"What's Your Name? Do You Shoot Drugs?": Power, Risk, and Constructing the 'Client' in a Harm Reduction Program in Odessa, Ukraine

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…it is not the harshness of a situation or the sufferings it imposes that lead people to conceive of another state of affairs, in which things would be better for everybody. It is on the day that we are able to conceive of another state of affairs, that a new light is cast on our own trouble and our suffering and we decide *that they are unbearable.*

~Sartre

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Abstract

This paper investigates the social processes and mechanisms through which intravenous drug users are conceived and constructed as specific subjects, or 'types,' by *Doroga k Domu*, a non-profit harm reduction organization in Odessa, Ukraine. The contextualization of this agency within both the global discourse of harm reduction and the local field, colored by the recent post-socialist transition, reveals this organization's efforts to construct local drug users as manageable subjects in a way that maximizes agency influence over specific, local risk environments. This analysis conceives of the relationship between this harm reduction agency and the drug users it serves as a relation of power between two agentive social entities, following Michel Foucault's theories of power and the subject. It also employs Bruno Latour's framework of the scientific production of knowledge, and theories of social labeling, as developed by Howard Becker, Erving Goffman, and George Simmel, in order to illuminate the social and cultural products of local and international discourses of health, risk, and prevention, in relation to the individual drug users positioned within these discourses.

Ethnographic data for this project was collected during the month of April 2007, at *Doroga k Domu* in Odessa Ukraine. Fieldwork was conducted over several weeks, which included extended observations of agency functions and multiple interviews with members of the agency's staff, outreach team, and client base.

List of Acronyms

CEU – Central European University

DkD – *Doroga k Domu*

HRW – Human Rights Watch

IDU – Intravenous Drug User

NGO – Non-Governmental Organization

OSI – Open Society Institute

UHRA – Ukrainian Harm Reduction Network

UNAIDS – The Joint United Nations Program on HIV/AIDS

WHO – World Health Organization

Glossary

Buprenorphine – A synthetic opiate commonly used in substitution therapy programs.

Harm Reduction – A philosophy in public health efforts that focuses on helping 'at-risk' populations avoid the harms that can result from 'high risk' behaviors, particularly those relating to illicit drug use.

Methadone – A synthetic opiate commonly used in substitution therapy programs.

Militsya – The state police force in Ukraine.

Narcoman – A technical term used in Russia and Ukraine to refer to persons addicted to narcotics.

Substitution Therapy – A treatment program for persons addicted to narcotics, which is designed to replace the use of illegal narcotics with a highly-regulated regimen of another, legally prescribed narcotic.

Introduction

Yuriy[1] has begun waving his arms wildly. When I answer his signals with a confused look, he pouts his full cheeks and points to a plastic cup of sweet tea that I carelessly left sitting by an open window. Yuriy cannot produce the words needed to tell me to move my drink, because he is waiting for buprenorphine tablets to dissolve under his tongue.

Another young man in the local dispensary looks on, the telltale white residue from his own opiate treatment clinging to the corners of his lips. He passes over another cup of instant tea, and Yuriy clears his palate with a large swig. As a nurse steps out of the back office in the clinic, both men turn to her and surrender their mouths for inspection. With a smile and a quick "*spasibo*," she checks that none of their pills, which pull in a pretty price on the streets of Odessa, remain undissolved.

Yuriy is claimed as an astounding success by *Doroga k Domu*[2] (DkD), the organization that runs this substitution therapy program. He adheres to his treatment regimen, has stopped using illicit drugs completely, and has returned to regular work, proving himself to be a capable, functional citizen. It is DkD, in fact, that has employed Yuriy as an outreach worker. He comes to the buprenorphine dispensary to be dosed every morning before making his rounds, visiting with and supplying sterile injection materials to intravenous drug users (IDUs) in the neighborhoods on his beat.

Doroga k Domu is an HIV-prevention organization in Odessa, Ukraine's largest port city. Odessa is considered, epidemiologically, to be both the origin and the epicenter of the country's HIV/AIDS epidemic (Nabatov et. al: 2002). Nationwide, reported cases of new infections in Ukraine remained very low—as few as 50 per year until 1995. Then,

[1] The names of individuals have been changed to protect their privacy.
[2] This name means, "The Way Home." In Russian, the name is written Дорога к Дому, and in Ukrainian, Шлах до Дому.

in the first few months of that year, 1500 new infections were reported. By the end of 1996, the number had reached 12,228 cases, at least half of which were known to have been transmitted through IV drug use (Ball, 1998). As of July of 2005, studies in Ukraine were reporting that 1.4% of the nation's population was infected with HIV—already the highest rate per capita in Europe (UNAIDS, 2004). Some have argued that the criminalization of drug use as well as the lack of social outreach and harm reduction services for IDUs in Ukraine help to make injection practices a major channel for the spread of communicable disease (DeBell and Carter, 2005; Hamers et. al: 1997). In response to this, many non-governmental organizations, like DkD, have formed in Ukraine in the past decade, to implement prevention efforts among drug users specifically.

Most harm reduction organizations in Ukraine, including DkD, receive the vast majority of their funding from western benefactors located in countries such as the United States and Canada. Uniquely positioned at this junction of western programming and local discourses, such organizations beg for the examination of these overlapping discourses. As a prevention strategy, the prescribed elements of harm reduction efforts are built upon particular conceptions of risk and agency, and rely upon local engagement with these concepts in order to predict the effective management of drug related harm. These prescribed ideas will not necessarily be mirrored by local understandings of health, risk, and social management, however, leaving local agencies, like DkD, to produce their own understandings of risk and health-narratives that are at once articulated in the given terms of the harm reduction philosophy, while also intertwined with local meanings and discourses.

The central question of this paper is how *Doroga k Domu* situates its harm reduction efforts locally, within a sociopolitical environment colored by post-Soviet transitions as well as Odessa's own cultural particularities, and, more specifically, how

this negotiation between 'local' and 'foreign' discourses shapes the relationships and subjectivities constructed between agency staff and local drug users. By engaging social theories of power, agency, and the creation of the subject, I use ethnographic data to explore this agency's projection of health risks, and efforts to reduce such health risk by constructing and assigning local drug users into roles as specific subjects who are effectively manageable as such. To do so, I analyze specific practices within DkD's programs, institutionalized mechanisms of knowledge production, social division, and social labeling, which result from this multiplicity of discourses, and which develop and define DkD's conception of its own client base.

Programs designed to mitigate the harms associated with drug use must tread delicately between attempts to steer individual agency and efforts to maintain environmental control in order to produce positive change. Illuminating the ways in which a local institution such as DkD manages this task is relevant not only to the theoretical understanding of medical discourse and social control, but also to the practical aim of halting the spread of HIV and providing effective supports for those susceptible to infection throughout Ukraine and Eastern Europe.

Theoretical Framework

Harm Reduction in the Post-Socialist State

Under Soviet rule, health care was billed as a basic right to which all citizens were entitled. Mark Field has described the Soviet system as "Third Party" medicine (rather than "Fee-For-Service" medicine often found in democratic countries). This "Third Party" medicine is characterized by the state's role as the financial intermediary between the healthcare system and the patient (1961: 253). In the Soviet Union, the medical system was informed by government control as well as the under-the-table commercialization of health care. Medical services were dispensed broadly as a fundamental citizens' right, but the quality and extent of medical care was greatly determined by the amount a patient was willing or able to pay (Field, 1988; Schecter, 1992). The responsibility of citizen health generally lay in the hands of the state, yet that responsibility was something which citizens often negotiated for themselves in their individual interactions with the medical industry and health care professionals.

Non-profit organizations, like *Doroga k Domu,* are not under the Ukrainian state's jurisdiction as an entity in the healthcare system, per se. The state has no financial ties to such organizations, and has little direct control over decisions concerning programming, finances, or services rendered. Yet the open availability of its voluntary services positions DkD as a central, singular source of healthcare. The underlying assumption that their client base has nowhere else to turn is, in large part, what keeps such non-profit organizations running. This puts a huge amount of responsibility for personal healthcare—which had fallen to the individual after the collapse of the Soviet state—directly onto this organization itself.

This gradual transition of personal responsibility from the hands of the state to the individual is characteristic of what Ulrich Beck calls "Risk Society," (1992). Beck defines this as a stage in the development of the modern state in which risks and dangers "escape the institutions for monitoring and protection in industrial society," (1994: 5). Individuals gain charge of their own protections, gambles, and opportunities, of the determination of their own certainties in their entirety (ibid: 14). Beck draws a link between this new face of modern society and the post-socialist sphere, specifically. He highlights the recent withdrawal of the Soviet state from efforts of civil protection and care, openly questioning whether western constructs of capitalist democracy can be generalized on a global scale in order to fill this deterministic void (ibid: 5).

