on the population body (Bourgois 2000:169).

However, as demonstrated earlier with the historical contributions of ACT UP, even US activists in the underground phase of the harm reduction movement were “immersed in a discursive regime of biopolitics” (McLean 2001:76), staking their calls for state-sanctioned syringe exchanges on a “right to life,” thus perhaps subverting or expanding the normative constitution of the population body to include marginalized individuals, but still mobilizing and therefore subject to the discourse. This had mixed...
effects, as evidenced by the perpetual state of tension and liminality PPP’s SEP workers finds themselves in.

For this reason, the SEP as a public health intervention is a perfect example of the forces of biopower on individual and population levels, and almost too easy of a comparison. Still, it’s worth identifying some anatomo-political and biopolitical dimensions of an institutionalized Harm Reduction organization to expose the insidious nature of a biopower regime.

At the level of the species body, the SEP directs a modality of power that renders docile the bodies of participants and volunteers through “codification that partitions as closely as possible time, space, and movement” (Foucault 1995[1977]:137). Each time I arrive at the PPP office for the Friday site a few minutes before opening at noon, there is always a line of people standing outside the door. As it gets closer to noon, participants begin checking their watches, some counting down and verbally announcing each minute until noon when the doors are scheduled to open. Such an attention and adherence to a regimented schedule suggests that participants are disciplined to accept and anticipate the strict management of time as a precious commodity. However, not all participants are as punctual, so the precise measurement of time is reinforced near the end of the site, when fifteen minutes before 3 PM, when the Friday site closes, someone working the front desk announces to everybody in the lounge and line that the “public bathroom is closed, we are closing in fifteen minutes, do your exchanges now.” Promptly at 3PM, the doors lock and anyone remaining inside the drop-in center is told they must leave unless they are waiting on a doctor or case manager. Very rarely do exchanges occur outside the allotted timeframe, and even at 3:05 PM people are turned away at the door for having arrived too
late. That most of the sites occur during working hours perhaps suggests to participants that they cannot be fully productive citizens and healthily manage their habits at the same time, but one must come before the other; this has an even further subjectifying effect.

The spatial distribution of the sites and careful arrangement of participants’ motions is another means of instilling a sense of docility among participants. The fact that the PPP offices, exist in a basement has a spatially disciplinary effect, and is “demoralizing” (DeMarco 2012). Everyone enters through a descending staircase, each step bringing one closer to a physical manifestation of a socially marginalized and stigmatized status [Figure 2]. Elsewhere in the city people arrive at a specific place often quite removed from their homes or places of work, thereby contradicting the harm reduction mantra of “meeting people where they’re at.” Once they arrive, they must line up one after the other. At the end of one Thursday site, some new volunteers from a local pharmacy school remarked to Gus about how “orderly” the site went, with people lined up in a “very organized” fashion. Just this past week, a velvet rope appeared in the hallway of the office for the Friday site as a means of keeping participants partitioned off into discrete cells from those walking back and forth down the hallway to meet with doctors. After participants arrive at the sites, they must keep their used syringes in their bags until the time to do their exchanges, a careful management of people’s movements with a justification that references another aspect of biopower. If the site worker does not physically witness how many syringes each person is exchanging, he or she will have not an accurate idea of how many syringes he or she is allowed to give out, as the number to exchange is strictly regulated by PPP’s “plus ten” and “one-to-one” policies described earlier. At the Friday site some workers, especially Mike, strictly direct people’s motions
across the line. Unlike the mobile site, where the sterile needles are in the van and supplies are laid out on a table outside of a van, such that participants can line up to do an exchange and then move to the supply table, on Fridays both supplies and needles are contained in the back room, which no one can enter except for volunteers and site workers, and program participants must line up in the hallway against a wall perpendicular to the path which volunteers take shuttling bags of syringes and supplies back and forth. As Luke says, this is an “entirely different dynamic” that keeps the participants invisible and alienated from the site workers, whereas there is much more mutual interaction at the mobile sites. This alienation creates a sense of professional disconnect between workers and participants, and some workers often enforce this boundary. I’ve attempted to transgress the narrow border separating participants in line from the site workers in the supply room several times, and Mike frequently chastises me. One time I stepped just past Mike to hand a box of five hundred needles to someone who had disappeared into the lounge, and he told me to not walk past him for two reasons. The first was that it “breaks the line,” thus interrupting the efficiency of the exchange process, an anatomo-political and Taylorist reasoning. The second was on the basis of health, to prevent “needle stick” injuries, since participants must carry exposed sharps in line to be counted, rather than dispose of them immediately. In the back room, volunteers make supply bags that are in and of themselves examples of a public health system that aims to discipline users through carefully outlined techniques of the self. The supplies offered, such as bleach, tourniquets, alcohol pads and saline promote a ritual of shooting up safely, as each item serves a specific purpose when used in a specific order. This not
only disciplines habits but also optimizes health, demonstrating another productive aspect of biopower.

