

Finding a place for needle exchange programs

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ABSTRACT *Using the concepts of stigma, NIMBY and place, this paper examines the difficulties of finding a place for needle exchange programs (NEPs). Data were drawn from semi-structured interviews with NEP staff (Ontario, Canada) that focused on operational policies and routines. An iterative, inductive analytic process was used. NEPs, their staff and clients are not always welcome additions to organizations or communities because of concerns about the 'dangerousness' of clients and the potential contamination of communities and workplaces by stigmatized individuals and their artefacts (e.g. contaminated injection equipment). Public parks where a lot of drug 'action' takes place are good destinations for outreach workers but these places are contentious sites for NEP activities, particularly when residents do not perceive a need for the program and/or want to redefine their neighbourhoods. Issues of 'place' are further complicated when service delivery is mobile. Finding a place within organizations is difficult for NEPs because of concerns about the diversion of limited financial and spatial resources to 'non-core' activities and 'undesirable' clients. Workers respond to these challenges by contesting the social and spatial boundaries of who is an acceptable client or neighbour and refuting the perceived 'differentness' of injection drug users. Implementation of an unpopular service involves a delicate balancing act of interests, understanding of the dynamics of particular communities and a willingness to reinvent and redefine programs. The sociospatial stigmatization of injection drug use has had a negative impact on NEPs, and perhaps limits HIV prevention efforts.*

Introduction

Finding a place for needle exchange programs (NEPs) within organizations and communities is an ongoing struggle. NEPs are public health programs designed to reduce the transmission of HIV and Hepatitis B and C among injection drug users (IDUs) and other community members through health education and exchange of sterile injection equipment (i.e. needles and syringes). Services are provided at fixed sites, through mobile services and/or through inter-organizational agreements (Hankins, 1998).

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Since their inception, NEPs have had a controversial identity in some jurisdictions (Reilly, 1990; Des Jarlais *et al.*, 1995; Stimson, 1995; Keene and Stimson, 1997; Hankins, 1998; Broadhead *et al.*, 1999; Des Jarlais, 2000a) because they are associated with illicit behaviours (i.e. drug use) and socially stigmatized groups (i.e. IDUs and sex-trade workers), and because they are often perceived to foster illicit drug use. However, NEPs are one of the cornerstones of HIV prevention among IDUs in the UK, Europe and Australia (Stimson & Donoghoe, 1996; Bastos & Strathdee, 2000; Gibson *et al.*, 2001).

NEPs target the behaviours associated with HIV transmission (i.e. unprotected sex and injection with contaminated equipment) that are often viewed as immoral, undesirable and/or illegal. NEPs have been extensively researched and these studies have shown that NEPs do not encourage injection drug use, nor do they create a public safety problem by increasing the number of contaminated needles in communities (Riley *et al.*, 1998; Des Jarlais, 2000b; Doherty *et al.*, 2000). However, NEPs have suffered from conflicting scientific evidence regarding their effectiveness in reducing rates of HIV transmission (Heimer *et al.*, 1993; Hurley *et al.*, 1997; Des Jarlais *et al.*, 1996; Bruneau *et al.*, 1997; Strathdee *et al.*, 1997; Schechter *et al.*, 1999; Bastos & Strathdee, 2000; Gibson *et al.*, 2001).

This paper examines the processes of stigmatization and the challenges of finding a place for NEPs in Ontario, Canada. Ontario is the largest province in Canada with a population of approximately 11 million people. The literature on stigma and place is reviewed below and is used as a framework.