Sarah D. Phillips (2005) has argued that the definition of civil society as a social realm exclusive from the state (Hegel: 1821), whose strength and growth are central to the health of a democratic society (Putnam: 2000), is inadequate when placed in the post-socialist context. She illustrates this point through her work highlighting the vast over-representation of women leading non-profit groups in post-socialist Ukraine (2004). Ukrainian gender roles commonly associate the female with the *Berehenya*, the "hearth mother." The ideal woman proudly lives out her social function as mother of the nation and protector of the home and family (Pavlychko, 1996; Rubchack, 1996). Phillips shows that Ukrainian women negotiate their place within the non-profit sector through claims of a privileged ability to resolve social ills, granted to them as women by their natural role as mothers and protectors. She also identifies this sphere as a healing space for women, where they may seek refuge from and coping strategies for their social and economic trials—a responsibility which until recently lay with the state (2005). She reconceives of Ukrainian civil society as a separate social sphere where women may come as marginalized citizens to mediate solutions to experienced social ills which were formerly resolved by the state.

Similar tensions between the need to resolve contemporary social ills and the recent absence of state responsibility for such problems frame the social and political landscape of Ukrainian harm reduction and HIV-prevention NGOs as well. IV drug use, and the associated health impacts, are condemned and criminalized by the Ukrainian state, yet little to no government services exist to ameliorate the harms suffered by IDUs or the behaviors (and underlying sociocultural environments) that cause them (HRW, 2006). In part, this tension is played out in the political origins of the harm reduction philosophy—namely, its perceived failure of the social and legal condemnation of illicit drug use to curb either the use of these drugs or the health consequences commonly resulting from their use (ibid). It also manifests in the shift of responsibility for IDUs' preventative and therapeutic healthcare from the individual to the organization. DkD does not overtly attempt to direct or inform private behaviors that do not relate to drug use or disease transmission, and does not constitute a "total institution" in this sense (Foucault, 1977). It does, however, pair the authority it asserts as a party responsible for managing the health and health-risks of IDUs with a notion of risk-management that gives sovereignty over private behaviors to the individual—reproduced from of the basic sociological assumptions underlying the harm reduction philosophy.

Organizations such as the World Health Organization (WHO) and UNAIDS endorse harm reduction as a preventative strategy for combating HIV and other ills associated with IV drug use. The WHO lays out its own strategy in five parts: (1) public education and the dissemination of information relating to the spread of disease, (2) the provision of easy access to both health care and social services, (3) proactive outreach to IDU populations, (4) the provision of safe and sterile injection materials, and (5) the use of substitution therapy with synthetic drugs such as methadone and buprenorphine

(1998: 4). The Ukrainian Harm Reduction Association[3] (UHRA) endorses a nearly identical program. It defines harm reduction as "a strategy that protects injection drug users, who cannot or will not stop using drugs, from the negative medical, social, and economic consequences, striving to resolve these primary problems for the reduction of risk, in association with injection drug users." The UHRA highlights the logistical backbone of harm reduction programs as well, specifically mentioning needle exchange services, the establishment of educational staff, outreach workers, community support groups, and the provision of substitution therapy (2006)[4]. The elements of this national program closely mirror the core components of harm reduction endorsed by the WHO.

The strong influence of such groups on local programs is due primarily to the fact that western non-profit organizations and philanthropic foundations provide most of the funding received by these programs in Eastern Europe. One of the underlying assumptions of these harm reduction principles promoted by groups like the WHO and UNAIDS is that access to both the correct medical information and proper, sterile injection materials is sufficient to ensure that individual IDUs will inject safely. This premise has been strongly criticized for its failure to take local social structure and power relations into account, denying the political economy that may influence or drive certain behaviors associated with both injection and non-injection drug use (Carlson, 1996; Frankenberg, 1993; Whiteford, 1996). Instead of contextualizing 'risky' behavior within the local environment, the burden of choice is placed entirely on the supposedly isolated individual.

Armed with these assumptions taken from other agencies, harm reduction organizations in the post-socialist environment not only face certain risks with an individualized conception of risk behavior, such as local definitions of 'risky' injection

[3] In Russian, Всеукраинская Ассоциация Сниженя Вреда. In Ukrainian, Всеукраїнска Асоціація Зменшення Шкоди.
[4] Translations of this website's text from the original Ukrainian are my own.

practices, but also maintain responsibility as an organization for risk environments, including clients' access to materials, education, and, proper healthcare. This intertwined notion of risk and responsibility is, in part, the result of the introduction of highly individualized risk narratives to a post-socialist society that only recently transitioned away from state-sanctioned health management. It also directly affects the social relationships established between 'staff' and 'clients' as well as 'drug users' and 'non-drug users' and the specific subjectivities formed between them. Before exploring further into the production of these subjectivities and relations, I will first unpack the concept of 'risk' and the role it plays in medical and harm reduction narratives.

Designing and Defining 'Risk'

The concept of risk concerns the quantification of the desirability of projected outcomes. It contrasts a perception of the present with a projection of the future. Risk also, instead of offering prescriptive instructions, demands avoidance. As Ulrich Beck described it, "risks tell us what should not be done, but not what should be done," (1994: 9). To avoid certain risks, one must not overeat, stop driving sport utility vehicles, and refuse to buy a home built in a floodplain. Whether we follow these instructions of abstinence or not, risk easily parades itself as a matter of practical calculation, in which the best choice for the present can be determined through the comparison of imagined futures.

What makes risk a slippery idea, however, is this connection between present and future, between now and then, which can neither be truly certain nor concrete. The key to possible futures is that they are just that—possible. While the quantitative comparison between future outcomes may seem an unbiased, objective device, those comparisons would not be possible unless social and cultural values were placed upon them. Within

the ever individualizing 'Risk Society,' described by Beck, the self-critical nature of modern society allows for multiple, competing risk narratives to exist, in which social authority is claimed through authority over those risks and dangers (1994: 11). Risk, then, cannot be constructed free of symbolic value, and its mere presence begs the question of what those values, projected as authoritative reason, actually are.

The notion of prevention follows as the calculated action that risk justifies. Both concepts are built around the same diachronic narratives, and the simple design of prevention efforts implies that one has a clear understanding of the causality that links the current status quo with the incidence of future harm. Richard Freeman (1992) distinguishes between different forms of prevention—those intended to prevent risk completely, and those intended to mediate and manage risk once it is considered inevitable. The first of these forms of prevention consists of adapting circumstances to individual needs, whereas the second involves adapting the individual in order to manage the circumstances (ibid: 39). Freeman's construct is useful for illustrating a certain social power that risk narratives can produce. Particularly in the case of health and disease, it is significant whether a course of action is focused on eradicating an illness, or simply managing its consequences. For if only the latter is the case, then we are left to ask whose authority is claimed over that risk, and how that authority, presented as knowledge of the nature of risk, is translated into power between actors.

Ronald Frankenburg (1993) has argued that the concept of 'risk,' particularly in medical and epidemiological narratives, is key to the management and regulation of 'deviant' persons and behaviors. Philippe Bourgois, for example, has made a strong case for the characterization of methamphetamine programs in the United States as a tool of state control over 'deviant' bodies, rather than an effective program for the promotion of individual health (2000). Central to such efforts of social management is the effective construction of 'risk-groups'—populations allegedly homogenous in ways related to

specific projections of danger or harm. This grouping can have hazardous affects on the perceived cultural complexity of those defined by such discourses. Though subcultures are, by definition, not generalizable across a large population, Nancy Schiller argues that this is precisely what occurs when risk-groups are conceptualized. She uses IDUs as an example, identifying several ways in which this subpopulation is culturally flattened with the frequent assumptions that they are poor, are racial minorities, and are individuals abandoned by friends and family (1992: 243). Schiller observes that social theorists usually attempt to avoid this by highly contextualizing 'risky' behavior (ibid: 239). Yet, creating such socially conceived divisions is something that even mindful social theorists cannot fully escape.

For example, Rothenberg, Baldwin, Trotter, and Muth (2001), undertook a comparison study between two groups of IV drug users—one in Atlanta, the other in Flagstaff. By combining maps of social networks with epidemiological data in each location, their study indicates that disease transmission increases with the complexity of local social structures (ibid: 28). However, because there is little to which one can anchor this difference in structural complexity except the rural or urban nature of the social environment, this study indicates that differences identified between IDUs in Flagstaff and Atlanta are somehow representative of differences found between IDUs in rural and urban environments, *in general*. Bourgois, Prince, and Moss (2004), conducted an ethnographic analysis, which discovered the social and cultural causes of an increased chance of hepatitis C infection among women in San Francisco. They identified daily struggles with economic and physical security, which led female members of this community to relinquish control over their own injection practices in exchange for the safety and stability found in exploitative (and often violent) monogamous sexual ties with men. Even as this study uncovered hitherto-unseen local particularities, a delineation of new risk-groups within this population was still inevitable. Women were reclassified as 'at

risk' for infection in a way not matched by the male population, and were set apart, divided and defined yet again, so that these social problems can be better managed. In each of these cases, even when these 'risk-groups' are not an overt subject of this research, they become, nonetheless, refined in the research process.

