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NEEDLE EXCHANGE: SOCIAL VALUE FOR OUTREACH WORKERS

by

ELISE D'ALESSANDRO

Under the Direction of Cassandra White, PhD

ABSTRACT

This thesis explores the public health practice of a needle exchange program from the perspective of outreach workers in a Southern U.S. city. I explore how outreach workers understand the harm reduction ideology that underlies needle exchange practices as well as intrinsic and extrinsic motivations for participating in the work. I also consider how the needle exchange impacts outreach workers' lives and its social importance as a therapeutic community. I argue that the needle exchange represents an important social space that functions as a therapeutic community for outreach workers where the harm reduction ideology is applied to both clients and outreach workers alike.

INDEX WORDS: Needle exchange, Harm reduction, Outreach workers

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ELISE D'ALESSANDRO

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

Master of Arts

in the College of Arts and Sciences

Georgia State University

2017

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2017

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DEDICATION

I would like to dedicate this thesis to all of the outreach workers at the Fairview needle exchange program. They work very hard to improve the lives of injection drug users and are truly making a difference in their community.

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I would like to thank all of the professors in the Anthropology Department at Georgia State University. In particular, I am grateful to my advisor Dr. Cassandra White for her encouragement, direction, and advice throughout this process. I want to thank Dr. Jennie Burnet for her mentorship and support throughout my time in the masters program. Dr. Steven Black has also been very helpful in providing guidance for this thesis. Finally, I would like to thank my family and friends for their support and encouragement.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	v
1 Introduction.....	1
2 Heroin, Needle Exchange, and Outreach Workers.....	5
2.1 Injection Drug Use, Health Disparities, and Structural Inequalities.....	5
2.2 Harm Reduction and Needle Exchange	16
2.3 Outreach Workers	22
3 Research Methods.....	28
3.1 Methods.....	28
3.2 Ethical Considerations.....	28
3.3 Limitations.....	31
4 Outreach Workers’ Definitions of Harm Reduction and Motivations	32
4.1 Fairview Needle Exchange	32
4.2 Definitions of Needle Exchange and Harm Reduction	355
4.3 Outreach Workers’ Intrinsic Motivations.....	400
4.4 Outreach Workers’ Extrinsic Motivations.....	499
5 Needle Exchange as a Social Space.....	522
5.1 Giving “Testimony”	522
5.2 Therapeutic Community	544
5.3 Challenges and Self-Care	63

6	Conclusion	712
	REFERENCES.....	755

1 Introduction

On the corner of a run-down city street a group of people gather on the sidewalk. Men and women of all different ages and ethnicities form a line. Some stand in silence. Others have casual conversations with each other or share their stories of the day's hardships. However, all of them wait with dirty needles in their possession until they get up to an outreach worker who sits by a red medical container. They put their needles on the lid of the container and wait to be informed on how many clean needles they will receive in return. Greetings and conversations with the worker ensue. As free, clean needles are given out, it is common for individuals to express their gratitude for the service, but complaints, disagreements, and arguments about the needles are not uncommon. When this happens the outreach worker often yells out "peace" over the commotion, and eventually the process continues and the disruption is forgotten. With clean needles in hand, many of the individuals migrate towards another worker who yells out "who needs Narcan?" while yet another one hands out injecting kits and wanders around socializing. Volunteers hand out bagels and an assortment of crumbling pastries to individuals, most who politely say thank you. Despite any negative reactions from the clients, bad weather, or police cars that slowly drive by and peer out their windows, the work continues on.

This is a typical scene of a needle exchange program (NEP) that functions because of a group of dedicated outreach workers. This particular program primarily serves heroin drug users in an impoverished community located in a southern city in the United States. NEPs are a harm reduction approach in public health that helps to reduce the spread of disease in injection drug users (IDUs). Health disparities in the IDU population exist because of various macro and micro

social, political, and economic forces that contribute to the production and maintenance of inequalities. IDUs have a disproportionate prevalence of human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS), hepatitis B, and hepatitis C that is the result of sharing needles or other injecting materials (Pates et al. 2012). This population often experiences social and structural oppression and stigma in the United States because of their intravenous drug use. Therefore, NEPs are vital to reducing health disparities in IDUs. Yet, these programs have further social implications and roles in the lives of the community health workers and volunteers, collectively called outreach workers in my research, who administer the NEPs.

This research focuses on a NEP in a very impoverished area in which there is a high rate of heroin use. For the purpose of this study, I have renamed this community Fairview. Clients choose to come to the program in order to exchange dirty needles for clean needles and thereby, reduce their chances of contracting HIV, hepatitis B, and hepatitis C. Heroin use has become a public health crisis across the United States resulting in an increase of associated diseases and overdose deaths (Baldwin et al. 2016). In 2015 heroin related deaths reached 12,989, which more than tripled from 2010. It is also estimated that opioids, which includes heroin, result in 91 deaths per day in the United States (CDC 2016). The CDC further cites that injection drug users represent 1 in 10 of HIV diagnoses (CDC 2016). The heroin epidemic impacts people across all races, classes, and genders (Baldwin et al. 2016). However, despite the public health need for NEPs and high numbers of heroin users, in many southern states exchanging needles is illegal. As such, the law impedes the ability for individuals to care for their health because of the lack of access to clean needles. The social and structural forces that help to produce and maintain the health and social inequalities that IDUs experience also shape the Fairview community at large and impact the lives of outreach workers. Some of the outreach workers live in or near the area,

are African American, and have some form of personal connection with illicit drug use. Thus, not only do outreach workers directly observe the inequalities in the lives of their clients, but some outreach workers have experienced similar hardships. It is important to note that I am also a volunteer at this NEP.

Therefore, the objective of this research is to obtain an ethnographic understanding of outreach workers' perspectives and interpretations of needle exchange and the meaning it has in their lives. The motivations for participating in the program are also explored, as well as the notion of outreach workers' self-care. Ultimately, exploring the implications of participation, both the benefits and challenges, will provide an understanding of the program's impact on outreach workers' lives. Prior scholarly research on needle exchanges, across multiple disciplines, has focused mainly on the clients of the program and the effectiveness in regards to decreasing medical risks. There is less scholarly attention on the outreach workers who participate in NEPs. However, outreach workers are vital to the success of programs and their work influences their lived experiences. As such, this research focused on outreach workers is guided by the following questions: how do outreach workers interpret, understand, and define needle exchange and harm reduction? What motivates the outreach workers to work with this program and with IDUs? How does the NEP impact outreach workers' lives? These research questions will not only provide an understanding of the motivations and implications of the NEP in outreach workers' lives, but will also explore the self-care of outreach workers.

The NEP represents a social space with inherent meaning and function. The outreach workers and IDUs, albeit for different reasons, choose to participate in the needle exchange. I argue that the needle exchange in Fairview is not just a public health strategy aimed at decreasing health risks in IDUs, but contains social value, meaning, and purpose as a therapeutic

and community space for outreach workers. Outreach workers recognize the structural violence that impacts Fairview and use the NEP as a social space to cope with social inequalities. The needle exchange is thus used by outreach workers to not only help their community and improve the health of IDUs, but as a therapeutic space where outreach workers can receive an audience to openly discuss their lives without judgment and receive social support from each other. Although there are challenges of self-care involved with the work, participating in the NEP and the harm reduction ideology is a significant part of outreach workers' lives.

In chapter 2 I provide information on the heroin epidemic, social and structural inequalities, needle exchange, and outreach workers. I also discuss anthropological debates that inform my research. In chapter 3 I explain my research methods. In chapter 4 I present my findings on how outreach workers understand harm reduction and explain the intrinsic and extrinsic motivations for outreach workers. In chapter 5 I describe the impact that the NEP has on outreach workers' lives including its function as a therapeutic community, place to give "testimony," and self-care. Finally, in chapter 6 I reiterate my argument and conclude with the significance and implications of this research.

2 Heroin, Needle Exchange, and Outreach Workers

A holistic picture of the heroin epidemic and harm reduction ideology in the United States and the South is necessary to understand the need for outreach workers to work with IDU populations, as well as to fully appreciate why they are motivated to exchange needles. This includes an analysis of the underlying structural and social forces that exacerbate and perpetuate drug use and social inequalities related to race, class, and gender. Therefore, inequalities of race, class, and gender from a critical medical anthropology and intersectionality perspective guide this research. In this chapter, I discuss the heroin epidemic, associated health disparities, and stigma that influence individuals. I then provide a background and critical analysis on harm reduction and needle exchange and conclude with an account of the role of outreach workers.

2.1 Injection Drug Use, Health Disparities, and Structural Inequalities

The public health need for NEPs in the United States is because of the increasing number of IDUs and the associated blood borne diseases of HIV, hepatitis B, and hepatitis C. There are currently approximately 185 million illicit drug users globally who are located in both inner-cities and rural areas (Baer et al. 2003:191; Baer et al. 2013:228). In 2014, 27 million people indicated that they had used illicit drugs (Hedden et al. 2014). Although individuals have used illicit drugs throughout the United States' history, the American cultural ideology condemns illicit drug use both legally and morally. The war on drugs and drug laws have the unintended side effects of contributing to the spread of diseases. Paraphernalia laws that criminalize carrying needles contribute to the spread of blood borne diseases and encourage needle sharing practices. This is because IDUs fear arrest from carrying needles and have limited access to clean needles (Rhodes et al. 2005:1034).

In addition to laws and policies that lead to the spread of disease, an increased prevalence of heroin use has resulted in a public health crisis among IDU populations (CDC 2015). Across the United States, including in the South, there is an epidemic of blood borne diseases and drug overdoses. From 2002 to 2013, heroin overdose deaths in the United States increased by 286% (Baldwin et al. 2016). In 2014, over 10,500 people died from heroin overdoses in the United States (Kass 2016). Historically, heroin has predominantly been used by African Americans, but recently has become commonly used across all ethnic groups, economic classes, and age groups (Baldwin et al. 2016; CDC 2015). The CDC defines those who are most at risk for heroin use as people with prescription opioid addictions and other drug addictions, uninsured people, people enrolled in Medicaid, non-Hispanic whites, males, residents of large metropolitan areas, and 18 to 25 year olds (CDC 2015). The large increase in heroin use and overdoses has been influenced by several major factors. One of which is the DEA's focus on stopping the "pill mills," which is the use of prescription medications for recreation instead of medical purposes. Instead of decreasing drug use, this has resulted in more drug users switching to heroin. The second major factor is the increase of opium production in Afghanistan, Mexico, Central America, and South America. In Mexico, opium production has risen as much as 50% in 2014 (Baldwin et al. 2016). This has resulted in a vast increase in heroin availability and decrease in prices. Another factor in the heroin epidemic, and specifically high rates of overdoses, is the inconsistency in the purity of heroin influenced by the use of fentanyl in mixing heroin. Fentanyl is a synthetic opiate that can be 80 times more powerful than morphine, and as such, the use of fentanyl in heroin has increased overdose deaths (Baldwin et al. 2016). IDUs can misjudge the purity of heroin and inject too much of the drug because they want to receive an adequate high resulting in an overdose and possibly death.

Not only are drug overdoses a major concern with the heroin epidemic, but injecting heroin is largely connected with HIV, hepatitis B, and hepatitis C. In 2013, out of approximately 47,352 new HIV infections in the United States, the CDC identified 7% as resulting from injection drug use (CDC 2015). Other studies have reported injecting drugs as the cause of one-third of all new HIV incidences in reported AIDS cases. 50-90% of IDUs are further estimated to be infected with hepatitis C (Rich et al. 2004:122-123). As these statistics indicate, IDUs have a disproportionate burden of disease.

Specifically in the South, there are increasing rates of heroin use, overdoses, and HIV infections. Heroin use is widespread in inner-cities, but is becoming prevalent in both suburban and rural areas. For example, in 2014 Fulton County, which includes metro-Atlanta, had 77 individuals die of heroin related causes, and in 2015 Fulton County had the highest heroin related deaths in Georgia (Baldwin et al. 2016; Kass 2016). In Florida, heroin related deaths rose by 89% during the first 6 months of 2013 (Hall 2014). An opioid related overdose occurs every two hours in South Florida with the Miami-Dade County experiencing the most deaths (NBC6 2016). Tennessee has also experienced an increase in heroin use. In Memphis, heroin overdose deaths almost tripled between 2015 and 2016 (Broach 2016). The increasing heroin use in the South has public health implications. Georgia has the second highest increase in HIV infections nationwide, and Atlanta has the fifth highest rates among metro areas in the United States (Miller 2016). Specifically within the Georgian IDU population, over 50% have serological evidence of hepatitis C or hepatitis B infection with a 1.7% HIV prevalence rate (Shapatava et al. 2005:537). Meanwhile, Florida is experiencing a rise in HIV and hepatitis C transmissions, primarily in the South Florida Miami-Dade and Broward counties (HALL 2014). In Miami-Dade County, 1 in 99 residents live with either HIV or AIDS as of 2012 (Care Resource 2017). Florida has the highest

rates of new HIV infections in the United States, which displays the public health crisis in the area (Bousquet and Auslen 2016). Tennessee also has a HIV problem; in 2013, the state ranked 15th in the United States for HIV diagnoses. Furthermore, between 2009 and 2013 reported cases of acute hepatitis B and hepatitis C increased by 82% and 200% respectively (CDC 2015).

Syndemics help to explain the disproportionate prevalence of HIV, hepatitis B, and hepatitis C in IDUs. Syndemics refer to “two or more epidemics interacting synergistically with each other inside human bodies and contributing as result of interaction to excess burden of disease in a population” (Baer et al. 2003:15). For instance, individuals with HIV have a higher likelihood of having a co-infection of tuberculosis (Baer et al. 2003:16). IDUs, who have an increased risk of HIV, hepatitis B, and hepatitis C, often are infected by two of these diseases (Estrada 2002:127). This disease clustering does not just occur within an individual body, but occurs within populations of people, such as IDUs, minority, or low socioeconomic populations. Co-occurring diseases not only perpetuate and worsen each other within a human body, but place already marginalized populations at even greater risk (Singer 2006:216). Therefore, the concept of syndemics is not only a central concern in the lives of IDUs that use the NEP, but influence the community at large.

It is therefore important to include how race, class, and gender influence and contribute to the inequalities in which IDUs, community members in Fairview, and in some cases outreach workers experience. This follows a critical medical anthropology (CMA) approach. CMA explores the political economy of health considering both the macro and micro level forces that contribute to health and can be defined as,

a theoretical and practical effort to understand and respond to issues and problems of health, illness, and treatment in terms of the interaction between the macro level of political economy, the national level of political and class structure, the institutional level of the health care system, the community level of popular and folk beliefs and actions,

the micro level of illness experience, behavior, and meaning, human physiology, and environmental factors (Singer 1995:81).

Macro level social and structural forces influence health, but micro level contexts, including the interplay of individual relationships, work together to create and perpetuate risk. As such, health disparities and prevention must be locally studied (Rhodes et al. 2005).

Thus, a CMA perspective holistically examines health as being influenced by social, political, and economic factors rather than merely the result of biology or individual health decisions. Adequate health is directly linked to access to material resources. Disease “does not exist in a vacuum” and is largely influenced by social conditions ranging from policies, access to medical care, socioeconomic status, access to public resources, education, and many other sociopolitical factors (Baer et al. 2003:17). For example, paraphernalia laws that illegalize needles restricts IDUs’ access to clean needles, which leads to needle sharing and the spread of HIV, hepatitis B, and hepatitis C. Furthermore, Fairview can be defined as a peripheral region where marginalized populations have unequal economic opportunity and access to quality social resources (Baer et al. 2003:191). This results in unequal health outcomes and disparities because of the structural and social barriers to obtaining medical care and reduced health choices available for residents in Fairview. Social conditions and circumstances create, limit, and perpetuate particular health outcomes in which the outreach workers must not only witness in the NEP clients’ lives, but for some, deal with in their own lives.

