

Sharps Containers are Red, Tourniquets are Blue: Harm Reduction's Abridged History and an Ethnography of Contemporary Programs

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Executive Summary

Harm reduction for drug use is a decades-old philosophy and practice with a rich history of improving the lives of people who use drugs (PWUDs) that continues to this day. However, **the people who provide and receive these services have largely been written out of academic narratives, and many contemporary programs struggle to prove their effectiveness to institutional bodies and secure consistent funding.** I learned about the existence of harm reduction from my time volunteering in high school with a local syringe service program (SSP), a type of harm reduction program (HRP). The program was called Portland People's Outreach Project (PPOP); through volunteering, I saw firsthand the positive impact harm reduction supplies and services had on the people who received them. As I volunteered with PPOP, I created, packaged, and delivered medical harm reduction supplies, biking them around Portland, Oregon in the late hours of the night, or on weekends by car. I also learned how to save people's lives and established close relationships with current and former PWUDs I both worked with and served. Unfortunately, I also saw the pervasive, crippling effects of various intersectional issues affecting many PWUDs with whom I interacted. In the words of Haruki Murakami in his book *1Q84*, which I learned from my thesis advisor, "*Violence does not always take visible form, and not all wounds gush blood*" (Morimoto 2022:1). Harm is not always biomedically or physically apparent.

During this time, I learned from my peers that **listening to and highlighting the voices of people involved in the harm reduction community directly affected by systemic discrimination, structural violence, and other harms, was an important first step to combatting the harm they experienced.** This form of research is essential because it allows people directly experiencing harm to **advocate for their needs and receive care** when they have been historically disenfranchised or deemed unworthy of care. **My thesis project is the first piece of social scientific scholarship highlighting community-identified priorities in harm reduction, which I determined by listening to the people directly involved with harm reduction practice.** I also examine harm reduction as a community and a framework rather than a solution to a problem.

The goal of my thesis project was to bridge the gap between the academic community and the harm reduction community, so I used the resources at my disposal to translate the needs of PWUDs into academic literature. To do so, I conducted unstructured interviews and conversations with organizational volunteers and workers while volunteering at four HRP field sites across the United States. I also spoke with a harm reduction advocate from the National Harm Reduction Coalition (NHRC), a nationwide advocacy organization for PWUDs based in New York State. In addition to learning on the ground, I conducted archival research, examined interdisciplinary research about harm reduction and its related fields, and engaged in ethnographic fieldwork.

This report is intended to teach people about harm reduction and address the closely related, community-identified issues faced by contemporary HRPs. My ethnography mobilizes individual stories to address greater structural forces involved in **the erasure of harm reduction's history, HRP difficulties accessing funding, incongruencies between practice and scientific evaluation, and a lack of attention to the care people provide one another.** By the end, I hope that readers will be

able to see the complex struggles contemporary programs face and recognize the importance of listening to PWUDs and community members. It is only then that we can take seriously the priorities they envision. Ultimately, my research demonstrates that **HRPs – especially those serving people who inject drugs (PWIDs) and providing drug paraphernalia – undertake an important service worth highlighting and fighting for in the social and policy spheres. To affirm this, Princeton can itself reduce harm through the implementation of and partnership with HRPs and related services; the Federal government can adjust its criteria for providing harm reduction funding.**

Information About Harm Reduction

What is *harm reduction*? According to anthropologist J. Bryan Page, harm reduction is an **“attempt to remove the primary sources of damage from behaviors suspected to cause problems with health”** (Page 1997:18), **without eliminating the behaviors themselves.** This definition can encompass many different types of harm and ways to reduce it, but the most common use of the term harm reduction is in regard to **drug use.** Because there are many different drugs that can be used (e.g. alcohol, marijuana, cocaine, methamphetamine, opioids, psychedelics, etc.), and a variety of ways that these drugs can be consumed (e.g. ingesting, smoking, snorting, injecting, inserting anally, etc.), **harm reduction encompasses a wide variety of approaches to many different issues affecting PWUDs.** These supplies and services can reduce biomedical harm (e.g. the spread of disease, death from overdose, or bodily harm), reduce the harms of structural and direct violence, and empower PWUDs to live their best lives. Most importantly, harm reduction philosophies help people by ‘meeting them where they’re at’, increasing their health and happiness as much as possible, and allowing people to choose their own strategies to improve their own lives.

