Caught Between the “Soft” and “Hard” Arms of the State: A Conceptual Apparatus for Situating the Formative Role of Drug User Organizations in National Policy-Making and Local Service Delivery – A Commentary

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The purpose of this commentary is to develop a conceptual apparatus for understanding the role of drug user organizations in the development and implementation of national harm reduction initiatives by extrapolating some general trends and important lessons derived from the collection of essays found in this special issue. The development of such a framework will include the findings of this research, while also suggesting systemic trends within which the role of drug users as “change agents” can be more generally examined.

As these essays demonstrate, the formative role of drug user organizations in public policy can be evaluated from a number of perspectives. But rather than present a causal reason for why drug users become involved in policy-making and service delivery, I propose a structural framework that links the theme of drug users as “change agents” to the antagonism that exists between the state institutions of public health (PH) and law enforcement (LE) over the most efficient means to reduce injection-related harm. This approach, which is developed to a certain extent by the essays in this volume, will enable us to assess the strategies that characterize “drug user activism” as well as allowing us to examine the sources of power that become available to drug users when they organize their efforts collectively as civil organizations.

In what follows, I will demonstrate how a universal asymmetry between the contradictory logics of PH and LE provides a tension from which to explore the myriad of forces that motivate drug users to become involved in service delivery and policy-making. While the specific antagonisms that exist in a particular country are relative to the ideological systems that inform its raison d’être, the internal, push-pull relationship between these two poles (LE & PH) nevertheless provides a general framework to examine both the factors that motivate drug users to become politically active and the “sources of power” that become available to them to achieve their goals (Rosaldo and Lamphere 1974).

Even with accounts from countries as diverse as those with strong traditions of political liberalism and social welfare, such as Canada and the Netherlands, to those that are more authoritarian in nature, such as the Ukraine or Thailand, some common themes emerge that, when viewed together, clearly illustrate a dialectical sequence at work. If we are willing to presume, following Marx (1859), that the structure of social relations condition people’s cultural perceptions then perhaps we can illustrate this venerable claim by demonstrating how the structural antagonism between LE and PH—over the best way to prevent the spread of drug-related harm—not only compels drug users to respond to what they perceive as an unresponsive and unjust system, but also how it conditions their subjectivity as drug users.

Since the five papers under consideration each, in their own unique way, exemplify a dialectical relationship between the structural, i.e. systemic, barriers that hinder access to life-saving resources and the subjectivity and agency of drug users, it is helpful to extrapolate the common components of this correlation and configure them in such a way that will enable the reader to situate drug user activism within a state apparatus that is entirely unresponsive to the health needs of people who use drugs. Taken separately, however, none of these components is surprising. Yet, when viewed together, we can clearly see that the impetus for drug users to become involved in service delivery or policy-making is related to a structural asymmetry between PH and LE over the issue of drug-related harm:

1. Each nation-state has an internal antagonism between the jurisdiction and institutional responsibility of LE on the one hand and PH on the other. The particular
3. Once drug users become involved in policy-making arrangements of these institutions is a creatively antagonistic arena whose centers and boundaries are always shifting depending on changes and tensions within and across civil and political society.

2. The prime motivator for the formation of drug user organizations is the state. The perception that the state’s response to injection-related AIDS is unfairly tilted toward LE and thus not able to respond effectively to reduce injection-related harm is the main reason for drug users to organize and act collectively. Whether it concerns a scarcity of sterile syringes (Thailand) or crack kits (Brazil), a lack of access to agonist therapies as a result of punitive and morally driven government regulations (Ukraine), the absence of a comprehensive strategy to reduce unsafe injections (Vancouver), or a lack of political representation in local and national policy-making (the Netherlands), the state is consistently perceived as failing to adequately address the issues of AIDS prevention and drug-related harm.

3. Once drug users become involved in policy-making and service delivery, there is a gradual modification of their subjectivity as drug users. When people who use drugs engage in social struggles with others, they begin to see themselves as responsible and engaged citizens who can and do create social and political change.