Social network theory appeared to offer a solution to this cultural flattening. Network analysis focuses on the individual, and the connections that the individual has to risk-potentials in his or her external environment. In the case of IV drug users, risk-potentials might consist of other infected persons with whom a mode of transmission (such as sexual intercourse or needle sharing) may arise, as well as the social, economic, and political situations, which predispose individuals to such behaviors. Friedman and Aral (2001) argue that this local specificity is important because social networks can be shaped by countless external factors such as race, gender, and socioeconomic status that can cause variations in infection rates among these demographics on a larger scale. However, in order to ground the analysis of a particular social network in more general patterns, which make it applicable to other situations, Friedman and Aral generalize by tying specific social network characteristics to these broader cultural categories. Rhodes et. al. come a step closer to providing an exit. Their study of HIV risk among IDUs stresses the diverse complexity of individual localities to argue that all interventions *must* be locally produced in order to be successful (2005: 1028). Despite this, the concept of 'risk-environment' is still identified as central to the determination of disease transmission (ibid: 1026). Consequently, HIV is still characterized as a behavioral disease acquired by certain 'types' of people (ibid: 1027). Both examples highlight the likelihood of this approach to take the long route back to the same problematic pattern of sub-dividing populations into risk-groups based on overly generalized, socially constructed characteristics.

While these concepts may hold steady in the face of criticisms, and may indeed assist in the efficacy of HIV-prevention efforts—a benefit that is *not* to be understated—they still leave the door open to groupings and subdivisions in society, which serve to manage 'deviant' groups and behaviors as much as to evoke real change in patterns of disease transmission. The social construction of a homogenous 'sub-culture' of IV drug use can simultaneously facilitate the creation of programs that successfully reduce the number of new HIV infections while *still* maintaining and feeding acts of power that are designed to manage and contain persons and behaviors, regardless of their connection to disease transmission.

Local harm reduction organizations pose no exception. If the goal of an agency is to provide effective services to a particular population, then that population must be defined before the efficacy of program strategies can be determined. Whether the underlying goal of a harm reduction agency is truly humanitarian or entirely disciplinary, whether these acts of social division are a deliberate tactic of social management or an arguably necessary byproduct of attempts to build HIV-prevention strategies that work, neither of these effects can be fully eliminated or dismissed from our understanding of these types of programs. In many ways, these two effects are mutually constituted. In the following overview of social theories concerning subjectivity, labeling, and the production of knowledge, I will elaborate further on how these processes play out the power relations that constitute harm reduction efforts in post-Soviet society.

The Creation of the Subject: Production of Knowledge, Labeling, and Power

The construction of a target 'client' population as a social category forces the cultural flattening of those persons assigned membership in that group. Through the

practices and discourses of the agency in question, a body of knowledge about this client population must be produced, and clearly defined subjectivities established, for the sake of rendering agency practices and the individuals involved in those interactions comprehensible. In other words, the 'risk-group' must somehow be generalized in order to be managed. In the case of *Doroga k Domu*, situated in post-Soviet Ukraine, this categorization is key to the management of risks and risk-behaviors, as they fall simultaneously to the individual and to the organization itself. Namely, those persons who become DkD clients must be manageable in a way that facilitates agency influence over the risk environments surrounding them.

The connections that Michel Foucault has drawn between power and the subject help illuminate these processes (1977; 1982). Though much of Foucault's work has involved the phenomena of power and resistance, he claims that these elements are relevant to his interests only insofar as they are intimately tied to the processes that produce subjects. Specifically, he argues that a subject exists only insofar as it is constituted within a particular power relation (1982). In part, that subject is created as a categorical 'other,' clearly defined and maintained by the different entities with which it exists in those relations of power (ibid: 220). Foucault further clarifies that power is not a matter of absolute control, but that the subject, if it is to be a subject as such, must retain its agency. He argues that "the 'other' (the one over whom power is exercised) [must] be thoroughly recognized as and maintained to the very end as a person who acts," (1982: 220). Power, then, should not be conceived as actions upon others but as "action[s] upon the *action* of others," (pp. 220; emphasis mine). Based on this, the subject is necessarily capable of both resisting the power exercised upon it, as well as participating in and validating its own subjectification, as when a subject acts in conformity with the delimited roles prescribed to it.

This requisite agency of actors in relations of power is articulated through temporal narratives, as are the concepts of risk and prevention. Erimbayer and Mische argue that agency cannot be limited to what they refer to as the "iterational" process, the selective reenactment of past patterns of structure and behavior (1998: 971). To do so would be to limit human agency to a simple process of recall and imitation, pre-empting any and all possibility of social change or human creativity—a clearly insufficient conceptualization. Instead, Erimbayer and Mische assert that actors are also capable of projective agency, in which the focus of action is on future imaginings and possibilities (1998: 984). It is this type of agency that informs much of the discourse surrounding risk and prevention. Projective agency is an interactive process in which an actor attempts to negotiate a future outcome or situation, whether that negotiating action is recalled and repeated or innovated and improvised. Additionally, they afford human agents the ability to contextualize social experiences within this field defined by past elements and future imaginings (1998: 994). In the case of DkD, this combination of re-enacting established structures (namely, harm reduction's basic assignment of responsibility for the safety of private practices to the individual) and imagining possible futures and actions (namely, local risk narratives and a faith in properly controlled risk environments to induce safer injection behaviors) makes a definitive element of harm reduction practices on the local level. It is from this contextualization with past and future that DkD is able to produce the concept of their ideal 'client' body, and begin to produce such IDUs as specific subjects.

The framework of this process can be illustrated with Foucault's identification of three distinct mechanisms of subjectification: (1) specific modes of inquiry, which try to objectify through the use of 'science', (2) practices of division, which separate groups based on the construction of meaningful differences, such as the mad and the sane, or the healthy and the sick, and (3) the transformation of the self into a subject, seen in

Foucault's work on sexuality (1982: 208). Each of these techniques constitute either '*social labeling*' or the '*production of knowledge*,' both of which are central to the creation of subjects, in so far as they define, delineate, or classify different 'types' within a greater social context. Through each of these processes, the subject is bounded and established—it is named and it is defined.

Bruno Latour's theory of the scientific production of knowledge illustrates one of these mechanisms. He identifies how the object of scientific inquiry is produced through the division and subdivision of physical or symbolic material into discrete categories. According to Latour (2000), scientific knowledge comes not from observations made through face-to-face interactions with the world, but rather through a direct translation between concrete material and abstract signs. He describes the production of knowledge as a traceable 'chain' of these translations, in which each new link is grounded in the abstraction of a concrete element that is itself a prior abstraction (ibid: 69-70). For example, drug users could be distinguished by quantitative differences, such as age. They could then be appropriately divided into abstract groups such as 'young IDUs' and 'old IDUs,' which are distinguished as two exclusive 'types' because the concrete differences between them are perceived as somehow meaningful. Latour calls this "a moment of substitution, the very instant when the future sign is abstracted from the [concrete]," (ibid: 49). Through this substitution, in which distinct objects are constructed through symbolic divisions, a system of knowledge is produced.

This process of producing knowledge through division and abstraction is similar to social labeling, though there are some noteworthy differences. Contrary to the mechanism described by Latour, the act of labeling does not necessarily force the recognition of its processes of production, or the particular ways in which that knowledge is 'situated' outside of the object. The authors of social labels are not, in this way, "accountable" (Harraway: 1989). Labeling does, however, take as its focus the

interaction between the object of a discourse and its immediate surroundings, rather than the object itself. It is the method by which an object is bounded and named by either those on the outside or, in the case of an agentive subject, by those within as well, each producing and reproducing knowledge and associations by which the object is further defined.

Erving Goffman and Howard Becker have both illustrated the abstract and participatory origins of social labeling. Becker's work has explored the nature of social deviance, and the labeling of individuals and behaviors as such. He notes that a 'deviant' act is not defined as such simply because it violates rules or norms. Rather, the application of such a label is determined by how others respond to the behavior in question (1973 [1963]: 11). In the case of an individual, a person can only be a 'deviant' insofar as others have successfully applied this label (ibid: 9). Additionally, Goffman's work concerning stigma, another construct for explaining the attachment of negative labels to social actors, has highlighted the acceptance of the label as key to one's stigmatization (1990 [1963]: 19). In both cases, social labels are not necessarily derived from concrete actions or characteristics. Instead, they exist simply because more powerful actors have allowed them to exist. Noting the relationship between successful labeling acts and relational power (as seen in Foucault's conceptualization of the subject and power), Becker observes that "differences in the ability to make rules and apply them to other people are essentially power differentials," (1973 [1963]: 17). Labeling, then, requires certain social actors to first believe that a label is appropriately applied and then to maintain the ability to enforce that belief in others.