When participants arrive at the front of the line to do an exchange, they are also subject to several ritualized scripts that reference the highly interconnected dimensions of a biopower system. One Friday when Luke went to do his own exchange, he repeated the desired script to Mike, saying, “Here’s my number. I would like ten 27 gauge syringes, a tourniquet, and supplies.” His speech was so pedantic as to suggest that he had either been conditioned by the ritual, or was merely performing it in order to condition the others in line behind him by example. If someone does not have their ID number or card on hand, they must endure an even more complex script for the site worker to find their unique identification number in the PPP registry. The script goes:

“What are the first two letters of your last name? What is the month and year of your birth? What are the first three letters of your mother’s first name?”

These questions are asked as a means of protecting the anonymity of each participant, but for many they have a confounding effect. Often participants are impatient, in a hurry, or do not speak English all that well, so when the last question about their mother’s first name is asked, many pause and ask to hear it several times before they understand, bearing humble expressions of bewilderment on their faces. Moreover, these questions are tied to demographic information the participant submits as a condition of registration, exemplifying the surveillance aspects necessary to run PPP as a state-sanctioned public health intervention. Each registration number and therefore participant is anonymously connected with information about their “race, gender they identify as, zip code, and drug most frequently injected.” While this is notably inclusive
of transgendered individuals, the zip code question still forces many homeless participants to admit their status in the line, as many do not know what zip code corresponds to the neighborhood they sleep in.

As a condition of legality, PPP must survey its participants according to public health guidelines. Thus, the sites are also opportunities for PPP to offer HIV and HCV testing to people, and this information about infection statuses gets sent to AACO. The emphasis on preventing infection filters down and becomes internalized by participants. In one such instance Sarah, a white woman in her mid-30s who is both a participant and a volunteer was drinking a cup of water in the back room during the Friday site. Another volunteer, a younger white female nursing student, asked if she could have a sip of Sarah’s water. Sarah quickly replied,

“No, I don’t want to. I’m not trying to be mean or anything, but I have Hep C, so it’s probably best if you don’t. A lot of people won’t tell you that so you have to be careful. I’ve been in the streets so I know. This one time I wanted to use a lady’s straight and she refused. I said, ‘Look, I’ll pay you’ and she still said no, and I kept asking and eventually she said, ‘No, you don’t want it; I have TB.’ So yeah, you gotta be careful. No one knows how big of a deal it is. Everyone’s so worried about HIV, but something like 90% of all IDUs will get it [HCV] at some point in their life, so it’s important to be aware of.”

This exchange highlighted how effective PPP is at promoting messages of health and safety at an individual level. Here Sarah engaged in a process of medical self-surveillance by taking personal responsibility for spreading infection, not only confirming her status but using it as a platform to promote the state’s message of infection prevention through individual behavior modification.

The mobile sites also inadvertently serve the state’s surveillance project towards IDUs in a much more direct fashion. In addition to registering participants’ demographic information and testing for infections, the mobile sites often expose participants to
heightened police surveillance. Although the police are “not supposed to” target IDUs who exchange at the sites, police cars drive by semi-frequently, possibly tracking the movements of those who do attend and intimidating others from coming at all.

