Nancy E. Stoller
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As I write about needle exchange, I think of my friend Helen who has Type I diabetes and needs to inject insulin daily. She has been without her own pancreatic production of insulin since she was nineteen. At one point in the past, she injected insulin less frequently, but now she uses "tight control." This involves monitoring her blood three to four times daily (by sticking her finger, dropping blood on a test strip and slipping the strip into a meter, then waiting thirty seconds for a reading on her sugar level) and injecting insulin—on rising, eating, and before going to sleep.

In her bathroom are two Sharps disposal buckets with syringe tops sticking out. On a small bathroom chest a syringe and two insulin bottles rest, casually interspersed with a hair brush, a wash cloth, and Third Force magazine. The refrigerator has more insulin. At my house, she has left syringes in the bathroom drawers and insulin in the refrigerator, just in case. When we are at a restaurant, and there is some privacy, Helen might turn her back to the nearest patrons, slip out her syringe and load the insulin. Then she will lift up her shirt, pull down the waistband of her jeans a little and gently

inject on the side of her abdomen. The syringe is recapped and back in her pocket in less than a minute.

I think about what Helen's life would be like if diabetes was not medicalized as a disease. Suppose it were just a condition of life, like the increasing farsightedness of old age or aching feet or bad posture? Suppose her treatment of it were considered a matter of choice or a personal attempt to make her life different than her natural lot? Even if her activity were still legal but not defined as a medical necessity, there would be no insurance to pay for insulin, syringes, and blood glucose monitoring equipment. She would have to pay full cost, somewhere in the range of $150-$200 a month just for supplies.

And if she were poor and could not pay, what might she do? She would not be able to buy all the syringes, insulin, or test strips she needed. What would she skimp on? Insulin? Test strips? Doctors' visits? Needles? Perhaps she would inject less often or use less insulin and watch her body deteriorate. Would she then deny that her health was getting worse. Or steal what she needed?

What if the insulin itself were illegal? What if her possession of syringes was criminal? She would have to buy her insulin on the black market, also her needles and syringes. Her kit would no longer be just a "kit"; it would become her "works," her illegal "paraphernalia." If she did not want to steal or buy on the black market, she would have to borrow needles from other users. What would she do as the ones she had got dull? Sharpen them? What about cleaning? What if she were out and had nowhere to clean her syringes, to do her boiling and bleaching, or else risk the possibility of hepatitis or HIV?

The simple and complete reason that there is no HIV epidemic among diabetics equivalent to that among "illicit" users is that diabetic needle use is both legal and covered by insurance, (which Helen is fortunate enough to have). Selfmanagement of insulin-dependent diabetes is not illegal, but by imagining such a scenario we can understand the structure and consequences of the illegality

think that's it. I think that's really the only thing that everybody agrees on, and I don't think that there's anything else that people agree on. I think that at this point the only thing that Prevention Point is doing as a unity thing is getting out the syringes, the alcohol patch, e.g., supplies. That's all that it's doing. It's all it's ever been doing. As far as I'm concerned, what I want Prevention Point and the director to do is look into a whole host of other services and things to do for this population, because we've got a great base to reach a population that's not reachable in any other way. And they need a lot of different things.

My interview with Alex Krai took place in November of 1995, when Prevention Point was stuck at the stage of organizational development in which the "work groups" (site volunteers) were comfortable with one another in a horizontal network but were unable to effectively utilize the non-profit structure which was designed to help them with funding. Anarchism and consensus management have worked well for Prevention Point if one thinks primarily of the numbers of needles exchanged; but to utilize their new financial resources, the volunteers might need a system of linkages and influence that would better connect them in fact, with power, to the world of non-profit funding.

agreed to action at one time were unsure at a later time. No letters were sent out, no formal action was taken by either Prevention Point, the HPP staff, or the two groups in unison. Informally, in the months following the confrontation, the director paid more attention to the Prevention Point volunteers, visiting sites more often and apparently listened to them more closely. But relative power relations were reaffirmed and not modified by the challenge.

As for Krai, I've just decided that I'm not going to be part of the PMT process anymore myself, so I'm just quitting it all because I don't have the time to sit around anymore and not make decisions. And I felt I did a push to really make sure that some changes would happen in this organization, and it didn't really look like people were willing to do that. And so I'm bowing out of it altogether.

However, Krai decided to continue to work as a volunteer for Prevention Point and, in an anarchistic fashion, struggled to find additional resources for clients at his site. This continued to happen at the other sites as well.