Finally, George Simmel's concept of 'the secret' illuminates ways in which labeling acts can be tied to each other. According to Simmel, the possession of a secret helps define a social group from within as well as without, as secrecy emphasizes both the exclusion of outsiders and the unique possession of that secrecy among those who

belong (1950: 332). The projection of the knowledge of a secret as a distinguishing characteristic is what Simmel calls, "adornment," an act of labeling, in which persons are marked as distinct types because they possess secret knowledge that others do not (ibid: 339). Those so marked are then considered members of a 'secret society,' whose secret "surrounds it like a boundary," and defines it as a separate entity, a social group composed solely of individuals who possess this qualitative difference (ibid: 362). While it is clear that adornment, as Simmel describes it, helps define and contain the group in question, knowledge and labels applied to members of the secret society can bleed into the social understanding of the secret itself, and vice versa, revealing the sources of differentiation and definition for such group to be potentially complex.

The sheer breadth of possible associations can make untangling the mechanisms that produce a particular subject a complicated, burdensome process, despite the fact that the structure of power relations that situate them can be as simple as a single pair of actors. Additionally, not all of these mechanisms related to the production of subjects are consistently traceable, making it nearly, if not entirely, impossible to account for the presence of all associated social forms. This does not, however, render an investigation into the subjectivities produced by an organization like Doroga k Domu moot. Rather, this organization's simultaneous positioning within both the globalized field of harm-reduction discourses and the unique sociopolitical environment of post-Soviet Ukraine allows for a useful contextualization of these processes, which can help to illuminate the relationship between DkD's harm reduction efforts and the social controls enforced upon those who come seeking their services. By engaging the theoretical framework for the production and positioning of subjects presented here, the invention of a definitive risk-group, of a particular species of person, that constitutes a drug using 'client,' can be traced through the symbolic and productive actions embedded in agency procedures and local perceptions of risk and responsibility.

Methods

Fieldwork for this study was completed in Odessa, Ukraine during the month of April, 2007. *Doroga k Domu* is one of but a few organizations in Odessa that seek IDU clientele for syringe distribution and health education under the banner of harm reduction. It was for this reason that I chose DkD as the subject for my research. DkD is also networked to other national harm reduction groups, such as the UHRA and the AIDS Alliance, which helps support the program financially. DkD receives a large amount of funding from international harm reduction agencies as well, including the Open Society Institute.

Before I first arrived in Odessa, I had already established ties with this agency. I was in contact with Marko, a lead project coordinator at DkD, during the previous winter. Over email, we discussed a possible collaborative grant offered through the Open Society Institute. At this time, I was also enrolled at the Central European University, an institution financially tied to, and heavily associated with, the Open Society Institute. By the time I came to Odessa in April, I was inescapably associated with this institute, one that provides DkD a significant amount of funding.

My position as a researcher with ties to a major benefactor dramatically altered the way in which I was approached and addressed by the professional staff. Although I have no formal ties with the organization, my strong association with this OSI allowed me to gain access to the full spectrum of DkD's programming and staff very quickly. When Marko first introduced me to several members of the office staff, he described me as a student from CEU who would be conducting research with their clients, and a guest who could count on the assistance of agency staff. That same day, Marko drove me to the community center, home to DkD's main needle exchange, located on the south side

of the city center. He presented me to the professional staff present there with the same grandiose introduction, telling them that I was allowed to go wherever I wanted to go and speak to whomever I wished to speak. Staff and outreach workers, alike, were aware of my coming visit. Some had even anticipated my arrival, and asked eagerly to show me different parts of their work, to meet clients with whom they were close, and to visit particular sites where they could give their own personal tour. I, in fact, ended up in many interesting situations because I was specifically invited into them by the staff.

Additionally, I was informed multiple times by agency staff that they receive no money from the Ukrainian government, which makes the extra effort to give a good impression to sources of international funding highly profitable. The staff knows how to present themselves and their organization to benefactors as successful or functional in particular ways, and during my formal interviews, I often felt like I was being given the 'right' answers. Questions about DkD programming were answered very quickly and clearly, in terms that can be easily quantified and translated into effective operations for an unfamiliar audience. Because funding does often hinge on this sort of agency presentation, having these ready-made speeches are part of what makes them good at their job.

It was apparent, however, when I was able to leave this space of ready-made answers and began inquiring about elements of their work that are not part of 'the speech.' This was particularly evident when I posed personal questions about their relationships with clients, certain fond or difficult memories they have of their work at DkD, or their own experiences with and opinions of drug use, prostitution, and HIV/AIDS. They would hesitate and occasionally admit that it was difficult to really formulate answers to such questions, because no one ever asks them such things. During an interview with Svetlana, a young social worker at DkD, I asked her if there were any instances of failure in the agency--with a particularly unresponsive client or in a

potentially difficult program--that she could share with me. She paused, and laughed with a big smile across her face. "Well, you know," she said, "We try not to call any one thing a failure, because we always try to stay so optimistic around here."

While completing my fieldwork in Ukraine, I shadowed DkD staff and outreach workers in their daily work and personal routines. During that time, I observed the gamut of DkD programs and agency spaces, including the central resource center, social work offices, private consultation areas, the community center, stationary and mobile needle exchange sites, the substitution therapy clinic, the Odessa oblast tuberculosis hospital, and various parks, alleys and public spaces frequented by outreach workers who seek clients on foot during the day. These observations, which led me through several weeks of full shifts at DkD, as well as semi-structured interviews with members of the agency's professional staff, dominated my collection of the ethnographic data presented here. My casual interactions with staff and clients alike, were in English, Ukrainian, and Russian. Interviews were held in English and Ukrainian—often a mixture of both[5].

The interviews were conducted with project leaders, physicians, and social workers, all of whom work directly with clients as well as oversee general operations within their particular area at DkD. This gave me an opportunity to do several things. First, the formality of the situation, the presence of tape recorders and the appointments made to hold the interview, helped build an official environment where I could ask any question about the agency and deliberately encourage them to give me their version of 'the speech' about what they do. Second, it afforded me time to sit down with these staff, each of whom were always busy, bumping from one office to the next. I could go an entire day without seeing them. Scheduling semi-structured interviews gave us the opportunity to delve more deeply into particular issues, exploring more of their personal experiences working at DkD.

[5] All translations into English are my own.

The rest of my time was spent with staff during their normal working days, being present throughout the agency's regular activities as an engaged observer. This element was crucial to my research, as I was able to observe and be part of interactions between clients and staff, learn how outreach workers did their jobs, and see the procedures for records and client enrollment as they were carried out. The fruit rendered by these efforts was a strong familiarity with the praxis of this agency—the ways, both minute and overt, in which the rules were broken, corners were cut, and clearly prescribed procedures were replaced with variations deemed to be more fitting in the immediate. It is in these daily practices that the local character of DkD comes out from underneath the cover of western harm reduction ideals—ideals that give the 'right answers' about what the agency does. In the quoditian, particularities become apparent, and the power relations, which define actors against one another, come into the light.

Analysis and Discussion

"Do You Shoot Drugs?"—IV Drug Use as a Social Label

"There are so many dogs here," I wonder out loud, as a small pack trot past me into the city park. "And they are all so healthy-looking."

Ihor looks at me inquisitively, and lets a drag of his cigarette go with a long, slow exhale. "Yes, these are street dogs. You do not have them in America?"

"We do. We have plenty. But the city collects them. Sometimes they try to find homes for them, but mostly they're killed."

He furrows his eyebrows in a distinctively condescending way. "In Odessa," he says, "we care for our animals."

Ihor is a young doctor who works two days a week with *Doroga k Domu*. In the mornings, he accompanies Katya, an outreach worker, on the bright, neon-colored bus, which serves as the agency's mobile needle exchange. Ihor sought out work at DkD for several reasons, not the least of which is the need to earn what he believes is an adequate paycheck. ("Doctors in America, they make big money, yes?" he once asked me. "Here, we make little money.") He also claims to have a strong, personal drive to work with impoverished patients who lack access to quality medical care, and, as an anesthesiologist, feels that his training has prepared him for helping narcotics users particularly well.

As a working pair, Katya and Ihor make a good model of DkD's larger social structure. While camaraderie among staff is high, there is a distinct divide between the work, roles, and responsibilities assigned to street outreach workers and those of the 'professional' or 'office' staff, most of whom, if not medical professionals like Ihor, are trained in social service or public health, and who often carry certifications for

counseling or social work. For the most part, only Katya interacts with clients[6] when the bus is out on route. Ihor is there to provide medical consultation to clients should they ask for it, and is very patient and helpful when approached, but otherwise spends the majority of his time lingering out the backdoor of the bus and smoking. When I join him in conversation, he stops frequently to tell me about the different clients that we see.

"This woman is AIDS positive," he says, pointing to a woman who has come up to the bus with her boyfriend. "This *narcoman*[7], he have lice in his head. He comes for medicine. And he," Ihor says, nodding to a fellow sitting in the front and pointing to his throat, "he is very drink [sic] today."

