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‘Because I’ve been extremely careful’: HIV seroconversion, responsibility, citizenship and the neo-liberal drug-using subject

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Abstract

In this article we examine how injection drug users who do not attribute their HIV infection to engaging in HIV risk behaviours take up and critique discourses of individual responsibility and citizenship relating to HIV risk and HIV prevention. We draw on data from a study in Vancouver, Canada (2006 – 2009) in which we interviewed individuals living with HIV who had a history of injection drug use. In this paper we focus on 6 cases studies of participants who *did not* attribute their HIV infection to engaging in HIV risk behaviours. We found that in striving to present themselves as responsible HIV citizens who did not engage in HIV risk behaviours, these participants drew on individually-focused HIV prevention discourses. By identifying themselves in these ways, they were able to present themselves as ‘deserving’ HIV citizens and avoid the blame associated with being HIV positive. However, in rejecting the view that they and their risk behaviours were to blame for their HIV infection and by developing an explanation that drew on broader social, structural and historical factors, these individuals were developing a tentative critique of the importance of individual responsibility in HIV transmission as opposed to dangers of infection from the socio-economic environment. By framing the risk of infection in environmental rather than individual risk-behaviour terms these individuals redistributed responsibility to reflect the social-structural realities of their lives. In this article we reflect on the implications of these findings for public health measures such as risk prevention messages. We note that it is important that such messages are not restricted to individual risk prevention but also include a focus of broader shared responsibilities of HIV.

Keywords

Risk; HIV; substance use; prevention; critique; governmentality; citizenship

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Introduction

In this article we examine the social dimensions of HIV prevention strategies. We use an extended conception of HIV prevention strategies in which HIV prevention is considered not only in terms of behaviour, but also in terms of social and political interventions (Davis & Squire, 2010). We examine the ways in which HIV prevention strategies engender particular ways of thinking about HIV, and give rise to particular HIV subjectivities. For example, we examine how some people who use drugs resist the dominant risk narrative grounded in exclusively behaviourally-focused HIV prevention strategies that remind people to adhere to methadone maintenance therapy, to inject in supervised injection settings, and most importantly not to share injection equipment. We examine how individuals who resist this narrative develop alternative narratives that privilege the social and economic causes of HIV infection. The purpose of this article is not to judge the plausibility of participants' accounts about HIV transmission; rather, we want to examine how the individuals in our study who attribute their HIV acquisition to an outside force engaged in and critiqued discourses of individual responsibility and citizenship relating to the transmission of HIV.

Risk, HIV infection and prevention

Substance use researchers have drawn extensively on poststructuralist work on governmentality to describe the ways in which institutionalised forms of social control function to discipline the bodies of people who use drugs through HIV prevention strategies and other medical interventions (Bourgois et al., 1997; Fischer et al. 2004; Moore, 2009; Moore & Fraser, 2006). However, less attention has been paid to poststructuralist conceptualisations of resistance to or, as Foucault (1978/1997) terms it, 'critique' of these forms of governmentality. In this article, we draw on Foucault's conceptualisation of 'critique' and notions of citizenship (Rose, 2007; Nguyen, 2005; 2007) in analysing the accounts of HIV acquisition by people who have a history of drug use and reject the view that engagement in HIV risk behaviours resulted in their HIV infection.

In classical liberal ideology which was broadly accepted in high income countries until the 1970s, the state was responsible for the social security and health of citizens. Following the various economic crisis of the 1970s and the concerns about rising health and welfare costs there has been a shift to neo-liberalism, in which the role of government is to provide information on risks that citizens should avoid, rather than to provide services. Citizens are expected to take responsibility for the 'care of the self', and to avoid risks to prevent illness. Neoliberal policies are reflected in the deinstitutionalisation of health care services, an increased emphasis on individual responsibility and the promotion of active citizenship among all citizens to be proactively involved in reducing their risk of ill health (Bunton, 2001). This was facilitated through the emergence of new forms of governmentality, where the notion of 'risk' and its avoidance has become a key technology of social control (Moore, 2004). Foucault's concept of governmentality broadens the notion of sovereign state power in neo-liberal states, to include forms of social control imbued in various disciplinary institutions, such as schools, hospitals, and public health. As such, social control in neo-liberalism, manifests itself by producing knowledge and certain discourses that get internalised by individuals and guide the behaviour of populations. This leads to more

efficient forms of government, as this internalised form of social control enables individuals to increasingly govern themselves (Lemke, 2001).