I've gotten a public health nurse now for our site, and I've got two new outreach workers with the city van, and we started giving out flu shots. And we're treating abscesses and providing all those kinds of [low-technology] medical services. Other sites have done different things. The Bayview site now is connected with a clinic and is able to give out some methadone maintenance detox slots for free. The women's site has childcare; Sixth Street has a doctor, med students and interns. All these things are site-specific. They're not, it's not through Prevention Point [or HPP], it's not through Prevention Point finding funding or finding these things or whatever. It's through the networks [of PP volunteers].

While he would prefer that the services were available or shared throughout the Prevention Point sites, Krai is resigned to not being heard. It seems to me that what Prevention Point has done from the beginning, and still is really only doing, the only thing that people really can all agree on is that there needs to be points [needles] gotten to people, that syringes need to get to people. I

of injection drug use without having to confront an already constructed set of judgments about mood-altering injectables. This stripped-down focus on the consequences of criminalization of needle use allows us to see needle users as rational people with needs. It may also help us understand the ethical motivation of needle exchange activists.

The illogical and stigmatizing ways that even those who are presumably at the center of HIV and substance abuse policy think about injection drug users was brought home to me by an article in the New York Times on September 20, 1995. A front-page article reported on the important findings by a panel of the National Academy of Sciences that needle exchange programs reduce HIV infection. A sidebar addressed the notion that drug users share needles as a bonding ritual. The sidebar article gave credit to anthropologist Steven Koester for proving to the Centers for Disease Control that "sharing [needles] was an act of desperation" not a bonding ritual. 1

According to T. Stephen Jones, of the HIV/AIDS prevention program of the Centers for Disease Control, the bonding notion had its origins in a study done in the Haight Ashbury district of San Francisco in the early 1970s. The notion of bonding had been used as a partial excuse by the federal government since the late 1980s for not supporting needle exchange or distribution programs. It seems that people at the CDC believed (or said they believed) that even if you gave junkies clean needles they would still share.

Koester's field work demonstrated that anti-paraphernalia laws and the illegality of various drugs made it too risky for users to carry syringes or dope. In Denver, according to Koester, users went to shooting galleries where they could find privacy (safety) and a needle, even if the needles were sometimes contaminated, blunted, or less effective than new ones.

Jones heard of Koester's work and invited him to the CDC. "His conclusions and similar findings by other investigators dispelled

the assumption that needlesharing was a bonding rite but was something forced on them by circumstances " 2

Why would someone use a dirty, beaten-up needle when she could use a clean, sharp one? Only if there were something odd and irrational in her behavior. It is this stigmatization and "othering" that is really behind the "bonding" theory. The stigmatization of the intravenous drug user as an "addict" with a disease that is mental as well as physical was the 1970s contribution of social science to the debate over the legality of mood-altering substances. The earlier judgment was re-assessed in 1995 by a comparable set of scientists—the anthropologist and the epidemiologist, who now declare the earlier judgement suspect. "What do you know?" they intone. "These 'criminals' are acting rationally given the illegality of their situation."

But even if faith in federal assessments of scientific knowledge leads us to accept that in 1994 (when the National Academy of Sciences panel began its work) the CDC and the federal government needed more data to decide on the appropriateness of funding needle exchange, evidence of the drug users' attempts to protect themselves from HIV had already been published almost a decade earlier. In 1985, Don Des Jarlais, Samuel Friedman, and William Hopkins reported on the changing behavior of intravenous drug users in New York City once they became aware of the risk of AIDS through infected needles. In the late spring of 1983, news of and concern about the epidemic filtered into the authors' Street Research Unit, an ethnographic storefront operation in a high-use area. By the fall, via interviews with eighteen intravenous drug users who were not in treatment, they found that all knew about the epidemic and believed that AIDS was spread through the sharing of needles.

They [the users] also reported an increased demand for "new" needles among intravenous drug users as a result of AIDS One indication that the demand for new needles had been sustained came in the summer and fall of 1984, when we heard reports of the selling of "resealed" needles. Needle sellers were placing used needles

tion, that the city demanded had to be spent on a women's site in the Mission and on a new site in the Western Addition. Now they came up with those ideas through the HIV Prevention Planning Committee ... that made the decision to give Prevention Point money, never asking any of the volunteers, never asking any of the Prevention Point people what it is we need. Now it's pretty obvious that we're the people who would know best, I think, what would be necessary. And Rosalyn, very new in the job, just went to the meeting, and she said, "Okay, let's start a women's site in the Mission. Sure, we'll take the money." So she obviously is making the decisions 27

Against this background and with the kind of resentment reflected in Krai's account of the events leading up to the meeting, thirteen people from among the seventy to eighty Prevention Point volunteers showed up, almost all of whom had other full-time jobs. The group agreed to prepare a letter summarizing their concerns and present it to the next participatory management team meeting, to which they would invite the director and the rest of the paid staff, now totaling four people. There was no formal consensus. When the letter was presented the following month, both the director and the rest of the paid staff expressed hurt and a sense of not being appreciated.