Katya spends much less time narrating her work to me. She generally stays busy talking with clients. While a few new faces are seen from time to time, the vast majority of the people who approach this electric green bus for services and supplies are long-time clients. The trust that has been built between them and Katya is very strong, and no matter who else is present—other clients, new doctors, or an unknown face—there is always a sense of security felt in Katya's presence. Many of the clients, particularly the startlingly few women who come on board from time to time, greet her with great affection, and the calm smile always on her face reveals the satisfaction she finds in what she does.

Today, while sharing a smoke and watching a rag-tag band of street dogs as they wait patiently for scraps outside a butcher shop, Ihor and I are outside the bus, expecting Katya's arrival. She has recently emerged, lit cigarette in hand, from the buprenorphine

[6] Many different terms are available for referring to persons who come to DkD for any variety of services (drug users, IDUs, clients, patients, addicts) each of which brings particular connotations to the definition of this group of individuals. In this context, I have chosen to use the word 'client' [клиент] because it is the technical term used by agency staff when referring to a person receiving DkD's services.

[7] "Narcoman" (наркоман) is the word commonly used to refer to opiate addicts in both Russian and Ukrainian. It is derived from the term 'narcomania' (наркоманія), a technical term for narcotics addiction.

dispensary, and has stopped to buy a cup of instant coffee from a kiosk on the street corner. After gathering early in the morning at DkD's community center to refill their supplies for the day, they always drive to this corner as the first order of business. Here, on the north side of town, opposite one of the busiest commercial centers in the city's bustling Old Town district, sits Odessa's only substitution therapy clinic, where Katya goes every day to take her prescribed dose of buprenorphine. All of the outreach workers at DkD are former users, many of who are also patients in this substitution therapy program. All of them, with the single exception of Katya, are men.

When asked about the reason for exclusively hiring former users as outreach workers, the professional staff at DkD answers in the terms of harm reduction strategy. Both DkD and the larger UHRA and AIDS Alliance networks, who also endorse this practice, refer to studies, which have shown that IDUs are best reached by those who were once IDUs themselves, thus characterizing this decision a matter of practicality rather than some agency-specific perception or strategy. When asked to explain why this is the case, staff remarks often turn to the outward characteristics of their former clients. IDUs and outreach workers are familiar with the same places, know the same dealers and buyers, and share common sympathies, but, even more importantly, they *look* the same. Ihor explained to me:

> If I want to go outreach worker [sic], I am not good because I not use drug. Katya and another outreach worker can. They—they speak with *narcomans*. And we [indicating the two of us] cannot do this work, because I am not *narcoman*. If I come to *narcoman* and say, 'Come with me I give you needles, condoms,' they not go. They think I work for police [said as he tugs on the collar of his designer jacket], not our organization. And Katya, outreach workers, they can sway [Ukr: довіруються] *narcomans*. They know Katya, these *narcomans*, and that they are not lied to.

Outreach workers at DkD share common personal histories with clients, but, as Ihor's explanation indicates, they are also considered to possess certain immutable characteristics, which are inseparable from that shared history. It is true that many

outreach workers carry markers of drug use upon their physical bodies. Small home-made tattoos cover the palms and fingers of many. Mild edema and swollen hands from scarred veins are also common among them, and most, though now in relatively good health, carry lines on their faces and tired expressions under their smiles, which betray the hardships of addiction that their bodies once suffered. Apart from these physical characteristics, though, outreach workers are seen as possessors of a certain knowledge and a certain mindset, which the office staff do not share—a difference never explicitly stated to me (nor, I suspect, quite clearly conceptualized), but which fully divides the staff into two types. In Simmel's words (1950), this is their 'secret,' which bounds them and marks them as a separate social group.

This dichotomy is even more apparent in the negotiation of space at DkD's main programming center. This side-street, basement property remains a relatively quiet place throughout most of the day, but hosts a busy, buzzing crowd in the afternoons, as outreach staff comes in between shifts to hand in paperwork and restock their satchels with materials for handout. The stationary needle exchange, which distributes all the injection materials for the program, is situated right at the front entrance. Three women, Anna, Oksana, and Ivanna, stay behind the counter, monitoring paperwork and distributing supplies to outreach staff and walk-in clients alike. These three women, each of them college educated with at least some history in social work, complete the same tasks every day, count out the same packets of needles, hover over the same daily records, and serve as the general welcoming committee for the agency. They operate a veritable factory of coffee and sweet tea, cups of which often appear in your hand before you even realize it's been offered. While these three women act with authority and a sense of ownership over this cordoned off area (which serves as both a minimalist office and a glorified supply closet), professional staff come and go from this space freely. They regularly pass through the door, gleaning materials, using the phone, and making

conversation with the women stationed there. Outreach staff, on the other hand, gather at the counter in groups. They often hold lively conversations with Anna and Ivanna, who are usually the first to notice empty hands and fill them with cups of tea, but these interactions are always conducted across the counter. While there is no rule explicitly forbidding them from entering the exchange space, the outreach staff members consistently conduct themselves as though this is an authority that they do not have.

Past the front entryway is a large room where men usually gather in the afternoon. There is a low couch, a few chairs, and a long wooden table where a backgammon game is nearly always in progress. Outreach staff and clients, alike, chortle with each other and circle around the game, waiting to see who will take on the winner. Behind this spaces lies the main community room. A long, vinyl couch runs along the interior wall, facing a flimsy table that keeps an electric kettle, plastic cups, hundreds of tea bags, and a large tin of instant coffee at the ready. In the far corner, there also sits a TV, a VCR and a small, dormitory-style desk with a computer, cluttered with notes, stickers, and photographs. With the exception of Iryna, the staff member in charge of operating this community center, only outreach staff and clients use these two rooms. Professional staff may pass through, or stop in to chat with someone, but they conduct almost no business, social or otherwise, in these two spaces.

Through this segregation of space, the social division perceived between outreach workers and professional staff is negotiated and acted out through daily routine. Professional staff maintain a certain level of authority, as they are uniquely privileged to go into any space in this basement center, whereas outreach workers operate in a limited geography consisting entirely of spaces designed for clients to occupy. Both the grouping of clients and outreach staff under the heading of 'drug users,' as well as the physical containment of this group in DkD's main program center are actions of social labeling, as described by Becker and Goffman. These two mechanisms feed each other,

simultaneously defining and reproducing a social division, adding strength to the "power differential" (Becker: 1973[1963]: 17), which provides professional staff the ability to enforce this division upon those contained by it.

Other social prescriptions are closely related with this division. For instance, DkD's professional staff is not very inclined to maintain close relationships with clients. In fact, a certain degree of professional detachment is expected from them. Svetlana, the young social worker, described the situation like this:

> In our work, we don't really have the right to be calling the clients, um, to be like their friend (други). If there is, um, if I am working with someone and it becomes clear that I am becoming like a friend to this person, then I can't be consulting that person.

This regulation partially conceals the adornment, the mark of specific, secret knowledge upon outreach workers as former drug users. This is, though, central to the justification of these rules, if not explicitly stated within them. Even if he changed his clothes and traded in his expensive shoes, Ihor could not be an outreach worker because he lacks this very element that they have by their own nature. It is this secret element that allows outreach staff the ability to build close, personal relationships with clients, and is seen as their key to blanket access among IDU communities in Odessa, a necessary element of their success.

These relationships between outreach staff and clients are openly negotiated in the community rooms at DkD, and it is in these spaces that the collective grouping of all these individuals into a distinct, bounded group of 'drug users' becomes concrete. Everyone greets each other with smiles and firm handshakes, whether they are staff or client. Phone numbers are swapped, personal stories shared, and recent news discussed. These conversations reveal the intimate knowledge and familiarity that define these friendships, positioning these individuals as equals against each other. Due to this

generalized behavior, even I often had difficulty determining if someone was an outreach worker or a client before being properly introduced.

It should be noted that the overwhelming representation of men in this group, heavily juxtaposed by the composition of DkD's professional staff, which is almost entirely female, certainly facilitates the division of these groups along gender lines. This was apparent especially when Katya and Ihor came into the center between shifts. Both of them preferred to be with others of the same gender, leading Katya to linger by the counter of the needle exchange and Ihor to join the men by the backgammon board. What is significant, though, is that, in spite of what are clearly complex, multi-faceted causes for this division, it was *consistently* articulated in terms of the presence or absence of a personal history with drug use. So much so that this attribute is not only connected to personal identity but to group identity. One of my interactions at the mobile needle exchange was particularly illustrative of this fact.

"What was your name, again?" Vera asks me. This quiet, middle-aged client gives a kind, embarrassed smile and adds, "Forgive me. I forgot."

"My name is Jennifer," I reply.

Vera pushes her large plastic sunglasses back up onto her nose, her fake nails brushing against the UV sticker that still sits affixed to the left lens. "How old are you?"

"I'm twenty-five."