In keeping with this shift from classical to neo-liberal governmentality, there has been a marked rise in attention to individually-focused preventative medicine and health promotion strategies that was accompanied by a re-conceptualisation of all citizens, including people who use drugs, as responsible actors capable of self-regulation and self-discipline (Burrows, Nettleton, & Bunton, 1995, Moore & Fraser, 2006). In line with this increasing emphasis on self-care and individual responsibility, HIV prevention campaigns typically convey a strong message of individual responsibility, which is commonly presented in isolation from any discussion of broader structural responses to HIV transmission and safer injection practices (Dodds, 2002). For example, the HIV prevention materials, analysed by Dodds (2002) strongly emphasised factual awareness and behaviour change by giving directions on proper condom use, and advice against the sharing of injection materials among injection drug users. Researchers have identified individualised approaches to health promotion as not only partially effective but also as perpetuating isolation and stigma for those who fall ill through assigning blame for not successfully abstaining from risk behaviours (Crawford, 1994; Dodds, 2002; Fraser, 2004). At its most simplistic level, the underlying message of individualised HIV prevention strategies is that if one merely avoids the risk behaviours associated with the transmission of HIV (such as unprotected sex, sharing injection equipment) one can avoid HIV. Therefore, HIV infection can become a marker of individual risk taking, individuals are blamed if they fail to listen and respond appropriately to HIV prevention messages, and continue to engage in behaviours typically viewed as amoral or criminal (Brandt, 1997).

In the neoliberal model, the state not only provides risk information but also specifically targets people deemed at 'high risk' of HIV, such as injection drug users, by providing needle exchange programmes, supervised injection sites and methadone maintenance therapy. As such, people deemed at 'high risk' are expected to behave responsibly and use these facilities (Moore & Fraser, 2006). There is evidence that these facilities do have a positive impact on the lives of many substance users in providing tools for the safer consumption of illicit substances (Kerr, Small, Moore, & Wood, 2007) and indeed, many of these interventions were based on the direct input from substance users. For example, peer-driven drug user organisations were instrumental in implementing the initial harm reduction interventions in response to the HIV/AIDS epidemic in the mid-1980s by providing the first needle exchange programme in the Netherlands (Friedman et al. 2007) or for running the first unsanctioned supervised injection site in North America (Kerr, Oleson, Wood, 2004). However, harm reduction proponents had to bargain hard to be able to gain legitimacy in the context of criminal justice focused drug policy approaches. As a result, services offered to substance users are often highly regulated by restrictive rules and regulations (Kerr, et al., 2007) and often exist in the absence of programmes that address the broader social inequalities that render particularly poor substance users vulnerable to negative health effects related to their drug use. As a result, many harm reduction services are somewhat removed from the grass-roots citizenship action that helped initiate them and have come to form part of the broader political shift that emphasises the self-responsibility of each individual to strive to protect their health by making use of these services.

The apparent neglect of socio-economic factors can be seen in the silence in the dominant discourse about the ways in which HIV infections affects those who are marginalised and experience prejudice. For example there is in the official discourse little discussion of the relationship between ethnicity and HIV transmission. For example in the area in which we undertook our research, HIV rates are almost twice as high among Indigenous injection drug users compared to non-Indigenous drug users (Wood et al., 2008). Recognition of the disproportionate burden of HIV and social suffering carried by Indigenous peoples highlights the continuing effects of colonialism, its ideological and material foundations, and its ongoing reproduction (Culhane, 2003; Bourassa, McKay-McNabb, & Hampton, 2004; King, Smith & Gracey, 2009).

Some scholars, drawing on the concept of governmentality, have argued that HIV prevention services can function as forms of social control to discipline injection drug users (for example Bourgois 2000; Fischer et al. 2004). Bourgois (2000) has argued that methadone maintenance therapy can be seen as an exercise in regulating pleasure at the level of brain chemistry to discipline economically unproductive bodies. Similarly, Fischer et al. (2004) have suggested that supervised injection sites are powerful tools of surveillance and discipline of 'unruly' drug users.

In the present paper, however, we draw on Foucault's conceptualisation of 'critique' in analyzing the accounts of HIV acquisition by people who have a history of drug use. Foucault (1978/1997) defines critique as an attitude that enables one not to be governed *like that*, by that, in the name of those principles, with such and such an objective in mind and by means of such procedures, not like that, not for that not by them (p. 44).

Critique, in Foucault's use of the term is a *practice*, a critical attitude towards the imposition of power by the dominant discourse, rather than a binary concept with clearly defined boundaries between conformity and critique. For Foucault:

There is no relation of power without the means of escape or possible flight. Every power relationship implies, at least in potential, the strategy of struggle in which the two forces are not superimposed, do not lose their specific nature, or do not finally become confused. Each creates for the other, a kind of permanent limit, a point of possible reversal. (Foucault, 1982, p. 794).

