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Challenging Medical Authority: Autonomous Health Movement and Contemporary Harm Reduction Practices in Minneapolis

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Challenging Medical Authority

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Statement of Purpose

Sometimes, I find it difficult to comprehend the vast problems and systems of inequity that exist within the United States' (US) healthcare system. The US's profit-driven model of health is so deeply integrated into our society that it feels impossible to change. It is hard to imagine an alternative. The COVID-19 pandemic has created an environment where the health of our communities is brought to the forefront. It is a moment when as a society we are beginning to understand that health crises are not a sum of individual failures, but instead are systematically produced and reproduced by systems of control. This is a reality that marginalized communities have been facing throughout history, a reality that marginalized communities have been confronting and organizing around. One way these issues are addressed is through the creation of autonomous health movements. In this paper, I contextualize the history and interventions of autonomous health movements and harm reductions practices and provide a case study of Southside Harm Reduction Services. I approach this study through thick observation and interviews with harm reduction practitioners. I argue that exploring autonomous health movements is a way to see alternative and liberating ways to address health in our community. Historical and contemporary examples of autonomous health work demonstrate that models of health independent of medical social control already exist. These models are already saving lives and creating new possibilities.

Keywords: Autonomous Health Movements, Harm Reduction, Community Care, Medical Authority, Medical Industrial Complex.

I: Introduction and Methods

I was first introduced to autonomous medicine during the summer of 2020. During the protests that followed the murder of George Floyd and the onset of the COVID-19 pandemic, communities took it upon themselves to protect the health of one another in various capacities. These moments of disruption amplified the pre-existing crises of colonialism, capitalism, and racism, and created new contexts for understanding their role as the underlying drivers of societal and individual health. Street medics, as they have done throughout history and in periods of state induced violence, became critical to protecting their communities during direct actions.[1] I started volunteering and attending training for a street medic group in my hometown of Des Moines, Iowa. The first training I attended was held in one of the leader's backyards. About 20 community members and I ate homemade banana bread and learned not only the basics of wound care, CPR, and chemical irritation treatments, but also what consent should look like when you are treating someone and how to provide comfort during an anxiety attack. We discussed ways to help calm someone who is in mental and/or physical pain. There were a few people teaching there that had "real" (referring to state authorized) medical training, but we were mostly taught by folks who had taught themselves medicine or learned from knowledge passed down by people providing medical care before them.

In the summer of 2021, I continued my education in community health and enrolled in a program in St. Paul, Minnesota to get my Emergency Medical Technician (EMT) license. For over a month and a half, Monday through Friday, I sat in a basement room (the kind with no windows) and was lectured on how to care for people. It quickly became apparent that this course would be solely procedural, as it focused on the protocols for health without consideration for the patient's experience, without consideration for the holistic view of the patient's life. While I value a scientific and procedural approach to medicine and see it as an essential component of health, I felt this training lacked a holistic approach. This deficit came to a head during the one-day where sexual assault, domestic abuse, and drug-related incidences were discussed. At

[1] Weinstein, *Street Medicine, Anarchism, and Ciencia Popular,* 91-95.

the end of a 7-hour day, our teacher, an ex-military-turned-EMT, put up a slide about “difficult 911 calls.” This was referring to calls we would receive as EMTs that had to do with sexual violence, domestic abuse, and people using drugs. During the hour-long lecture on these “difficult 911 calls” one theme was made abundantly clear; as EMTs it was our duty to rely on the police and adhere to strict protocol, that in instances of health crisis are not comprehensive. In these situations, we were not taught to care for people, we were taught to turn them over to a system based on principles of punishment and authority.

Comparing these experiences of community health and learning about health patterns within my communities and throughout the US, I became frustrated with the dissemination of health knowledge and the ability of health care institutions to withhold this information. I appreciated my EMT course for the medical knowledge it gave me, but I felt as though I was not taught to truly care for people and their actual needs. I was taught to plug them into a system. I was taught to enforce authority over their health. I learned more about what it means to care for someone during my two days of training with the street medics than I did in the month-long EMT program. This experience, along with my coursework focused in American Studies and Biology at Macalester, has pushed me to question what it means to care for someone and for my community. My background in American Studies has given me the tools to understand the health care system in the US in terms of white supremacy and racialized capitalism. As someone who is planning on a career in health care, I find it imperative that I work in a system that both gives autonomy back to the people and rejects the notions of medical domination and control. I am left asking the question: how do we redefine health and give autonomy back to communities?

