Assembling Harm Reduction Policy in Taiwan

by

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For my mom, whose unconditional love
has nourished my will to know…

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Abstract

This dissertation depicts and analyzes the emergence of Taiwan's harm reduction policy as a governmental strategy to address the epidemic of HIV/AIDS among intravenous drug users (IDUs). The policy is portrayed as a biopolitical project situated in Taiwan's unique history of drug control. It was made possible by *the offic*e, a heterogeneous assemblage of human and nonhuman actors and elements associated with each other by *guanxi*. Within this assemblage, different experts endeavored to educate themselves, make alliances, or establish a new profession. This policy fashioned citizen addicts on the one hand and offered opportunities for rethinking policy transplantation on the other.

The study utilized archival research, in-depth interviews, and field observations as its data sources. The analysis was informed by the constructivist tradition of grounded theory, especially situational analysis. The concept of assemblages was used to address the fluid and transient situations encountered in the making of harm reduction policy.

The theoretical implications of this study include: integrating the discussions of technoscience into a Foucaultian critique of modernity, reappraising the global and the local as explanatory terms, searching for a useful analytic frame such as *the office* or assemblages, de-centering Euro-American versions of biopolitics, studying the significance of short-lived events, and suggesting a new socio-epistemic position for experts.

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Chapter One

Introduction

1.1 What Is Harm Reduction?

Harm reduction in Taiwan is a policy orientation that puts into practice the ideals of American neoliberalism. This statement may surprise many harm reductionists in the US or elsewhere, because American neoliberalism has been often depicted as contributing to the socio-economic disadvantage and unjust treatments of illegal drug users (Bourgois 2009) that harm reduction is intended to address. But my analysis reveals how slippery harm reduction can be when it is implemented as a method of neoliberal governance. In addition, Taiwan's harm reduction policy should not be seen as an aberrant form. Instead, its claimed success leads serious readers to rethink a fundamental question: What *is* harm reduction?

Generally believed to be founded on principles of tolerance and pragmatism, harm reduction emphasizes drug users' autonomy, freedom of choice, and empowerment (Inciadi and Harrison 2000). However, all these are values of American neoliberalism within Foucault's exegeses (Foucault 2008). In sharp contrast with the previous criminalizing tendencies and moralizing discourses, harm reduction seriously takes addiction as a recurrent behavioral pattern that needs tolerance rather than suppression (Inciadi and Harrison 2000; Riley and O'Hare 2000). It is not entirely incompatible with the medical model of addiction on the one hand, and is bound up with the well-being of the population on

the other. Even though what it entails in real practice remains to be defined, most harm reductionists in the Euro-American context agree that we should treat drug users as human beings with equal entitlements to basic life needs such as health, food and housing (Riley and O'Hare 2000). A T-shirt I got from the Harm Reduction Coalition at a national harm reduction conference (Oakland, CA; 2006) has printed on it:

> Harm reduction (harm ri·duk'shen) 1. Modality of working with individuals and communities to minimize adverse consequences of drug use, e.g. Overdose [sic] prevention, syringe access, healthcare especially for HIV, hepatitis, and mental health needs, drug law reform including prison reform, housing, and drug treatment. 2. A movement for social justice.

Even though I will show later that this is *not* how harm reduction was shaped in Taiwan, these words nonetheless picture an ideal battle that harm reductionists must fight, at least in the US where this T-shirt was made.

But one thing is clear. In the West or in the East, actively pursued or passively imposed, harm reduction indeed involves the re-distribution of rights and responsibilities, entitlements and duties (Riley and O'Hare 2000) between government and individuals. But little has been discussed about how this fact makes harm reduction an issue of citizenship. For me, it is a pivotal issue. It leads us to a landscape where those once disenfranchised are now governed in a new way. Once criminalized felons, they are now medically and socially deprived victims who are entitled to care and concern. It is their right. This is why harm reduction is heralded by some advocates in the US as a social movement (as noted on the HRC T-shirt) for equal rights. Drug users have now become sufferers of a chronic medical illness and/or pernicious social environments. Regardless, they deserve respect, support and treatment.

However, what is the case in the Euro-American context is not necessarily so in the Asian context. First of all, in Asian countries harm reduction is rarely a community-based initiative. Rather it is often a policy program provided by the government (Stimson 2007). Therefore it is practiced as a policy more than as a movement. This brings forth the second key issue of difference: Harm reduction in Asian countries has begun relatively late and usually aims specifically to control blood-borne disease transmission among intravenous drug users. As such, it represents a socio-political strategy deployed to address collective health and well-being. It is, thus, a form of biopolitics (Foucault 1997a, 1997b, 2000c).

Taiwan's harm reduction policy is at the same time a point of convergence for various lines of thought: Foucault's biopolitics, neoliberal practice, citizenship controversies, and governmentality formation that involves disciplinary knowledge and self technologies (Foucault 1991a). Considering the historical fact that Taiwan was a Japanese colony (1895-1945) where the opium question was debated and managed for decades (Hsu 2008; Liu 2008), another issue for contemporary harm reduction policy is its relations with colonial heritages and postcolonial situations.

1.2 A Brief Introduction to Harm Reduction Policy in Taiwan

Harm reduction did not become the policy of choice in Taiwan until 2004 when it was first noted in statistical reports that the population of injection drug users (IDUs) had increased drastically among newfound HIV-positive cases. According to the CDC,

> [The CDC] conducted a demographic study among IDUs with the National Bureau of Controlled Drugs (NBCD). It found that there was indeed a pattern of infection that was regionally organized and clustered. IDUs contract HIV because they share needles or diluting solution. (2004, not paginated)

The severity of this problem was later highlighted by two distinguished public health scholars, one of whom was the director of the CDC (Steve Hsu-Sung Kuo), in their co-authored paper in *Lancet*. Clearly, their estimate was alarming, considering Taiwan's population of 23 million people (Ministry of the Interior 2009): "Of the 60,000 to 100,000 intravenous drug users in Taiwan, 10-15% may be infected with CRF07_BC," said Chen and Kuo (2007: 623). CRF07_BC refers to a specific strain of HIV, whose significance will be discussed in Chapter Four.

Strictly speaking, harm reduction was not an entirely novel idea in Taiwan, but it had never entered formal policy deliberations as a legitimate alternative until this surge of HIV-infected IDUs was recognized.[1] However, when IDUs started to represent the majority of new HIV-infected cases, two issues surfaced that forced policymakers to take new steps. One was the failure of older suppressive drug policies over the past few decades, and the other was the urgency to strategize HIV/AIDS prevention in a new light. As a result, harm reduction was introduced in Taiwan by the CDC, the office in charge of epidemic control, as a proposed tactic of the government to address the rampant spread of HIV among IDUs (Chen and Kuo 2007). A series of policy actions then took place, officially periodized as follows:

[1] Some interviewees, such as Dr. Tang Xing-Bei from Chianan Psychiatric Center, told me that the idea of harm reduction was introduced into Taiwan back in the 1990s when addiction specialists visited treatment facilities in other countries. However, the idea was put aside because the threat of HIV epidemic among IDUs was minimal at that time.

(1) Awareness Stage (01/2004 to 01/2005): CDC statistical reports showed a drastic increase of HIV-positive IDUs, and harm reduction was proposed. Minister Chen Chien-Jen sought to negotiate with the Minister of Justice about harm reduction issues but failed to reach a doable conclusion. A nationwide program was implemented, in which CDC-sponsored HIV screening was integrated into existing prenatal exams for all pregnant women.

(2) Planning Stage (01/2005 to 03/2005): Deputy Minister Hou Sheng-mou urged the CDC to formulate an action plan for the rampant transmission of HIV. He was later promoted to the position of Minister (February 17, 2005). The action plan then became the harm reduction pilot program. Taipei City and County, Taoyuan County, and Tainan County were chosen as the implementation sites of the pilot program. Interestingly, harm reduction in Taiwan was translated into Chinese as *jianhai* (減害), different from its Chinese name *huanhai* (緩害) in Hong Kong. The translational difference was intentional and significant. In Chinese usage, 減 (*jian*), to cut off, is stronger in meaning than 緩 (*huan*), to slow down. According to Director Kuo of CDC, 減害 (*jianhai*) was adopted specifically because it better illustrated the determination of CDC to stop the epidemic of HIV/AIDS. It is, therefore, compatible with the momentum-making efforts of CDC and may in fact be consequential.

(3) Consensus Stage (03/2005 to 11/2005): Harm reduction was formally advanced in the meeting of the Executive Yuan. Prime Minister Hsieh Chang-Ting (Frank Hsieh) delegated Secretary-in-Chief Lee Ying-Yuan as the

coordinator of policymaking. Deputy Magistrate of Tainan County Yen Chun-Zuo actively participated in the meeting as a concerned expert.

(4) Pilot Program Stage (11/2005 to 07/2006): Needle syringe program (NSP) began in November, 2005. The proposal of a Harm Reduction Pilot Program for IDUs with HIV/AIDS was formally approved by the Executive Yuan in December. Prime Minister Su Tseng-Chang proclaimed that harm reduction would be part of the integrated anti-drug policy that unified the actions of different governmental units. Methadone was successfully and legally imported. Methadone maintenance treatment (MMT) was first offered on an outpatient basis in February, 2006. Hospital-based methadone clinics soon flourished throughout Taiwan.

(5) Program Expansion Stage (since 07/2006): Minister Hou expanded the scale of the program and made it a nation-wide policy after its preliminary effects on HIV/AIDS control came out positive.

(Revised from Yang 2008, powerpoint slide 5)

The officially defined periodization is not offered merely for the sake of convenience of understanding, but rather portrays the policymaking process in a fashion that pertains to a certain form of rationality. It follows a clearly delineated path that extends from central to local government. It presumes a rational undergirding cause-effect relationship between social events and governmental actions. The process presented by this periodization frame is clean and straightforward. At first glance, harm reduction in Taiwan is nothing new and particular. It is *just a policy* like any other.

However, if we compare this policy with its counterparts in Europe or America, its particularities stand out. First of all, it is fast. It takes only a year or two to transform this idea into a real nationwide policy. If we take into account the worldwide history of harm reduction (Riley and O'Hare 2000; Stimson 2007), we can see clearly that the response of the Taiwanese government is prompt and swift. Second, unlike its counterparts in Euro-American contexts, harm reduction does not stem from the community. It is intrinsically a technology of government. This feature of being "top-down", although similar to instances in many other Asian countries in that they were relatively late in facing the epidemic of HIV/AIDS in IDUs (World Health Organization [WHO] 2008), leads to numerous consequences uncharacteristic of the bottom-up harm reduction movement. Third, the Taiwan case is distinct from most other Asian countries because it has no formal and direct relationship or guidance from WHO, the Joint United Nations Program on HIV/AIDS (UNAIDS), and the United Nations Office on Drugs and Crimes (UNODC). Because it is not recognized as an autonomous nation-state, Taiwan must rely on informal, and mostly personal, communication channels to access and absorb the necessary know-how to make policy. This informality makes the promptness of action all the more impressive because, given the relative lack of systematic organization and attentive supervision, the policy is infused with a strong improvisational style.

How these differences bring about the uniqueness of the harm reduction policy in Taiwan and how this empirical uniqueness offers theoretical insight in terms of contemporary governmentality therefore constitute the main undergirding themes of this dissertation. However, to avoid misunderstanding and better situate Taiwan's harm reduction policy, it is necessary to be clear about what harm reduction means on a policy level in

Taiwan. According to the official program by the Department of Health (DOH), the harm reduction policy is officially named as the HIV/AIDS Harm Reduction Plan for Patients with Drug Addiction (毒癮病患愛滋減害計畫; *duin binghuan aiz jianhai jihua*). This plan has three parts:

(a) Expanded screening and education;
(b) Drug substitution therapy, which in fact refers to methadone maintenance treatment (MMT);
(c) Needle syringe programming (NSP), which includes distribution of clean needles and syringes and non-compulsory recycling of used paraphernalia. (Center for Disease Control 2005: 49)

While these programs are compatible with the formal recommendations by WHO, UNAIDS and UNODC, they are more problem-oriented and therefore limited to the public health domain only, failing to extend to other social areas where drug issues are more entrenched and entangled. If we trace the evolutionary trajectories of harm reduction in their original Euro-American contexts, we see that from the outset, harm reduction approaches were noted for their social movement features. That is, harm reduction has been mostly a self-organized, community-based effort to improve drug users' lives in a pragmatic and nonjudgmental way. McVinney (2005) specifies four major features that constitute a "good" harm reduction program: user involvement, any positive change, strong agency support, and collaboration with other services. From his perspective, Taiwan's harm reduction hardly fulfills any of these four criteria. Users barely participate in the overall policymaking; positive changes are appreciated but under strict surveillance; formal agency support is often shaky; and inter-departmental collaboration is unsteady and sometime conflicting.

Despite the lack of a broader harm reduction "spirit" and its various provisions such as safe injection rooms and naloxone distribution program, Taiwan's harm reduction policy has claimed success in merely four years. The Asian Harm Reduction Network (AHRN) praises Taiwan's experience, calling it "a beacon of hope for countries across Asia grappling to stop the spread of the AIDS epidemic among injection drug users (IDUs)" (Macan-Marker 2009, not paginated).

The Taiwan case is interesting not just because it is successful, but also because it represents a different configuration of collective action that has a unique genealogy and trajectories. To my knowledge, the existing literature relevant to harm reduction, except public health, is at most scanty and fragmented. There has been no comprehensive scholarship to date devoted to the making of harm reduction policies in non-Western countries. To examine harm reduction policy in Taiwan, I have developed the concept of *the office* and also utilize Deleaze and Guattari's (1987) concept of assemblage. I am able to describe the workings of *the office* that makes the policy. I offer the theoretical and methodological tool of assemblages (Deleuze and Guattari 1987; Irwin and Michael 2003; Ong and Collier 2005) to understand the implications of harm reduction policy in terms of biopolitical formation, expertise cultivation, policy globalization and citizenship imposition. These themes lay the foundation for the following chapters and help to portray a contemporary biopolitical regime that mingles knowledge with power, discourse with action, and the global with the local.

Furthermore, my study provides an illustrative example for rethinking the theoretical constructs and formulations in the West without being self-Orientalized. To some degree, this dissertation is postcolonial in the sense that it intends to illuminate the intrinsic local-

ness of any theoretical elaboration that claims universality (Lie 2008). It also challenges the diffusionist perspective (Basalla 1966) that implicitly takes the West as the center of technoscientific knowledge and the standard of judgment. What is more, my ultimate ambition is to delineate, with my research, "distinctive East Asian STS theories, not to mention distinctive STS stories, case studies, and histories" (Fu 2007: 5).

1.3 Historical Sketch of Injection Drug Use and Policy in Taiwan

According to the Ministry of Justice (2009), the most widely used drugs in contemporary Taiwan are methamphetamine (meth), heroin, ketamine and marijuana. Other less commonly used substances include morphine, cocaine, crack, hypnotics/sedatives, and some other amphetamine-type substances (ATS) that have recently emerged as novel party drugs. Heroin is usually more expensive than meth and it is used by smoking or more frequently, intravenous injection. In contrast, meth is often used in a way similar to the so-called "dragon chasing"— heated on a tin-coated paper before being inhaled by the nose (Lin 2004).[2] For this reason, when "injection or intravenous drug user (IDU)" is used in this dissertation, it refers to habitual heroin injectors.

