Harm Reduction Policies:
A Study of Global Efficacy

by

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Certificate of Approval

This is to certify that the accompanying thesis by Isabella Rivera has been accepted in partial fulfillment of the requirements for graduation with Honors in Global Health.

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Abstract

This thesis discusses harm reduction as a philosophy born within specific cultural values and structures, and as one method of responding to the problem of drug use. Harm reduction is a philosophy that aims to reduce the harms associated with injection drug use, through practices such as syringe service programs (SSPs), medication assisted therapy (MAT), and safe injection facilities, among others. These practices are implemented in order to reduce the risk of disease transmission through shared needles and to provide services for people who continue to inject drugs, rather than requiring abstinence. As this thesis explores, the acceptability of harm reduction is highly reliant on the specific context of a community; historical, political, social, and cultural factors influence how and why harm reduction practices can be implemented. Through semi-structured interviews with harm reduction workers in three locations – rural Washington state, U.S., the industrial city of Togliatti, Russia, and the border cities of Tijuana and Mexicali, Mexico – I found that context must guide harm reduction practices. Finally, this thesis places harm reduction within the larger picture of global health initiatives, using a postcolonial and biosocial lens to improve future global harm reduction initiatives.

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Introduction

Illicit drug use has often been viewed from a moral perspective, in which drug use is associated with violence and harmful behavior, and therefore must be eliminated from society.[1] Yet drug use continues to be present in most societies, as globally, the use of drugs has reached an all-time high, with injection drug use present in 179 of 206 countries throughout the world.[2] When considering why drug use persists, it is important to understand the structural factors that influence how and why a person chooses to use drugs. Having worked at a local syringe exchange for almost a year now, I've heard countless stories from clients who inject drugs about why they started using and what prevents them from stopping their use. Many clients have told me how they grew up with parents or relatives injecting drugs, or how they've always dealt with anxiety or depression and they've found that drugs help them. The fact is, there is no one pathway to using drugs: anyone can start injecting drugs. As rates of drug use increase globally, there has been a growing movement to address the harms associated with injection drug use. The potential harms that an injection drug user might face, extend beyond the individual to the community. Injection drug use requires a syringe and several other components (cookers, tourniquets, clean water, etc.). When these instruments are not sterile or are shared among drug users, blood-borne illnesses – such as HIV and hepatitis – can spread easily. Additionally, any type of injection, but especially in locations such as muscles,

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[1] Stelios Stylianou, "Control Attitudes toward Drug Use as a Function of Paternalistic and Moralistic Principles," Journal of Drug Issues 32, no. 1 (2002): 119-151.

[2] Tammy Saah, "The evolutionary origins and significance of drug addiction," *Harm Reduction Journal* 2, no. 1 (2005): 8; Katie Stone and Sam Shirley-Beaven, *The Global State of Harm Reduction 2018* (London: Harm Reduction International, 2018) https://www.hri.global/files/2019/02/05/global-state-harm-reduction-2018.pdf

increases the chance of bacterial infection, which can lead to painful abscesses.[3] Without proper knowledge of how to inject properly – using clean needles, finding a vein, etc. – injection drug users (IDUs) have a higher chance of contracting illnesses or other harms to their own health (infections and abscesses, endocarditis, etc.). Since HIV can also be transmitted sexually, IDUs also present the risk of transmitting diseases to the larger community, beyond IDUs themselves. An effective response to mitigating these potential harms is a philosophy known as harm reduction. Harm reduction is a broad term encompassing several practices, but its main tenet is to reduce the harms associated with drug use. Harm reduction acknowledges that it is difficult for individuals to simply stop using drugs for a variety of reasons, and ultimately seeks "to meet people where they are at", rather than requiring abstinence.[4] Harm reduction policies support programs such as syringe exchanges, which give IDUs clean needles in exchange for used ones, substitution treatments, which use opioid substitutions to help people with opioid use disorders, and safe injection sites, which provide safe, clean facilities for IDUs to inject their drugs. Despite critics falsely claiming these practices condone illicit drug use, harm reduction policies have been implemented largely due to their efficacy in reducing rates of disease transmission and overdose-related deaths.[5] Harm reduction practices have been promoted globally, as these programs prove more effective in providing valuable public health services to both individual IDUs and communities.[6]

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[3] American Addiction Centers Editorial Staff, "Abscesses from IV drug use," Rehabs.com, Accessed May 3, 2020, https://luxury.rehabs.com/iv-drug-use/abscesses/

[4] Harm Reduction Coalition, "Principles of Harm Reduction," Harm Reduction Coalition, accessed May 3, 2020, https://harmreduction.org/about-us/principles-of-harm-reduction/

[5] Lianping Ti and Thomas Kerr, "The impact of harm reduction on HIV and illicit drug use," *Harm Reduction Journal* 11, no. 7 (2014); Paul Webster, "Report Criticized Federal Drug-control Policies." *CMAJ : Canadian Medical Association Journal = Journal De L'Association Medicale Canadienne* 185, no. 11 (2013).

[6] Webster, "Report Criticized Federal Drug-control Policies."

As harm reduction policies are increasingly exported around the world, this thesis calls to consideration how harm reduction can be implemented without reinforcing Western global hegemony, ultimately providing effective health and social services to injection drug users. Part one will address why harm reduction is important and how it responds to the "problem" of drug use. I will begin by presenting how conceptualizations of drug use have changed over time, comparing the impacts of different responses to drug use. I will then discuss the definition of harm reduction, its critiques, and the ethics which justify its practices, in an attempt to understand the cultural ideas which support harm reduction, and subsequently which sociocultural environments have historically been more conducive to harm reduction implementation. In part II, I will explore how harm reduction policies have been adopted in different cultural, political, and social environments. I will focus on three case studies to analyze data from local harm reduction initiatives and interviews with harm reduction workers. These case studies include perspectives from a harm reduction organization in rural Washington state in the U.S., from an American working with harm reduction in an industrial city, Togliatti, Russia in the early 2000s, and from a professor of drug policy in Central Mexico currently working to implement harm reduction practices in the border cities of Tijuana and Mexicali in Mexico. Finally, in part III, I will complicate the exportation of harm reduction strategies, aiming to understand how concepts such as cultural imperialism, global health, and biopower play a role in the efficacy of globalizing harm reduction. Critiques of cultural imperialism within global health have taken many forms; here I will focus on the hegemonic forces of biomedicine and Western conceptualizations of individual health as it relates to harm reduction acceptability, in order to advocate for the adoption of both a

biosocial and postcolonial approach to global harm reduction practices. I will conclude with brief recommendations for how to approach harm reduction implementation all over the world, in order to be responsive to the particular needs of a community and to prevent the unethical cultural imposition of harm reduction practices.

Part I: Drug Use & Harm Reduction

Drug use has been considered through a variety of perspectives. Rhetoric surrounding drug abuse and addiction varies from ideas of human agency and choice, health and disease, supply and demand, or crime and punishment. I will begin by exploring the most common frameworks in which drug use has been understood throughout history – from criminalization to medicalization to a biocultural framework. I will then briefly present how harm reduction has emerged in response to these changing conceptions of drug use, ultimately taking its place within a biocultural framework so as to acknowledge the myriad factors which prevent individuals from quitting drugs or injecting drugs safely. While the theory and practices of harm reduction focus on just one aspect of injection drug use – safety for both individual drug users and for the general public – there has been significant debate and critique over the definition of harm reduction, and its role in society. I conclude with a discussion of the dominant definitions and critiques of harm reduction, the assumptions of agency and health which harm reduction relies on, and the ethics of harm reduction strategies.

Drug use has long been an inevitable component of society – from licit drugs such as alcohol and tobacco, to pharmaceutical drugs, to illicit drugs, such as heroin, LSD, or methamphetamine. This thesis focuses on harm reduction policies in response to a specific type and method of drug use – injection drug use of illicit substances. I will first present the major conceptualizations of drug use in a broad sense (not limited to illicit injectable substances) and how they have shifted over time. It is important to note that these shifts in conceptualizations of drug use have not occurred in the same linear

evolution in all parts of the world. As understandings of drug use and addiction are highly subject to the cultural, social, and political dynamics of a society, some of these frameworks have been more prominent in a specific place or time period rather than others. The evolution of conceptualizations which I present follows the most prominent transitions of discussions and critiques among academics and drug policy scholars from an American perspective.

Moral and medical models of drug use

One common understanding of drug use takes a moral approach, based on the idea that drug use violates societal norms. Under this framework, drug use is a deviant behavior – a morally corrupt behavior that violates the "collective conscience" of the community.[7] This moral understanding of drug use has been the foundation for a prohibitionist approach to drug use, in which one component is the criminalization of certain psychoactive drugs and drug users. A common example of this approach is the United States' War on Drugs, which first began in 1971 when President Nixon named drug abuse "public enemy number one."[8] This followed with increased efforts to combat illicit drug use, mainly through the escalation of penalties, enforcement, and incarceration for drug offenders. This prohibitionist approach has been widely criticized for a variety of reasons, but most importantly, for "its inability to achieve what it promises to achieve –

[7] Manuella Adrian, "How Can Sociological Theory Help Our Understanding of Addictions?" Substance Use & Misuse 38, no. 10 (2003): 1385-1423. 10.1081/JA-120023391.
[8] Chris Barber, "Public Enemy Number One: A Pragmatic Approach to America's Drug Problem," Richard Nixon Foundation, June 29, 2016. https://www.nixonfoundation.org/2016/06/26404/.

curbing illicit drug consumption and availability."[9] The growing body of criticisms towards a criminalization approach has contributed to the search for a new model to guide responses to drug use.

A shift towards medicalizing drug use and addiction occurred alongside the dominance of modern scientific medicine at the turn of the twentieth century, based on the germ theory of disease.[10] Erickson and her colleagues describe how public confidence in modern medicine and scientific advancements in understanding diseases have allowed for a process of "medicalization of deviance."[11] This is vividly portrayed in the expansion of medical problems to include alcoholism and opiate use. Treating such "deviant behaviors" as medical problems has advantages over criminalization, by "lifting the moral, or criminal, stigma from the deviant" such that "a patient in the 'sick role' is not held responsible for his/her sickness, but obligated to seek medical help."[12] However, this merely transfers the subjugation of drug users under criminal law to the power dynamics of medical paternalism, which prioritizes biomedical expertise over individual choice.

Moreover, the moral and medical conceptions of drug use often materialize in conjunction. In American society in the late twentieth century, normative culture represented both components of the medical and moral models of addiction, forming a unique perception of illicit drug use, as seen by a 1999 study of U.S. university students.[13] The study was conducted through an electronic mail survey, which compiled student ratings of three types of perceptions of drugs: based on "how society should

[9] Patricia G. Erickson et al., *Harm Reduction: A New Direction for Drug Policies and Programs.* (Toronto: University of Toronto Press, 1997), 4.
[10] Erickson et al., *Harm Reduction: A New Direction for Drug Policies and Programs.*
[11] Ibid., 5.
[12] Ibid., 6.
[13] Stylianou, "Control Attitudes toward Drug Use as a Function of Paternalistic and Moralistic Principles."

react" in terms of control, through perceptions of self-harm, and perceptions of immorality.[14] When considering university students as a representative sample of the U.S., Stylianou concluded,

> The dominant normative culture in the U.S. is one of opposition to drug use. This opposition and the corresponding drug-control policies are typically presented in paternalistic terms: society should control drugs to protect its citizens from harm. The present study shows that that there is also a moralistic element in anti-drug norms. Thus, the control of drug use is not only a matter of harm control. It is a matter of moral control as well.[15]

In the late 20th century, Michel Foucault wrote about the transfer in administration from sovereign power to biopower, which utilizes politics and technologies to govern society through individual bodies.[16] The methods of control revealed in U.S. society through Stylianou's study are avenues of biopower, performed through both moral and paternalistic modes of thought, and have real impacts in governing individuals. The authoritative power of historic conceptions of drug use based on moral and medical models has resulted in excessive criminalization of drugs and has worked to marginalize drug users, further isolating them within society.

Neurobiological findings on opioid abuse

While the medical model of drug use does not go without criticisms, there are aspects of modern medicine which may illuminate our understanding of drug use and addiction. Scientific research provides an avenue in which to ground an understanding of

[14] Stylianou, "Control Attitudes toward Drug Use as a Function of Paternalistic and Moralistic Principles," 128.
[15] Ibid., 144.
[16] Michel Foucault, *History of Sexuality, V. 1*, trans. Robert Hurley (New York, NY: Vintage Books, 1988); Koch, T. *Thieves of Virtue: When Bioethics Stole Medicine*.

drug abuse within a fairly objective lens: neurobiology. While neurobiological research has explored the impacts of continued use for a variety of substances, I will focus specifically on research relating to opioid use. Opioid use is increasing worldwide at incredible rates: a 2010 study estimated the global disease burden of opioid dependence increased by 73 percent from 1990 to 2010.[17] In the U.S., as individuals have developed a dependence on licit opioid prescriptions, there has been a movement towards using illicit substances, such as heroin, which may be more accessible.[18] In a study that estimated the global burdens of disease and morbidity attributed to drug dependence of four types of illicit drugs (amphetamines, cannabis, cocaine, and opioids), Degenhardt et al. found "the highest estimated global burden was attributable to opioid dependence."[19] With the global opioid crisis still progressing and the specific severity of opioid dependence in contributing to global burdens of disease and morbidity, there is a need to understand the complex neural mechanisms affected by continued use of opioids and how to best construct methods of response.

In the past 50 years, there has been significant neurobiological research into the neurological circuits which promote the continued use of opioids, allowing for physiological and psychological addiction to occur.[20] A major component of how drug

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[17] Louisa Degenhardt et al. "Global Burden of Disease Attributable to Illicit Drug Use and Dependence: Findings from the Global Burden of Disease Study 2010." *The Lancet* 382, no. 9904 (2013): 1564-574.
[18] Richard J. Bonnie et al. *Pain Management and the Opioid Epidemic: Balancing Societal and Individual Benefits and Risks of Prescription Opioid Use*, Consensus Study Report. (Washington, DC: National Academies Press, 2017), 6.
[19] Degenhardt et al. "Global Burden of Disease Attributable to Illicit Drug Use and Dependence: Findings from the Global Burden of Disease Study 2010," 1570.
[20] G. F. Koob and E. J. Simon, "The Neurobiology of Addiction: Where We Have Been and Where We Are Going." *Journal of Drug Issues* 1, no. 39 (2009): 759-776; Christoph Stein, "Opioid Receptors" *Annual Review of Medicine,* 1, no. 67(2016): 433-451; P. Sanberg and S. Portis, "How opioid addiction alters our brains to always want more." The Conversation, June 27, 2018 https://theconversation.com/how-opioid-addiction-alters-our-brains-to-always-want-more-96882; I. Haydon, "How opioids reshape your brain, and what scientists are learning about addiction." MedicalXpress.com, published August 1, 2018, https://medicalxpress.com/news/2018-08-opioids-reshape-brain-scientists-addiction.html

use impacts the brain is through the central reward system – which includes the amygdala and the prefrontal cortex. The amygdala is considered the emotional and reward-processing center of the brain that is governed by the prefrontal cortex, otherwise known as the "logic center."[21] Opioids interact with the neural circuits and receptors, effecting both short term and long-term physiological changes within these structures of the brain.

The body contains natural opioid-like chemicals which bind to specific opioids receptors to control pain and reward circuits in an evolutionarily beneficial way.[22] However, exogenous opioids – drugs such as heroin, fentanyl, and prescription opioids – bind to receptors in an unregulated fashion to inhibit pain, creating dangerous manipulations to natural reward circuits which promotes drug-seeking behavior.[23] Therefore, when one consumes exogenous opioids, they are not only relieving pain, but also positively reinforcing drug-seeking behavior. This is exactly what makes an individual extremely susceptible to opioid abuse.

The mu and kappa receptors play the largest roles in the development of an addiction, given their placement in brain structures and systemic effects when activated. The Ventrolateral Tegmental Area (VTA) in the midbrain is central to the reward pathways of the nervous system and neurons in this structure synthesize and secrete dopamine—a neurochemical that mediates brain stimulation reward and serves as a "hedonic signal" that drives motivation for driving goal-directed behavior, e.g., foraging for food. The VTA also has the highest density of mu opioid receptors which allow for endogenous cannabinoids, like those released with strenuous exercise, to modulate the

[21] Sanberg & Portis, "How opioid addiction alters our brains to always want more."
[22] Julie Merrer, "Reward Processing by the Opioid System in the Brain." *Physiological Reviews* 89, no. 4 (June 26, 2009): 1379-412.
[23] Stein, "Opioid Receptors."

reward pathways and thereby mediate reward learning. When opioids bind to these receptors, the VTA triggers the release of dopamine in target regions of the brain, such as the prefrontal cortex and the amygdala, to drive a sense of pleasure thereby associating the behavior leading to increased opioids in the brain with pleasure and creating a motivational drive for the behavior. Though initial opioid use is likely to influence both pain and reward pathways, continued opioid use is likely mediated solely based on reward pathways. Therefore, when people use opioids, they may reap the benefits of a reduction in pain, but at the cost of manipulating normal reward circuits.[24]

The consistent use of opioids also causes side effects that result in many long term, irreversible consequences. The amygdala and prefrontal cortex are just two examples of where the devastating effects of opioid abuse can be seen. In addition to processing emotion, the amygdala has a role in processing pain, and communicates with the prefrontal cortex—the "logic" center—to influence decision-based behavior or executive function and reciprocally the prefrontal cortex communicates with the amygdala to influence emotional processing. When opioids interact with these two brain regions, they promote addiction through the development of drug cravings and unregulated drug-seeking behavior.[25] By comparing the brains of individuals with no exposure to opioids and individuals with long-term opioid exposure, researchers found significant volume reduction in the amygdala and damage to the connection between the amygdala and the prefrontal cortex in the brains of the individuals with long-term opioid

[24] Merrer, "Reward Processing by the Opioid System in the Brain."
[25] Volker Neugebauer et al. "The Amygdala and Persistent Pain." *The Neuroscientist* 10, no. 3 (June 2004): 221–234.

exposure.[26] These structural changes come with unfortunate health consequences. First, the distorted amygdala structure and the loss in grey matter in the amygdala are associated with inaccurate perceptions of pain and an increase in drug cravings. Also, opioids disrupt the pathway between the amygdala and prefrontal cortex and hinder the natural regulation of reward-seeking behavior allowing reward-seeking behavior to dominate an individual's actions.[27] For example, recovering drug users may feel triggered to use again when they are confronted with something related to their previous drug habit. With the irreversible changes occurring in the brain, individuals with an opioid addiction will have a limited ability to resist the impulse to use again. Therefore, opioids impact normal pain perception, compromise decision-making processes and lead to long lasting changes in brain circuitry that undermine rehabilitation from addiction.