Throughout this paper I explore the ways in which the alignment between the US capitalist economy and systems of healthcare has created a medicalized and elitist view of health. I argue that this structure of healthcare fails our communities, with the effects heightened for oppressed communities and those requiring care in stigmatized fields. I explore the framework of autonomous health organizing to understand how

communities' question medical authority and reclaim autonomy over their own health. I explore the ways in which autonomous health organizing lies at the intersection of health and liberation work. To do so, I am drawing on a history of work in the field of medical humanities to understand what medical authority is and how it operates. I will then explore autonomous health movements (AHMs), how they operate to combat medical oppression, guided by research and writing done by people who have organized and practiced AHMs. Lastly, I will offer a case study of a specific autonomous health organization. For the past four months, I have been an intern at Southside Harm Reduction Services, a harm reduction (HR) network in South Minneapolis. I view HR work as a prime example of how autonomous health organizing is able to break down systems of medical authority and give agency back to those who are without. Through an understanding of the history of HR, my experiences working with HR, and ethnographic interviews with those who work at Southside Harm Reduction Services, I explain how radical health care work fits into a restructuring of our communities based around care.

One aspect of autonomous health movements (AHMs) I aim to explore is the importance of positionality: that those who have experience with a certain health concern hold knowledge. Lived experience is a form of medical knowledge. In this way I think it is important to acknowledge that I am a white, cis woman. I have never worked as a professional medical provider, I have never been unhoused, nor have I ever been addicted to drugs. I do not have the lived experience to speak about these health experiences from a personal position. Instead, I will rely heavily on the work and voices of those who have this lived experience. I hope to learn from their experiences to create a more equitable view of health and care, as well as uplift the resources that have guided me.

I believe that the work of autonomous health movements (AHMs), such as harm reduction (HR), should be viewed as an act of radical caregiving, a template for how health work can shift within our communities. Through my research, interviewing my coworkers at Southside Harm Reduction Services, and working within an autonomous

health framework, I am able to understand that the templates for a liberated view of healthcare already exist. This is a concept explained by the framework of Black Ecologies of Mutual Aid. A theory originally created by Justin Hosbey and J. T. Roane,[2] Black Ecologies of Mutual Aid asks the question, "How do Black residents contend with the deep, sociohistorical antagonisms between feelings of scarcity and aspirations for creating sustainable, collective spaces that meet everyone's needs?"[3] I apply this lens towards the health organizing done by Black and other marginalized communities in the US, looking at how these communities have taken the realities of an oppressive health system and fought to create spaces, knowledge, and community that meet everyone's health needs. It is our duty to look to the communities that have come before us, to learn from their activism and work, and to spread that knowledge and action back into our own communities.

II: Medical Authority and the Medical Industrial Complex

Within the last century, medicine in the US has radically changed. Advances in technology and industry have pushed medicine out of the home and our communities and into a new systematic approach.[4] The creation of the modern hospital system, medical education system, non-profit health complex, and health insurance structures have become entrenched within the capitalistic economy of the US, in what scholars refer to as the "medical industrial complex."[5][6] The medical industrial complex is a framework that allows us to understand the corporatization of medicine in the US, functioning as a new market of the economy.[7] Through this framework we are able to

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[2] Roane and Hosbey, *Mapping Black Ecologies.*
[3] Reese and Johnson, *We All We Got: Urban Black Ecologies of Care and Mutual Aid,* 27.
[4] Wilson, *Chaos in Western Medicine: How Issues of Social-Professional Status Are Undermining Our Health*.
[5] The non-profit health complex refers to the abundance of non-profit health organizations across the US. These organizations fall into what has been called the nonprofit industrial complex, a framework that explains non-profits as an extension of state control. INCITE! describes the non-profit industrial complex as, "encouraging social movements to model themselves after capitalist structures rather than to challenge them." More information on the specifics of the non-profit industrial complex can be found in INCITE!'s foundation text, *The Revolution Will Not Be Funded: Beyond the Non-Profit Industrial Complex,* or on the INCITE! website: https://incite-national.org/beyond-the-non-profit-industrial-complex/
[6] Navarro, *U.S. Marxist Scholarship in the Analysis of Health and Medicine*.
[7]Stevens and Glatstein, *Beware the Medical-Industrial Complex*.

understand that the advancement in medical technology and the stratification of the medical system have come about not to create better health outcomes, but to maximize profit.[8] Thus, we see the healthcare industry becoming more and more concerned with creating and maintaining profit than with meeting the needs of people and communities.[9]

In an effort to maximize profits, scholars argue that the medical industry in the US has shifted how we view our health. It has been argued that health has been "medicalized", turned into a simple dimension of our lives that can be fully understood and treated by science.[10] Disease and illness, when viewed only in a medical sense and not connected to our social worlds, become isolated and distinct from the rest of our lives. The medicalization of health affects our society's perception of health as something that can only be solved by professionals, denying traditional or cultural forms of knowledge.[11] The people who hold this science, who hold this knowledge, have dominance over the treatment and care.[12] This effectively keeps medical power, knowledge, and profit as a resource that is held by an elite class. Because of this, the knowledge and care are not informed by the communities who actually need that care. The creation of this medical authority is not beneficial because it creates an elite system of knowledge and power that has adverse effects on health outcomes.[13] Phil Brown, a professor at Brown University studying medical sociology, refers to this growth in medical authority as "medical social control", explaining, "The overwhelming cause of concern is this dominance of the medical profession both within the wider domain of general healthcare and outside of it – perpetually imposing the perceived authority and dominance despite growing evidence of its ultimate failure to provide increasing standards of service and subsequent increased states of health across the globe."[14]