At the end of 2004, Dr. Lin Shi-Gu from the Taipei City Psychiatric Center, with sponsorship from the National Health Research Institute (NHRI), published a monograph, *Health Influences of Heroin* (2004). The monograph summarized the up-to-date informa-

[2] The reason why meth, similar to crack in its stimulating effects on the human central nervous system, is inhaled while heroin is smoked or injected remains unclear because there has been no well-designed research on this issue. Given the scarcity of adequate research, the drug user's perspective has been elusive and perplexing. According to Dr. Chou Sung-Yuan at the Taoyuan Psychiatric Center, there seems to be a (fortunately erroneous, to him) shared belief among drug users that the meth they buy is impure so injection may cause physical harm. However, the fact that the heroin circulating in the underground market is notoriously adulterated appears to pose no problem. Further in-depth observational study is still needed to elucidate the underlying causes.

tion and knowledge about heroin use and its bio-psycho-social treatment. It pointed out the lack of adequate treatment facilities and trained personnel, as well as the insufficiency of funding sources. To make things worse, the medical treatment of substance dependence per se was excluded from national health insurance (NHI) coverage, a universal insurance characteristic of Taiwan's healthcare system (Lin 2004). For example, a habitual heroin injector would be covered by insurance when he sought medical help for injection-related *physical illnesses*, e.g., infection, pain, and nutritional insufficiency. However, if he simply wanted to get rid of his dependence ("detox", 戒毒 *jie du* or 戒癮, *jie in*), he needed to pay for detox services himself. The mind-boggling inadequacy of NHI coverage further aggravated the dearth of acute detox and long-term rehabilitative facilities as well as the lack of addiction specialists.

The marginalized status of drug problems in Taiwanese society has many causes, and its socio-historical origins are illustrated in the next chapter. However, harm reduction policymaking is very difficult to portray without providing an outline of the relevant governmental infrastructure. For the sake of clarity, a simplified chart of the government organizations involved in harm reduction is given below:

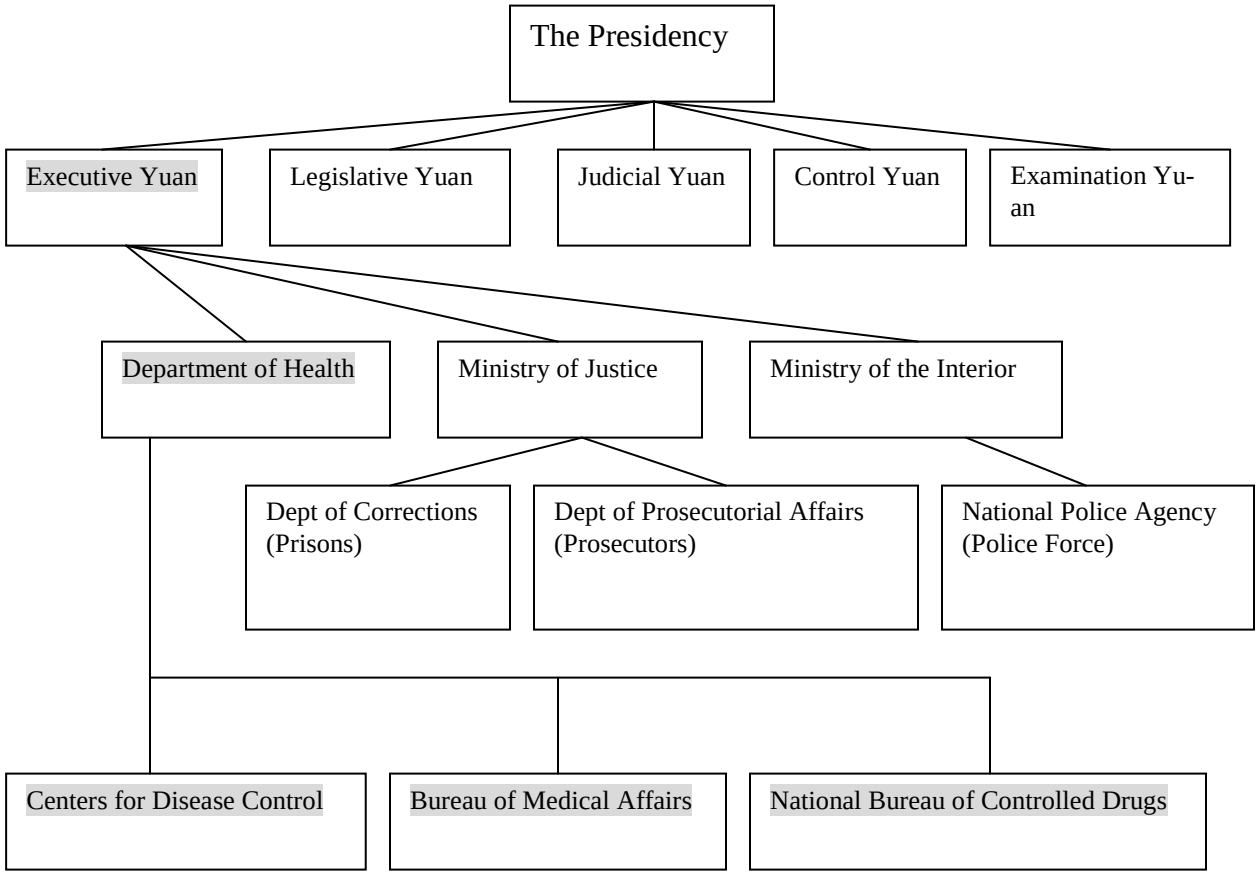

Figure 1-1 The central governmental organizations involved in the making of harm reduction policy. Shaded areas indicate the main players. Retrieved, adapted, and summarized July 4, 2009, from websites of the Office of the President (http://www.president.gov.tw/en/), the Executive Yuan (http://www.ey.gov.tw/ct.asp?xItem=52759&ctNode=1327&mp=11), and the Department of Health (http://www.doh.gov.tw/EN2006/index_EN.aspx). Irrelevant governmental units are omitted for the sake of clarity.

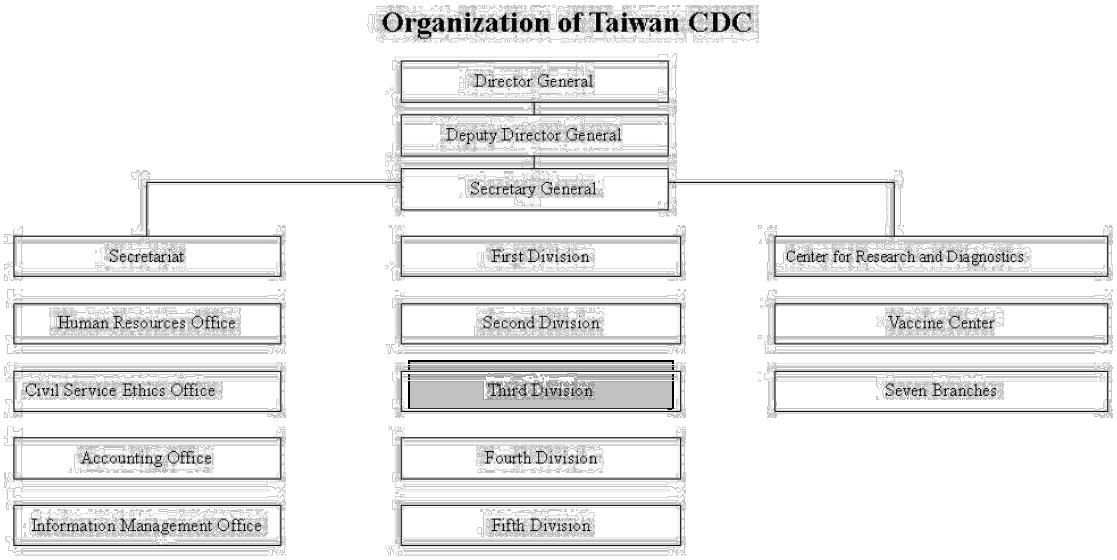

Figure 1-2 The organizational structure of Taiwan Centers for Disease Control. The third division (shaded square), mainly in charge of HIV/AIDS and TB, is the major player in harm reduction policymaking. Since 2004, three directors have chaired this division: Tsai Su-fen, Yang Shih-yang, and Yang Ching-Hui (in the order of their service). Retrieved and adapted on July 4, 2009 from the CDC website: http://www.cdc.gov.tw/lp.asp?CtNode=1050&CtUnit=338&BaseDSD=7&mp=5&xq_xCat=3

The issues of illegal drugs are managed by both the legal system and the public health system in most countries, and Taiwan is no exception. However, what these two systems really mean in Taiwan begs some brief explanation. First, the so-called "legal system" covers the police, prosecutorial, penitentiary, and juridical dimensions, in charge of different units in the central government. The court belongs to the Judicial Yuan, and the affairs of prosecutors and prisons are assigned to the Ministry of Justice, which is subordinated to the Executive Yuan. In addition, the organization responsible for police action, the national police agency, is subordinate to the Ministry of the Interior.

Compared to the legal system, the "public health system" is more concentrated in form, even though it is divided among many administrative units within the Department of Health. As the story of the harm reduction policy unfolds, we will see that the CDC is the major player because it supervises HIV/AIDS control. However, since this policy inevitably involves the regulation of medical practice and controlled substances, both the Bureau of Medical Affairs (BMA) and the National Bureau of Controlled Drugs (NBCD) have to work with the CDC in terms of the policy's design and implementation. On the city/county level, each local government has a Bureau of Health that handles health-related issues, including harm reduction. It also supervises the health stations (*weisheng suo*) in its administrative region. A health station, as a rule, has a medical-administrative director (usually an M.D.) and several public health nurses, the number of which depends on the assigned workload and area of concern. Health stations take care of local people's health principally by offering physical checkups, giving routine vaccinations, following up people with major illnesses, reporting local health issues, promoting health education and, in many rural areas, providing basic medical outpatient care.[3] The presence of health stations is a distinctive feature of Taiwan's public health network. Its history can be traced back to the medical police system of the Japanese colonial period (Chin 1999; Liu 2004). As widespread sentries of people's health, they play a significant role in the implementation of harm reduction policy in Taiwan. In collaboration with larger hospitals, they greatly improve the accessibility and convenience of MMT and NSP in areas that are less populated and are underserved for healthcare, such as Yunglin County.

[3] The functions and duties of each health station are quite different, but basically all health stations share some regulatory and promotional purposes. In some regions, health stations may expand into local health centers, with more medical facilities and treatment services. Here is an example of Tucheng City, Taipei County: http://www.phc.tpc.gov.tw/_file/1461/SG/32627/D.html

Institutions aside, the legal regulations that frame harm reduction-related issues are also of great importance. As a matter of law, the illegality of substances such as heroin requires that the legal system incriminate drug users. In contrast, the public health system hopes to secure some space for them to seek treatment. Quite reasonably, then, in the early days of the harm reduction policy design and implementation, many CDC officials were worried that their harm reduction measures would be considered illegal. To give a sketch of why these laws matter, I therefore briefly introduce what they define or regulate.

(1) *Narcotics Hazards Control Act*: Last revised in 1998, these regulations redefined drug users as "sick criminals" instead of their original status as outright criminals. This redefinition was made to allow more room for medical intervention in correctional facilities in addition to the existing punitive approach, basically incarceration. Despite this legal redefinition, drug users still suffered long-lasting stigmatization and marginalization. For example, even today, there is no advocacy group whatsoever for drug users. As we will see, this fact matters immensely in the later development of harm reduction in Taiwan.

(2) *Controlled Drugs Act*: This act focuses on substances rather than substance users. It follows international regulations and defines the categories of controlled substances.

(3) *HIV Infection Control and Patient Rights Protection Act*: Originally named as the AIDS Prevention and Control Act, it was expanded in 2007 to include patient rights protection. The protection was, for example, embodied in the demands

that HIV/AIDS control issues be discussed in governmental committees only when representing advocacy groups, private organizations and scholarly experts consist of no less than one half of the participants. It in some sense reflects the long-standing fight of advocacy groups for greater representation on the policy level.

In addition, the act also codifies the free provision of antiretroviral medications to people living with HIV/AIDS. At the same time it regulates the surveillance imposed upon these people so as to achieve and maintain optimal control. These regulations guarantee the HIV-positive drug users free access to medications, basically antiretroviral medicine and methadone. However, it is not legally binding for the government to offer free methadone to HIV-negative drug users. Furthermore, the act is remarkable because it decriminalizes the possession of paraphernalia and controlled substances for the purpose of promoting HIV/AIDS prevention. This code relieves public health personnel of the psychological burden that they could be arrested for what they do. This was one of the great fears among the initial frontline workers who carried out harm reduction policy.

These laws and institutions constituted the backdrop for the unfolding of the harm reduction policy in its embryonic stage. Even though my dissertation does not analyze governmental organizations per se, it is still sociologically organizational in the sense that this study examines how people organize themselves in an attempt to advance a public health policy. Nonetheless, there is no distinctive, circumscribed organization with clear-

cut boundaries, but rather a series of amorphous assemblages that take form and constantly change their shapes. My goal is to adequately describe the processes by which harm reduction policy is made possible, feasible and eventually successful in Taiwan.

In addition, I use this descriptive account as the basis for analysis of a larger biopolitical project to reveal the trace of a specific governmental rationality imbued with neoliberal thoughts and practices. The practices and effects of this governmentality, à la Foucault, involve the selection, cultivation, and inclusion of relevant experts and expertise, as well as the birth of "citizen addicts"[4] along with the re-definition and imposition of their conditional citizenship (Porter 1999). As my description and analysis unfold, I intend to show that the examination of the harm reduction policy may lead to a deeper understanding of contemporary biopower and biopolitics as they are born, transplanted and transformed across nations and cultures (Rabinow and Rose 2006).

1.4 Theoretical Framework

The idea of assemblages is an overarching concept that pertains to the methodology and theoretical framework of this study. However, other concepts and theories are also needed to build up specific arguments. These concepts and theories I take mostly from what I am most familiar with—science and technology studies (STS) and the works of Michel Foucault, mainly his later theses and lectures on modern political reason (Foucault 1976, 1978b, 1991a, 1997b, 2003a, 2003b, 2006, 2007, 2008). With the illumination provided by the theoretical framework, I aim to render a broad landscape of the bio-

[4] The term *citizen addicts* emerged in a discussion of mine with Peter Davidson and many other students and scholars interested in drug issues. It is used to describe the conceptually conflicting combination of drug addicts and citizens, which I elaborate in Chapter Five.

political regime that manifests itself in Taiwan. As readers will see, I weave my theoretical reflections into the empirical findings presented in each chapter, thus making them both well-grounded and provocative.

The notion of assemblages has been used by various social science scholars to interpret a wide variety of phenomena that range from political reconfiguration and economic globalization to knowledge formation and technology transposition. Originating in the work of Deleuze and Guattari's *Anti-Oedipus* (1983) and *A Thousand Plateaus* (1987), this concept stems from their post-modern criticism of modernity. It is usually considered particularly capable of portraying an aggregate of heterogeneous elements and rhizomic associations.

Assemblages are coined by Gilles Deleuez and Felix Guattari, who intended to establish a new way of comprehending things and events that is by definition post-modern, that is, beyond the grasp of modernity. In *Anti-Oedipus* (1983), they used Sigmund Freud's famous case, Judge Schreber who lived a long time and thought he had lost visceral organs, to illustrate the schizophrenic ways of being "reinserted into the process of production" (p.8). In this mode of being and thinking, things are re-ordered often in a random and non-systemic (or in their terms, rhizomic) way. In a later work, *A Thousand Plateaus* (1987), they developed the concept of assemblages. Assemblages are characterized by the propensity of incessant de-/re-territorialization. In other words, they are loosely aggregated entities, with constantly dis-/re-appearing territories and both machinic and enunciative aspects. Deleuze and Guattari (1987: 87-88) further define the "machinic" aspect as the corporeal dimension of assemblages and the "enunciative" aspect as the collective, non-corporeal dimension. These two aspects are "co-constitutive yet inde-

pendent" (p.88). The concept of assemblages thus relates to the schizophrenic ways of being and knowing, *body without organ*s, or the rhizomic ways of association (Deleuze and Guattari 1983, 1987). However, in their original work, the notion of assemblages is scratchy and under-developed, and its importance in analyzing contemporary phenomena was not fully appreciated or elaborated upon until scholars reappraised its potentials recently.