Injection drug use, stigma and places

Stigmatization is a social process through which some individuals are defined as acceptable and others as unacceptable (Goffman, 1963). Stigmatization often arises in response to physical, behavioural and social attributes that are socially devalued and can result in a 'spoiled identity' (Goffman, 1963). The degree to which stigmatized people are discredited varies along a diverse set of dimensions, including: (a) individual functionality/productivity; (b) the aesthetics of appearance; (c) interference with social interaction; (d) individual culpability for the attribute; (e) individual unpredictability and dangerousness; (f) curability or reversibility of the attribute; (g) ability of others to empathize with a condition; and/or (h) the infectiousness or contagiousness of a condition (Takahashi, 1997a). The stigmatization of IDUs occurs along many of the dimensions listed above. For example, some IDUs: (a) are unemployed; (b) frequently have deficient personal hygiene as a result of homelessness; (c) are held to be responsible for their addictions; (d) can be violent, belligerent or unpredictable after consuming drugs, when in withdrawal and/or because of an existing mental illness; (e) have difficulty achieving and maintaining sobriety; and/or (f) are perceived to have feared infectious diseases such as Hepatitis B and C and HIV. These attributes contribute to IDUs' stigmatized status and social isolation as individuals, and isolation from formal social and healthcare services as a group. Herek (1999) suggests that when individuals are held responsible for their disease, the social response is often anger and moralism instead of pity or empathy. This has been the case in the realm of addictions where concerns about individual and social

morality often supersede more relevant health concerns (Hankins, 1998; Bourgois & Bruneau, 2000).

The concept of stigma has also been examined as it pertains to places. Places refer to bounded settings in which social relations and identities are socially created and recreated. Takahashi (1997a) suggests that the identities of places and the people who inhabit them are mutually constitutive. The social processes of stigmatization can affect places because the stigma ascribed to individuals and groups can become embodied by the places they frequent, including the facilities of human service organizations. Conversely, the stigma of a place can lead to the stigmatization of individuals who frequent such places.

The link between stigma, organizations and place is exemplified in what is termed the NIMBY phenomenon. NIMBY is an acronym that refers to a 'not in my backyard' attitude adopted by community residents who oppose the siting of facilities. NIMBY is linked to stigmatization when the 'fear of difference is projected onto objects and spaces comprising the home or locality which can be polluted by the presence of non-conforming people, activities or artefacts' (Sibley, 1995, p. 91). Opposition to siting of human service facilities (e.g. group homes for the homeless, mentally ill, parolees and individuals with HIV/AIDS) has been traced to NIMBY attitudes (Arens, 1993; Graber & Aldrich, 1993; Chiotti & Joseph, 1995; Colón & Marston, 1999; Piat, 2000). Factors that contribute to the NIMBY phenomenon are varied and can include: personal and family security concerns, potential negative effect on quality of life (e.g. fear of disruptive neighbours) and concerns about negative effects on property values (Piat, 2000).

Methods

Data for this paper were derived from structured, qualitative interviews that were based on institutional theory, the strategic response literature and impression management concepts. Interviews were used to explore how NEPs establish, define and defend their existence within their home communities. Interviews were designed to be sufficiently detailed to allow for focused examination of organizational issues, but sufficiently open to allow for examination of emergent meanings and constructs. As part of the interview, all participants were asked to provide limited sociodemographic information (i.e. age, sex, education and previous employment history) and a range of questions pertaining to their work responsibilities, concerns and attitudes.

All coordinators, managers and workers of NEPs in Ontario (i.e. as of November 1998) were approached to participate in this study. To provide historical depth and to understand the organizational contexts in which these programs are embedded, Medical Officers of Health, Executive Directors and key informants from the Ontario Ministry of Health and Long-Term Care were interviewed. In total, 59 individuals participated in the study. The response rate for programs was 100% and 95% for individuals. Of those who participated, 56% were women, 44% men and 39% of participants worked for, coordinated or managed the NEP when it first opened.

Interviews were transcribed into WordPerfect, verified and entered into the Ethnograph V.5.0. The methods of qualitative analysis described by Lofland & Lofland

(1995) and Strauss & Corbin (1998) were used for this investigation. All data collected during interviews were coded based on theoretical concepts or new concepts were created where appropriate. An iterative coding process was used wherein each transcript was read, reread and the coding adjusted as necessary. Transcripts were coded manually and the codes were entered into the Ethnograph program. Following the coding procedure, the text subsumed under each code was reviewed, summarized and an analytic memo was written to capture the major issues relevant to this code.