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[8] Wilson, *Chaos in Western Medicine: How Issues of Social-Professional Status Are Undermining Our Health*.
[9] Sterba, *Neoliberal Capitalism and the Evolution of the U.S. Healthcare System*, 20-21.
[10] Blasco-Fontecilla, *Medicalization, Wish-Fulfilling Medicine, and Disease Mongering: Toward a Brave New World?*
[11] Viniegra-Velázquez, *Colonialism, Science, and Health*, 170.
[12] Brown, Phil, and Zavestoski, *Social Movements in Health: An Introduction*, 681
[13] Brown, Phil, and Zavestoski, *Social Movements in Health: An Introduction*, 682
[14] Brown, Phil, and Zavestoski, *Social Movements in Health: An Introduction*, 682

The consequences of medical authority and a medical system focused on profit are often felt by the most marginalized and/or stigmatized communities who are not able to access affordable/and or reliable healthcare or resources.[15] Racism and prejudice are well documented throughout the medical industrial complex, including but not limited to the racial bias in medical training, medical mistrust, profit based barriers, and the reality of race-based disparity of health outcomes.[16] The mechanisms and history of medical racism are immense, and deserve far more attention and detail than this paper can offer. One function of medical disparity that I believe is necessary to understand in the context of medical authority is the creation of medical knowledge. Those who have power within the medical industry, historically cis-white-men, get to decide what a disease is and what the most effective treatments are.[17] The diseases and struggles of marginalized groups can be systematically ignored, adding a layer of stigma and often criminalization to the risk factors of a health issue.[18] Take the historical medical view of drug addiction, where the medical system treated drug addiction as more of a crime than a disease, ignoring the needs of an already stigmatized and marginalized community.[19] In this way, the authority that medicine has over disease and treatment can be utilized, along with other systemic barriers, to deepen disparity in healthcare.

III: Autonomous Health Theory

The growth of medical social control has occurred alongside the growth of resistance movements, with many taking the form of autonomous health practices. Autonomous health movements (AHMs) take many forms, but generally encompass movements where people have reclaimed autonomy over their own and their community's health by looking past stigma and institutionalized ideals of health and meeting people's actual needs. Consider the *Common Ground Clinic*, a free health

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[15] Campbell and Cornish, *Public Health Activism in Changing Times: Relocating Collective Agency*, 131.
[16] Byrd and Clayton, *Racial and Ethnic Disparities in Healthcare: A Background and History*, 456.
[17] Blasco-Fontecilla,. *Medicalization, Wish-Fulfilling Medicine, and Disease Mongering: Toward a Brave New World?,* 106.
[18] Braine, Naomi, *Autonomous Health Movements: Criminalization, De-Medicalization, and Community-Based Direct Action*, 86.
[19] Braine, Naomi, *Autonomous Health Movements: Criminalization, De-Medicalization, and Community-Based Direct Action*, 89.

clinic created by community volunteers in response to the plethora of health crises during and after Hurricane Katrina.[20] Consider the *Jane Collective*, a self-managed abortion group in Chicago performing illegal and non-medically authorized abortions in the early 1970s.[21] Consider *Cooperation Jackson*, an environmental justice organization that is focused on water distribution during the Mississippi water crisis.[22] Each organization falls under the category of AHMs, although they are addressing varied and distinct problems. Movements such as these historically understood that medicine is not an elite knowledge that should be kept within institutions, but instead something to be shared, that everyone has a responsibility to understand. Professor and Sociologist Naomi Braine outlines the three main pillars of AHMs,

> "Three characteristics appear to be conceptually central, particularly in relation to the 'autonomous' element of autonomous health movements. One, the health practice involves de-medicalization through community use and control of medical knowledge and technology. Two, this process of de-medicalization results in significant shifts in power relationships between marginalized, often criminalized, contexts and populations and mainstream medical institutions in ways that enhance the autonomy and self-determination of the marginalized. And three, activists within autonomous health movements demonstrate a willingness to work at the fringes of or outside the law when necessary."[23]

I want to take time to move through these central concepts so we can understand how these ideals are critical to challenging medical authority and the social control that follows.

The first pillar of autonomous health movements (AHMs) is the use of medical knowledge within the community. AHMs are typically focused on diseases that are stigmatized or only highly effect already marginalized communities. Because of the stigmatized nature of the diseases or health concerns, the health industry is able to

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[20] Crow, *Black Flags and Windmills: Hope, Anarchy, and the Common Ground Collective*.
[21] O'Donnell, *Reproducing Jane: Abortion Stories and Women's Political Histories*.
[22] Cooperation Jackson, *Our Work.*
[23] Braine, Naomi, *Autonomous Health Movements: Criminalization, De-Medicalization, and Community-Based Direct Action*, 91.

ignore the problem, which means not treating it or treating it in an inaccurate manner.[24] This lack of attention forces communities to build their own medical knowledge or understanding of how to navigate the health resources that exist, as a means of survival and contestation of social medical control that would deem them as dispensable.[25] Members in the community can learn to treat their own and each other's symptoms, can relocate resources, can hold space to educate collectively, create support groups, etc… The cultivation of community medical knowledge and organizing techniques is critical to community care.