Social theorist Manuel DeLanda (2006) expands this Deleuzean concept as a useful metaphor of society to theorize about the philosophy of contemporary society. It is notably different from pure constructionist stances in that it recognizes some social reality as conception-independent, such as "the existence of institutional organizations, interpersonal networks and many other social entities" (DeLanda 2006:2-3). Nonetheless, this distinction does not make it just another realist theory, as DeLanda's theoretical stance is "all about objective processes of assembly: a wide range of social entities, from persons to nation-states, will be treated as assemblages constructed through very specific historical processes, processes in which language plays an important but not a constitutive role" (DeLanda 2006:3). Society is not simply "out there," nor is it purely a projection or construction of the human mind. It is an assemblage, and the assembling processes both constitute and specify its "reality."

In this sense, DeLanda is careful not to refute the significance of meanings in the social construction of reality, but he advocates emphasis on the processes and products of assembling. In his opinion, a major goal for this assemblage theory is to define, not presume, the presence and shape of social reality. DeLanda endeavors to maintain the explanatory flexibility of his assemblage theory by depicting it as anti-totalistic and anti-

essentialist. To fortify his argument, he notes that a major characteristic of this Deleuzean concept is its emphasis on the relations of exteriority instead of the relations of interiority. By "relations of exteriority" DeLanda means two things. First, "a component part of the assemblage may be detached from it and plugged into a different assemblage in which its interactions are different" (DeLanda 2006: 10). It is, therefore, in sharp contrast to the relations of interiority which characterize the totalistic organismic metaphor of society since the nineteenth century and in which the "component parts are constituted by the very relations they have to each other" (DeLanda 2006: 9). He argues that an assemblage, à la Deleuze and Guattari (1987), features on the one hand the transmuting machinic and enunciative dimensions of constitutive elements. On the other, it also features the incessant de-territorialization that makes the assemblage hard to be de-/con-fined. DeLanda's assemblage approach, it seems to me, refutes the essentialist stance in a manner reminiscent of Foucault's by focusing on historical processes of emergences and positing a space of possibilities where constitutive elements (what he calls *individual singularities*) interact contingently (DeLanda 2006: 28-29).

DeLanda argues that his elaboration of Deleuze and Guattari's original concept may help to resolve the long-held opposition of the macro and the micro because the assemblage approach, considering its flexibility, best exposes the convergence of both in cases of emergence. In addition, an assemblage can always be part of an even larger assemblage or contain a varying number of smaller assemblages.

Ong and Collier (2005) use the term *global assemblages* to conceptualize phenomena that have been grouped in the cluster of globalization. Irwin and Michael (2003), in contrast, use the term *ethno-epistemic assemblages* for the aggregates of various persons

(thus *ethno*-) and a vast array of knowledge involved (thus *epistemic*) in contemporary cases of technoscientific innovations and controversies.

DeLanda's articulation of assemblage theory is in many ways similar to, though not identical with, those of Irwin and Michael (2003) and Ong and Collier (2005). From their formulations, I conceive of assemblage formation as a highly changeable process of aggregating heterogeneous elements, some of which may be universal (or *global* in Ong and Collier's terms) and some contingent, into an ephemeral yet functional unit. *How* it functions is open to empirical examination.

Regardless, given their territorial variability, amorphous contours and changeable associability, assemblages exert their impact not merely by top-down influences but also by bottom-up as well as by tangential modifications. The N-wayness of impacting nicely echoes Foucault's conception of power, which is capillary and relational (Foucault 1976). I therefore contend that the notion of assemblage formation is particularly suitable for the analysis of contemporary phenomena, especially those of globalization, where numerous forces and various actors converge and diverge in spaces that are problematized and constantly re-mapping.

Phillips (2006: 106-108) approaches the potential of assemblages as a useful analytic concept by clarifying its French connotation. What we know as "assemblage" in English, according to him, is in fact "*agencement*" in French, which can also be translated as "association". The potential of association is further elaborated by Marcus and Saka (2006: 106) who explain that, an assemblage, as a "strategically deployed but passing term," can be used to expose "the imaginaries for the shifting relations and emergent conditions of spatially distributed objects of study in the contemporary period of so-

called globalization." As my dissertation will show, the so-called globalization or transplantation of policy, along with its administrative know-how and technoscientific knowledge, is better conceptualized as a series of assemblage formations (see Chapter Six).

In addition to assemblages, Michel Foucault's notion of biopolitics is certainly a major pillar of this work. In many ways this dissertation is an attempt to see how biopolitics works in an Asian country where I argue this concept should be carefully reassessed. I also attempt to introduce the discussion of citizenship into the rethinking of biopolitics. Although Foucault does not elaborate on citizenship in his work, the themes of biopolitics and biopower, in fact, clearly pertain to citizenship because they all have a shared concern—the power relations between the state and its people. Of course, we may take Foucault's later concepts of governmentality and technologies of the self as continuations of his former, genealogical formulations of modern political reason and subject formation. However, as Rabinow and Rose (2006) and Beck (1997) indicate, there have now been new ways of organizing selves and forming sociality other than simply being a governed subject. In other words, the governed subject may be approached in more than one way. Rabinow (1996) raises the idea of biosociality to indicate one way, among many others, that individuals may perceive and organize themselves not by nationality, class, race or gender, but by genetic markers, biomedical labels, and illness identities. New modes of organization mean new ethics and relations. More recently various kinds of citizenship have been elucidated, which more critically situate the individual vis-à-vis the government and expose the aspects of rights, responsibilities, entitlements, and duties (Biehl 2007; Nguyen 2005; Petryna 2002; Rose 2007; Rose and Novas 2005).

Ironically, the issues of citizenship, once central to nation-state building, are now rekindled partly because of recent globalization (Faulks 2000; Kymlicka 2001; Ong 1999; Turner 2001). Globalization is often conceptualized as faster, greater and freer flows of capital and labor across national borders; cultural and technoscientific flows are added to the concept too (Appadurai 1996; Held 2000). On the one hand, for those who are affluent and capable, citizenship becomes transnationally valid and differential (Ong 1999, 2000, 2004). However, what happens to those who are marginalized and condemned for their drug use? How can we apply this notion to those who were once disenfranchised but now are newly entitled through HIV/AIDS prevention, for example?

Harm reduction offers an excellent example in this regard. To begin with, it is a transplanted policy, but just like any other transplant, it has to fit into local environments, which include historical heritages, existing infrastructures, political cultures and legal constraints. It also involves a re-adjustment of rights and duties between the government and the so-called "citizen addicts." Moreover, it is about producing new and useful knowledge, about manufacturing relevant experts and expertise, and about maneuvering power in a way that makes collective life and prosperity a target for governmental action.

But that is not enough. Scholars of Foucault attending to his work on political reason would note that Foucault was acutely aware of the impact of liberalism on both governmentality and biopolitics (Barry, Osborne, and Rose 1996). Relevant discussions could be seen in his recently published lectures at the Collège de France, especially those delivered from 1976 to 1979 (Foucault 2003b, 2007, 2008). In these lecture notes we may understand how Foucault explicated this problem differently from his previous works on clinical medicine (Foucault 1994) and human sciences (Foucault 1970). As a matter of fact,

his analysis of liberalism and its modern derivatives as a form of political reason ought to be seen as an extension of his critique of modern subject formation and state-building, both of which are so entangled that only a detailed genealogical tracing can extricate its complexity.

In *Society Must Be Defended* ([1976] 2003b), Foucault depicted the process of modern nation-state formation and its accompanying consequences, during which not only nation-states were built up as people's proxy to wage wars but also society as we know it today was born with constant enemies from within. The distinction of self and others was founded on biologically inscribed differences such as race (a distinguishing feature between nation-states) and criminality (another distinguishing feature within a society). In *Territory, Population and Government* ([1978] 2007), Foucault continued delving into the process of making modern states and subjects: In addition to keeping its territory intact and undisturbed, the raison d'etat gradually expanded to the prosperity of the governed population. The state re-defined its finality. To be clear, this was the time when biopolitics emerged, when the maneuvering power was to give life rather than to take life, and when the question of government, that is, how things and people should be managed properly, became pivotal for the burgeoning state.

Following the flow of discourse, in *The Birth of Biopolitics* ([1979]2008), Foucault finally discussed how (neo-)liberalism was introduced into the prevailing biopolitics of the twentieth century. In this series of lectures he distinguished two kinds of twentieth-century liberalism: German Ordo-liberalism and American anarcho-liberalism. The two types of liberalism arose in different times for different reasons, but they both shared a feature that distinguished them from earlier versions of liberalism—both argued that the

role of the state is to facilitate, rather than just stay away from, the operation of the market. It is the "nature" of the market that will determine how things are arranged. In the American version, or the type of neoliberalism that originated well before but was compatible with the discipline of economics at the University of Chicago in the 1970s,[5] human beings are further viewed as rationally calculating entrepreneurs who tend to accumulate their human capital and make choices accordingly. This approach expands classic liberal thought, making it not only an economic principle but also a political and even cultural dogma. The rise of the market in governmental agendas does not signify the decline of state power. On the contrary, it is just a transformation of state governance that deals with the public in a different way. Corresponding to this art of government, materialized in the form of policy, is a specific set of technologies of the self. In other words, as part of the neoliberal governmentality, technologies of the self may take different shapes when different policies are imposed. Government and self are co-constitutive.

Postcolonialism is also an implicit part of the theoretical backbone of this study, but I do not intend to delve into this theme too much since a comprehensive review and critique are neither possible nor necessary. Instead, I specifically examine the work of science and technology studies (STS) scholars who apply this concept and select those who explore how science and technology matter in the postcolonial projects of modernization or nation building. Their studies not only expose the contrasts (and questionability) of "the West" and "the East" (Hall 1996; Said 1995), but also illustrate the importance of tracing how scientific knowledge, body concepts, and technological artifacts are displaced and

[5] The history of neoliberalism is beyond the scope of my dissertation. Interested readers may consult David Harvey (2005). However, Foucault contended the foundation of American neoliberalism had existed since the establishment of the American Enterprise Institute in 1943. See Foucault (2008), especially pp. 246-247 and note 13.

promoted to “the East” (Anderson 2000, 2002). In the old diffusionism, the transmission of science and technology originally based in the West was very often taken for granted because of their claimed neutrality and universality (Basalla 1967). The postcolonial perspective which challenges this simplifying “dissemination” theory is particularly vital and useful to Taiwan. Taiwan is a cultural-political hybrid of China and Japan (Chin 1998; Roy 2003), both of which colonized, to use a broad conception, this island of Formosa, originally named by Portuguese explorers and later constructed as an outpost of the Dutch (Roy 2003). Similar things happened to its nearby Philippines. Warwick Anderson (2006) recounts the various facilities and practices of American colonization in the Philippines, some of which are salient even to this day. In addition, some innovations actually go from the colony to its mother nation rather than the other way around. As I will show, the public health infrastructure in Taiwan, in the shape of widespread health stations, is one of the many colonial legacies that were mobilized during the implementation and promotion of the harm reduction measures.

Although many scholars of postcoloniality stress the uniqueness of local experience as opposed to the implicitly Euro-American version of universalism (Chakrabarty 2000, 2004; Chatterjee 1993; Prakash 1994; Turnbull 2000; Verran 2002), I am more concerned here with the dynamics between the universal and the local. It may seem at first glance that I am talking about “frictions” generated when universalizing forces sweep over the local (Tsing 2004), and I am. But I further intend to place existing discussions of knowledge transmission in STS in conversation with my analysis of universalizing phenomena. By introducing and analyzing the notion of “transplantation” to capture the travel and (re)embedding of a policy package, I question the validity of the global/universal and the

local/particular as adequate conceptual tools to comprehend what is going on. Instead, I argue that the transplantation of a policy/knowledge package may be postulated, in a quite postmodern way, of course, as a series of assemblage formations where ephemeral contingencies abound and liquid relations ebb, flow and eddy about (Bauman 2003; De-Landa 2006).

It seems to me, then, that asking how things travel, be they technologies, sciences or policies, becomes a more productive approach than simply dwelling on what the postcolonial condition is. The question of travel turns the analytic eye from what the thing is to what it does, from the static to the dynamic, and from the dichotomy of indigenous versus imposed to the processes of transplantation of foreign ideas and technologies. It diverts scholar attention from Basalla's (1967) uni-directional diffusionism to more tenuous transpositions of technoscience. In addition, this type of inquiry is associated with issues of experts and expertise formation, a central debate in STS as well as in policy studies owing to the preponderance of expert knowledge in public decisions (Collins and Evans 2007; Jasanoff 2004; Pielke Jr. 2007; Renn 1995; Rip 2003; Wynne 1992, 2003). To date such reflections on the excessive dependence of public policy upon scientific expertise rather than local opinions still originate in Euro-American contexts. This renders a serious appraisal of them even more urgent, because policy-relevant expertise for most policy initiatives in Asian countries is transplanted from elsewhere to solve newly emerging domestic problems. How is this possible? How does it take place? How does it become a legitimate factor in deciding public affairs? How does such transplanted expertise contribute to the making of a policy that aims to solve a local problem? How do local experts feel about and react to this?

If we introduce insights from postcolonial STS perspectives (Anderson 2002; Anderson and Adams 2008), these questions can be seen as related to how reception of knowledge under postcolonial conditions is made possible. Significantly, this knowledge receiving involves not only an Orientalist representation but also an Occidentalist imagination. As Director Kuo of the Taiwan CDC told me in his interview, he believed there had to be previous examples in the West from which Taiwan could learn because it was very unlikely Taiwan would be the first to encounter such problems. In many ways, he was right. That the HIV/AIDS epidemic was exacerbated by IDUs was not news to the US or European countries. But this does not mean that their situations and solutions were well-established and ready for use in Asian countries. Each locality has its own histories and idiosyncrasies, and therefore its own peculiar ways of facilitating management. Taiwan, in the face of this troubling combination of HIV/AIDS and intravenous drug use, was no exception. Its response, as a result, is at the same time unique and common. It is unique in the sense that it has to strategize on the basis of its particular settings, knowledge, morality status, resources and manpower. It is common in the sense that it has the same or at least a similar reservoir of policy choices, scientific reviews, and forms of practical know-how, which were all founded on the experiences of Euro-American countries.

In a nutshell, this research about harm reduction links with a broader picture in which Taiwan occupies the position of knowledge receiver vis-à-vis the international multi-layered flow of science and technology. This situation in a sense both frames and is framed by how a domestic social problem can be understood, structured and addressed. This is a less discussed facet of globalization because it does not directly involve labor

and capital, but rather the arts and rationalities of government. In this light this research offers another way to look at global governmentality (Larner 2004), offering what has been called a "parallax vision."[6]

1.5 Materials and Methods

This is a multi-sited ethnographic study that utilizes grounded theory principles and methods (Charmaz 2006; Clarke 2005; Strauss 1987) to examine the processes of the introduction and implmentation of the harm reduction policy in Taiwan. The study was conducted mostly in Taipei and Taoyuan, two major cities/counties in northern Taiwan. The central government, where most of the harm reduction policy was designed and formulated, is located in Taipei City, and Ju Shan Hospital, my original site of field observation, is located in Taoyuan County (See Appendix C for the map of Taiwan). But I also visited several southern cities/counties such as Tainan and Kaohsiung for the sake of interviewing and observing. During the research period (from July 2007 to January 2009), I collected large amounts of data from archive research, in-depth interviews and field observations. I went back and forth among them, and then abstracted useful findings that contributed to my final analysis.