This tripartite progression serves as a conceptual apparatus along the lines of Weber’s (1978) ideal type precisely because its characteristics derive from actually existing tensions that have transpired during the historical epoch of AIDS, while also functioning as a universal schema that can be applied across geography, culture, and polity. In this way, the institutional asymmetry between LE and PH serves as a methodical scaffolding from which to build up a number of sociological inductions that proceed from the particular to the universal. Such a broad-spectrum model will allow us to locate the wide range of state responses to injection-related AIDS along a continuum where the sources of power and agency available to drug users can be seen in relation to the institutional arrangement of that particular country. This is an important facet of the model’s efficacy since history demonstrates that nation-states do not act as monoliths in their response to disease epidemics. Rather, what we often perceive as “the state apparatus” is actually an assemblage of government institutions riddled with internal tensions and contradictions.

This is most apparent in how nation-states have responded to disease epidemics. As history demonstrates, health crises have often served as a raison d’être for countries to reconfigure the institutional arrangement between PH and LE (Rosenberg, 1992). At various points during the twentieth century, whether it was a panic over syphilis, tuberculosis, or cholera, governments have employed both PH and LE strategies in their attempt to define, regulate, and govern the “risky” behavior of its citizens (Fee & Fox, 1988). This dual role reveals that the bureaucratic institutions of modern state do not act in concordance, all with mutual views, shared priorities, and joint strategies for protecting the health of civil society. Instead, state institutions possess varied and often contradictory policy logics for how they handle disease epidemics, and these conflicting principles—depending on the form the contagion takes and the types of behaviors that are said to determine its proliferation—condition the state’s response.

With the onset of AIDS, as countries faced the initial threat of an unknown contagion, many states supported the forced quarantine of infected persons as the most proficient and effective tactic to prevent the future spread of the disease. Yet, with AIDS, this practice came to be seen as a dubious approach for two reasons. First, although AIDS is a fatal disease, HIV, the virus that causes it, is not, which means there is a strong potential that a long time period can elapse between when a person first acquires the virus and when that person will die from AIDS. Second, the HIV virus is not a communicable or air-borne contagion, so besides unprotected anal and vaginal sex, drug injection with a contaminated syringe, blood and organ transplants, or semen donation, it is not easily transmitted. Fortunately, these discoveries led to a rather straightforward set of remedies for preventing future infections, whereby screening organ, semen, and blood donations; offering safer sex education; expanding condom distribution; and increasing access to sterile syringes were found to significantly reduce the number of infections, especially as people began to think and act differently with regard to their sex and drug-using practices.

Although these characteristics make prevention—rather than the containment—an efficient and relatively inexpensive strategy for protecting civil society from AIDS, they also make it unlike any other modern disease epidemic. The fact that HIV is primarily transmitted through unprotected sex and drug-injecting means that AIDS is not democratically acquired since the virus disproportionately affects men who have sex with men and drug injectors (and now more people of color than whites). And since these groups are independently unpopular, meaning that drug injecting and being gay were socially and politically demonized well before the onset of AIDS, the ability for civil society to sympathize with those at risk for infection is always already poisoned by the dominant norms and moral judgments of that society.

THE INSTITUTIONAL ANTAGONISM BETWEEN LE AND PH

Bearing this in mind, I will now turn to the first part of the schema: the internal antagonism between the institutions of LE and PH. As soon as “the needle” was discovered to be a vector for HIV transmission, it was immediately caught at the intersection of two contradictory policy logics. As Peter Baldwin explains:

On the one hand law enforcement is part of the formal state apparatus and is charged with fighting illegal drug use through drug control strategies aimed at interdiction, incarceration or rehabilitation, while on the other hand, the institutions of public health, also part of the formal state apparatus, is charged with protecting the health