Many of the conflicts I’ve witnessed at the SEP sites concern the regulations that workers enforce, crystallizing another distinction between the nature of an underground exchange and an aboveground enterprise. One time at the Thursday site, a man whom no one knew but had attended the site before walked onto the van, telling Gus he had come to volunteer. Gus, an ordinarily genial man, immediately stood up a little straighter than usual and says quite deliberately, “We have enough volunteers today, and I need to talk with you before you can volunteer here.” Several minutes later as the site is underway, the man had moved to the right of the supply table that I was working at, sitting on a stool next to the condom bin and breaking down boxes of syringes that people did not want to take with them. He handed the boxes to me to hand to another volunteer in the van to recycle. After a few more minutes I went back in the van to get a few more bottles of bleach, and Gus asked me, “Did that guy just start working?” to which I replied, “Yeah, well he’s been standing next to me but he’s not really doing much.” While he was breaking down boxes, he wasn’t set on a specific task like any of the other volunteers, but he wasn’t really hurting anybody or getting in the way either. Still, Gus’s tone insisted that we maintain a distinction between official volunteers and others. As the site got busier, more people arrived and asked questions about where to acquire works or supplies, and the man began telling people to “Go over there to Gus, he’ll help you out.” When people asked for condoms, he gave them out. Soon, I began speaking over the man to answer questions instead, and when people needed condoms I reached into the bin
before him, telling him “Don’t worry, I got it.” I realize now that I had quickly internalized and reproduced the strict regulations surrounding who can volunteer at the site, making it my personal duty to enforce the boundary between volunteer and participant. Unlike in its underground iteration, where input and spontaneous support from participants was likely encouraged or at least appreciated, this rigid border between official volunteers and participants seems wholly a product of a more biopolitical SEP. This could have to do with the fact that volunteers receive tokens as compensation, and since PPP’s financial resources are limited, they can’t offer tokens to anyone who spontaneously decides to hand out a few packets of condoms.

This phenomenon of resource restriction compelling regulation enforcement is the prime motivator for the most common conflict during sites. At least three or four times over the course of a site, whoever is directly interacting with a participant about an exchange will dispute the amount of syringes dispensed. Sometimes participants will bring in containers filled with trash or rocks in order to receive more syringes, and Mike will call them out on it, saying, “Please, don’t put trash in there. We have to pay to get these incinerated.” Other times, if someone dispenses a soda bottle or two of syringes and requests 500, Mike will pick up one of our standard medium-sized biohazard sharps containers and say, “When these are full, they hold 450. There is no way I can call that 500.” The most interesting aspect of these regulations is that they are hard to reconcile with a biopower framework. If the state were fully dedicated to using PPP as an organization that would make users’ bodies productive, it would provide PPP with more money with which to accomplish the life-enhancing and optimizing task of biopower.
effectively. Workers enforce regulations due to frustrations stemming from state-imposed resource constraints, suggesting the need for a more complex biopolitical analysis of PPP.

Although PPP subjects its participants to surveillance, regulation, and disciplinary measures, these repressive effects should be understood as consequences of a broader biopolitical framework, as the organization itself is also subject to state regulation and surveillance. As Jose explained to me, “PPP has evolved around rules, because people are watching everything they do. We have to jump through hoops for funding. We have to make sure every single number is correct, because AACO wants to find two numbers that are not correct just to withhold funding” (DeMarco 2012). Biopower thus operates in two iterations, regulating not just participants who are subjects of the program, but the organization itself, subject to state restrictions.