1.5.1 Materials

[6] The term *"parallax vision"* is taken from the title of a book on US-East Asia relations and used here as a metaphor to imply different perspectives from different angles. However, my intent here is far from the essays in the edited volume. See Cummings, Chow, and Laotian (2002).

The materials for my research were collected in three ways, namely archival research, in-depth interviews and field observations. Archival research was undertaken to search the relevant literature for discourses of significance that would help to delineate the historical trajectories of Taiwan's drug policy, along with the viewpoints and debates about harm reduction. The major sources of information included medical and public health journals, governmental documents, and several major newspapers (*China Times, United News* and *Taipei Times,* for example). These archival materials are vital for reconstructing the trajectories of harm reduction because they represent the ways in which medico-scientific experts, government entities and the media have constructed drug problems and the measures used to deal with them over time.

The in-depth interviews constituted the second and major part of data collection. For a qualitative study that focuses on the interactions within and about policymaking, whose facts are difficult to collect due to their invisibility to the public, Wedel and colleagues (2005) have argued that intensive interviewing is frequently "the only means of gathering firsthand information" (Wedel, Shore, Feldman, and Lathrop 2005: 41). In my case, the people involved were from many walks of life: bureaucrats, psychiatrists, HIV professionals (researchers and workers), pharmacists, and so on. Even though, as I will show later, they are thought to work within an assemblage, there are few, if any, real sites or institutes where they actually come together and interact. In other words, they are neither confined in a given locality nor bound together by some social groups. Rather scattered spatially, they interact with each other only on some *ad hoc* occasions for policy discussion into which outsiders like me are mostly unable to participate. For these reasons I interviewed them to learn what they think and do in terms of harm reduction. Certainly ho-

nesty and validity are always significant issues, and I designed the interviews to offer the choice of either "on the record" or "off the record" to help ensure that participants could speak comfortably and candidly. Quite to my surprise, many people circled "on the record" even though the interviews touched on fairly sensitive issues. One possibility that may account for this is that the majority of my interviewees are from the CDC. I interviewed them when they were preparing to transfer their duties to the BMA and the NBCD. As a result, they were largely talking about things that would soon be in the past (read "no longer my major concern"). In contrast, the interviews with people from the NBCD and the BMA were not as fruitful as I anticipated. Moreover, some of the interviewees preferred to speak off the record.

Most participants were interviewed just once due to limited availability. I also did some brief (i.e., less than 15 minutes) follow-up interviews with some of the participants. I also supplemented my interviews with participants' public speeches and articles about them from newspaper. Over half of my interviews extended beyond the originally set time frame (about one hour) because the participants simply had so much to say. My previous training in psychiatric interviewing was greatly helpful in eliciting candid responses and personal opinions. Some of the participants told me that they had been interviewed by other qualitative researchers, but these researchers adopted a more structured approach, like questionnaires or semi-structured interviews. In contrast, my open-ended style made these subjects feel freer to talk about whatever came to their minds. While I intended to interview 35 persons, two refused my invitation and one was so occupied that a scheduled interview was impossible. For these individuals I tried to collect their articles

and opinions from public media. In the end I collected interviews with a total of 32 subjects with some brief follow-up interviews.

The third component of data collection was field observation. I used this strategy to supplement the interviews with information gathered from direct contact with my interviewees and/or my personal interactions with drug users. The observations of drug users were mostly carried out in Ju Shan hospital, where I once worked. It has been offering traditional-style detox medications to drug users for years (for details, please see Chapter Five). The observations were originally designed to see whether there had been any changes in abstinence-oriented medical facilities after methadone maintenance treatment (MMT) became more widely accepted among drug injectors. Following the guidelines in Hammersley and Atkinson (1983), Prior (2003), and Emerson, Fretz, and Shaw (1995), I took field notes and collected documents such as propaganda fliers and pamphlets. Through these three approaches I sought to include as much information as possible to achieve a comprehensive understanding of this issue.[7]

1.5.2 Methods:

My research questions and analytic methods are, first of all, informed by the constructivist tradition of grounded theory (Charmaz 2006; Strauss 1987) and especially its

[7] Traditional qualitative research has been honored for its ability to triangulate the observed truth and therefore maximize its validity and reliability. However, my approach in this dissertation is rather interactional and interpretive, so I try to avoid the positivist terms that characterize a successful qualitative study. Instead, I emphasize the fluidity of concepts and observed phenomena as they both link to the central integrating concept, assemblages, that I use in this dissertation to depict the unfolding and transformation of harm reduction policy.

postmodern revision, situational analysis (Clarke 2005). In many ways my approach in this dissertational project is manifold, multi-sited, and mosaic in style.

In practice, archival materials, field notes, and intensive interviews transcribed verbatim constitute the main source of the study data. Methodologically, the collected data are serially coded (open coding, axial coding and selective coding), analyzed and compared to established theoretical frameworks. They are treated as Strauss (1987) suggests. That is, the coding paradigm focuses on the conditions, interactions among the actors, strategies and tactics, and consequences of a given situation (Strauss 1987: 27-28). However, we should not equate the word *paradigm* with a rigid frame of thinking and analyzing. Instead, as Strauss (1987: 8) wisely points out, "Methods, too, are developed and change in response to changing work contexts." In his words, these are flexible guidelines and rules of thumb, not rigid rules. Following his advice, I therefore adopt the suggestions given by Charmaz (2006) in terms of coding and memo-writing, and à la Clarke (2005), pay attention to the significance of discourse, the presence of implicated actors, and the situational map that consists of both humans and nonhumans.

On the one hand, this approach includes as many voices as possible vis-à-vis a given issue and therefore, as Clarke (2005: 37) rightly argues, "in simplified form, situational or relational ecology is closest to policy arena analyses." "[W]e assume multiple collective actors (social worlds) in all kinds of negotiations and conflicts in a broad substantive arena focused on matters about which all the involved social worlds and actors care enough to be committed to act and to produce discourses about arena concerns." This pluralistic and interactional spirit seems to capture best the various stakeholders, objects, practices, and discourses flowing through the processes of policymaking.

On the other hand, I did not formulate my case strictly in a social worlds/arenas way of analysis (Clarke and Star 2008; Clarke and Friese, forthcoming). Instead, I intend to expand the existing conceptual toolbox of the social worlds/arenas framework by adopting a concept that accommodates more fluid and transient interactions and commitments. In short, I utilize the concept of assemblages instead. The foremost reason for this choice is that the contestations of harm reduction are so ephemeral and so dissipated that their contours are ill-defined and their contents shifting. From my fieldwork experience, it is difficult to even delineate an arena where these actors would all agree they are debating, negotiating or collaborating. To be sure, harm reduction is what initially brings them together but what it means, as I will show later, can be highly diverse for different actors and in different stages. In this case it is hard to tell if there are concerted actions even within the same social world, because disciplinary identities or official credentials are not the defining features. Boundaries are constantly transgressed. Most of the time things are quite fluid and amorphous. As a matter of fact, what this arena of harm reduction is actually about is what these participants, intentionally or accidentally, are disputing. Consequently, I prefer the concept of assemblage to depict the whole process of policymaking in a relatively short period of time (in this case, about 5 years).

1.6 Overview of the Dissertation

As noted above, my original purpose for conducting this research was a humble one—to portray the process by which harm reduction became a policy in Taiwan. Somewhat unexpectedly, it has turned out to aim at more profound sociological issues and im-

plications. In the following chapters I present the making of Taiwan's harm reduction policy in a chronological as well as thematic order. Each chapter has its emphasis upon important issues yet roughly corresponds to a certain period of time. This does not mean the issues are specific to that period only, but that the issues are made particularly salient, compared among many others during that period.

Chapter Two situates harm reduction in, and contrasts it with, the socio-historical trajectories of Taiwan's drug policies over the past one hundred years or so. These policies originated both from the public hygienic measures taken during the Japanese colonization period (1895-1945) and from the cold-war politics between the KMT (Kuomingtang, or the Chinese Nationalist Party) and the CCP (Chinese Communist Party). These can be traced back to the founding moment of the Republic of China (1911), or even further back to the Qing Dynasty. However, in terms of Taiwan's current drug policy, the moment of the greatest significance was in 1945, when Taiwan was ceded to the KMT government by Japan. The two influences from Japan and China, respectively, converged. During the post-war period, Taiwan's drug policy was initially noted for its suppressive features. The medicalized social control model of opium regulation was mostly ignored, and consequently, addiction medicine was seriously marginalized and underdeveloped. The convergence of Japanese colonial medicine and Chinese punitive control did not reveal its full effect until the 1990s. At that time, drug problems resurfaced as a major socio-medical issue and drug users were redefined from criminals, pure and simple, to a hybrid yet ambiguous category of "sick criminals." Only after drug users were redefined as such could the medical system legitimately encroach upon a domain of ju-

risdiction that used to be governed by the juridical system. However, most treatment facilities were unsatisfactory.

Another point of interest is the public cultural image of drug users in the cold war period. They were mostly depicted as not only moral derelicts but also political traitors because opiate drugs, first opium and morphine and then heroin, were thought to be smuggled into Taiwan, Free China, as part of the communist conspiracy mounted in the mainland. It is noteworthy in the history of drug use that using drugs was considered a sign of political disloyalty. Even though this was no longer the way drug users were imagined later on, the negative impressions this period etched in common people's minds remained especially unchanged. This makes the prompt adoption of harm reduction policy in Taiwan all the more un-thinkable and therefore difficult to analyze.

Chapter Three depicts the organization of *the office* in the very initial stage of policy formulation in Taiwan. It focuses especially on how the policy was established within the net of *guanxi*, or personal relationship that lubricated the collaboration between bureaucratic units. This chapter also focuses on how the policy was characterized by a tendency toward devolution that left program details up to local government units. Consequently, the office was an assemblage with heterogeneous components, human and non-human, associated with each other in new yet unstable ways. Biases and controversies were commonplace. Statistics and syringes/needles represent two examples that expose the conflicts between objectivity and subjectivity, for instance. To further illustrate the conflicts, I draw on Foucault's notions of *Homo economicus* and *Homo juridicus* to account for the two inherent conceptions of drug users in the burgeoning harm reduction policy.

Chapter Four focuses on a central issue in the making of harm reduction policy, that is, the making of experts and expertise. Here I concentrate on the formation of locally self-/educated experts rather than the internationally renowned foreign experts who contributed their ideas and experiences to the Taiwan government. I treat the organizing and self-cultivating of local experts also as a process of assemblage formation, including not merely people but their specialized knowledge and social connections as well. The emphasis on local experts and expertise formation, or expertization, is analytically pertinent because harm reduction policy was fervently disputed by various specialists from different disciplines throughout the period of policymaking. Notably, the whole process featured not the consolidation of extant disciplines but the emergence of new self-made expertise that transgressed disciplinary boundaries and even transcended national borders. The participants strived and competed for these precious opportunities for professional growth in their knowledge and influence during temporary encounters with other professionals and technocrats in the central government. In a matter of speaking, they became both the technoscientific backbone of harm reduction policy and the spokespersons for drug users and HIV/AIDS sufferers, even though they often feel disrespected and even neglected vis-à-vis the government. In the portrayal of the making of experts and expertization, the vibrant creativity and resilient persistence in self-growth and professional development of participants in the making of harm reduction are colorfully illustrated.

Chapter Five turns to another phenomenon illuminated by harm reduction policy in Taiwan—the citizenship of drug users. Highlighting citizenship issues among this population has multiple purposes. First, it supplements the lack of discussion of drug users per se in this policymaking effort and clarifies the fact that they are implicated policy

"users" rather than agentic "shapers." Their rights and duties are therefore re-defined. By examining these revisited entitlements and responsibilities, the marginalized status of drug users can be illuminated in a new way. Many harm reduction programs in the world are undertaken in the name of universal human rights, which Bryan Turner (1997) argues is the newest form of citizenship compared to old-time civil, political and social citizenship. A detailed examination is thus necessary to see whether Taiwan's harm reduction policy really fulfills the promise to improve drug users' human rights. Second, by delineating the special type of citizenship imposed on drug users, the maneuvers of biopower upon each and every subjected drug user within this biopolitical regime can be elucidated in greater details. Also, in this chapter we again see how neoliberal thought permeates the fabric of government.

Chapter Six deals with the "transplantation" of policy/knowledge, which I conceptualize as a better way of understanding the globalization of a knowledge-intensive policy or governmental strategy. Globalization as a concept has become too broad and too wide to do such analytic work. Consequently, I discuss the various ways that knowledge-intensive policies like harm reduction get transplanted transnationally. The use of a botanical metaphor "transplant" attends not only to how the plant matters but also highlights that the soil and its ecology are vital. Therefore Latour's immutable mobile and translation theses (Latour 1986, 1987, 1988) seem insufficient, because they fail to account for the requisite local adaptations that make this object or truth work, especially in a policy-related setting. However, attributing successful transplantation entirely to social technologies, milieus and manipulations may tend to ignore the redefinition of the social in the transformational process (Jasanoff 2004). I therefore suggest that we formulate this

transplantation/globalization process as one of an assemblage de-/re-territorialization where rhizomic associations between various components arise and dissolve, ephemerally and unstably, in the name of harm reduction.

Chapter Seven concludes my research by depicting the aftermath of harm reduction policy being normalized and routinized (*changtaihua*) in Taiwan. I also elucidate the theoretical reflections generated from this case study. In 2008, the CDC planned to transfer its burden of implementing methadone maintenance treatment (MMT) and part of the public educational efforts to the BMA and NBCD. The CDC would continue implementing the Needle Syringe Program (NSP). Interestingly, this effort to *changtaihua* harm reduction, in my opinion, signifies yet another de-/re-territorialization of the policy assemblage of harm reduction. It terminated some previously *ad hoc* features and started to fit its activities into the abstinence-oriented medical treatment modality. Old connections were disentangled and new links created.

Following the description of the aftermath is a series of discussions and reflections. These insights span the domain of STS and beyond. First, I argue that the consideration of technoscientific knowledge and practice is indispensable to a Foucaultian critique of modernity. Also, I contend that terms like local and global need serious reappraisal and, if necessary, re-conceptualization. Third, I suggest that we seek a useful framework to theorize the ways in which biopolitical regimes and neoliberal governmentality are applied to situations beyond their original milieu. That is to say, instead of indiscriminately treating them as universal, we need to pay attention to their particularities and localness. In this regard, I follow Dipesh Charkrabarty's (2000) suggestion of "provincializing Eu-

rope" and raise my fourth reflection which is concerned with the de-centering of the Euro-American version of biopolitics.

Fifth, I urge interested researchers to scrutinize a short-lived phenomenon or event, which often offers an invaluable opportunity for researchers to approach its conditions of singularity. Sixth and lastly, I suggest we rethink whether the antagonism of experts and laypeople in terms of policymaking has to be inevitably painful or even inevitable. Past STS studies have been devoted to removing the veil of expertise by exposing its social inadequacies or political orientations. However, how these deconstructive efforts may lead to normative changes remains uncertain. It is supposed to be asked whether, somewhere between blind trust and sheer skepticism, people, including experts themselves, should and could take a stand without sacrificing either democratic participation or scientific insight.

In sum, I do not offer closure so much as I create space of problematization. This is a rich story yet it is still open. My dissertation does not mark its end but its beginning in another guise.

So the story begins.