Traditionally, all countries have regulated the possession and distribution of syringes by classifying them as drug paraphernalia and placing them under the jurisdiction of LE, whereby possession without a prescription is most often punishable as a criminal offense. This practice is based on the institutional logic of LE, where the needle is seen as more than just another technique for the consumption of illicit drugs, say, compared to sniffing or smoking, but as a “metaphor for illicit drug use itself and associated with criminal activity, family disintegration, child neglect, economic ruin and decay” (Gostin, 2004, p. 248). This symbolism is an instrument of a policy logic that views the legal restriction on needle access as compulsory to protect civil society from the dangers of drug injecting. In other words, the view that illicit drug use is a social evil and an immoral practice that needs to be controlled and punished not only serves to constrain people’s ability to see the PH benefits of needle exchange, but it also functions as a justification for the state’s law-and-order approach to HIV prevention.

The problem with this punitive logic, however, is that it runs counter to what researchers have determined to be the main cause of injection-related HIV transmissions: namely, the scarcity of sterile syringes (National Research Council, 1989; Vlahov & Junge, 1998). The fact that HIV is spread among injection drug users through the use of contaminated needles means that restrictive needle policies will increase HIV transmission because interdiction creates a scarcity of syringes (which is the objective) and the ensuing high price of sterile syringes on the black market is what causes street injectors to use contaminated needles. The logic of interdiction is so entrenched that even when faced with a mounting AIDS epidemic, the restrictive approach remains justified on grounds that “liberalizing” syringes poses a greater threat to society’s safety than a bunch of drug addicts dying from a virus that they should have avoided in the first place. This is the cultural terrain where the punitive logic of LE becomes antagonistic to the epidemiological logic of PH.

Like LE, PH is also part of the formal state apparatus, and as such, its institutions and agencies have similar statutory privileges that allow it to restrict the individual liberty of those persons who pose a (medical) threat to civil society. Thus, contrary to the pragmatist view now embraced by many health departments around the world, the employment of compulsory measures at the beginning of the epidemic, such as forced quarantine, is an indicator of the health department’s coercive power. Still, the one significant difference between LE and PH is that, unlike criminal prosecutions, PH strategies are not intended to punish individuals for morally culpable behavior. “Civil remedies, therefore, are forward-looking attempts to prevent harm and improve health, whereas criminal penalties are backward-looking attempts to punish wrongdoers” (Gostin, 2004, p. 181). This pragmatic logic is what allows PH workers and substance abuse counselors to more readily inhabit the tenets of harm reduction, since, as Jonathan Engel notes, “[m]any in the public health field have spent their careers improving the lives of people whose behavior and proclivities defied accepted social norms: alcoholics, drug users, victims and perpetrators of domestic violence, unwed mothers, and the like” (2006, p. 79). This experience requires that they convey a sense of moral neutrality when counseling addicted persons so that people already suffering from drug dependence, domestic violence, or any other malady associated with drug addiction are not discouraged from accessing prevention services that can save their lives.

It is important to note, however, that the tension between moralism and pragmatism over who is deserving of services is not just true for AIDS. Indeed, the modern history of disease epidemics reveals a consistent antagonism between those who want to help the infected, or those at risk for infection, and those who want to banish them: “Disease epidemics bring out the best and worse in human beings” (Gostin, 2004, p. 179), as Lawrence Gostin reminds us, because in any epidemic, there are those folks who will risk their lives to help care for others, whether providing care, advocating for their rights, or helping them access services, but at the same time, as this altruism unfolds, there are also factions of civil society that shun, banish, and discriminate against those who have acquired the disease (Gostin, 2004).