The strides neurobiology and scientific research have made in understanding the implications of prolonged opioid use contribute greatly to the importance of harm reduction initiatives. This neurological research has supported the notion that continued drug use and drug dependence are not a choice, but rather, are fostered through physiological pathways. Furthermore, this research shows the strong influence of environmental and social cues on brain circuitry, thus contributing to the increased susceptibility of continued opioid use once the behavior that leads to increased opioids in the brain (for example, injecting heroin) has been performed and has neurologically been associated with feelings of pleasure. This biological background provides clear evidence of the inherent difficulty in ending a drug habit and maintaining abstinence. As stated

[26] Jaymin Upadhyay, "Alterations in Brain Structure and Functional Connectivity in Prescription Opioid-dependent Patients." *Brain: A Journal of Neurology* 133, no. 7 (July 1, 2010).
[27] Neugebauer et al. "The Amygdala and Persistent Pain."

previously, harm reduction does not aim to address the issue of addiction directly, but rather focuses on reducing drug-related harms. However, harm reduction is highly dependent on the notion that individuals face inherent difficulties in stopping consistent drug use, such as opioids. The neurological research which explains the intense impacts of opioid abuse, therefore, supports this notion that drug users may not be able to simply solve their dependence on certain substances through abstinence-oriented programs, given that the cessation or even regulation of drug use is biologically inhibited in individuals with substance use disorders. While neurobiological research into drug use and addiction is incomplete, advancements in our understanding of the physiological manifestations of drug use have greatly contributed to developing more effective approaches for treating substance use disorders and providing services to drug users, such as harm reduction, which aims to serve individuals who continue to use drugs, as one avenue of responding to the problem of drug use.

Furthermore, this scientific research has contributed to the development of programs that aim to minimize the physiological symptoms of opioid withdrawal without providing the sense of pleasure that reinforces drug-seeking behaviors, in order to wean people off illicit substances. Medication assisted therapy (MAT) utilizes a substitution drug – generally either methadone or buprenorphine (also known as suboxone). For individuals dependent on opioids, MAT has been an effective mechanism for not only suppressing physical withdrawal symptoms, but also preventing overdose if an opioid dependent individual were to relapse and use opioids again.[28] This is because drugs such as buprenorphine are synthetic opioids, and treatment of daily buprenorphine doses

[28] Christine Vestal, "In Fighting An Opioid Epidemic, Medication-Assisted Treatment Is Effective But Underused." *Health Affairs (Project Hope*) 35, no. 6 (2016): 1052-1057.

would thus maintain the tolerance to opioids, making deadly overdose very unlikely.[29] While this treatment has proven incredibly effective, it remains limited in implementation given the stigma associated with drugs like buprenorphine and methadone. The use of these drugs, critics claim, lead to "trading one addiction for the other", as buprenorphine and methadone are still opioids.[30] Yet given that harm reduction does not focus on abstinence from drugs but rather the reduction of drug-related harms, MAT programs fit well within the framework of harm reduction, as it can help individuals struggling with substance dependence to stabilize their drug use, and thus other areas of their lives.

While the medical model of drug use and addiction has made several important contributions, both by denying the moral model of drug use and supporting harm reduction practices, medicalization of substance dependence places the focus on the substance itself – as a foreign "hijacker" of neurocircuitry that transforms the individual into a medicalized subject, or "sick" person. With the focus on the substance itself, not only does this reinforce negative stigmatization associated with certain substances and substance users, but it also draws causality away from the social and environmental factors which influence an individual's susceptibility and experience with substances, and potentially prevent abstinence. Thus, I will now turn to the biocultural framework which addresses the faults of the medicalized model of drug use.

[29] Vestal, "In Fighting An Opioid Epidemic, Medication-Assisted Treatment Is Effective But Underused," 1054.
[30] Ibid., 1053.

Biocultural framework of substance use

The prevailing notion of illicit drug use through a medicalized lens obscures the social and environmental factors which contribute to prolonged drug use and dependence, and moreover, categorizes all drug users under one label: addicts. In recent decades, there has been a movement away from this disease model of addiction and drug use. This transition in understanding drug use was officially stated in the 1982 report of the Advisory Council on the Misuse of Drugs in London:

> Most authorities from a range of disciplines would agree that not all individuals with drug problems suffer from a disease of drug dependence… There is no evidence of any uniform personality characteristic or type of person who becomes either an addict or an individual with drug problems.[31]

This statement signifies the movement away from relying on a purely medicalized understanding of drug use, denying the notion that all drug users have a disease of addiction.

While neuroscientific research has worked to destigmatize addiction through the creation of a diagnostic category and medicalization, the category of "disease" offers its own stigmatization and places subjects in a "sick role" under the paternalistic care of medical professionals. Yet to completely ignore scientific perspectives of drug use and addiction is unproductive. As Kushner, a professor of public health and neuroscience, writes, "all addictions operate through a combination of cultural and social constraints as they interact with biological mechanisms of substances and behavior."[32] There has been a growing movement to bridge both medical and social science perspectives on addiction,

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[31] Gerry Stimson, "British Drug Policies in the 1980s: a preliminary analysis and suggestions for research." *British Journal of Addiction* 82, no. 5 (1987): 477.
[32] Howard I. Kushner, "Toward a cultural biology of addiction." *Biosocieties* 5, no. 1 (2010): 18.

what Kaye refers to as a biocultural framework.[33] This framework does not aim to negate the role which biology plays in the context of addiction, but rather, to question "how a series of socially established meanings and behaviors come to shape the 'activation' and significance (or non-significance) of this material [biological] reality."[34] In other words, while biology plays an important role in an individual's relation to substance use, an understanding of addiction or substance abuse cannot be limited to biology. Rather, a biocultural framework acknowledges the social and political stakes which have assisted in shaping an individual's material reality – in this context, drug use. Whereas drug use and addiction are at the forefront of the medical model, a biocultural framework aims to understand how social and political processes, such as the construction of disease risk, shape drug use and addiction. Thus, unlike a moral or medical model, the biocultural framework understands addiction and drug use as constructed through biological, social, political, and cultural influences.

Taking a biocultural approach and similarly addressing these external influences on biology, Rhodes and his colleagues found that social and structural factors influence HIV risk among injection drug users.[35] Rhodes et al. drew from the work of Paul Farmer and his colleagues in relating structural violence to risk production: structural violence refers to "'large-scale forces—ranging from gender inequality and racism to poverty—which structure unequal access to goods and services', which in turn create the social, emotional and physical conditions producing HIV risk."[36] Similarly, 'everyday violence'

[33] Kerwin Kaye. "De-medicalizing addiction: toward biocultural understandings," in *Critical Perspectives on Addiction*, ed. Julie Netherland (Bingley: Emerald, 2012), 27-51.
[34] Kaye. "De-medicalizing addiction: toward biocultural understandings," 39.
[35] Tim Rhodes et al., "The social structural production of HIV risk among injecting drug users," *Social Science & Medicine* 61 (2005): 1026–1044.
[36] Ibid., 1033.

is used to characterize normalized brutalities which become invisible due to their ubiquity, thus contesting understandings of social pathologies that blame victims for their self-destructive behaviors.[37] Bourgois, Prince, and Moss uncovered these forces at work while completing an ethnographic study among women who inject drugs in San Francisco.[38] Within this setting, violence is normalized as a part of youth drug culture and follows gender lines, with violence being closely associated with ideas of masculinity and power. The ubiquity of violence, and specifically, violence towards women, contributes to increased risk of hepatitis C (HCV) infection, as violence within romantic relationships and social hierarchies constrains many women in their ability to act on knowledge of HCV transmission.[39] Thus, while many women understood the mechanisms of HCV transmission through injection drug use, "they are too overwhelmed by everyday gendered violence" to change their behaviors based on their knowledge of HCV prevention.[40] Based on this ethnographic work, Bourgois et al. argue that to effectively respond to the disproportionate HCV rates among women IDUs, public health outreach might be more suited to address issues of gendered violence rather than limiting prevention education to safe injection practices.[41] This study reveals how a biocultural framework can address the myriad social factors which shape biological realities of drug use and addiction, without subjugating individuals to moral or medical judgements.

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[37] Nancy Scheper-Hughes and Philippe Bourgois, "Introduction: Making Sense of Violence," in *Violence in War and Peace: An Anthology,* eds. Nancy Scheper-Hughes and Philippe Bourgois (Oxford: Blackwell Publishing, 2003): 1-27.
[38] Philippe Bourgois, Bridget Prince, and Andrew Moss, "The Everyday Violence of Hepatitis C among Young Women Who Inject Drugs in San Francisco," *Human Organization* 63, no. 3 (2004): 253-264.
[39] Ibid.
[40] Ibid., 260.
[41] Ibid.

The biocultural framework allows for a more nuanced approach to understanding why people continue to use drugs, while also allowing room for the critique of biopower within addiction services. Thus, I turn to harm reduction which fits within this biocultural framework: harm reduction recognizes that some drug users may be unable to quit and instead of requiring abstinence from drug use, it aims to reduce the harms associated with drug use for individuals who continue to use drugs.

Defining harm reduction

Since its emergence, the definition of harm reduction in regard to illicit drug use has been widely debated.[42] One aspect that can be agreed upon is the primary goal of harm reduction: the reduction of drug-related harm to both drug users and the general public. Thus, harm reduction is merely one link in the chain towards responding to drug use and making treatment effective and accessible. In this section, I will present a nuanced definition of harm reduction – taking into account the common critiques and debates within the field itself – and the ethics of harm reduction policies.

The ideas behind harm reduction policies are abundant throughout many countries' laws and legal systems. As opposed to governing policies which aim to change behavior, the goal of harm reduction is to reduce the harm associated with risky behaviors, rather than banning or condemning that behavior altogether. While harm reduction is more generally associated with policies towards illicit drug use, Stephen Holland presents an example that reveals the ubiquity of harm reduction reasoning in our

[42] Stephen Holland, "Harm Reduction." In *Public Health Ethics* (Malden, MA: Polity Press, 2015): 160-185.

society: driving cars. "Driving cars is dangerous," Holland explains, yet all over the world driving cars is allowed.[43] Instead of banning cars to prevent dangerous behaviors, by "ensuring that drivers keep to speed limits and wear seat belts, and by getting people to drive less by promoting other forms of transport," the danger associated with driving can be reduced without banning this efficient and useful form of transportation altogether.[44] Holland's example provides a useful way to identify and evaluate harm reduction interventions. Harm reduction policies aim to reduce potential harms of risky behaviors, rather than attempting to eradicate the behavior. From Holland's example we also see how there is often some method of justification for harm reduction policies – the utility of cars justifies harm reduction strategies.[45] In turn, the ubiquity of injection drug use justifies harm reduction policies.

Yet the intention of harm reduction extends further beyond its primary goal. Aimed at reducing the harm associated with drug use for users who continue to inject drugs, harm reduction attempts to avoid the moralizing power of criminalization approaches and the paternalistic gaze which the medicalization approach invokes. Instead, harm reduction situates itself as 'non-moralistic' – avoiding the question of whether using drugs is morally wrong.[46] While harm reduction presents a pragmatic, non-judgmental approach to drug use, it still depends upon specific ideas of human agency, and health and well-being.

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[43] Holland, "Harm Reduction," 161.
[44] Ibid.
[45] Ibid.
[46] Ed Leuw, "Drugs and Drug Policy in the Netherlands" *Crime and Justice* 14 (1991): 229-276; Erickson et al., *Harm Reduction: A New Direction for Drug Policies and Programs.*

Two sociologists with extensive experience in drug and alcohol research, Ditte Andersen and Margaretha Järvinen, acknowledge that "harm reduction rests on a paradigm that assumes rational behavior on the part of individuals who are willing and able to take responsibility for their actions."[47] There is a precedent of emphasizing individualism within the fields of social work, public health, and criminology.[48] Following this precedent, harm reduction assumes that if it can create the right conditions, people will make the right choices. Andersen and Järvinen complicate this assumption of agency within the drug user community through interviews with harm reduction workers in Copenhagen.[49] As there has been a shift within social work in Denmark since the late 1980s towards prioritizing client autonomy and responsibility, Andersen and Järvinen seek to understand how this prioritization impacts the work of harm reduction staff at treatment institutions in Copenhagen. While in general, the interviewees found the focus on client autonomy to be positive, there remain pitfalls in this approach. Andersen and Järvinen quote one interviewee stating "After all they have to come and tell us if they want something to change, because otherwise nothing may happen. So they had better be capable of speaking up. And of course not all of them are capable."[50] Andersen and Järvinen state "the problem that should be noted here is that this rationale poses considerable and perhaps unrealistic demands on the user."[51] In this

[47] Ditte Andersen and Margaretha Järvinen, "Harm Reduction: Ideals and Paradoxes," *Nordic Studies on Alcohol and Drugs* 24 (2007): 243.
[48] P. O'Malley, "Consuming Risks: Harm Minimization and the Government of "Drug-users"," in *Governable Places: Readings on Governmentality and Crime Control*, ed. R. Smandych (Brookville: Ashgate, 1999); Tim Rhodes, "The 'Risk Environment': A Framework for Understanding and Reducing Drug-Related Harm." *International Journal of Drug Policy* 13, no. 2 (2002): 85–94; N. Rose "Community, Citizenship, and the Third Way," *American Behavioral Scientist* 43, no. 9 (2000): 1395-1411.
[49] Ditte Andersen and Margaretha Järvinen, "Harm Reduction: Ideals and Paradoxes."
[50] Ibid., 244.
[51] Ibid., 245.

case, these demands assume that individuals are aware of their needs and have the confidence and ability to vocalize them and seek help. Given that these demands cannot and should not be taken for granted, it seems there must be a balance between promoting and prioritizing client autonomy while also providing support and structure when needed. Moreover, it should not be assumed that individual agency can be relied upon when doing harm reduction, given the myriad factors which influence agency.

Since harm reduction assumes rationality and a certain degree of agency among its clients, institutions and networks which support and promote these very characteristics among users are incredibly crucial to the success of harm reduction initiatives. One avenue proven to be effective in promoting agency and responsibility can be through building community among drug users. For example, it was a group of heroin users in Rotterdam – forming an organization called "Junkiebond" – who were able to mobilize hundreds of users to demonstrate against a proposal for forced detoxification, produce and distribute pamphlets on methadone programs, and start an underground needle exchange to protect against hepatitis B.[52] Friedman and his colleagues reveal how drug users themselves form the primary practitioners of harm reduction and have historically been the first to promote harm reduction strategies in response to increased disease transmission among IDUs.[53] Thus, Friedman et al. argue that there is incredible potential for social and political power within drug user organizations – through both formal and micro-social (small group) activities.[54] Scholars have similarly written about the unique

[52] Friedman et al. "Harm reduction theory: Users' culture, micro-social indigenous harm reduction, and the self-organization and outside-organizing of users' groups" *International Journal of Drug Policy* 18 (2007): 107-117.
[53] Ibid.
[54] Ibid.

role which IDUs play in harm reduction, given their expertise and community connections.[55] These networks may also address the need to include individuals who may feel incapable of speaking up, by promoting support through social organization and cultivating a political and social voice for a highly marginalized group.

Furthermore, harm reduction understands the concept of "health" in a broader sense than medicine usually does, thereby challenging the assumed antithetical relationship between drug consumption and health. Whereas a criminalization or medicalization approach to drug use would posit health in terms of physiological standards of abstinence, a harm reduction perspective does not necessarily equate health with cessation from drug use. Moore and his colleagues critique the rhetoric that generally places addiction and drug consumption in opposition to health and well-being through interviews with drug users in Australia.[56] Through interviews with users who self-identify as living with addiction or drug dependence, Moore et al. reveal how for some users, "consumption is constituted in the assemblage as a force active in the maintenance of health and well-being."[57] They describe health as an 'assemblage', drawing from the work of Cameron Duff, a professor investigating the interactions between social theory and drug use, who presents an analysis of health as not merely "the preserve of a discrete biological agent…[but rather] as a relational achievement, as the

[55] Marie Jauffret-Roustide "Self-support for drug users in the context of harm reduction policy: a lay expertise defined by drug users' life skills and citizenship" *Health Sociology Review* 18, no. 2 (2009):159-172; D. Baxter, "Teaching Harm Reduction as a Life Skill: Outcomes from Peer-led Education and Outreach Programs Among a Socially Marginalised Community of Injecting Drug Users" *Drug and Alcohol Review* 33, no. 15 (2014).
[56] David Moore et al., "Challenging the addiction/health binary with assemblage thinking: An analysis of consumer accounts" *International Journal of Drug Policy* 44 (2017): 155-163.
[57] Ibid., 161.

effect of bodies acting together in force and sympathy."[58] Given the complex relationship between the assemblages of health and addiction, Moore et al. conclude that "recognizing that 'addiction' and health can be generated within the same assemblages may allow for more nuanced, effective responses that do not treat consumption as necessarily inimical to health."[59] Many harm reduction programs draw from these reconstructions of the meaning of health in the context of drug consumption, promoting health in terms of minimized harms, social integration, economic support, and overall happiness.