"Ah, still young. I am thirty-seven," she laughs. "Do you shoot drugs?"

"No," I say casually, "I don't inject."

Vera pauses a moment. "Where are you from?"

"Chicago."

"Where?"

"Chicago," says Ihor. "In the USA, by Lake Michigan."

"Wow!" She exclaims with a laugh. "You are so far away!"

This interaction with Vera served as more than just a casual introduction. The conversation was her deliberate attempt to determine my position within locally (or in this case, immediately) relevant social structures. Following the conclusions of Howard Becker, Vera's question, "do you shoot drugs?" reveals the degree to which this label, indicative of a distinct social 'type,' has been "successfully applied" (1973 [1963]: 11). She asked this question because my response would allow her to situate me with respect to this division. Vera also revealed her own acceptance of this label (Goffman, 1990 [1963]) through her reproduction and use of this sign in a meaningful context. All those present at the needle exchange belonged either in or out of this 'IV drug user' category, and Vera sought the specific information needed to define me in this way.

In every moment at DkD in which daily agency practices reinforce this marking of drug users as a specific type of person, this act of social labeling, in turn, drives the same programs that create these daily practices by providing the agency with a clear subject around which to design its efforts: the 'IV drug user' as a potential 'client'. This is the most basic construct upon which discourses of risk and subjectivity are locally produced at DkD, and it is this label of 'IV drug user,' and the specific knowledge produced about those to whom it is applied, around which western concepts of individualized risk and risk-management must be negotiated. In the following section, I will illustrate further the specific notions of risk that are locally engaged.

Constructing Local Risks in Odessa

When asked to state the greatest risks facing drug users in Odessa, the staff at DkD generally provide the same response: illness and disease. Ihor described health problems among the agency's injecting clientele as though it were a plague.

> These patients have more problems, because they have more disease. If you do injection, you have AIDS, you have hepatitis. If these patients talk

> to other *narcomans*, then they might have tuberculosis. They have psychological diseases, epilepsy. If they have hepatitis, cirrhosis of the liver—or liver cancer—this it is very bad. These people die very quickly.

Svetlana similarly characterized the risks of injection as health-related.

> Svetlana: My first aim for [my clients] is harm reduction, and building trust. The second goal for my clients is prevention, through confidential [substitution] therapy…
>
> Me: Then, is one of the goals of the program for your clients to stop using drugs entirely?
>
> Svetlana: Yes, yes. Uh-huh.
>
> Me. Why? What are the risks for your clients?
>
> Svetlana: The biggest risks for them are HIV infection, AIDS. There are also abscesses [pause]. Yea, those are the big ones.

A focus on health risks is a part of the DkD's identity as a harm reduction organization, and dovetails with the general goals of harm reduction as articulated by DkD and the umbrella organizations with which it is networked, such as UHRA and the AIDS Alliance.

It is, perhaps, in this discourse of health risk where the influence of 'foreign' risk-narratives is most clear. In its focus on individual injection behaviors—as seen in the strategies of both the WHO and UHRA—the basic philosophy of harm reduction forces many of the known consequences of IV drug use, such as disease transmission, out of their local contexts. Had HIV not exploded through IDU populations in Odessa many years earlier, then DkD staff might well have a very different idea of what the greatest risks are that injection drug use creates for their own clients. It is also entirely possible that certain IDU populations in Odessa are protected from HIV infection in ways unknown or unacknowledged by DkD. They could be in closed social groups into which the virus has not yet infiltrated, or could be influenced by their immediate environments to avoid injection behaviors that make disease transmission possible. Even in a location

with an infection rate as high as that in Odessa, it can be difficult to defend a claim that all drug users are equally exposed to the same threats of harm. As no characteristics of the local context of HIV transmission are indicated by DkD's staff, the idea that these risk narratives are reproduced from other harm reduction projects is strongly supported.

DkD does not only employ risk narratives that it has adopted from outside, though. There are other social problems commonly faced by IDUs, seen as a secondary to their drug use, which DkD works to combat. Ihor, for one, mentioned the stigma that HIV positive people suffer in Ukraine as a harm resulting from drug use that many clients are faced with. "These [HIV positive] people have problems with family, with social life, because our society is not ready to communicate [Ukr: спилкування] with these people." Similarly, IV drug use, itself, is strongly associated with social deviance in Ukrainian society. This can lead to a host of other problems for IDUs, including run-ins with the local *militsya*, or police force, in Odessa.

The *militsya* is, in fact, a source of harm and conflict for the agency and clients alike, which DkD must deal with on a regular basis. For instance, while the purchase of syringes at pharmacies is technically legal in Ukraine, it is not at all uncommon for IDUs to be stopped by police and have their materials confiscated. Extortion is not uncommon either. Human Rights Watch (HRW) has documented many instances in which police have threatened both clients and outreach workers with arrest or violence if they will not pay money to the officer on the spot (1996). In its own words, HRW has described IDUs as "undesirable" in Ukrainian society, and, because of this, claim that police face little risk of censure for allegations of abuse. (ibid: 21). Ihor indicated to me that this sort of harassment is common, and that the police often stop drug users who are guilty of nothing more than being easy targets. He said that it meant trouble to be caught by the police with drugs on your person, as this crime is seen as a social infraction that justifies

arrest and jail time. "But if you are only drug user," he told me, "this is *your* problem. Police just arrest. You pay, and then go home."

DkD staff find the police to be a particularly significant threat to their clients not only for this risk of extortion, arrest, and violence, but also because police often interfere with DkD's day to day activities. On one of Katya's morning shifts, operations on the mobile exchange had to be shut down because two members of the *militsya* were lingering by that morning's scheduled site. On that day, I watched from the front of the bus as one client left, hastily grabbed the supplies that Katya had gotten out for him. Moments later, another dashed onto the back of the bus, and peered, eyes darting, through the slits in the blinds covering the back windows before also slipping quickly away. When my gaze fell to the sidewalk outside, I saw that a group of clients, huddled outside of the bus just minutes ago, had also disappeared.

This scene marked an abrupt end to what had been a very busy morning. Clients, both new and old, had crowded the bus when we first arrived. Katya had even begun to run low on supplies. When I asked her what was going on, she pointed out the window with an aggravated look on her face. Two men in plain, dark clothes were standing on the opposite sidewalk, talking to each other and maintaining strong body language that indicated they weren't moving anytime soon.

"They are *militsya*," Katya said.

"Are you not able to work with police around?" I ask.

"Well," she says with a sigh, "It's technically ok. But…" She waved her arm out to the deserted sidewalk and shrugged. In minutes, we had left that morning's scheduled location and moved on.

Outreach workers have also been known to suffer harassment from the local *militsya*. Despite the fact that all outreach staff carry ID cards indicating their role in a public health organization, DkD's program leaders have reported to HRW that their

outreach workers have been beaten and detained by police for being in possession of agency-distributed injection materials. The perception, though, is that the *militsya* does not target outreach workers, specifically. Rather, these individuals suffer police abuse because "they are all ex-drug users themselves, so they *look* like drug users," (HRW, 1996: 40; emphasis mine). Even as successful participants in DkD's harm reduction and prevention programs, agency staff is forced to acknowledge that they still fall into the same, "undesirable" social category as current drug users and addicts.

These social, physical, and psychological injuries received from the police are constructed by staff as a specific risk faced by drug users in Odessa. As opposed to reproduced concepts of individual health risks, like HIV infection and AIDS, this highly contextualized construct frames DkD's harm reduction efforts immediately within local discourses. The risk of police abuse threatens to interrupt DkD's prevention efforts at the individual level, as when clients are harassed or extorted, and also at the agency level, as when the two *militsya* officers effectively shut down the mobile needle exchange one morning. This threat of potential harm does not stem directly from individual injection practices, but is part of the greater risk-environment that influences those behaviors. If an IDU has all of his sterile needles confiscated, then he is no longer capable of injecting safely. In this way, the risk of police abuse contradicts harm reduction narratives that tend to de-contextualize injection practices, and is a central to DkD's efforts to control local risk environments as the party responsible for the provision of healthcare services to its clients. I argued earlier that, because of this perceived responsibility, DkD's active construction of drug users as a particular subject must aim to facilitate the agency's control over these risk environments as well as manage the individual clients. In the following section, I begin to trace out the specific mechanisms by which IDU subjectivities are produced, in order to illustrate this relationship between client management and environmental control.

Creating 'Clients'

Officially, are no rules governing who is allowed to participate in DkD's harm reduction program. There are no demographic requirements limiting those eligible. You cannot be too young, too old, too rich or too ill. You need not have AIDS or hepatitis. You don't have to be homeless or a single mom. You don't even have to be a drug user, although I did see, once, an outreach worker completely stumped by what to do with a new client who did not inject.