Theoretical and substantive memos (i.e. mini-analyses) were written throughout the coding process. These memos were used as the basis for the overall analysis of the data. Analysis was conducted using an iterative process of comparing theoretical concepts with data, and data with theoretical concepts. The purpose of this approach was to use theory as a guide, but also to use the data to empirically verify concepts and suggest future concepts that may be relevant to understanding NEPs and other programs. The purpose of these analyses was to provide a rich understanding of the contexts in which issues are identified and actions taken and, where possible, the determinants of these issues.

To ensure the quality of this study, several techniques were employed. First, a detailed diary was prepared throughout all stages of the project to ensure that decisions made concerning data collection, analysis and interpretation were documented and later could be reviewed. Second, during the process of coding, each code was assigned a definition and a log kept of all changes. The log allowed for an examination of the evolution of coding. Third, the credibility of findings was assessed in several ways, including regular discussions with committee members familiar with NEPs and with a colleague conducting a study of outreach workers in another city. Fourth, preliminary results of the study were presented at scientific meetings where several of the study participants were present and asked for feedback. Fifth, informal discussions were held with key participants regarding the findings. Sixth, throughout the results section to follow, attempts were made to provide sufficient description of the context in which NEPs operate to allow the reader to judge the credibility and trustworthiness of the data. Excerpts from the interviews were selected to illustrate the analysis. Each excerpt is followed by a numeric code that indicates the program and participant. For example, a code of '13.2' refers to program no. 13 and participant no. 2 in this program.

This study was designed, conducted and reported based on an underlying standpoint that moral and/or religious beliefs should not interfere with the design, delivery and provision of health and social services to drug users or other members of society. While the research team is supportive of NEPs, the goal of the project was not to advocate for NEPs, or a harm-reduction approach, but rather to assess the environment in which the NEPs are embedded and to comment on the impact this environment has on HIV prevention initiatives.

Results

Gathering Support

In Ontario, IDU-focused services are relatively new services for public health departments and AIDS service organizations. The first NEP in Ontario opened in

1989. By 1999, the number of programs had increased to 15, with programs in all major regions of the province. Typically, NEPs are founded by workers in public health units, AIDS service organizations or Medical Officers of Health who invite representatives from local agencies (e.g. drug treatment, police departments, probation services) and injection drug users to participate in program development. Founding committees are formed for pragmatic and symbolic reasons: to provide program founders with diverse expertise and to prevent opposition before it develops. Founding committees often contain cautiously supportive members (e.g. senior managers) who are intent on implementing an HIV prevention program for drug users, but view NEPs with some reserve. In four locations, vocal opponents such as police officers, members of religious groups and/or drug abstinence advocates sought membership or were invited to participate. Although opponents complicate the NEP development process, founders note that, over time, opponents tend to be swayed by the scientific evidence concerning NEP effectiveness and testimonials of NEP advocates.

In fact it was interesting because there's a police officer that is on the committee today and is a really good community advocate for the program and he initially ... wanted to make sure that it never happened. (6.1)

As a requirement of funding, these committees must be formed and founders must demonstrate the need for, and capacity to deliver, NEPs. For the oldest NEPs in Ontario, programs in other parts of the world (e.g. Europe and Australia) were used as models. Replication of service models serves pragmatic and symbolic purposes: it provides founders with a starting point in the planning process and can be used to claim conformity with internationally 'accepted' NEP service standards. As well, each program must demonstrate that the local police department is supportive or has agreed not to interfere with the NEP. NEP funding is administered through public health units, under the supervision of the Medical Officer of Health. Designating responsibility for NEPs to a 'respected' public official is seen as a strategic manoeuvre because the Medical Officer of Health is likely to be seen by the public as a person who would act in a 'responsible' manner with public funds.