The second pillar of autonomous health movements (AHMs) relies on the relocation of power. AHMs aim to give power back to those who are experiencing the most harm from the systems that they are living under. As discussed above, marginalized groups face the brunt of harm from medical authority and are not granted autonomy within the health system. By returning medical knowledge and resources to the community, individuals feel able to take control of their own health.[26] Within our current system there is a strict power dynamic between professional health providers and the community. Professional health providers have the authority and resources to treat, as well as the credentials to create medical knowledge. Thus, the community is forced to rely on the resources and knowledge of a medical system that may not reflect their identity. AHMs aim to balance the power dynamic between medical systems and marginalized communities, by shifting who the communities must rely on. If people can rely on each other and themselves, they do not need to ascribe to these social hierarchies and control of modern medicine.[27]

The last pillar of autonomous health movements (AHMs) that Braine outlines is the rejection of legality. One aspect of the medical industrial complex is its reliance on

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[24] Brown, Zavestoski,McCormick, Mayer, Morello-Frosch, and Gasior Altman, *Embodied Health Movements: New Approaches to Social Movements in Health*, 51.
[25] Epstein, *Credibility and Trust in Scientific Fact Making*, 17.
[26] Campbell, *Social Capital, Social Movements and Global Public Health: Fighting for Health-Enabling Contexts in Marginalized Settings*, 3.
[27] Braine, Naomi, *Autonomous Health Movements: Criminalization, De-Medicalization, and Community-Based Direct Action*, 91.

bureaucracy and protocol, a tool used for the protection of profit that can often hinder the actual care of individuals.[28] When doctors and medical staff must follow strict protocol, they are unable to adjust the care they are giving to meet the individual needs of their patients. AHMs recognize that it can be in the best interest of both parties, the givers of care and the receivers, to break the rules in order to provide the most effective care. This disregard for protocol and tradition follows a legacy of community activism, where communities uphold that legality is an incorrect measurement of morality.[29] Legality is based on the interests of the elite, and to best care for one another, we must actually listen to one another. AHMs advocate for a philosophy of liberated health care that best serves the community and rejects the idea that authority must know best.

Autonomous health movements (AHMs) lie within the framework of self-determination and bodily autonomy, forcing us to question concepts of knowledge, profit, and legality. AHMs reject the separation between health, medicine, and community. Whereas medical authority pushes us to view health as individualistic, something inherent and centered within each person's body, AHMs understand health in a collective manner, forcing us to work on health issues as a community rather than in isolation. AHMs uniquely address the concerns of stigmatized and marginalized communities, pushing these narratives that are often ignored, to the forefront of the conversation. Within the medical field, disease can be reduced to a medical issue while AHMs provide a holistic approach that connects discrimination in its many forms to health outcomes. Particularly, AHMs address diseases that have become criminalized and thus ignored by the healthcare community. When health professionals play into the social narrative of crime by ignoring the health of already marginalized communities, as in the case of drug addiction or the AIDs epidemic, AHMs are able to build networks of care that advocate for the community without shame or punishment.

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[28] Yamin, *Struggles for Human Rights in Health in an Age of Neoliberalism: From Civil Disobedience to Epistemic Disobedience,* 359.
[29] Yamin and Cantor, *Between Insurrectional Discourse and Operational Guidance: Challenges and Dilemmas in Implementing Human Rights-Based Approaches to Health*, 459-463.

IV: Harm Reduction, Harm Reduction in Minnesota, and Southside Harm Reduction

In order to examine what autonomous health movements (AHMs) look like in the community, I offer a case study of South Side Harm Reduction Services (SHRS), a harm reduction non-profit operating in South Minneapolis, MN. I am eternally grateful for the work done by SHRS, the staff, and how welcoming they were to me during my internship. To begin, I want to lay out a brief history and context of harm reduction work in the United States, in Minnesota, and then move to what I learned during my time at SHRS. To accurately understand the ideas and operations of SHRS, I interviewed three of my coworkers. Each interview lasted approximately one hour. I came into the interviews with a set of questions focused on the ideas that guide SHRS services, but allowed my coworkers and their experiences to be the main guide for the interviews. To protect their privacy, I do not share the name or personal details of any of my coworkers. Additionally, all three of my coworkers stated that they do not believe they are qualified to speak for all of SHRS, thus their opinions represent only their experience at SHRS, not a monolithic experience.

