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COMMENTARY

Street-level Research on Street-level Interventions Among Drug Users: Commentary on Papers by Frank et al., Hayashi et al., Small et al., and Domanico and Malta

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The research collected in these four papers does not form a single comparative study across multiple nations. Yet, reading these works together, one cannot help but notice a great consistency among the issues faced by each of the community-based initiatives supporting and protecting drug users even across such different social and political contexts. As well, there are clear trends in the relations between the organizations that emerge from these communities and the state and city agencies with which they most interact. For all of the differences in public health and criminal justice policies, these street-level organizations appear to be in the same boat, trying to address similar problems. What political processes, strategies, and constraints do these similarities reveal?

First, we can see that across national settings, the organizations dedicated to harm reduction, education, and protection among active drug users recognize each other as part of the same social world. Each of the four papers demonstrates how these groups look to one another for support, how they form or join transnational advocacy groups, and how they share information, expertise, and personnel. Simply put, they network. Small et al. (this issue), for example, note that community-led syringe exchange organizations in Vancouver and elsewhere provided the basis for health workers and advocates to create an injection support team in Vancouver. This program soon established a separate governance structure that relied extensively on active and former drug injectors. After a lengthy process of weighing risks and benefits, this community-based organization initiated a model safe injecting program which began operating on the very boundaries of legality which they now, in turn, seek to propagate and reproduce among other communities.

It is also important to note that these community-based networks generally reflect the structures of state-centered national and transnational drug policy institutions that these groups must navigate. That is, as Hayashi et al. (this issue) and Domanico and Malta (this issue) observe, national HIV/AIDS prevention policies have typically improved in terms of condom distribution and safer sex campaigns, but drug use-related interventions are limited by politics and drug wars. Both the improvements in some areas and the limitations in others are related to global networks, both private and public. Health agencies, criminal control agencies, and advocacy organizations for drug users reach across national lines to share information and other resources.

The second point, however, is that for the users themselves, these are very local matters. Drug use may occur anywhere, but tends strongly to concentrate in major urban areas. Even in relatively small nations, and despite rising rural rates of use, one may find visible "communities" of drug users in the cities. Drug distribution, purchasing, and consumption, as well as the medical and social responses to these, are experienced at the neighborhood level. Initiatives to assist and protect the users, therefore, also occur at the neighborhood level, though frequently organized through multi-city and transnational networks of local groups.

Curiously, while the legal and political environments for drug control and harm reduction are nominally defined by states, most of the work done by, for, or against drug user communities occurs either "above" or "below" the nation-state. Domanico and Malta (this issue) describe public harm reduction efforts that are led by international NGOs, while Frank, Anker, & Tammi (this issue) demonstrate the importance of transnational networks of community-based organizations. Yet, as Frank and colleagues also observe, "Many associations are city based rather than national even though they see themselves as working on a national basis."

A third trend concerns the relations between the user organizations and the agencies with which they interact. Across all of the cases, we see that centralized

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efforts at the criminal control of drug use are highly developed, while public health efforts are limited, usually focused on a single strategy, such as methadone maintenance, and restricted in terms of outreach. This leads to a singular, though not terribly surprising, finding: that virtually all of the innovations to protect the health and well-being of drug users and their intimates that are analyzed in these four papers are led by the affected communities themselves. This is not always strictly a matter of self-organizing. For example, Domanico and Malta (this issue) describe how user-led pilot programs for harm reduction among crack cocaine users in Brazil were funded by the Brazilian STD/AIDS and Viral Hepatitis Department but developed and run by users.

There are many reasons why state and city agencies cannot be expected to launch or even necessarily to support the kinds of community-based programs studied in the work described in this commentary. None of the work presented here attempts to explain these conditions in detail. They only note as a starting point that much of the organizing on behalf of drug users occurs at the community level, and that this fact determines the particular strengths and limitations of such groups. Nonetheless, one of the major goals of almost all the organizations in these studies is to connect with the state and city agencies, just as such agencies often rely on community-based groups to go where they cannot. In Vancouver, as described by Small et al. (this issue), both syringe exchanges and the safe infecting programs advocates initiated their work in an unsanctioned, underground fashion, but eventually convinced public health officials to support it.

Some street-level organizations directly challenge laws and policies. Some negotiate for slightly improved access to health care or for an easing of tensions with police. Many of them participate in official policy boards and study commissions, recognized by government as experts on drug use questions. And, importantly, several of the organizations receive funding and other support from government agencies. In all of the cases presented here, such efforts to connect have had partial success. Even in the harshest, most repressive cases, there is some official support for what they do. Likewise, even in the most cooperative institutional setting, there are official limits, negative media attention, sudden funding cuts, and distinct political and law enforcement opposition.

For community-based organizations representing a marginalized and criminalized population, legitimacy may be the key resource to their survival. This is a fourth shared finding. Through their negotiations with agencies, participation in conferences, service on panels, data collection, needs assessments, and more, the various drug user groups attempt to become legitimate collaborators with the institutions that cannot directly do what the community does for itself.

In each of the four cases, the idea of the community in itself, acting for itself, emerges as a defining characteristic. Despite the obvious disadvantages that these groups face due to the extent of their dependence on indigenous resources, they all go to great lengths to demonstrate that they are, in fact, of the community and not brought in from the outside. This, too, is a question of legitimacy, and seemingly a much more important one than the matter of external legitimacy. All of the organizations attempt to collaborate with their "clients" in program planning, service delivery, and research. Most of them routinely hire former or active drug users in outreach, data collection, or peer-to-peer training positions. And most seek to maintain a board of directors or other governance structure in which at least half of the members are of the target community.

Hayashi et al. (this issue) directly address the particular advantages and challenges that come from doing public health work in collaboration with the public. While all of these studies demonstrate the importance of community partners, Hayashi's case study of street-level work in Bangkok reminds us as well of the role of researchers, evaluators, and public health professionals as sources of support for user-led efforts. Of course, programs that seek to maximize the benefits of their embeddedness in their communities must yield a great deal of control over such collaborations to their community partners. Even among community-based organizations, that can be a lot to ask. At a more formal level, this may be a concession that city and state agencies cannot make. Yet, as we have noted, service agencies experience and recognize the same legitimacy concerns in their outreach to drug users. This is a key reason that such agencies often seek to train *former* clients for outreach and some service delivery functions.

The acceptance of the usefulness of peer-based services creates a dilemma for formal agencies who need credibility and access within their target communities, but are bound by administrative requirements. Increasingly, this dilemma creates opportunities for just such community-based organizations as the research reviewed here are studying. To the extent that the community initiatives can gain credibility within government-centered circles, they can vie for service contracts from the state and municipal agencies. State-community collaborations are often perceived as situations in which everyone wins: the community groups receive stable support, and the formal agencies gain street-level access. Yet, the community groups are often hesitant to enter into such agreements. Given the nature of the target population – consumers of illegal drugs – and the needs of this population, much of the work of the community groups is not legal. They can only serve their primary functions by remaining relatively hidden. This is actually the point where this discussion started. Community groups arise in order to do things that formal agencies cannot or will not do.

At present, these four case studies suggest that the most successful programs are the ones that are unofficially tolerated, and therefore not repressed. More than most comparable organizations, community organizations serving such marginal populations, operating on the farthest margins of the law, rely on strong local and transnational networks of other community-based groups, and only weakly on support from government. Along with the users themselves, user groups survive on the resources of their own kind.

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