Harm reduction supplies allow people to **use drugs more safely, and address the intersectional and diverse struggles PWUDs face.** These include but are not limited to

- Safer **Injection** Supplies¹
- Safer **Snorting** Supplies²
- Safer **Smoking** Supplies³
- Safer **Boofing** (consuming drugs through the anus) Supplies⁴
- **Overdose Prevention** Supplies⁵
- **Other** Supplies⁶

There are also ***harm reduction services.*** These may include HIV, hepatitis C, and STD testing, safe disposal for used needle syringes, case management, bathroom access, dispensing PrEP and PEP (pre-and post-exposure prophylaxis for HIV), naloxone training, wound treatment, supervised drug consumption, outreach (providing services and supplies out in a community rather than allowing

¹ e.g. sterile needle syringes, tourniquets, sterile water ampoules, sterile cotton balls, ‘cookers’, cooker handles, etc. Cookers are vessels where people ‘cook’ their drugs to prepare them for injection.

² e.g. sterile scoops for transferring powdered drugs, sterile plastic razor blades for snorting line formation, sterile surface cards off of which drugs can be snorted, sterile water for nasal aftercare, etc.

³ e.g. sterilizable or single-use bubble pipes (glass pipes with spherical bulbs which can be used for smoking methamphetamines) and hammer pipes (a type of pipe created so people can smoke heroin instead of injecting), filters, steel wool, etc.

⁴ e.g. sterile syringes, sterile water ampoules, cookers, etc.

⁵ e.g. intramuscular or nasal spray naloxone (an opioid antagonist medication that can reverse overdoses), fentanyl test strips, etc.

⁶ e.g. sharps containers (for safely storing used needle syringes), warm weather clothing, safer drug use information pamphlets, safer sex supplies (e.g. lube, condoms, or dental dams), wound care supplies (e.g. bandaids, gauze, triple antibiotic ointment, benzalkonium wipes, etc.), hygiene products, warm food, coffee, potable water, etc.

people to pick them up from a fixed location), Medication Assisted Treatment (MAT, a treatment for opioid use disorders by way of long-acting opioids methadone and buprenorphine, or naltrexone, an opioid inhibitor; all are often used in combination with behavioral therapy or counseling), and more.

Every HRP is different; programs **ask PWUDs what they need** at a given moment, and examine community-wide needs in real-time **instead of assuming their needs or imposing particular beliefs.**

Methods

Scholarly research: Using existing scholarly articles about harm reduction in combination with research in various disciplines such as medical anthropology and sociology, history of science, biomedical and scientific studies, American studies, epidemiology, philosophy, drug policy, psychology, public health, and historical narratives, I developed a literature review examining and critiquing the state of current academic literature affecting harm reduction in both its philosophy and practice.

Archival research: I examined existing obituaries, op-eds, posters, magazine articles, and biographies of major figures historically and currently involved with the harm reduction movement in order to re-examine harm reduction's history not included in mainstream academic histories, articles, and studies.

Ethnographic fieldwork: I spoke with organizational volunteers and workers, and examined existing facilities and practices at the following HRPs⁷ around the United States:

- ★ **Portland People's Outreach Project (PPOP)** in Portland, Oregon
- ★ **The People's Harm Reduction Alliance (PHRA)** at the University District and Aurora in Seattle, Washington (also serving King and Kitsap Counties in Greater Washington)
- ★ **Alaskan AIDS Assistance Association (Four As)** in Anchorage and Juneau, Alaska, and its corresponding mobile **Four As Syringe Access Program (FASAP)**
- ★ *A fourth American HRP, which has been **anonymized** for the safety and privacy of the people affiliated with the organization.*

HRP Volunteer work: I volunteered with all four of the above organizations: my work involved providing PWUDs with harm reduction supplies and services, conducting outreach, and creating kits of safer drug use supplies. I also corresponded with several volunteers and workers over direct messages, texting, and email about logistical information.

Interview with Shannon Curry-Izzo: I conducted a three-hour informal interview over Zoom with Shannon, the current Training and Content Development Coordinator of the NHRC who is a harm reduction advocate with over 10 years of experience in providing care to PWIDs, working in mental health counseling and behavioral health clinics, and practicing harm reduction.

Findings

While conducting my fieldwork and research, I discovered **three key issues that negatively impact the ability of contemporary HRPs to function effectively.**

⁷ Because I learned during my fieldwork that SSPs and organizations serving PWIDs are constantly under high levels of scrutiny, I ensured that every program I attended served PWIDs and offered needle syringe services.

Observed Issue #1: *There is inadequate documentation of people practicing harm reduction in academic literature, which prevents it from being taken seriously. The following are reasons why:*

1. Institutional Review Boards (IRBs) define PWUDs as a vulnerable class, preventing them from engaging in research. I initially pursued a project speaking with PWUDs receiving services, and Princeton’s IRB determined that my “recruitment [process] may be coercive”⁸ because of PWUDs’ inability to consent. I told Shannon about my inability to interview them; she argued that the idea that PWUDs are always “sick” or “under the influence” was “categorically false”.