According to Krai, Rosalyn ended up walking out of the meeting towards the end of it, and she said flat out, "If this is your process for getting these kinds of things, I'm not participating in it. I don't believe that you did this. I don't believe in this process. And this is going to make me want to change things less than more." That was her reaction, at which point the different people, PMT members who had been at that meeting, some of them started kind of backpedaling and this and that, and it was kind of ugly. 28

At this point the complaint process fizzled out. The Prevention Point volunteers, including those at the second meeting, did not want anything sent out with out consensus, yet few had been at both meetings and many had been to none. Even those who had

inally been created to serve it. Roslyn Allen, the new director, came from Bayview Hunter's Point Foundation, an organization in a heavily African American area of San Francisco that originally had not approved of needle exchange, seeing it as a diversion from the more important goal of getting people off drugs altogether. She had never worked in a needle exchange program. Her primary substance-abuse experience was within a hierarchically organized non-profit serving the black community. Alex Krai described the new director's style as top-down management. She rarely visited the exchange sites and only occasionally came to participatory management team meetings. To Prevention Point volunteers, the director's absence from participatory management team meetings was unacceptable. They compared her unfavorably to George Clark, who had been "one of us." After hearing other volunteers and members of the participatory management team complain about the situation for months, several decided to hold a meeting specifically to discuss the problem. As Alex Krai remembers, Well, the main reason I called the meeting was to have us figure out as the PMT, actually as Prevention Point, figure out what the role of PMT should be, what decisionmaking power it should have, and how it should go about getting that power. Because as it was I saw it as a kind of a pinball machine of people not really making decisions. Embedded in this whole concept or this whole meeting was that we had always thought, or it was always considered that the paid staff are working for Prevention Point in the sense that they are helping to make sure that Prevention Point runs the way it should. And they kind of help assist on a bigger [level], you know, whether it's office or getting the stuff ... so that Prevention Point can do the work. That whole idea had flipped. So it seemed like we were all working for them, doing their work. We made a decision to exclude paid staff from the meeting because ... the staff is HPP staff ... And there is a definite us and them.

Rosalyn made her own [decision], without ever talking to any of us, to accept $100,000 from the city, through the AIDS Founda-

back into the original packaging, resealing the packaging, and then selling the needle as new. The resealing is done with heat sealing machines that can be purchased in local hardware stores ... To study the demand for new needles in greater depth, our Street Research Unit conducted interviews with persons "hawking" needles on the street during the spring of 1985 Eighteen of twenty- two (eighty- two percent) needle sellers reported that new needle sales had increased over the last year ... One seller was chanting "Get the good needles, don't get the bad AIDS" as a sales pitch for his wares. 3 The researchers concluded that the "data clearly contradict the stereotype of intravenous drug users as incapable of modifying their behavior and as unconcerned with their health." This report was published in 1985 in Annals of Internal Medicine, one of the most distinguished medical journals in the U.S. It was followed by other studies that provided similar results.

In 1987, Friedman and his colleagues reported on even more extensive behavioral adjustments to the epidemic in their New York City neighborhood. They began to talk of "self-organizing" as a way of comparing the attempts by users to protect themselves with the more successful attempts by the gay community. They noted serious obstacles to organizing by injection drug users on the individual level: Addiction takes time and energy and poverty limits access to resources. They also noted obstacles at the level of local organization and culture: The predatory social relationships of the drug market result in distrust and a lack of solidarity. On a broader societal level, severe legal repression and stigma, including a hostile press and public, raise serious barriers to organizing. On the other hand, the researchers found examples of organizing by current and former users including a New York group, ADAPT, which was made up of exusers and adopted a nonjudgmental attitude toward existing users. 4 But the most striking organizations were the junkiebonds of the Netherlands; these organizations of injection drug users began before the HIV epidemic to combat the

spread of hepatitis among needle users and were now continuing with specific grassroots anti-AIDS strategies.