Finding a place within organizations and communities

Regardless of year of founding and preliminary planning activities, NEPs have generally faced difficulties finding a place in their communities and parent organizations. As well, despite nearly a decade of NEP service availability in some parts of Ontario, each time a new NEP is proposed, NEP founders must contend with opposition or scepticism regarding these programs. For example, one coordinator said:

At the beginning needle exchange was all alone, you know? Like we were out there and we were alone and people didn't really want us. They wanted us to do what we were doing because of HIV but didn't really want us. We weren't treatment. We weren't really public health either, you know, because we weren't nurses. We weren't doctors ... As a matter of fact for the longest time I was referred to as the fucking druggie in the needle exchange. (2.1)

As the quote above suggests, NEPs, their staff and clients are not always welcome additions to pre-existing organizations or communities. This issue is examined from the perspective of the workers and managers of these programs and their accounts of the opposition they have faced.

NEPs and public safety

Public opposition to siting human service facilities in a community can be traced to concerns about dangerousness and the potential contamination of communities by stigmatized individuals and artefacts of their presence (e.g. contaminated injection equipment). From the workers' perspective, residents are concerned that NEPs will draw IDUs into their community and create and/or exacerbate existing drug problems (e.g. theft, sex trade, assaults). Residents see provision of sterile injection equipment as sending the 'wrong' message to IDUs and potentially increasing the risk of needle stick injuries. The primary concern of residents appears to be the maintenance (or creation) of the 'purity' of their communities by excluding IDUs and the artefacts of their presence. Furthermore, the presence of an NEP is seen as a statement that there is a drug problem in the community and that it is serious enough to warrant this type of program.

To find a place within communities, NEPs struggle to convince residents that the program will not create a public safety problem. However, media reports about discarded needles in parks and other public areas complicate efforts. While needles may have been improperly discarded in the community before, once the NEP opens discarded needles are attributed to the NEP and its clients. Almost all of the programs have been held accountable for improperly discarded needles in their communities. Claims that NEPs increase public safety by removing contaminated needles from circulation are hampered by exchange rate statistics (i.e. the ratio of needles taken in versus needles given out multiplied by 100) of less than 100%. Opponents use this statistic as evidence that the program has failed to achieve the public safety goal.

Opposition to NEPs often takes the form of verbal and written complaints to politicians, public health authorities and newspapers. Residents who complain often portray the NEP as a public safety hazard. Further, NEP clients are defined as irresponsible citizens and/or criminals who lack concern not only for their own health but the health and safety of 'innocent' others in the community, or as outsiders drawn to the community by the NEP. As one worker noted, NEPs fear the consequences of public statements such as: 'those damn addicts littering our streets. This damn needle exchange is part of the problem' (11.2).

When needles are found in public places, NEP staff often deny responsibility. Staff suggest that the needles did not originate from the program or the program's clients and that the program cannot be held responsible for the disposal practices of non-clients. In addition to denying responsibility, culpability for the discarded needles is often widened to others in the community (i.e. diabetics or steroid users) in an attempt to divert the focus of attention away from the NEP and its clients. By taking these stances, staff hope to reposition clients as responsible service users and citizens.

Other NEPs elect a non-confrontational and pragmatic response: they encourage community residents to telephone the NEP when needles are found. NEP staff are

quickly sent to dispose of the needles. Programs that adopt a non-confrontational stance try to keep a low profile in the community. These programs believe that a confrontational attitude increases the visibility of the program and the potential for opposition. Those who try to maintain a low profile acknowledge that acceptance may be difficult to achieve. A manager reflects this attitude in the following remarks:

And I mean we just simply acknowledged that a certain percentage of the population will never support needle exchange and we can't change that percentage of the population. So how can we work with what we can work with and not, you know, have dents in my forehead from . . . slamming my head up against the wall trying to change the unchangeable. (5.1)

Whose backyard?

Injection drug use involves the use of public settings because drugs maybe purchased, prepared and/or consumed in public places. In the outreach model of delivery adopted by most NEPs, services are organized to meet the needs of the clients. Parks where a lot of drug 'action' takes place are good destinations for outreach workers. However, parks and other public places can be contentious sites for NEP activities, particularly when residents do not perceive a need for the program and/or want to redefine their neighbourhoods.