2. People often engage in harm reduction in order to survive – which can be dangerous – and are thus unable to document their own history due to a lack of time, bandwidth, or resources.

- “There are people who can and who do and who will make big contributions to their communities, and do so under total loss of social capital, arrest, and livelihood, but they’ve still done it anyways. People were dying and someone had to do something” – Shannon, NHRC
- “We were the first group in Portland that started handing out meth pipes...we didn’t know if it was legal, but we didn’t care” – Tabs, PPOP volunteer
- “When I was doing harm reduction, I was doing illegal stuff 10 times a day” – Anonymous

3. Academic whitewashing is a visible symptom of violence against harm reduction communities, manifesting as a lack of attention, and sometimes erasure along the lines of race, gender, and class. Whitewashing also obscures the violence enacted against communities practicing harm reduction; anthropologist Helena Hansen articulates that this whitewashing formed the present opioid ‘crisis’, which is labeled as such because of its effect on white futures (Hansen 2017). Because of the pervasive nature of whitewashing, Shannon argued that it affects the harm reduction community as well, stating that “harm reduction is not immune to institutional racism”. Many of the figures people in the community spoke with me about were white, male, and cisgender, even if people with these identities might experience more physical violence (Page 1997; Muehlmann 2018).

4. PWUD voices are discredited or excluded. Harm reduction community history is often oral, and not written down⁹; Shannon says “Harm reduction is oral history that hasn’t been put to paper yet”. This type of ephemeral evidence is in opposition to the uniformity expected of academic literature, even if the mutual exchange of information within the community keeps knowledge and people alive. Activist Allan Clear attempted to write down the history of syringe exchange for an academic journal but was constrained to 1,500 words. When he chose to use the word count to address governmental obstacles faced by contemporary HRPs, reviewers called his work “sloppy” and “biased” (Clear 2010a:2) when he chose to not address broader history or science. Reviewers did not address his lack of formal academic training. He argued, “Activism, and in particular the role of drug users within the activist community, will be written out of the history as only ‘balanced’ or ‘nuanced’ versions are constructed and published” (3).

5. There is a general stigma against PWUDs and drugs in general. Shannon told me that “some people could not be associated with the movement”; this was because high levels of stigma against this type of work and against drugs more generally prevented certain people from being publicly involved. Thus, many people’s ability to contribute was dictated by the policies and laws of the times and places they were involved. In addition to the consequences of whitewashing, Shannon said “There are so many people doing legwork that you are never going to know about”.

⁸ This is related to Section 11, Question 14 about consent, which asks whether research subjects will be cognitively impaired.

⁹ Sometimes for reasons listed in #1.

Observed Issue #2: *HRPs have difficulty obtaining funding and lack governmental recognition.*

Shannon claims, “Harm reduction has historically not been taken seriously”, while Alaskan harm reduction practitioner Venus claims, “Harm reduction is kind of a buzzword right now...especially now that more people have a grasp of what it is”. These two positions are not contradictory; **I argue that there are major discrepancies between the U.S. Federal Government’s definition of harm reduction, and what true community-based harm reduction is. This in part has to do with the lack of academic recognition of HRPs and harm reduction in general.** Below, I will demonstrate key differences between the two approaches that I found during my research and learned from my interlocutors.

Community-Based Harm Reduction	U.S. Governmental Harm Reduction
A decades-old community-identified strategy to care for others	A ‘novel’ solution to treat the opioid crisis after a milestone of 100,000 deaths (SAMHSA n.d.:1), addressing white futures (Hansen 2017).
Based on a model of ‘meeting people where they’re at’, addressing unique needs without “proselytizing or evangelizing towards recovery” - Tabs	Focused on addressing “substance abuse disorders through prevention [of drug use], treatment [of drug users], and recovery” (SAMHSA n.d.:1); stopping drug use is an end goal
Paraphernalia that allows for safer drug use (as mentioned in “Information About Harm Reduction”) are provided if people want it	Drug paraphernalia (e.g. needle syringes, pipes, etc.) may not be provided under any circumstances in accordance with a 1988 federal ban, which prevents enabling of drug use (Raymond 2015)
Services typically provided in-house	Services are primarily information-based (i.e. “ensure linkage”, "Referral to", "Provision of education", or "Provision of information" (SAMHSA n.d.:4), as well as naloxone, fentanyl test strips, and MAT
Funded by donors, counties, states, or private organizations	Funded via a federal “Harm Reduction Grant” given to 25 organizations by the Substance Abuse and Mental Health Administration (SAMHSA)
Harm reduction must be community-engaged and run by people receiving the services	“State, local, Tribal, and territorial governments, Tribal organizations...primary and behavioral health organizations” (SAMHSA n.d.:3) can all receive harm reduction funding
Syringe services save lives and allow people to be healthier	Syringe services enable drug use (Raymond 2015), which is illegal; governmental information about drug use is sometimes influenced by “half-truths” (Clear 2010b:2) residual from the War on Drugs
(H)arm (R)eduction: “A philosophical and political movement focused on shifting power and resources to people most vulnerable to structural violence” (NHRC 2020:2)	(h)arm (r)eduction: “The approach and fundamental beliefs in how to provide the services” (2), based on distribution goals