Chapter Two

Harm Reduction as a Socio-historical Project

2.1 War and Medicine

In November 2007, *The New Opium War: In Search of Contemporary Du Congming* （新鴉片戰爭：尋找現代的杜聰明; Xin yapian zhanzhen: xunzhao xiandai de Du Congming）was published in Chinese. [8] Written by Yen Chun-Zuo, Deputy Magistrate of Tainan County and an enthusiastic physician, this book records most, if not all, the major events of harm reduction policy in Taiwan (Yen 2007). Although this book contains personal essays that somehow make it a form of self-advertisement, there are still certain messages that intrigue careful readers. For example, the juxtaposition of the Opium War and Du Congming is confusing at first because there seems to be no direct connection between Du (1893-1986), a medical specialist on opium addiction in colonial Taiwan, and the Opium Wars (1839-1842 and 1856-1860), which subjected China to the commercial and political exploitation of European countries, mainly England and later France. On the other hand, the combination appears anachronistic as the Opium War was a 19th-century event but Du is a 20th-century character. It is also conceptually conflicting be-

[8] The English translation of Chinese names is always a puzzling issue. Several systems of translation are used today. For the sake of simplicity and comprehension, I use the Hanyu Pinyin System. However, I keep the habitually accepted translations (e.g. Taipei instead of Taibei) of some cities and places. Furthermore, the surname comes first in Chinese, and there has been a trend in English literature to follow this rule when Chinese names are mentioned. I adopt this way of naming as well unless the person preferred to be named otherwise. Note that Du Congming is sometimes spelled as Tu Somei, which corresponds to its pronunciation in Japanese.

cause the Opium War arose in the wake of a strict repression of opium use, while Du's medical treatment of opium smokers exemplified a more lenient regime of governance.

However, the message is clear. Harm reduction, as the book argues, is a way of fighting against the various adverse consequences of drug use (hence, the image of war), and it embodies the doctrine of tolerance manifested in Taiwan by Du's medical treatments. In a way, to endow a current policy like harm reduction with an honorable past is a way of legitimating it retrospectively. Subsequently, I will show that this hybrid and unique combination of Du and the wars reflects the socio-historical situatedness and inherent conflicts of harm reduction policy in Taiwan.

When harm reduction was first proposed by the Taiwan Centers for Disease Control (CDC) in 2005 as an efficacious way of controlling rampant HIV infection among injection drug users (IDUs), it was almost immediately rebuffed. This idea was so incongruous with the prevalent "war on drugs" ideologies that the CDC had to keep it as low-profile as possible. Some newspapers gave it a shocking report, calling it a way to "contain a poison with another poison" （*yidu yandu*; 以毒養毒）or "attack a poison with another poison" (*yidu gongdu*; 以毒攻毒) (Chang 2005). In Chinese, drugs and poisons are often synonymous. Illegal drugs are called *duping* (毒品), which literally means poison. Similar terms include *ye*n (煙) and *mayao* (麻藥), which mean smoke and anesthetic agents, respectively (Zheng 2005).

Retrospectively, it makes sense that harm reduction needed to take shelter in the weird combination of the Opium War and Du Congming, but only when the policy is situated within the particular socio-historical trajectory of Taiwan. Although the history of drug control before the year 1945 is not very relevant to my research, its vestiges have

remained influential in subsequent policymaking. Therefore, I herein offer a cursory overview to better understand drug policy in Taiwan after 1945.

There were actually two Opium Wars, one from 1839 to 1842 and the other from 1856 to 1860. The first broke out because of the Chinese government ban on opium imported from British India (Wang 2005; Zheng 2005). Lin Zexu was a major character in this anti-opium ban. As a Qing official, he abhorred opium for its physical, psychological, and social damage, so he burned all the confiscated opium in Humen. His behavior, however, irritated the British government and triggered a series of combats that lasted more than two years. Although China lost the war, Lin was made into a heroic savior of the Chinese people. China's defeat in the first Opium War exacerbated the hostility of its people toward foreigners. In this flare-up of nationalistic rage, even the religious activities of foreign priests were targeted. Conflicts between foreigners and natives heated up and finally escalated to a level so that violence was the only solution. Eventually the second Opium War broke out. This time, the war involved not only Britain but also France. They pushed for legalization of opium on the one hand, and revenged for the loss of their properties and the lives of their priests on the other (Zheng 2005). China was the loser again.

These two wars and their subsequent unequal treaties resulted in lasting changes: opening up several ports for international trade, loss of Chinese sovereignty over certain activities of foreigners, and cession of Hong Kong (and later Kowloon) to Britain. These unequal treaties further weakened China's declining international status and, not surprisingly, became the very symbol of shame for the Chinese. Opium use, although popularized and intensified through this political transformation and commercial expansion, be-

came viewed as a major source of national disgrace (Dikoetter, Laamann, and Xun 2004; Wang 2005; Zheng 2005). After the Qing Dynasty was overthrown in 1911, the management of opium-related problems was still considered central to the prosperity of this burgeoning country. Dr. Sun Yat-sen, the founding father of the Republic of China, contemplated the significance of opium prohibition vis-à-vis desirable governance for the young nation-state: "The problem of opium prohibition in China is synonymous with the problem of good government" (Sun [1924] 1961, quoted in Slack Jr. 2000: 256).

What happened in the following years confirmed Sun's statement. In both the Nationalist Party, which is also called the Kuomintang (KMT), and the Chinese Communist Party (CCP) governments before 1945, opium policies were usually associated with both the aim and means of nation-building. This history has been detailed elsewhere (see Brook and Wakabayashi 2000), but suffice it to say that it was easy to define opium smoking as an evil of the past and commonplace to eradicate it as a way to establish a new body politic. As a result, both parties incorporated the enforcement of opium suppression into their governmental rationality (Wang 2000; Zuo 2000). For example, the New Life Movement promulgated by Chiang Kai-shek of the KMT in the 1930s and 1940s signified such a political initiative combining state-making with the self-discipline of individual citizens. Certainly, abstinence from opium was included (Wang 2000).

In contrast, Taiwan under Japanese rule experienced a tremendous change in terms of opium control in the 1930s (Hsu 2002, 2008).[9] The earliest record of opium use

[9] The Opium Question lingered in Taiwan studies for quite some time, and many scholars have approached this issue from various angles, most of which concentrated on how this question was integrated with the question of governance: how colonized people should be disciplined and monitored, how this issue was situated in a particular political economy of Taiwan, and how this question reflected the relationships between the colonizer and the colonized. However, I only address the parts of the whole Opium Question debates that are relevant to and used in current harm reduction policies in Taiwan. For more details on the Opium Question, see Liu (2008) and Hsu (2008), both of which I think best illustrate the history of the

in Taiwan can be traced back to the eighteenth century. It was prevalent among those single men who were considered ill-behaved scoundrels. The main source of opium was the Dutch East India Company at Batavia (Hsu 2009). When Taiwan was ceded to Japan in 1895, the new governing class discovered the alarming prevalence of opium smoking among Taiwanese inhabitants. Consequently, feverish debates soon arose about whether a strict restriction policy was needed. Eventually the Japanese government adopted a policy of gradual rather than abrupt prohibition (Hsu 2008; Liu 2008). In 1896, the Japanese colonial government established in Taiwan a monopoly system on opium that took charge of everything from production to distribution. A similar but not identical monopoly system had been effective in Japan since 1879 (Hsu 2009). Addicted smokers needed to be registered and monitored to be eligible for purchasing officially made opium (Hsu 2008). However, these smokers were not entirely passive. The Japanese monopoly soon discovered that it had to cater to local tastes if its product was to compete with illegally smuggled opium. Laboratory science was then introduced for the sake of product optimization (Hsu 2009). However, as local resistance in Taiwan grew under Japanese rule, this gradual prohibition strategy of opium control soon became its target. Leading Taiwanese intellectuals thought that the production and provision of opium, for whatever purposes, was a malicious act that weakened Taiwanese people's bodies and minds. This gradual prohibition policy was fiercely criticized during this period as blatantly exploitative and viciously damaging. The historical lessons of the Opium Wars were once again invoked (Hsu 2002; Hsuang 1998; Liu 2008), with the English and French intruders replaced by Japanese colonizers while victimized Taiwanese smokers substituted for Chinese "sick men." The war against the invasion of foreign forces turned into an anti-colonial struggle

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Opium Question.

for health and autonomy. In addition to the resistance and criticism from within, the internationalization of the opium problem also compelled the Japanese government to adopt a more restrictive strategy. In 1929, a new Opium Ordinance was enacted in which opium smokers were required to receive medical examinations to determine the severity of their addiction. Severely addicted persons were allowed to continue using opium with their licenses, while persons with mild addiction were required to receive medical treatment in either public hospitals or at Kosei Hospital, a special hospital established in the early 1930s (Hsu 2008). Managed by Du Congming, the first locally trained Taiwanese physician with a doctoral degree in basic science, Kosei Hospital performed multiple roles. It was a medical center, of course, but it also acted as a correctional facility as well as a scientific laboratory (Hsu 2008; Hsuang 1998). Interestingly enough, Kosei (更生) in Japanese means rebirth in English. Smokers were expected to become new individuals upon discharge.

On an international level, Kosei Hospital was not an isolated phenomenon. In the US, a federal "narcotic farm" was established in Lexington, Kentucky, only slightly later (in 1935). Just like Kosei Hospital, it served both research, clinical and penitentiary purposes (for the detailed history of the narcotic farm in Lexington, see Campbell, Olsen, and Walden 2008). Retrospectively, it is amazing how Kosei Hospital generated so much knowledge about opium addicts through the meticulous measurements of their socio-physiological characteristics: gender, age, height, weight, chest circumference, pulse, blood pressure, education, intelligence, and so forth (Du 1931). Measurements of the chemical traces in their urine and blood were made and published (Du and Rin 1933). Therapeutically, Kosei Hospital undertook a substitution therapy in which morphine was

used to replace smoked opium, and then tapered gradually during hospitalization. Interestingly, about two decades earlier, another Taiwanese physician, Lin Qing-yue, had used heroin as part of his regimen for treating opium addiction, but his method was not adopted by Du (Hsu 2002). When all the other public hospitals were relieved of the duty to treat opium addicts in 1934 (with 8,870 smokers treated), Kosei Hospital became the only treatment center for the entire Taiwan area. When it was finally closed in 1946, it had treated 11,498 opium smokers in its 16-year history (Hsu 2002). As the "Opium Question" no longer remained important and opium smokers largely disappeared in the late colonial period, Du soon became a medical legend. No wonder that his achievement at Kosei Hospital was revived in the promotion about harm reduction almost 60 years later.

2.2 Post-1945 Drug Policy in Taiwan

When Taiwan was returned to the KMT government in 1945, immigrants from China, the so-called mainlanders (*waishen ren*; 外省人), also brought with them historical memories that entailed shame and ambivalence about opium use over the past 200 years. In contrast, the locals (*benshen ren*; 本省人) were just recovering from the modernization project under the previous Japanese colonization. In the early period of KMT governance, mainlanders basically held the most important positions in the government (Roy 2003). The disparities in political power and cultural difference on the one hand resulted in overt social conflicts. For example, the 228 event led to the subsequent "white terror" period in which freedoms of speech, publication, and activity were compromised

or suppressed under martial law for the sake of national security. Anti-communist slogans, posters, teachings and radio messages were everywhere. Economically deprived and politically precarious, Taiwanese people in general had had little chance to gain access to narcotic drugs of any kind except under limited medical circumstances where their use was allowed (Li 2004). Strict repression was in force. It was during this time that the public image of opium and its derivative products (morphine and heroin) metamorphosed. Illegal use of opiates was still depicted as a threat from the outside, but the "outside" did not mean foreign forces but the CCP across the strait. In this sense, the smuggling of opiate substances was just a minor part of the "cold-war" opposition and was therefore subjected to rather harsh treatment by the KMT government.

In Ko's (2006) classification of Taiwanese criminal policy on illegal drugs, this period was characterized by the old Controlled Drugs Act (1945-1998). From the 1940s to the 1970s, those who smuggled opiates (raw opium, morphine, and heroin, for instance) were seen as committing capital crimes, as these substances were said to be produced mostly in "the communist regions" and therefore were obvious evidence of the communist conspiracy of intoxicating Free China, that is, Taiwan (Ko 2006). Addicts using these drugs were slaves to communists, to say the least, and sometimes they were even treated as partisans of communism. These anti-drug discourses linking drug use to communism were not only held in Taiwan. Harry J. Anslinger, the "drug czar" of the U.S. at that time, shared a similar view (Musto 1999: 231).

The association of drug use with communism is significant in many ways. As has been well documented, the legality of substances is determined by the government and is subject to the effects of globalization (van Schendel and Abraham 2005). This example

clearly illustrates the political connotations of drug use in a moment of human history that is characterized by its salient tendency of ideological dichotomy. In this strict repressive regime, it is no wonder that June 3, 1839, the day Lin Zexu burned poppies and opium products, was annually commemorated in Taiwan as the "Anti-*ye*n Day" when a symbolic amount of confiscated opiate goods was burned in public. Ceremonies like this were not only anti-communist but also inherently nationalistic because *yen* was directly linked to the collective morality instead of health. In 1960, an editorial in the *United News* read,

> Opium the poison has become the label of our national shame since the Nanking Treaty in 1842….Prohibition of *yen* has, since Lin Zexu's days, been emphasized because of the damage to national health, but there are more reasons. *Yen* causes deteriorated national morality, which facilitates the activities of communists in the current political opposition. Certainly the loss of morality is personal to those who use drugs, but to get access to drugs, these people are driven to gambling, prostitution, robbery, burglary and murder so rampant that the detrimental effects on national ethics are immeasurable. (United News, 1960)

Despite the burning ritual and moralizing remarks, the social damage and legal problems caused by addictive substances were relatively minor, as the masses simply could not afford them (Ko 2006; Li 2004). In this sense, the constant war-waging of the KMT government did not indicate so much the severity of drug problems as it revealed the determination to compare the opposition of nationalists and communists with that of the good and bad. Drugs were obviously in the domain of "the political," as Carl Schmitt ([1932]2007) stated, because they were yoked to the distinction of friend and foe. In addition, I contend that the nationalistic repulsion for drugs was closely linked to the cold-war mentality as well as the state-building of the KMT government in Taiwan.

In Foucault's (2003b) opinion, nation-states in Europe burgeoned when the power to wage war no longer belonged to individuals or tribes. One way to consolidate the state's right to life remained in the creation of dangerousness that resided not outside the boundary of society but inside or among the individuals constituting the body of the society (Foucault 2003b). He pointed out that dangerousness can exist in the form of race, but race should be explained broadly (Foucault 2003a, 2003b). It should be understood as a way of difference-making articulated by the production of systemic knowledge. In other words, the distinction between "us" and "them" was born along with the specific forms of knowledge that justified its presence. This fundamental distinction was both rooted and demonstrable in colonial settings, as Stoler (1995, 2002) has demonstrated. However, in the case of Taiwan's state-making through drug suppression, we see a different mechanism in action. It was not by medicalizing or biologizing these drug users that the state turned its power inward and established its own *raison d'etat*, but it was by morally degrading them that put Taiwan in sharp contrast with Mainland China. À la Foucault, I contend that the opposition during this period was characterized more specifically by sovereignty concerns, as it did not yet possess the essential features of biopower (Foucault 1976, 2003b, 2007, 2008). However, as time went by, the across-strait situation improved. Drug policies, along with their represented rationalities, were transformed accordingly.