Issues of 'place' are further complicated when service delivery is mobile. Some NEPs offer service from vans/cars that travel through the community. As such, the 'place' for NEPs is defined not by a building but rather a neighbourhood. While the mobility of service improves accessibility for clients, it can also lead to community opposition, particularly when the van is visible in the community (e.g. markings on the van advertising the program). For one NEP, mobile outreach in a particular neighbourhood has been severely curtailed by resident opposition. Residents deny an existing local drug problem and believe that the NEP services are unnecessary. Further, some residents believe that delivery of NEP services has drawn drug users and others (e.g. sex-trade workers) into the neighbourhood, creating a drug problem. Residents who deny the existence of a drug problem in their community before the NEP van started offering services believe that if the van discontinues offering services the 'drug problem' will go away. A worker offered the following remarks:

I think they're irrational. Like, they honestly believe, because there have been several articles [in newspapers] that we bring the drugs there, that we brought the prostitution there. Well, we went there because it was there, you know. And for years and years, even years ago, there have been books written by addicts that have lived in that neighborhood and described how awful it was and stuff like that. (15.4)

When residents attempt to redefine (or purify) their communities and rid themselves of undesirable 'elements', NEPs tend to be particularly unwelcome. Residents in several Ontario communities have opposed the opening of an NEP because they believe that the program conflicts with their efforts to improve their neighbourhoods by eliminating the

local drug and sex trade. The experiences of two NEPs are reflected in the following remarks:

Honestly, some people believe that we brought it there. The drugs there and the prostitution. And the community's really trying to clean up their neighborhood, which is good. I mean, I wouldn't want it [i.e. drug scene and sex trade] in my backyard either, you know. So I understand where they're coming from but if it was me, I'd just move. (15.7)

The people in the building weren't concerned about it. It was the community around the building and we got caught up in this phenomenon . . . of people in the east community, wanting to revitalize So there was a lot of stuff around . . . 'we want to get rid of drug users and hookers and you're just going to bring them here' . . . you know, and we were trying to say we're here because they're here And all the people who live there want all the nasty people to go away. And I mean sex trade workers and street people and drug users have been in the east for thirty or forty years. (5.1)

To cope with resident opposition, one NEP moved the fixed site to another location that it believes is less accessible to clients. The other NEP negotiated a compromise that resulted in the development of strict policies where the NEP van can provide services. Specifically, the NEP and the local community group negotiated a set of rules regarding the distance the NEP van must be from schools and daycare centres when delivering services. Some residents attempted, but were not successful, in imposing stricter rules to include avoidance of seniors' residences and churches. Despite observance of the van rules, workers report continued harassment by community residents. The van observes the 'stopping' rules but workers are also obliged by law to observe traffic rules including stoplights and stop signs etc. Several residents have objected when the NEP van has stopped at 'red' traffic lights that are adjacent to parks. Residents have verbally harassed staff and hit the van with their fists. For many staff, resident expectations are perceived as absurd and to interfere with the provision of service.

Not in my workplace

This disdain for the NEPS and the IDUs they serve is prevalent not only in the community but also within organizations that oversee the NEPs. Finding a place, both physical and financial, within an organization is difficult for NEPs because of the larger organization's concerns about diversion of limited financial and spatial resources to 'non-core' activities and 'undesirable' clients. Regardless of the parent organization, the vast majority of programs are conceptualized as 'outside' the agency mandate. Although NEPs are legally mandated in Ontario (Strike *et al.*, 2001), the perception of NEPs as non-core or marginal programs persists. This perception is related in part to the funding arrangements. At the time of this study, NEP funding was obtained from the provincial government and sometimes supplemented by the local government. However, NEPs' funds are administered by public health units and AIDS service organizations. As a result,

most NEPs do not have a place in the core budgets of parent organizations. While many medical and executive directors support NEPs, they often face internal opposition to the programs because of fears that diversion of funds to the NEP will threaten the viability of other programs perceived to be more important to the organization.