Ultimately, the health disparities are the result of structural violence. Structural violence is a systematic and institutional social form of oppression. The oppression can take the form of low socioeconomic class, racism, or gender inequality that result in the unequal access to goods and services (Farmer 2004:307-308). Structural violence is the product of larger social forces that have historically shaped present day situations and continue to form the current social and

structural realities. Anthropologist Paul Farmer (1999:13) explains, “social forces, ranging from political violence to racism, come to be embodied as individual pathology.” Essentially, institutional oppression, such as drug policies, prison sentences, and disadvantaged neighborhoods, become physically manifested in bodies. For example, not only do disadvantaged communities have an increased prevalence of HIV, but they have lower access to prevention, treatment, and other health services (Rhodes et al. 2005:1030). Unequal prison sentences based on racial inequalities provides another example of how structural violence contributes to health disparities. In cocaine sentences, although only 15% of cocaine users are African Americans, they represent 40% of the charges, and 90% of convictions; moreover, prisoners have an AIDS incidence rate that is four times higher than the general American public (Rhodes et al. 2005:1031). As evident by the inequality in prison sentences coupled with the disparity of AIDS incidence rates in prison inmates, institutional violence in the criminal justice and prison system directly threatens and increases health risks in certain populations. However, because structural violence is systematic and embedded into structural institutions, social oppression permeates into all aspects of life (Baer et al. 2003). As I will illustrate later, Fairview is impacted by structural violence due to the extent of drug activity, racism, and poverty in the community.

The illegality of drug paraphernalia, like needles, is also related to structural violence. States have different paraphernalia laws regarding the distribution of needles. Some southern states have legalized the distribution of needles while exchanging needles continues to be illegal in other states. Some state laws on the legality of exchanging needles are unclear and open to interpretation. For example, one southern state’s paraphernalia law states it is “illegal to give, lend, lease, buy, sell, exchange, or otherwise distribute a hypodermic syringe or needle, unless all is done for a legitimate medical purpose” (Oni and Namkoong 2015). This law makes

conducting a NEP technically illegal, but the phrase “a legitimate medical purpose” can be interpreted to justify exchanging needles. This phrase represents a “grey” area in the law. Therefore, the relationship between NEPs and police departments is influenced by each state’s laws and how they are interpreted. Recently a ban on federal funding for NEPs has been removed, but federal money cannot be used directly on needles and only for the associated costs of running programs. However, IDUs will still be arrested based on paraphernalia laws (Miller 2016). The drug laws in the United States are contributing to negative health consequences. Various studies have provided evidence of increased levels of HIV infection among IDUs in geographical areas where needle distribution is illegal. Furthermore, these laws promote needle sharing, which contributes to the spread of blood borne diseases, because IDUs fear arrest from carrying needles (Rhodes et al. 2005:1034).

Not only can IDUs be influenced by structural violence in part due to their minority and low socioeconomic status, but they are further stigmatized by their drug use and assigned criminal status based on the dominant society’s moral outrage against drug use behavior (Baer et al. 2003). Both outreach workers and clients can experience social stigma resulting from a variety of conditions that includes an association with an illegal activity (distributing needles), illicit drug use, HIV/AIDS, racial minorities, and low socioeconomic statuses. Stigma can be defined as an “invisible marking” that differentiates an individual and allows for labeling, stereotypes, and discrimination that results in a lower-status as seen by the individual and outsiders (Stutterheim et al. 2016:124; Wutich et al. 2014:557). However, the invisible marking or attribute partially obtains its meaning through stereotypes and is also perpetuated by both the stigmatized individual and outsiders (Goffman 1963:5-7). Stigma can take the form of both personal and structural stigma. Personal stigma is “individual psychological processes” that

contributes to prejudice and discrimination whereas structural stigma results from sociopolitical forces that reduce opportunities for those stigmatized through policies and institutions (Corrigan et al. 2005:551). Thus, individuals can simultaneously experience both levels of stigma. It is important to note that there are power differences in those who are stigmatized and those who are not, and as such, stigma has a large influence on life choices and opportunities (Link and Phelan 2001:375-382). With the criminalization of drugs, IDUs can become marked as social deviants and criminals. The stigma associated with illicit drug use has increased the associated harms due to policies that promote stigma and IDUs who forgo treatment from fear of stigma. Ultimately, social stigma and discrimination results in further inequality and the internalization of stigma and shame from not being “normal” (Rhodes et al. 2005:1028; Goffman 1963). One drug user explains, “Stigma impacts people very negatively. That’s why a lot of people don’t give a shit if they use a dirty needle...If you think you’re completely worthless, you’re going to act accordingly” (Gowan et al. 2012:1255). Moreover, drug users are associated with a lack of control and immorality (Baer et al. 2003:188). They are characterized as being powerless to their drug addiction, which in turn reduces their perceived agency and ascribes the drug user label as their primary identity (Gowan et al. 2012:1254). For example, an IDU observed, “Yeah, and once you cross a line and you’re a needle user, it’s like, yeah, I’m a leper, a super villain, I’m banging dope...it’s like – you’ve got that bad guy image already, whether you want it or not” (Gowan et al. 2012:1255). IDUs can be discriminated against by friends, family, medical professionals, law enforcement, and the general population. Stigma practiced against IDUs and others ultimately is another form of structural violence (Rhodes et al. 2005:1034).

HIV/AIDS is also a stigmatized disease because of its perceived association with homosexual encounters, sex workers, and IDUs. There is fear and misinformation surrounding

HIV/AIDS that contributes to the stigma (Stutterheim et al. 2016). The stigma surrounding HIV/AIDS is decreasing, but still factors into peoples' decision whether or not to receive treatment. Some are stigmatized by both their status as a drug user and HIV infection, which is known as layered stigma (Stutterheim et al. 2016:125). Furthermore, low socioeconomic class communities become "vilified" because of the intersectional connections of stigma with poverty, race, illicit drug use, and health disparities. Ultimately, stigma produces a range of negative health consequences, which can affect individuals, groups of people, and geographic areas (Wutich et al. 2014:557). It is important to note that stigma is both experienced and reproduced by actors (Middelthon 2005:428).

Ultimately, an understanding of drug use and the lived experience of both outreach workers and their clients cannot be separated from intersections of race, class, and gender inequalities. This perspective is called intersectionality and argues that the interactions of race, class, and gender are connected and dependent on each other, meaning that they cannot be separated in understanding marginalization (Norris et al. 2007; Choo and Ferree 2010). These social identities represent "identity politics" where intersections of identities both shape and reinforce one another. For example, violence against women of color is not just influenced by sexism, but racism further impacts individuals' experiences (Crenshaw 1993:1242-1243). The social inequalities and discrimination interact together to produce a particular lived experience and ultimately contributes to the inequalities and violence experienced by marginalized groups (Norris et al. 2007:334; Choo and Ferree 2010; Ortner 2006:73; Crenshaw 1993:1244). It is important to account for intragroup differences when studying social marginalization (Crenshaw 1993:1242). For example, categorizing all IDUs together and not accounting for differences within the group ignores the diversity of the social group. IDUs are often concentrated in cities

and in lower socioeconomic neighborhoods with higher proportions of African Americans (Baer et al. 2003:191). Although this is changing as rates of heroin users from higher socioeconomic classes and all racial groups are currently increasing, not all heroin users experience the same social and structural inequalities because within IDUs there is racial and class inequality. To be more specific, the greatest health risk factor in IDUs is not associated with the rituals of drug use, but instead the “nature of class, race, and other relations” (Baer et al. 2003:218). One study found that African American IDUs, in comparison to other ethnic groups, were three times more likely to have hepatitis B (Estrada 2002:129).

Communities, such as Fairview, that are socially and economically deprived are known as “clusters of disadvantage” because of the numerous risk factors that produce, maintain, and increase vulnerability (Rhodes et al. 2005:1030). Philippe Bourgois has argued that “inner city apartheid” in the United States, which has been influenced by socioeconomic forces and structural inequalities, produces marginalization that differentially shapes patterns of drug preferences, means of administering said drugs, and health risks along ethnic lines (Rhodes et al. 2005:1031-1032). Marginalized communities have decreased access to public resources, medical services, and other forms of social capital, which has direct consequences for both IDUs and non-drug users alike in such areas. For instance, socially and economically vulnerable populations have disproportionate levels of increased HIV risk. Furthermore, a lack of socioeconomic resources and opportunities is associated with increased illicit drug use (Rhodes et al. 2005:1032-1033). Racial inequalities and poverty are thereby connected with social suffering and perpetuate one’s drug use and social status at large. For example, studies from New York have shown that the loss of housing in low-income communities have resulted in increase drug use and HIV particularly for minority individuals (Rhodes et al. 2005:1030). Homeless

populations also display the drug use connection with socioeconomic situations and the increased burden of disease. Estimations of homeless individuals who are chronic drug and/or alcohol users range from 26% to 67% (Rhodes et al. 2005:1030). Furthermore, drug laws are racially enforced; African Americans constitute 13% of all drug users, yet African Americans are 35% of drug users who are arrested and 74% who serve prison time (Small 2001:297). This has contributed to one out of every 15 African American men in their twenties being incarcerated (Rhodes et al. 2005:1031). Ultimately, anthropologist Hans Baer et al. (2003:245) recognizes, “illicit drug use is not a pathology of poor people per se, but rather an unhealthy condition that is shaped by the implementation and enforcement of laws, by the character of class and racial relations in society, and by the effort of the oppressed to cope with the hidden and overt injuries of racism, classism, and other forms of social bigotry and structural violence.”

As evident, race and class inequalities cannot be separated from the marginalization of IDUs and communities like Fairview, but gender differences also produce inequalities. In IDUs unequal power relationships between males and females structures social interactions and places women at increased risk (Rhodes et al. 2005:1033). In injecting practices males have greater levels of control over decisions, which has direct health implications. A study in San Francisco found that the hepatitis C seroconversion rate among female IDUs is 50% higher than men, and women further have an elevated HIV risk (Rhodes et al. 2005:1033). In addition, female IDUs receive more stigma than their male counterparts. However, there is little difference between levels of drug use among males and females (Ahamad et al. 2014). At the NEP in Fairview there are generally more male clients than female as well as more male outreach workers than female workers.

2.2 Harm Reduction and Needle Exchange

Thus, to deal with injection drug use and the associated health disparities and social inequalities in the United States, harm reduction is an activist and public health approach that decreases the negative health and social effects in high risk behaviors like illicit drug use. Harm reduction initially started in the United States by a group of activists as a direct response to the HIV/AIDS epidemic in the 1980s (Riley et al. 2012:10). Activists saw the drug paraphernalia laws, war on drugs, and stigmatized status of IDUs as directly contributing to the disproportionate disease prevalence and mortality rates in IDUs (Carter et al. 2012:124). The International Harm Reduction Association (IHRA) states, “People who use drugs do not forfeit their human rights, including the right to the highest attainable standard of health, to social services, to work, to benefit from scientific progress, to freedom from arbitrary detention and freedom from cruel inhuman and degrading treatment” (Carter et al. 2012:115).

In opposition to laws that define drug use as a criminal problem rather than a public health concern, harm reduction is premised on the belief that health is an inherent human right despite personal choices. A harm reduction framework does not necessarily aim to decrease or stop illicit drug use. The overarching principle is to reduce harm through non-judgmental strategies. Because of its focus on high risk behaviors, harm reduction often serves marginalized and vulnerable populations with the recognition that changes in behavior are not always obtainable or desired (Riley et al. 2012:10). Instead, harm reduction considers any “positive change” as a successful outcome and ultimately aims to keep people alive (Hunt 2012:161). Harm reduction approaches consist of a variety of strategies including NEPs, HIV testing, methadone clinics, and health education (Carter et al. 2012:111). Harm reduction thus focuses on

particular risks and identifies approaches to decrease harm due to said risk (Carter et al. 2012:182).

As such, needle exchange is a harm reduction approach that is aimed at decreasing the spread of blood borne diseases like HIV, hepatitis B, and hepatitis C that occur due to the reuse of needles. Using clean needles reduces disease transmission because blood borne diseases spread not from the use of drugs per se, but rather from the reuse of needles and other dirty injection equipment (Pates et al. 2012:135). The CDC recommends that a new needle should be used for every injection to protect oneself from HIV (Shaw and Singer 2003:33). IDUs both reuse needles and share needles with others for a variety of reasons, but primarily due to a lack of access to new, clean needles. The lack of access stems from the illegality of buying or exchanging needles, in many places in the South, and for many a lack of financial means (Pates et al. 2012:135). Therefore, studies have shown that NEPs reduce the reuse and sharing of needles, which in turn decreases the incidence of HIV, hepatitis B, and hepatitis C (Burrows 2012). NEPs collect used, dirty needles, and in return provide IDUs with new, clean needles; programs vary in their specific operations, but typically the service is free and provides an one-for-one exchange. Exchanging needles has not increased the number of IDUs and is a cost effective public health strategy (Burrows 2012:49). As such, NEPs have become a relatively mainstream public health method because of the effectiveness in reducing disease prevalence, but still remain politically controversial and illegal in many states in the South and other conservative areas.

Harm reduction, NEPs, and illicit drug use have been the subject of numerous public health and anthropological studies primarily gaining attention during the start of the HIV/AIDS epidemic. The studies often contain the overarching goal of preventing HIV transmission and are

focused on IDUs who utilize NEPs (Page 2010:14). Within the anthropological field, the focus has generally been two-fold. First, is the ethnography of needle sharing practices and how clients make use of clean needles. For example, these studies seek to understand the period of time between when needles are distributed and returned (Page 2010:17). The second large focus is policy implications, the political economy of health, and social inequalities associated with illicit drug use.

For instance, Merrill Singer (2004:287) questions the ease of obtaining illicit drugs as opposed to the difficulty of receiving treatment and assistance. He criticizes laws and police enforcement that do not adequately address drug problems, but promote structural and racial inequalities. Singer believes the role of critical medical anthropologists is to help change policy and study the public health strategy to ensure NEPs are adequately addressing the needs of their clients (Shaw and Singer 2003:32). Singer also is concerned with the disproportionate burden of disease in IDUs and their interaction known as syndemics. Syndemics account for the fact that “diseases are not discrete conditions brought on by identifiable pathogens, environmental conditions, genetic predisposition, injury, or set of sufferer behaviors but rather diseases often and particularly under certain social conditions cluster and mingle both within populations and within the bodies of the members of those populations” (Singer 2006:216). As explained previously, syndemics perpetuate multiple diseases and are propelled by social situations in particular segments of society, such as IDUs.

Philippe Bourgois is another major anthropologist studying illicit drug use and its connection with social inequalities. Bourgois studies the historical and structural forces that have resulted in illicit drug use in marginal populations (Bourgois 2004:303). For example, he focuses on homeless heroin addicts in San Francisco and the interacting social and structural forces that

contribute and maintain their marginal status. In opposition, anthropologist J.B. Page focuses on the behaviors of IDUs and their use of needles. He sees the need for ethnographic accounts on injecting practices in order for NEPs to adequately address all of the risk factors, particularly on what happens to the needle from when it is given to the IDU and returned (Page 2010:23-26). Ultimately Page calls for ethnographic evaluations of programs in order to assure their effectiveness in mitigating risks since blood borne diseases can be transmitted through means other than just needles (Page 2010:17). Similar to Singer, Page notes the importance of anthropology's role in advancing the effectiveness of NEPs and inducing policy changes.