This broad goal of well-being is also represented by the diversity of professions involved in harm reduction initiatives. Virginia Berridge discussed how the movement towards harm reduction in the 90's helped to promote a transition to a multi-disciplinary approach, shifting from a primarily medical community to a broader composition of social service workers, researchers, and civil servants within the Department of Health in the UK.[60] A defining feature of harm reduction is thus its broad understanding of health – not necessarily excluding drug consumption – and the diverse avenues in which health and safety can be promoted among individuals who continue to use drugs.

Another defining feature of harm reduction is the importance of empiricism in evaluating and demonstrating the efficacy of harm reduction. Early acceptance of harm reduction was based largely on its measured ability to reduce transmission of diseases such as HIV and hepatitis.[61] Yet contested concepts and definitions of what harm

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[58] Duff, Cameron. *Assemblages of health: Deleuze's empiricism and the ethology of life*. (Dordrecht: Springer, 2014), 185.
[59] David Moore et al., "Challenging the addiction/health binary with assemblage thinking: An analysis of consumer accounts," 161.
[60] Virginia Berridge, "Harm Minimisation and Public Health: An Historical Perspective," in *Psychoactive Drugs & Harm Reduction: From Faith to Science*, eds. Nick Heather et al. (London: Whurr Publishers, 1993), 55-64.
[61] Webster, "Report Criticized Federal Drug-control Policies."

reduction must look like may pose problems for determining empirical efficacy. Newcombe argues for the importance of "developing precise concepts [of the reduction of drug-related harm] … [since] it allows us to measure the effectiveness of harm reduction interventions, and measurement is the basis of evaluation."[62] To begin, let's consider the primary goal of harm reduction: the net reduction of drug-related harm. To quantify harm requires a definition of harm. Newcombe suggests a framework to evaluate harm based on desired harm reduction goals, outlining nine categories of drug related harm, shown in figure 1 below.

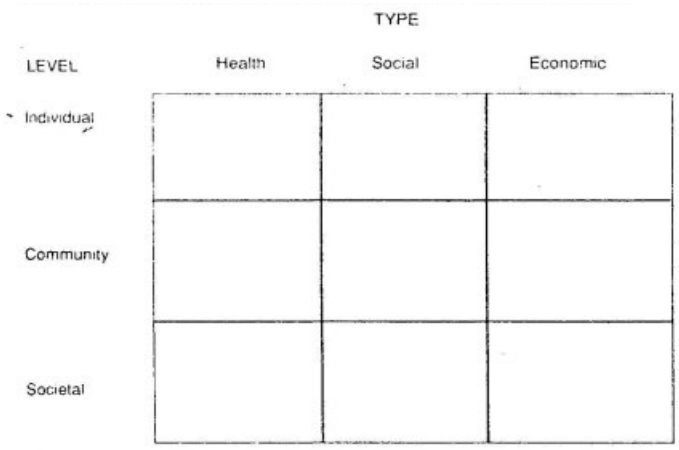

Figure 1. Classification of the consequences of drug use. Source: Newcombe, R. "The reduction of drug-related harm: A conceptual framework for theory, practice and research", in The Reduction of Drug-Related Harm, eds. Pat O'Hare et al. (London: Routledge, 1992).

Newcombe expands upon these types of harm, further differentiating between time, duration, and/or severity dimensions.[63] While Newcombe's categorization of drug-related harm may be useful, Lenton and Single make a crucial critique of Newcombe's strategy for quantifying harm:

[62] Russell Newcombe, "The reduction of drug-related harm A conceptual framework for theory, practice and research," in *The Reduction of Drug-Related Harm*, eds. Pat O'Hare et al. (London: Routledge, 1992).
[63] Newcombe, "The reduction of drug-related harm A conceptual framework for theory, practice and research."

> the key issue is that what will be shown to reduce harm will be made in dynamic and subjective social context where research will at best provide some of the major building blocks of measurement. However, judgements of effectiveness will more often than not be made on the basis of incomplete evidence.[64]

Lenton and Single critique the feasibility of measuring efficacy of a certain harm reduction strategy, given that different strategies may be more effective or socially accepted depending on the context. While harm reduction is often justified in terms of measured efficacy, it is important to recognize the inherent difficulties in taking accurate measurements and defining appropriate methods of evaluation for determining success.

Furthermore, the types of empirical evidence often expected are biomedical metrics, such as rates of disease transmission or number of deaths caused by drug-related overdose. While these biomedical measurements surely contribute to the validity of harm reduction, they also exclude important factors in judging efficacy of certain harm reduction practices. For example, syringe service programs (SSPs) provide nonjudgmental spaces for drug users to connect with health professionals – a space not necessarily provided elsewhere. This benefit – the strengthening of relationships between users and health providers, or even simply, the improvement in users' perceptions of health providers – cannot be easily quantified through standard biomedical metrics.

The emergence of harm reduction

Debates over the true scope of harm reduction related to injection drug use reveal three major components of harm reduction as a philosophy guiding practices. The emphasis of individualism and agency is immediately apparent in harm reduction

[64] Simon Lenton and Eric Single, "The definition of harm reduction," *Drug and Alcohol Review* 17 (1998), 217.

philosophy, as it rests on the assumption that IDUs will change risky behaviors when given the right resources and knowledge. Harm reduction also is founded in an expanded understanding of health, not limited to abstinence from substances, but encompassing larger components of well-being. Lastly, harm reduction has been dependent on empirical research to support the validity of harm reduction practices and encourage their implementation. The emergence of harm reduction in the past decades clearly shows the importance of these components.

While harm reduction in response to injection drug use has recently become widely accepted around the world, it has a history going back to the mid-twentieth century. Strang describes how in the late 1960s and early 1970s there were drug clinics in London which provided education on safe injection and rooms for users to inject drugs.[65] Other examples of early harm reduction practices include the dismissal of restrictions on the public sale of needles in Italy in the 1970s and the opening of methadone programs (substitution treatment) and syringe exchanges in The Netherlands in the 1980s.[66] It is important to note that these practices first emerged in countries centered on democratic ideals, which inherently focuses society around individualism. The assumptions of agency which support harm reduction already existed in these environments, and thus may have aided in the acceptance of such practices. Additionally, the emergence of these practices was most often in response to epidemics of blood-borne diseases – which are

[65] John Strang, "Drug Use and Harm Reduction: Responding to the Challenge," in *Psychoactive Drugs & Harm Reduction: From Faith to Science*, eds. Nick Heather et al. (London: Whurr Publishers, 1993), 4.
[66] E. Tempesta and M. Giannantonio, "The Italian epidemic: a case study," in *AIDS and Drug Misuse: The Challenge for Policy and Practice in the* 1990s, eds. J. Strang and G. V. Stimson (London: Routledge, 1990): 108-117; E. Buning, "The role of harm reduction programmes in curbing the spread of HIV by drug injectors" ," in *AIDS and Drug Misuse: The Challenge for Policy and Practice in the* 1990s, eds. J. Strang and G. V. Stimson (London: Routledge, 1990); John Strang, "Drug Use and Harm Reduction: Responding to the Challenge," in *Psychoactive Drugs & Harm Reduction: From Faith to Science*, eds. Nick Heather et al. (London: Whurr Publishers, 1993)

easily transmissible through shared needles. Given the empirical data proving the efficacy of harm reduction in mitigating the spread of blood-borne diseases, harm reduction practices were accepted and adopted within these limited settings.[67] Yet with the AIDS epidemic growing globally in the 1990s, harm reduction as a theory became even more politically feasible: "A policy that previously could be advanced only slowly, as the unspoken other side of penal policy, 'came out' as a result of AIDS."[68] While many countries throughout the world and parts of the U.S. still do not support harm reduction services, the pressure of responding to the AIDS epidemic surely contributed to the increased acceptance of harm reduction, even if just for limited periods.[69] Thus, harm reduction has been most readily accepted based on its measured efficacy in reducing transmission rates of diseases such as HIV and hepatitis, which are standards based in biomedicine.[70]

Ethics in harm reduction

Harm reduction has received a significant amount of criticism, mainly because harm reduction allows risky, illegal behavior to continue. Popular arguments, generally propagated by anti-drug lobby groups, have proposed that harm reduction practices not only allow illegal behavior but encourage it.[71] While harm reduction aims to avoid judgement on the morality of drug use, these criticisms are founded in ethical principles –

[67] Webster, "Report Criticized Federal Drug-control Policies."
[68] Virginia Berridge, "Harm Minimisation and Public Health: An Historical Perspective," 57-58.
[69] Berridge, "Harm Minimisation and Public Health: An Historical Perspective."
[70] Ti and Kerr, "The impact of harm reduction on HIV and illicit drug use"; Webster, "Report Criticized Federal Drug-control Policies."
[71] Ti and Kerr, "The impact of harm reduction on HIV and illicit drug use."

mainly, Kantian deontology. However, harm reduction has been advocated for from several theoretical justifications – most significantly, from utilitarianism and virtue ethics.[72] In this section, I will present the arguments which have been made to ethically condemn or justify harm reduction. Holland locates the main ethical point of contention within harm reduction as the fact that it allows risky behavior to continue, but distinguishes between harm reduction approaches aimed towards legal versus illegal behavior.[73] I will focus on harm reduction practices geared towards the latter, specifically, in relation to injection drug use.

At its core, deontological ethics assume that actions can be deemed right or wrong based on their nature, rather than their consequences.[74] Deontology can thus be used to oppose harm reduction practices: harm reduction cannot be ethically justified based on whatever improved consequences it may induce, but rather since it allows a morally wrong behavior to continue, it is ethically flawed. This is echoed by rule-utilitarianism, in which actions are evaluated indirectly, based on whether the action follows the rules of a society.[75] Thus, the argument follows, since harm reduction allows illegal behavior to continue, it undermines the rules set by a society and is deemed morally wrong.

However, utilitarianism has also been invoked to ethically justify harm reduction, given that the primary goal of harm reduction is to reduce drug-related harms and ultimately achieve good consequences. This represents an act-utilitarian standpoint, in which actions are judged to be morally right when they produce the greatest good for the

[72] Holland, "Harm Reduction."
[73] Ibid.
[74] Joseph Kranak, "Kantian Deontology," in *Introduction to Philosophy: Ethics*, eds. George Matthews and Christina Hendricks (Rebus Community, 2019): 53-64.
[75] F. A. Abumere, "Utilitarianism" in *Introduction to Philosophy: Ethics*, eds. George Matthews and Christina Hendricks. (Rebus Community, 2019): 45-51.

greatest people.[76] This is easily applied to harm reduction practices, as they aim to reduce harms associated with injecting drugs and thus improve the consequences of illicit drug use for those who continue to use drugs.

Drawing from Aristotle's virtue ethics framework, Christie and his colleagues present a different approach to ethically justify harm reduction practices.[77] Rather than focusing on individual actions, like Kantian deontology or utilitarianism, virtue ethics focuses on the character of the agent. As Christie et al. point out, a "virtue ethics model takes account of context and consequences, without reducing ethics to simple matters of promoting pleasure, avoiding pain, or doing one's duty."[78] Using the 'mean' to determine whether a character trait is a virtue, Aristotle's virtue ethics framework posits virtues as a correct balance between too much and too little of a certain character trait.[79] In the context of harm reduction, Christie et al. identify compassion as a virtue – in which too much would be considered overly sensitive or "too soft" and too little would be not having enough sensitivity or "too hard."[80] Compassion, as the mean between these extremes, is the driving character trait in harm reduction policies, and can provide a strong justification for these practices. As Christie et al. write, "it is virtuous to promote virtue; it is vicious to promote vice", and since harm reduction policies do not promote an increase in drug use, but in fact may lead to rehabilitation, "compassion is the appropriate moral response" and harm reduction is morally valuable.[81]

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[76] Abumere, "Utilitarianism."
[77] Timothy Christie, Louis Groarke, and William Sweet, "Virtue ethics as an alternative to deontological and consequential reasoning in the harm reduction debate," *International Journal of Drug Policy* 19 (2008): 52-58.
[78] Christie, Groarke, and Sweet, "Virtue ethics as an alternative to deontological and consequential reasoning in the harm reduction debate," 56.
[79] Ibid.
[80] Ibid., 56.
[81] Ibid., 57.

From this debate surrounding harm reduction, it is clear that harm reduction practices can be ethically justified through several frameworks. Moreover, the most common argument against harm reduction – that it promotes illegal behavior – has been disproven, time and time again.[82] As utilitarianism provides a clear justification for harm reduction practices, appropriate and accurate methods of evaluation are needed to maintain its validity. Yet the nuances of the virtue ethics framework are also critical, as this takes into account context of actions.

Part I conclusion

Harm reduction has emerged in response to changing conceptualizations of illicit drug use, most often in societies which have moved away from a moral understanding of drug abuse. It is important to note that the core philosophies of harm reduction fit best within a biocultural perspective of drug use, and thus societies in which the dominant view of drug use is based on moral or medical models may present greater challenges to the adoption of harm reduction practices. Moreover, since harm reduction first emerged and developed in distinct societies – mainly Western, progressive nations – the efficacy of these practices must be considered within those cultural contexts. One aspect of this emergence is particularly useful to consider; networks of IDUs have historically helped to ease the introduction of harm reduction policies, as in the Netherlands with an active political organization of drug users. Furthermore, we must consider the cultural values which harm reduction has developed within, so as not to extend these assumptions globally. In particular, the centrality of human agency and well-being within harm

[82] Ti and Kerr, "The impact of harm reduction on HIV and illicit drug use."

reduction practices are not culturally universal. Thus, considering harm reduction as a philosophy that can produce different adaptations of services may be useful when implementing services in different global settings.

Part II: Case Studies

In this section, I will look at three case studies to explore harm reduction implementation in different social, cultural, and political environments. I had the opportunity to interview people who have worked with harm reduction in each of these places: rural Washington State, USA; Togliatti, Russia; and Tijuana and Mexicali, Mexico. To protect the privacy of interviewees, I have used a pseudonym for each interviewee, and do not disclose the name of the harm reduction organizations they have worked with. All interviews were conducted during the months of February – April 2020. Each case differs in unique ways, whether that be legal restrictions, cultural factors that influence stigmatization, or historical precedents and biases related to healthcare and community. Exploring the social, political, and historical factors which influence harm reduction implementation in these three locations thus allows for an analysis of how harm reduction takes different shapes depending on context. I will begin with the case of rural Washington in the U.S., followed by Togliatti, Russia, and then the border cities of Tijuana and Mexicali in Mexico. I will conclude this section with a synthesis and comparison of themes learned from harm reduction implementation in each of the three locations.

Rural Washington, U.S.A.

While harm reduction initiatives aimed at injection drug use first emerged in the UK, the Netherlands, and Australia in the early 1980s, the first publicly funded syringe

exchange program began in the U.S. in Tacoma, Washington in 1988.[83] This program represents just one victory within a long battle to promote similar programs in the U.S., aimed at diminishing rates of HIV and hepatitis infection among injection drug users. While today, in 2020, the practice of syringe service programs (SSPs) has been endorsed by the US Centers for Disease Control and Prevention, these programs were far from publicly acceptable just a few decades ago. After the election of President Ronald Reagan in 1980, a prohibitionist response to drug use accelerated as drug control through law enforcement ramped up and First Lady Nancy Reagan preached "Just Say No" to potential users.[84] Punitive policies aimed at drug users became the norm in the U.S., most clearly demonstrated in the 1988 Anti-Drug Abuse Act. The 1988 Anti-Drug Abuse Act extended penalties for drug possession and drug-related offenses, including a mandatory minimum sentencing for crack cocaine offenses.[85] This act also placed a ban on the use of federal funds for the purchase of syringes, thus restricting a major source of funding for SSPs. Proponents of the federal ban on funding for syringes claimed that SSPs portrayed a tacit approval of injection drug use, which would ultimately increase the amount of injection drug users in the U.S.[86] While this was debunked through extensive research that proved SSPs reduce the spread of injection-related HIV and do not promote illicit drug use, the ban remains enforced today, despite being partially lifted under Obama

[83] S. Sherman and D. Purchase, "Point Defiance: A case study of the United States' first public needle exchange in Tacoma, Washington," *International Journal of Drug Policy* 12, no. 1 (2001): 45-57.
[84] Mark C. Donovan, *Taking Aim: Target Populations and the Wars on AIDS and Drugs*, (Washington D.C.: Georgetown University Press, 2001), 36-38.
[85] D. Vagins and J. McCurdy, *Cracks in the System: 20 years of the unjust federal crack cocaine law,* Washington D.C.: American Civil Liberties Union, 2006.
[86] Carl Hulse, "Surge in cases of HIV tests US policy on needle exchange," *New York Times*, May 16, 2015, https://www.nytimes.com/2015/05/17/us/surge-in-cases-of-hiv-tests-us-policy-on-needle-exchanges.html

from Dec. 2009 to 2011.[87] It has remained a divisive political battle, as conservative lawmakers hold that SSPs encourage drug use and should not be federally condoned.

While this federal ban remains intact, it has been amended to allow states and local governments to approve funding for SSPs. Gradually, more states in the U.S. have turned to support SSPs, most often in response to research proving the efficacy of SSPs in reducing disease transmission and as states have suffered sudden emergences of HIV or hepatitis among IDUs. As of 2019, 28 states and the District of Columbia allow SSPs to operate, however, a 2018 poll revealed that only 39% of Americans support legalizing SSPs in their communities.[88] In 2015, in response to a major HIV outbreak in Scott County, Indiana, then Governor Mike Pence, declared a public health emergency and allowed limited SSPs to operate temporarily in Scott County.[89] Thus, while SSPs have become more widespread in the U.S., SSP proponents must still grapple with an overall culture of fear and stigma surrounding drug users and services for users. In rural Washington, these problems persist today.