Friedman's interest in social movements and community organizing kept the National Drug Research Institute research teams focused on the actual behavior and potential of the users. 5 His own and his colleagues' articles on drug users' responses to AIDS were published shortly before needle exchanges burst onto the American scene, first in Tacoma, Washington, in early 1988. Needle exchange programs to combat AIDS were established as early as 1986 in England and Scotland, where pharmacists were also being encouraged, but not required, to sell needles for "non-therapeutic" purposes, i.e., to drug users. 6

In other words, a new discourse and a new set of social institutions concerning injection drug users and ways of cooperating with their own attempts to protect themselves from HIV were developing. Despite the limitations imposed by stigmatization and criminality, these changes paralleled the new organizations and institutions developing for AIDS prevention among gay men, prostitutes, and people of color. Each group was confronting a set of stigmas, stereotypes, moral condemnations, and legal issues and developing a language that justified its activity on the grounds that the epidemic's deadliness required the larger society to "bracket" its judgments and allow the members of the group to stay alive by protecting themselves from the virus. After all, the representatives were arguing, even if drug use is illegal, the state has not mandated a death sentence as the penalty for shooting up.

In San Francisco, one such needle exchange organization, Prevention Point, has been in operation since 1988. By 1996, services were being provided four evenings a week for two hours at ten stationary locations in areas of the city with sizable needle using populations. These are all multi-ethnic, low-income neighborhoods.

Like most other needle exchanges, Prevention Point participants exchange needles rather than merely receive new sterile ones. This requirement is intended to reduce the number of contaminated sy-

was a regular check-in from every site every month. Each site selected someone to represent it, and the group as a whole was called the "participatory management team."

Some members of Prevention Point objected that creating this structure would establish a new "government" for the organization. The strongest support ers of the idea of participatory management were the "old timers" who felt that a formalized process would assure representation from all the spokes of the wheel. Two members of the team who were also volunteers (George and Yana) were involved in the reorganization. They supported the decision to allow members of the team to be paid $50 per meeting "voluntarily." (Some volunteers were opposed to the payment on the ground that it should be unnecessary.)

During the first year, the monthly meetings were used as a time for check- ins and updates, but no decisions of significance were made. Prevention Point's requirement that decisions be reached by consensus and its commitment to not making decisions for others kept these formal meetings from functioning in any sort of management mode overseeing the various sites. So long as the organization faced no crises, this lack of centralized management apparently worked well. I would bring up issues myself of things like distribution [giving out needles without requiring a one-for-one exchange] —some of the larger issues. Small issues are dealt with, you know. We've got a problem here; let's deal with it. But larger issues, like should we do a distribution rather than exchange, issues which were generally shot down by people as even discussion topics, you know. I wasn't even allowed to bring up that as a discussion topic. It was too much of an issue, or something… But it really didn't change much as far as I'm concerned, after the PMT [participatory management team] started. 26

In the fall of 1994, HPP hired a new executive director, the first who had not been a volunteer. This step marks the start of the third phase of Prevention Point's development: the movement's increasing subservience to a formal organization that had orig-

der what circumstances that was. But from what I hear from a lot of people, from a lot of the original people, one day George came to the meeting and had made the decision on his own … that he would take city funding. I think that was probably the biggest moment of change, because once you take public funding, then people ask you to do things differently. Then all of a sudden organizations need to be put into place, anarchy and consensus and all those things kind of get thrown out because funding agents want different things. 24

According to Krai, from that moment on, some people stopped going to Prevention Point meetings in protest against taking city funding. However, they still considered the work of needle exchange important enough that they wanted to continue to do it. They said, "Well, I'm not going to have anything to do with this organization except for doing the work." 25 The decentralized nature of Prevention Point's work made it possible for activists to continue on as volunteers on the streets while distancing themselves from the organization as such. By early 1993, Prevention Point had a budget, a paid director, and the other staff needed to organize supplies and coordinate volunteers. Officially, they were employees of a separate organization sheltered by SFAF called the HIV Prevention Project (HPP). Because the director, George Clark, had come from the Prevention Point ranks and was still an active volunteer, the differences between the grassroots movement and the formal organization were minimized. But to Krai and other newcomers, Prevention Point looked like a small non-profit:

It was an organization like any other non-profit organization as far as I'm concerned. I saw no element of anarchy, I saw no element of, "We're doing something strange, or we're doing something not, you know, some civil disobedience" or any of that. I never had any sense of that. When I started I knew that it was, you know, semi-legal and I knew all that, but it really just, from when I started, I think it was an establishment. In March 1994, Prevention Point decided to formalize the team meetings of the volunteers who actually did the distribution and exchange work to make sure that there

ringes in circulation. Outreach workers also provide information on safer sex and drug use, referrals to drug treatment programs and health care agencies, and tangible items such as bleach, alcohol wipes, cottons, and condoms. Program providers act as conduits to such other social services as drug counseling and referrals to drug treatment programs, health care services, and HIV-related services.