Meanwhile, the public health field in particular has focused on establishing drug use as a public health problem and the effectiveness of exchanging needles as a strategy to reduce disease transmission in IDUs. They have included aspects such as the high rates of injection drug use, associated disease prevalence, successes and challenges of running a program, access and policy issues, challenges to delivery of care, injection practices, and HIV prevalence among NEP users versus non-NEP users (Rudd et al. 2016; Shapatava et al. 2005). The public health field has also prioritized providing evidence that NEPs do not increase or encourage drug use (Page 2010). This attention to providing evidence for the health value of exchanging needles has stemmed from the political hesitation of supporting NEPs, due to the fear of condoning drug use (Page 2010:14). Studies also include information on the cost-effectiveness and feasibility of implementing a program in order to gain public support. For example, studies have found that for every dollar invested, NEPs provide 15 dollars in return benefits to society (Burrows 2012:49).

However, despite the public health benefits of NEPs, harm reduction is influenced by neoliberal and biomedical agendas. A.R. Moss (2000:1385) notes "politics is the basic science of public health." Health and public health strategies are not outside of culturally constructed

meaning or ideology. Foucault (cited in Carter et al. 2012:126) explains “health is a cultural fact in the broadest sense of the world, a fact that is political, economic, and social as well, a fact that is tied to a certain state of individual and collective consciousness. Every era outlines a ‘normal’ profile of health.” A culturally defined profile of health and the associated practices tied to it is known as biopower. Biopower is an internalized form of control organized through scientific progress that establishes an ideal means of caring for our bodies and minds (Bourgois and Schonberg 2009:18). It results in the accumulation of scientific techniques, policies, and definitions of proper care, which becomes a form of power and control (Carter et al. 2012:126). Biopower permeates and becomes naturalized in society because knowledge production, which is ultimately a form of power, establishes cultural meaning, “truth,” and behavior. Thus, the knowledge-power relationship, of power creating knowledge and knowledge serving the power structure, produces social reality (Foucault 1977). As such, drug use is a deviant behavior, but harm reduction can be seen as a means of disciplining IDUs (Carter et al. 2012:127). Harm reduction approaches, such as needle exchanges, injection facilities, and methadone clinics, simultaneously medically aid and govern IDUs. These approaches, based on biomedical knowledge, shape drug users into “productive” members of society and reduce their visibility in society. For example, in Vancouver during the 2010 winter Olympics the government established injection facilities in order to “clean up” the city and diminish the signs of drug use among the urban poor (Elliott 2014:29). Harm reduction approaches have also changed drug subculture into a defined public health “community” with particular health needs and challenges (Roe 2005:244). Notions that a defined public health population requires specialized care can result in the creation of underlying discourses that the group thus needs to be controlled, which

contributes to stigma from the production of negative stereotypes and misrepresentations (Elliott 2014:29).

The biopolitical role of NEPs relates to the United States neoliberal shift. Neoliberalism is the market-based and capitalist shift from state control to private actors resulting in a decrease of public services and increase reliance on non-profit organizations to provide social services (Fisher 1997). Harm reduction has thus changed from a group of activists challenging the dominant ideology to a public health campaign aiming to decrease both the health and social risks, such as crime, associated with drug use (Roe 2005:245). Thus, neoliberal ideology has shaped both “politics of knowledge and politics of compassion” in the field of public health (Elliott 2014:12). This points to the fact that cultural values and ideology influences medical science, which is neither apolitical nor devoid of underlying social biases, as well as beliefs about peoples’ responsibility as social actors and patients (Elliott 2014:26). As a public health method NEPs have placed the responsibility of health on the individual and have removed responsibility from the state. This has resulted in a greater emphasis on self-care (Elliott 2014:10). However, providing clean needles and other injection equipment gives IDUs the illusion of empowerment and control of their own health, but in the macro context, IDUs are still subject to larger social and structural inequalities and barriers to care (Roe 2005). NEPs, without advocacy, do not address the social problems that have contributed to and continue to reproduce drug use and disproportionate disease risk. The neoliberal NEP merely breaks the complex social problem of drug use into discrete risks and targets those risks through specific practices that makes IDUs responsible for their own social situation and attaches moral connotations to said practices.

Thus, NEPs have been characterized as a low-cost, “band-aid” approach to what is a complex structural, social, and health problem (Gowan et al. 2012:1256). The biopower that influences harm reduction maintains social inequalities and continual harm to populations. One elected official expressed, “I cannot condone my government telling communities ravaged by twin epidemics of drugs and AIDS that clean needles are the best we can do for you” (Page 2010:15). However, NEPs do have public health value in that they are successful in decreasing risk of HIV, hepatitis B, and hepatitis C and often provide additional services. A more nuanced understanding and application of NEPs is necessary to maintain their public health value while accounting for the fact that the social and structural problems that perpetuate inequalities and drug use also need to be considered and addressed.

2.3 Outreach Workers

Predominantly, as previously noted, the literature and research on NEPs in the anthropological field and other disciplines have been focused on the IDUs who use the program, the effectiveness of such programs in regards to decreasing medical risks, and a critical perspective on needle exchange. There has been far less attention placed on the community health workers and volunteers who run NEPs despite that they are often community members and former or current drug users, although it should be stressed that this is not always the case (Kelley et al. 2005:370). The outreach workers represent a significant aspect of NEPs in terms of both the ability for programs to function and help IDUs, and the implications that exchanging needles has on outreach workers. One study that has concentrated on outreach workers in a NEP is by Margaret S. Kelly et al. (2005:363) that explores the implications of a NEP in San Francisco changing from an illegal, civil disobedience group to a legalized organization. The study focuses on the reasons that volunteers initially started distributing needles, the resulting

community formed, and significance of the work in volunteers' lives. Participating in the work became a part of volunteers' social identity. Volunteer motivation, primarily related to HIV/AIDS concerns and connections with drug users or other volunteers, was used to assess how the volunteers felt about transitioning into a structured public health organization (Kelley et al. 2005:370). Most volunteers in this particular NEP believed that the harm reduction ideology and former illegality of the work created a unique bond; however, the program's reorganization did not change or influence the volunteers' desire to participate in the work or belief in its value (Kelley et al. 2005:374-381).

The role of outreach workers in the NEP and their motivations for participation relates to the anthropological notion of community health workers as being promoted either as change agents or cultural brokers. Community health workers have been encouraged as a strategy to improve health in high poverty areas around the world since the 1970s and have gained increased popularity in the 2000s. Community health workers vary significantly in their role, but a general definition used by the World Health Organization describes them as individuals, closely connected with the community in which they work, who have received less training than typical health workers, but still provide basic health services in support of the larger health system (Greenspan et al. 2013). Community health workers can be paid or unpaid workers and therefore, are motivated to work in the field for a variety of reasons. Some theorize community health workers as having the social power to induce change because they are perceived as actors purely motivated by the desire to improve a community, typically their own, and ability to empower individuals (Colvin and Swartz 2015:30). Thus, they are considered to not only provide health care, but politically advocate on behalf of the community because of their status as community health workers and often their own experiences of inequality based on racism, sexism, and

socioeconomic status (Colvin and Swartz 2015:34; Mason et al. 2010:2215). For example, during the Nicaraguan revolution from 1979 to 1990 community health workers helped with their community's health issues as well as tried to bring attention to the underlying development problems that caused them (Maes 2015:3). This use of community health workers in social justice roles also occurs in the United States. In Massachusetts community health workers have worked to decrease racial inequalities in health care reforms (Maes 2015:3).

In opposition, others have defined the role of community health workers as being cultural brokers working between a targeted population and biomedicine. In this perspective, community health workers function to successfully translate between potentially competing ideologies and understandings of health with the ultimate goal of promoting biomedical treatment (Colvin and Swartz 2015). As such, community health workers are considered to be valuable because they “speak the language” of the community and are merely a health “delivery mechanism” and “apolitical health technicians” (CDC 2013; Maes 2015:4-5). However, whether acting as an activist or cultural broker, the idealized community health worker does not translate into a reality in the field. Rather community health workers are influenced by a multitude and complex set of motivations and their own roles are structured and limited by their organizations, communities, and governments (Maes 2015). Furthermore, community health workers, in addition to the public health problems they are meant to solve, are not static and change.

The motivations behind the work of outreach workers are an important aspect in studying their decision to participate in a public health role. Thus, western theories of intrinsic and extrinsic motivations have been used to understand community health workers' motivations. Intrinsic motives are internal and altruistic rewards that can include self-fulfillment, empathy, and concern for a community while extrinsic motivations are based on material or external

rewards, such as money, material rewards, opportunities, or status (Greenspan et al. 2013; Maes 2015:5). However, there are debates on the relationship between intrinsic and extrinsic motivations and more specifically on whether or not community health care workers should be paid (Maes 2015:6). Some argue that extrinsic benefits can overtake intrinsic motivations, ruining a “volunteer spirit” and making that actor self-interested rather than altruistic known as crowd out theory (Maes and Kalofonos 2013:53; Maes 2015:6). This displays the problem and potential to take advantage of community health workers and justify free labor (Maes 2012:54-55). Rather, community health workers can have multiple motivations that are derived and influenced by their personal lives and social circumstances (Ramirez-Valles 2001:153).

However, motivations to work as a community health worker can be impeded by the associated difficulties. In particular, when community health workers do not receive payment for their services, their ability to participate is limited as they need to meet their own everyday needs (Lehmann and Sanders 2007; Musick et al. 2000:1541). Not having enough economic resources to be capable of working as a community health worker, as well as other job related difficulties including stress, psychological distress, and poverty issues, contributes to high attrition rates (Lehmann and Sanders 2007:14; Maes and Kalofonos 2013:57). For example, the government funded program, *Barrio Adentro*, in Venezuela provides free health care to marginalized communities (Cooper 2015:58). The program is completely run by volunteer community health workers who keep the clinics functioning. Even though they do not receive any form of payment, their work provides the opportunity to induce meaningful change in their community by influencing the government’s use of resources (Cooper 2015:62). For these community health workers, their largest challenge is the lack of pay, which impedes their ability to volunteer and their livelihood (Cooper 2015:70). Another example is female community health workers in

Mexico who are motivated to participate in the health work because of varying degrees of desires to serve others, change their everyday life routine, learn, and empower women (Ramirez-Valles 2001:155-161). It is also important to note that care-giving, which for community health workers includes both caring for their clients and themselves, is a “moral experience” (Kleinman 2013). Care constitutes a relationship and shared experience. Moreover, social suffering influences everyone and not just patients (Kleinman 2013). As evident, community health workers are influenced by a variety of incentives and goals, life circumstances, and political contexts.

Under these theoretical perspectives, needle exchange and community health workers have been divided into either an ideological activist approach against the dominant norm or a public health and biomedical commitment to reducing health risks (Roe 2005:245). This division in the function of NEPs is too binary of a distinction as both NEPs and outreach workers can have multiple roles and meanings, both explicit and implicit. The community health worker model cannot be parsed into a discrete category of either change agents or biomedical handmaidens (Maes 2015). Rather community health workers simultaneously work within their sociopolitical context and use their agency to choose how to perform their job whether that includes social justice efforts or not.

Ultimately, IDUs, outreach workers, and Fairview community members are subject to the larger social and structural forces that constrain and shape life histories and experiences (Maes and Kalofonos 2013:57). In the ethnographic section of this thesis, I will argue that outreach workers in Fairview use the NEP as a social and therapeutic space and are motivated by a variety of intrinsic and extrinsic motivations. They serve as both change agents and cultural brokers within the biomedical system. NEPs are influenced by neoliberal policies and do not address the underlying social problems. Yet, they still provide an important public health service. In chapter

3 I present my research methods before I provide my ethnographic account on the lived experience of outreach workers in chapter 4 and 5.

3 Research Methods

In order to research the lived experience of outreach workers at the Fairview NEP, I used ethnographic methods. I followed the research plan of establishing a problem, determining a method to investigate the problem, collecting and analyzing data, and supporting or rejecting the proposed question (Bernard 2011:54). Therefore, to ethnographically study outreach workers I relied on participant observation, semi-structured interviews, and informal conversations and framed my analysis through grounded theory.

3.1 Methods

I conducted participant observation on a street corner in Fairview where the NEP occurs for a period of 12 months. I acted as both a researcher and volunteer at the needle exchange where I actively participated in the work. As a volunteer I immersed myself into the program, observed the experiences of outreach workers, and learned the culture (Bernard 2011:258). I used the time to observe outreach workers and clients as well as their interactions. During the NEP I focused on both individual attribute data and cultural data. Individual attribute data refers to population descriptions while cultural data is a cultural description (Bernard 2011:113).

My methods also included conducting semi-structured interviews. I interviewed both community health workers and volunteers who participate in the NEP. This included some individuals who are no longer volunteering at the program. My interviews were guided by prepared open-ended questions, but as conversations ensued questions were changed and added according to each interview. These types of questions provided a holistic understanding while also gathered specific experiences and examples (Bernard 2011). I used non-probability sampling and found informants through both purposive and convenience sampling. Purposive sampling is finding informants that fit the researcher's needs (Bernard 2011:145). In my case, I

chose individuals to interview who are outreach workers at the NEP. Convenience sampling is choosing informants based on their ease of availability (Bernard 2011:147). I interviewed individuals who had the time to meet with me and consented to the study. Interviews lasted between one to two hours. Some interviews were recorded while other informants asked not to be recorded. In these cases I only wrote notes during the interviews. Recorded interviews were transcribed. I have used pseudonyms to protect the identities of all informants and individuals involved in the NEP. Furthermore, while at the NEP I had informal conversations with outreach workers. These conversations also occurred outside of the program. Informal conversations were deliberate and contributed to the ethnographic data obtained.

In analyzing my ethnographic data I used grounded theory as my technique. Grounded theory involves coding for themes and finding patterns in the ethnographic data (Bernard 2011:429). Patterns are then framed and supported by anthropological theory (Bernard 2011:435).

3.2 Ethical Considerations

In order to conduct ethically based research, I received Institutional Review Board (IRB) approval from Georgia State University and obtained permission to conduct research from the NEP. However, since the IRB does not inherently protect research subjects, I was mindful to follow the “do no harm” anthropological etiquette in both conducting field work and in my writing. Since I simultaneously acted as a researcher and volunteer, during fieldwork I ensured that my research agendas did not distract from my volunteer responsibilities. My role as a volunteer was to help provide the service of exchanging needles and to perform the job asked of me by outreach workers. Although this sometimes meant that I did more participating rather than observing, I believe this was my ethical responsibility.

Additionally, I have prioritized and been attentive to protecting the identities of those involved in the Fairview NEP in the write-up of this thesis. Sjaak Van Der Geest (2003) has acknowledged the difficulty of protecting identities in certain research sites and particularly with sensitive subject matters. When writing his research he realized that even using pseudonyms for the community and informants was not enough to fully protect the confidentiality he had promised (Van Der Geest 2003:15). However, Van Der Geest recognizes the culturally shaped values that influence the anthropological standard regarding protecting people's identities. As another anthropologist Van Den Borne (cited in Van Der Geest 2003:18) notes, "[a] straightforward application of those international guidelines [the anthropological code] remains problematic and is unable to address the tensions between universalistic and relativistic perceptions of ethics when dealing with transcultural research." As this indicates, ultimately it is the anthropologist's responsibility to adequately protect informants' identities based on their specific situation. Since my research site constitutes a mixture of people – some who are very open and others who prioritize their privacy – I have decided to take particular care in ensuring the anonymity of all individuals who are involved with the NEP.

Thus, as previously noted I used pseudonyms to protect identities of my informants. However, because of the sensitive nature of the subject matter and controversial politics surrounding NEPs in the United States, I have also chosen not to reveal the location of my field site. I not only renamed my field site community to Fairview, but I have intentionally left out identifying characteristics, information, and ethnographic data for the community, program, and individuals involved in the NEP that might result in a breach of confidentiality. I have further chosen at times to keep identities general by simply referring to an individual as an outreach worker rather than using their pseudonym; this decision is to provide an additional level of

anonymity as always using names throughout the thesis means a person's story, and as such identity, can be more easily pieced together. The final strategy I employ to protect identities is separating identities (Burnet 2012). At times I divide an informant's stories or characteristics into two different pseudonyms. This provides further anonymity while not losing or distorting any meaning.