Harm reduction (HR) in the United States is typically said to have found its origins in the 1980s as a community-centered reaction to the HIV epidemic.[30] Although the HIV epidemic was a critical time for the creation of more systematic forms of HR, HR as a practice has been utilized by communities long before the HIV epidemic.[31] Harm reduction has been a philosophy utilized by marginal communities and closely linked with mutual aid work throughout history, making it hard to pin down a distinct starting point. However, the HIV epidemic laid the foundation for HR work becoming more mainstream. The stigmatized and politically charged topic of HIV being structurally abandoned by those with medical power forced highly stigmatized communities made up mostly of queer and BIPOC individuals to turn to HR organizing.[32] Syringe exchange

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[30] Henman, Paone, Des Jarlais, Kochems, and Friedman, *From Ideology to Logistics: The Organizational Aspects of Syringe Exchange in a Period of Institutional Consolidation.*
[31] Tula, *People Power and the Original Harm Reductionists: The History of a Movement*, 44.
[32] Braine, Naomi, *Autonomous Health Movements: Criminalization, De-Medicalization, and Community-Based Direct Action*, 90-91.

programs, which first came to being in New York, and community knowledge sharing about HIV, became more prolific during the HIV epidemic. By the mid 90s, due to the work of Chicago based activist group called *Chicago Recovery Alliance,* HR work expanded to include overdose prevention, by distributing and educating about the use of Naloxone.[33] It is important to recognize that before HR was a model utilized by non-profits and the public health industry, it was a survival mechanism created and carried out independently by, as Shira Hassan explains, "Black, Indigenous, and People of color (BIPOC) who were sex workers, queer, transgender, using drugs, young people, people with disabilities and chronic illness, street-based, and sometimes houseless."[34] The history of HR must be understood as a grassroots movement, a survival technique that marginalized communities crafted in order to care for themselves and each other when the larger social systems would not. For a deeper understanding of the origin of HR work in the US, that works to give attention to the leaders who devoted themselves to their communities and HR, I would suggest reading Shira Hassan's book, *Saving Our Own Lives: A Liberatory Practice of Harm Reduction.*[35]

Harm reduction (HR) has always been fueled by demanding autonomy and self-determination, it is work that is continued by people who used drugs, for themselves and for others who use drugs, outside of state control or institutional supervision.[36] The foundation of the organized HR movement began at a time when the US War on Drugs, and thus the criminalization and stigmatization of people who use drugs was escalating.[37] It is important to note that the War on Drugs primarily functioned to target Black and other racially marginalized communities, making HR work positioned to fight medical discrimination, specifically medical racism.[38] The movement of HR challenged

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[33] Braine, Naomi, *Autonomous Health Movements: Criminalization, De-Medicalization, and Community-Based Direct Action*, 88.
[34] Hassan, *Saving Our Own Lives: A Liberatory Practice of Harm Reduction,* 2.
[35] Hassan, *Saving Our Own Lives: A Liberatory Practice of Harm Reduction.*
[36] Braine, Naomi, *Autonomous Health Movements: Criminalization, De-Medicalization, and Community-Based Direct Action*, 89.
[37] Braine, Naomi, *Autonomous Health Movements: Criminalization, De-Medicalization, and Community-Based Direct Action*, 88.
[38] Woods, *Bringing Harm Reduction to the Black Community: There's a Fire in My House and You're Telling Me to Rearrange My Furniture*, 305.

these racist assertions of medical authority by locating stigmatized persons and communities as the key actors in their own health, allowing them to fight back against medicine influenced by social authority and to do what was best for their own health. HR work situates people who use drugs as valuable community members who are able to intervene in health crises; a process that is typically only allowed to credentialed authority figures.

This process of taking medical authority away from the elite and handing it to communities causes a disruption in the narrative of medical authority. Naomi Braine explains this phenomenon through the ways in which HR work is able to demedicalize health work in the community writing,

> "HR de-medicalizes important technologies (such as sterile syringes and naloxone) that people who inject drugs need to autonomously manage their own health and bodily self-determination while using drugs, reducing their vulnerability to medical (and other) institutions that typically stigmatize and marginalize users of illicit drugs. More radically, HR positions active users of illicit drugs as valued members of their communities, fully capable of health-sustaining action on their own and another's behalf."[39]

Through de-medicalizing the process of care, people who use drugs and their communities are empowered to have authority over their own health. For more information on the political and power disruption caused by HR practices, I would suggest *Undoing Drugs: How Harm Reduction Is Changing the Future of Drugs and Addiction* by Maia Szalavitz.[40]

Minnesota continues the legacy of radical harm reduction (HR) work. Again, it is hard to say exactly when HR work started in Minneapolis, because community members, especially BIPOC and queer people, have often been providing their communities with HR principles long before non-profits were created. The Minnesota

[39] Braine, Naomi, *Autonomous Health Movements: Criminalization, De-Medicalization, and Community-Based Direct Action*, 91.
[40] Szalavitz, Undoing Drugs: How Harm Reduction Is Changing the Future of Drugs and Addiction.