I learned that syringe services are an integral part of most HRPs. Thus, **the Federal Government does not subsidize a form of essential harm reduction supply.** Without subsidization, there are organizations that do not have the resources to purchase them on their own; one volunteer spoke of their organization by stating, “We’re poor and we need money”. When organizations could not supply PWIDs with sterile needle syringes, I saw this cause people to risk their health and assume bodily harm, which affected their ability to live healthy, meaningful lives. **This in turn affects harm reduction’s ability to continue as an effective practice since its continuation requires the work of PWUDs.** This cycle damages harm reduction as a whole and hurts the people who benefit from it the most. Ultimately, **my ethnography demonstrates organizations cannot claim to support true harm reduction without accepting drug paraphernalia as an integral tool for safer drug use.**

Observed Issue #3: *Harm reduction is often perceived as scientifically or biomedically ineffective.*

1. **There is a difference between efficacy (ideal, trial conditions) and effectiveness (real-world outcomes).** Harm reduction demonstrates *effectiveness* (i.e. I saw many people who felt good about

the services they received), but **its efficacy cannot always be measured**. For example, harm reduction strategies cannot be tested via a randomized controlled trial, the current scientific ‘gold standard for *efficacy*’ (Adams 2013), and some HRP strategies, like outreach, have “no controlled trials” at all (Ritter and Cameron 615).

2. Perceived efficacy is often influenced by cost-effectiveness, but even if harm reduction is cost-effective, it is not recognized as such. The CDC-backed Many Men, Many Voices is an HIV prevention retreat costing \$6,840 for 15 people, where its cost-effectiveness is touted as an essential part of its efficacy (CDC 2010); undiscounted lifelong HIV treatment is \$597,300 for 1 person (NIH 2023). SSPs have been proven to reduce HIV (Ritter and Cameron 2006; Yale Medicine Magazine 2001), and the combined annual budget of the 120 SSPs in the U.S. in 2008 was \$21.3 million (Raymond 2015:3). Considering that “preventing a single HIV saves roughly \$230,000 in lifetime medical expenses” (3), **SSPs’ yearly budget costs were similar to treatment for only 100 people.**

3. Historical conditions also affect perceived efficacy. Alcoholics Anonymous (AA) is a well-known, abstinence-based intervention with a solid footing in scientific addiction discourse; it has been expanded to address other drug use even if it is not medical. AA came into existence in the 1930s, a time when verifiable control-trial evidence for medical interventions was not the norm (Armstrong-Hough 2018). In combination with negative perceptions of drugs, this allowed it to gain popularity and acceptance. Today, studies demonstrate that AA has historically been understood (in both society and medicine) to have just as much if not more effect than other biomedical interventions, especially in regard to the phenomenon of ‘hitting bottom’ (Kirouac and Witkiewitz 2017), the idea that hitting rock bottom is a necessary part of the recovery process. Many harm reduction advocates criticize AA and related programs for being too punitive. AA has perceived *efficacy* but is not always effective; its success rate may only be 5 to 8% (Glaser 2015:7).

4. Funding difficulties actually hinder the ability of HRPs to be effective. My interlocutors told me that only providing needle syringes when people return used ones was less effective than providing them on the basis of need. At Four As in Anchorage, the organization received funding from an organization (Mat-Su Foundation) on the condition that it would only use the funding for a particular valley region and not in the City of Anchorage. As a result, the organization may be hindered in its ability to provide universally effective care to the regions it serves.