In many respects, this Manichean formula is far too simplistic for the case at hand, given that the various settings of these articles range from drug users operating under extremely repressive conditions (Thailand and Ukraine) to those operating in countries with deep traditions of political liberalism and social welfare (Canada and the Nordic Countries), and with Brazil positioned somewhere in the middle. The difficulty, then, in trying to locate trends among drug user organizations operating in different countries is due to the considerable amount of variation between states and their systems of governing: differences between juridical systems, discrepancies over the role of government, distinctions between political and religious traditions, variations in drug laws, divergent approaches to civil rights, contrasts in cultural perceptions of drug use, among others. Seeing as the actually existing antagonisms between PH and LE over the question of drug-related harm is historically contingent on the social changes and political tensions within any specific country, this constantly shifting political terrain makes it difficult to gauge, with any degree of certainty, how any one country might respond to a crisis such as injection-related AIDS.

This is where the structural model is helpful because it allows us to locate a particular country’s response on the continuum between LE and PH. In states such as Thailand and Ukraine, for example, governments have historically taken an authoritarian approach to AIDS prevention as LE is granted a privileged position over PH as the most efficient way to contain the epidemic. As Hayashi et al. (this volume) make clear, Thailand remains committed to a law-and-order approach to injection-related AIDS prevention, and this punitive orientation has contributed to the extra-judicial executions of drug users and other blatant human rights abuses, massive syringe borrowing
as a result of needle scarcity, the planting of evidence by police, forced drug treatment, and a general lack of access to comprehensive prevention, care, and treatment. Similarly, in Ukraine, Golovanetskaya et al. (this volume) report that the use of methadone and buprenorphine as treatment options is being altogether discarded because the state continues to view drug addiction through the time-worn logic of Soviet narcology; a way of thinking, the authors note, that perceives illicit drug use as an imminent threat to the state where drug users have described themselves as “[b]attling a state machine that essentially sought to destroy drug-dependent people.”

Yet, these draconian practices are not confined to the more authoritarian states. According to Frank, Anker and Tammi (this volume), the Nordic countries have also “followed a relatively repressive drug policy seeking to limit and control drug use through criminalization and possession and/or use of drugs.” They contend that excluding Denmark, “all the Nordic countries have been in favor of abstinence-oriented treatment and abandoned harm reduction ideas and alternatives.” Here, we can see how the Nordic countries, save perhaps Denmark, also fall on the LE side of the continuum, but the strong traditions of political liberalism and civil rights in these countries provide drug users the ability to flex their constituent power since these countries have already established channels of political reform that operate with strong democratic participation.

This means that although Thailand and Sweden may both support a LE approach to AIDS prevention, the variations between liberal democratic and authoritarian political systems make for differences in the types of punitive measures both states adopt, what extent they are enacted, and the degree to which drug users can participate in policy-making efforts. Recognizing the differences in political systems is essential for assessing the constituent power available to drug users and the potential for drug user organizations to inscribe themselves into policy debates as legitimate actors. As Frank et al. (this volume) explain, “[t]o gain legitimacy, drug user organizations have to inscribe themselves in the debates and understanding of drug use that exist. Moreover, they must find openings and space where they can have a say.”

Yet, as is evident in Sweden, just because a country has deep traditions of constituent power, a strong welfare state, and democratic opportunities for drug users to become involved in policy-making, does not imply the state will always adopt a evidence-based and rational approach to AIDS prevention. Indeed, as evident in Denmark, it is very likely that states will traverse the continuum and shift between LE and PH approaches to injection-related AIDS depending on the political party in power and the extent to which a nation’s moral entrepreneurs hold sway over public opinion. As a result of this interplay between the two poles of LE and PH comes a contradictory set of Dutch policy initiatives where “the soft left hand of the state, in the form of public health and social services, was jockeying with the hard right fist of law enforcement” (Bourgois & Schonberg, 2009, p. 218), the result of which is a dual-track health policy, with repression going hand in hand with welfare and health initiatives.