Although a biopower analysis is useful to examine different aspects of PPP, such as the way it manages individual participants the way the organization itself is managed by the state, it leaves some loose ends untied. Unlike organizations in other states and countries, PPP is constantly fighting desperately for resources; like their participants, the organization itself is fighting for survival. Federal and state funding bans combined with hierarchically and financially imposed restrictions on the duration and location of mobile sites all reflect a patchily implemented biopolitical intervention that would be better described as a precarious public health (McLean 2011:72). For an organization in a constant state of tension and liminality, this precarious state should be analyzed not just with a biopolitical perspective, but also with an attention to its flipside: necropolitics.
IV. NECROPOLITICS AND PRECARIOUS PUBLIC HEALTH

Achille Mbembe outlines the concept of necropower as a companion of biopower, using the examples of modern colonial occupation to better theorize how the sovereign’s right to kill still coexists with the State’s desire to foster life. For Mbembe, racism is a technology of biopower that “regulates the distribution of death and [makes] possible the murderous functions of the state” (Mbembe 2003:17). When late modern colonial powers occupied territories such as South Africa or modern day Palestine, the definition of sovereignty necessarily relied upon violence that “relegated the colonized into a third zone between subjection and objecthood” (Mbembe 2003:26), thus wielding the capacity “to define who matters and who does not, who is disposable and who is not” (Mbembe 2003:27). For a people under siege, biopolitical, disciplinary, and now necropolitical forces combined to subjugate life to the power of death.

In the US, a neoliberal hegemony has occupied poor populations of inner cities through rapid gentrification, the collapse of welfare, and declining social services. This contributed to an expansion of the lumpen, a class of citizens below that of the proletariat who are unlikely to contribute to production and must focus instead on the everyday struggles of survival, which for many includes merely acquiring enough money to buy another bag of heroin to get high and last them through the next few hours (Bourgois and Schonberg 2009). A notion of biopower cannot fully theorize the contribution of this class to society because, in many respects the state has now given up on their capacity for contribution, and, in public health discourses, deems them vectors of disease from which the productive public must be protected.
The state of PPP is also analogous to that of the lumpen under neoliberalism. What began as an underground strategy to aid the socially marginalized in their daily struggle for survival has been co-opted and therefore occupied by the State to serve both a biopolitical, disciplinary, and necropolitical purpose. While on the one hand, PPP does participate in a system of biopower as a public health intervention, on the other, its constant state of precarity suggests that the organization itself, like its participants, is also struggling daily to survive and fully meet the needs of its base. From this perspective, where syringe exchange is concerned the state is invested in both the optimization of some lives through regulation and techniques of the self and the subjugation of other non-productive, lumpen lives to the power of death. As the man responsible for the reinstated federal funding ban on syringe exchange, Representative Danny Rehberg once stated, “The problem with AIDS is, you got it, you die. So why are we spending money on the issue?” (Moraff 2011). Where those at risk for infection are concerned, a necropolitical stance that leaves them to die better characterizes the state’s contribution to the precarity of ongoing public health interventions.

As my fieldwork progressed, I noticed several examples of a necropolitical system working in concert with a biopolitical one. Within my first few months of volunteering, I learned that the city slashed the number of condoms given to PPP by 70%. As a result, the SEP began to use its budget for syringes to buy its own condoms, and also relied on donations from other public health groups such as GALAEI, stretching resources thin across organizations to demonstrate the citywide effect of a necropolitical policy. Furthermore, many of the donated condoms were nearly expired and of poorer quality and prone to breaking, according to Gus, a sad example of precarious public
health resources. PPP is also not allowed to distribute proper condom use booklets with their condom packets because in the 1990s they distributed a ‘zine for sex workers and the city censured them for promoting prostitution, thereby prohibiting them from including even the manufacturer’s proper usage booklet with condoms. Whereas larger organizations in Philadelphia get millions of dollars to open entire clinics, PPP operates on a mostly volunteer basis, relying on medical students from surrounding hospitals to serve their participants in daily rotations. In one instance, I went to get my flu shot on a Friday from a team of first and second year medical students. For fifteen minutes the two of them fumbled around a syringe while pinching my deltoid muscle before finally jabbing me with the shot, a simple procedure that surely most of the participants in the exchange line could have completed in a fraction of the time. As I sat in the chair waiting for the students to figure out how best to administer the shot, I wondered if I had been at another public health organization serving a less stigmatized social group, perhaps I would have received more well trained and competent care. Only in the past month has PPP included sterile alcohol pads with their supply bags, previously stocking non-sterile alcohol pads. Although this is admittedly a minute example, it is also a microcosm of how precarious public health simultaneously mobilizes and synthesizes biopolitical and necropolitical strategies that inadequately execute the displacement of responsibility for public health onto individuals.