In this article, we argue that paying attention to the ways that prevention messages are framed and the way in which responsibility is distributed is crucial if we are to conceive of, and intervene in, the context in which HIV transmission occurs. We present the accounts of 6 people living with HIV with a history of injection drug use, who reject the notion that engagement in HIV risk behaviours resulted in their HIV infection. We explore how these individuals use their narratives to critique the dominate discourse on HIV infection.

Methods

In this article we draw on a study of individuals who are living with HIV and in particular on the narratives about HIV transmission which individuals with a history of injection drug used to account for their infection. For this analysis we focus on a small number of

individuals, six, who rejected the dominant discourse that their risk behaviours caused their HIV infection. We see our analysis as a way of examining how the storytellers incorporated their social and normative understandings of a given issue (Cortazzi 2001) Therefore our analysis of these data enabled us to gain insight into how people living with HIV and a history of injection drug use engage in the dominant discourses of individual responsibility and blame.

We recruited the interview participants from the Vancouver Injection Drug User Study (VIDUS). VIDUS is a prospective cohort study comprising people with a history of injection drug use and involves semi-annual HIV-testing and the completion of an interviewer-administered questionnaire assessing a range of demographics and drug-related risk factors (Wood et al., 2005). Between 2006 and 2009, we invited cohort participants who had been diagnosed with HIV while enrolled in the VIDUS cohort to participate in qualitative interviews to learn more about the circumstances surrounding their HIV transmission. In total, we conducted 28 interviews with cohort participants who had seroconverted within the two years prior to the qualitative interview.

Four experienced interviewers (two men and two women) conducted the interviews at the VIDUS study office. Interviews were facilitated through the use of a topic guide encouraging discussion of participants to tell us how they thought they acquired HIV and their sexual and drug-using practices, among other topics. The interviews lasted between 20 and 60 minutes, we tape-recorded all interviews and subsequently transcribed them verbatim. We asked all participants to provide informed consent prior to their interview, which they did. The study was undertaken with ethical approval granted by the Providence Healthcare/University of British Columbia Research Ethics Board. Participants were remunerated with \$20 CAD stipends for their time. In this article all names and some potentially identifying details of participants' circumstances have been changed to maintain confidentiality.

We derived the data we use in this article from six of the 28 participants. These six, participants did not attribute their HIV acquisition to engaging in HIV risk behaviours. In the context of a qualitative interview, asking participants to describe the circumstances of their HIV transmission may have contributed to participants feeling responsible for contracting the virus. Additionally, the confessional character of qualitative interviewing, and that interviewers may have been viewed by participants as representing the medical establishment likely shaped participants interview narratives (Bourgois et al., 1997). The extent to which interview participants lived and enacted the subject position they negotiated during the interview is not ascertainable through an interview-based approach (Bourgois et al., 1997; Fraser, 2004). Nonetheless, focusing on six case studies enabled us to examine in detail how these six participants engaged in and critiqued discourses of individual responsibility and citizenship with regards to their HIV acquisition during the interview. The focus on these six case studies allows for a detailed examination of some of the unintended consequences of overly narrow, individual-focused conceptualisations of HIV transmission and may facilitate a better understanding of the configurations through which responsibility is distributed in HIV transmission. In analysing participants' HIV transmission accounts, we

drew on a narrative analysis approach (Reissman Kohler, 2008) and notions of critique (Foucault, 1978/1997) and citizenship (Rose, 2007; Nguyen, 2005; 2007)

Findings

While the six individuals we are focusing on all reject the dominant discourse of HIV infection via risky behaviour, they all did so in different ways. To enable a more contextual understanding of how participants discussed their HIV infection and rejected the notion that HIV risk behaviours contributed to their HIV acquisition, we present their accounts of HIV transmission in the form of six case studies. The case studies illustrate how these individuals engaged in and critiqued discourses of citizenship and individual responsibility in relation to their HIV infection and tentatively allude to the broader political, structural and historical circumstances that propelled them towards HIV infection.

Peter

Peter, an Indigenous man (in Canada this term refers to descendants of original inhabitants including First nations, Inuit and Métis peoples) in his early forties, supported himself by ‘middling’ for dealers, which involves bringing together buyers and sellers of illicit drugs. Peter presented himself as a responsible subject who did not engage in any sexual or injection-related HIV risk behaviours leading up to his diagnosis. As a responsible drug user, Peter had his HIV status tested every six months over the last few years and the timing of his HIV acquisition was well defined. Since being diagnosed with HIV three months prior to his interview, Peter had moved to primarily injecting street-obtained morphine and Dilaudid, rather than heroin, a move that may be interpreted as an attempt at self-transformation through the use of pharmaceuticals rather than heroin.