A VERY PRODUCTIVE ANTAGONISM

The papers gathered in this volume all point to government’s lack of response as the key factor for generating the political conditions for activists and advocates to participate more directly in policy-making and service delivery. This push-pull relation is what informs the second component of our analytical framework. Having one’s government continuously support an LE approach to AIDS, while simultaneously thwarting all PH efforts meant to prevent people who inject drugs from acquiring HIV and hepatitis, is the “motive force” driving people to take a more confrontational approach to politics and what compels them to act outside of the traditional channels of reform. By challenging policy-makers and other city officials, drug users begin to take on a more confrontational role as they organize collectively to redefine the contours of AIDS policy-making in their respective countries.

We can see this in Sweden as the Swedish Drug Users’ Union was formed in direct response to the country’s abstinence-only drug policy and its affect on the restricting of suboxone treatment: “The motivation to form an organization emerged because many drug users experience that they could not get maintenance suboxone treatment because of an abstinence-oriented drug policy” (Frank et al., this volume). In a similar vein, Golovanetskaya et al. (this volume) describe the struggles of Ukrainian drug users as they attempt to remove the institutional barriers that have hindered access to suboxone. According to these authors, the antagonism between the two approaches has made the Ukrainian government severely ill-equipped to deal with addiction-related health issues by the way the two institutions are pitted against each other.

The authors explain that soon after the Ukrainian Health Minister endorsed increased access to suboxone as part of a comprehensive prevention strategy, the Cabinet of Ministers attempted to reclassify it as a List 1 drug, a move that would essentially ban its use in treatment. According to one informant: “What the Ministry of the Interior sought to block on the one hand was, on the other, waved forward by the Ministry of Health, influenced by the Clinton Administration. The Ministry of Interior or local LE undermine what the Ministry of Health promotes!”

This, the authors report, prompted an outcry from both drug users and the nation’s leading AIDS organization: “It was time for us to stand up for our right to live, our right to access evidence-based treatment and social services. Our life was in need of serious change and this called for unity and participation.” We can see that, in both cases, it was the antagonism between the state’s LE approach to

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2Elsewhere (Zibbell, 2004), I have shown the limiting power of public policy discourse as drug users attempt to penetrate the demanding lingo and poetics of policy-making, and this difficulty holds true for the institutional setting of the welfare state more generally as it defines certain spaces and procedures for involving clients in the process of decision-making.
drug treatment and the ensuing criminalization of suboxone that motivated service users to become involved in the struggle to secure the drug as a safe and effective treatment modality.

Thailand provides another example of where the tensions between LE and PE have generated some important initiatives: “The rather contradictory national policies pertaining to injection drug use in Thailand, specifically those that criminalize illicit drug use while admitting the needs for HIV surveillance and prevention for IDU, has made room for research involving IDU to be conducted” (Hayashi et al., this volume). Here, the authors note that “[i]n a context where repressive policies marginalize the population of focus, it is notable that new, scientifically sound information that adequately reflects the needs of local drug users has begun to emerge.” Again, it was the contradiction between Thailand’s LE approach to AIDS prevention and the proven ineffectiveness of that approach that led to “a group of active and former drug users united to form the Thai Drug Users’ Network to address the health and human rights concerns of Thai injection drug users.”

Similarly, Small et al. (this volume) describe how members of the Vancouver Area Network of Drug Users (VANDU) formed the Injection Support Team (IST) as a response to what they saw as a troubling health concern. Since there were no services to address unsafe and assisted injections, the IST implemented a strategy that would allow its members to become trained as “hit doctors” and assist people “by providing education and guidance during the injection process rather than providing safer injection education when injection is not occurring.”

The propensity to administer health prescriptions without the legal backing of the state, or well before PH departments implement comparable interventions, is what defines drug user activism during the first 10 years of the needle exchange controversy in both the US and Europe (Lane, 1993). The accounts presented here build upon this activist tradition by illustrating the propensity for drug users—when faced with the likely possibility of dying a slow, vicious, and unnecessary death—to become “agents of change” as they search out new ways to protect themselves, commit extra-legal actions, and invent new powers of action, new modes of interaction, new needs, new desires, and new speech.