AIDS project created a needle exchange program in the 1970s, but this work was mainly focused on stopping the spread of HIV as opposed to holistic support for all drug users.[41] Although other grassroots HR work continued, I want to focus on the work done by Sue Purchase and the creation of Women with a Point! (WAP), because I believe WAP is an important point in HR work in Minnesota and part of the legacy that leads to the creation of Southside Harm Reduction Services (SHRS). WAP was founded in 1998 by Sue Purchase and Toni St. Pierce.[42] Professor Amy Sullivan, through research and interviews with Sue Purchase, outlines the story of WAP in her book *Opioid Reckoning*, which I utilized heavily in understanding HR work in Minnesota. She explains that WAP was a project meant to focus specifically on women, who often had a harder time reaching needle exchange services. WAP did something that not many non-profit HR organizations were doing at the time: they created a mobile service that brought supplies directly to drug-users, a model that aimed to make safe drug use more accessible for the most marginalized communities.

As of October of 2022, Hennepin County, Minnesota, a county that includes South Minneapolis, is experiencing an HIV outbreak.[43] In 2021, there were a reported 340 deaths caused by drug related overdoses in Hennepin county.[44] Preliminary data for January-early August 2022 shows that at least 108 people have died from drug overdoses in Hennepin County, and in the first seven days of October 2022, there have been 55 drug overdose deaths in Minneapolis.[45] This data, which is most likely underestimated due to lack of city attention to the houseless population, is an important context for why harm reduction (HR) work is so necessary in South Minneapolis. Beyond this, according to research done by the Drug Policy Alliance, “Despite using drugs at roughly the same rate, Black people are 5x more likely to be arrested for drugs than white people. Arrests of Black individuals account for 24% of total US arrests despite Black people being 13% of the US population.”[46] I bring this up to center the fact

[41] Billund-Phibbs, *Minnesota AIDS Project (MAP)*.
[42] Sullivan, *Women of Substance: Harm Reduction in Minnesota,* 141-177.
[43] MN Department of Health, *HIV Outbreak Response and Case Counts.*
[44] Hennepin Public Health Data, *Opioid Epidemic.*
[45] Minneapolis Health Department, *City Sees Spike in Drug Overdoses.*
[46] Drug Policy Alliance*, Drug War Statistics.*

that drug criminalization and stigma continues to affect Black communities at disproportionate rates, that marginalized communities face the harshest effects of the state's reaction to drug use. The health system and their treatment of drug addiction need to be understood as part of the criminalization process. It is not just the criminal justice system's racist history that continues the disproportionate effects of drug criminalization, the health industry is also part of this process.

For the past 4 months, I have worked as an intern for South Side Harm Reduction Services (SHRS), a nonprofit operating in South Minneapolis. SHRS began in 2017, as an operation continuing the legacy of WAP, providing education and resources directly to people who use drugs. In 2017, SHRS was a small, mutual aid-based collective, run out of the trunks of a few people's cars. It was during the summer of 2020, during the uprising that followed the murder of George Floyd, that the intense need for harm reduction was recognized and that mutual aid groups in Minneapolis, and all over the country, started to operate and organize in a more resourced way. More funding and attention has been pouring into mutual aid; a pattern that has allowed SHRS to expand its operation with a focus on sustaining the work they do to provide resources for people who use drugs within Minneapolis.

Southside Harm Reduction Services (SHRS) operates with two main objectives: limit the spread of infectious diseases in the community and reduce deaths caused by drug overdose. SHRS goals are generally aligned with the goals of professional public health organizations. However, SHRS addresses these problems in a way that operates outside of medical authority and aims to confront the root of the problem. To do so, SHRS provides a range of services: deliveries, outreach, training, HIV testing and street clean-up (see table 1). These services, the daily practices of SHRS, are informed by and align with the philosophy of autonomous health organizing. Through both my time working at SHRS and the interviews I conducted, I found that the focus of their work, the thing that separated them from the typical model of public health that relies on medical authority and an elite view of health knowledge, is the way they listen to and integrate the knowledge and needs of the community.

SHRS Service	Service Logistics	Goal of Service
Deliveries	Each week, Monday-Wednesday, SHRS delivers drug use supplies (including syringes, naloxone, and other safe use supplies) to participants. Participants request supplies through a hotline. SHRS brings the equipment directly to the participants, also offering educational material during the visits.	Creating access to safe drug use supplies and accurate drug use-information in a non-shameful and safe environment.
Referrals	SHRS has created a directory of resources within Minneapolis that has information on how the resource responds to people who use drugs. SHRS staff respond to requests on the referral line throughout the week.	The fear of shame/stigma can hold people who use drugs back from reaching out for resources or asking questions. Referrals aim to spread accurate, non-judgmental resources to increase drug-related health knowledge and safety.
Trainings	SHRS offers public naloxone training every month. These trainings, as well as more specific trainings, are available for organizations, businesses, and schools.	By creating community understanding of naloxone and harm reduction philosophy, SHRS aims to create a safer community for drug users.
HIV Testing	SHRS provides mobile HIV testing. The testing occurs at community events, or participants can request the HIV testers to come directly to them.	People in the community can be turned off by going to medical offices for HIV testing for fear of stigma-based care. SHRS aims to provide shame free confidential testing to reduce the spread of HIV.
Street Clean	Every week, SHRS organizes a group of volunteers to clean-up areas of the community, focusing on picking up used needles.	Keeping neighborhoods clean of used needles helps reduce the risk of disease spread through used needles.