With the HIV outbreak in Scott County, Indiana in 2015, and emerging hepatitis C epidemics throughout the U.S., there has been more focus on the lack of prevention services for IDUs in rural and suburban areas in the U.S. A 2013 telephone/mail survey of SSPs in the U.S. found that only 20 percent of SSPs had primary locations in rural

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[87]Matt Fisher, "A History of The Ban on Federal Funding for Syringe Exchange Programs," *Smart Global Health* (blog), February 7, 2012, https://www.csis.org/blogs/smart-global-health/history-ban-federal-funding-syringe-exchange-programs; Hulse, "Surge in cases of HIV tests US policy on needle exchange."
[88] "Public Support for Needle Exchange Programs, Safe Injection Sites Remains Low in U.S." Published June 5, 2018. https://www.jhsph.edu/news/news-releases/2018/public-support-for-needle-exchange-programs-safe-injection-sites-remains-low-in-US.html
[89] G. Gonsalves and F. Crawford, "How Mike Pence Made Indiana's HIV Outbreak Worse," *Politico*, March 2, 2020, https://www.politico.com/news/magazine/2020/03/02/how-mike-pence-made-indianas-hiv-outbreak-worse-118648

areas, compared to 69 percent reporting primary urban locations.[90] This presents a significant disparity, considering that a 2015 study on the geographic variation of IDUs in the U.S. revealed that about half of IDUs reside outside of metropolitan areas.[91] Access to SSPs and harm reduction services in rural communities is thus severely limited. A qualitative study of SSPs in the rural state of West Virginia stated that some clients had to drive several hours in order to access an SSP, concluding that services needed to be expanded in many rural communities.[92] This study also revealed several key themes for SSP implementation in rural areas: the lack of models for the development of SSPs in rural communities, the importance of community support in facilitating SSPs, and the impact of local law enforcement on SSP efficacy. These findings have proven consistent with the challenges faced by the harm reduction organization in this case study, which operates in rural eastern Washington.

The organization in this case study began operating in the mid-1980s as a compassionate care organization that provided people living with HIV/AIDS assistance in navigating healthcare. As the wave of over-prescription of opioids in the Washington state began and more people began abusing drugs, the organization moved towards providing prevention services and implemented an SSP in 1998. While the organization began its harm reduction services through simply exchanging syringes, over the years these services have expanded to include food and housing assistance, case management, and most recently, medication assisted therapy (MAT). Medication assisted therapy has

[90] Don C. Des Jarlais et al. "Syringe Service Programs for Persons Who Inject Drugs in Urban, Suburban, and Rural Areas — United States, 2013" *MMWR. Morbidity and Mortality Weekly Report* 64, no. 48 (2015): 1337-1341.
[91] Alexandra Oster et al. "Population Size Estimates for Men who Have Sex with Men and Persons who Inject Drugs," *Journal of Urban Health* 92, no. 4 (2015): 733-743.
[92] Stephen Davis et al. "Qualitative case study of needle exchange programs in the Central Appalachian region of the United States," *PLOS One* 13, no. 10 (2018).

often been seen as a more controversial harm reduction program than syringe exchange, given that opioid users are treated with substitute drugs – generally methadone or suboxone. This treatment program uses opioid substitutes to eliminate drug cravings and withdrawal symptoms users experience when attempting to stop illicit drug use, yet do not get users high. Opponents to MAT claim that this program merely trades one drug for another, especially given the addictive nature of methadone.[93] Yet MAT has proven to be highly successful in getting opioid dependent users off more harmful illicit drugs, such as heroin.[94] This organization emulates harm reduction services in other parts of the U.S., following a fixed-site syringe exchange model (clients come to a specific site to exchange syringes) and a MAT model that incorporates case management and wrap-around care.

The philosophy behind this organization is harm reduction: nurses, case managers, and outreach workers all aim to reduce the harms faced by drug users in the community without requiring abstinence. Yet for some community members, harm reduction services for injection drug users is not appealing. My interview with Kate, a nurse who also served as the harm reduction coordinator at this organization, uncovered how opposition to harm reduction services often stems from misunderstandings and stigma surrounding addiction and drug use. Kate said, "We have a very defined idea of a what a drug addict looks like and acts like, and how they are not part of society, which is untrue when you really look at the research data surrounding addiction, and it can happen at any socio-economic level, any culture or race, but we like to think of addicts as the other."[95] Otherizing 'addicts' promotes shame around drug use, which can further prevent

[93] Vestal, "In Fighting An Opioid Epidemic, Medication-Assisted Treatment Is Effective But Underused."
[94] Betty Tai, Andrew Saxon, and Walter Ling, "Medication-assisted therapy for opioid addiction," *Journal of Food and Drug Analysis* 21, no. 4 (2013): 13-15.
[95] Interview with Kate (pseudonym), March 12, 2020.

users from seeking help and services. Furthermore, as Kate continued, opposition to harm reduction services is often founded in ignorance on the nature of addiction:

> there's also the idea that addiction is a moral choice or a personal responsibility to solve and misunderstanding of why people can't just stop. And then a judgement upon why they just don't stop even though bad things are happening, even though that's the actual definition of addiction, it's continuing to use despite negative consequences.[96]

As Kate explained, this organization provides services to users that will minimize the harms associated with their drug use, and also create a space where users can find support and acceptance. Despite community members viewing drug use and users as a "scourge of society," Kate noted that users are not evil, but in fact, "the people we see at the exchange are trying to use responsibly and find appropriate ways of disposing of their sharps, they are careful about the exposure of other people to injury or diseases."[97]

In a similar vein, Tempalski argues that "prejudice attached to drug use is reinforced by the illegal and covert nature of illicit drug use," giving people the idea that all IDUs are junkies and criminals.[98] This negative stereotype along with a common association of HIV with immorality contributes to an overall disapproval of SSPs, which is then, not grounded in personal experience or understandings of SSPs.[99] The misunderstanding and ignorance around drug use, addiction, and HIV – which are based on specific ideas of immorality – leads to opposition to harm reduction services. Kate revealed how community acceptance of their services has a big impact on their organization. She spoke of how one of their SSP sites had to move twice in two months,

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[96] Kate, March 12, 2020.
[97] Kate, March 12, 2020.
[98] Barbara Tempalski, "Placing the dynamics of syringe exchange programs in the United States," *Health & Place* 13 (2007): 425.
[99] Ibid.

due to concerns from the local city council. Yet she said this pushback from the community wasn't necessarily shared among everyone:

> You can have a community that generally might be in favor of syringe exchange or at least doesn't really care because it doesn't affect their own lives, and then have a few vocal opponents of it who create a media campaign of fear and disinformation, which makes it difficult to provide services according to best practices that have been researched, according to science.[100]

Thus, this method of propagating disinformation builds on stigma already surrounding drug use. However, while many people might not care about harm reduction services, from her understanding, Kate explained how opposition to their SSP has played out along political lines:

> Most people don't think about the syringe exchange, so they don't really have an opinion about it. If you were to press them, they might have some stigma and some fears that cause them to express a general sense of unease with syringe exchange, but the idea that they would actually go to a city council meeting and do something about it, is rare. So, it's really driven politically on the spectrum, as far as democrats versus republicans, so it becomes very political in that sense, as far as who opposes and who advocates for it. It's definitely down party lines unfortunately.[101]

In other words, stigma surrounding drug use in the U.S. is often appropriated by party politics and extended towards services for drug users (such as SSPs), which further entrenches this stigma at the societal level, despite many individuals not having personal experience with SSPs.

Kate also discussed how opposition to harm reduction services takes another form of argument. "The idea of giving something for free to drug users, there's an idea that drug users don't deserve it like the rest of society," Kate explained, "the idea that someone who uses drugs is not deserving of government services, government money,

[100] Kate, March 12, 2020.
[101] Kate, March 12, 2020.

rubs people the wrong way."[102] Thus, the argument can mutate into another question: "Why don't diabetics get their needles for free?"[103] While SSPs cannot accept diabetic needles given restrictions due to funding, Kate responds, "the argument there is why are insurance companies making diabetics pay for their needles? Not why can't diabetics bring their needles in to a syringe exchange for injection drug users, that's a why don't we have Medicaid for all question."[104] Here, Kate brings up a larger cultural belief among Americans regarding healthcare and individual agency. The U.S. was founded on strong beliefs regarding the sanctity of the individual – individual rights and freedoms are the fundamental premise of the U.S. constitution, and continue to guide U.S. culture and politics. This culture of individualism remains clearly apparent in the U.S. today, particularly in the context of healthcare. The U.S. remains the only industrialized nation in the world that does not have universal health coverage.[105] Bruce Vladek, a U.S. professor of health policy, presents ten possible explanations as to why the U.S. still does not have universal healthcare, mainly surrounding the fact that Americans tend to have negative attitudes towards the government and the political-structural barriers that prevent the distribution of wealth and services to the poor, working class.[106] I would also argue that the emphasis on the individual in the U.S. leads people to associate health problems or needs with personal blame and ownership. Furthermore, the U.S. healthcare system privileges individual medicine over public health. Public health often relies on people giving up certain freedoms for the benefit of the larger community, with directly

[102] Kate, March 12, 2020.
[103] Kate, March 12, 2020.
[104] Kate, March 12, 2020.
[105] Annalisa Merelli, "A history of why the US is the only rich country without universal health care," *Quartz*, July 18, 2017, https://qz.com/1022831/why-doesnt-the-united-states-have-universal-health-care/
[106] Bruce Vladek, "Universal health insurance in the United States: Reflections on the past, the present, and the future," *American Journal of Public Health* 93, no. 1 (2003): 16-19.

contrasts the individualistic culture so essential to the U.S. Thus, opposition to services for IDUs may be heavily influenced by specific cultural ideas of human agency and rights to healthcare.

This opposition to harm reduction services can be mitigated, as Kate explains, through education and relationship building. "We as an organization have to be careful about how we enter into a community and respect some of their boundaries," she says, "we do want to grow those relationships and provide understanding, versus being antagonistic when we come into areas."[107] Building relationships means also reaching out to opponents of SSPs. Kate talked about how this has been done in Tacoma, where staff at a syringe exchange brought donuts and cupcakes to protestors outside the SSP. While this may not change the opinions of everyone, it helps to treat them like human beings, and "eventually, they were able to bring them in, show them the space, and some of those people – not all – but a couple of those people changed their minds."[108] In Davis et al.'s study of SSPs in rural West Virginia, they similarly found that "[SSP] program openings were significantly facilitated by support from the community."[109] Emile, the director of the harm reduction organization in rural Washington, explained how support from the community works to help the organization to function:

> There are a lot of stakeholders […] so talking to them, especially if you're in a small town, helps to get everybody to see the vision. Because if people don't trust the […] director of a syringe non-profit because of what we do, they might trust the sheriff, or they might trust the chief of management at the hospital. So, the more people you bring on to help with the program, then that helps […] I don't have to be the messenger for everything […] my board can be the messenger,

[107] Kate, March 12, 2020.
[108] Kate, March 12, 2020.
[109] Davis et al. "Qualitative case study of needle exchange programs in the Central Appalachian region of the United States," 8.

> clients who are in recovery can be messengers […] there's lots of opportunities there. And then you're building bridges and partnerships.[110]

Relationship building with the community also entails relationships with law enforcement agencies. Kate stated how "some of law enforcement's animosity towards syringe exchange doesn't make sense because it actually helps protect them and the community from that risk."[111] Building relationships and educating police officers on harm reduction can go a long way in helping the organization to function more effectively, as Kate explained,

> we also talk to law enforcement, whenever we go into a community. There's a meeting with the law enforcement to let them know what we're going to do, because if we don't have a good relationship with law enforcement, there's always a chance, and it can still happen with rogue officers, that they'll sit in front of the syringe exchange, and either just their presence can intimidate access, or even this idea that they're under surveillance.[112]

Since Emile, the director of the organization, "has good relationships with the law enforcement people here, [and] they haven't seen a big increase in drug use or needle stick paraphernalia laying around in the parks or anything like that, it's a little more accepted here. Which is why we can be open four days a week, from 8:30-5pm."[113] Building relationships with law enforcement is essential. Tempalski also found law enforcement to generally represent a significant barrier to SSPs in the U.S. "stemming from the illegality of drug possession and distribution of drug paraphernalia, such as syringes."[114] Given the common negative views on drug users and illicit nature of drugs,

[110] Interview with Emile (pseudonym), April 19, 2020.
[111] Kate, March 12, 2020.
[112] Kate, March 12, 2020.
[113] Kate, March 12, 2020.
[114] Tempalski, "Placing the dynamics of syringe exchange programs in the United States," 425.

working with law enforcement to minimize this stigma and promote better relationships with users and police officers aids the organization in accomplishing their goals.

Peer support is another crucial aspect that contributes to the efficacy of harm reduction. "I find that when people find out that I used opiates and that that was my drug of choice, they're more likely to disclose things to me and talk with me about it," Kate said, "I think it also takes some of the shame around it and gives them hope, because the idea that now I'm able to be on this side of the table and do these kinds of things means that they have that opportunity to do that in their lives as well. That addiction isn't the end of their life."[115] Just as Kate said her own experience with opiates helps for her clients to open up to her, a qualitive study of a Canadian SSP also found that "IDUs often report seeking services at the [SSP] because of familiarity and comfort with the peer workers."[116] As someone who has struggled through substance abuse, Kate explained how her work is also beneficial for herself:

> Me telling people about it, helps me too. So, it takes the shame away for me, the more people I tell […] the less I carry that burden of shame and guilt from my own addiction and choices I made during my addiction, like using around my children. Which is why I find 12-step meetings helpful for people, because they can hear that they aren't the only one that did those things. And that's the reason why I think people don't seek help, and don't want to quit. It's because they don't feel they're worth it, because of all the guilt they have around what addiction has caused them to do.[117]

While Kate's organization does not have a specific model of peer support, many of the people working in the organization have had some experience with substance abuse –

[115] Kate, March 12, 2020.
[116] Dan Small et al. "The Washington Needle Depot: fitting healthcare to injection drug users rather than injection drug users to healthcare: moving from a syringe exchange to syringe distribution model," *Harm Reduction Journal* 7, no. 1 (2010).
[117] Kate, March 12, 2020.

whether with a family member or friend, or personally. While peer support is not necessarily the one solution to helping users, Kate said,

> I think that idea that one addict helping another – which is literally NA literature – comes a lot from 12-step programs […] I don't necessarily agree with that, I think lots of time training helps to, like say a therapist might be better at helping some people than their sponsor might be. But that is a special relationship that is different and unique, and I think could be utilized in a different manner.[118]

The importance of peer workers in harm reduction has also been concluded in several studies, as "preliminary evidence suggests that the use of peers in the recovery process can lead to reductions in hospital readmissions and length of sobriety, post-discharge treatment plan adherence, increased housing stability, and improvements in mental health functioning."[119] Ashford et al. conducted a study of a harm reduction organization in Missouri, finding that clients with more peer engagements were more likely to have a previous health diagnosis or stable housing, and were less likely to be on parole or probation.[120] Not only does peer support provide a unique relationship for current users – allowing for more personal connections over similar struggles, and helping to destigmatize drug use and encourage safer behaviors – but it may also help current IDUs to find better overall support for building a more stable lifestyle.

This organization in rural Washington aims to reduce harms associated with drug use. Yet as Kate explained, harm reduction services and the validity of their organization often depends on research and specific metrics of success:

> It's the most researched public health initiative ever. It's had more research done on it than any other public health program […] because people are worried about it, and they want to prove that it doesn't increase drug use or needles in the field

[118] Kate, March 12, 2020.
[119] Robert D. Ashford, Brenda Curtis, and Austin M. Brown. "Peer-delivered harm reduction and recovery support services: initial evaluation from a hybrid recovery community drop-in center and syringe exchange program." *Harm Reduct Journal* 15, no. 52 (2018).
[120] Ibid.

> […] all those statistics that we say, the good things syringe exchange does – 5 times more likely to get into treatment and 3 times more likely to stop or reduce their use […] and the idea that it saves public health dollars, for every dollar spent on syringe exchange, you save 7 public dollars on hep C or HIV treatment – that litany that we go through, that's all from the research.[121]

But the actual scope of benefits provided by this organization is not always understood within the community. Kate talked about how often to 'prove' the success of a harm reduction organization, "what people always want to look at is how many people you get into treatment."[122] Yet there are issues with this metric, as Kate explained, "the majority of people who stop using, don't come back and tell you about it. Every once in a while, someone does. But I believe there are people that stop using that don't ever want to come back to a syringe exchange, understandably."[123] Measuring success of harm reduction interventions based on the number of clients who have transitioned into treatment thus conceals the true purpose and impact of harm reduction. Kate explained this by discussing Roger, an employee and outreach worker at their organization:

> The primary goal of syringe exchange is infection risk, but really the heart of the syringe exchange is that relationship building. I mean, you see [Roger] with them at 23 years, they know him, they trust him. They're able to talk to him about things they might not tell other people, get answers to questions or referrals to other sources around town for their needs, and that's what's going to help someone struggling with addiction in the long run, is a consistent positive relationship with a community organization that they can trust. So that when they are ready to stop using, they have a place to talk to about it.[124]

Relationship-building is crucial to making harm reduction services effective and is necessary in order to truly provide support for drug users in the community. Given the weight of research in supporting and proving the efficacy of harm reduction, conveying

[121] Kate, March 12, 2020.
[122] Kate, March 12, 2020.
[123] Kate, March 12, 2020.
[124] Kate, March 12, 2020.

the positive impact of relationship building due to services such as syringe exchanges would go a long way in promoting these organizations. Yet from her experience, Kate explains how this is actually quite difficult: "People like numbers, and you're never going to be able to quantify relationship building. You can do, you know, qualitative studies, but these qualitative studies are not something I can bring to a council member and that they're going to read and care about."[125] While personal stories of the wholistic positive impacts of harm reduction can be useful to donors or supporters of the organization, these stories don't often help to change the minds of opponents. Kate believes this too stems from stigma:

> Again, we're talking about this other side of the coin where people really marginalize drug users, so they don't care about their story. They don't care about why they started using drugs, that they smoked crack with their mom at 13, what their life was like and the fact that they probably didn't have much of a chance of not being a drug user when they got older. Those don't tend to change people's minds as much, I don't know why. People like rational numbers that they can grab on to.[126]

Kate's organization has made steps to better record different measurements of success, such as supportive counseling: "we do supportive counseling pretty much at every exchange, because that's just active listening. So like, listening to them and reflecting back what they said, counts. So those would be indicators of relationship building that could be numerically quantified, as how many times we provide things like supportive counseling."[127] Recording these types of metrics is vital to relaying the importance of SSPs and other harm reduction practices, as these facilities work to humanize and destigmatize IDUs, making community reintegration much easier. While these types of

[125] Kate, March 12, 2020.
[126] Kate, March 12, 2020.
[127] Kate, March 12, 2020.

metrics may ultimately help to better portray the impacts of harm reduction and alleviate many of the misconceptions and fears surrounding harm reduction, it is also crucial to note the inherent difficulty in obtaining accurate measurements, given that former IDUs who benefit from harm reduction services may not always report back to these organizations.