2.3 Taiwan and Drugs in the 1990s

As is widely recognized in Taiwan, and most of my interviewees concur, it was not until the 1990s that illegal drug use became a serious social problem (Li 2003, 2004). The abolition of military rule and restoration of across-strait communication in 1987 soon promoted the interchange of people and many other things, including diseases and drugs, between Taiwan and Mainland China (Roy 2003). This friendly move also reflected a new and open mentality of the Taiwanese government vis-à-vis globalization. Sadly enough, in a few years, the rapid spread of illegal substances such as methamphetamine (meth) and heroin, especially among young adults and students, resurfaced to public awareness and they became the targets of the new War on Drugs heralded in 1993.

The Taiwanese version of anti-drug policy in the 1990s, apparently echoing its American counterpart, was a threefold program including drug seizures, education, and detoxification. It was often pictured as a reaction to international as well as domestic pressure (Diao 1994). Internationally, Taiwan was accused by the US of being the largest site of drug transportation in Asia. Domestically, the rapid increase of incarcerated drug criminals and seized drugs ignited a social panic that reflected the major changes over the decade. These changes included improved national income, transformed social structure, dissolution of political authority, enhanced individualism, and confusing social values (Diao 1994).

However, the diplomatic-military opposition between Taiwan and China was absent in the discourses of this time. With this newly formed policy, border surveillance was enforced, big rallies were held, and psychiatric services for addiction were provided, albeit of limited size. Not surprisingly, the Opium Wars were again used to justify the need for more governmental actions on drug use, but the campaign was not without criticism. A

report in the *United News* at the height of this anti-drug craze demonstrated this discontent:

> One day when we look back at the pop culture of Taiwan around the spring and summer of 1993, we may never ignore the island-wide anti-drug movement. In that year, it was no less popular in Taiwan than the Jurassic Park that Americans were crazy about, women's bell-bottoms, platform shoes, and across-strait communication….But who is the biggest and ultimate beneficiary in this anti-drug movement? (Liu 1993)

Grandiose as it may seem, this campaign obviously needed a down-to-earth strategy, so many solutions were proposed later on. First, a major revision of the current regulations was suggested, hence the birth of the new Controlled Drugs Act in 1998. From this a new classification of drug users was born—sick criminals. This redefinition lent legitimacy to psychiatric intervention in addiction and allowed cooperation with correctional facilities. This medicalization, although partial, was a consequence of the previous anti-drug policy, which criminalized drug users and was described by the mass media as detrimental. However, there were simply not enough qualified, affordable and trustworthy mental health services offering drug treatments. In a *United News* report entitled *Formosa, Your New Name Is Island of Drug Use*, the author remarked,

> Current regulations define drug users as criminals and squeeze these unfortunate people into already overcrowded prisons without treating them medically and prescribing adequate therapies for them....Privately owned detox centers have now had more beds than public hospitals. Even though more expensive than public ones (1000 versus 800 NTD per day), they are swamped by drug users. On the contrary, vacancies are common in public hospitals, as drug users simply dare not go there for fear that they may get caught. (Li 1994)

Overall, medical services for addicts either outside or inside the prisons were underdeveloped. Six years after the new Controlled Drugs Act, a survey report by the Control Yuan (2004) concluded that prison hygiene, medical treatment, and detoxification services were heinously understaffed, underequipped, and underfunded. For drug users who were not yet incarcerated, medical resources with adequate quality of care remained few. In my own experience as a physician offering detoxification (detox) services from 2001 to 2004, the "revolving door" phenomenon was common. When a patient no longer came in for treatment, it almost invariably meant they were either arrested or dead, rather than cured of their addiction.

Indeed, the legislative revision in 1998 created a space for medical intervention, but that space was empty most of the time. Addicts were clustered in jail as usual. In a way, this situation reflected the ambiguous and conflicting positions of drug users in society—not only in Taiwan but in the U.S. as well. Carolyn Acker (2002) found that the criminal-patient distinction was fervently disputed in the progressive era of the US as well. Harry Anslinger, the drug czar, defined drug addicts as morally defective and criminally condemnable. In contrast, Lawrence Kolb, who was a physician working in the first US Narcotic Farm in Lexington, Kentucky, advocated treating addicts as medically ill. Even today, many books on U.S. drug policy repeat this "either-or" condition of drug users. In Taiwan and the US, the glaring political discourses about communist conspiracy have now disappeared but moralizing, criminalizing, and medicalizing discourses remain lively.

As we will see later, little had changed until the harm reduction policy unfolded a decade later. To many people, the anti-drug war only scratched the surface of the social

problem, while the majority of addicts remained invisible. This once welcome campaign was soon displaced by other pressing issues, although illegal drug use appeared from time to time in the newspapers, arousing short-lived attention. The window for an innovative policy change was closed. It awaited a new stroke to open again.

2.4 Situating Harm Reduction Policy Socio-historically

"No HIV/AIDS, no harm reduction." Many of my interviewees expressed the same opinion: Without the rampant increase of HIV-positive IDUs noted in 2004, harm reduction policy would have been postponed or completely impossible. As Director Kuo pointed out in my interview with him (Aug 15, 2008, in the CDC), harm reduction was a "policy by crisis." How do we make sense of this statement? What is the crisis that motivated the policy?

The latter question is intriguing, as it illustrates the relationship between the state and society in light of policy formation (Hall 1993; Light 2000). It is also related to the issues of expertise and governance, discussed in Chapter Four, because experts are usually vital intermediaries between society and the state as well as key players in biopolitical governance.

To begin with, infectious diseases like HIV/AIDS have often been constructed as a major threat in the contemporary world. They have been linked with the development of public health, preventive medicine, and other forms of bodily and population surveillance (Porter 1999; Rosen 1993). However, in the wake of increasing flows of people and capital characterizing contemporary globalization, infectious diseases pose even more

danger to an island country like Taiwan, with its long coastline that is hard to patrol. Considering Taiwan's geographical position and high susceptibility, infectious diseases obviously constitute a common object of fear that easily attracts public attention and quickly becomes politicized and moralized. Severe Acute Respiratory Syndrome (SARS) is a glaring example (Kleinman and Watson 2006). At the climax of the social panic in 2003, Angela Lu, then Vice President of Taiwan, publicly denounced China for its improper suppression of health information that led to spread of the disease to the Taiwanese people. For this reason, she called SARS "Chinese pneumonia" (Wang 2003). Incidentally, she was also the one who imprudently described AIDS as an "illness of God's wrath." That statement aroused great anger and dissent among HIV-afflicted people and advocacy groups (Song 2003). This example illustrates how a prejudiced point of view, if it is expressed by someone of high political status, may produce or reproduce the marginalizing stigmatization.

Nevertheless, HIV/AIDS is, after all, different from SARS. For one thing, most Taiwanese people see SARS as spreading indiscriminately. In contrast, HIV/AIDS is limited to certain groups (e.g., MSM) [10]. However, when most new HIV-positive cases were found in IDUs, public anxiety soared. People fear uncertainty. As no one knew for sure how many IDUs were clandestinely living within society, everyone seemed susceptible. Without effective measures to stop the epidemic, it could get out of control.

In policy studies, policy formation is often described as going through a series of phases or stages. According to Kingston (1995: 165), the health threat of HIV/AIDS was a policy window for changes, "an opportunity for advocates of proposals to push their pet solutions, or to push attention to their special problems." In his depiction of the "flow" of

[10] MSM means "men having sex with men." It is often used as a statistical category in HIV/AIDS literature.

policymaking, Kingston states that a policy window may occur due to a problem window (e.g., a pressing social problem) or a political window (e.g., a political event or change). It can open for varying lengths of time and close for a wide variety of reasons. While his classification is schematic and clear, he fails to scrutinize the intertwining relationships between society and the state. Furthermore, not only does his scheme homogenize both society and state, which may be confusing and analytically unproductive, but it fails to address the ways in which a public policy is situated not just in its immediate practical demands but also in socio-historical lineages. As I have discussed earlier, Taiwan's harm reduction policy is unique because of its colonial past and historical legacies. The policy in many ways illustrates the dynamics between and within the state and society. These two entities are not static, nor are they impermeable to the effects of policy that is generated from their interactions. In other words, policy and the divide of society/state are co-evolved. Kingston's over-simplistic scheme simply does not capture the complex dynamics, which, as will be shown, are especially conspicuous in Taiwan.

I further contend that the uniqueness of Taiwan's drug policy involves more than the thoughts and practices represented by the Opium Wars and Du Congming. It also lies in historical and contemporary government apparatuses such as the public health infrastructure and bureaucratic organizations. I next describe these two aspects and explain how they relate to the creation of harm reduction policy in Taiwan.

The public health infrastructure in post-1945 Taiwan is a hybrid of historical administrative arrangements from both the Japanese and KMT governments (Chin 1998). Notably, before Taiwan withdrew from the UN and WHO in 1971, funding and assistance from the US also played an important role in shaping action programs and training

projects on malaria eradication, tuberculosis control, polio vaccination, medical education, and maternal and child health issues, including family planning (Kuo 2006; Chang 2006). These factors fashioned the ways in which public health measures were implemented in Taiwan. In the colonial period, public health functions were closely combined with the police system. Strict surveillance was implemented to monitor health threats such as tropical illnesses and infectious diseases (Fan 2005; Liu 2004). After the KMT government arrived in Taiwan, its administrative apparatuses were imposed upon the existing structure. Public health was separated from police work (Chin 1998). In the next few years, the KMT government set up numerous health stations to implement health policies. Directed by local health authorities, health stations offered basic medical services including outpatient services, vaccination, and physical examinations. Physicians, nurses, and other health workers in these health stations reached out to schools, factories, and individual homes to investigate and solve local public health problems (Hsuang 1998). Their function was especially salient in remote areas where health services were scarce and hard to obtain. Public health campaigns were mostly made possible by these far-reaching stations and their personnel, especially public health nurses (Chin 1998). Part of the public health reconstruction work was facilitated by sponsorship from the US and other countries. These countries provided not just money and personnel but also knowledge and technologies. The BCG (Bacille Calmette-Guerin) vaccination program for the prevention of tuberculosis in the 1950s and 1960s was a well-known example (Chang 2009).

In spite of these changes, it is generally believed that there was considerable continuity in the pubic health system during the transition from Japanese rule to KMT gover-

nance (Chin 1998). In addition to health stations, public hospitals provided accessible health services across the whole island of Taiwan to people high and low. Although private hospitals have multiplied in recent years, public hospitals remain important in the control and management of many public health hazards. For example, during the initial phase of the SARS endemic, the Municipal Hoping Hospital in Taipei was the designated hospital in charge of quarantining, isolating, and treating suspected cases of SARS. As we will see in the next chapter, public hospitals including psychiatric centers are now the main sites where methadone clinics are located.

The second aspect of Taiwan's unique governmental apparatuses is bureaucratic organization, which I have largely addressed in Chapter One. To avoid unnecessary redundancy, it may be sufficient to say that complex and multi-level coordination among different functional units is an important feature distinctively characteristic of Taiwan's harm reduction policy as a biopolitical project. This in fact reflects the immense complexity of drug problems as viewed from the governmental perspective. Intimate collaboration among elements in the assemblage of harm reduction policy is mandatory because each of them has different governmental responsibilities and none of them is intrinsically indispensable. For example, the CDC took the initiative of implementing harm reduction, but it is in charge of infectious disease control. In proposing and revising related administrative regulations, it had to coordinate with the National Bureau of Controlled Drugs (NBCD) that supervises the production and consumption of addictive substances, and the Bureau of Medical Affairs (BMA) that regulates all kinds of medical services. In addition, it also had to negotiate with the Ministry of Justice (MOJ) because the CDC's public health approach and the MOJ's criminalizing approach would very probably collide. Fur-

thermore, novel associations were created in the process, connecting people, knowledge, and technology globally. In short, to make harm reduction policy work, it takes collaborations, negotiations and associations. These were not always carried out officially. Very frequently informal channels had to be established. This issue is addressed in Chapter Three.

In addition to processual, socio-historical and organizational complexities, the fact that Taiwan's harm reduction policy is in fact a globalized as well as globalizing one warrants serious theoretical consideration. However, traditional policy studies often leave the transnationality of policy untouched. As science and technology studies (STS) have shown, technosciences travel (Latour 1986). As I shall discuss in Chapter Six, it is apparent and significant that in this example, harm reduction itself is a policy orientation that also travels transnationally.

Let me now return to harm reduction and discuss its initiation as a doable policy. As noted above, the HIV/AIDS epidemic triggered government actions that transformed harm reduction from an idea to a policy. Thus, the CDC played a vital role in its realization. What did it actually do? Did it define a social problem and enacted state will by addressing the problem? Or, on the contrary, did it simply respond to an emergent as well as urgent social problem? In a nutshell, did it act or react?

At first glance, this may appear to be just another example of Kingston's classification of problem and political window (Kingston 1995). However, I would like to demonstrate that a policy window does not usually just emerge "out there." Drawing on the work of Hilgartner and Bosk (1988), I argue that a social problem like this is the product of a process of collective definition. It has to be created from the interactions of interested

groups. Each group is competing for scarce public attention in the policy arena that makes their issue or proposal salient. In Hilgartner's later work (2000), he elaborates on the dramaturgical model borrowed from Irving Goffman (1959). He explicates the ways that a given issue of science is made into a publicly relevant one. Given the constructivist definition of social problems, I find that in the case of Taiwan's harm reduction policy, the CDC created a social space where the rapid increase of HIV-positive IDUs was prioritized theatrically by the mass media. Then implementing the harm reduction policy appeared to the public as more relevant and less repugnant. This depiction defies the pluralist method of dissecting a policy into distinct stages or phases in which certain agendas compete with and dominate others. But it does not mean that the CDC wholly fabricated the phenomenon *per se*. The government did not have full control, and contingencies abounded. Steve Kuo, Director of the CDC, told me (05/15/2008 in the CDC), the CDC just "sounded the alarm" for the right issue at the right time.

In retrospect, what the CDC did in 2003 and 2004 was utilize a social technology that put this issue to the forefront. HIV/AIDS among this special population was framed as a serious threat through the collaboration of the CDC and the mass media. An anonymous scholar of the media (interviewed on January 22, 2009) firmly suggested that the CDC should handle its messages for public distribution in a better way because these messages might create adverse impacts. But in fact, the messages from the CDC achieved their expected effects. Tsai Sufen, former Director of the Third Division of the CDC, expressed the thought that the mass media exerted its influences on the public by revealing some alarming news such as the novel youth culture (e.g., rave parties) and homosexual house parties where illegal drugs and unprotected sex were common. They also supplied

health statistics that identified drug users as the main reason for the drastic increase in HIV infection. Who gave the media these data? It was the CDC, of course. According to Director Kuo, the disclosure of certain HIV/AIDS information was somewhat purposeful because it was a way to garner social support and political commitment more quickly. By manipulating which news was to be released—or in his words, "sounding the alarm"—, the CDC fabricated the urgency of this phenomenon to gather more political support. When interviewed (08/15/2008), he said, "As a Taiwanese saying goes, people do not repair their pots unless the cracks are big enough….[We] simply created a social problem that could be perceived, and let the people 'up there' see this was a noteworthy problem."

Therefore, the phenomenon had been present, and what the CDC did was merely to frame it in a way that would attract sufficient public attention. In my fieldwork, I have heard anecdotes that a member of the Control Yuan, whose work was to supervise the other government organizations, once complained to the Minister of Health that the problems of drugs and HIV were reported all over the media and urged the Department of Health (DOH) to do something about it. Nevertheless, to think that the news was actually leaked to the mass media from the CDC makes it difficult to say what motivated what in terms of policy initiation.

In a rigid but common scheme of the state and society (conceptually corresponding to the political and the civil spheres, respectively), one either affects or is affected by the other. Sometimes the two directions are called state-structural (society affecting the state) or state-centric (the state affecting society) (Hall 1993). However, this classification may very likely miss the point because the state and society are not static concepts. They are co-constituted.