TRANSVERSAL STRUGGLES AND THE RECONFIGURATION OF JUNKIE SUBJECTIVITY

The preceding discussion has suggested that the characteristic aspects of drug user organizations can be related to the universal opposition between PH and LE. So far, I have proposed that this structural asymmetry serves as a conceptual framework from which to explore the forces that motivate drug users to challenge the priorities of government by infiltrating the relatively closed terrain of AIDS policy. In this last section, however, I want to expand this analysis to include my third (and final) point: that once drug users become involved in policy-making and service delivery, there is a gradual modification of their subjectivity as drug users. Here, the subjective aspects of activism are linked to the capacity for drug user organizations to generate a sense of individual and community empowerment for its members (Friedman et al., 1987).

Olga Belyaeva, the co-founder of the Association of Substitution Treatment Advocates of Ukraine, illustrates the sense of empowerment that comes from people uniting around a common issue: “It was time for us to stand up for our right to live and our right to access to evidence-based treatment and social services,” she avows, “Our life was in need of serious change and this called for unity and participation.” Although these collective efforts were in response to the rigid provisions of suboxone treatment, Golovanetskaya et al. (this issue) explain that they also provided a sense of empowerment and self-sufficiency: “As patients struggle to respond to the excessively rigid and controlling policies and practices regulating substitution treatment provisions in the Ukraine, this experience—of participation and activism—brought an improved sense of empowerment and autonomy to many methadone and buprenorphine patients.”

What I find most interesting is how the very stereotypes that set drug users apart from the rest of civil society and demarcate their activities are acquired by these very same drug users and employed as a basis for their group solidarity and self-worth.3 In Ukraine, for example, “[p]atients are finding empowerment in joining forces with like-minded people resolved to change the status quo, in understanding the laws and regulations governing provision of substitution treatment, and in using this knowledge to impact overly rigid policies and practices” (Golovanetskaya et al., this volume).

Thus, a final reflex on the opposition between PH and LE can be seen in the subjective effects that this antagonism has on the personal identity of drug users. The accounts presented here all provide notable insights into the subjective aspects of drug user activism by the way they illuminate the social processes by which drug users are able to develop a new modus operandi as they begin to see themselves and their drug use in a whole new light. The ability to accomplish this type of subjective reconfiguration is, as we shall see, relatively contingent on whether drug users can shed their historical subjection as “deviant” and “unproductive” individuals and begin to see themselves as responsible and engaged citizens who have the power and ability to make real change.

The work of the late Felix Guattari (Deleuze and Guattari, 1987) can assist us in making sense of this transformative process, and particularly his bizarrely useful concept of transversality, a terms most often associated with his and Deleuze’s esoteric work A Thousand Plateaus. Transversality was a term advanced by Guattari

3I find drug users’ appropriation of the disparaging terms “addict,” “junkie,” or “dope fiend” to be similar to the way African Americans have appropriated and transformed the N-word or how gays and lesbians embrace the term “queer”: as a means to appropriate what has hitherto been a pejorative designation and transform it into an empowering tool for association, identity, and self-worth.
as a result of his work as a committed Lacanian at the La Borde in France during the 1950s, a clinic near Paris that was noted for its innovative therapeutic practices. Guattari initially employed the concept of transversality as a way to reconfigure the institutional arrangements of psychiatry that were traditionally based on the development of transference between the expert analyst and the pathologized patient. According to Adam Shatz, the term was used by Guattari “to describe La Borde’s program for disrupting the ‘binary structural oppositions’ that governed life in the psychiatric clinic: between patients and analysts, between individual and group consciousness, between mental illness and normality” (2010, p. 9). The practice of transversality, Guattari insisted, would allow patients to begin to speak about themselves on their own terms as a means to liberate themselves from the pathological categories that have hitherto classified and characterized them as crazy, schizophrenic, depressed, etc. Within the clinical relationship, specifically, it would mean “the authority of the analyst would be thrown into question” (2010, p. 9).