While harm reduction has already been proven effective at reducing transmission of blood-borne diseases, Kate's experiences at this harm reduction organization in rural Washington reveal how these services, in fact, provide more to drug users and the community than simply the reduction of disease transmission. However, in order for these services to function effectively, it is important for the organization to work within the specific needs and climate of the community. This means building relationships with law enforcement and opponents of the organization, providing education and humanizing relationships that convey the importance of their organization.

Togliatti, Russia

Compared to in the U.S., harm reduction implementation in Russia faces its own unique challenges. This case study focuses on a harm reduction initiative in the city of Togliatti, an industrial hub located on the Volga river, just over 600 miles east of Moscow. In a 2003 qualitative study on injection drug use in this city, Rhodes and his colleagues found the common perception of Togliatti to be associated with drug use and HIV/AIDS.[128] An interviewee from the study described the city as comprised of "two

[128] Tim Rhodes, et al. "Situational factors influencing drug injecting, risk reduction and syringe exchange in Togliatti City, Russian Federation: a qualitative study of micro risk environment." *Social Science & Medicine* 57 (2003): 39-54.

groups of people: alcoholics and drug users. No-one else. The whole area here, where small families and hostels are, is about addiction."[129] The harm reduction worker interviewed for this case study, John, is originally from the U.S., but has worked with harm reduction in many different global contexts, including his work in Togliatti from 2002 to 2005. At the time John began working in Togliatti, there had been a sudden increase in the prevalence of HIV infections in several cities in Russia, including Togliatti. Whereas cases of HIV in the U.S. began increasing in the 1980's, it wasn't until 1999 that Togliatti had its first identified case of HIV. This was largely due to travel restrictions maintained during the time of the Soviet Union, as John explained, "because of being walled off, the Soviet Union had actually been, in an odd way, a form of HIV prevention, because the Soviet Union regulated so tightly who could come in to the country and who could go out."[130] The residual impacts of the Soviet Union, however, stretched even farther, contributing to a very unique context in which to implement harm reduction services.

An important aspect of the legacy of the Soviet Union in regard to harm reduction, was the Soviet conception of narcology. Narcology was a term used during the Soviet Union to describe the medical discipline within psychiatry that dealt with substance use, focused on compulsory abstinence-based treatment for drug and alcohol addicts.[131] In his book on alcoholism in the post-Soviet era, *Governing Habits*, Eugene Raikhel writes that narcology was unique, in that "as a medical specialty that was created

[129] Rhodes et al. "Situational factors influencing drug injecting, risk reduction and syringe exchange in Togliatti City, Russian Federation: a qualitative study of micro risk environment," 43.
[130] Interview with John (pseudonym), February 27, 2020.
[131] Richard Elovich and Ernest Drucker, "On drug treatment and social control: Russian narcology's great leap backwards." *Harm Reduction Journal* 5, no. 23 (2008); Eugene A. Raikhel, *Governing Habits: Treating Alcoholism in the Post-Soviet Clinic.* (Ithaca: Cornell University Press, 2016).

by decree during the 1970s, the ethos and organization of Soviet narcology were much more closely aligned with the security and policing organs of the Soviet party-state than were those of other medical specialties."[132] Practices promoted by narcology were limited to an authoritarian style of treatment – compulsory detoxification.[133] Narcologists have continued to denounce harm reduction initiatives, specifically attacking substitution treatments such as methadone and suboxone, in favor of abstinence focused treatment programs. In a 2007 official memorandum attacking methadone treatment in favor of abstinence-based treatments, the authors stated:

> The effective way to solve the problem of drug addiction treatment is an intensive search for and introduction of new methods and means that focus on complete cessation of drugs use by patients with addiction, their socialization into a new life style free from drugs, but not on exchanging from one drug to another.[134]

The persistence of narcology has been extensively criticized by Vladimir Mendelevich, a professor at Kazan State Medical University, placing the practice of narcology in a larger global context:

> Many principles of Russian narcology contradict healthy reason and diverge from the agreed-upon foundations of the worldwide professional community. The entire world criticizes the practice of compulsory treatment for addicts; we are for it. Everyone is working to introduce 'harm reduction' programs; we are against them. Everyone condemns paternalistic and manipulative methods in narcology; we support them.[135]

Implementation of harm reduction in post-Soviet Russia thus continues to face challenges as it clashes with the historical and cultural dominance of narcology.

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[132] Raikhel, *Governing Habits: Treating Alcoholism in the Post-Soviet Clinic,* 7.
[133] Elovich and Drucker, "On drug treatment and social control: Russian narcology's great leap backwards."
[134] V. N. Krasnov et al. "SAY NO TO METHADONE PROGRAMS IN THE RUSSIAN FEDERATION." (2007). Retrieved from: https://www.opensocietyfoundations.org/uploads/3ce1ac6c-0db7-4b63-bf65-c1edd1d63ff8/sayno_20070226_0.pdf
[135] Raikhel, *Governing Habits: Treating Alcoholism in the Post-Soviet Clinic,* 3.

Another challenge of doing harm reduction in Russia has to do with the continued struggles of civil society. Analyzing the history of conservatism in Russian political culture, Richard Pipes argues that there has been a strong tradition of autocracy and centralized political authority.[136] Not only has conservatism remained a dominant political ideology in Russia, but this has contributed to a lack in partnership between the state and society.[137] Under tsarist regimes and then the socialist state of the Soviet Union, civil society was difficult to build as the government ran everything and kept a close supervision of all associations.[138] With the collapse of the Soviet Union in 1991, international donors rushed to fund nongovernmental organizations (NGOs) and other civic projects in Russia, in an effort to promote democracy in this former socialist country.[139] Since then, NGOs have come under attack mainly by President Putin; in 2012 he signed the "foreign agent law" requiring organizations that receive foreign funding to register as "foreign agents" and in 2015 he signed a law that allows the Russian government to shut down any "undesirable organizations."[140]

This climate of distrust towards foreign NGOs has greatly impacted how harm reduction can be implemented in contemporary Russia, given that harm reduction initiatives have been funded and implemented by foreign NGOs.[141] This animosity

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[136] Richard Pipes, *Russian conservatism and its critics: A study in political culture*, (New Haven: Yale University Press, 2005).
[137] Ibid.
[138] Joseph Bradley, "Associations and the Development of Civil Society in Tsarist Russia," *Social Science History* 41, no. 1 (2017): 19-42; Evans, Alfred B. "Introduction: Civil Society in Contemporary Russia." *Communist and Post-Communist Studies* 45, no. 3-4 (2012): 217-18.
[139] Henderson, Sarah L. *Building Democracy in Contemporary Russia: Western Support for Grassroots Organizations.* Ithaca: Cornell University Press, 2003.
[140]Rossella, Cerulli. "How Putin's Crackdown on NGOs Threatens Opportunities for Public Diplomacy with Russia," American Security Project, June 17, 2019. https://www.americansecurityproject.org/putins-crackdown-on-ngos-threatens-public-diplomacy-with-russia/
[141] The Lancet, "The future of harm reduction programmes in Russia," *The Lancet*, *374*, no. 9697 (2009): 1213.

towards foreign NGOs may be related to "Russian national consciousness", which Diligenksy and Chugrov describe as "highly vulnerable and very sensitive to any interference or "signals" sent from the West."[142] With harm reduction services being promoted internationally, "several nongovernmental organizations (NGOs) started programs for drug users, but the government offered no funding for what it saw as "Western" ideas that went against conservative Russian culture—and to this day opiate substitutes remain outlawed."[143] Thus, in addition to harm reduction being constructed and based in Western societies and cultures, the fact that foreign NGOs have been the main space in which harm reduction is implemented in Russia contributes to a larger threat of Westernization already felt among the Russian population and government.

In Togliatti, John worked with two foreign organizations to develop an SSP and other services, including HIV counseling. At the time of John's work in Russia, President Putin's prohibitions on NGOs had not yet been put in place, yet NGOs were still not commonly understood. Not only did John discuss how NGOs were "a brand-new thing" at the time, but he also said, "harm reduction was a completely foreign concept."[144] Yet what allowed for the implementation of harm reduction in Russia was the urgency of the situation. John described how the need to address the sudden emergence of HIV, concentrated mainly among injection drug users and sex-workers involved with IDUs, helped to allow for the development of harm reduction:

> In a 3-year period they had more cases than we had in 20 years, in Washington state. And virtually all of those cases were either among people who inject drugs or people who had sex with someone who injected. So, the context was really

[142] Diligensky, Guerman and Chugrov, Sergei. ""The West" in Russian Mentality." Brussels: Office for Information and Press, 2000, 38.
[143] Jon Cohen, "Russia's HIV/AIDS epidemic is getting worse, not better." Sciencemag.org, June 11, 2018. https://www.sciencemag.org/news/2018/06/russia-s-hivaids-epidemic-getting-worse-not-better
[144] John, February 27, 2020.

> scary, there was a lot of fear, there was a lot of stigma, and so there was really an urgency, a real, real urgency to do something.[145]

The need to do something was in terms of preventing high rates of HIV transmission, rather than doing something for injection drug users. "Addiction was really not understood," John said, "a lot of this was really a legacy of post-Afghanistan, just as in the United States there was a legacy of post-Vietnam, [there was] a lot of addiction among soldiers coming back."[146] Through John's work, harm reduction was presented as a response to HIV rather than to addiction or injection drug use, as John said, "the goal was – and I don't know whether any of us explicitly, then or now, talked about the fact that HIV prevention was, to use the old cliché, sort of the camel's nose under the tent of getting harm reduction fully into the tent."[147] Thus, much of John's work was simply educating people about harm reduction: "I spent a lot of my first visits there, really doing in-depth harm reduction training for all of the staff, even the bookkeepers. Like everybody had to be on board with knowing what harm reduction was, and why that was the philosophy and practice that we were using."[148]

Given the recent introduction of NGOs – especially those funded by foreign governments – John found that relationships were critical to the proper functioning of their organization. John was working with an organization that had a syringe exchange, yet "interestingly enough, in Togliatti, there was no governmental resistance or police resistance to syringe exchange. And a lot of that just had to do with personal relationships."[149] John described how relationships allowed for the exchange to function:

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[145] John, February 27, 2020.
[146] John, February 27, 2020.
[147] John, February 27, 2020.
[148] John, February 27, 2020.
[149] John, February 27, 2020.

> The woman that was running the NGO that we were working with in Togliatti was a medical doctor, and […] she'd been born and raised and had her entire professional career in the Soviet Union as a well-respected medical doctor. So she had a close personal relationship with the Chief of Police […] [who] also had been born and raised and had a professional career. They had a personal relationship, so she went to him and said 'Look, you know, this is a big deal, leave these people alone.' And he was like 'Ya, da da da, we won't mess with them at all, we won't mess with your outreach workers, they can do whatever they want'.[150]

John acknowledged that these relationships today would not be enough for this work to continue, with Putin's extensive crackdown on NGOs.

The disdain for foreign NGOs today in Russia, however, was still present during the time John received funding from the US government – from USAID specifically – to do harm reduction work in Togliatti. Yet this funding first passed through another organization before coming to John. Given the distrust and contempt for foreign government funding, John would always say his funding came from the middle organization, rather than USAID. The NGO in Togliatti which John was working with, was also partly funded by Open Society, the philanthropic organization started by George Soros. As John had to be careful about disclosing the origins of his funding, he noted that

> this situation of 'where does the money come from' is really important to harm reduction globally. So Open Society and George Soros are very highly regarded in some areas of the world, and the funding is deeply appreciated. And the flip side of that, is that Open Society and Soros are vilified and demonized and hated in many other parts of the world.[151]

Thus, being aware of the local reception of different donors and influences through harm reduction is necessary in order to gain local support of harm reduction services.

Funding had other restrictions on John's work with harm reduction in Russia. As mentioned in the previous U.S. case study, U.S. federal funding for syringes is strictly

[150] John, February 27, 2020.
[151] John, February 27, 2020.

prohibited. Since John's funding originated with the U.S. government, he said, "one of the strings attached to it was it could not be used in any way shape or form to actually do syringe exchange […] So, I was doing a lot of education and training around effective syringe exchange, but none of our money could actually buy syringes."[152] Costs for syringe exchange supplies in Russia, however, were much more expensive than in the U.S., where John explained that syringes cost 7.5 to 9 cents each and one condom cost about 11 cents. For harm reduction in the U.S., labor – staff salaries – was the most expensive line item, yet John explained,

> when I got to Togliatti, and it was like either our first or second trip, I just had this moment of like 'Oh my god, things are so different here.' A perfectly adequate salary for an outreach worker was $100 a month […] So that would be like maybe a day and a half for an outreach worker here in the US, and so the labor was cheap. What was expensive was the syringes and condoms. Because they were paying exactly the same price that I was paying, or a little bit more. And whereas, 11 cents a condom in the US is cheap, that was expensive for them.[153]

While syringe exchanges in the U.S. often give out other supplies for safe injection, such as alcohol wipes, this was not the case in Togliatti: "In terms of syringe exchange, it really was syringes. Very, very rarely did they have alcohol wipes, tourniquets, cookers, any of the other supplies that are sort of standard."[154]

While funds for supplies remained limited, there was an aspect of harm reduction that could be altered to improve the efficacy of the syringe exchange. John was also working with staff and researchers from two other organizations while in Togliatti. These organizations insisted on following a model of a fixed syringe exchange site, like most programs in the U.S., which offered a facility for people to bring their used needles and

[152] John, February 27, 2020.
[153] John, February 27, 2020.
[154] John, February 27, 2020.

exchange them for clean ones. While syringe sales are legal in Russia and can be purchased at pharmacies, IDUs are reluctant to use this resource out of fear of police harassment.[155] Thus, fixed site SSPs pose a similar threat, given that IDUs must travel to access an SSP and then must carry syringes on their person. John found this fixed site model to be incompatible in the Russian context, as he questioned the level of accessibility the SSP would provide:

> All this stigma associated with drug use, and you're asking people to come into a fixed site facility where everyone in the neighborhood knows that this is a syringe exchange? And where there's HIV testing and counseling going on? You need to do mobile exchange. And you need to actually like go to people's houses and apartments, and so they were doing that and that was proving to be really effective.[156]

Mobile exchange can be incredibly effective for broadening the amount of people who will use the exchange, as fixed sites require people to enter a facility known for its purpose.[157] Given the stigma surrounding injection drug use and HIV, people using a fixed site syringe exchange are putting themselves at risk for being associated with drug use and HIV. John maintained that mobile sites would thus be more effective in reaching more people in need of these stigmatized harm reduction services. Irwin et al. similarly argue for the promotion of secondary syringe exchange, which allows for the distribution of syringes through networks of IDUs, in order to expand harm reduction services to reach the largely hidden IDU population in Russia.[158]

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[155] Irwin et al. "Secondary Syringe Exchange as a Model for HIV Prevention Programs in the Russian Federation." *Substance Use & Misuse* 41 (2006): 979-999.
[156] John, February 27, 2020.
[157] Irwin et al. "Secondary Syringe Exchange as a Model for HIV Prevention Programs in the Russian Federation."
[158] Ibid.

However, as the other researchers John worked with argued, fixed sites were necessary given the evaluation techniques being used. John explained,

> their evaluation strategy […] was sort of again, modeled on what we do here in Europe, or in North America, which is that we interview people who come to us. We interview people who come into our SEP, and in exchange for $10 or $20 or a chocolate bar or something, we ask them questions about their injection habits.[159]

This method of evaluation requires that people come into a fixed site, yet it does not capture data from the entire IDU population. As John had learned while doing harm reduction in Seattle,

> for the evaluation to have any meaning at all, we also needed to know something about drug injectors who did not use syringe exchange. So we had done like a lot of ethnography, of going out and finding people who did not use syringe exchange and talking with them. So that's what I was saying to these folks there [in Togliatti], you know, you need to probably do a lot more ethnography, and you need to have your evaluators to be willing and able to go out in the community and not sit and wait for people to come to them.[160]

Instead of measuring success based on metrics developed in countries and contexts where fixed syringe exchange sites are more feasible, John proposed altering the methods of evaluation, arguing that "you don't change the prevention to fit your evaluation, you change your evaluation to fit the prevention."[161] Instead of using "a sort of North American or Anglish definition of what successful HIV prevention would look like," John responded,

> this is a completely different context, if you were going to measure success based on the estimated percentage of injection drug users that access your fixed site syringe exchange, for which you guys are spending tons and tons of money and nobody is coming to, then this is going to be a very unsuccessful intervention. But if you are going to measure success based on the number of outreach consults that these outreach workers are having, with whom you are not spending a lot of

[159] John, February 27, 2020.
[160] John, February 27, 2020.
[161] John, February 27, 2020.