Peter estimated that he used the local supervised injection site (Insite), in which individuals can inject pre-obtained drugs under medical supervision, for approximately 20% of his injections, mainly when he wants to avoid sharing drugs with his cousin who lived in the same single room occupancy hotel. After breaking up with a long-term partner over a year prior to the interview, Peter stated that he had been practicing safe sex with the few partners he had had in the meantime and thus presented himself as a responsible HIV citizen. Peter attributed his HIV transmission to being accidentally poked by used syringes that his cousin left behind in his room. His cousin was able to access Peter’s room because of a damaged lock that his landlord refused to repair. He explained:

I’ve been doing a lot of thinking about how I got it [HIV]. And the conclusion I came up with is that, my cousin, Anna, who also lives in the same hotel as me [was the source of his exposure to HIV]. I had lost the key to my room, so she had access to my room, while I was out. On several occasions, she had left an uncapped rig [syringe] lying around and I would tell her to put the cap on the rig. There are times where I knew she had been in my room, when I was out and I would find uncapped rigs [in my room]. On a few occasions, while cleaning up my room, I picked up some plastic shopping bags with garbage in them and more than once I’ve been poked by a syringe. And that’s how I got it. I believe that she has it and she hasn’t been tested for it.

Among the six participants included in this analysis, Peter was the one who most clearly presented himself as a responsible drug user and HIV citizen who always made sure that he adhered to HIV risk reduction strategies. He portrayed himself as a hygienic citizen, who was concerned not only with protecting himself but also other drug users from the dangers associated with used syringes:

Because I've been extremely careful for myself when injecting. And when I would have other guests over, I would keep tabs on their used rigs and, what's done with them after they're used.

Peter contrasted the representation of himself as a responsible drug user and HIV citizen with the representation of his cousin, whose irresponsible behaviour he suspected had contributed to his HIV infection. Peter contrasted himself with his 'irresponsible' and 'pleasure-seeking' cousin, drawing on analogies that positioned her behaviour as animal-like. For example he described her animal-like qualities in the following way:

My cousin is one of those girls that when she does a whack of down [heroin], she starts acting like a primate and becomes unaware of her surroundings. For her life goes on and she's just happy as a pig in shit, getting wasted all the time.

By positioning himself as a responsible drug user in relation to other drug users, such as his cousin, Peter may be attempting to 'neutralise' his own interaction with HIV risk (McGovern & McGovern, 2011) to further highlight his status as a responsible HIV citizen.

Lydia

Lydia similarly rejected having engaged in any HIV risk behaviours and attributed her HIV infection to a break-in into her room. We interviewed Lydia, a woman in her early thirties who was living with her partner of seven years in a single room occupancy hotel, two weeks after her HIV diagnosis. Lydia was injecting heroin and smoking crack-cocaine daily, and had recently been to prison for the first time on a drug possession charge. Lydia, like Peter, presented herself as a responsible drug user and sex worker who was risk averse and always practiced HIV prevention strategies. Lydia's claim that she never shared syringes and injected heroin either alone or with her long-term partner, was a way in which she presented herself as a responsible drug-using citizen. Lydia supported herself through sex work but emphasised that she protected herself from HIV by not engaging in intercourse with clients. She was unable to explain the source of her recent HIV infection and drew on prevention messages, which indicated that the sharing of razors can pose a potential HIV risk (UNAIDS, 2008). To make sense of her recent seroconversion, Lydia suggested that she might have contracted HIV by using a razor or toothbrush that might have been contaminated during a break-in into her room:

I'm really not sure when or how I got it [HIV], cause I don't share needles. And when I do work the streets [engage in sex work] I don't do lays [intercourse] or anything, so I'm not sure. My room was broken into when I went to jail in August and a lot of my stuff was stolen and whatnot. And uh, I heard you can get it from sharing razors or toothbrushes and things like that. So that's a possibility but I'm not sure.

When asked what might have changed in her life in the six months preceding her diagnosis, Lydia rolled the clock back much further to talk about the time when she first engaged in sex work and started using drugs. In so doing, she indicated that those transitions marked a more significant change in her life with regards to exposure to HIV risks than any smaller changes that had taken place in the six months before her seroconversion.

My life's been pretty much the same. I've been a hooker since I was thirteen. And, I've been using drugs since I was like about sixteen. At seventeen I started shooting drugs and I've been doing it pretty much steady ever since, so. I don't know anything else.

Reiterating her subject position of sex worker and drug user seemed to reflect Lydia's broader awareness of her membership of 'high risk' groups, which she offered here as contributing to her HIV diagnosis. Thus, while Lydia rejected the idea that her behaviour contributed to her contracting HIV, she drew on her membership of populations identified as at high risk for HIV to make sense of her diagnosis. This reference to her membership of 'high risk' groups may be read as tentative critique on discourses of individual responsibility in HIV transmission.