Not only is funding a source of opposition to NEPs but inclusion of NEPs within organizations is often perceived to alter the 'core' identity and purpose of agencies. For example, managers in AIDS service organizations noted that these organizations were established by gay men to provide HIV prevention to gay men, and also to provide support to gay men infected with HIV. Integration of programs and services for other groups of people has not occurred because of resistance to expand these organizations to others, particularly IDUs. About this situation, a senior manager said:

Historically AIDS organizations were set up by . . . middle class, white, gay men, who were educated and motivated to set up organizations for middle class, white, gay men, right? And our challenge as AIDS organizations has been to figure out how do we acknowledge that and honor that and also become accessible to new populations who are impacted by HIV and AIDS. So one of my roles here at the AIDS Committee is to continually advocate on behalf of injection drug users or street populations and young people, within the agency, for change that will increase accessibility to those populations. (5.1)

Internal resistance to NEPs also can be traced to the fear that IDUs are violent and dangerous, which fuels resistance to accepting IDUs as 'clients'. A worker based in an AIDS service organization offered the following description of this situation:

For a number of years my clients were really not viewed as being clients of the agency. My clients very rarely come in to this building. And there has been some resistance, you know? Even, you know, to the extent where, you know, people said, you're going to have *those* people here? Which is pretty fucking strange for an AIDS service organization to be making those kind of comments. (14.4)

Defending highly stigmatized clients

Workers resist the social and spatial boundaries of who is an acceptable client or neighbour set by co-workers and residents by contesting the reputed 'differentness' of IDUs. Staff approach this task by challenging moral judgements. However, efforts to redefine clients are difficult because of the many discrediting identity characteristics IDUs possess (e.g. criminal records; homelessness; severe mental illness). Workers described their clients and social responses to drug users as follows:

Well it's a marginalized population considered disposable by so many segments of society and they're simply not disposable. I have really strong beliefs about, as many do in the agency, that every individual is unique and wonderful in their own right and because they happen to use drugs, or inject drugs, that's, to us that's a non-issue. (5.2)

To find a place for service delivery, the staff of all NEPs have adopted a rhetoric that repositions drug users as ‘worthy’ recipients of public health efforts and contests the ‘differentness’ of IDUs from others in the community. Specifically, workers attempt to normalize drug use behaviours by reminding community members that many people consume drugs. Normalizing drug use involves reminding opponents that drug dependence is not uncommon. For example, some workers suggest that everyone has someone in their family who is dependent on some type of drug: tobacco, caffeine or alcohol. During community presentations, one worker typically asks his audience:

How many of you drink three or four times a week? How many of you are hung-over right now? How many of you smoke? How many of you have a coffee in front of you right now? (11.2)

Workers also try to convince opponents that drug addiction is not a matter of personal choice and that bad times could fall on those with whom they are closest. These types of accounts are used to remind opponents that IDUs come from all walks of life.

Strategies used to reframe IDUs as worthy citizens are also used within parent organizations. However, the proximity of IDUs to co-workers within agencies requires additional reframing efforts because thefts within the NEPs occasionally occur. Workers in one NEP said that all thefts in the building housing the NEP are blamed on their clients with or without evidence. In these situations, workers try to normalize thefts by noting that thefts occur in all workplaces, not just NEPs, and that security measures are necessary in all work settings. Workers tend not to blame clients for thefts—they accept that sometimes clients do things they should not. To prevent these events, workers reduce opportunities for thefts by locking up personal possessions and other items of value. Hence, responsibility is transferred from the client to the staff.

According to workers, clients are generally non-violent. As part of efforts to re-define clients as worthy, NEP workers contest depictions of IDUs as violent and predatory. For example, a worker said:

Like people sort of see it as very dangerous work and, you know, very dangerous people. That has not been my experience. Like I said, people are people. I’ve ran into more trouble in a bar with a bunch of miners than I have working with, you know, street people. So I think that needs to be clear. I’m not dealing with . . . a group of individuals who will knife you for twenty cents to buy more drugs. That’s not how they work. (6.3)

Workers often reverse the issue and state that clients react badly towards poor treatment in human service settings. By reversing the blame from the client to the service providers, workers reposition clients as victims of poor service. To avoid difficulties, providers must demonstrate to IDU clients that they are on the client’s ‘side’. If NEP clients are treated with respect, they will return respect. Issues of staff safety complicate efforts to reframe clients as non-violent and ‘worthy’. Over a 10-year time span, less than 10 incidents were reported where the workers’ safety was compromised. Although infrequent, these incidents undermine contentions that clients are non-violent.