3.3 Limitations

This study has its limitations. To begin with, my presence as a researcher and outsider of the community inevitably influences the field (Bernard 2011). I also have an etic perspective, and I recognize that my perspective is shaped by my own background, anthropological training, and positionality (Dilger et al. 2015). My identity as a young, white, female, student, and non-drug user status shapes how individuals may perceive and interact with me as well as how I understand the field. My long term field immersion and rapport that I gained helps to decrease these limitations that my identity presents. Another limitation of my research is related to what task I am conducting at the NEP. Whether I worked handing out food and water or helped with the collection of the needles influenced what I could primarily focus on and most directly observe. However, by volunteering and working in both positions over an extended period of time, this limitation has been mitigated, at least to a degree. Finally, the validity of some information provided by informants is a potential limitation. Because of the sensitive nature of the topics about drug use, illegal activity, and health along with the associated moral discourses and stigma, informants might not always have been forthcoming. However, gaining rapport before conducting interviews and doing participant observation helps to decrease this limitation.

4 Outreach Workers' Definitions of Harm Reduction and Motivations

In this ethnographic chapter, I present my findings on outreach workers' motivations and how working at the needle exchange impacts their lives. This includes noting both the benefits and the associated challenges of participating in the work. I begin with a description of the NEP and Fairview community before discussing the lived experience of outreach workers. I then discuss how outreach workers define needle exchange and harm reduction before examining their intrinsic and extrinsic motivations for working with the program. I conclude this ethnographic section with how the NEP impacts outreach workers' lives and their lived experience.

4.1 Fairview Needle Exchange

The Fairview NEP follows the larger harm reduction principles and ideology. The Fairview needle exchange is a mobile unit that travels to a street corner in the community where there is a lot of foot-traffic and drug activity. This particular street contains run-down buildings, vacant houses and land lots, occupied houses, a store, a bus stop, and "playgrounds" (spots for shooting heroin). The numbers of outreach workers vary each day; the community health workers, who in this study represent paid workers, range from one to four workers while volunteers typically range from one to five individuals or sometimes more. Most of the outreach workers consistently attend the NEP and have long-term involvement with the program although participation by volunteers can also be sporadic. Involvement ranges from several weeks to over ten years. Occasionally there are short term volunteers who come to the NEP and volunteer for only a few days. Often these volunteers are students at local universities or court-mandated volunteers. The majority of outreach workers are middle-aged adults and are African American. Multiple times a week the outreach workers come to the street corner to exchange needles, hand

out injection kits and Narcan, and give out free food. The number of clients (IDUs) typically ranges from 30 to 100 people per day. Many clients regularly attend the NEP. Community members who are not IDUs also will come to the program to socialize and receive food.

During the NEP an outreach worker counts the number of dirty needles that each client brings, disposing them into a medical container, and hands out free clean needles in return. The number of dirty needles that the clients bring determines how many new needles they receive. The exchange rules are an one-for-one exchange plus several extra needles for additional incentive to return all dirty needles. For example, a client who brings 50 dirty needles will receive 60 clean needles in return. Paperwork is recorded on each exchange in order to keep a written record to help with grant purposes, but information recorded is minimal and non-intrusive to the clients' identities. In addition to exchanging needles, clients are given injection kits, which help to provide safe and clean injection materials. The injection kits include citric acid, rubber ties, cotton balls, alcohol pads, and cookers. Furthermore, the outreach workers provide clients with Narcan and explain both how and when to use it. Narcan is an opiate blocking drug that is very effective in saving individuals from drug overdoses. When the Narcan is given out, the clients also provide information on the last time they used it and the outcome of the individual who overdosed, meaning whether they lived or died. Meanwhile, other outreach workers hand out food and drinking water to clients. The food typically consists of bread, bagels, and pastries but varies depending on what the program is given by other organizations. Outreach workers provide information on other services and socialize with the clients and each other. Occasionally, HIV or hepatitis C testing is available at the NEP. When requested by clients, outreach workers try to connect clients with other social services such as medical services, homeless shelters, housing options, and rehab programs.

Essentially, outreach workers' responsibility is to provide the material services and establish respectful relationships and rapport with clients, which adheres to the larger harm reduction framework. Yet, relationships and interactions between outreach workers and clients are further shaped by the larger drug treatment discourses. Summerson Carr (2009) notes how neoliberal language structures drug treatment speech. In her research of a drug treatment center, she found that the social difference between clients and therapists is informed and enacted through speech and particular "scripts" or treatment narratives (Carr 2009; 2011). The influence of neoliberal discourse can also be seen in the needle exchange where IDUs are called clients. The use of the word client displays the neoliberal health influence in structuring roles of patients versus health providers. Despite this, the harm reduction ideology prioritizes respectful relationships and equality among outreach workers, clients, and community members.

As previously mentioned, Fairview is a community that experiences social and structural inequalities because of racial and class politics combined with an extensive illicit drug market. With a poverty rate of 32%, high African American population, unstable housing situations, and a general lack of public resources, Fairview represents a marginalized community (Puckett 2014:24). Illegal drugs are a major problem in the community. One Fairview resident said, "heroin, cocaine, speedball. It's real easy to get. Every corner. Woman or man, it doesn't matter. Everybody you see out there, that's what they are doing. Most of the whites who come through we know they're coming to buy dope" (Baldwin et al. 2016). Because of the prevalence of heroin, Fairview has been defined by outreach workers as a "high risk area" and "overdose city." An outreach worker described her first encounter with Fairview as shock and sadness at the state of the community thinking "these are people's children." As such, the community is influenced by these social and structural inequalities that increase risk. Farmer (1999:15) explains,

“inequality itself constitutes our modern plague.” In the end, health risk and drug use are the product of society based on the interplay of social and structural forces that perpetuate inequalities.

4.2 Definitions of Needle Exchange and Harm Reduction

Outreach workers participate in the NEP because of their belief in the harm reduction ideology. Harm reduction for the Fairview outreach workers goes beyond merely representing a public health strategy, but is a lifestyle and mode of thinking. The outreach workers recognize that life is full of risk and whether or not people inject drugs, “people are people” and deserve the ability to live a healthy and safe life. One outreach workers stated: “Harm reduction recognizes that people are going to do what people are going to do. Have sex, take drugs, take all kinds of risk.” Because needles are the main vector of spreading blood borne diseases in IDUs, providing clean needles is a means of decreasing the risk from the drug use behavior. Following the larger harm reduction ideology, outreach workers use particular interventions for each risk, focusing on the mechanics of the behavior.

In following the larger harm reduction framework, outreach workers must work within the neoliberal environment, in which health care is a commodity, while trying to implement their harm reduction ideology of health being an inherent human right. As previously discussed, needle exchange is influenced by neoliberal frameworks as it places the responsibility of health onto patients and does not actively address social and structural issues that influence health. Nevertheless, needle exchange does have medical value. Due to its health value and health as a human right ideology, outreach workers believe that NEPs are a significant and necessary public health practice despite the complexities of neoliberal influences in health care. However,

outreach workers have no option but to perform their work within the neoliberal cultural and political context in which they try to operationalize their harm reduction ideology.

The complexity of the intersection of the competing ideology and larger social frameworks can be exemplified through the use of Narcan. As Joao Biehl (2007) explains, biopolitics in global health care have become dominated by neoliberal, market-based solutions, which prioritize medications. Biehl (2007:1100) refers to this pharmaceuticalization as “magic bullet approaches” because the medications and scientific technology are provided to patients when there is not necessarily health care infrastructure. As such, this medical approach is providing access to medical drugs, but is ignoring all other health factors resulting in patients failing to receive holistic treatment for their health problems. With Narcan, clients receive the drug for free, which is important as it reverses the effects of a drug overdose, but access to this life saving drug does not help the problem of the heroin epidemic or health disparities in IDUs. Access to Narcan follows the health as a human right ideology to a degree, but the larger social and structural reliance on medical drugs ignores the multifaceted health and social problem. Narcan does save peoples’ lives, but it does not promote equality in public health care. Rather, Biehl (2007:1104) emphasizes, “drugs are ancillary to the full treatment of the disease.” Ultimately, neoliberalism influences and constrains the degree in which outreach workers can implement their ideology into on-the-ground public health practices.

However, for the outreach workers harm reduction goes beyond the typical public health versions of high risk behavior of injecting drugs and sex. For the Fairview outreach workers “there is all sorts of harm reduction” because it constitutes an entire lifestyle. For example, providing food and water at the NEP is harm reduction because it helps people avoid hunger and dehydration. This perspective includes all behaviors that could lead to potential harm: “Harm

reduction is global. It's sunscreen. It's safety belts. It's helmets. It's designated drivers. It's Uber and Lift and all those cab hailing services because even with surge pricing the most expensive cab fare, the most expensive Uber and Lift fares are cheaper than DUIs. It's using oven mitts when you are dealing with something in the oven." As evident, outreach workers define harm reduction not just as a strategy for high risk behavior, but an everyday practice for even the most mundane actions. Essentially, harm reduction is what "grandma called 'safety.'" Before one outreach worker started working in the harm reduction field or even knew what harm reduction technically meant, his actions and practices followed the "do no harm" ideology. He said, "I think in a way I have always been performing harm reduction." This statement refers not only to personal care for his health, but to volunteer activities he has previously participated in of handing out clean needles and food to homeless addicts.

Therefore, outreach workers understand harm reduction as being focused on the ability to make choices based on adequate information and knowledge. They believe that everybody has the right and potential to live "productive lives," but in order to improve one's life both proper education and the ability to choose healthy practices is necessary. Ultimately, outreach workers depict the first step to changing a lifestyle is simply being alive. Thus, when clients come to the NEP they are choosing to mitigate their risks and obtain clean needles to protect their health. By providing a NEP, outreach workers are allowing the possibility for IDUs to, at least to a degree, choose their health because "where there's life there's hope." From this perspective, outreach workers see themselves as being health "enablers." As one individual describes:

I am enabling people. Yes I am. I am enabling people to live healthier lives. I am enabling people to protect themselves from HIV, hepatitis B, hepatitis C, any other blood borne bug. We are enabling sex workers to get free condoms so that they can practice safer tricking. We are enabling crack smokers crack cocaine smokers to protect their lips. We at times enabled people to get free check-ups. To have abscesses tended to... we help

people to live healthier lives and make wiser choices. We help people into drug treatment.

As such, the harm reduction ideology and resulting needle exchange practice is considered to be a “tool,” which provides individuals the ability to change. In providing choices for IDUs, outreach workers believe it is not their prerogative to judge or force decisions onto people. Rather enabling for outreach workers means functioning as a resource and “bridge” to medical and social help. For example, outreach workers help connect clients with numerous social programs ranging from obtaining medical aid for abscesses to finding homeless shelters. A worker explains how outsiders can misunderstand harm reduction goals by stating: “There are those you think that anything recovery, anything drug treatment, is against harm reduction, but no we are a bridge to treatment. We can be a bridge to recovery. And trying to get somebody into treatment, detox get into a treatment bed with no money and no insurance – it’s some work. It’s hard work, but we manage to do it over and over again.”

Their focus on not forcing decisions onto individuals stems from the emphasis placed on respecting all people despite their life choices. Showing respect towards people, whether it is to clients, community members who frequent the program, or other workers, is a key component of the practice and environment of the NEP. For example, when a client was negatively discussing and outing another client for using someone else’s dirty works (needles), an outreach worker reminded him “you can’t judge anyone for their decision.” Also if an individual makes any disrespectful, judgmental, or rude comment to a client, the outreach workers reminds them to be respectful and says that if they are not, they should not volunteer at the program. As is evident, being non-judgmental and respectfully conducting oneself is synonymous with the Fairview NEP. This further displays how outreach workers understand harm reduction as being contingent on interpersonal relationships. An outreach worker defined harm reduction as, “We all work

together and keep everything all right. That's what harm reduction basically is." The outreach workers work with each other, as well as with the clients and the community, to improve the overall health of anyone who decides to use the program. As such, creating an environment where people feel comfortable and safe, especially considering the sensitive and stigmatized nature of drug use, is a vital aspect to incentivizing individuals to use and trust the program. The interpersonal relationships are evident by the close connections between outreach workers and clients. Throughout the program outreach workers and clients greet each other and over time develop personal relationships. As will later be expanded on, outreach workers also develop close relationships and support with each other. Thus, in addition to providing clean needles, this mutual respect and "speaking the same language of the people" is a core aspect and requirement of the work in Fairview.

Since harm reduction's primary principle is to prevent harm, outreach workers consider their job as ensuring that everyone is ultimately physically and emotionally healthy according to their own desires and needs. Care is further extended towards outreach workers and society at large because of outreach workers' holistic and global definition of harm reduction. For example, when one worker did not call or show up to the NEP for several days the outreach workers stopped by his house because as one individual explained, "We are going to make sure he is ok. That's what we do, make sure that everyone is ok." The ideology is also applied to small, mundane aspects of workers and volunteers' lives even for situations that do not fit a typical public health definition of risky behavior. Another example of this is when an outreach worker used the harm reduction perspective to give me advice when I was training for a marathon. When dealing with a small knee injury, he reminded me to "not overdo it" with training, which would result in further injury. Essentially, outreach workers understand and actively apply the harm

reduction ideology and needle exchange act as simply “helping people” whether that is through providing clean needles, helping individuals into treatment, or giving advice on any life circumstance. During one program an outreach worker told a client “come by we always have something for you,” which is the essence of the Fairview NEP and fundamental principle of harm reduction for outreach workers.

4.3 Outreach Workers’ Intrinsic Motivations

Outreach workers’ understanding and perspective on harm reduction ultimately connects to their motivations for participating in the NEP. In addition to their belief in the harm reduction ideology, outreach workers are intrinsically motivated to partake in the work because they consider the NEP as directly saving lives. The Fairview NEP program started because several concerned citizens began noticing a large quantity of discarded needles on the streets and were concerned about the HIV/AIDS epidemic in the area. In fact, there were so many dirty needles on certain city streets that several of the outreach workers used to wonder the streets picking up the used syringes with tongs. The outreach worker Heather remembers there being a “sea of orange” referring to the orange caps of syringes, especially around injection sites where many IDUs gathered together, but she said people would even find used needles in their backyards. Dirty needles at injection sites and on the streets represent a public health concern not just for drug users, but for the entire community. In particular, the outreach worker Mark fears for any young children who might see a needle on the street and unknowingly pick it up and accidentally poke themselves with the point. Therefore, in running the NEP, outreach workers believe that collecting used needles is an important preventative measure for the entire community.

Furthermore, they connect exchanging needles as directly preventing HIV/AIDS in drug users. When the needle exchange program first started Frank said HIV/AIDS in the area was

rampant, and he was initially attracted to the work because he knew that “needle exchange saves lives” by reducing the spread of blood borne diseases. Although the Southern city still has a HIV/AIDS problem, Frank believes there has been a large improvement. The outreach workers consider exchanging needles to be a logical public health practice to prevent the spread of disease. When analyzing a needle exchange from purely a cost-effective standpoint, which also displays neoliberal influences in the practice, an outreach worker noted the importance of using the NEP for prevention:

It is always easier and cheaper to prevent something than to treat it, or try to cure it if there is a cure. Condoms cost 6 cents whole sale, syringes cost 9 cents whole sale. I'd rather take that 15 cents and help prevent something than to try to deal with the consequences... You know if you can keep people from not catching something they live a better life, and really I'd rather spend that 15 cents than to spend the, I think it is – I've heard varying numbers but I believe it's something like \$368,000 that it costs to treat someone with HIV from diagnosis to death.