> money and where they are rationing the amount of condoms they are giving to people, the definition of success is going to look really different.[162]

The definition of success depends on the goal of the harm reduction initiative. While harm reduction is effective at reducing rates of HIV transmission, John gave a different picture of what harm reduction aims to accomplish:

> fundamentally at the root of harm reduction is respect, for the dignity and the integrity of the people you are working with. Where your success is not based on the number of syringes your organization distributes, your success is how well do you respect the people that you are working with, and how much do those people recognize that they are in fact respected.[163]

Keeping the goals of harm reduction at the forefront of services also means adapting evaluation methods to appropriately measure these goals.

Given the importance of mobile exchange in Togliatti, John also discussed the role of outreach workers. John said outreach workers often had a connection to the populations which the organization was trying to reach: "if they hadn't injected drugs themselves, they had family or friends that were injection drug users. And if they hadn't done sex work themselves, their sister was doing it, or their next-door neighbor."[164] This was a vital component of the organization, as they aimed to implement a mobile exchange. John explained how this wouldn't have been possible without people from the community, saying, "I was going into people's apartments; I was hanging out in parks with people. As a result of the outreach workers' connection with the community, I instantly had a connection that I never, ever would have had, I would've had to live there for years, full time."[165] Reflecting on the role of peer outreach workers who have

[162] John, February 27, 2020.
[163] John, February 27, 2020.
[164] John, February 27, 2020.
[165] John, February 27, 2020.

connections with IDUs in the community, John said that in order to implement harm reduction effectively, "the more stigmatized, the more marginalized, the more demonized, the more underground people are, the more critical it becomes to rely on indigenous people."[166]

Reflecting on his work with harm reduction all over the globe, John advised that "you really need to figure out what's the cultural context here. As someone from very, very liberal – at least on paper – Seattle, I cannot parachute into Alabama and start talking about exchanging eight million syringes a year, and why that's a good idea. I can't parachute into some foreign country and figure out how and why."[167] Understanding the cultural context – the extent of stigma associated with drug use or HIV, the legal frameworks of a country, perspectives on NGOs and "Western" concepts such as harm reduction, etc. – is vital to constructing an appropriate and effective method of harm reduction.

Tijuana and Mexicali, Mexico

In Mexico, the 'War on Drugs' approach has materialized to be more widespread and literal than in the United States. This militarized response erupted in 2006 when President Felipe Calderón deployed Mexican soldiers across the country to battle drug traffickers and cartels.[168] Mexico has been a critical component of global drug trade since the end of WWII, exporting cannabis and heroin, along with providing trafficking routes

[166] John, February 27, 2020.
[167] John, February 27, 2020.
[168] Tomas Keliner and Francesco Pipitone. "Inside Mexico's Drug War." *World Policy Journal* 27, no. 1 (2010): 29-37.

for cocaine and other drugs exported from Latin America.[169] Given the massive drug demand in the U.S., the drug trade in Mexico has blown up since the 1960s and 70s.[170] Beginning in the mid-1990s, drug gangs in Mexico began fighting for more territory, leading to large eruptions of violence all over the country.[171] Not only has drug trafficking in Mexico contributed to increased violence, but also "there is strong evidence to suggest that the role played by many Latin American countries in the cultivation, refinement and transshipment of drugs is related to the patterns of drug use in the region."[172] Indeed, according to a national survey in 2016, the percentage of Mexican men (12-65 years) who have used illicit drugs has nearly doubled over the previous decade, while the percentage of women has more than doubled.[173]

For this case study, I interviewed Juan, a professor of drug policy in Central Mexico who works with harm reduction organizations along the Mexico-U.S. border, specifically in the cities of Tijuana and Mexicali, to support naloxone (an opiate overdose reversal drug) distribution and harm reduction education. Juan described Tijuana as a place where injection drug use is common and visible, saying, "you can see people injecting openly in the streets of downtown Tijuana. And generally, the perspective is that they are homeless people who don't want to get better."[174] As in most parts of the world, there is a lot of stigma associated with injection drug use in Mexico, particularly

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[169] Teague, Aileen. "The Drug Trade in Mexico." *Oxford Research Encyclopedia of Latin American History*. Ed. William Beezley. New York: Oxford University Press, 2016. (Encyclopedic Entry) Oxford Encyclopedia of Mexican History and Culture, 2018.
[170] Ibid.
[171] Tomas Keliner and Francesco Pipitone. "Inside Mexico's Drug War."
[172] Catherine Cook and Natalya Kanaef. *Global State of Harm Reduction 2008: Mapping the Response to Drug-related HIV and Hepatitis C Epidemics. (*London: International Harm Reduction Association, 2008), 67.
[173] Joshua Partlow. "Mexico's Drug Trade Hits Home*," Washington Post*, December 21, 2017. https://www.washingtonpost.com/graphics/2017/world/mexico-s-drug-traffic-is-now-hitting-home/
[174] Interview with Juan (pseudonym), March 4, 2020.

because "Mexico is an extremely conservative society."[175] Juan said this can be clearly seen,

> with the president saying publicly that we should stigmatize drug users, basically any drug use. That anyone who uses drugs is kind of like an immoral person. So, if we're talking about that, just generally about substance use, when we go down to injection drug use, it's even more stigmatized. The fact that having to inject I think, crosses a threshold that scares people.[176]

Indeed, interviewees from a 2008 qualitative study in Mexico indicated the government promotes animosity towards IDUs, with one interviewee stating,

> I think the government is not interested because it feels that there is no solution for these people, they are not interested that many people have a drug problem […] if you watch the news you are not going to hear about a program concerned with drug users or alcoholics. No, you don't hear this and I think it is because the government is not interested in these types of people.[177]

Another interviewee commented on the overall perception of drug use in Mexico, saying "We have these concepts in our culture that drug users continue to be delinquents, and these then become impairments because it affects politics on various levels."[178] With the stigmatization of injection drug use being propagated by government rhetoric, this leads many people to believe that drug users present a harm to society, an evil that must be eliminated. This leads to increasingly risky behaviors, as Juan explained, "the idea goes that, it's just imperative not to have them in plain sight. And that is leading people to go into more crazier places to inject drugs, putting themselves at risk."[179] Injection drug use is particularly common in border cities, given the spillover from drug shipments to the U.S., with Tijuana reporting "three times the national average of individuals consuming

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[175] Juan, March 4, 2020.
[176] Juan, March 4, 2020.
[177] Philbin et al. "A qualitative assessment of stakeholder perceptions and socio-cultural influences on the acceptability of harm reduction programs in Tijuana, Mexico." *Harm Reduction Journal* 5, no. 36 (2008), 4.
[178] Ibid, 4.
[179] Juan, March 4, 2020.

illicit drugs."[180] Juan described a canal along the border of the U.S. near Tijuana: "a no-man's land, it's a sewage system so there's no other people living there, so [IDUs] have taken up the space. You will always read from the newspapers, particularly from the business community, that that should not be the image that Mexico wants to give its visitors. And that we should get rid of the problem."[181]

Given the national culture which stigmatizes and demonizes drug users, law enforcement often targets users despite syringe possession being legal. Juan explained that

> It's a failed decriminalization scheme, that when you have a Mexican drug user, the police sometimes will say sometimes that 'Well, possession of syringes is not illegal but you have drugs within that syringe, so we need to book you in because we need to see what's going on there.' So, having syringes once again becomes kind of like a de facto crime, because they assume that you're going to be using them for using substances.[182]

Miller et al. also discovered that police harassment poses a significant barrier for IDUs in Mexico in finding clean needles and impacts the spaces used for injection.[183] An interviewee in Miller et al.'s study stated that IDUs must "look for abandoned houses or an old car or an isolated place or something that, well, where not many people pass by, nor the police" in order to inject safely without scrutinization from the police.[184] Juan has worked with law enforcement, attempting to educate police officers on harm reduction and the legality of syringe possession. Yet he called this "a difficult battle", estimating that about one in every ten police officers will change their views.[185] Juan's work with

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[180] Miller et al. "Injecting Drug Users' Experiences of Policing Practices in Two Mexican-U.S. Border Cities: Public Health Perspectives." *The International Journal on Drug Policy* 19, no. 4 (2008): 324-325.
[181] Juan, March 4, 2020.
[182] Juan, March 4, 2020.
[183] Miller et al. "Injecting Drug Users' Experiences of Policing Practices in Two Mexican-U.S. Border Cities: Public Health Perspectives."
[184] Ibid., 327.
[185] Juan, March 4, 2020.

law enforcement also depends upon the current administration of a city, which changes every three years. After working with law enforcement once, the new administration decided to discontinue their collaboration, halting the progress Juan was attempting to instill. Yet some members of law enforcement have held onto the trainings that Juan provided:

> some of those that changed, some of them have been able to be, for example, in management or in leadership. And for example, the police precinct chief, who is in the area where we work with, in the organization, is one of those people who changed their views, and he has, for example, now allowed for police officers to carry naloxone.[186]

Thus, implementing harm reduction philosophies among law enforcement workers is largely dependent on governmental acceptance, and looks quite different from the relationship building with law enforcement carried out in a place like rural Washington state, as explored previously.

Given the geographic location and the pervasiveness of drug cultivation and trafficking in Mexico, the U.S. has pushed for Mexican drug policy to align with U.S. policies. Thus, as drug consumption erupted among middle- and upper-class Americans, both the U.S. and Mexico altered the punitive approach to consider drug abuse as more of a public health problem.[187] This shift in approach led to the Mexican government passing federal drug policy reforms in 2009 which partially decriminalized drug possession and called for the expansion of drug treatment services."[188] The predominant drug abuse treatment programs in Northern Mexico have been limited to *anexos*, or in-patient

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[186] Juan, March 4, 2020.
[187] Miguel Ruiz-Cabañas, "Mexico's permanent campaign: Costs, benefits, implications" in *Drug Policy in the Americas*, ed. Peter Smith (Boulder: Westview Press, 1992).
[188] Bazzi et al. "Social and Structural Challenges to Drug Cessation Among Couples in Northern Mexico: Implications for Drug Treatment in Underserved Communities." *Journal of Substance Abuse Treatment* 61 (2016), 27.

residential centers.[189] However, these treatment facilities are not necessarily effective or ethical, as Juan explained,

> they only offer residential treatment with entities that don't have quality standards of care. So, in many cases they're jails, kind of, typically you suffer abuse – physical, mental, in some cases sexual. In some other cases, these people have franchises of these rehab centers in other cities around Mexico. So, they will basically exile the people out from the city. So, you might be picked up in Tijuana and then you are sent off 200 km or 300, 400 km away to one of the other rehab centers of the same community.[190]

Mistreatment is common in these rehabilitation centers, as Syvertsen et al. found through a qualitative study of participants in treatment centers in Mexico.[191] Moreover, there has even been intense violence in some rehabilitation centers; in September 2009, 17 people at a treatment facility in the border city of Ciudad Juarez were killed in an attack.[192] The violence and mistreatment endured at rehabilitation facilities has embedded mistrust and cynicism towards treatment among IDUs.[193] Furthermore, the Mexican government does not support medication assisted treatments.[194] There are only a few methadone clinics in the entire country, and they are private and costly. Juan explained the focus on abstinence-oriented treatment as a possible result of government officials' personal preference, saying that "they are AA believers, many of the cases is that the directors themselves used to be substance users, not only drugs but also alcohol, and they believe

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[189] Bazzi et al. "Social and Structural Challenges to Drug Cessation Among Couples in Northern Mexico: Implications for Drug Treatment in Underserved Communities," 27.
[190] Juan, March 4, 2020.
[191] Syvertsen et al. "Managing La Malilla: Exploring Drug Treatment Experiences among Injection Drug Users in Tijuana, Mexico, and Their Implications for Drug Law Reform." *International Journal of Drug Policy* 21, no. 6 (2010): 459-65.
[192] Lacey, Marc. "17 Killed in Mexican Rehab Center." *New York Times*, September 3, 2009. https://www.nytimes.com/2009/09/04/world/americas/04mexico.html?_r=0
[193] Ibid.
[194] Juan, March 4, 2020.

that that model is the model that helped them, so it's the model that would help everyone else."[195]

Given the emergence of HIV in Mexico occurred in the early 1980s, Juan discussed how the federal government has changed the national response to drug use. Beginning in the early 2000s, the federal government began financing NGOs that did needle exchange, however, this was ended just a few years ago when an executive order banned federal funding for NGOs. Juan explained how this affected the presence of SSPs in Mexico:

> During the height of the financing of the HIV ministry, there were around probably 8 syringe exchanges in the country. Now, the new federal government that got into power a year and a half ago, decided, through a presidential executive order, that the government was not going to give any more money to any kind of NGOs in the country. These included all the harm reduction NGOs. So, even though that last year the Congress had allocated money for needle exchange and other harm reduction services, the HIV ministry was not allowed to give it to the organizations. So, as of now, there are currently only 3 needle exchanges running in the country.[196]

Given the lack of funding, the organizations Juan works with have to rely on international donors, and also must limit clean syringe distribution to one per person. This limit on syringe distribution has already impacted the prevalence of HIV among IDUs, as Juan said, "we are already detecting new cases of HIV infection among our clients because people are resorting back to reusing, selling, or renting syringes."[197] Juan stated that despite officials in the Ministry of Health potentially believing in the evidence-based efficacy of SSPs, the federal government's ban on funding for NGOs is rooted in a fear of corruption within NGOs.

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[195] Juan, March 4, 2020.
[196] Juan, March 4, 2020.
[197] Juan, March 4, 2020.

When the harm reduction organizations Juan works with do have funding, outreach is a critical component of their work. Juan believes the employment of peer workers in outreach is "vital", since "the places where we walk in could not be reached without having someone who knows the community."[198] He believes that the

> previous administration has not funded adequately the engagement of peers into harm reduction tasks. A little bit, but not enough. But mostly I think that there is the belief that we need to only hire people that are free of substance use, that you cannot hire people who are active drug users for harm reduction activities. And that I think is one of the biggest mistakes that was lacking in the previous policy. We are trying to change that, and we have now engaged with people who still use […] we try to also, when possible, support people who have lived experience.[199]

He went on to say that harm reduction began with drug users themselves, not researchers:

> Needle exchange programs started because people who used drugs realized they were getting infected, and they made the decision to open their own arms to do something for their community. So I believe in places such as Mexico, the empowerment of people who use drugs is a lacking issue that we need to address, that some other places like Canada and Europe have embraced through a long struggle, but that places of low resource settings need to promote more, even though we have conditions of violence and poverty, but we need to understand that without them, harm reduction will have no impact.[200]

The lack of participation of current IDUs in harm reduction initiatives in Mexico may perhaps be attributed to the specific type of stigma associated with IDUs. The rampant activities of drug cartels and the violence associated with drug use in Mexico may influence the perception of IDUs to the point where the IDU community must remain largely invisible, out of necessity for safety or in response to potential animosity among the larger Mexican population towards IDUs. Yet, the empowerment of people who use drugs is an important tenet of harm reduction and can be accomplished through peer outreach. This outreach allows for better access to the total population of injection drug

[198] Juan, March 4, 2020.
[199] Juan, March 4, 2020.
[200] Juan, March 4, 2020.

users, not just the people who are willing and able to enter a fixed syringe exchange site. Juan argues that "fundamentally harm reduction does not only have to be a fixed service, but in the settings that we work in, we need to have a robust outreach program that allows to find people where they are, which is also another tenet of harm reduction."[201]

Juan also discussed how evaluation standards of these harm reduction organizations often do not capture the full picture of their work. Juan described the goal of these organizations, saying,

> The goal is improving life quality […] We don't mandate abstinence as a solution to your problems. We would rather have you come in even though you're continuing to use so we can check up on you regularly. And I think we just try to diminish the burden of disease on the really key segment of the population that is affected by substance use problems. Also, we try to provide the harm reduction philosophy as a space with dignity and respect of human rights for everyone.[202]

This broad goal is difficult to quantify and evaluate, and not something that policy makers are concerned with. Juan explained,

> Obviously for policy makers, the first question that they ask us with services like the safe consumption site is how many people have stopped using drugs. And that is not something that we encourage itself as a condition to use our services, but that policy makers would like to see more. I think we need to develop better metrics of how we help in the community.[203]

When asked what improved metrics would evaluate, Juan described the wholistic care which these organizations provide:

> needle exchange or safe consumption sites are only one tool to bring people into the services and help them into stabilizing their life, or trying to find a job, or housing, or food security and other measures of success for quality of living that people should have. So, we are in dire need of trying to set up this more comprehensive case management systems that would allow us to better assess the impact that we're making in the long run among the lives of people who use our services.[204]

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[201] Juan, March 4, 2020.
[202] Juan, March 4, 2020.
[203] Juan, March 4, 2020.
[204] Juan, March 4, 2020.

However, developing more appropriate methods of evaluation must be put on the back burner, as the lack of funding prevents these organizations from hiring people to measure impacts and systematize proper evaluation.