As an organization, PPP’s constant resource constraints are evidence of the state’s necropolitical stance that aims to maintain the most effective public health intervention for IDUs in a constant state of precarity. Although PPP serves 4000 clients around the city and survives in a basement “all on top of each other,” upstairs in the same building
the Public Health Management Corporation has giant offices with hardwood floors and large flat screen TVs, only serving a fraction of PPP’s client base (DeMarco 2012). Even when PPP does get money from the city it is slow to arrive, requiring the Executive Director to, on occasion, pay salaries to staff from his credit cards (DeMarco 2012). When I ask Jose why a scientifically proven public health intervention must constantly struggle to operate, he shakes his head, saying, “Even with the cost effective argument, they still don’t listen. They just don’t care if people die, they just don’t.” (DeMarco 2012). One slow Friday, Gus and Luke discussed the state of syringe exchange nationwide, bemoaning how the better-run exchanges seem to be shutting down more frequently, when the poorly run ones are staying open. Gus suggested “the exchanges that are really bad are so bad because the government has its hands too deep in them to actually make them work.” It seems the state’s limited dedication to syringe exchange maintains the programs in a constant state of tension between the underground and aboveground, and as a result fosters a culture of resistance among site workers themselves.
V. MICROPOLITICS OF RESISTANCE

Although adherence to biopolitical and necropolitical constraints is an unfortunate condition of working at PPP, as with any situation of transition characterized by insecurity, site workers demonstrate micropolitical acts of resistance to several dimensions of State power, medicine, and public health, and cultivate an oppositional identity through mutual solidarity with drug users. Many consider biopower a totalizing system and discourse with no possibility for escape, but as Foucault describes,

“where there is power, there is resistance, and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power…the existence [of power relationships] depends on a multiplicity of points of resistance…These points of resistance are everywhere in a power network…Just as the network of power relations ends by forming a dense web that passes through apparatuses and institutions, without being exactly localized in them, so too the swarm of points of resistance traverses social stratifications and individual unities. And it is doubtless the strategic codification of these points of resistance that makes a revolution possible” (Foucault 1990[1978]:95-6).

Resistance is an inherent part of a network of forces in biopower, so while it is appropriate to analyze and critique the biopolitical and necropolitical dimensions of PPP, it’s also necessary to examine resistance to this system within the organization itself. One example is how site workers consistently de-ritualize the unique identifier registration script. Although the protocol requires workers to ask the series of questions in a deliberately scripted fashion to protect anonymity, many participants simply offer their birth date, last name, and mother’s first name. From this observation, workers such as Luke often take a shortcut around the official script by simply asking each participant the questions they would normally offer answers to, resisting a state-mandated protocol that slows down the line and could confuse or humiliate people in the process.
Even though many conflicts at the exchange concern the number of syringes disposed versus the number of needles given, many times workers will break down and give as many as the participant said they exchanged, even if the true number was clearly lower. Occasionally, some clients receive more than the 600 syringes per day limit, and more often than not workers will use their own registration cards to give someone an extra ten syringes, redistributing their daily allotment to participants. In fact, on my first day of volunteering Emily registered me in the system, knowing full well I am not an injection drug user but giving me my own card so I can “help others out” when they need extra syringes, an honest redistribution of resources.