The procedure for enrolling a new client is simple. When someone arrives at a DkD location for the first time, a staff member fills out a brief questionnaire for that person. The same intake form is used by all agency staff. After a few short questions about the client's name, age, contact information, and employment, the questionnaire asks for the drug users to define the kind of narcotics that they use and their "stage of drug use" (Rus: стаж употребления). It asks whether the client has been through a rehabilitation program, and whether he or she is interested in completing one. It asks clients to list their TB status, whether they have contracted any form of hepatitis, and, if the answer to either one of these is 'yes' to specify the type or form of the infection. The form ends by asking whether the clients have had an HIV test in the past or would like to be tested again.

This intake questionnaire is a central tool in DkD's process of objectifying their clients. The information that is recorded assumes certain facts about these IDUs—particularly, that they use narcotics, and have done so for a significant period of time—and frames them in these terms. It allows for the easy quantification of concrete characteristics about each individual, such as the presence or absence of a virus in the client's bloodstream or the specific length of time during which the client has engaged in

injection drug use. From this, the questionnaire aids in the formation of abstract distinctions between the clients as well as between clients and non-clients. Just as Latour (2000) described the translation from concrete to abstract in the scientific production in knowledge, this intake process helps transform specific, concrete details about each individual into abstract terms that can be used to situate them with in the greater body of program participants.

This initial intake process also allows for two additional 'moments' of labeling to take place. First, it associates these new clients with the so-called 'secret society' of drug users (Simmel, 1973). Their experience with illicit drug use, confirmed and validated by the answers listed on this intake form, mark these new clients as bearers of the specific knowledge, which distinguishes the group. This is the moment when such labels are first applied to individual drug users by DkD staff. Second, this transition into one's career as a DkD client allows the association of these individual with whatever knowledge exists about drug use and IDUs *in general*. For example there is a certain fatalism that defines the perceived relationship between HIV infection and IV drug use in Odessa. The rate of seroconversion among IDUs continues to be so phenomenally high, it is often assumed that drug users *do* have HIV until they are tested and it is proven that they do not. One afternoon in the main needle exchange, I watched as Vasyl, one of DkD's senior most outreach workers, transferred used needles, collected on his shift, from a shopping bag to a hard, plastic container for their disposal. I cringed each time he shot his bare hand into this sack, retrieving handfuls of syringes with their needles exposed.

"Are you not afraid of being stuck?" I ask him.

"Yea," he says, "Very afraid, because they're dirty and…" He pantomimes sticking his hand with a needle and makes a very ugly, frightened face.

As a matter of minding his own health, as well as contextualizing the health status of the assortment of clients he interacts with, Vasyl (as well as Ivanna and Anna,

who nod eagerly in agreement) categorizes all of his clients as potential and *likely* carriers of HIV. When IDUs become official clients of DkD, this is one of the assumptions that is transferred to them as well. For new clients, this intake re-constructs them from an unknown entity into a known 'type': an object around which a specific body of knowledge is produced, and a subject that interacts with the agency and agency staff from with in this relation of power. It is simultaneously an act of subjectification and a rite of passage.

Following the completion of the intake form, new clients are given ID cards to keep in their wallet, which verify their status as an enrolled participant in DkD's HIV-prevention program. Each card bears the name of the agency, a declaration of their HIV-prevention philosophies, several reference numbers for the city code that define this program, and a blank space labeled "client number." Each client is assigned a specific ID number, which remains connected to them for the remainder of their participation in DkD programming. This number is written on the new ID card, for the client to keep, and then noted on all agency records for this client in lieu of his or her name. This is done for assuring a certain level anonymity. Documents which link client numbers to identifying information are kept separate and secure, but every visit, every exchange, every test and consultation is recorded with the client's ID number, so that the activities of the client may be tracked by the agency, but each of the services received by any individual persons leaves no identifiable paper trail.

These cards are part of an innovative program in which DkD is participating in conjunction with the AIDS Alliance. The cards provide DkD clients with a certain level of immunity from the aggressive behaviors of the local police. When Anna and Oksana introduced me to these cards, they took their time telling me the relevance of client ID numbers to their meticulous record keeping, a matter of responsibility and pride for both of them. Outreach workers offered me a slightly different characterization of the cards'

purpose. "If I am stopped by the police," said Katya, holding up the card and a bag of clean needles with a smile, "I can say, 'Oh, I am sorry. I am participating in this HIV-prevention program. I have all these materials from *Doroga k Domu*. I am allowed!" A look of smug satisfaction crossed her face as she imagined giving this speech to the local *militsya*. City legislation has been enacted in Odessa that sanctions this program and supports card-carrying IDU's by granting them immunity, protecting them from extortion and their clean materials from confiscation. "It won't help you if you are carrying drugs or dealing," said Olya, a professional staff member who works in DkD's financial offices. "But, it may save someone from trouble who is carrying around old needles with residue. It tells the police that they are not doing anything illegal."

These ID cards help DkD manage clients and the clients' risks in two ways. First, it symbolizes the reconstruction of an otherwise unfamiliar drug user into the agency-tailored role of a 'client.' Secondly, thanks to the city ordinances granting the program's participants certain immunities, which DkD helped establish, these cards actively re-design the local risk environment for those who possess them. This is a primary example of the agency's construction of drug users as subjects with the deliberate manipulation of those IDU's immediate risk environments specifically in mind. It also serves to show the interconnectedness of 'local' and 'foreign' risk narratives in Odessa, and their joint influence on agency practice. The use of this ID card system, as a device for risk management, is founded simultaneously on the premise that individual IDUs are responsible for their own behaviors once presented with the proper education and supplies, and DkD's perception of itself as the sole agent responsible for its clients' healthcare, obligating it to manipulate the local social and political terrain to allow for individual agency in the first place.

Once a client has been fully enrolled into the program at DkD, the rules of the needle exchange are in force. Taped to the wall above the counter in the front entryway hangs a printed list with these regulations:

> 1) It is forbidden to enter the exchange with narcotic substances or while intoxicated by alcoholic or narcotics.
> 2) Syringe distribution: 2 needles per client per day.
> 3) Syringe exchange: 1:1, up to ten syringes per client per day
> 4) Syringes can be received and exchanged (a secondary exchange) for an additional 10 clients per person (only possible when presenting the project cards of all clients).

These are the only rules that clients are given to follow, yet, in day-to-day operations, most of these rules are skirted. Only once did I ever witness a client surrendering needles for disposal at any exchange, but ten new syringes were given to every client at each visit with out exception. When materials are distributed, Anna, Oksana and Ivanna make sure that every item that leaves the exchange is written down. On a daily record sheet, they list the client's number, how many needles were given to that person (always 10) and the amount of other materials distributed, such as alcohol swabs, condoms, and anti-bacterial ointments. The number of needles surrendered is not indicated, however, because there is no place on the form to record this value.

Marko, the program leader, ensured me that these records were necessary, among other reasons, for determining the real program costs of the needle exchange. If they don't know exactly how many supplies they are handing out, they won't be able to write their budget. Svetlana also told me that, while agency records are confidential, the AIDS Alliance, who helps fund this program, makes sure that they are recording everything properly. It is possible to determine, based on these records, whether too many syringes are being distributed to each client. It is not possible, however, to ensure that enough needles are being turned in. In the absence of such controls, it becomes clear that getting sterile materials into the hands of clients can be counted among the staff's higher

priorities, where as collecting dirty needles and tracking the exact distribution of new ones cannot

Additionally, the stated rule that clients may pick up needles for others by presenting multiple ID cards is not followed to the letter. The clients who regularly take materials for others are well known by the staff. Oksana keeps a sheet in her personal notes that lists the ID numbers of those who regularly pick up larger quantities, as well as the numbers of those for whom they take needles. She, and the other two women running the exchange, know, for instance, that Olga always takes seventy needles, Dmitri takes sixty, and Andrei ninety. The staff does not ask to see the additional ID cards. They simply write down the numbers if each absent client as listed on their personal notes, assign ten of the outgoing needles to each in their records, and give the whole lot to the one client who has come in.

The one regulation that *is* consistently enforced, though, is the use of client ID numbers. Without them, staff cannot properly fill out paperwork, and their interaction with the clients cannot be properly recorded. The clients are taught to present themselves to staff with this number, and when it is forgotten, an embarrassing situation ensues. A staff member must pull up old intake forms and search for the client's number by their name. This occasionally happens, and the staff gently, but firmly, instructs the client to remember in the future.

"You need to remember this number the next time you come in," said Anna to a young client, "So that we don't have to stop and look it up next time. Remember this. You're 638."

"638, Ok," came the response. "638. 638. 638. Yea, I'll remember."

This process of numbering reinforces the label assigned to each individual drug user as a 'client.' It also requires the regular acceptance and reproduction of this label if the client is to get the what he wants, which only serves to reinforce the validity of this

label (Goffman 1990[1963]) and afford greater social strength to the agents who are applying that label in the first place (Becker 1973[1963]). This imposition bears directly upon the actions of clients who come to the needle exchange. When they walk up to the counter and define themselves by the number that has been given to them, they repeatedly internalize their role within this relationship. They reproduce their own construction as a specific, productive subject within this program, subordinate to certain desires of the staff.