Finally, Juan commented on the need to educate community members in the cities in which harm reduction services are needed and implemented, in order to increase the acceptability of these organizations. For example, Juan explained how educating the community about the policies of an organization's safe consumption site proved beneficial:

> People will say that we're only providing services that keep people using drugs. But once we explain to them, for example, the concept of safe consumption site […] once we explain that our service is a service only directed to women and that it's just a door for us to engage with the population, people become a little more open to having this project in their area and community.[205]

When community members are educated on why the organization's services exist and the vulnerable population which they are geared towards, this may allow for greater acceptance. While community members might first oppose the idea of an SSP in their neighborhood, education and open communication can go a long way toward combatting initial stigma and fear, ultimately allowing for harm reduction initiatives to function more effectively.

Case Study Conclusions

These interviews and analyses of harm reduction programs in three different case studies has yielded important themes for effectively implementing harm reduction

[205] Juan, March 4, 2020.

services for people who inject drugs. At the forefront is the necessity of adapting harm reduction to the specific cultural context of a community. Given that harm reduction services first began in Western liberal contexts, it is imperative that these services are not simply copied and pasted into different contexts. In the case studies of Russia and Mexico, harm reduction workers aimed to preserve the core philosophies and tenets of harm reduction while adapting services to fit the needs of the community best. In Togliatti, this meant taking into account the intense stigma surrounding drug use and adapting an SSP to improve access, through peer outreach and a mobile exchange. This is similar in the case of Mexico, where police pose a significant threat to users and may prevent access to a fixed exchange site. In these cases, harm reduction is not simply represented by a traditional fixed SSP site, but rather is emulated through the component of harm reduction which aims to "meet people where they are at" – in these cases, physically through mobile exchange.

Furthermore, relationship building is key to adapting harm reduction to different contexts. As harm reduction is not compatible with all countries' legal restrictions regarding drug possession and syringe possession, relationship building between harm reduction staff and law enforcement is vital to maximizing success of harm reduction initiatives. In the case study of rural Washington state in the U.S., communication between law enforcement and city governments and SSPs can help to quell resistance to harm reduction services. In Togliatti, these relationships with law enforcement leaders were also necessary for allowing harm reduction workers to continue their services without harassment from police officers. This is also useful in places where there is a disconnect between legal guidelines and actual practice – such as in Mexico where the

law stipulates syringe possession is legal, yet police officers often still arrest users claiming their syringes will eventually be used for illicit drugs. Training and education among law enforcement can thus improve relationships between users and officers, and limit violations of the laws that criminalize users.

As revealed from the interviews from all three case studies, at the heart of stigma associated with drug use is misinformation and fear. To address the resistance to harm reduction thus necessitates careful education on drug use and addiction. While in most societies there are specific ideas on what a drug user looks and acts like, Kate in rural Washington explained how these are often misconceptions. Addiction can happen to anyone, and most people don't realize that. Sharing stories of users – how their drug use began and the barriers that have prevented them from stopping use – might be useful for correcting common ignorance surrounding drug use. John, in Togliatti, found through his work with harm reduction that fear is also often the root of stigma. In Togliatti, this fear was partly due to the sudden emergence of HIV in communities. John explained how understanding this fear can help to address the concerns of the community and improve overall understanding of HIV transmission and risk factors. In the case of Mexico, which continues to experience increased violence due to illicit drug cultivation and trafficking, the intense stigma associated with drug abuse and IDUs must be acknowledged in order to better adapt harm reduction services – by promoting harm reduction education with law enforcement and community members and making use of peer networks to better reach the IDU population.

Furthermore, these case studies revealed the necessity for peer support and outreach. In all three case studies, the harm reduction workers explained the unique

benefits of employing peer workers. Not only can peer workers engage with users over common experiences and struggles, but they are also necessary for reaching broader networks of injection drug users. Additionally, the employment of drug users who continue to use can assist in empowering users, which is one component of harm reduction. As Kate explained, her experiences with drug use and her success in working with harm reduction helps to both motivate clients and to support herself in continuing to deal with her past. This type of relationship is unique and provides key support systems for both current and former users.

Finally, in all three case studies, there is a clear need for better metrics of success in order to appropriately convey the wholistic impacts of harm reduction in a community. Rather than simply a focus on reduction of HIV transmission or rate of users referred to treatment programs, success within harm reduction initiatives includes promoting respect and dignity among users, providing housing or food assistance, and improving the overall well-being of users. While this data is more often represented through testimonials and qualitative studies, Kate explained that people often want numbers and quantifiable data. Adjusting metrics to appropriately capture this data – such as in Washington, where Kate is counting the number of times SSP staff provide supportive counseling – can go a long way for representing the extensive impacts of SSPs. As research capturing the effects of harm reduction services has been vital to promoting these programs globally, the portrayal of positive impacts initiated through harm reduction in its entirety may also improve overall acceptability of harm reduction services. If more people can understand the long-term benefits of harm reduction, more communities will be willing to support harm reduction organizations.

Part III: Globalizing Harm Reduction

This final section seeks to situate harm reduction within the larger context of international health initiatives. Harm reduction has proven to be effective in not only reducing rates of blood-borne disease transmission and public dollars spent on healthcare, but also in connecting IDUs to healthcare services, including treatment, by promoting communal support and individual agency among IDUs. This philosophy has recently been exported from Western progressive countries throughout the world, with practices such as SSPs and substitution therapies implemented in many different contexts. The 2019 Global State of Harm Reduction publication reported that SSPs have been implemented in 87 countries worldwide.[206] However, the exportation of any public health initiative from the West runs the risk of reifying colonial structures and maintaining the dominance of Western knowledge. In this section, I address whether the exportation of harm reduction to different environments can be done without reinforcing Western global hegemony. Interviews with harm reduction workers in three different locations – rural Washington, U.S., Togliatti, Russia, and Tijuana and Mexicali, Mexico – reveals that it is essential to adapt harm reduction to the specific cultural, historical, and social context of a location. Given the importance of context, I argue that a postcolonial critique of global health initiatives can illuminate how harm reduction practices can be better implemented around the world. This approach calls for a critique of biomedicine and Western conceptualizations of health which can contribute to exporting harm reduction as a form of cultural imperialism.

[206] Harm Reduction International. "Global State of Harm Reduction: 2019 updates." Accessed April 25, 2020. https://www.hri.global/global-state-of-harm-reduction-2019

Postcolonial critique of global health and biomedicine

There has been extensive critique of modern global health initiatives, in an attempt to deconstruct the political and social processes which contribute to global health disparities. Previous scholars have argued for a biosocial approach to global health, which "posits that such biologic and clinical processes are inflected by society, political economy, history, and culture and are thus best understood as interactions of biological and social processes."[207] One useful impact of this approach, for example, is analyzing how biopower has affected global healthcare, allowing for a new form of governance of individuals through medicine. Rather than simply understanding disease risk and prevalence through a biomedical lens, a biosocial approach allows for a deeper analysis of how global processes shape medical care and accessibility. However, there is room for greater critique of modern global health initiatives through a postcolonial perspective. A postcolonial approach focuses on the centrality of colonialism in the development of the modern world. Sanjay Seth, a published author and professor interested in postcolonial theory and international relations, writes, "postcolonial theory has at its heart an epistemological concern, namely to question the universality of the categories of modern social scientific thought, and of the disciplines into which it is divided."[208] A postcolonial critique thus adds a new dimension to a biosocial approach of global health, calling into question the universality of biomedicine and the legacy of colonialism in modern global health practices. A combination of a biosocial approach and a postcolonial lens when

[207] Bridget Hanna and Arthur Kleinman, "Unpacking Global Health: theory and critique," in *Reimagining Global Health: An Introduction.* Eds. Paul Farmer et al. (Berkeley: University of California Press, 2013), 17.
[208] Sanjay Seth. *Postcolonial Theory and International Relations: A Critical Introduction*, (New York: Routledge, 2013), 2.

applied to global health can aid in acknowledging and preventing the reinforcement of colonial power structures.

The legacy of colonialism in global health

To understand the nature of modern global health initiatives and practices through a postcolonial lens, it is necessary to first explore the emergence of the field and the structures and relations it has facilitated and upon which it depends. Global health can be traced back to colonial endeavors in the nineteenth century when healthcare and science were used to partially justify imperialist pursuits.[209] Rather than disseminating medical knowledge for the altruistic purpose of improving healthcare for colonized people, the purpose of colonial medicine originated to support the military and to "protect the health of the laboring populations insofar as local labor was required to run the vast plantations and mines that extracted economic resources for colonial interests."[210] As Alice Street writes in her ethnography of hospitals in Papua New Guinea,

> "Colonialism made hospitals a major export of the Western world and an important part of the infrastructure of governance. In many colonized countries, biomedicine and its institutions were introduced as material signs of progress, rationality, and civilization that justified the colonial venture and operated as important tools in the shaping of colonial regimes, bodies, and subjectivities."[211]

Global health in the context of colonialism thus took racialized forms, as a "moral language of health, hygiene, and the "civilizing process" suffused colonial discourse… and was invoked to justify the continued imperial presence throughout the first half of the

[209] Jeremy Greene et al. "Colonial Medicine and its Legacies," in *Reimagining Global Health: An Introduction.* Eds. Paul Farmer et al. (Berkeley: University of California Press, 2013), 33-73.
[210] Ibid., 38.
[211] Alice Street, *Biomedicine in an Unstable Place*. (Durham, London: Duke University Press, 2014), 20.

twentieth century."[212] Franz Fanon wrote about how for the colonized, Western medicine remained inseparable from colonization, as "colonial medical practices perpetuated a sense of inferiority among the colonized."[213] Early anthropologists attempted to distinguish biological differences between races, asserting differences in skull size as proof of the inferiority of non-White peoples.[214] Despite this biological theory of race being extensively debunked, thanks in part to the work of Franz Boas, as Farmer et al. explain, this mentality has persisted in modern global health rhetoric and policymaking: "in 2001, the head of the U.S. Agency for International Development (USAID), the lead U.S. funder of development efforts in what is now termed the developing world, decreed that antiretroviral therapy would fail in Africa because Africans 'don't know what Western time is.'"[215] The assumed inferiority of former colonized nations and peoples which helped to justify and develop colonial medicine has in fact been embedded in modern global health mindsets.

Missionary medicine has also had lasting impacts on the current state of global health. As opposed to colonial medicine geared towards population health, missionary medicine focused on the health of the individual – both the body and the soul.[216] Missionary medicine maintained that "Western civilization and Christianity [was] a solution to illness and a pathway to salvation."[217] In contrast, "traditional medicine was often linked to "heathen" religions", thus helping to set a precedent of rejecting

[212] Greene et al. "Colonial Medicine and its Legacies," 44.
[213] Ibid.
[214] Reginald Horsman. *Race and manifest destiny: The origins of American racial anglo-saxonism. (*Cambridge, Mass.: Harvard University Press, 1981)
[215] Jeremy Greene et al. "Colonial Medicine and its Legacies," 44.
[216] Ibid.
[217] Ibid., 46.

indigenous medical systems and knowledge.[218] Coinciding with advances in medical science and the emergence of germ theory was the professionalization of the medical field in the nineteenth century, which led missionaries to obtain professional training in clinical care.[219] Mission doctors thus became more effective in their work, and in turn, became iconic figures in the West.[220] For example, David Livingston helped to popularize the role of the physician in the "civilizing mission", as he wrote of his exploration into the unknown continent of Africa, in search of the source of the Nile river."[221] The idolization of Western medical professionals traveling to impoverished nations has persisted today, revealing another existing remnant of colonial and missionary medicine.

The history of global health is rooted in imperialist endeavors, and yet while the era of colonialism has ended, the hegemonic structures which allowed for the development of global health and biomedicine still impact current global health practices. Johanna Crane's book, *Scrambling for Africa: AIDS, Expertise, and the Rise of American Global Health Science*, provides an excellent example of how global health can merely be a masked form of cultural imperialism."[222] Crane exposes the inequities within the emerging field of "Global Health", with her description and analysis of the international response to the HIV/AIDS epidemic in Africa in the late 1990s and early 2000s.[223] The international discourse on the HIV/AIDS crisis in Africa reinforced negative stereotypes

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[218] Greene et al. "Colonial Medicine and its Legacies," 47.
[219] Ibid.
[220] Ibid.
[221] Rachel McCallion, "David Livingstone: The Boy from Blantyre Who Became an African Legend." Scotland.org (blog), September 3, 2019, https://www.scotland.org/features/david-livingstone-the-boy-from-blantyre-who-became-an-african-legend
[222] Johanna Crane. *Scrambling for Africa: AIDS, Expertise, and the Rise of American Global Health Science.* (Ithaca: Cornell University Press, 2013).
[223] Ibid.

of a dark, poor Africa – as can be seen by the previously mentioned quote from the head of USAID which resulted in the reluctance to introduce antiretroviral treatment for HIV/AIDS in the continent.[224] As HIV/AIDS erupted in Africa, American research institutions rushed to find "partners" in the developing world, yet partnerships were not equitable.[225] Patients and health institutions in the developing world have become a commodity, a popular attraction for privileged (mostly White) scientists and students. The inequality in these developing nations is the very quality that attracts global health specialists. Not only were global health initiatives in Africa disseminated along inequitable relations, scientific knowledge and health services were biased to Western standards.[226] Crane discussed how this change in expertise occurred at the Immune Wellness Clinic in Uganda.[227] While the doctors at the clinic originally based their work on qualitative factors and took descriptive notes, an American doctor brought an electronic record-keeping system that changed how healthcare and doctors worked.[228] Since "clinical expertise is less valuable in the world of international research, which answers to the standards set by leading journals and funding bodies", value is taken away from clinical expertise.[229] With this shift of dependence on qualitative to quantitative health work, real people are objectified, simply turned into numbers and data points. Furthermore, the prioritization of quantitative data conceals the importance of the cultural and social context within which patients exist.

[224] Johanna Crane. *Scrambling for Africa.*
[225] Ibid.
[226] Ibid.
[227] Ibid.
[228] Ibid.
[229] Ibid., 86.

Alice Street observes a similar clash of biomedicine and indigenous health expertise in her ethnography of a hospital in Papua New Guinea.[230] Street identified a challenge in adopting biomedical knowledge and resources at this hospital, as the biomedical dependence on technology, in fact, inhibited attempts to improve healthcare.[231] In a place where laboratory technicians are limited and time-consuming tests cannot be completed quickly, specific and accurate diagnoses are not generally made.[232] Thus, this hospital failed to make patients visible under the "clinical gaze" which localizes disease based on pathological anatomy, and instead identified "generally sick" bodies.[233] Street also observed the inequitable relations among medical researchers and the indigenous population in the context of biomedical research.[234] Biomedical research in Papua New Guinea first took hold as an opportunity for Australian scientists to gain international credibility by contributing to modern scientific and medical research.[235] While the dependence on a place of health deficiencies and poverty as a mechanism to gain international recognition is undoubtedly unethical, it further transforms the purpose and space of the hospital.[236] The hospital becomes a place where its patients are further subjugated under biomedicine, and where researchers can capitalize on the suffering and experiences of illness in the hospital.[237] However, the conditions which have formed an environment and community with a high prevalence of illness and suffering are not acknowledged or addressed. These global health disparities

[230] Alice Street, *Biomedicine in an Unstable Place*.
[231] Ibid.
[232] Ibid.
[233] Ibid.
[234] Ibid.
[235] Ibid.
[236] Ibid.
[237] Ibid.

are often the result of a general lack in healthcare infrastructure, low resources, lack of education, and more, which are lasting impacts of Western colonialism.[238] Yet in an environment dependent on wealthy donors and Western countries, professionalism and technology are given priority, and thus institutions are pressured to adopt these methods rather than using skills that would respect the humanity of the patients, attending appropriately to their needs, or rather than using skills that might be better suited to environments where technology is not reliable.

Questioning the universality of biomedicine

A postcolonial critique of global health also challenges the assumed universality and hegemonic power of biomedicine. To understand how biomedicine has become a form of cultural imperialism, I will first explore Michel Foucault's concept of biopower. Foucault asserted that in the late eighteenth century, a new form of governance emerged in relation to the body:

> the old power of death that symbolized sovereign power was now carefully supplanted by the administration of bodies and the calculated management of life. During the classical period […] there was an explosion of numerous and diverse techniques for achieving the subjugation of bodies and the control of populations marking the beginning of the era of 'biopower.'[239]

The rapid development of disciplines to address issues of birth rate, public health, housing, and migration, among others, was deployed through political practices and economic observations.[240] Biopower allowed for the subjugation of the individual body to

[238] Farmer, Paul. "An Anthropology of Structural Violence." *Current Anthropology* 45, no. 3 (2004): 305-25.
[239] Michel Foucault, *History of Sexuality, Volume 1*, 139-140.
[240] Ibid.

authoritative knowledge, which "brought life and its mechanisms into the realm of explicit calculations and made knowledge-power an agent of transformation of human life."[241] Through Foucault's analysis of biopower, we can thus understand how the emergence of biomedicine as the dominant form of knowledge related to illness and health became a form of governance over the individual.

Biomedicine locates disease and illness inside the body yet asserts individual habits and behaviors as responsible for disease production. Thus, biomedicine often obscures the impact of political and social processes on disease prevalence and construction of risk. While biomedicine must be understood as a cultural phenomenon, it is unique in that, "as a social system inside the system of science, [it] claims the monopoly of distinguishing sickness and health with the difference by which that system has established itself: true/false."[242] In other words, biomedicine asserts power through its foundation in scientific fact, yet this identification of truth is constructed by biomedicine itself. As biomedicine has become widely adopted and accepted as truth, it reinforces its own power through a general consensus in its validity. In the era of biopower, as biomedicine has gained more traction as a dominant form of knowledge, the power of biomedicine has "extended beyond accidents, illness, and disease, to the management of chronic illness and death, the administration of reproduction, the assessment and government of "risk", and the maintenance and optimization of the healthy body."[243] Furthermore, biomedical techniques have developed alongside technological

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[241] Foucault, *History of Sexuality, Volume 1*, 143.
[242] Nicolas Carrier, Julie Laplante, and Julie Bruneau, "Exploring the contingent reality of biomedicine: Injecting drug users, hepatitis C virus and risk" *Health, Risk & Society* 7, no. 2 (2005), 126-127.
[243] Nikolas S. Rose, *Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-first Century.* (Princeton: Princeton University Press, 2007), 23.

advancements, resulting in a form of technomedicine, which is highly reliant on sophisticated diagnostic and therapeutic equipment.[244] Biomedical rhetoric and expertise in the construction of disease and risk thus propose biomedical technology and responsible behavior as management tools of disease. Through biopower, biomedicine has become a form of governance, maintaining power through knowledge and technology over the individual's body through regulatory and corrective mechanisms related to health.