Prevention Point began as an act of civil disobedience by a group of pagan, hippie anarchists who wanted to force the state to provide clean needles to the criminalized injection drug users of California. 7 Throughout the following account, we will see that Prevention Point's anarchism has produced a unique situation: It has survived for eight years as a large group of decentralized volunteers who do the work of exchanging needles; but their material goods (needles, bleach, cotton, AIDS prevention guides), and to some extent even the sites where they work, are now "managed" by a small hierarchically organized staff who publicly represent the needle exchange and over whom the volunteers have no effective control.

Luis Kemnitzer, a long-time volunteer, describes the start of Prevention Point this way: There was research going on about risk of injection drug use. Also, people were doing HIV testing of the drug users. They immediately realized that they had to give the results to the people tested. That led to having counseling, because you couldn't give the results back, especially if the results were positive, without providing counseling. This then led to the realization that maybe you could do something to slow infection rates beyond counseling and that was to clean up the needles somehow. So first, people realized that you could distribute bleach.

Jennifer [Lorvick], at Urban Health Study [a San Francisco-based drug research organization], was the first person to actually figure out the mechanics. She put the bleach in little bottles. Then they [UHS] started distributing condoms and bleach. Nevertheless, they got in trouble with the cops, or I should say the recipients got in

trouble with the cops. Especially the women got in trouble about the condoms because they were treated as a sign of prostitution, and the woman could be harassed or arrested for having a lot of them. Also, police are rumored to have punched needle holes in the condoms. But with publicity, eventually people were able to slow that up and get the police department to stop it.

But workers realized that this distribution was not enough because it is a problem to get clean needles, so they thought it would be a responsibility of theirs to somehow get clean needles to the users. On the one side there was responsibility and commitment. On the other side, there were the police. Meanwhile there were some pagan anarchist cd [civil disobedience] hippie junkies who wanted to do something about this. This last group, including Moher Downing and Rose Dietrich, were the founders of Prevention Point. They brought in the non-hierarchical model. They planned to get arrested from the start in order to get the issue into the public eye. Once they were arrested they planned to move on to getting various celebrities arrested as a way to draw attention and then change the law.

However, they did not get arrested. And that missed arrest led to the long-term organization of Prevention Point, including its transformation from a civil disobedience organization—of an unusual nature—to a somewhat anarchic network of small "service" organizations. What were the nuts and bolts as well as the original intent of this initially illegal activity? In August 1988, the founders-to-be of Prevention Point began meeting. The group consisted of fewer than ten women and men who shared some important characteristics. Everyone had some experience using mood-altering drugs. All were involved in AIDS prevention work or research with injection drug users. All had experience with civil disobedience in the anti-nuclear movement of the 1980s, and all but one identified as anarchist and pagan.

These origins in anarchism and paganism are significant in terms of both the culture of Prevention Point and the organi-

Prevention Point's early anarchistic, unfunded phase stretched from 1989 to 1991. Between 1991 and 1994, the organization sought and obtained funding from the city of San Francisco and at the same time was able to maintain a sense of autonomy and self-rule. Eventually, however, Prevention Point was forced to succumb to the demands and strictures of corporate non-profits, which directly conflicted with how Prevention Point had managed itself in its early years. Ironically, Prevention Point's greatest strength throughout its history—its anarchism and consensus approaches to decision making—proved to be a great weakness in the power struggles that developed with the non-profit organization that it established in order to have a legal supplier of syringes.

While Luis Kemnitzer was part of Prevention Point's first wave of involvement, Alex Krai is part of what he himself calls the "second wave." Krai, a public health epidemiologist and staff member at an AIDS research organization, arrived in San Francisco and became a Prevention Point volunteer in 1993. By that time, Prevention Point was already legitimate and officially protected by the mayor. Since 1991, the city had paid for Prevention Point's syringes and, through the San Francisco AIDS Foundation, it had provided a legally separate organization with part-time paid staff to assist the volunteers. Krai's memory of the events of the next two years tells the story of Prevention Point's attempt to maintain its original movement structure while conforming more and more to the demands of its funders. Krai's feelings about these developments is typical of many of Prevention Point's volunteer activists.