The stigma of parent organizations

Issues of place are also important from the perspective of clients. IDUs are generally distrustful of health and social service providers because of prior bad experiences, concerns that disclosure of injection drug use will result in harsh treatment and the potential for arrest (McKeganey *et al.*, 1989; Barnard, 1993; Malcolm, 1998). In addition, Daker-White (1997) argues that drug users are unlikely to use services in 'drug scenes' or other areas with which they do not identify. As a result, IDUs tend to be wary of services offered by public health units because they are perceived to be too governmental. As well, the stigmatized identity of AIDS service organizations can be a disincentive for some IDUs. For example, workers in a program based in AIDS service organizations noted that some clients believe the AIDS service organization serves only gay men and/or people with HIV infection. Clients worry that attending this program might confer an identity as a gay man and/or someone with HIV.

To find an acceptable place for clients to access services, three NEPs relocated to sites closer to the core drug-using areas of the city. Interestingly, local church groups donated all of these sites. However, physically dislocating the NEP from the parent organization is not always possible owing to budget restrictions and/or an inability to access donated space. Other NEPs have altered the physical layout and accessibility of the program within the parent organization. For example, three NEPs moved the entrance to the program to another part of the building (e.g. alley and/or side door) to 'separate' the NEP from the parent agency.

Selecting an appropriate fixed site can be a challenge, as the following example illustrates. Fear that clients would not attend an NEP housed at an AIDS service organization because of attitudes towards gay men and also the physical distance from the core 'drug-using' area prompted an NEP to rent store-front space in the core 'drug-using' area. Program founders hoped that the concentration of clients in this neighbourhood would increase service accessibility. After the opening, community residents demonstrated against the NEP outside the site. In response, the NEP held several community forums. The community forums were not successful in changing negative opinions of the clients or the NEP. As a result, the program was relocated to the parent AIDS service organization. However, staff noted that the new site is too distant from the core drug-using area and the image of the parent organization as a 'gay' organization has impacted on the willingness of IDUs to attend the site. These two factors, location and image, are said to have severely curtailed the development of the client base.

Discussion

Reflecting on the experience of NEPs in Ontario, the sociospatial stigmatization of injection drug use has had a negative impact on NEPs, and perhaps limited HIV prevention efforts. Not only have NEPs had difficulty finding acceptance for their clients, they have also had difficulty finding acceptance for their services and their workers. Within organizations, opposition to NEPs and their clients serves to reinforce the stigmatization of IDUs at a social and spatial level. This study shows that stigma

confines the physical and organizational space for the delivery of service to marginalized members of society. Specifically, stigmatization leads to the exclusion, or attempted exclusion, of individuals and groups deemed 'undesirable' from neighbourhoods, neighbourhood resources (e.g. parks), workplaces and workplace resources (e.g. office space). This marginalization and exclusion is automatically extended to NEPs by association.

NEP service providers have long recognized that to gain community acceptance for their services and clients that they must address the social and spatial dimensions of stigmatization. These dimensions are believed to exacerbate the health and social problems experienced by IDUs and further complicate the work of NEPs. To address these issues, NEPs in Ontario have attempted to prevent opposition where possible and contend with that which cannot be prevented using varied approaches. First, NEPs involve community partners during the planning process. Second, NEPs try to prevent criticism by designating financial responsibility to a respected public official. Third, NEPs have tried to maintain a low profile in their communities. Fourth, some NEPs encourage community members to report improperly discarded needles to the programs and staff ensure the needles are properly discarded. Fifth, one NEP negotiated program delivery locations with community residents to resolve complaints about the program. Sixth, programs have moved to less contentious locations. Seventh, NEPs have tried to influence community and co-worker negative judgements about IDUs by repositioning clients as worthy recipients of public health efforts. These efforts reflect advice provided by other authors (Reilly, 1990; Des Jarlais *et al.*, 1995).