Ralph

Ralph was a 22 year-old White man who denied having engaged in any sexual or injection-related HIV risk behaviours. Ralph injected opiates and smoked crack-cocaine. His drug use patterns involved frequent binges that often last several days and usually end in Ralph getting arrested by police for shoplifting, drug trafficking or related charges. In between his drug binges, Ralph lived in the suburbs away from the drug scene, sometimes with his partner and other times with his mother. Over the last few years, Ralph had frequent episodes in juvenile detention, jail, and drug treatment facilities. Ralph was diagnosed with HIV during a prison stay a year prior to our interview. He stated that he was getting tested for HIV and Hepatitis C on a relatively regular basis, usually when he entered drug treatment or was sentenced to juvenile detention or jail. In his interview he indicated that before his positive HIV test he had expected the results to be negative. He had been 'a bit more careless' but had not shared needles or had sex with an unsafe partner:

Well, whenever I get into an institution, whether it's jail, treatment whatever, I always just get a test. Yeah, you know like, fuck, I've been through so many of them they always, come back the same, right? Negative, negative, negative. And this time I was kind of worried that I might have Hep C, right? I kind of freaked, fuck man I better not have Hep C. Holy fuck! Because I fuckin' just, was, sharing a lot more pipes than normal. Just kind of being a little bit more careless. I wasn't sharing rigs [syringes], or having unprotected sex. Or, I wasn't having any sex actually except for my girlfriend, right? And she is negative.

Like Peter and Lydia, Ralph presented himself during the interview as a responsible drug user who is well aware of the risks associated with syringe sharing and unprotected sex and talked extensively about how he has taken an almost academic approach to educating himself regarding HIV. However he did describe how his drug use sometimes led him to engage in riskier behaviour:

Well, once I found out I had it, I got a stack of fuckin' books...Do I look like a retard? Well, I'm not. I got my math twelve [grade 12 mathematics qualification]. I got my chem. twelve and shit. Like, you know, I'm half booksmart, right, and fuckin' it's just the dope that makes me retarded. But, I do like to be educated on things you know.

On several occasions during the interview, Ralph stated that he had never shared a used syringe or injection-related supplies (such as cookers) and had not engaged in any sexual risk behaviours. Instead, Ralph hypothesised that he might have been infected with HIV in his sleep but refused to further elaborate on his theory of how he acquired HIV. However, Ralph did state that he had shared crack pipes, a risk behaviour that he was willing to disclose, and he might have 'hung out with a dirtier crowd' in the months leading up to his diagnosis.

Towards the end of the interview, Ralph expressed a desire to be of assistance to help prevent other youth from contracting HIV and, in this context, Ralph described different HIV prevention approaches for different audiences:

I think it would depend on the crowd [audience], right? It would depend on what type of person or people I'm talking with. If I was in a juvenile detention centre, I might be a little bit more rough...Be like, 'You don't think it's such a big deal? How about we go get a rig [syringe] right now and I'll fuckin' give you a smash [injection] of my blood? If that's how fuckin' unimportant it is to you. If you're that invincible, come on let's do it.' If I was to talk to the homeless street crowd, I'd just say, 'Listen man, for the fuckin' extra ten minutes or ten seconds or ten cents or whatever it is to fuckin' take that extra step, it will save you a lot of fuckin' hassle and heartache...' But it's impossible when you are dope sick. It sounds like logical to say something like that. But it's just so fuckin' irrelevant, when you're in that situation, you know. It's like I don't care if it's got someone else's blood and I know for a fact I'm gonna get HIV. I'll deal with those problems later.

While Ralph talked about notions of invincibility when discussing prevention strategies targeting other youth, his insistence during the interview of not having engaged in syringe sharing can be viewed as an attempt to uphold the subject position of responsible drug-using citizen. In his account Ralph critiqued behaviourally-focused HIV prevention strategies and highlighted how such messages appeared logical in theory but were rendered irrelevant in the context of situational pressures, such as withdrawal symptoms (Bourgeois & Schonberg, 2009; Moore, 2004). In pointing out the disconnect between HIV prevention messages and the reality of injecting drugs on the street, Ralph put forward a critique of the dominant discourse of behaviour focused HIV prevention strategies.

Patrick

Patrick's account of his HIV transmission differed from those we have already discussed as he accepted that he had engaged in HIV risk behaviours, such as sharing syringes and having unprotected sex with his partner who was HIV positive. Despite this admission, he still asserted that he contracted HIV as a result of a malicious attack involving a syringe that was contaminated with HIV. We interviewed Patrick, a White man in his early forties, nine

months after he received his HIV diagnosis. He had just been released from a two-month prison stint for a drug-related offence. Patrick's views of HIV were highly moral, and he argued that only people who committed a mortal sin could be affected by HIV.