As this outreach worker's logic displays, the belief is that exchanging needles saves lives from diseases and avoids any negative effects from diseases. The outreach workers are certain that without the NEP as a prevention method “there would be an epidemic” in Fairview. For example, the outreach worker Mike did not realize the extent of the health problem in the community until he started volunteering, but then was convinced of the program's public health value. He explained his position as “Well, once you get that first experience going to outreach then you kind of get the whole necessity to it. You know why it is being done.”

The needle exchange's public health value and disease prevention that ultimately is depicted as saving lives is so important to outreach workers that they are willing to participate in the program despite the unclear state law regarding exchanging needles. Frank describes the law regarding drug paraphernalia and exchanging needles as it is “illegal but legal.” Although the law technically does not legalize exchanging needles, the wording allows for a degree of

interpretation. Therefore, the outreach workers have chosen to interpret the law based on their scientific and moral beliefs in the health value of needle exchanges. One outreach worker characterizes their actions as “[we] are acting as if it is legal because we feel that stopping or attempting to stop the spread of HIV, viral hepatitis, STDs, STIs is a legitimate medical purpose.” Another worker noted that not only is it a legitimate medical activity, but that no worker has ever been arrested even though it is not uncommon for police officers to drive by the NEP and even at times park their cars nearby and watch the program.

The importance of the NEP is also evident through the consistent efforts of outreach workers. Although many of the workers are volunteers who do not get paid, many of the long-term volunteers have continued to do the work for years. Moreover, the NEP is conducted even in the worst of weather because the clients need clean needles and rely on the program for help. For example, whether it is pouring rain or very cold temperatures, the NEP still occurs. There was one day where the outreach workers arrived right as tornado sirens and warnings started going off throughout the city, but rather than cancelling the program, the needle exchange occurred as normal; several days later that outreach workers acknowledged that it probably was not the safest decision but enjoyed several jokes about the fact that while most people were taking shelter in buildings, they were setting up their fold-up chairs outside and continuing the NEP like nothing out of the ordinary was happening. This example helps to illustrate the motto that is often told to new volunteers: “We are like the post office and will be out [there] rain, shine, sleet, snow. Every time because people depend on us. Even if the people aren't there, we will be.”

Additionally, collecting dirty needles and providing clean needles is not the only service that outreach workers provide that they define as directly saving lives. Narcan is also distributed

to clients; Narcan is an opioid blocking drug that reverses the effects of a drug overdose if used promptly. Outreach workers have referred to Narcan as a “miracle” and “blessing” because of how effective it is at saving individuals from overdose deaths. They encourage clients to always carry Narcan on them just in case, but most clients do not need much convincing of Narcan’s value. For example, when a client stated that she always carries Narcan on her the outreach worker Joe’s response was: “Exactly. Save a life.” When clients are given Narcan, they always give reports on when they last used it and who they saved. One client has saved over nine people because of the Narcan that outreach workers provide and his own preparedness for potential overdoses. He not only carries Narcan on him, but has said he places them in injection sites around the community in order to always be prepared. Every week it is common for clients to report new overdoses, and although it is certainly not always the case, the reports often include how Narcan saved said individual. Not only do outreach workers distribute Narcan for clients to save people, but several of them have used Narcan to prevent an overdose death. For example, Emily prevented a death when a client called her about an overdose that was occurring several blocks away and she rushed over to use Narcan to save the individual. She said waiting for the person to wake up was the longest seconds of her life. The Narcan drug is highly valued by outreach workers because they directly see the lives that have been saved due to its accessibility.

In addition to the outreach workers’ role in reducing the spread of blood borne diseases and preventing drug overdoses, distributing food and water is considered to be a vital part of helping people. This is based on their belief as harm reduction as an entire lifestyle. For example, outreach workers depict having water, especially during the summer, as helping save lives and people from dehydration. On multiple occasions, a volunteer has expressed his role in helping to provide food for clients and how people would go hungry without his efforts.

The direct association of the needle exchange as saving lives is also emphasized through the clients' thankfulness in the work that the outreach workers perform. It is common for clients to directly thank and praise workers telling them "you guys are saving lives." The clients value the public health practice of exchanging needles and use the NEP in order to protect themselves from HIV/AIDS, hepatitis B, and hepatitis C. During the NEP many clients have described the problems they face because of their heroin addiction, but express the importance of being as safe as possible. For example, one client admitted that although he would hold a gun to his mother's head in order to get heroin when dope sick that he would never share or use a dirty needle in an effort to be safe. This client's definitive statement on always using clean needles may or may not be exaggerated, but it nevertheless displays the health value that clients put on their ability to access clean needles. During one program where few clients came to exchange needles, one client remarked, "Where is everyone at? Man, this is not good." He was referring to the fact that if IDUs are not receiving clean needles from the NEP that the resulting effect would be individuals sharing or reusing needles, which would increase their risk for disease.

Another client who regularly exchanges needles on one occasion was particularly thankful for the NEP's services after saying, "I missed the van the last two weeks. It's been a struggle." A volunteer empathized agreeing with the client's statement. In addition to clients' verbal praise for outreach workers' role in saving lives, sometimes clients show their appreciativeness through random acts of kindness or gifts. For instance, occasionally a client gives one of the outreach workers small gifts that range from a canned food item to a paper hand-fan. These small gifts represent clients' appreciation for the aid that outreach workers provide, which ultimately translates into a longer and healthier life. Both outreach workers themselves and clients believe that the NEP is helping to save lives. The ability to help save lives is a

significant motivation for participating in the NEP for outreach workers; they are not only thanked and reminded for their role, but they also can directly see lives they have helped.

Previous experiences of loved ones who have died from preventable diseases, such as HIV/AIDS, is another motivating factor to help save and improve lives. For example, over the course of the outreach worker Jimmy's life, he has witnessed a lot of people who have taken drugs; some of his friends were ex-addicts who had completely changed their lives and were using their experiences to help others. However, during the 1980s these friends and other acquaintances started dying from HIV/AIDS. Jimmy realized that many of his friends would still be alive today if they had access to clean needles while they were still drug users. Thus, this personal connection with the spread of HIV/AIDS from drug use has framed Jimmy's belief in the value of needle exchanges and motivation to ensure that everyone has the ability to receive clean needles.

Another outreach worker's motivation to reduce the spread of HIV and help save lives also began when the disease first emerged. She describes the time period in the following way:

I remember HIV and AIDS before it was called HIV and AIDS... I had a lot of gay male friends who were *whispering* about that thing. That thing was sickening and killing their friends and friends of their friends... God I didn't know how big [HIV would be]. I remember the brochure 'Understanding AIDS' that then Surgeon General mailed out to every address in America because there was just so little known about AIDS. I remember then health and human services secretary Margret Heckler had a big old press conference. 'We have found a virus to this condition. This condition is AIDS – acquired immune deficiency syndrome. It's a group of diseases, symptoms. The virus is HIV – human immune deficiency virus'... I remember the Reagans' silence about HIV and later on learned about their contempt they had for people living with HIV. I remember Reagan not really addressing HIV till the door was about to hit him on the butt... I have friends and family members who have HIV. Some have died from it. Died from AIDS, complications thereof. I still have a lot of friends living with the virus – some better than others. There were a lot of people in Fairview who died of HIV. There are a lot of people in Fairview who are living with HIV – some better than others. That's where it [interest in HIV/AIDS work] started.

The lack of intervention and prevention has motivated the outreach worker's desire to participate in the NEP and desire to reduce the spread of blood borne diseases. Another outreach worker Mike said his mother died due to her heroin use when he was a child, which motivates him to "want to help more." As evident through these life experiences of outreach workers, they have personal connections to the NEP's prevention work that helps to motivate their desires to save lives.

Furthermore, giving back to the community is a significant theme that outreach workers depict as part of their reasons for participating in the NEP work. Yet, the desire to contribute to the betterment of the community is not merely based on moral character, but is also influenced by previous life events. To begin with, in part outreach workers participate in the NEP because they themselves were once "saved" or "escaped" similar situations that many clients currently face. Many outreach workers either have experienced drug use or poverty situations at some point during their lives or at least witnessed these circumstances first-hand. However, it should be stressed this characterization is not a truism for everyone. For example, Tony's life story and personal struggles helps to demonstrate this point. At one point in his life Tony went broke. He then became involved with drug-use, but after an incident Tony decided to change his life around. As such, "giving back" to others is important to him since he was "lost at one point" himself. Now Tony is happy with his life and is at a point where he believes he is able to support and give to others. Because Tony experienced a situation similar to ones that many clients confront, he can directly empathize with individuals and appreciate the value of support. As a strong believer in the importance of emotional and spiritual assistance, Tony wants to provide "belief" in other people who could benefit from encouragement and support.

Another example is Mark's long term commitment as an outreach worker and desire to help his community, which is influenced by his own ability to escape the lifestyle that most clients lead. He credits the NEP and the services they provide with not only saving him, but also changing him for the better. He was a homeless addict on the streets when an outreach worker got him into housing and supported him with other social services. Another outreach worker described his childhood, growing up in a bad environment, but he said that he was able to "escape" gang-life due to an individual who acted as a positive role model who saved him from the streets. One of the outreach workers notes that many former drug users will come to give back by volunteering. Thus, now as outreach workers, they are trying to provide support because they received help from others at some point in their lives. As these examples display, many outreach workers have first-hand knowledge of the clients' difficult lives while others consider themselves as lucky to have escaped the life of the people they serve who were not so fortunate.

Another outreach worker not only experienced a life very similar to many clients, but further has expressed that volunteering in the NEP as an opportunity to right previous wrongdoings and choices. Thus, helping current IDUs is a means of making amends for past drug related choices and mistakes since he was "lucky" enough to leave the scene. Before moving to Fairview, this volunteer defined himself as a "major drug dealer" in another Southern city. He said he used to sell and take drugs explaining, "I did *a lot* of bad things...so I guess I'm calling myself giving back." Not only is he referring to being in a gang and selling drugs, but selling needles for three to five dollars per needle. Now, surrounded by Fairview's poverty and high HIV prevalence rate, he recognizes the need for free and clean needles. He further explains, "I did my thing and selling those people that stuff and to see that what I was actually doing was destroying a lot of people. And I didn't realize that until I got here [Fairview]." Now Mike

considers that lifestyle to be in the past and even though he financially struggles some and is unable to find a job, he says he is happy because he is “doing the right thing.” As he explains, “I’m retired. I’m done. That life is no longer in existence. It’s a past existence.” However, several months after this statement was made, Mike stopped volunteering at the NEP and now participates in the program as a client exchanging needles. This example in part displays that motivations for participation in the NEP are not static, but rather life problems, whether that is drug use, health implications, or job opportunities, impact involvement in the NEP.

Finally, outreach workers also describe a desire to help the community based on the value placed on morality. Every outreach worker who partakes in the NEP is expected to follow the underlying ideology that characterizes the Fairview needle exchange by respecting all people and simply “serving the people.” As such, outreach workers come to the NEP to selflessly provide aid to the clients. For example, one outreach worker compared choosing to participate in the program as an effort to “console that misery” that many clients experience. Therefore, volunteering, specifically, at the NEP is his attempt at trying to be “better towards other people.” The outreach workers understand their work as contributing to the betterment of the community. Thereby, knowing their actions in part help other individuals provides a “peace of mind or peace of joy.” Moreover, outreach workers’ reactions to challenges that occur at the NEP displays the importance of the ideology of providing the services to clients. During a NEP it is not uncommon for clients to start arguments or cause commotions. Sometimes these problems are directed at outreach workers. When this occurs, outreach workers are expected to refrain from engaging in the fight and behave respectfully to the clients. For example, at one NEP a client was upset about the food he was receiving and started making a scene. When one of the volunteers started talking back to him another outreach worker defused the situation and reminded all

workers that “we are just here to help.” He further emphasized that the NEP comes to provide a service and “to be friendly no matter what anyone does.” As this incident displays, having a desire to serve and help other people is a basic premise of the NEP that all long term outreach workers subscribe to. As one outreach worker expressed, “I see where the community is and I want to help.” Thus, giving back to the community and helping other people is a simple moral principle that guides participation and behavior at the NEP. The intrinsic motivations of saving lives and giving back to the community are significant underlying beliefs and incentives in outreach workers’ participation in the NEP.

4.4 Outreach Workers’ Extrinsic Motivations

The material rewards that outreach workers receive from participating in the NEP are limited, but still play a role in outreach workers’ lives. Some of the outreach workers receive monetary payment for their work, but many are volunteers. Since the NEP distributes free food to clients, outreach workers also have access to the food while at the program as well as both before and afterwards. Although the food is primarily for the clients, outreach workers often take food home with them. Many times when preparing to distribute the food outreach workers will save an item they want for themselves. The primary difference with outreach workers and clients receiving food is that outreach workers have the first pick of items and have more freedom in quantity. Sometimes these actions become critiqued by other outreach workers or clients. For example, at there is a running joke among the outreach workers and certain clients that if all of the food is gone to look in George’s pockets. At one NEP a client, and former volunteer, who came at the end of the exchange complained about there not being any food left for her and she was hungry. Then she muttered to herself that she needed to start volunteering again in order to get food. As evident, receiving free food is an important aspect of volunteering at the NEP.

Periodically the NEP will have other everyday items to give away that outreach workers have access to. For example, once clothes were brought to distribute among the clients. Furthermore, outreach workers occasionally receive small gifts from clients. As mentioned previously, this can range from a canned food item to a cigarette to a box of candy. Similar to clients, outreach workers also have access to the social services and connections that the NEP has to offer. The few material benefits that outreach workers receive in comparison to the more significant intrinsic motivations that shape outreach workers' participation in the NEP further demonstrates the importance of the harm reduction ideology and belief in improving the lives of the clients that underlie outreach workers' involvement in the NEP. However, the value of access to free food cannot be discounted either. Both intrinsic and extrinsic factors contribute to motivations to work with the needle exchange.

As this chapter outlines, outreach workers subscribe to the harm reduction ideology, which they holistically apply to all aspects of life and underlie their priority of respecting all individuals. This resolute belief along with desires of helping to save lives and give back to the community are significant factors that lead to outreach workers' continual involvement with the NEP. Thus, outreach workers' lived experience provides a personal connection to the value of the work and motivation for participating in the NEP. The personal connections range from former experience with drug use or drug users, escaping similar situations that clients currently endure, dealing with the deaths of loved ones, making amends for past mistakes, and trying to be a moral, altruistic person. This relates to care giving as a "moral experience" based on interpersonal relationships and shared experiences (Kleinman 2013). Furthermore, receiving small extrinsic benefits, such as food, is a valuable and advantageous aspect of working with the NEP. In the next chapter, I discuss my findings of the impact that the NEP has on outreach

workers' lives that include functioning as a therapeutic community, giving testimony, and self-care.

5 Needle Exchange as a Social Space

With an understanding of the outreach workers' motivations for participating in the NEP, I now present an ethnographic account on how their involvement with the program influences their lived experience. I ultimately argue that despite some challenges of self-care, the NEP represents an important social space and therapeutic community for social support and a means to cope with structural violence and social inequalities. Thus, the NEP is a significant part of outreach workers' lives and contains not only public health benefits, but social value.