While NEPs in Ontario have experienced opposition, the number of programs has steadily increased over time. This suggests that while NEPs may be unpopular with some segments of society, that opposition has not prevented their implementation and diffusion. As Keene & Stimson (1997) suggest, acceptance of NEPs tends to vary depending on the pre-existing and prevailing drug treatment philosophy. However, the experience reported here suggests that where there is sufficient support to ensure NEP implementation, that opposition may still arise and consume limited operational time but not prevent implementation.

To understand the NIMBY phenomenon, it is important to take into account that people define 'home' places (i.e. residences and neighbourhoods) as 'desirable' and intrusions of 'undesirables' into these places can be seen as threats to the spatial boundaries segregating 'normals' from the stigmatized (Takahashi, 1997b). Furthermore, identities are formed in part by the types of places people inhabit. As such, the siting of controversial human service facilities near 'home' places may be perceived as a threat to identity of self and community, particularly in neighbourhoods under renewal. Extending this idea of home places to the workplace, it could be said that the dual opposition to NEPs can be traced to concerns about 'pollution' of the neighbourhood and the workplace with undesirable people and unacceptable services and associated threats to individuals' identities as particular types of residents and workers.

Delivery of services to the socially marginalized can be a complicated endeavour. In terms of facilitating access, service providers may favour locations proximal to potential clients. However, neighbourhoods are not necessarily homogeneous and non-clients may not welcome these facilities. Residents may coexist in a neighbourhood because of similar economic situations but may differ in many other aspects of their lives. These differences

may be the source of attempts to establish symbolic and spatial boundaries between residents. Nevertheless, prior research has shown that community residents who lack social and economic power are less able to oppose the siting of these facilities (Dear & Wolch, 1987). These neighbourhoods are often labelled 'areas of least resistance' (Dear & Wolch, 1987). Thus, opposition in these types of neighbourhoods does not always hamper service providers. However, the converse can also be seen from this study. Neighbourhoods that could be labelled as 'areas of least resistance' because of their low median income have been very vocal, and in one case very successful, in opposing the siting of an NEP in their neighbourhood. Intrusion of the NEP van or fixed sites thwarts attempts of some residents to resist a particular portrayal of their neighbourhood and perhaps themselves. Siting of an NEP in these communities is seen to reinforce an unwanted image of their neighbourhood as a 'drug haven'. Other research has noted that residents of neighbourhoods in the process of renewal (or gentrification) often oppose the siting of 'undesirable' facilities (Colón & Marston, 1999). As yet, this has not been the case for NEPs. However, NEPs may have to contend with opposition to existing or proposed service delivery sites, when neighbourhoods begin to change. As such, bringing services directly to the socially marginalized can be a complicated and difficult endeavour, particularly for contentious programs.

In the past, studies of opposition to human service facilities have focused on fixed-site facilities. Mobile NEPs present a different example of the difficulties of finding a place. As this study shows, service settings can be variable and service mobility does not necessarily prevent opposition to these services. While some residents worry that fixed-site facilities will draw in the 'wrong element' to their neighbourhood (or backyard) and 'spoil the identity' of the neighbourhood, travelling to areas where 'undesirables' live does not always solve problems of place. Although a fixed site might provide an easier target for coordinated opposition, mobile service may simply introduce a new range of issues to negotiate with community members. Mobile service can exacerbate issues of place because residents have multiple sites to complain about and defend from 'spoiling'. These results have implications for other service providers who use mobile and/or street-based modes of delivery to reach stigmatized clients (e.g. homeless, mentally ill) in locations where they live.

NEPs have tried to quell opposition by using scientific evidence that demonstrates effectiveness and shows that NEPs do not contribute to public safety problems. For NEPs, conflicting scientific evidence of effectiveness has received widespread media attention and complicated their attempts to demonstrate that NEPs are effective and/or benign. And, as Graber & Aldrich (1993) suggest, community members may discount scientific evidence when there are perceived personal implications concerning a health hazard. Thus, implementation of an unpopular service involves a delicate balancing act of interests, understanding of the dynamics of particular communities and a willingness to reinvent and redefine programs.

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