I guess I'm gonna go to hell with this fuckin' disease. That's what you do, you go to hell. Because in order to get this disease you have to be doing a mortal sin, right? That's only how you can get it, by doing a mortal sin. So you're going to hell. This kind of confirms it to me I'm goin' to hell.

In the context of his highly moralised views, Patrick attributed his HIV infection to being intentionally poked with a used syringe by his partner, despite admitting to engaging in HIV risk behaviours, such as sharing syringes and unprotected sex with his partner.

She poked me with a needle and that's all it fuckin' took. One poke. She had just used the rig fuckin' thirty seconds before, she poked me with it and she just jabbed me through my shirt and everything.

In the face of his moralised views of HIV, to uphold a tenable subject position deserving of care, Patrick rejected responsibility for his HIV infection and attributed it to his partner's ill intentions. This stance points to the more sinister side of HIV prevention messages that frame HIV prevention behaviours as the individual's moral responsibility (Crawford, 1994; Brandt, 1997; Fraser, 2004) and can leave people who contract the disease with intense feelings of shame and guilt. However, Patrick's assertion and rejection of individual responsibility for his HIV infection may also be read as a form of critique of these dominant public health discourses.

Albert

Albert, an Indigenous man in his forties, was diagnosed with HIV two years prior to his interview. While Albert talked about having engaged in a 'carefree' lifestyle, he attributed his HIV acquisition to the actions of a racist health care professional. After more than twenty years of living in precarious housing, Albert had recently obtained a one-bedroom suite in a supported housing programme. Since moving in, Albert had stopped using illicit drugs and only smoked medically prescribed cannabis to stimulate his appetite. Albert blamed a nurse for his HIV infection.

How I got HIV was with the nurse down at the walk-in clinic. She purposely infected me with the virus. I used to go and get tested every six months. I got talked into just going to a walk-in clinic in the neighbourhood, where the lady purposely infected me because I had a bad attitude from living down there. I treat people the way they treat me. And she came at me, with a bad attitude so that's what she got right back. And she took it on herself that I was a bad person. She did everything she could to try and find all the equipment to get me, um, positive. She even diagnosed me. Yeah, right after she stuck the needle in me. The needle was practically still in my arm. And she said, you're HIV positive after I've been going to get tested every three months. That's not possible. I was negative, and they are racist down there. I went to get tested a few more times after that, and explained to all the nurses, that were testing me, what had happened to me at the walk-in clinic. And they told me what should and shouldn't have happened. They said the nurse in

the walk-in clinic, she, had this wire mesh, box in the bottom of the vial where she drew my blood into. And, the people at another clinic told me that there should be nothing in the vial where there was blood and then said that she could have been incubating something. And right then and there I knew she was, incubating the AIDS virus. So she knew exactly what she was doing to me. Yeah and I have to live with that. And it's hard.

Albert put forward a critique of the discourse of individual responsibility, by situating his HIV infection outside of his responsibility, in a historical context driven by racism and the history of colonisation. Unlike Patrick, Albert avoided directly referencing specific HIV risk behaviours he may have engaged in but stated that he had lived a 'carefree' life. Nonetheless, even before his diagnosis Albert presented himself as a responsible citizen who rather than getting his HIV status tested semi-annually, made sure to get tested every three months. In his account of acquiring HIV, Albert seemed to reference the fact that, in Vancouver, Indigenous people are disproportionately affected by the HIV epidemic. In the local context, HIV rates are almost twice as high among Indigenous injection drug users compared to non-Indigenous drug users (Wood et al., 2008). Recognition of the disproportionate burden of HIV and social suffering carried by Indigenous peoples highlights the continuing effects of colonialism, its ideological and material foundations, and its ongoing reproduction (Culhane, 2003; Bourassa, McKay-McNabb, & Hampton, 2004; King, Smith & Gracey, 2009).

Maria

Maria is a woman of English and Indigenous ancestry in her mid-fifties who had been living with HIV for two years at the time of the interview. Maria had been using drugs for many years and sees drug use as a choice people make who do not fit in with mainstream society. As she explained:

There are people in this world, we don't think alike, we don't behave alike, and a lot of us will grow up thinking, well we got a choice in life, either be a productive person in society, or be a person that sits in those drug places all day and do drugs. It's a bad choice, I'm not being a judge here, but it's not the way to go. Here I'm 55 almost and drugs took my heart. It's not the answer.