Table 1: Explanation of the main services at SHRS

In order to differentiate themselves from traditional public health approaches, Southside Harm Reduction Services (SHRS) views drug addiction in a decriminalized lens. Whereas many professional health structures view the use of drugs as the problem that needs to be solved, SHRS understands that the problems they are addressing are not drug use, but instead poverty, racism, the criminalization of houselessness, lack of resources for mental health, etc… Using drugs does not make anyone unworthy of health care, or care in general. With this viewpoint, participants are not seen as criminals and are not shamed for their decision to use drugs.[47] Instead, they are seen as community members who deserve to be safe and who deserve autonomy in their own health and life decisions. During an interview with my coworker, they explained,

> "I think so many times it's if someone goes in to the doctor because they have a huge wound on their arm, the responses is, 'all right, well, we'll bandage this, but you really just need to stop using drugs', when really it could be conversations of, 'let's try to like figure out what feels good in terms of rotating spots' or, 'you probably have never formally been taught how to use a syringe, let's go over that.' There's just a lot of these things that people, I think professionally, think that they can't talk about with people. When it's really in their best interest to talk about it."

To differentiate themselves from this authoritative model, SHRS focuses on working *with* their participants instead of working *on* them. Each service SHRS provides allows the workers time to spend with participants and community members, listening to what they need and responding not with commands, but recommendations and resources. To do this, SHRS recognizes that connections must be made. Participants, especially because they are people who use drugs, and a high proportion of them are BIPOC, can be incredibly wary of medical resources, due to experiences where they have been shamed or punished. SHRS places a focus on building trust-based relationships. As an organization, they understand that to care for someone, there must be honesty and vulnerability between the person giving the resources and the person receiving them.

[47] Participants is the term SHRS uses to refer to people who utilize their services.

This does not mean there is no power dynamic between giver and receiver, but instead that the relationship extends beyond the power dynamic, that both the giver and receiver have autonomy within the relationship. My coworker explained,

> “I think that some of the big, big needs are just having that connection. Recognizing the community strengths and how we are collectively strong people. Understanding the ways in which systems have harmed people and how that contributes to harmful or risky behaviors.”

This philosophy sees SHRS participants not as the problem, not as the ones to blame, but instead as the greatest resource. It is recognition that control and authority actually lead to the problem they are trying to address by erasing the needs, wants and knowledge of an already stigmatized community. Creating connections where the voices, opinions, and knowledge of drug users is utilized to care for each other in better and more informed ways.

The creation of community driven knowledge was another thing that stood out about the practices of Southside Harm Reduction Services (SHRS). Instead of a dynamic where the workers hold all the knowledge, where knowledge of care is a stagnant and objective fact, medical knowledge at SHRS is a process. SHRS utilizes the medical knowledge that comes from research done in the medical field combined with the lived experience and expertise of people who use drugs and utilize the resources. My coworker explained this concept,

> “I think that in a lot of ways with the medical systems, there's so much of this ‘I know what to do, I know how to take care of you’ without asking people ‘what they need’ or ‘what they've been doing to take care of themselves’ and ‘what's worked for them.’ And it's this ‘I'm gonna fix you mentality’ when that's not what needs to happen. We need to pay more attention to what someone's been doing, what's been working for them, what they want and how they want their health to look like.”

By integrating community knowledge and the lived experiences of drug users into the medical knowledge, SHRS is able to have a more holistic approach to health work. This concept breaks down the idea that people who use drugs are unable to care for themselves or don’t want to care for themselves. It acknowledges that people do know

how to take care of themselves in many ways, that people do want to care for themselves and their communities, and that people need more access to resources for this to happen.

To effectively respond to the needs of the community, Southside Harm Reduction Services (SHRS) recognizes the need to resist the conventional organization structure of most medical institutions. SHRS is intentional about power sharing within the institution, working to maintain a non-hierarchical power structure where each employee, and each volunteer, is given space for input and critique. Within the framework of a non-profit, it is almost impossible to not fall into hierarchical organization, but at SHRS this pattern was openly discussed to hold each other accountable. Beyond internal challenges to hierarchy, SHRS resists the notion of medical domination within the community. Instead of trying to become the only and most powerful HR resource in the community, SHRS recognizes that communities are best served when resources and knowledge is openly distributed, shared, and built upon. My coworker explained,

> “I view Southside as a network, as opposed to being one group of people. Every time that we refer people to other organizations, it's [groups] that we know about them and trust them, we don't just send people to whoever. And we have secondary exchangers. We take our materials, distribute them out to other people within their networks. That's how I view these sort of alternative medical or health structures, as being a network and a web of community support as opposed to an organization that has all the power. It's not any one thing and I think that's beautiful.”