The existence of the “safer smoking” crack kit alone is another example of resistance. Responding to a need within the non-IDU community, the crack kits are not officially sanctioned by the city, but when workers explain how the registration card protects participants from prosecution, they warn, “It doesn’t technically work with the crack kits, but the police don’t know that, so if they find you with a straight just give them your card and tell them it covers it.” This speech resists both enhanced criminalization and a sluggish bureaucratic response to real needs within communities, mirroring the impetus for the first underground exchanges several decades ago. Staff members are also not always thrilled with the supplies we hand out, mainly bleach. Luke has stated, “I wish we didn’t give out bleach, man, but to stop giving it out we’d really have to be giving out more needles, because you should really just be using a clean needle every time.” Other workers have noted that most people don’t always use the bleach for its intended public health purpose anyways, but instead request several bottles for cleaning things around the house, or dying their hair and clothes. Contained within
these statements is an implicit critique of the symbolic violence of public health outreach that promotes “hypersanitary messages [that] clash with the realities of practical survival on the streets,” and reinforces a public health discourse that compels users to only make individual behavior modifications to stay healthy rather than compelling governments to provide more resources (such as a sufficient number of sterile syringes to distribute) that would render individual sanitary actions largely unnecessary (Bourgois and Schonberg 2009:106-9). Every week Luke leads Narcan trainings that are by definition peer-based, disrupting the medical hierarchy of knowledge and thus resisting state requirements – the same requirements for which the Camden exchange, which distributed Narcan without doctors, was shut down.

The public bathroom of PPP also houses a de-facto safer injection site on Fridays, as both Jose and Luke acknowledge (Smith 2011). “We know what people go into the bathroom to do, we’re not stupid. I just hope no one goes in to take too big of a hit, and it’s like, ‘Where’s the Narcan?’” (DeMarco 2012). Near the end of a site one Friday Luke came back to the supply room saying, “Man, sometimes I just think about having a safer injection site you know? There’s this guy back there been trying to hit in his neck for the past twenty minutes, it’s a bloody mess.” It seems the bathroom has developed in resistance to the precarious condition of public health that PPP occupies. While having a true SIS would be “so wonderful. We could have more than one person at a time” (DeMarco 2012). In the meantime, the bathroom is an unspoken but fully acknowledged condition of resistance to a bio and necropolitical system.

For a period of time, also in an effort at efficiency given the severely limited hours during which the SEPs can operate, Gus decided to forego putting boxes of
hundreds of needles into paper bags as the city and just hand participants unopened boxes directly. Within a few months, PPP received complaints from the community about empty boxes of syringes piling up as trash around the Kensington neighborhood. This anecdote is revealing on several fronts. First, it seems the city-mandated “needles into bags” policy indicates the city’s necropolitical stance towards required inefficiency. As Gus contends, “we could do so many more things rather than waste our time filling up bags of syringes from the boxes we already have.” Second, the reason the community complained about the boxes is an example of synecdoche, standing in for larger structural problems concerning the socioeconomic status of the entire neighborhood that the harm reduction movement seeks to address. Here, the boxes were hypervisible in the community not only because they signified endemic drug use, but also because the area itself has little garbage pickup, and is widely known as a place where people from around the city can come to “dump anything.” It seems that if the community found the boxes so offensive, perhaps it was not solely because of their relation to drug use, but more because they served as a not-so subtle reminder to residents that they live in a chronically and institutionally ignored neighborhood that lacks basic social services. The root of the problem could be solved by increased trash pickup, itself another synecdoche for enhanced social services that would begin to address the “socioeconomic origin” of drug use (Tabor 1970). The act of giving needles in boxes directly to participants not only refuses state-mandated inefficiency, but also inspires a more structural analysis of the context of drug use in the area.

These acts of resistance occur every day, and when coupled with explicit political signs such as the old ACT UP posters mounted on the wall of the office or fliers for
upcoming ACT UP demonstrations taped to office doors, it’s clear that workers within PPP deliberately maintain an oppositional identity. This is either as a way to promote ongoing political activism for the harm reduction movement, or to declare mutual aid and solidarity with drug using participants in a reference to the underground era, mitigating the uneasy and ongoing transition and thus maintaining trust and support from a socially marginalized community by highlighting PPP’s institutionally marginalized status.