In some cases, the classification and opposition of society and the state as an explanatory framework simply does not work well. In Taiwan, advocacy groups for people with HIV/AIDS were apparently marginal, and, what is worse, there were no such advocacy groups for drug users. In other words, the so-called civil or public sphere for the targets of this policy was seriously underdeveloped compared to the political sphere, that is, the state. The underdevelopment of civil space has in many ways attributed to more state intervention and less community activity. Similar social processes can be seen in Taiwan's national health insurance. Here a post-authoritarian state is expected to dominate the agenda and provide a nationwide insurance plan (Lin 2003). Although public policy-making has always been considered a privilege of the state, there have recently been voices in Taiwan arguing for more public participation. Aside from public hearings and mass investigations, which were already commonplace, Taiwanese scholars have recommended and practiced deliberative democracy to help create various regulatory policies covering issues ranging from surrogate mothers to national health insurance (Deng and Wu 2004; Lin and Chen 2003, 2005).

However, not every issue can be discussed this way, at least, not harm reduction. When the experiments with deliberative democracy were taking place, a civic meeting for harm reduction was scheduled as well. Nevertheless, to put such a controversial issue in the forefront was a great risk, as no one could estimate the possible extent of public disagreement. It was cancelled at the last minute because the CDC decided to keep this policy as quiet as possible. Thus, a dilemma emerged. If the program was to be effective, it needed to be promulgated to its potential targets. If the propagation was too successful, however, then resistance from non-drug users might occur. These ambiguous and some-

times murky features characterized the harm reduction policy situation that would follow, as we shall see.

Early in 2005, the CDC presented a proposed harm reduction policy to the Executive Yuan. It was then discussed in a conference that specifically dealt with interdepartmental coordination. Such coordination was desperately needed by the CDC, as many of the proposed measures could not be realized without the cooperation of the other departments, especially the National Police Agency and Ministry of Justice. As many CDC interviewees told me, the CDC needed to be sure that the people who carried out the harm reduction policy would not be arrested by the police or prosecuted by the law, because at that time, giving out needles for the sake of drug use constituted "reasonable doubt" that justified a bodily search. This position was firmly held by the Ministry of Justice even though it was also legal to sell needles and syringes in a licensed pharmacy. An intriguing situation might arise: If one bought, say, 100 sets of needles and syringes from a licensed pharmacy, then how could the police know if they were purely for medical use or for supporting a secret habit? More often than not, the police prefer to intervene based on reasonable doubt because this is how they can apprehend addicts and take credit for it on the record. For many of those who have participated in policymaking, to change this was understood to be a major task that would consume a great deal of time and energy. By calling this proposal a pilot program rather than a full-scale policy, the CDC found a way to temporarily circumvent these obstacles. The resultant proposal defined harm reduction as a three-pronged program that included drug maintenance treatment, a needle syringe program, and focused health education and screening. The pilot program was scheduled

to begin in August 2005. Despite lingering suspicions, the CDC was determined to make it work. Nevertheless, many issues were not yet settled.

2.5 Summary

Chronologically, this chapter introduced the history of opiate control in Taiwan, mainly from 1945 to the eve of the implementation of the harm reduction pilot program in 2005. Theoretically, this chapter rebuts the analytic perspectives that take policy-making as a unidirectional and staged process resulting from the power struggles between the state and society and that unwittingly ignores the global or transnational transplantation of a knowledge-intensive policy. On the one hand, I argue that the socio-historical trajectories have great impacts on the making of a new drug policy such as harm reduction. On the other hand, I contend that the policymaking process itself is one that refashions the boundaries of society and the state. Therefore policy is not only a product, but a producing process and mechanism as well.

Two issues stand out and need to be clarified further. First, I demonstrated that a public health project like this is embedded in the local national socio-history that in part accounts for its uniqueness (Porter 1999; Rosen 1993). Even though harm reduction is now a transnational concept, its practical configurations of design and implementation vary from place to place (WHO 2008). The variations cannot be all idiosyncratic, and they need to be described and explained. Just as Lin's study (2003) on national health insurance illustrates, every policy possesses a certain level of path dependence, that is, continuity with its precedent events or decisions. In this case, the continuity of infrastructure

is apparent. Path dependence is a useful concept to explain the emergence of a major event, and it does not preclude the existence of contingency (Lin 2003). However, it seems to me that what matters more is how to account for the ways in which continuities and disjunctions occur simultaneously. As noted above, the evolution of drug policy from stringent suppression to harm reduction is sometimes irregular and, in some aspects, usually incomplete. Legally, the perception of drug users has changed from pure criminals to sick criminals (Conrad and Schneider 1980; Conrad 2007). They deserved more medical treatment than punitive incarceration. But in reality, medical services in correctional facilities are still lacking. Socially they are no longer labeled as victims of communist conspiracy but are still viewed as dangerous individuals. Punishment persists no matter what name it bears. Interestingly enough, it is when their dangerousness was considered unbearable to "the public" (which, as I have depicted, is often [mis-]represented by the newspapers and TV news) that they became the center of policy attention and government concern. A utilitarian logic is clearly in operation. While they were marginalized and invisible most of the time, only to be seen in prisons and sometimes in hospitals, the emerging epidemic of HIV/AIDS among intravenous drug users finally pushed them to the fore.

The second important issue is that the emergence of a crisis like this is a result of state/society dynamics that defy defining policy as either state-willed or society-motivated. Instead of treating policy as an institutionalized product of staged process (Kingston 1995), I urge to redirect our analytic focus to the actors, strategies, memories, knowledges, and rationalities that are mobilized, connected and even separated in the policymaking process. This is of course an insight from science and technology studies

(STS). From this angle, policy work is boundary work (Gieryn 1983, 1999), but what is demarcated is not just the boundary between science and non-science, but also between society and the state. With the intentional promotion of CDC, the social space that was opened up was quickly filled with actors from various locations with different agendas. It was intentionally engineered in favor of the forthcoming harm reduction policy. In later chapters, we shall see the actors disassembled and pursued their disparate goals when the project was routinized.

Situations change. The state is not the only mover in this plan. From the outset, the CDC knew it could not always dominate the whole issue, as the social space it opened up was swamped in no time by healthcare workers, addiction specialists, local pharmacists, public health professionals, HIV/AIDS activists, and of course the IDUs. Who is going to enter the core of *the offic*e — the assembled group that has the power to decide the design, implementation, and evaluation of the harm reduction policy? How is the office taking form? How does this policy constitute a biopolitical project that fosters desirable governmentality? More importantly, what insights do we get if we compare our empirical findings with Foucault's ideas?

These will be the themes of the next chapter.

Chapter Three

Harm Reduction in Taiwan as a Biopolitical Project

3.1 Introduction

This chapter has three main purposes. The first is to describe the evolution of the harm reduction pilot program starting in August 2005, to its full-scale expansion in July 2006. I examine the use of health statistics as the scientific foundation upon which the harm reduction policy claims its legitimacy. In addition, I review the process by which the CDC finally chose the right needles and syringes for exchange and distribution. These two examples illustrate the complex intertwining of subjectivity and objectivity that characterized this policy.

The second purpose is to delineate the shape and form of *the office,* a new concept that I conceived to refer to the heterogeneous group of people more or less involved in the formulation and implementation of the harm reduction policy. *The office* as an analytic concept is framed for specific reasons. *The office* is obviously opposed to *the street*, which has been depicted in numerous drug-related ethnographies. Like *the street*, *the office* is not limited to a specific well-circumscribed locality, nor does it refer to a well-orchestrated group. Rather, it is portrayed as an assemblage, à la Deleuze and Guattari (1987), in the sense that it ostensibly defies a traditional, organizational, or spatial definition. In their words, assemblages are de-territorializing and re-territorializing all the time.

This constantly metamorphosing dimension of *the office* as an assemblage has advantages over older analytic concepts, like the state, in characterizing harm reduction as a form of governmental action. It places agency and subjectivity back into the individuals involved and treats public policy not as a mechanistic manifestation of a dominating ideology but rather as a collective project that does not leave out individual aspirations and contributions.

The third objective is to examine how injection drug users are fashioned in this policy by adopting Foucault's concepts of *Homo juridicus* (men of right) and *Homo economicus* (men of economy). Foucault elaborated on modern political reason and subject formation in his later works, especially the recently published lectures at the Collège de France. Here I draw on his ideas and theorize harm reduction in Taiwan as a biopolitical project greatly informed by contemporary neoliberalism. This analytic perspective will open up many important issues to be explored in the following chapters.

3.2 Numbers and Needles

Statistics has a long history. In addition to the function of taming chance (Hacking 1990), it constitutes a major social technology of trust with which many modern policies are made (Porter 1995). Taiwan's harm reduction policy is no exception. Statistics, shown in Figure 3-1, Figure 3-2, and Table 3-1, were often presented by the CDC as solid evidence of the severity of the epidemic of HIV/AIDS among IDUs that should be addressed through social policy.

However, statistics need to be problematized. Even though statistics are numerical and therefore appear scientific, they often camouflage issues of causality and reduce the complexity of social relations that they intend to show. Therefore, it is all the more important to examine how the statistical data in this specific case were actually produced, because readers may then realize the gains and losses from expressing things in numbers.

Figure 3-1 and Table 3-1 clearly illustrate the increase in HIV-positive cases over the years and the rates of their identified risk factors. They show that the rapid increase of newly found HIV-positive cases started in 2004 and that 72.6% of the new cases in 2005 were drug users. Figure 3-2, especially its pie charts, and Figure 3-3 further demonstrate the longitudinal trend in which the percentage of IDUs increased dramatically from 2003 to 2005. Before 2003, most of these HIV-positive IDUs were identified in prison. But after that year, more and more such cases were found in the community (Figure 3-3).

The pilot harm reduction program was scheduled to begin in August 2005. The needle syringe program (NSP) was implemented first. However, the drug maintenance program did not begin until February 2006, because the purchase and importation of designated medications were delayed for administrative reasons. As needle-syringe distribution sites and methadone clinics rapidly multiplied, newly diagnosed HIV-positive IDUs decreased steadily over the next few months, as shown in Figure 3-4.

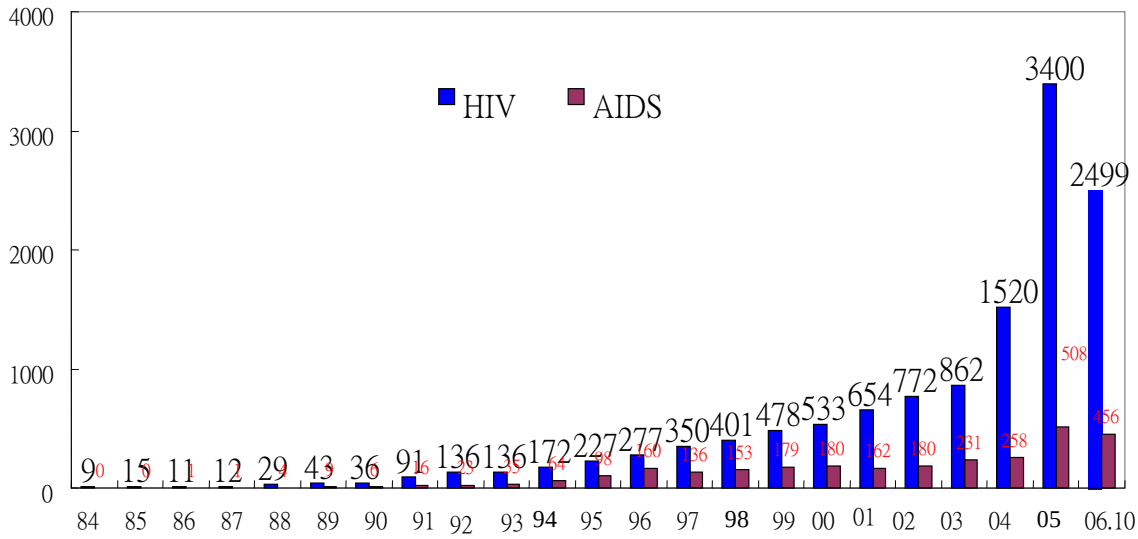


Figure 3-1: Number of HIV and AIDS cases from 1984 to 2006. The vertical axis indicates the number of affected persons, and the horizontal axis shows the year. Note the sharp increase of HIV-infected persons in 2004 and 2005, as well as the decrease in 2006. Adapted and translated from CDC (2006: not paginated)

Risk factors	2004		2005		2006(Jan-Nov)		2006(Nov)		1994-2006(Nov)	
	Number	Percentage	Number	Percentage	Number	Percentage	Number	percentage	Number	Percentage
Heterosexual contact	303	19.9%	318	9.4%	383	13.9%	45	17.0%	3118	24.1%
Homosexual contact	531	34.9%	511	15.0%	533	19.3%	38	14.4%	4307	33.3%
Pure homosexual	443	29.1%	431	12.7%	440	15.9%	30	11.4%	3407	26.4%
Bi-sexual	88	5.8%	80	2.4%	93	3.4%	8	3.0%	900	7.0%
Hemophilia									53	0.4%
Drug users	630	41.4%	2467	72.6%	1667	60.4%	104	39.4%	4941	38.2%
Transfusion	3	0.2%			1	0.0%			16	0.1%
Vertical transmission	2	0.1%	5	0.1%	4	0.1%	1	0.4%	19	0.1%
Uncetain	51	3.4%	98	2.9%	173	6.3%	76	28.8%	468	3.6%
Total	1,520	100.0%	3399	100.0%	2761	100.0%	264	100.0%	12,922	100.0%

Table 3-1: Classification and statistics of risk factors for HIV/AIDS. Note the change of the percentage of IDUs among HIV/AIDS cases. Adapted and translated from CDC (2006, not paginated).

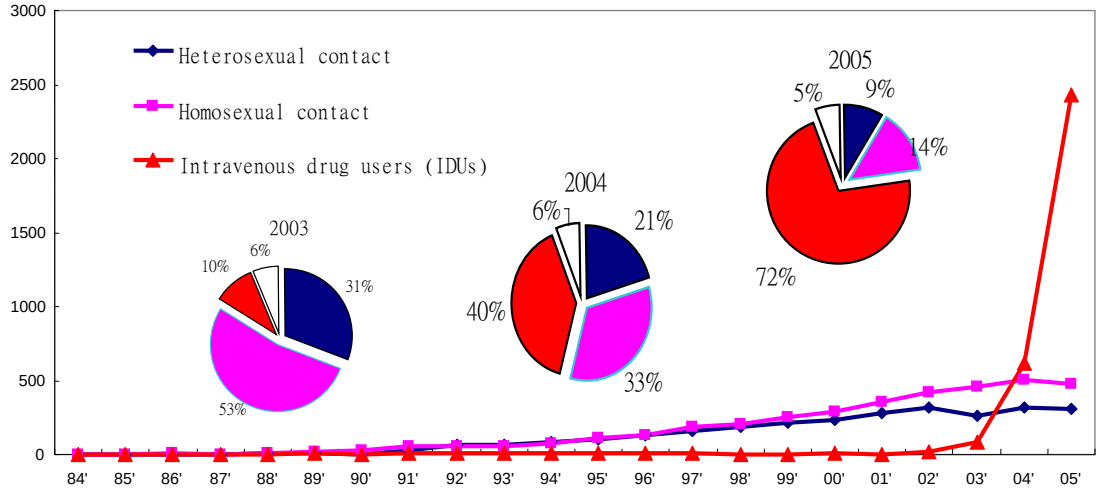
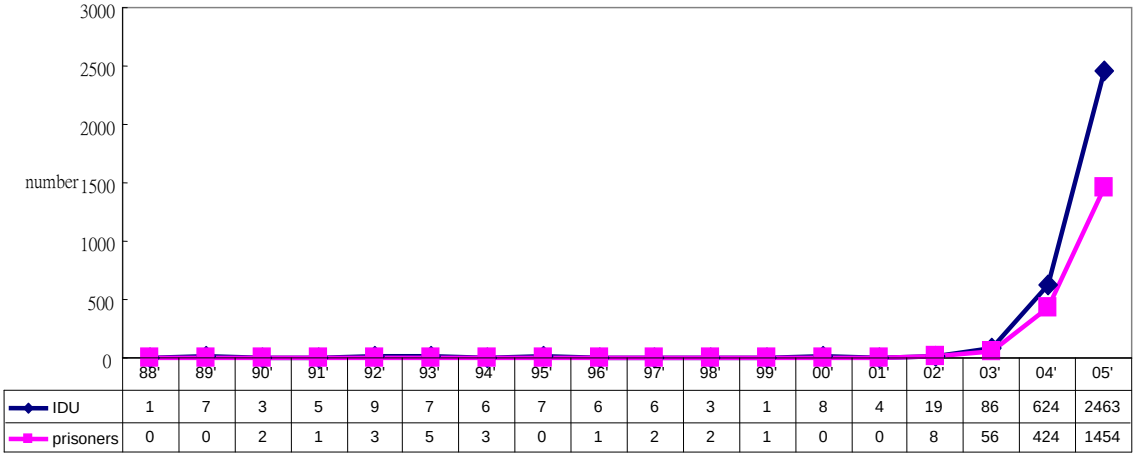


Figure 3-2: An illustration of the number of HIV and AIDS cases from 1984 to 2006. Note the increasing share of the red region in the pie charts. Adapted and translated from CDC (2006, not paginated).