This view of harm reduction work allows SHRS to stay flexible and in tune with the needs of the community, rather than creating a rigid set of services and resources that the community must navigate. By operating as a network and a point of connection, SHRS recognizes the complex and individualistic nature of health.

Southside Harm Reduction Services (SHRS) serves as one example of how harm reduction works, and the work of autonomous health movements (AHMs), to disrupt medical authority and the medical industrial complex. I see the work done at

SHRS as continuing a legacy of the principles of autonomous health organizing, following the principles outlined in Section Three of this paper. SHRS aims to build community-based health knowledge, aims to return power and autonomy back to people who use drugs in Minneapolis, and rejects the criminalization placed on people who use drugs. I offer these reflections on my time at SHRS and the theory behind SHRS's work in an attempt to show that community based medical care is already a resource within Minneapolis, it is already a necessary reality that community members rely on. The organization of such structures, while not perfect, can be seen as examples that medicine does not have to rely on capitalist and authority-based structures. The medical industrial complex is not the only reality. There are other ways.

V: Caretaking and Conclusion

Throughout the course of writing this paper, I have reflected upon the experience I had during my EMT training where I felt simultaneously excited about the prospect of the medical knowledge I had access to and frustrated with the role I was being trained for. This internal conflict feels present whenever I think about working in a health system. On one hand, there is nothing more exciting to me than the prospect of being able to care for someone, nothing more freeing than working with someone to help them heal, whatever that means to them. However, the current conventional structures of health care feel limited. I do not feel, even after training, that I should have authority over someone who holds lived experience and knowledge. I do not want a relationship with a patient in which their autonomy is threatened. I do not want to add to a system of racial disparity and criminalization. Through this research, the experiences I have had with street medics, and the time I have spent with Southside Harm Reduction Services, I have felt a growing sense of relief. I believe that health, the health of the individual and the health of the community, is a foundational aspect of liberation. Caring for yourself and caring for your community is an act of radical resistance, resisting a system that aims to profit off of health and separate health from the rest of our lives. There are structures, created from the hard work of activists and community members, that

already exist, both guide us into a better relationship with health care and offer us more control over our health. The work done by harm reduction networks and other autonomous health movements allow us to focus on the ways in which stigma and criminalization amplify health risks, while also providing a framework for addressing these issues in a liberatory and community-centered way.

This paper, as well as the research that has been conducted in critique of the United State's medical industrial complex, is in no way asking us to throw out the medical knowledge and care given by professionals, nor to ignore the work done by health professionals. The technology and advancements made are critical to supporting our population in better ways. It is, rather, the constant critique and pushback by the community that will guide the evolution of how we deliver healthcare. The work of autonomous health movements, such as harm reduction, should be viewed as an act of radical caregiving, a template for how health work can shift within our communities. This critique is not meant to devalue the work of health care professionals either, I believe it is the opposite. It is asking us to see health care as a form of radical community care and to stop seeing it as a means to make profit. To follow the legacy of autonomous health movements, to refuse to comply with systems that promote harm, we need to view health care as a part of the radical web of work done that will question systems of power in the US. As Ruth Wilson Gilmore states,

> "Abolition is not absence, it is presence. What the world will become already exists in fragments and pieces, experiments and possibilities. Abolition is building the future from the present, in all of the ways we can."[48]

I believe autonomous health movements and harm reduction, at their core, are about imagining and working towards these life-affirming institutions, which often means critiquing and tearing down systems that are already in place.

Although I believe the US healthcare system needs to change, it is necessary to note that the co-option of autonomous health movements is a growing threat. If our

[48] Gilmore, *Making Abolition Geography in California's Central Valley.*

healthcare system adopts the ideas of harm reduction, or other autonomous health movements, without addressing the systemic issues of racial disparity and a profit-driven view of health, the marginalization and criminalization of health issues will continue. Shira Hassan explains,

> "People often ask me, 'What's an example of public policy that's harm reduction?' And I am like, well, it's about the removal of criminalizing laws. It's about decriminalization. And it's about legalization. But it is never about reform because reform is such a blunt instrument, and its purpose is always to create harm in certain people's lives and to create criminalized survivors because it has to uphold this other part of the illusion of safety."[49]

Autonomous health movements are inherently about the redistribution of power back into the community and to the individual. As such, their autonomy, knowledge, and lived experiences must be accepted as valuable even when it does not fall into or contradicts the medical industrial complex.

[49] Hassan, S*aving Our Own Lives: A Liberatory Practice of Harm Reduction*, 317.

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