Near the end of a site on a Thursday, a woman named Kathy walked up to the van, and after completing her exchange she hung around chatting with some friends and SEP workers. A few minutes later, she asked out loud to a group of us, “Any of you seen a bag of dope? I think I just lost it. Shit, you’ve got to be kidding me.” Immediately Gus, Mike and I walked around the lot to scour the ground with our eyes. The dirt was already littered with trash and little plastic wrappers, so finding a small bag of dope was hard. After a few minutes of looking, she traced her steps for us and we followed her, but to no avail. This couldn’t have come at a worse time for her, as her eye was extremely infected and in need of medical attention, so the dope would have at least temporarily alleviated her pain. Mike tried to console her by asking her where she got the dope, and told her, “Well those Superman bags are just shit though. They’ll put anything in it – plaster, baby laxative. Whenever you get shit from South Philly it looks like coke because it’s so shitty.” Kathy appreciated his effort and said, “Yeah, that’s true. I just hate losing shit. Goddammit, I can’t believe it.”

This anecdote illustrates harm reduction’s embrace of the dignity and choices of each individual participant within an institutionalized Harm Reduction organization. The SEP workers did not pay Kathy lip service with a shallow apology, but actually attended
to her pain and immediate crisis by looking for the dope in earnest. This goes further than mere acknowledgment of drug use by actually validating some participants’ desire to get high immediately, demonstrating mutual aid across the worker-participant border on the basis of solidarity. This solidarity is a condition of the deliberately vague line separating worker and participant, allowing workers to tailor advice to participants outside of and in opposition to medical, state, and public health discourses of drug use. In another instance, Anna, a participant and occasional volunteer came to the back room to help make supply bags and discuss her suboxone prescription with Luke. Luke talked with her casually, and since she expressed wanting to shoot up later in the weekend, he told her not to take another suboxone if she wanted to, but that she would “be fine by noon tomorrow to get high if you’ve only taken one so far,” and then reminded her how much better it is than in the old days before suboxone, because “when you quit cold turkey you’d get really sick and it sucked.” Although this is not the intended medical use of suboxone, here Luke re-appropriated it to address the immediate needs of a drug user, both validating the dignity of her choice and resisting biomedical authority.

These small, everyday acts of micropolitical resistance to “apparatuses and institutions” (Foucault 1990[1978]:96) proliferate as a condition of the SEP’s ongoing transition from harm reduction ideology to Harm Reduction practice. In order to understand the larger implications of these examples, it’s necessary to return to the political roots of harm reduction. It is no accident that PPP takes its name from the original and overtly anarchist San Francisco-based Prevention Point (Stoller 1998:104), or that PPP’s SEP evolved as an outgrowth of ACT UP Philadelphia, which to this day operates on an anarchist model, which Jose explained to me as, “you know, I do
something, you do something” (DeMarco 2012). Unlike Marxism, anarchism is rare in
the academy because it derives less from the intellectual theories of armchair activists
strategizing revolution and more from on the ground experiments in direct democracy
and non-hierarchical organizing. As anthropologist David Graeber claims, “Anarchism
has tended to be an ethical discourse about revolutionary practice” (Graeber 2004:6), and
indeed these rather non-strategic and ongoing micropolitical acts of spontaneous
resistance at PPP fit within that framework. PPP is not a base of revolutionary strategy,
but a fertile ground for the germination of diverse revolutionary practices necessary to
meet participants on an ethical level. Each SEP worker who indulges his or her resistance
to biopolitical and necropolitical repression is actively engaging in a project of praxis,
deriving theory from practice, and this ethnography account aims to further this project
by putting those practices back into theories that will enhance an ongoing resistance to
bio- and necropower (Freire 1970). Thus, an ethnographic assessment of resistance
within PPP fits both an anthropological and anarchist goal of observing the internal logic
of people’s everyday actions and deciphering that logic to offer organically developed
“ideas back, not as prescriptions, but as contributions, possibilities – as gifts” (Graeber
2004:12). Faced with incredible institutional opposition, PPP’s SEP workers are
themselves the wellsprings of knowledge needed to maintain the survival of this most
essential organization and the harm reduction movement as a whole.
VI. CONCLUSION