Not only should biomedicine be critiqued through its forms of governance, but it also must be viewed as a cultural system in itself. Biomedicine is built on a system which classifies disease based on criteria of diagnostics and symptoms, based on scientific analysis of molecular and physiological interactions. Biomedicine emerged alongside modern scientific thought, with seventeenth century natural philosophy at its core, based on a conception of nature as "a neutral domain capable of mechanistic explanation and, most important, prediction and instrumental manipulation."[245] This period of enlightenment drastically changed how humans perceived the world, based on the central characteristics of "the supremacy of reason, scientific objectivity, direct causality, belief in progress, compartmentalization of life into facts versus values and belief in the autonomous individual."[246] These characteristics have shaped the evolution and construction of biomedicine in the modern world, as responsibility for health is placed on the individual and biomedical expertise and technologies are assumed to be the only true solutions to disease.

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[244] Rose, *Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-first Century*.
[245]Joseph Davis, "Biomedicine and Its Cultural Authority." *The New Atlantis,* no. 48 (2016): 60.
[246] Donna Matheson, "A right to health: Medicine as Western cultural imperialism?" *Disability and Rehabilitation: Cultural Considerations in Disability and Rehabilitation* 31, no. 14 (2009), 1192.

Biomedicine, as it has been exported throughout the world, must thus be considered as a form of cultural imperialism, that may conflict with alternative cultural constructions of illness and health. The foundation of modern medicine in the characteristics of the European Enlightenment period – grounded in the perceived ability to view the world based on objectivity – has contributed to the notion that biomedicine is a universal truth:

> The supremacy of reason and particularly the prominent role of science created a society in which facts and science were part of the public world to be shared by all, whereas values and religion were part of the private role, and as such did not have validity in the public sphere. As well, because the human mind was the source of reason and had discovered science, it was clearly supreme, thus promoting the idea of the human being as autonomous, emancipated and individual.[247]

Thus, as Western science – focused on reason and objectivity – greatly impacted Western modern medicine, Donna Matheson argues that two aspects of biomedicine as it is shaped by modern culture, are evidence-based medicine and a belief in the rights of the individual.[248] While evidence-based medicine is often assumed by Western medical practitioners to be universally valuable, Matheson argues that this must be understood as culturally-based rather than universal.[249] Matheson does not argue that there is no value to evidence-based medicine, but rather that evidence-based medicine is not always prioritized.[250] For instance, in Angola, expert or traditional authority is respected more than evidence-based medicine: "for patients, a traditional authority, such as the traditional healer, is to be trusted, even with evidence to the contrary. Alternately, an expert opinion

[247] Matheson, "A right to health: Medicine as Western cultural imperialism?"
[248] Ibid.
[249] Ibid.
[250] Ibid.

from a doctor who has been working for many years can also be trusted. New, scientifically proven ideas cannot necessarily be trusted."[251]

Similarly, the assumption of individual rights in health is not necessarily shared across cultures. In Western cultures which often preserve the rights of the individual within healthcare, health decisions are often made by the patient. However, Matheson found this value is not common in Angola, since

> the doctor is regarded as the expert, patients do not expect to be given options and asked to decide. If this happens, the patients will frequently answer with a comment such as 'whatever the doctor thinks is best'. Many patients live in a very authoritarian community as well, in which the oldest person in their family will make the decisions for them.[252]

The clash of biomedicine with alternative cultural values is not unique to Matheson's experience in Angola but has been documented by several scholars.[253] Since the values inherent to biomedicine cannot be said to be universal, the imposition of biomedicine in non-Western contexts often takes the form of cultural imperialism.

Biomedicine and governance in harm reduction

As I established in part I of this thesis, harm reduction was developed in Western, progressive contexts. Historically, harm reduction has often been accepted due to the extensive evidence-based research which suggests that harm reduction practices present biomedical benefits to the individual drug user and to the community – by reducing rates of disease transmission. Harm reduction as it has been practiced in Western contexts must

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[251] Matheson, "A right to health: Medicine as Western cultural imperialism?" 1195.
[252] Ibid., 1197.
[253] Fadiman, Anne. *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures.* (New York: Farrar, Straus and Giroux, 2012); Street, *Biomedicine in an Unstable Place*; Crane*, Scrambling for Africa.*

be viewed as a philosophy developed within specific cultural values of individualist ethics and based in the assumed authority of biomedicine. Harm reduction has biomedical value; this I do not dispute. However, the importance attributed to the biomedical foundations of harm reduction cannot be assumed to be universal. Moreover, for harm reduction to function most effectively, we should not rely on the assumption that biomedical knowledge and expertise governs all individuals' actions.

The importance of denying the universality of biomedicine within harm reduction can be gleaned from the results of a 2005 qualitative study of how IDUs understand the risk of contracting hepatitis C (HCV), a virus that is easily transmitted through the sharing or reuse of needles. Carrier et al. set out to understand how meaning is associated with the HCV virus and the risk of contracting the virus among IDUs in Canada.[254] The authors discovered that "the multiplicity of social discourses means that even if biomedicine claims to be the sole possessor of truths about disease – in our case hepatitis C – people continually experience discourses and situations that can be given meaning outside of biomedicine's constructions of reality."[255] Rather than only taking biomedical expertise on HCV into account in assessing individual risk, IDUs in this study often used their own knowledge, personal experience, or the experiences of other IDUs with HCV within their perception of risk.[256] Thus, "the biomedical model of cause, infection by contaminated blood, and the effect, infection and the symptoms of hepatitis C is one discourse amongst many and drug users may 'test' it against the experience of their

[254] Carrier, Laplante, and Bruneau, "Exploring the contingent reality of biomedicine: Injecting drug users, hepatitis C virus and risk."
[255] Ibid., 127.
[256] Ibid.

everyday lives and find it wanting."[257] Biomedical knowledge thus cannot be assumed to be prioritized in an individual's understanding of risk.

However, it is exactly biomedicine through biopower which identifies risk populations and asserts governance over such populations. The expansive power of medicine has allowed for biomedicine to extend its reach into the realms of social and political problems. The formation of "risk" populations subjugates individuals – often without consent – into broad groups that are posited to present risk to both themselves and society. This categorization of people to risk groups may also perpetuate stigma associated with diseased bodies. Individuals located within risk groups are thus subjected to the governance of biomedicine, as a regulatory mechanism which maintains control over the health and livelihood of the general population. Public health initiatives addressed at these risk populations assume that individuals in this group understand risk based on biomedicine. However, as seen with the study of HCV risk perception among IDUs in Canada, biomedicine is not always at the foreground of an individual's perception of risk or actions related to risk. Not only does the formation of risk populations extend control over individuals and their bodies, but it does so under the assumption of the universality of biomedicine.

Global harm reduction implementation

Part II of this thesis revealed how harm reduction implementation in different settings is greatly dependent on context: historical, social, political, and cultural. A

[257] Carrier, Laplante, and Bruneau, "Exploring the contingent reality of biomedicine: Injecting drug users, hepatitis C virus and risk," 138.

postcolonial approach to global harm reduction policies calls for a careful analysis of the colonial legacies which prevail in current global health initiatives and any assumptions of universality within these approaches. As I have previously unpacked, the colonial legacies in global health have contributed to inequitable international partnerships and the assumed authority of biomedical knowledge. These legacies provide significant challenges to the effective implementation of harm reduction throughout the world. As the case of Togliatti, Russia demonstrates, harm reduction entered the country mainly through international donors and NGOs, resulting in general opposition from the Russian government towards the culturally Western practice, which threatened the traditional Russian field of narcology. While the Western tradition of harm reduction focused on fixed site SSPs, John explained how this form of harm reduction was incompatible in Togliatti, due to the specific stigma associated with injection drug use in Russia. Modification of harm reduction in the form of mobile SSPs proved more effective in reaching the larger IDU population. This was similarly the case in Mexico, in which Juan explained how law enforcement posed a significant threat to IDUs, and thus presented a barrier to access of fixed site SSPs. Taking into account the historical implications of drug cultivation and trafficking and the intense criminalization of drug abuse in Mexico reveals the specific stigma associated with injection drug use that differs from the stigma present in Russian or American society. In the case of rural Washington state in the U.S., Kate explained that opposition to SSPs and harm reduction is often rooted in a reluctance to offer services to IDUs. This reluctance is representative of a larger cultural characteristic of the U.S., that of individualism, which asserts the individual is at fault for health problems. In each of these cases, specific characteristics of context influence how

harm reduction can be effectively implemented. Recognizing the cultural specificity of harm reduction thus must be at the forefront of developments of harm reduction practices throughout the world.

Moreover, in each of these cases, the harm reduction workers interviewed identified flaws in metrics of success and evaluation of harm reduction programs. Biomedicine places importance on the absence of disease or illness, and further, it medicalizes substance abuse as a disorder. Instead of prioritizing the health of IDUs in terms of wholistic well-being – having a stable job, access to nutritious foods, or feeling fulfilled and happy – biomedicine defines health as abstinence or cessation from drug use. Thus, biomedical metrics of harm reduction services are generally preferred to exhibit the success of such interventions in diminishing rates of disease transmission and increasing the number of IDUs in recovery. This is likely due to the cultural importance placed on biomedicine in global health initiatives. However, as all the interviewees stated, these standards do not encapsulate the full impact of harm reduction services. The development of metrics that capture the entirety of the benefits of harm reduction services might allow for greater acceptance of harm reduction in communities. Education on harm reduction among law enforcement and community members was thus seen as an effective tool for improving the efficacy and acceptability of harm reduction in all three case studies.

The role of IDUs within harm reduction provides an important potential avenue through which harm reduction can not only be implemented more effectively but might also suppress the imperialistic qualities of harm reduction itself. As seen in all three case studies, exploiting existing IDU networks to disseminate harm reduction practices greatly

expands the reach and efficacy of these practices. It also serves to empower IDUs in taking control and agency of injection drug use behaviors and conceptions of risk. The 2005 study of HCV risk perception among IDUs in Canada exemplifies how IDUs may prioritize personal experience and knowledge from peers over biomedical expertise. Just as biomedical knowledge often trumps indigenous experiences in global health initiatives, the assumption of biomedicine as a universal truth may inhibit the efficacy of harm reduction practices when solely propagated through medical professionals. In other words, harm reduction cannot be dependent entirely on pamphlets distributed by health professionals about safe injection techniques or overdose reversal education given that IDUs do not necessarily prioritize biomedical knowledge over personal experience. Education of IDUs thus helps to disperse the validity of harm reduction practices through existing networks, empower IDUs in taking agency within risky behaviors, and prevent a culturally imperialistic imposition of harm reduction.

Conclusion & Recommendations

This thesis sought to unpack the cultural specificity of harm reduction as it has been historically practiced in order to recommend better implementation of harm reduction practices throughout the world. In the first part, I explored the differences in societal conceptualizations of drug use and how this has contributed to policies in response to drug-related harms – from drug trafficking to substance abuse epidemics and drug-related disease transmission. The biocultural framework of understanding drug use reveals the importance of harm reduction, and as this approach has pushed moral and medical models out of the dominant view of drug use, harm reduction acceptability has increased. I also discussed how the concept of harm reduction has been difficult to define, and thus is best understood as a philosophy which must be adapted to different places. The emergence and development of harm reduction within a specific culture informs us of the specific values which harm reduction relies on, that of individualism and agency, human rights, and the idea of well-being. As these values are not universal, it is thus vital that harm reduction is implemented with consideration of the cultural, historical, political, and social context of a place.

In part II, the three case studies I focused on supported this notion of the importance of cultural context in harm reduction implementation. Moreover, these case studies revealed the necessity of education of harm reduction philosophy among law enforcement, IDUs, and the general community in order to increase both the acceptability and efficacy of harm reduction practices. As stigma plays a huge role in the ability for organizations to provide harm reduction services and education, it is necessary to understand how a specific form of stigmatization of either illicit drugs or drug abuse has

been constructed and perpetuated. Education on harm reduction can help to deconstruct societal misconceptions of drug abuse. Furthermore, the harm reduction workers in each of these case studies all advocated for the role of IDUs and indigenous knowledge in harm reduction implementation. In both Togliatti and the border cities of Mexicali and Tijuana, harm reduction must often be carried out through IDUs themselves – providing harm reduction workers with greater access to the entire IDU population. IDUs also play a unique role in supporting other IDUs through struggles with drug abuse habits and recovery, as Kate in rural Washington explained. Juan, in Mexico, similarly called for the empowerment of IDUs as an important tenet of harm reduction philosophy. Finally, analysis of harm reduction work in these three case studies elaborated on the wholistic impact of harm reduction despite metrics of success often being limited to biomedical standards. The harm reduction workers in all three locations thus advocated for expanded measurements of harm reduction efficacy, attempting to relay how harm reduction practices don't simply serve to reduce disease transmission or deaths by overdose. Given that harm reduction is based on an expanded understanding of traditional, biomedical health – well-being – standards used to measure efficacy and success of harm reduction practices must match the ideal of well-being which harm reduction strives to accomplish for the IDU population.

To provide recommendations for global harm reduction implementation, I took a biosocial and postcolonial approach to harm reduction in part III. A biosocial approach to global health initiatives unpacks the inequitable relationships perpetuated through global health, the social, political, and environmental factors which influence health and illness, and the influence of biopower on individual perceptions of health. In addition, given the

colonial undertones of current global health initiatives, a postcolonial critique of global health and biomedicine may help to maintain the positive goals of harm reduction – reducing injection drug related risk and exchanging valuable scientific knowledge – while avoiding the reification of colonial practices and rhetoric. The remnants of colonial structures in modern global health and the assumed universality of biomedicine (based on the centrality of individualism) support the notion that harm reduction is rooted in cultural biases, and thus must be implemented through indigenous knowledge in order to adapt harm reduction to the specific cultural context of a place. Furthermore, it calls for the expanded role of IDU's in harm reduction, so as not to impose harm reduction in a culturally imperialistic fashion by assuming biomedicine as a universal truth in an individual's understanding of risk and harm. Moreover, this critique, which denies the universality of biomedicine, supports the construction of new metrics of success when evaluating harm reduction.

For future harm reduction implementation, policy makers and harm reduction workers should first seek to understand societal conceptualizations of drug use, including the historical and political processes which have helped to construct a specific type of stigmatization. Education on harm reduction philosophy can then be tailored to addressing the roots of this cultural stigma and potential misconceptions regarding drug use. Education of IDUs on the importance of harm reduction must also be central, as IDUs have the ability to advocate for harm reduction practices among peers and in their own experiences. Harm reduction services can then be implemented with input from IDUs and indigenous healthcare workers, so as to adapt services to fit the needs of the IDU population best. Different cultural adaptions of harm reduction services should be

shared across the globe, so as not to perpetuate the notion that there is a true and traditional form of harm reduction that is universal. Finally, when seeking to evaluate harm reduction practices, biomedical metrics should not be relied upon, given that they do not encompass the wholistic impacts of harm reduction. The expansion of standards to measure harm reduction can aid in increasing global acceptability of harm reduction, and thus the ability to reach more IDUs who can benefit from harm reduction services. The conclusions of this thesis are merely recommendations, however, and the main point which I've attempted to solidify is the importance of recognizing and responding to the specific cultural context of a community when implementing harm reduction. When placing this at the forefront of global harm reduction, there is a better chance of implementing services that are actually beneficial to a community and that do not reify Western hegemonic practices.

Appendix A: Interview Guide

Overarching thesis questions: *How are harm reduction strategies most efficiently implemented in different environments? What aspects of "traditional" SSPs must be adapted or modified? How is success of these programs evaluated? Future recommendations for continuing to combat drug use epidemics and prevent spread of diseases such as HIV/AIDS and Hep-C?*

The following questions provide a guide for semi-structured interviews:

How would you describe the cultural and social climate surrounding drug use in your area?

- How is addiction understood generally in society? Is there a term for addiction?
    - How is injection drug use viewed among the people you work with? How do the police understand injection drug use? Community members? IDUs?
- How do you think the understanding of addiction effects implementation of HR?
- To what extent are drug users stigmatized in the community?
- What drugs are most prevalent? Why?

Has your agency ever had trouble with the law?

- Are there any legal restrictions effecting implementation of SSPs?
- Is possession of syringes illegal?
- Is possession of drugs illegal? Which drugs?
- Are these laws enforced and how?

Harm reduction interventions – what type of organization did you work at? How was this organization/program first started?

- What HR interventions are most common in the US? Why?
- Are these programs governmental or NGOs?
- Have you had any difficulties acquiring funds for your organization's activities? Where does funding come from?
- What is the primary goal of this organization? How does health/well-being factor into the work of harm reduction?
- How does your organization measure success? What do you credit that success to?

What services does your organization/initiative offer?

- Do you have a fixed or mobile SSP? Why?
- What supplies are provided? Do you have trouble acquiring supplies?
- Who oversees distribution of syringes? Disposal of used syringes?
- Has there been a need for educational services (information on HIV/AIDS, safe injection practices, safe disposal) within the community?
- What does outreach look like – education in community? Do you employ former users for peer outreach?
- How has the community responded to the activities of the SSP? Community/social perception of SSP?

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