5.1 Giving "Testimony"

The NEP is an opportunity for outreach workers to receive an audience to share stories, exchange information, and find emotional support, or in the words of some clients, to "give testimony." To begin with, the NEP is a place to tell stories and joke around with other outreach workers and clients. Especially when there are not a lot of clients waiting for the services, the relaxed and social atmosphere provides the opportunity to socialize and to engage in banter with each other. Thus, while at the NEP outreach workers always have an audience that gives them attention, which includes both other outreach workers and clients. For example, jokes always occur during the NEP. For several programs there was a group of college students who came to volunteer. There was some friendly banter taking place between the outreach worker George and a student because the student was giving George a hard time for falling asleep the previous day while on the job. George then joked with the student about being "green" (inexperienced). Instances like this show how outreach workers use the time to have fun with each other and try to keep the atmosphere light. Stories are also exchanged during the NEP ranging in topics. For example, while volunteering at the NEP, I have been told stories about the largest rat someone has ever seen, childhood stories, stories involving drug use and illegal activity, and family drama

among many other topics. Both outreach workers and clients partake in this activity; as one client said to an outreach worker as he walked up, “it’s story time.” Essentially, anyone who is willing to listen to a story will find themselves in a conversation.

In addition to telling stories and joking while participating at the needle exchange, outreach workers commonly exchange information with one another and clients. This information is typically community related news, mundane life events, and personal life updates. For instance, outreach workers and clients will exchange information about other clients or community members. More specifically, updates on who is currently in jail or receiving treatment will be told. Also, information and details regarding deaths that have occurred in the community is discussed at the NEP. As previously mentioned discussions include individuals who have died from overdoses, but also deaths of people who are not users of the NEP. Mundane life and events are further spoken about, such as exchanging information ranging from housing details to the score of professional sports games. Many outreach workers further talk about updates in their life. For example, Bob regularly updated me on his housing situation.

The social atmosphere further relates to the NEP as being a time to talk about and receive support for life problems and more serious topics of conversation. For example, when Mark had some health issues and pain, he voiced his frustration over the situation and other outreach workers gave advice and sympathy. One outreach worker jokes that I provide “therapy services” to Mark because of all the conversations we have and stories he tells me. Heather explains that “we [the NEP] are a safe place to hang out with for a little bit. You can hang out with us at the syringe exchange and have some quite stimulating conversations.” For instance, during a slow day, a community member pulled up and tried to sell some goods, such as movies and hair products. Although no one was interested in purchasing anything the man started giving his

“testimony.” He told everybody his story how he used to sell drugs among other crimes, but when serving a long prison sentence he found God and changed his life. He said that now he is “still on the streets,” but selling a “different product” (i.e. legal goods). Everybody congratulated him for his efforts to improve his life and business endeavor. Other “testimonies” are more mundane with outreach workers talking about their business opportunities, family member or personal achievements, roommate problems, or events that occurred that day. The outreach worker Ted shares his stories and updates about his projects. Sometimes he comes to the NEP to “escape his house and think.” Another outreach worker and a client talked about the simple joys of life when the client talked about how a friendly exchange with a stranger left her smiling all day. She said she wanted to “give her testimony” to the outreach worker.

As these instances exemplify the NEP is a safe social space to hang out, socialize, and exchange information. It is also an opportunity to tell stories, make jokes, discuss life events, and receive an audience for attention. Depending on the number of clients, it is not uncommon for some outreach workers to only socialize during the NEP. Consequently, the NEP represents a safe place to congregate and socialize with other outreach workers and clients.

5.2 Therapeutic Community

Ultimately the ability to “give testimony” during the NEP represents its value as a social space that functions as a therapeutic community to discuss and cope with larger social issues of drug use, poverty, and racism. As such, the NEP does not just aid IDUs, but its implicit use as a therapeutic community for outreach workers is a significant social aspect of the NEP. Fairview, as previously described, is a marginalized community impacted by three interacting social problems of drug use, poverty, and racial inequalities. The intersectionality of these social factors all contribute to the marginalization of Fairview, influencing the entire community. The NEP

thus becomes a therapeutic space for the outreach workers to cope with drug use, poverty, and racism through the ability to congregate with like-minded people who have similar experiences and a non-judgmental ideology that provides the opportunity for open discussion.

First, the NEP is a space to discuss drug use. However, the conversations around drug use do not just address addiction, health side effects, or treatment but at times explore underlying reasons for drug use. Heather said, “I do get to talk about sex and drugs a lot. That’s always fun and when I’m really lucky we have conversations around why do people use drugs. We need to have so many of – so many more of those conversations and we need to act on the answers.” Many outreach workers recognize that a large contributing factor to drug use is people trying to “self-medicate” because of dealing with a variety of social and personal issues. Frank believes many people do drugs because of “low self-esteem, depression, and oppression.” He expressed his own ability to avoid any drug use even while living in a “bad environment” and “seeing a lot of things” because of being “sure of myself.” Because of the marginalized status of Fairview, the residents of this community are subject to inequality stemming from structural violence and stigma in which several of the outreach workers recognize these larger structural inequalities that contribute to drug use. Bourgois and Schonberg (2009:133) state that society typically misunderstands crime, violence, and drug use characterizing “involvement in illegal activities is usually considered to be a personal choice that reveals an individual’s moral defects.” However, rather than blaming individuals for their drug use, some of the outreach workers, like Frank, reject the self-blame discourse and recognize the structural violence that underlies the heroin epidemic.

However, the NEP is not only a place to discuss drug use and the underlying social issues connected with it, but further for some outreach workers it can be a reminder and form of drug

prevention in regards to their own illicit drug use. Some of the outreach workers have experience with drug use, although I would like to emphasize that not all do. Because of the larger macro social forces, heroin and other drugs are easy to obtain anywhere in Fairview. Heroin is so prevalent in Fairview that an outreach worker said he could walk out his front door and find heroin. Therefore, in coping with such easy access to drugs as well as other forms of temptation, the NEP provides a therapeutic space and community to deal with previous drug use. As one volunteer said, “the devil is always out and wanting to get you into trouble.” First, it connects outreach workers with other ex-drug users and people who are subject to similar social situations and as such are relatable. The non-judgmental NEP is a safe place for ex-drug users to talk about their drug experience, past mistakes, and current hardships. As one outreach worker said, “I’ve been to prison all my life, well half my life, and I have seen some shit you understand.” Others have noted “seeing a lot of things” or “serious things” indicating the importance of being able to relate to similar hardships and experiences when having dealt with comparable difficult environments. As Joe describes, “what I see over there [in Fairview] is just something I am used to seeing.”

Seeing the clients also reminds outreach workers of the negative aspects of drug use. The clients become examples of the consequences of heroin use including homelessness, hunger, and dope “sickness.” Also, clients give reports on their personal and others’ jail sentences, hospital visits, and overdose stories. One volunteer who is an ex-drug user described “these guys out here [the clients] help me survive.” Volunteering at the NEP helps to remind him of his past in order to keep him grounded and “moving forward.” For example, during one NEP on the other side of the street a client, who was holding a needle in his hand, was moaning, stumbling, and falling

over while trying to walk. His attempt to walk lasted for a long time in which Abby commented seeing someone like that is a great means of deterring anyone from using drugs.

Mark recognizes that being an outreach worker helps to keep him out of trouble by giving him a purpose and activity to participate in. Otherwise, he thinks he might do “bad things” if he spends too much time at home. Participating in the NEP thus becomes a structured activity that is a way for him to “avoid extra time.” He also expresses that the Fairview area is “bad news.” Mark wants to “avoid any temptations or bad people.” For example, sometimes individuals will come to his place to either look for heroin or to inject. Because drugs are so accessible in the community, for those who live in the community, they can still see the negative consequences of drug use outside of the NEP. The difference is that the NEP represents a structured environment and a social separation between an ex-drug user acting as outreach workers and other community drug users. Because being a current or ex-drug user is such a large part of a person’s identity, the NEP helps the outreach workers to socialize in the “streets” with their fellow community members, friends, and acquaintances without being in a comprising situation of actually being in the “streets.” Thus, the NEP can be used as a social space and therapeutic community to discuss not only the contributing factors to drug use, but can be utilized, to a degree, by some outreach workers as a form of prevention, reminder, and a connection with people who are able to relate to their background.

Additionally, the NEP becomes a social space to address issues of poverty and socioeconomic inequality. The Fairview community is a high poverty area, in which outreach workers witness the financial hardships in the lives of their clients and in some cases have experienced their own financial difficulties. One outreach worker who lives in the area said, “I’ve seen the poverty. I’ve seen the poverty of this place. Then I started seeing the poverty of

the people and for people to be on drugs in this poor town. You can imagine! It's a high risk place. Very high risk." As he explains merely living in Fairview represents a risk, but he believes that the NEP does not just provide a means for disease prevention, but decreases risk in a holistic sense. "Harm reduction makes it [life] a little easier. Not for people just like them [clients], but people like me too." He is referring to the various services, like receiving food, and social networks that the NEP has connections with, in which outreach workers can benefit from if needed. Being unemployed, he was trying to find a food bank when he accidentally found the NEP instead. "When I needed help they [the NEP] were there." This support in part prompted his interest in volunteering as an outreach worker, but as evident by his entry into the NEP, he directly experiences the effects of the poverty in the area.

Ted explains that "you learn how to survive on the streets in poverty situations," which is a lesson he learned as a young adult and now only witnesses in the lives of clients and other community members. Many of the clients squat in various abandoned houses in Fairview and have little money. Homelessness is a situation that some of the outreach workers can relate to. For example, Mark has been homeless at various times throughout his life and has lived in other places that did not have electricity or running water. Other outreach workers have similar experiences.

Furthermore, outreach workers are able to discuss the larger inequalities that contribute to the poverty of Fairview at the NEP. For example, at one needle exchange Frank and a client discussed at length the systematic inequalities in medical care and how "people get angry, but don't know why they are. They just know that something isn't right." This ultimately speaks towards recognition of the underlying structural violence. Another example revolves around the community's lack of easy access to healthy foods. An outreach worker lamented how far

someone would have to travel to reach a farmers market and critiqued a festival that occurred in the area that only consisted of booths from outside of the community. Not only did he voice his concerns about how this took money out of the community, but was further disappointed when no one in the community seemed interested in the problem. Heather also observes the role that socioeconomic class plays in the stigma against drug users and in particular heroin users. She further notes how policies discriminate against the lower socioeconomic class. For example, she depicts the conservative political agenda that tries to reduce food stamps, unemployment benefits, and require drug testing as directly contributing to drug use rather than reducing it. Heather critiques not only these policies that promote social inequality, but the higher socioeconomic class individuals who do not try to understand the drug problem. As she explains,

Well-housed, well-fed, well-clothed, Republicans – I’ve seen them tend to act as if it will never happen to them until you know their daughter in [rich suburb] all of a sudden has a heroin habit. A lot of people are intoxicated on power, and they act as if they are untouchable. As if their families are untouchable. Perhaps they use powder cocaine, which is still the rich person’s drug. Perhaps they like a nice Merlot. You know their drugs of choice are different and they think they have a handle on them – maybe they do maybe they don’t. I see a lot of people who have it. Who made it. *They are a have as opposed to a have not looking down.* They just don’t get it... Goodness just the gall of someone who has a house, a car, eats regularly, eats well, are clothed well, have education, have privilege. They are snubbing people who may not have that, and they act as if it won’t ever happen to them.

As evident by Heather’s statement, those who are well-off, the “haves,” help to produce the stigma and inequality that lower socioeconomic classes and “have nots” experience. As such, the NEP is a space to both openly discuss the poverty and inequality in Fairview as well as a means to help reduce the associated harms.

Finally, race is a factor that also influences the lives of the outreach workers, clients, and community in which the NEP provides a social space that can function as a therapeutic community and opportunity to discuss and cope with racial inequalities. As previously

mentioned, the majority of outreach workers are African Americans and some of them have discussed incidents of racism with me. For example, one outreach worker recalls an event from his childhood that shaped his perspective, which ultimately influences his outreach work. When he was young, a white friend took him to a community organization where the worker refused to let him inside because of his skin color. This racist encounter deeply affected and hurt him, but even at a young age he knew that racist attitudes are a learned behavior. Therefore, rather than letting that encounter harden him or make him hateful, he instead adopted a non-judgmental perspective that “people are people.” As such, he does not pay attention to the “outside of a person,” but focuses on being compassionate to everyone. Yet, he still recognizes the automatic privilege that comes with white skin. This is also an observation that Beth shares. The state has a law that legalizes the possession and use of Narcan, which is an important drug that reverses opioid overdoses, but she expresses that a major influence in the passage of the law was because the advocacy came from a group of higher socioeconomic class, White individuals: “They used their privilege to a great advantage.” Not only is she referring to the privilege of their skin color, but their “good jobs with benefits” that allowed them to have the time to advocate for the bill and educate state legislators. The individuals and their stories “got the mostly white male legislators attention” and the bill passed on the first try in a Republican majority legislature.

The influence of race was not only a potential factor in the passage of the drug related law, but has influenced how others perceive the outreach workers and the community at large.

For example, when the NEP first started Heather remembers,

Well it was me, a Black woman, and four White women. Well, we were in a high intensity drug trafficking area in Fairview. We were neither buying nor selling anything. We so puzzled and confused the cops. They would come across us picking up syringes for proper disposal, handing out condoms, and talking to people. So they showed extreme care about – well at least most of our well beings. They roll up on the white women: ‘Are

you ok? Do you know where you are?’ ‘Yes officer we are ok. We know where we are.’
‘Are you sure you know where you are? Well you call us if you need anything.’

[Did the officers treat you the same way?] No, I looked like the people in Fairview. And I was with these White women. Again none of us were buying or selling anything so they just kind of ignored me.

Although this occurred many years ago, the racial inequality in the community is still a problem.

There is the common idea that a white person in the area must only be there to purchase drugs because there would be no other reason for a privileged person to come to Fairview. For example, one day while I was waiting for the outreach workers to arrive at the needle exchange, a man approached me and started talking. After conversing for several minutes, he asked me what type of drug I was looking for. I responded I was just waiting for the needle exchange to volunteer and was not using or buying. As this exemplifies, the man interpreted that my presence on the street must have meant I was trying to find drugs. At another time an outreach worker reminded me to be careful in the area when I am alone, but also noted he was pleased to see that I was not like “most white people [who] are afraid to come into Fairview.” These comments, assumptions, and characteristics of the area display the racial division and confrontations that influence the community.

Furthermore, the NEP can be used as an opportunity to discuss and cope with such encounters. For example, Mark once started talking about the different professions or activities that he never sees African Americans doing, such as professional skiing or surfing, and wonders why that is the case. At another NEP Ted told the group about how his recent encounter with the police that angered him because of the underlying social inequality. He was “profiled” based on his clothes, looks, area, and time of night by a police officer who stopped him while walking for no reason. He has also pointed out the various cameras that are placed throughout the community, including on the street where the NEP occurs, saying “they [police officers] are

watching.” Also, one day while waiting for the outreach workers to arrive, a client and I were talking about life in general when the client started sharing his life story, which included racial inequality he experienced and witnessed. He described the instances of racial segregation in another U.S. city he previously lived in and talked about how he was one of the few African Americans working at his old job. He said that it took around a year to be fully accepted by his coworkers, and during that time period he consistently heard racial slurs. He worked mostly with Italians and Irish individuals in which there were also racial tensions between the two ethnicities. However, he further considers himself lucky because he grew up with friends from all different backgrounds, which enabled him to have an open mind and experience different perspectives; he characterized the lack of ethnic differences in Fairview as a problem because he felt that most people in the community are not able to fully experience or have regular interactions with people of different backgrounds.

Another example of how the NEP is used to bring attention and discuss racial inequality is illustrated by the conversation about interracial families that occurred at a needle exchange. A client spoke about his biracial background and how growing up one side of his family was displeased about the racial difference. He believes that many people are “ok about race” until it directly influences their family: “They are ok until their son or daughter brings home a black person.” An outreach worker agreed with his assessment and added when one of her family members brought home a person of another race she accepted the individual as family. As she describes, “God didn’t create us to judge other people.” This nonjudgmental attitude regarding racial differences moreover relates to harm reduction ideology and its use as a holistic term. Mike notes, “I think harm reduction makes a big impact on the community as far as bringing people together and showing we can work together regardless of what creator or whatever

nationality.” As Mike’s statement alludes to, the NEP creates a safe and inclusive environment where outreach workers and clients can come together and have the ability to discuss racial issues and tell their own stories.