The first wave of volunteers was basically a group of civil disobedient, anarchist people that kind of saw a need and just went ahead and did the work. And at that point, they met every week, I believe, as a group. And all decisions about the organization needed 100 percent consensus, and they didn't take any public funding. It was all privately funded in different ways. And I think they ran that way for a long time, until one day, as far as what I've heard anyway, George [Clark] became director, and I don't know exactly how, un-

We've been wanting to try to do this for years now in this neighborhood." And so consequently we decided to set one up there. And the process by which we did that was basically we talked to all the peo pie, we went to the Western Addition Neighborhood Association meeting. We went to the tenant's association at those projects, we went to the cops in Northern Station, we went to the three kind of most well-known church leaders in the Fillmore, and we went to Ella Hutch Community Center. And we talked to all the leaders there and kind of asked about their concerns and thoughts and everything like that, and in that way kind of got the whole neighborhood rallied around it and made sure that we would take care of all the concerns of people in the neighborhood. 23

To assist them, Krai and Pearson had help from two African American outreach workers. One had been working in the neighborhood for fifteen years. Two more African American men from the neighborhood already active in AIDS work joined them. But it was Krai and Pearson who went to the meetings and generated public support from the community.

People were pleased, and they didn't play the race cards at all. We were expecting them, but there wasn't really the concern. And when we started the site, the first day of the site we had the two [African American] outreach workers kind of roaming all of the site for a couple of hours before and trying to get people involved and this and that, people to come out. And then we had the four of us, which were the two of us, Charles and I, white, and then two other African American people. And actually after about a month or so, the other people quit because they moved across the Bay so they didn't have time to do it. So we only had the outreach workers for the first two weeks actually, to kind of, and I think they helped a lot in legitimizing us as people to the community, though we only saw about thirteen or fourteen people those first two times. Throughout its history Prevention Point has been able to cross the color line in multi-racial neighborhoods because of this type of groundwork and nonjudgmental service.

zational forms its leaders chose. From the start, as Kemnitzer noted, they expected to be arrested, but they did not want users to face arrest. They did not know about the Tacoma exchange, begun in August, although they were aware of and in fact had helped develop the bleach distribution projects in San Francisco. Although they did not use the language of "harm reduction"—a public health philosophy that advocates doing what is possible within a potentially dangerous social context to reduce harm, even if one cannot remove the entire threat—they were operating within this prevention model. The organizers knew they wanted to have an "anonymous, non-judgmental, user-friendly model with no requirements for participation other than the possession of a syringe and the willingness to exchange." 8

In order to design a procedure that would meet these criteria the organizers, in good action-research tradition,9 arranged a hot dog dinner for needle users living at the Ambassador, a single-room occupancy hotel in San Francisco's Tenderloin district. They walked the halls, knocking on doors, telling people of the available hot food, and handing out a flyer that proclaimed: We are a group of concerned folks not associated with any organization. We are tired of waiting for the needle laws to change. We are willing to be arrested in order to make clean needles available to people who need them. We would like to start a "peoples' needle exchange program." Each week we would come to the Tenderloin for about two hours and exchange one dirty needle for one clean one. This may seem unfair, but we want to duplicate the kind of program that we believe could be made law here in California. Only a needle exchange [as opposed to simple distribution] seems to fit that bill.

The flyer went on to talk about general plans and ask for feedback. The organizers asked each person arriving for supper where it would be best to set up the needle exchange and how to organize it. Within a few days they went to the various locations suggested to further examine their potential. The organizers consciously adopted four criteria in selecting sites: the ability to mimic

street syringe selling, including surreptitious transactions; accessibility and convenience for intravenous drug users; no infringement on existing social interactions, legal or illegal; and sufficient space to locate monitors who could alert participants to potential problems with police or local merchants.

After some research, the organizers chose an approach that used a "stationary team" and a "roving team." The stationary team was located near a park where intravenous drug users frequently congregated. Prevention Point assumed that workers at this site would be arrested by the police because of the site's visibility. Initially it was considered a decoy to deflect attention from the mobile part of the distribution system, which was designed for both safety and to reach those who would not come to the more open site for fear of identification or arrest. On October 28, 1988, the organizers had their final preparatory meeting. The agenda included such matters as a needle supply report, role plays, legal issues, and how to handle the media if there were arrests. They prepared an informed consent script for those who came to get needles that warned them the exchange might be illegal.