Conclusion

One solution I advocate in this ethnography is to **pay attention to effectiveness; how people feel**, especially those who may be considered undeserving under scientific and legal regimes. I extensively documented the care occurring at HRPs and in the harm reduction community as I conducted my fieldwork. My work demonstrates that this is one of **harm reduction’s greatest strengths if not the very thing driving its effectiveness**. I saw countless times that actors within the harm reduction community were able to identify the profound effects of reciprocal care. **Translating this effectiveness and the important care work HRPs do for their communities into an academic narrative may allow others to appreciate it as well, which may in turn increase institutional recognition, funding security, and the ability for harm reduction history to be recorded.** Because issues related to historical erasure, funding difficulties, and efficacy debates intensify one another, it is crucial to recognize their intertwined nature when tackling them. Using ethnographic fieldwork allowed me to see this while simultaneously amplifying the perspectives volunteers and PWUDs continue to fight for every day. This project is just the beginning: adding this work to academic harm

reduction discourse will hopefully allow some of these cycles to be broken within my lifetime. **Harm reduction saves lives.**

Recommendations at Princeton

1. Reevaluate IRB glossary and consider prioritizing the inclusion of PWUDs in research: In order to make successful community-engaged programs possible, the University must be open to the possibility of engaging with PWUDs in an ethical way. I recommend that the **Princeton IRB Human Research Committee reevaluate its definition of “cognitively impaired” in its Glossary of Terms in consultation with PWUDs and members of the harm reduction community**¹⁰. **I advocate this definition must be clarified with new criteria such that PWUDs are not perpetually unable to consent** so they can make valuable contributions to academic research if given the opportunity. This revision will allow researchers interacting with harm reduction communities to prioritize research helping PWUDs in accordance with new criteria set forth by people directly affected by the research. **I also recommend that Princeton urge other institutions to do the same.**

2. ProCES & SSP partnership: I learned through my fieldwork that a large number of HRPs – especially SSPs – are underfunded and lack institutional recognition, which prevents people from receiving lifesaving services. To give back to the local community, **I propose that ProCES form a partnership with a pre-existing SSP focused on providing (H)arm (R)eduction** – “A philosophical and political movement focused on shifting power and resources to people most vulnerable to structural violence” (NHRC 2020:2) – **with my guidance** so I can advise program coordinators on how best to work with the organization and provide students with opportunities¹¹.

3. Princeton Naloxone Access: In order to reduce the stigma around drug use and prioritize the safety of students and the surrounding community, **Princeton should make naloxone a resource that students can access on campus**¹².

4. Exercise Care: I ask that future ProCES programming be **kind and mindful of the language used to describe PWUDs and PWIDs** served by Princeton-affiliated programs (e.g. **avoiding using terms like addict, junkie, druggie, etc.**). I learned from volunteers like Tabs that **care and attention to people are sometimes just as effective and life-saving as the supplies and services themselves.**

Policy Recommendations

1. Reexamine the ban on federal funding for SSP safer use paraphernalia: The 1988 ban on the use of federal funding for drug paraphernalia is a major factor affecting the ability of HRPs to continue providing effective care to PWUDs in terms of manpower and financial resources. **I urge government officials to reexamine the undue burden of this ban on HRPs and pay attention to**

¹⁰ At present, the definition states, “Persons under the influence of or dependent on drugs or alcohol...may also be compromised in their ability to make decisions in their best interests”, which limits the possibility of collaboration with community partners that could provide new, fruitful research opportunities.

¹¹ The current closest HRP to Princeton is **a mobile outreach program called Operation in My Back Yard, based out of Kensington, PA, 40 minutes away from campus.** I would prefer to support less-well-funded organizations in New Jersey and Pennsylvania as opposed to New York City, as five organizations there received federal money from SAMHSA; the city itself also received funding. If this approach is not feasible, I am willing to work with ProCES to organize a Princeton-based HRP or SSP, which can be done using resources from the North American Syringe Exchange Network.

¹² To prevent further naloxone shortages, I also **request that Princeton be mindful of the needs of organizations specifically created to help PWUDs** (i.e. HRPs, SSPs, community naloxone banks) and **deliver naloxone to students via a request system**, as opposed to a hand-out system which may encourage stockpiling and the provision of naloxone to people who will not use it.

the organizations’ community-identified effectiveness as a motivator for overturning the ban. Hopefully, this will allow the government to prioritize SSPs in future funding allocations.

2. *Federal adoption of (H)arm (R)eduction*

PWUDs are a diverse group of people, and I believe that ‘meeting people where they’re at’ must include resources to not just help people use drugs more safely, but to empower them to live better lives. Many HRPs do this, but not all organizations that received federal funding do. The NHRC definition for (H)arm (R)eduction encompasses this, and thus, I recommend that program evaluators for the next federal “Harm Reduction Grant” adopt this definition as a requirement for receiving federal funding.

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