Maria in her discussion of 'choosing' drugs drew on the neo-liberal discourse of choice. However in her personal story of HIV infection, she rejected the choice discourse, by attributing her HIV infection to a malicious attack by a stranger on the street, who stabbed her with an infected needle. Maria explicitly attributed some of the responsibility for her HIV infection to structural factors and explicitly critiqued the discourse of self-responsibility in relation to HIV. Maria felt that the 'government' should have done more to protect people from HIV.

I think human beings ain't born to have HIV in their systems, you know? And as far as we know it's a new thing that I'm pretty sure the government came out with. We never had HIV like this. The first person that came here to Canada, we shoulda quarantined him and not let anyone else in the country that had HIV. Then we wouldn't be in this situation we are. It didn't come from all monkeys. It's the

government. They could've done a little bit better than they did. They disappointed a lot of people, a lot of deaths since then, eh?

Maria also suggested that there was a conspiracy in which those outside the labour market had been deliberately infected to reduce their life expectancy and cost to the government:

They use HIV to control life - humans. They can't give us all jobs, they got no jobs for half the people. So you give 'em money and pills keep 'em going for a couple years, and away they go! Next life. Next!

In both Albert's and Maria's accounts their HIV infection is located within a broader socio-economic context and outside the control of the individuals. Their critiques of the dominant narrative of individual responsibility and blame draw on conspiracy theory discourses that are evident globally amongst some marginalised and disenfranchised populations with the least economic and political power (Fassin, 2007; Bogart & Thorburn Bird, 2003).

Discussion

While these accounts of seroconversion are diverse, they are bound together by participants' rejection of the notion that their risk behaviours contributed to their HIV infection. Participants embodied the governing power of individually focused HIV prevention discourses as they strived to present themselves as responsible HIV citizens deserving of care. Taking up this subject position may allow participants to fashion themselves as deserving HIV citizens and to escape culpability for their illness, which is implicit in purely behavioural conceptualisations of HIV risk. However, by rejecting blame and the notion that their risk behaviours contributed to their HIV infection and alluding to broader political, structural and historical factors, participants put forward a tentative critique of the imperative of personal responsibility in HIV transmission.

As Foucault (1978) has observed, the confessional character of qualitative interviews, and the fact that the researchers may have been understood as representing the medical establishment, could have contributed to participants' rejection of responsibility for their HIV infection, to avoid culpability and being judged as incompetent or reckless (Bourgois et al., 1997). However, the fact that participants drew upon the discourse of responsible subjects, and engaged in impression management in their interactions with the interviewers, indicates their familiarity with it. Thus, behaviourally-focused HIV prevention strategies shaped how participants living with HIV conducted themselves, and what they thought it means to be a responsible and deserving HIV citizen.

The notion of 'biological citizenship' (Rose & Novas, 2004; Petryna, 2002; Rose, 2007) has emerged as key in conceptualising the rights and responsibilities that arise based on membership to specific biological categories. The concept of biological citizenship has been taken up by a number of authors in relation to HIV prevention and treatment technologies (see for example Robins, 2005; Nguyen, 2005; 2007; Biehl, 2007; Davis and Squire, 2010) and is relevant here as it helps to elucidate how issues of responsibility play out in the context of HIV. Nguyen (2005; 2007) defines 'HIV therapeutic citizenship' as a set of rights and responsibilities of individuals living with HIV. Rights, in his definition, refer to a political claim to access to HIV treatment and welfare services on the basis of one's

biomedical condition. Nguyen (2005) locates the responsibility that is inherent in therapeutic citizenship in an expectation of patients to transform themselves into deserving HIV patients, which may include ‘responsible’ sexual conduct and injection practices, a concern with not spreading the virus, treatment adherence, and abstaining from the consumption of illicit substances. Thus, in order to gain access to care, even in the context of universal access to HIV treatment, marginalised people are expected to break with their ‘old habits’ and communities to fashion themselves as deserving HIV citizens, who are appraised by service providers as ‘suitable’ candidates who can achieve HIV treatment adherence and are worthy of disease monitoring (Biehl, 2007; Robins, 2005). Thus the HIV care system can come to divide people living with HIV into either ‘responsible citizens’ – who live a healthy lifestyle, reduce or abstain from drug use, practice safe sex and adhere to treatment – or ‘dysfunctional, undeserving patients’ (Robins, 2005).