The power relationship between agency staff and IDUs is, in part, mediated by this process, in which the staff requires the clients' compliance with the system of naming by numbers in order to acquire materials. However, at the same time that DkD staff exercises this social power, which, as Foucault described it, "[acts] upon the actions" (1982: 220) of clients by enforcing rules and prescribing specific modes of self-presentation, DkD clients reap concrete benefits from their participation in this power relation. By conforming to this role, they acquire certain safeguards against police harassment, which alleviates a very real hindrance to personal safety and the ability to practice safe injection. DkD has produced an ideal 'client,' which can be individually managed in concert with the management of the local risk environment. This is not the only example of the simultaneous management of risks defined by both individual and organizational responsibilities. This trope is repeated among the agency's true success stories: those who enlist as patients in substitution therapy, becoming not only 'former drug injectors,' but also 'patients.'

From 'Clients' to ' Patients': Greater Agency Control

At DkD's community center, outreach workers and clients share an intense camaraderie, but those who are officially on DkD's staff are clearly positioned as senior

members of this 'society' of drug users through their privileged knowledge of agency staff and procedures. Outside of the community center, though, this social plane is flattened in contexts where the group's 'othered' identity overpowers the significance of its internal structures. The buprenorphine dispensary is the main equalizing space for addicts, where the line between client and outreach staff is blurred, and each individual's status as 'patient,' under the benediction and supervision of the medical staff, is the most pronounced.

All the outreach workers I spoke with reported that their relationships with medical staff at the dispensary are positive. While introducing me to one of the physician's assistants, Yuriy, my first host at the dispensary, exclaimed "Jennifer! This woman here is my sister!" She laughed, embarrassed by his energy. "Ha! I am not your sister," she scoffed at him with a smile. The distinguishing social capital and confidence afforded to outreach workers ends here, though. Workers and clients, alike, are subject to the same procedures and the same rules, and their bodies are equally subject to the medical staff in charge of operations. In the eyes of this substitution therapy program, they are no different from anyone else in the clinic.

Denis, a former narcotics injector, who also works as a psychologist a few days a week in DkD's community center, told me that he knows everyone there, all the staff, all the patients, each one by name, because they are all there everyday of the week. He pointed around the small, brightly painted room, indicating the office in the back with a nod. "Back there, there is one doctor and a few doctor's assistants," he said. When you arrive, he explained, the medical staff note your arrival, and give you your dose of pills to dissolve under your tongue. Once finished, the staff must check your mouth to make sure that the pills have completely dissolved. If you are caught sneaking pills to sell on the street, you can be cut off, and kicked out of the program. When I ask Denis if the staff there is very nice. He looked at me with a gentle pout and said, "They are nice

people [Ukr: цумпатечни]." He should know. He has been coming to this dispensary every day for nearly two years.

The dispensary is open every day of the week, including Sundays and holidays, because those enrolled in this program must take buprenorphine daily. If they aren't able to, they would suffer through withdrawal symptoms that day, and the program itself would not in compliance with its charter. When talking to Ihor about this program, I wondered out loud if it wasn't a burden for people to have to go to this clinic every single day of their lives. "Isn't that difficult?" I ask him.

"Yes," he replied, "but it is better, because these patients see a doctor everyday."

Constant medical supervision is not the only benefit of this program. Ihor also pointed out that many of the clients he sees in his own work are interested in enrolling in substitution therapy not for the sake of quitting injection drug use, but to become, as he put it, "a legal narcoman." As patients of this substitution therapy program, these clients would be able to continue receiving the drugs to which they are addicted, but the cost would come out of someone else's pocket. Their addictions would no longer lead them into trouble with the law, because the buprenorphine dispensary is operated with the approval of the state. The only significant difference between current drug use of these hopeful clients and their potential, future drug use as patients of this substitution therapy program, is that, as enrolled 'patients,' they would be maintaining their addictions legally, and with out expense, while under the full control of the dispensary.

The only drawback to this plan, however, is that the buprenorphine affects those who take it, like any other narcotic substance would. Katya was often quiet and irritable in the mornings. She usually cheered up after her treatments, though, and always kept a cup of coffee close her in the hours following, to keep her going during her shifts. Yuriy, a very energetic, excited person, continued to talk to me at a rapid-fire pace after his treatment, just as he did before, but once the buprenorphine had entered his system,

however, his speech would begin to slur. He became almost impossible to understand, and was continually distracted from what he was saying by the need to wipe down his dripping face and brow, which would sweat profusely after he left the dispensary. Though substitution therapy is often characterized as a medical 'treatment' for addicts, it delivers only what is indicated by its name: the substitution of one addiction to a particular narcotic with another addiction to a different narcotic, one no less forgiving in terms of its physical and mental affects or the regularity with which it must be taken to avoid withdrawal.

DkD's decision to operate a substitution therapy program can be interpreted as a direct extension of its own construction of 'clients' and 'drug users' as subjects. So perceived as a bounded social group, 'drug users' are considered to be persons afflicted with illness and disease, either as a natural consequence of their drug use or as a perceived, natural disposition of the people who fall under this label. Likewise, the illnesses that are broadly associated with the group 'drug users' are grave—Vasyl highlighted the assumed prevalence of HIV/AIDS among this group, and Ihor identified other transmittable diseases that he believes to be common, such as hepatitis and tuberculosis. When drug users are, in this way, constructed and produced as a type of person who is naturally ill or naturally predisposed to illness, the perceived benefits of keeping addicts under close medical supervision become apparent. It is also quite significant that this substitution program helps eliminate the need for addicts to seek out and use drugs on the street by providing a place to acquire and ingest drugs legally. This aspect helps lower IDU's susceptibility to police abuse by actively containing this drug use both physically and temporally, with in the sanctioned environment of the dispensary.

In many ways, this program functions in a similar manner to DkD's methods of client enrollment and identification. Drug users are re-conceptualized as 'patients,'

rendering them both quantifiable and manageable. This subjectivity of 'patient,' under the supervision of healthcare providers, is constantly reproduced as these individuals surrender their bodies daily to program participation requirements and routine physical inspections. By so producing 'the patient' as a subject, DkD is successfully allowing, yet again, for the simultaneous management of clients as a social group (and a group of social bodies), and the exogamous risk environment, which hinders individual and organizational risk management by allowing for conflict with both the state and the local *militsya* because of the perceived legal and social deviance of IV drug use. In short, substitution therapy aims to manage drug users' health (because they *cannot* do it themselves) and contain their deviant behaviors (because they *will not* do it themselves).

This, in a way, is the ultimate irony of the substitution therapy program. Those clients who successfully move through DkD's harm reduction programs, those who have participated to the fullest extent possible in the alleviation of the social, legal, and medical risks tied to their own drug use, these clients arrive at this final stop on a path supposedly leading to personal betterment, to find themselves under the strictest social controls that DkD to offer.

Conclusion

Doroga k Domu, in Odessa, is situated at the intersection of multiple, variant discourses. As an independent agency, it is, to a great extent, left to its own devices to determine how best to navigate these spaces between socialist and post-socialist society, local and global discourse, between generalized risk and individual responsibility, and structural reproduction and cultural innovation. Due to its multiplicity of influences, this agency adopts both 'local' risk narratives, framed in large part by the absence of the Soviet state, and 'foreign' risk narratives, which emphasize individualized risk-management responsibilities. In so doing, DkD conceives of itself as an organization responsible for managing both of these discourses, through individual risk management with individual clients, and organizational efforts to manage generalized risks, through deliberate attempts to manipulate specific local risk environments.

Through its own practices, which are based on these two distinct concepts of risk, DkD actively transforms the IDUs enrolled in their programs from 'drug users' into 'clients', and, in cases of noteworthy success, from 'clients' into 'patients.' With each transformation from one subjectivity to the next, DkD relocates these communities of IV drug users into bounded, sanctioned environments, where they are always under the watchful eye of social work and healthcare professionals. Once contained in this way, drug users still retain their 'othered' social status. They maintain their previously established social networks within DkD community spaces and activities, and are even granted the opportunity to continue feeding their addictions through substitution therapy. All in all, a significant portion of these drug users' lives remain essentially unchanged, while this agency and its practices continually recast them as different subjects—still an 'other,' but a more managed and manageable and 'other'.

What still remains to be uncovered are the subtle social complexities that shape the lives and experiences of IV drug users, both in Odessa and elsewhere in Ukraine. The tendency of even the most well-intentioned constructions of risk and prevention to generalize IV drug users into homogenous entities does not mean that the sociocultural realities of these persons are so much the same. By gaining a better understanding of how this cultural flattening can occur through an agency's subjectification of its clientele, social researchers and harm reduction organizations, alike, can begin to dismantle this structural scaffolding that can be seen binding drug users into particular roles and behaviors.

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