As the process of transference can only serve to reify the unequal power relations that define the institution of psychiatry, mainly by its ability to distinguish the patient from the analyst, Guattari’s aim was to disrupt this subjectifying process by introducing a more egalitarian arrangement that would operate by “transversing” the discursive boundaries of the institution itself. “Broadly speaking, Guattari used the term transversality as a conceptual tool to open hitherto closed logics and hierarchies and to experiment with relations of interdependency in order to produce new assemblages and alliances” (Kelly, 2005). This experimentation does not assume that people can escape the unequal power relations that define a particular institution—the clinic, the prison, the school, etc.—just by using different words to define themselves and their relations to others. The important point, for Guattari, is that a discursive reconfiguration is a necessary beginning stage so that people can start to redefine themselves in relation to institutionalized norms and statuses. This would allow its subjects to break out of their subjection (at least symbolically) by creating new ontological categories as a means to achieve individual empowerment and social solidarity, whose goal would be to subvert hegemonic categories, to generate collective power, and to create alternative and nonhierarchical social relations.

If we focus less on the psychoanalytic modeling of the term and more on its ability to challenge the binary structural oppositions that define a particular institution, the concept can help us recognize the different ways drug users can manipulate, elaborate, and undermine their stereotypical roles and identify the kinds of changes that they can affect on their own accord. When drug users become involved in policy-making, as these papers demonstrate, it becomes necessary for them to rupture the binary categories that inform the PH industry in order to validate their experience and knowledge as equal to that of policy-makers. This means replacing the hierarchies that have traditionally defined the addiction industry (client/provider, patient/doctor, social worker/drug addict) with a more egalitarian nomenclature (participant/worker, service user/service worker, people-who-use-drugs/drugs workers).

Contrary to the unequal power relations that characterize these traditional hierarchies, the relations developing from the logic of transversality would be governed by an alliance of interdependency between people who use drugs and people who work with people who use drugs. A mouthful, I know, but one insisting that services need to operate through the practice of mutual identification and mutual respect for mutual ends. When practiced, this radical mode of operating would allow drug users to experiment with reconfiguring the relations of dependency that currently exist between themselves and the social services they utilize. The objective would be to generate new institutional arrangements and alliances as a means to propel the addiction industry toward a more humane and evidence-based modality. As we witness in the Ukraine, it was the antagonism between LE and PH that “compelled patients to move beyond the role they have been traditionally assigned—that of the docile recipient of services—to become outspoken activists, seeking not only to adapt to the changing environment but to confront the unyielding system and its laws and regulations to secure their right to evidence-based treatment” (Golovanevskaya et al., this volume).

We can see this logic espoused by the Danish Drug Users Union in their attempt to move beyond the pathological ordering of “abuser” and “addict” that informs the normative characterization of the drug user: “The overall aim of the organization [DDUU] is to represent and promote the interests of active drug and methadone users. It tries to detach itself from the denomination of drug abusers or drug addicts and refers to its members as active users, meaning that they are not just helpless victims but citizens with rights and resources” (Frank et al., this volume). In relation to the health needs of people who inject drugs, they are not deviant persons with criminal tendencies “but clients or patients subject to inclusive and empowering services.” From the experiences of the Nordic countries, we can see how a strong welfare state with established traditions of including patients into policy planning and consultation has allowed for an easier transversing of institutional boundaries: “In Norway, the inclusion of drug users into the Patient’s Rights Act and the construction of drug users as patients have made user involvement more acceptable . . .” (Frank et al., this volume).

For another example of this transversal logic, consider the way team members of VANDU’s injection support team (IST) tap into the experiential knowledge they have accumulated over many years of drug injecting and how they inhabit the traditional role of “doctor” within their community. The status of “doctor” allows them to engage with fellow drug users as experts and to interact with them with respect to the numerous health issues they face as street-based users: “During these types of interactions, Team Members draw on their knowledge of the circulatory system, as well as their own person experiences injecting, to suggest strategies that will help achieve venous success. The ability to convey educational information as
well as mobilizing experiential knowledge represents one of the unique aspects of the instruction delivered by the IST” (Small et al., this volume).