The first day of the exchange, November 2, was the Day of the Dead, a date specifically chosen by the organizers both to commemorate those who had died from AIDS and because of its pagan origins. In its own history of that night, which Prevention Point has been able to make official by setting up its own "Prevention Point Research Team" (indistinguishable in membership from the organization's core members and their partners), thirteen Prevention Point members exchanged thirteen needles in a two-hour period in the Tenderloin. 10 The numbers may be mythical, but they do have a recognizable pagan significance and are therefore an important part of the organization's origin story. After the distribution, the Prevention Point founders gathered for the first of their post-distribution meetings to discuss the process and make plans for the future. The agenda included the need for money, planning for

in San Francisco was estimated at approximately 49 percent white, 26 percent Latino, and 24 percent African American. Ethnicity of users of the Prevention Point services was approximately 5 1 percent white, 3 1 percent African American, 12 percent Latino, 3 percent Native American, and 3 percent Asian. 21 By 1990 the race issue was clearly on the table, as minutes from a Prevention Point retreat demonstrated. Half the discussion was about making sure that the Prevention Point teams were multi-cultural and reflective of the specific composition of the neighborhoods in which they worked. The minutes summarized concerns:

Needle exchange must be street-based and sensitive and responsible; no suits—blend in—not just clothing or complexion, but attitude, sensitivity, hipness, comfort to MIRROR THE CLIENTELE according to the NEIGHBORHOOD; this reduces judgmental stuff and makes it accessible; cultural/class affinity; ability to hang. A model: The aggregate of all the neighborhood teams reflects multi-cultural and multi-racial representation, but teams should be organic and appropriate to their neighborhoods including language. E.g. Native Americans in the Mission, signers everywhere, blacks from Bayview on a Bayview team, a primarily Japanese team for around Japantown. 22 Despite (or perhaps because of) its white, hippie, anarchist, pagan origins, Prevention Point did become the most successful of the needle exchanges. Building community support and attention to neighborhood politics were the primary sources of its success.

In February 1994, two relatively new white volunteers, Alex Krai and Charles Pearson, decided to start an exchange site in a predominantly black and poor area of the city. According to Krai, There was a large amount of people that weren't using needle exchange that lived in that area right over there. So I said, "Well, this is perfect. I think that's where we should do it." And I went and talked to some outreach workers, and the outreach workers basi cally said, "Yeah, that those projects right there, there's probably fifty or sixty injection drug users who live there, and they aren't being served.

that it was tantamount to abetting the crime of drug abuse. One flatly stated, "I am not in favor of cooperating with evil." 17 As a result of black opposition in New York, the health department's needle exchange program was severely curtailed. It operated out of a health clinic near a police station and far away from the nearest location frequented by injection drug users. The combination of government sponsorship and location may have doomed the New York program to low levels of exchange from the start. 18 The Department of Health exchange was later supplemented with less institutionally based services, but the 1988 New York experience was very much on the minds of San Franciscan needle exchange proponents throughout 1989.

In Boston, in 1990, Jon Parker, a white activist, had set up a branch of his National AIDS Brigade needle exchange project in an African American neighborhood without working with community people. The ensuing debacle led tphysical confrontations, picketing, and the closing of the Boston needle exchange program. 19

Memos from Prevention Point's files and research conducted by the Institute for Scientific Analysis indicate that the issue of racial representation continued to nag the organization. In a media worksheet from February 1989, the "racial issue" appeared in a list of "hard questions" that might be asked by the press. The topic listed was "whether they were participating in genocide through promotion of IDU in minority communities." In other words, was Prevention Point putting guns in the hands of members of the minority community by providing users with needles and making it easier for them to shoot up? Yet another question to be answered, and a difficult one, as Prevention Point would learn. The organization began as predominantly white and has continued to be predominantly white in its volunteer base. As late as 1995, when it had expanded to twelve sites at eight locations, 70 percent of its volunteer "staff" was white. 20 In 1989, at the time of the initial development of Prevention Point, the injection drug-using population

the next exchange (the following week), and ideas for combining disposal of needles with the stillanticipated arrests.