Although harm reduction responded and adapted to different situations internationally and nationally, its genesis as a radical project of self-determination and mutual aid remained consistent. Internationally, drug users’ unions directly influenced State public health policies while continuing autonomous actions to more fully realize harm reduction principles. In the US, AIDS activists joined with drug users to create syringe exchanges in an act of civil disobedience against a government unable or unwilling to confront a national health crisis. As public health officials quickly understood the benefits of these underground exchanges, the state dragged harm reduction from its social justice principles into a new realm of institutionalized, Harm Reduction practices. As a consequence, both nationally and internationally many movement principles were corrupted or misappropriated to serve a neoliberal public health rationality. Harm Reduction practices emphasized discourses of agency and empowerment while ignoring initial harm reduction calls for systemic-level analysis, thereby firmly placing the locus of “harm” in individual behaviors and not networks of structural forces. In the US, the AIDS movement’s embrace of harm reduction facilitated this process. By advocating for government legalization of harm reduction on the basis of health rather than the rights and dignity of every individual, regardless of choices and risk factors, activists located harm reduction firmly within a discourse of biopower, at once challenging the State’s normative constitution of the national body but still legitimating and reinforcing its power of subjectification. As a result, the implementation of Harm Reduction strategies in public health has been inadequate and precarious, suggesting both a biopolitical and necropolitical stance towards the lives of IDUs.
PPP embodies the tensions inherent in an uneasy transition between the principled, anarchist harm reduction of the underground era to the disciplinary, biopolitical and necropolitical realities of its present status as a Harm Reduction public health organization. It now offers a gamut of services to legitimate its standing in the public health community amid a constant struggle to acquire enough resources to ensure the survival of its origin and core, the SEP. As a result of this struggle, SEP workers have simultaneously cooperated with the consequences of State regulation through acts of discipline and surveillance, and resisted the more repressive aspects.

For the time being, it seems PPP will continue to survive as it is, in a constantly precarious state with high staff turnover and fewer resources than it needs to serve its community. In the meantime, it can do things to publicly advocate for and secretly achieve more progressive harm reduction goals. On a discursive level, I think PPP should start to produce its own media in the form of videos that confront the “stigma, criminalization, and marginalization which are a consequence of the ill-conceived War on Drugs” (VANDU Manifesto), thus re-orienting the discourse on harm reduction from a health-based one to a rights-based one with a systemic level analysis. Active drug users who work at the SEP should attempt to organize a region-wide drug users’ union, first in the form of a support and discussion group and eventually as a political group publicly championing the rights of drug users to have a direct say in further development of Harm Reduction policies. With enough political power and clout, this hypothetical union and PPP itself should recommend an expansion of the Executive Order 4-92 to include Bucks and Chester Counties, thereby better reflecting the demographics of its participants. It could also agitate for the city to consider sanctioning a safer injection site, with the help
of ACT UP. PPP could urge more resources directed towards the SEP in particular, enabling them to open more sites for longer hours at better locations, including after hours operations. With more resources, the organization could open a physically aboveground and thus more accessible office and drop in center, offer meals and showers, and abandon the necropolitical “plus ten” exchange policy in favor of a distribution model. With a distribution model, needle stick injuries would be avoided since everyone would drop their syringes in the sharps container immediately, and then wait in line to request as many sterile syringes as they require. In the meantime, PPP could explore deepening its connections with other harm reduction styled organizations, including low threshold shelters, in an effort to create a homeless shelter for IDUs. By enhancing relationships with local hospitals, PPP could act as translators and advocates for IDUs during ER stays. Internally, PPP should simplify its unique identification registration process to cut down on length and confusion in lines, re-hire a coordinator for the SEP program who identifies as a drug user and can advocate for the program within PPP itself, and attempt to maintain an even racial and gender representation within the SEP staff, with at least one fulltime site worker fluent in Spanish.

PPP does many things right within its constraints but it can continue improving. By highlighting its political heritage with posters in the office, or fliers during sites, the organization could slowly politicize participants and perhaps generate new ideas about how to not only fight restrictions, but also better serve IDUs amidst such restrictions. PPP should also solicit the help of local professors, researchers, and community leaders to draft articles for newspapers and letters to politicians urging an expansion of the SEP program not solely from a public health perspective, but also from a human rights
perspective. Attention to rising social inequality in the US has never been higher, leaving the harm reduction movement perfectly poised to attach itself to a broader agenda for social transformation.
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