People living with HIV are faced with a dilemma. The dominant HIV prevention discourse is based on individualistic HIV prevention messages that imply that HIV infection is the result of their irresponsible or even immoral behaviours such as engaging unprotected sex or sharing injection equipment (Crawford, 1994). However, to be ‘worthy’ of support and treatment individuals living with HIV have to present themselves as responsible HIV citizens, that is individuals who do not engage in irresponsible behaviours (Robins, 2005; Nguyen, 2005; 2007; Biehl, 2007; Davis and Squire, 2010). Especially for the most marginalised people living with HIV, such as those who use drugs, this self-transformation into deserving HIV citizens is not easy and may, as highlighted by the above accounts, lead to the denial of responsibility for their HIV infection in order to present themselves as responsible HIV citizens. Thus, as Moore (2009) proposed, participants may strategically accommodate the discourse of individual responsibility by rejecting responsibility for their HIV infection in order to reject culpability and uphold a tenable subject position vis-à-vis the interviewer, care providers and, perhaps, themselves.

However, participants’ denial of responsibility for contracting HIV can also be read as a form of critique of the discourse of individual responsibility and HIV citizenship. Indeed, participants’ rejection of the blame for HIV transmission may constitute a form of resistance of the dominant discourse of individual responsibility. Our participants also referred to the broader political, structural and historical circumstances that made them vulnerable to HIV infection and critiqued the individualist conceptualisation of HIV risk. For example, Peter and Lydia pointed out that their room was broken into and, thus, alluded to their unsafe housing situation as a factor that puts them at risk for HIV. When discussing HIV prevention strategies for homeless people, Ralph vividly highlighted how forms of HIV citizenship that do not consider the situational pressures of injecting illicit drugs are not realistic. Albert’s account pointed to his awareness that it was not just his ‘care-free’ lifestyle that contributed to his HIV infection. Rather, both Albert’s and Maria’s accounts placed their their HIV infection in the broader historical context of racism, colonisation, and poverty.

It is in these breaks with the dominant discourse that Foucault (1982) locates space for critique. In the tradition of poststructuralist thought, critique does not constitute a normative ‘universal truth’ that arises in opposition to the truth claim made by the dominant discourse and is thus not a binary concept with clearly defined boundaries between critique and

conformity. Rather, critique is the act of putting forth an alternative, which functions to limit the power inherent in the dominant discourse (Butler, 2002). Critique, as outlined earlier, constitutes a *practice* – a continual attempt to reduce and change the way one is governed (Foucault, 1978/1997). In this context, participants' rejection of the link between HIV risk behaviours and their HIV infection, together with their allusions to broader political, structural, and historical factors that may have contributed to their vulnerability to HIV, can be read as a form of critique of the dominant discourse of individualised forms of HIV citizenship and responsibility. Indeed, we suggest that participants' rejection of blame for HIV transmission may constitute a form of critique of or resistance to the dominant discourse of individual responsibility in HIV prevention.

While those advocating health promotion and prevention claim that their messages are based on objective scientific evidence and therefore neutral, these messages are set within and impact on social realities by allocating and distributing responsibility and blame. As we found in our analysis of six accounts, the dominant discourse creates particular kinds of subjects and shapes how participants present themselves and give rise to particular HIV subjectivities. However, HIV prevention strategies and other medical interventions should not be viewed solely as forms of governmentality and social control (Moore & Fraser, 2006). In this article we have noted that it is important to pay close attention to the ways in which these messages are taken up and critiqued. The critiques of the dominant discourse of responsibility and HIV citizenship presented here represent precarious and tentative attempts to set limits on the power of the dominant discourse. Although they could easily be dismissed as simple excuses or a way to evade blame, they nonetheless problematise the current focus on individual responsibility and citizenship in HIV and allude to the broader structural factors that shape HIV risk when read as a form of Foucauldian critique.

Conclusion

In this article, we have argued that those involved in HIV services need to pay attention to the way they frame prevention messages if they wish to change the pattern of HIV transmission. In particular, it may help if there is some reflection on the configurations through which responsibility is distributed. Prevention needs to be placed in ethics and culture of responsibility, where the burden of responsibility for health harms among the poor and marginalised does not sit solely with the affected populations. Instead, it should be shared with society at large, understood as contingent on the larger political environment and the degree this environment is marked by solidarity and equity. As such, the 'critical space' for dialogue regarding HIV, drug use and poverty needs to be expanded to carefully work through shared notions of responsibility, citizenship and deserving clients. It is crucial to integrate notions of broader shared responsibilities into public health efforts (Dodds, 2002) in order to generate community responses that include attempts to reduce social vulnerability among those most at risk of HIV transmission. This includes HIV prevention strategies that acknowledge and address the impact of the social and structural environment on HIV risk, include the voices of people who use drugs and explicitly acknowledge the shared nature of responsibility for HIV infection between individuals and society at large. Without a strong commitment to effecting social and structural change, individually focused HIV prevention strategies will continue to constitute a source of social suffering and

'symbolic violence' (Bourgois & Schonberg, 2009), particularly for highly marginalised substance users who are asked to prioritise their health in the context of severe material and social disadvantage.

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