As such, the outreach workers not only recognize social inequalities, such as class and race, that impacts the community and perpetuates drug use, but they use the NEP as a social space and therapeutic community as an opportunity to discuss these issues with other like-minded people who directly understand. Some outreach workers have experienced and see the intersection of drug use, poverty, and racial inequalities in which participating in the NEP becomes an outlet to discuss and deal with such inequalities. This “therapeutic process” can be understood as “a series of actions occurring in a social context in which individuals living in ordered relationships of roles make decisions about their own welfare on basis of partially shared classifications, values, and knowledge” (Janzen 1987:76). The NEP offers a site and social space for relationships to form and for individuals to find help, whether that is in the form of obtaining clean needles or ability to discuss social inequalities. Ultimately, the NEP is a community where people can address personal and societal problems with drug use, socioeconomic, and racial inequalities.

5.3 Challenges and Self-Care

As I have argued, the needle exchange is influenced by a variety of motivating factors and contains social meaning and value, but despite its significance in outreach workers’ lives, there are also challenges associated with the work. These challenges include dealing with the associated stigma from the work, knowledge that one can provide only so much aid, problems with clients, and being mindful of potentially dangerous situations. Because of these aspects, some express “outreach will get to you.”

To begin with, since NEPs remain politically controversial despite their public health value, at least in conservative areas, there is some associated stigma. Any stigma experienced by outreach workers are characterized as minor acts of “judgment” or “funny looks.” However, they ignore any disdain from others because of their own beliefs in the value of their work and self-confidence. When asked how she deals with stigma, one outreach worker said, “Walk it out. Breathe it out. Hope the person will or people will understand.” Thus, rather than take offense, outreach workers continue to perform harm reduction by recognizing that letting people believe and do what they want is “a part of harm reduction” and “hope they never have someone in their family who is dealing with addiction or homelessness.” The lack of understanding the issues related to drug use often comes from those who are not acquainted with the problem or population; Mike explains this can occur “especially if you’re not talking to a person like me” while others believe “fear has gotten in the way.” As such, outsiders can ‘other’ IDUs and the NEP at large because of the differences and ‘alternative’ lifestyle that becomes socially marked as being inferior or immoral. Heather depicts the difficulties of working with a stigmatized population as,

We’re not dealing with kittens, puppies, and babies. People don’t want to deal with the harsh reality of drug use, of poverty, of mental illness, of survival sex work, of disease, of death. People don’t want to deal with that. People don’t want to deal with homelessness. It is a hard sell. Uh *sighs* we’re working with people that society would rather not work with. And therefore, we are always under something – underfunded, misunderstood, understaffed, but we make it happen.

Therefore, running a NEP can be a “challenge” because of the associated stigma connected with drug use, homelessness, poverty, and other social issues. However, the nonjudgmental harm reduction ideology and belief in the health value of the work prompts outreach workers to continue providing the needle exchange despite the difficulties and potential for instances of stigma.

The challenges of convincing people of the value of the needle exchange include dealing with police officers who consistently drive by the NEP. As previously explained, the legality of exchanging needles is unclear, which makes relationships with the police also unclear but important. One outreach worker noted, “We are finding some friends with badges these days,” but there have been police officers who do not necessarily support the work. For example, several years ago one policeman came by the NEP and started giving clients a hard time and pointing out everyone who he had arrested before. Another time the NEP ended several minutes early because a police car was watching the program. However, no outreach worker has ever been arrested and mostly police cars only drive by and look out their window at the needle exchange. Occasionally a police car, sometimes unmarked, will be parked across the street but has never interfered with the NEP. During one program a police officer stopped her car to inform everyone that she was in the area and to “stay safe.” These relatively good relationships with police officers are important to outreach workers: “You know harm reduction is about relationships so we have to form some relationships with the police.” Relationships with the police include police officers telling outreach workers about certain areas or houses that are filled with used needles that need to be cleaned-up and properly disposed of. Also, outreach workers work with police officers to help them carry Narcan on them since they are often the first responders on a drug overdose scene. Therefore, despite the question of the illegality of exchanging needles, interactions with the police force have been unproblematic.

Another challenge of conducting a needle exchange and working with IDUs is dealing with the fact that not everyone wants help and that ultimately outreach workers are restricted in the amount of help they can provide. An outreach worker explains that “not everyone wants help, but if they come you have to give it to them” while Frank adds that you can never make someone

do something that they do not want. Respecting people's choices is ultimately a principle of the harm reduction ideology that further helps outreach workers from "going crazy" trying and failing to help people who are not ready for it. Along with accepting that not everyone wants help, outreach workers are constrained in their ability to provide assistance, which can be emotionally exhausting. Outreach workers are constrained by their funding and a limited amount of time, which limits the number of needles, Narcan, and other injecting equipment they can distribute. For example, towards the end of the calendar year when the budget becomes low outreach workers need to ensure they have enough needles and supplies to last the remainder of the year. Sometimes this is characterized as being in "crisis mode," but outreach workers continue to "make it happen." Having limited supplies can be a challenge, not only in dealing with clients trying to obtain more needles, but because outreach workers know "there is always need." As previously discussed, the larger neoliberal political and medical system also shapes and restricts the amount of aid outreach workers can provide to clients.

Furthermore, while at the NEP it is not uncommon for there to be confrontations and arguments between clients and other clients as well as clients and outreach workers. Occasionally clients cause trouble for outreach workers. Sometimes clients are angry about not receiving everything they want or merely appear to be in a bad mood. At times clients complain about the number of needles they receive or about the NEP not having the right type of needles they prefer (i.e. size and diameter). For example, during one exchange a man was impatiently waiting for his turn and got into an argument with another client about a couple of dollars she owed him. Then when it was his turn to exchange, he became angry at me after I asked him for his number that is required from every person who is exchanging needles. He also started yelling and complaining to the outreach worker counting and distributing the needles because he wanted

more than what he was supposed to receive and only wanted a particular size. His anger directed towards outreach workers is a common occurrence with this particular client. Clients will also sometimes become agitated if they are not able to receive the food they want. With limited food outreach workers can only handout a certain amount to each individual in order to ensure that everyone who comes receives something to eat. This restriction can result in clients being angry at the outreach workers. For example, at one program juice bottles were handed out, but each client could only receive one. One client asked for a second juice claiming someone else took hers, but she was told she could not receive another one. She started complaining and making a scene until an outreach worker eventually told her she had to leave and that she was “hanging around too much.” After cursing at one of the outreach workers she eventually left. Sometimes clients can insult or be rude to outreach workers for no apparent reason. For instance, one client once yelled at an outreach worker for “breathing all over” him. This example helps to display the potential for unpredictability when working with the clients.

These problems produce momentary disruptions to the NEP before outreach workers either choose to ignore the outburst, continuing with their work, or take control of the situation. Mark says, “You just have to let it go in and out.” Yet, several other outreach workers note the importance of displaying that they are in control of the NEP in order to ensure they are not taken advantage of by clients. For example, one outreach worker uses his “sailor voice” to prevent any further argument or misbehavior, and if clients are causing too many problems he will ask them to leave after they received their services. Sometimes this means that outreach workers threaten to “pick up and leave” or “stop serving you” if clients do not discontinue their negative actions, but this never actually happens. Some of the outreach workers are honest and direct when a client is being difficult stating “you are becoming a problem” or “you are stressing me out.”

Outreach workers will also remind the client that they “come here to help everyone” or yell out “peace and love” to calm everyone down. These small interventions are enough to stop the problem and continue providing the services, but as one outreach worker observes, “You have to be patient man. They [clients] cuss you out one day and the next day they want to hug you.”

As these common problems that clients sometimes generate depict, outreach workers recognize and must deal with the need to always be “aware” in this potentially “dangerous environment.” Frank explains that “you always need to be watching.” Although one outreach worker respects the clients and considers some of them to be “great people,” he also acknowledges that because of their addiction they are “capable of doing anything at any time.” Being aware of the potential dangers does not mean that outreach workers disrespect IDUs, but rather means they are careful to avoid a compromising situation that would not only be negative for themselves but also for the clients. Recognition of the “sickness” that addiction causes is a product of time and experience with doing outreach. As such, outreach workers are cautious but “comfortable” with the environment they work in. For example, both outreach workers and clients need to be careful about their belongings because stealing is a problem. According to Mark, “you can’t trust anyone in Fairview. Anything is up for stealing.” At one NEP a client stole a box of needles, and although outreach workers figured this incident out as the client was about half way down the street, they decided it was over with. However, this situation not only was difficult because the outreach workers were “just there to help,” but there was anger because the situation that enabled the client to be able to steal was ultimately preventable.

More common, minor instances are clients trying to lie about the number of needles they return in order to receive more clean needles. Additionally, sometimes outreach workers need to be sure that problems previously mentioned do not turn into any more serious issues. Although

this does not commonly occur, on occasion a client might make an empty threat under their breath that is interpreted as “just talk,” and although this talk is harmless, outreach workers still must deal with the situation. An instance of such a situation happened at one program where a client was angry about having to wait to receive food. He mumbled under his breath that he could shoot someone, but the outreach worker knew this was not a real threat and handled the situation by joking that “nobody is shooting. There are too many witnesses. You will get it [the food] when it is your turn.” However, the outreach workers are safety conscious and are willing to act accordingly if necessary. For instance, several years ago when the street they were working on became “a little too hot” because of competing gang activity, which resulted in some shootings and killings, the outreach workers changed street locations in order to protect themselves as well as the clients. Thus, outreach workers are relaxed yet aware in their environment in order to avoid any potential dangers or unpredictable behaviors from clients.

Therefore, in dealing with some of these challenges of the work, outreach workers look out and care for one another, which ultimately follows the harm reduction principles. Care for others includes using the harm reduction ideology for mundane and simple acts like reminding each other to drink water on hot days, but also helping deal with problematic clients. For example, when a client was angrily shouting at Marry, another outreach worker told her he would “take care of it” and made the client leave. When another client was causing problems at the food table and “lingering” too long, an outreach worker reminded the client to treat everyone with respect. A final example of this occurred when a client, who has caused many problems in the past, was starting to make unwanted suggestive remarks to me, and another outreach worker told him to stop and leave. After thanking him for his help, he reminded me that we look out for each other. As these examples indicate, outreach workers ensure they care for each other and

help one another deal with problems since avoiding all types of harm for everyone is significant aspect of harm reduction for outreach workers.

However, it is important to note that not only do outreach workers help each other, but sometimes clients will provide support and aid when there is a problematic client causing trouble. The support from clients further helps to exhibit the clients' appreciativeness of outreach workers and the services they provide. For example, when one client was complaining and being rude to the outreach workers who were distributing food, another client apologized for his behavior. When another client was yelling at Abby multiple other clients started intervening on her behalf until the client causing the problem was asked to leave. Also, during one instance a client was yelling and arguing with an outreach worker about needles, another client came over to check on the outreach worker and ask if he needed help. The outreach worker thanked him for his concern, but said he could handle the situation. Thus, care for outreach workers is a valued aspect of the NEP by both outreach workers and clients.

As these challenges of participating in the NEP indicate, outreach workers must be prepared for the unique difficulties associated with the work. This includes having the "right type of mind set" to deal with the potentially difficult behaviors of clients and be willing to prioritize the needs of the clients. However, in order to avoid "burn-out" from the challenges of the work, a level of self-care is necessary and valued by outreach workers. Especially since the "emotional part" of the work often is difficult to detach from, outreach workers note the importance of finding "outlets." For example, some believe that therapy can be helpful while others try to partake in exercise, time with friends, listening to music, or other small activities that are a useful in dealing with stress. These activities are a means to release the "toxic" out of one's system because negative emotions and stresses from the job is depicted as being neither good for one's

family nor clients. Outreach workers recognize, “We have to remember to take care of ourselves. Can’t pour from an empty cup. Can’t take care of anybody else if you don’t take care of yourself.” Ultimately, “self-care is harm reduction.” Heather explains the connection between self-care and harm reduction as, “This work is about baby steps. It’s about incremental change so we also have to use those baby steps, that incremental change, to take care of us. So it is about self-care too.” Again, this refers to a holistic understanding of the harm reduction ideology that includes daily health habits, such as exercising and staying hydrated, which helps to ensure that the emotional aspect of the work does not negatively impact anyone’s life.

Although outreach workers deal with challenges when participating in the NEP that include emotional difficulties, problems with clients, and the potential for danger and unpredictability, ensuring care for each other and self-care is a feature of harm reduction. Ultimately, the NEP is more than just a public health strategy for IDUs, but prioritizes holistic self-care and contains social value and use for outreach workers who conduct the NEP. The NEP provides a social space and community of people that provides support and a nonjudgmental space for discussing and dealing with social issues such as drug problems, poverty, and racial inequalities.

6 Conclusion

In conclusion, the Fairview NEP and its social space represent a complex combination of challenges, motivations, and meaning for outreach workers. The Fairview NEP has the explicit function of providing clean needles and other services to IDUs in the area in order to decrease

their likelihood of contracting HIV, hepatitis B, and hepatitis C and improve their health.

However, the NEP has an implicit and underlying value for the lives of outreach workers who do not use the program to exchange needles, but rather as an opportunity to help the community and as a therapeutic community that provides a supportive environment based on shared experiences.

The holistic application of harm reduction by outreach workers results in the Fairview NEP not just being a public health strategy, but an ideology and lifestyle that is applicable for clients, outreach workers, and community members. As such, the outreach workers do not just use a harm reduction framework to decrease high risk behaviors, but as an approach to all behavior, including daily mundane choices, to ensure the overall health of an individual. This emphasis on a global application of harm reduction relates to a holistic approach to care and disease treatment advocated by anthropologists such as Paul Farmer and Arthur Kleinman. Both Farmer (1999) and Kleinman (1988) not only advocate for the underlying social and structural inequalities that create unhealthy conditions, but the social factors that need to be addressed during care and treatment. As Farmer (1999:182) explains, “we have before us an awesome responsibility – to prevent social inequalities from being embodied as adverse health outcomes.”

This global use of harm reduction means that although there are challenges and difficulties involved with working in the needle exchange, the outreach workers prioritize self-care and care of each other. The outreach workers’ emphasis on respecting everyone and being non-judgmental moreover contributes to the ability for the NEP to function as a social space and therapeutic community. The needle exchange provides a social space for the outreach workers, clients, and community members to congregate and socialize, thereby providing the opportunity to openly discuss and cope with the social issues. These social inequalities include drug use, poverty, and racism in which the NEP can be used as a therapeutic community to receive

attention, support, and empathy with other individuals who have a shared experience and recognize the underlying structural violence. Outreach workers are motivated to participate in the NEP for a variety of reasons based on their backgrounds and life histories, which includes a desire to save lives and to give to the community. However, the social value of the NEP that functions as a therapeutic community becomes an underlying and significant aspect of the Fairview NEP.

These findings on the perspectives, interpretations, and value of the NEP on outreach workers' lives have several larger implications. To begin with, this research indicates that in addition to public health benefits, NEPs contain social value for outreach workers that are important to take into policy considerations and organizational procedures. Also although the literature on harm reduction primarily focuses on high risk behavior, the holistic application of the harm reduction ideology by outreach workers signifies the importance of harm reduction as an attitude and use for mundane behaviors; thus harm reduction is an ideology that is not only used to help IDUs through the act of exchanging needles, but the principle of reducing harm and self-care benefits the lives of outreach workers. Both of these implications illustrate the importance of NEPs allowing anyone to work and volunteer at the programs, and in particular, individuals who have experienced similar life circumstances with the clients they serve. This is because the NEP provides a community of people, social space, and holistic health ideology that ultimately benefits individuals who participate in the needle exchange as outreach workers.