The transversal progression is manifest when drug users make use of the practical skills they have acquired as people who inject drugs by employing that knowledge in drug-using communities as a means to teach people safer injection practices. Stated somewhat differently, in the social milieu of street injecting, “hit doctors” are able to take the experiential knowledge they have accumulated as drug injectors and reconfigure those experiences as the bona fides that allow them to inhabit the role of expert. Following the destabilizing logic of transversality, the re-configuration of what it means to be an “injection expert” is predicated on a new designation of expertise where the practical knowledge that makes someone a “hit doctor” stands on par with the normative status that the “doctor” occupies in mainstream society: “The social identity of the founding team members permitted the IST [Injection Support Team] to build on the important drug scene role that doctors play and afforded opportunities to raise awareness of the hazards related to assisted injecting” (Small et al., this volume). We see this occurring in Thailand as well, when “one peer researcher [was] recognized as an overdose expert, due to having many overdoses, [and] was unanimously selected by the group as a peer presenter on the topic of overdose” (Hayashi et al., this volume).

It is important to recognize that as drug users struggle to shed the deviant categories and institutional arrangements that subjugate them, in an effort to change how these institutions operate and to gain more control and power in their lives, their attempts to create an alternative arrangement, or to inhabit a different identity, or a more engaged modus operandi, remain constrained by the hegemony of those deviant categories in civil society. As evident in Ukraine, “[p]atients are finding empowerment in joining forces with like-minded people resolved to change the status quo” (Golovanetskaya et al., this volume). “Yet,” as the authors lament, “even in their role as agents of change, they remain patients, as well as members of a stigmatized group” (Golovanetskaya et al., this volume) And we know in the accounts from Brazil that even when drug users participate in program development and evaluation, they remain junkies and “hardly seen as PH agents by health professionals.” And in Thailand, where drug users are simply trying to secure their universal rights as human beings, we can witness how participatory action research can contribute to these transversal struggles by “providing information that countered the dominant cultural discourse that serves to stigmatize drug users and perpetuate the state-sponsored human rights violations against them” (Hayashi et al., this volume).

**CONCLUSION**

As I stated at the outset, the purpose of this essay was to develop a conceptual apparatus in order to understand the role of drug user organizations in local and national harm reduction initiatives. By incorporating the findings of these papers, my goal was to propose a general framework from which the role of drug users as “change agents” could be analyzed and explained. In attempting to do so, I have suggested that the universal asymmetry between the contradictory logics of PH and LE provides a structural model from which to explore the myriad of forces that motivate drug users to become involved in political activism, service delivery, and policy-making. Such an approach provides a general frame to examine both the factors that motivate drug users to become politically active and the “sources of power” that become available to them to achieve their goals. It is here that the recurrent theme of drug users as “change agents” can be seen in relation to the political and social struggles that ensue over the most efficient and responsible means to reduce injection-related harm.

Moreover, these five cases reveal that the distinction between drug users’ ability to generate social change and the recognition that they can and do act as “change agents,” is crucial to the study of drug user organizations. And although these accounts come from countries that vary in polity, culture, and geography, the particulars of these cases do not weaken our structural framework, as they highlight relative orientations of PH and LE and the effects that this institutional arrangement has on the subjectivity and agency of people who use drugs.

While the model cannot predict future events, it nevertheless permits us to illuminate the types of structural arrangements that can either uplift or degrade the subjectivity and agency of people who use drugs. By appreciating the multifarious ways drug users have destabilized and exploited their stereotypical roles, we can begin to recognize them as “change agents” in a range of political systems, and more importantly, we can recognize the types of systemic changes that drug user organizations can influence on their own.

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REFERENCES