When no arrests followed, Prevention Point settled in for the longer struggle to change public policy. They continued the exchange, began to build community support both for the exchange per se and for an anticipated "coming out" in the press, and they began to strategize about ways to influence local and state policy. Almost a year later, Prevention Point delivered 2,000 used needles to a San Francisco Health Commission hearing considering legalizing needle exchanges. Between November, 1988, and that hearing in September, 1989, Prevention Point had exchanged more than 100,000 needles. By 1992 it had become the most extensive exchange in the country, having exchanged over one million needles at five San Francisco sites. 11

From the start Prevention Point was concerned about its image in the press. Organizers wanted to show that their model was appropriate to the situation and did not want to be dismissed because of their organizational style, personal and cultural commitments, or politics, all of which were alternative. Unlike ACT-UP, for example, which strove to assert its cultural identity as part of its politics of change, Prevention Point wanted to hide its identity from the mainstream while at the same time revealing certain aspects of itself to its user-participants sympathy to and solidarity with drug users, willingness to risk arrest, and anarchist leanings. One of the organization's internal handouts illustrates both their approach and their sense of humor:

Things we will not say to the media (a working list) 1. We won't reveal names of people involved, location(s) of the exchange, or nights that the exchange operates. We will say that it operates in "an area of high IV drug use several times a week." 2. We won't say the names of researchers involved in the evaluation. 3. We won't talk about outfit girl or tell the story about the old lady kicking the baby carriage. 4. We won't ever admit to distributing a needle without exchanging it. 5. We won't say where we get our funding

though we will say we are supported by "private contributions." 6. We won't say that we have been given pens, buttons, dice, plungers, bags of marijuana, etc., in lieu of used syringes. 7. We won't say that we had one stolen. 8. We won't say where we get our needles although we will say that "we are buying them and not diverting them." 9. We will not xerox or circulate this list. 10. Do not reveal our political leanings, such as anarchism, paganism. 12

As winter wore on, Prevention Point members began practicing for their coming out in the media, planned for March 1989, when a Mayoral Task Force was due to make some pronouncements on needle exchange. They consciously picked two "poster girls" as interviewees, both of whom were willing to be photographed and named—Tia Wagner, an African American, and Rose Dietrich, a white woman. They discovered that a reporter for the San Francisco Chronicle was about to publish a story on the exchange and decided to cooperate, giving their first interviews. The front-page story appeared on March 13, 1989, and began the public career of Prevention Point. 13 Within a week the head of the Department of Public Health urged that needle exchange be considered for the city, 14 and one arrest of a Prevention Point volunteer occurred. 15 The charges were dropped, and the moves toward legalization and funding of the exchange continued.

Between the time of the Mayoral Task Force Report, which recommended needle exchange as possibly "beneficial in curtailing the spread of AIDS in the IDU population," and a fall hearing before the city's Health Commission, which would have to authorize such a program, various individuals and community organizations responded to needle exchange. The idea very quickly became racially politicized when significant opposition was voiced by Naomi Gray, an African American member of the Commission. She argued against the proposal because it encouraged illegal behavior for which African Americans were more likely than whites to be arrested and sentenced. There was no evidence that it was effective, she claimed, and it sent the wrong message to youth: "that

it's OK to break the law if there is a slight possibility that it would protect them against AIDS." Needle exchange was also opposed by the majority of black religious leaders and then followers. Gray concluded her written statement with these words: Imposing a program on a people who are against it will not work politically or otherwise and will create a divisive debate here and in Sacramento over the legality of a plan to distribute clean needles. These energies could be better spent fighting for more education, prevention and treatment funds to fight AIDS and crack cocaine. This would be a more productive outcome. 16

In response, Prevention Point, a predominantly white organization, drew on its multiracial community support, including the Third World AIDS Advisory Task Force, the Latino Coalition on AIDS/SIDA, and the Black Coalition on AIDS, all of which were very supportive of the needle exchange program. In addition to its public support of Prevention Point, the Latino Coalition had sponsored a needle exchange site with Prevention Point in the Mission district of the city.

Charges of racial genocide and assertions that whites were imposing foreign and unwanted solutions on black communities have been prominent in a number of cities where needle exchange has been attempted. In New York, for example, African American opposition to needle exchange programs was widespread in 1987 and 1988, when that city was attempting to establish an experimental program. In January of 1988, when ADAPT received widespread publicity about a planned distribution to addicts, the city cut off its funding for three months. When the Department of Health did start a limited exchange program in November of 1988, racial criticism was voiced by New York Mayor David Dinkins, the chair of the City Council's Black and Hispanic Caucus, Congressman Charles Rangel, the head of another drug treatment program, and several prominent clergy.

Some of these black leaders felt that the exchanges would keep the black community endlessly chained to drugs. Others thought