As these social benefits indicate, NEPs may have limitations, but still contains medical and social value that makes them an important public health practice. Although NEPs are a product of neoliberal policies and do not necessarily address larger social problems from a structural perspective, this does not mean that the participants do not understand and discuss the social and

structural inequalities that influence drug use. Nor does it imply that NEPs do not provide benefits for the participants. The outreach workers work within the neoliberal social context to promote their ideology of the human right to health as best they can. While noting the limitations of NEPs, this research argues that the Fairview NEP does provide significant social value as a community of people and therapeutic space for those who choose to participate in the needle exchange whether they are outreach workers or clients.

As such, NEPs are an important public health strategy that reduces the spread of blood borne diseases, but they moreover contain significant social meaning and benefits for outreach workers. The Fairview NEP is a social space used by outreach workers to save lives and help others, but also functions as a therapeutic community to address and discuss social inequalities that they have experienced or observe in Fairview. The outreach workers' holistic definition of harm reduction translates into prioritizing the safety and health of their clients, themselves, and community members. The Fairview NEP thus not only contains public health value, but has social meaning, implications, and significance for the lives of outreach workers.

REFERENCES

- Ahamad, Keith with Kora DeBeck, Cindy Feng, Todd Sakakibara, Thomas Kerr, and Evan Wood
 2014 Gender Influences on Initiation of Injecting Drug Use. *The American Journal of Drug and Alcohol Abuse* 40(2): 151-156.
- Baer, Hans A. with Merrill Singer and Ida Susser
 2003 *Medical Anthropology and the World System*. 2nd edition. Westport: Praeger.
- Baer, Hans A. with Merrill Singer and Ida Susser
 2013 *Medical Anthropology and the World System: Critical Perspectives*. 3rd edition. Westport: Greenwood
- Baldwin, Kevin with John Speir, Eric Scott, Applied Research Services Inc, and Merrill Norton
 2016 A Brief Window of Opportunity: Heroin in North Fulton County. ARS Report. Atlanta: Office of the Fulton County District Attorney.
- Bernard, Russell
 2011 *Research Methods in Anthropology: Qualitative and Quantitative Approaches*. 5th edition. Lanham: AltaMira Press.
- Biehl, Joao
 2007 Pharmaceuticalization: AIDS Treatment and Global Health Politics. *Anthropological Quarterly* 80(4): 1083-1126.
- Bourgois, Philippe
 2004 U.S. Inner City Apartheid and the War on Drugs: Crack Among Homeless Heroin Addicts *IN Unhealthy Health Policy: A Critical Anthropological Examination*. Arachu Castro and Merrill Singer, eds. Pp. 287-302. Walnut Creek: Altamira Press.
- Bourgois, Philippe and Jeff Schonberg
 2009 *Righteous Dopefiend*. Berkeley: University of California Press.
- Bousquet, Steve and Michael Auslen
 2016 Florida leads U.S. in New HIV Cases after Years of Cuts in Public Health. *Miami Herald*, January 22.
- Broach, Janice
 2016 Heroin Overdose: An Epidemic in Memphis. *Wmcactionnews5*, October 19.
- Burnet, Jennie E.
 2012 *Genocide Lives In Us: Women, Memory, and Silence in Rwanda*. Madison: The University of Wisconsin Press.

Burrows, Dave

2012 A Brief, Personal History of Harm Reduction Advocacy. *IN* Harm Reduction in Substance Use and High-Risk Behavior: International Policy and Practice. Richard Pates and Diane Riley, eds. Pp. 49-58. Oxford: Wiley-Blackwell.

Care Resource. "HIV/AIDS Statistics." 2017. <http://www.careresource.org/hiv aids/statistics/>.

Carr, Summerson

2009 Anticipating and Inhabiting Institutional Identities. *American Ethnologist* 36(2): 317-336.

Carr, Summerson

2011 Scripting Addiction: The Politics of Therapeutic Talk and American Sobriety. Princeton: Princeton University Press.

Carter, Adrian with Peter G. Miller and Wayne Hall

2012 The Ethics of Harm Reduction. *IN* Harm Reduction in Substance Use and High-Risk Behavior: International Policy and Practice. Richard Pates and Diane Riley, eds. Pp. 111-123. Oxford: Wiley-Blackwell.

CDC "A Summary of State Community Health Worker Laws." State Law Fact Sheet. Centers for Disease Control and Prevention June, 2013.

CDC "Drug Overdose Deaths in the United States Continue to Increase in 2015." Centers for Disease Control and Prevention. December 16, 2016. <https://www.cdc.gov/drugoverdose/epidemic/>.

CDC "HIV and Injection Drug Use in the United States." Centers for Disease Control and Prevention. October 27, 2015. <http://www.cdc.gov/hiv/risk/idu.html>.

Choo, Hae Yeon and Myra Marx Ferree

2010 Practicing Intersectionality in Sociological Research: A Critical Analysis of Inclusions, Interactions, and Institutions in the Study of Inequalities. *Sociological Theory* 28(2): 129-149.

Colvin, Christopher J. and Alison Swartz

2015 Extension Agents or Agents of Change? Community Health Workers and the Politics of Care Work in Postapartheid South Africa. *Annals of Anthropological Practice* 39(1): 29-41.

Cooper, Amy

2015 What Does Health Activism Mean in Venezuela's Barrio Adentro Program? Understanding Community Health Work in Political and Cultural Context. *Annals of Anthropological Practice* 39(1): 58-72.

Corrigan, Patrick W. with Amy C. Watson, Gabriela Gracia, Natalie Slopen, Kenneth Rasinski, and Laura L. Hall

2005 Newspaper Stories as Measures of Structural Stigma. *Psychiatric Services* 56(5): 551-556.

Crenshaw, Kimberle

1993 Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color. *Stanford Law Review* 43: 1241-1299.

Dilger, Hansjorg with Susann Huschke and Dominik Mattes

2015 Ethics, Epistemology, and Engagement: Encountering Values in Medical Anthropology. *Medical Anthropology* 34(1): 1-10.

Elliott, Denielle

2014 Debating Safe Injecting Sites in Vancouver's Inner City: Advocacy, Conservatism and Neoliberalism. *Contemporary Drug Problems* 41: 5-40.

Estrada, Antonio L.

2002 Epidemiology of HIV/AIDS, Hepatitis B, Hepatitis C, and Tuberculosis Among Minority Injection Drug Users. *Public Health Reports* 117: 126-134.

Farmer, Paul

1999 *Infections and Inequalities: The Modern Plagues*. Berkeley: University of California Press.

Farmer, Paul

2004 An Anthropology of Structural Violence. *Current Anthropology* 45(3): 305-325.

Fisher, William F.

1997 Doing Good? The Politics and Antipolitics of NGO Practices. *Annual Review Anthropology* 26: 439-464.

Foucault, Michel

1977 *Discipline and Punish: The Birth of the Prison*. New York: Random House, Inc.

Goffman, Erving

1963 *Stigma: Notes on the Management of Spoiled Identity*. Englewood Cliffs: Prentice-Hall.

Gowan, Teresa with Sarah Whetstone and Tanja Andic

2012 Addiction, Agency, and the Politics of Self-Control: Doing Harm Reduction in a Heroin Users' Group. *Social Science & Medicine* 74: 1251-1260.

Greenspan, Jesse A. with Shannon A. McMahon, Joy J. Chebet, Maurus Mpunga, David P. Urassa, and Peter J. Winch

2013 Sources of Community Health Worker Motivation: A Qualitative Study in Morogoro Region, Tanzania. *Human Resources for Health* 11(52).

Hall, James N.

2014 Drug Abuse Trends in Miami-Dade and Broward Counties, South Florida: June 2014. Proceedings of the Community Epidemiology Work Group, June 2014:1-21.
<https://www.drugabuse.gov/sites/default/files/miami2014.pdf>.

Hedden, Sarra L. with Joel Kennet, Rachel Lipari, Grace Medley, Peter Tice, Elizabeth A.P. Copello, Larry A. Kroutil, Peter Tice, and David Hunter

2014 Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health. *Center for Behavioral Health Statistics and Quality*: 1-37.

Hunt, Neil

2012 Recovery and Harm Reduction: Time for a Shared, Development-Oriented, Programmatic Approach? *IN Harm Reduction in Substance Use and High-Risk Behavior: International Policy and Practice*. Richard Pates and Diane Riley, eds. Pp. 155-170. Oxford: Wiley-Blackwell.

Janzen, John M.

1987 Therapy Management: Concept, Reality, Process. *Medical Anthropology Quarterly* 1(1): 68-84.

Kass, Arielle

2016 Fulton County, Atlanta Fighting Heroin Epidemic. *The Atlanta Journal-Constitution*, April 7.

Kelley, Margaret S. with Howard Lune and Sheigla Murphy

2005 Doing Syringe Exchange: Organizational Transformation and Volunteer Commitment. *Nonprofit and Voluntary Sector Quarterly* 34(3): 362-386.

Kleinman, Arthur

2013 From Illness as Culture to Caregiving as Moral Experience. *The New England Journal of Medicine* 368(15): 1376-1377.

Lehmann, Uta and David Sanders

2007 Community Health Workers: What do we Know about Them? The State of the Evidence on Programmes, Activities, Costs and Impact on Health Outcomes of using Community Health Workers. *World Health Organization*: 1-34.

Link, Bruce G. and Jo C. Phelan

2001 Conceptualizing Stigma. *Annual Review Sociological* 27: 363-385.

Maes, Kenneth

2012 Volunteerism or Labor Exploitation? Harnessing the Volunteer Spirit to Sustain AIDS Treatment Programs in Urban Ethiopia. *Human Organization* 71(1): 54-64.

Maes, Kenneth

2015 Community Health Workers and Social Change: An Introduction. *Annals of Anthropological Practice* 39(1): 1-15.

Maes, Kenneth and Ippolytos Kalofonos

2013 Becoming and Remaining Community Health Workers: Perspectives from Ethiopia and Mozambique. *Social Science and Medicine* 87: 52-59.

Middelthon, Anne-Lise

2005 A Room for Reflection: Self-Observation and Transformation in Participatory HIV Prevention Work. *Medical Anthropology Quarterly* 19(4): 419-436.

Miller, Andy

2016 'Needle Exchanges' Still Left out of State's Anti-HIV Fight. Georgia Health News.

Moss, A.R.

2000 Epidemiology and the Politics of Needle Exchange. *American Journal of Public Health* 90(9): 1385-1387.

Musick, Marc A. with John Wilson and William B. Bynum Jr.

2000 Race and Formal Volunteering: The Differential Effects of Class and Religion. *Social Forces* 78(4): 1539-1570.

NBC6

2016 1 Opioid Overdose Each 2 Hours in South Florida Epidemic: Law Enforcement Officials. September 22. <http://www.nbcmiami.com/news/local/1-Opioid-Overdose-Each-2-Hours-in-South-Florida-Epidemic-394510411.html>.

Norris, Adele N. with Yvette Murphy-Erby and Anna M. Zajicek

2007 An Intersectional Perspective in Introductory Sociology Textbooks and the Sociological Imagination: A Case Study. *Race, Gender & Class* 14(1): 333-344.

Oni, Adé and Hyun Namkoong

2015 A Syringe Exchange Love Story with Atlanta Harm Reduction Coalition. Atlanta: North Carolina Harm Reduction.

Ortner, Sherry B.

2006 *Anthropology and Social Theory: Culture, Power, and the Acting Subject*. Durham: Duke University Press.

Page, Bryan J.

2010 Needle Exchange and Reduction of Harm: An Anthropological View. *Medical Anthropology* 18(1): 13-33.

Pates, Richard with Robert Heimer and Danny Morris

2012 Injecting. *IN Harm Reduction in Substance Use and High-Risk Behavior: International Policy and Practice*. Richard Pates and Diane Riley, eds. Pp. 135-154. Oxford: Wiley-Blackwell.

Puckett, Mechelle

2014 Mobility in the Neoliberal City: Atlanta's Left Behind Neighborhoods. Masters Thesis, Department of Geosciences, Georgia State University.

Ramirez-Valles, Jesus

2001 "I Was Not Invited to be a [CHW]...I Asked to be One": Motives for Community Mobilization Among Women Community Health Workers in Mexico. *Health Education and Behavior* 28(2): 150-165.

Rhodes, Tim with Merrill Singer, Philippe Bourgois, Samuel R. Friedman, and Steffanie A. Strathdee

2005 The Social Structural Production of HIV Risk Among Injecting Drug Users. *Social Science & Medicine* 61: 1026-1044.

Rich, JD with M McKenzie, GE Macalino, LE Taylor, S Sanford-Colby, F Wolf, S McNamara, M Mehrotra, and MD Stein

2004 A Syringe Prescription Program to Prevent Infectious Disease and Improve Health of Injection Drug Users. *Journal Of Urban Health* 81(1): 122-134.

Riley, Diane with Richard Pates, Geoffrey Monaghan, and Patrick O'Hare

2012 A Brief History of Harm Reduction. *IN Harm Reduction in Substance Use and High-Risk Behavior: International Policy and Practice*. Richard Pates and Diane Riley, eds. Pp. 5-16. Oxford: Wiley-Blackwell.

Roe, Gordon

2005 Harm Reduction as Paradigm: Is Better than Bad Good Enough? The Origins of Harm Reduction. *Critical Public Health* 15(3): 243-250.

Rudd, R.A. with N. Aleshire, J.E. Zibbell, and R. Matthew Gladden

2016 Increases in Drug and Opioid Overdose Deaths – United States, 2000 – 2014. *American Journal of Transplantation* 16: 1323-1327.

Shapatava, Ekaterine with Kenrad E. Nelson, Tengiz Tsertsvadze and Carlos del Rio

2005 Risk Behaviors and HIV, Hepatitis B, and Hepatitis C Seroprevalence Among Injection Drug Users in Georgia. *Drug and Alcohol Dependence* 82(1): 35-38.

Shaw, Susan and Merrill Singer

2003 Communities in Conflict: The Struggle for AIDS Prevention. *Practicing Anthropology* 25(3): 32-36.

Singer, Merrill

1995 Beyond the Ivory Tower: Critical Praxis in Medical Anthropology. *Medical Anthropology Quarterly* 9(1): 80-106.

Singer, Merrill

2004 Why is it Easier to Get Drugs than Drug Treatment in the United States? *IN Unhealthy Health Policy: A Critical Anthropological Examination*. Arachu Castro and Merrill Singer, eds. Pp. 287-302. Walnut Creek: Altamira Press.

Singer, Merrill

2006 Something Dangerous: Emerging and Changing Illicit Drug Use and Community Health. Long Grove: Waveland Press.

Small, Deborah

2001 The War on Drugs is a War on Racial Justice. *Social Research* 68(3): 896-903.

Stutterheim, Sarah E. with Ronald Brands, Lilian Lechner, Ineke Baas, Hilde Roberts, Jeannot Schmidt, Gerjo Kok, and Arjan E.R. Bos

2016 Stigma Experiences Among Substance Users with HIV. *Stigma and Health* 1(3): 123-145.

Van Der Geest, Sjaak

2003 Confidentiality and Pseudonyms: A Fieldwork Dilemma from Ghana. *Anthropology Today* 19(1): 14-18.

Wutich, Amber with Alissa Ruth, Alexandra Brewis, and Christopher Boone

2014 Stigmatized Neighborhoods, Social Bonding, and Health. *Medical Anthropology Quarterly* 28(4): 556-577.