	88'	89'	90'	91'	92'	93'	94'	95'	96'	97'	98'	99'	00'	01'	02'	03'	04'	05'
IDU	1	7	3	5	9	7	6	7	6	6	3	1	8	4	19	86	624	2463
prisoners	0	0	2	1	3	5	3	0	1	2	2	1	0	0	8	56	424	1454

Figure 3-3: HIV-positive IDUs from 1988 to 2005. Note the curve upward starting in 2003 and the rapid increase since 2004. Adapted and translated from CDC (2006, not paginated).

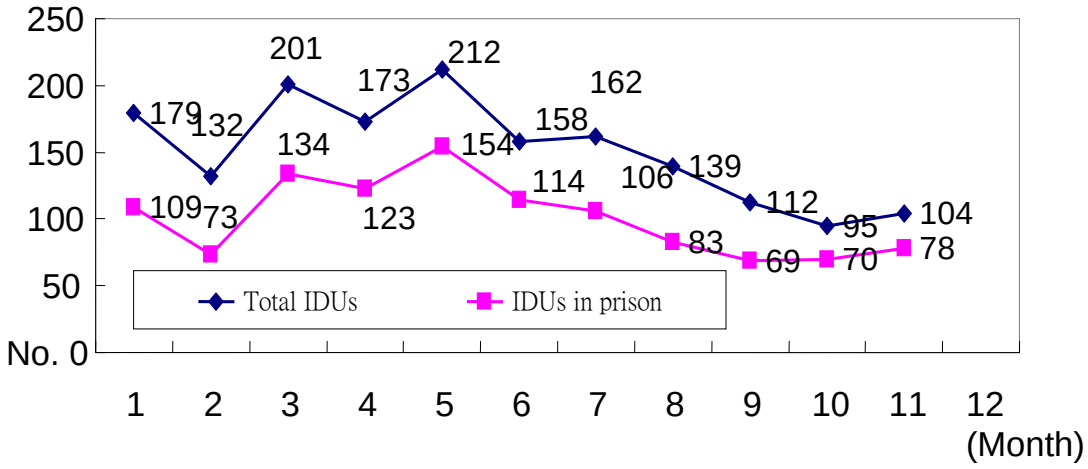


Figure 3-4: The change in HIV-positive IDUs in 2006. The vertical axis indicates the number of identified cases and the horizontal axis indicates the month. Adapted and translated from the CDC (2006, not paginated).

Based on these statistical numbers and their graphic expression, the CDC claimed victory over this allegedly devastating epidemic. These statistics are solid facts that speak for themselves. Nonetheless, how were they produced?

Scrutinizing the production of statistical numbers is necessary not just because the process of production may be flawed but also because the production, even if it is consensually correct, can be so bound up with the policy orientation that its claimed truthfulness supplements the rationality of government. In other words, the art of government lies in the truth of statistics. In previous scholarly works, statistics have been viewed as products of long historical processes that involved modern society formation and subject creation (Hacking 1990; Porter 1995) by its connections with demography and vital statistics (Schweber 2006). In Foucault's terms, statistics is an indispensable part of the knowledge produced through biopolitics (Foucault 1997). Contemporary science and

technology studies (STS) scholars have also elaborated on the co-production thesis of scientific knowledge and sociopolitical order (Jasanoff 2004).

According to a CDC official who prefers to remain anonymous, these numbers and graphs are generated by a registration system that engages both central and local governments. She explained to me how the system works: Whenever a case is found to be HIV-positive, he or she will be reported to both local health authorities and the CDC. A public health nurse then visits the patient and asks questions about his or her risk factors for contracting HIV/AIDS. The list of risk factors includes heterosexual contact, homosexual contact (divided again into homosexual and bisexual groups), hemophilia, intravenous drug use, vertical transmission, and blood transfusion. If none of these factors can be identified in the case, the person will be categorized as "uncertain" (see Table 3-1). Only one major risk factor is included in the analysis, thus the percentages of risk factors in Table 3-1 always sum up to 100%. The law demands that every prisoner be tested for HIV upon their admittance. HIV testing is also offered in many other situations such as screenings for pregnant women. In 2006, for example, 60 to 80 percent of IDU cases were actually in prison when they tested HIV-positive (Figures 3-3 and 3-4). When prisoners are reported as fresh HIV-carrying cases, workers from the local health authorities visit them in jail and undertake a similar risk factor investigation.

Although straightforward and effective, this method of gathering and presenting HIV data has serious drawbacks. First is its reductionist choice of identifying only a single risk factor for each person. However, one risk factor can only correspond to one risk behavior. What if a person injects drug and practices unprotected sex at the same time? The official who I interviewed, somewhat embarrassed, explained to me that only intra-

venous drug use was counted because in their experience, these drug users, mostly male, usually had such low libido that their sexual contact was a negligible factor. However, when I discussed this with Professor Tony Lee, he was quite skeptical about this matter (interview on November 17, 2008). A long-time researcher working with marginalized groups such as homosexuals and prostitutes, Lee carried out a study of heroin users in 2002. He proposed then that pharmacies all over the island be used as sites for needle exchange. This suggestion was not adopted until three years later when the pilot program was instituted. A *Taipei Times* report on the eve of the pilot program (July 31, 2005) detailed his earlier criticism:

> Other critics of the CDC's pilot program said blaming drug use for HIV transmission also aggravates the situation and makes it difficult for infected persons to get help. Bombarding the public with statistics that finger point needle sharing is misleading, said Tony Lee (李思賢)….The figures do not discriminate between unsafe sex and drug injection practices, suggesting transmission between IDUs could be a result of unprotected intercourse.
> The [CDC] views these statistics in a mutually exclusive way. If we put all our money and energy into providing clean needles and ignore the risks of unsafe sex, then we give the wrong impression on (sic) the public…It is more difficult to get IDUs to use a condom than a clean needle. (Freundl 2005)

Aside from these numbers being misleading, there is a second problem in this numerical expression of an emerging problem. As far as effective policymaking is concerned, it is better to frame drug use as a social-behavioral process than as a statistical correlation because behavioral change is usually the desired outcomes of a policy. For example, a new traffic rule is made not just to decrease the mortality rate related to traffic accidents. It also aims to change the ways in which people behave when they hit the road. In other words, not only is a social-behavioral perspective more comprehensive, but it

provides more insight for policymakers to use to design preventive or interventional measures. However, this socio-behavioral perspective was not a part of the policy. Professor Tsai Tzu-I, a qualitative researcher responsible for the assessment project of this pilot program, expressed a feeling of frustration when she found out that the whole pilot program was not designed to understand these users' perspectives and modes of drug use. She attributed the insufficiency to the training orientations of the major decision-makers: epidemiology, clinical medicine, and quantitative research.

The processes and situations of drug use appear significantly relevant but these numbers do not give a satisfying answer to certain questions. For example, given the fact that heroin use had been prevalent for more than a decade, why did this steep increase in HIV/AIDS happen in 2004 instead of, say, five years earlier? No persuasive studies have been conducted to date that explain the occurrence at that specific time. But several possibilities surfaced from my field work. According to Dr. Tang Xinbei, an addiction specialist, a likely reason is that heroin use changed from inhalation to injection, which occurred roughly in 2001. It corresponded to a contemporaneous economic depression. When heroin buyers' economic situations went downhill, they turned to a more efficient method of use. With a faster onset and better absorption, intravenous use has a higher degree of satisfaction than inhaling the same amount. Because at that time, most pharmacies sold needles and syringes and the regulations were quite loose, everyone could easily get cheap and clean injection supplies. With clean needles and syringes, intravenous use did not seem so dangerous. If so, then why and when did this intravenous use become a source of contagion? According to a focus group study of drug users (Chang and Lew-Ting 2006), the SARS epidemic in 2003 partly precipitated the breakout of HIV/AIDS

within this vulnerable population. As SARS is a contagious disease freely transmitted through the air, the strict regulatory measures enforced during the epidemic prevented some drug users from freely going out to drugstores or pharmacies for clean needles and syringes. Sharing then became even more prevalent. Even though this remains one of the many speculations about the causes of the HIV/AIDS spread, the limitations of statistical surveys in explaining the process are clear. People tell stories; numbers cannot.

While the statistics represent a way of objectifying drug users, the choice of needles and syringes constitutes another dimension in which invisible drug users demonstrated their resistance and subjectivity vis-à-vis the glaring ignorance of governmental officials. The case also points out the unwanted effects on efficacy and efficiency when the users of a policy are not treated in the right way. To be more exact, "the right way" is predicated on the agency of drug users, namely the "users" or "customers" of this policy, in the face of regulatory measures. This case also illustrates how drug users, without the organizational assistance of advocacy groups, may participate in the biopolitical project called harm reduction.

During my first few interviews, some experts complained about the lack of adequate consultation and planning when the CDC organized and implemented the pilot program in 2005. Clean needles and syringes were supposed to be distributed to drug users via pharmacies, hospitals, and health stations. However, what kinds of needles and syringes best served this end? This may seem to be trivial technical knowledge at first glance, but the story about it is quite illustrative of the government's lack of knowledge about drug users' perspectives and how these may "matter." Moreover, it shows how difficult it is for drug users to have a say in the policymaking process, at least initially. "Why not ask

those users?" was the first thought that came into my mind when I learned of this issue. However, for the CDC officials, most of whom were simply novices in drug issues in spite of their years of experience in dealing with HIV/AIDS problems, this was a brand new question because they had never had direct contact with drug users before. And more importantly, as one CDC interviewee candidly told me, "we thought the needles were all the same."

But not all needles are the same, of course. The first batch of purchased needles was rejected immediately by drug users because they were just not the right kind. This information was soon relayed by local health authorities to the CDC. The CDC then chose to distribute "safe needles" to reduce the possible hazards if these needles were disposed of randomly. But this attempt also failed. Finally, the CDC officials finally realized a simple fact that science and technology studies have repeatedly demonstrated: a technology, however safe and convenient, can be accepted more easily if users' perspectives are integrated in advance. Although technologies can have a shaping effect on their users, users can show their resistance. In many ways, technologies and users are co-constructed (Oudshoorn and Pinch 2005).

For HIV/AIDS experts who have dealt with drug users for some time, choosing the right needles and syringes is a total "no-brainer." Professor Chen Yi-Ming expressed his puzzlement with regard to the CDC's ignorance of expert opinion and the subsequent waste of money. Eventually, however, the CDC learned to listen to its "customers" (some interviewees actually used this term). It started to collect information from drug users via local authorities and purchased the "right tools for the job" (Clarke and Fujimura 1992). The CDC found that although ordinary needles and syringes for insulin injection can

serve as make-dos, drug users prefer needles with a larger bore. For diabetics, the injection is hypodermic so the bore is smaller (usually 29 Gauge, or 29 G) while for intravenous injection of heroin, a needle of 27 G works better.[11] In addition, as drug users do not want to waste any heroin in the connecting part between the needle and the syringe, they like the syringes fused with the needles as shown in the pictures below.

[11] Gauge is used to indicate the bore of a needle. The larger the number, the smaller the bore.

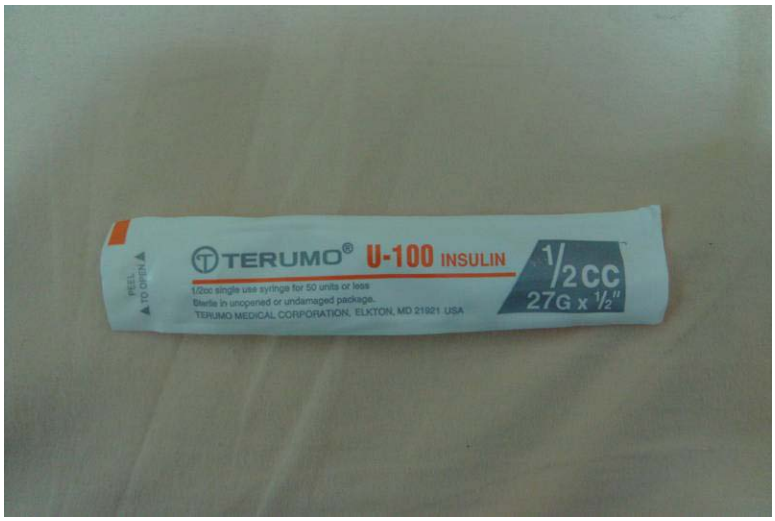


Figure 3-5 A needle-syringe distributed by the CDC. Note the gauge number (27G). Photographed by the author.

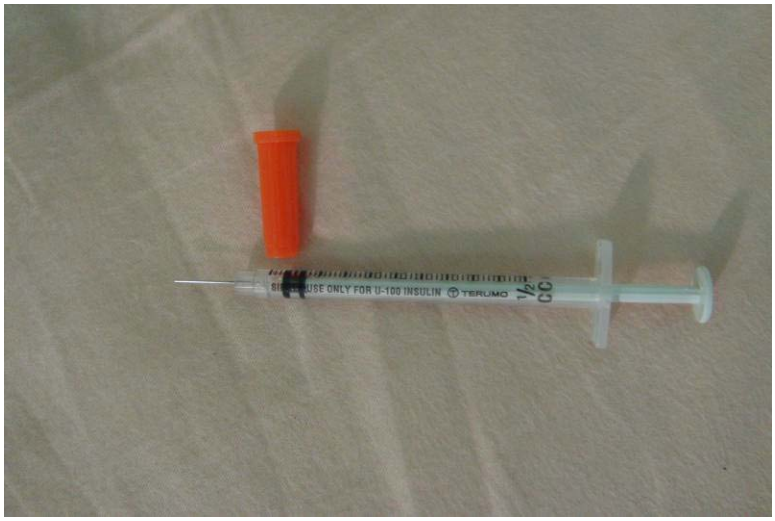


Figure 3-6 An uncapped needle-syringe. Note the fused part between the needle and the syringe. Photographed by the author.

In sum, these two vignettes about numbers and needles illuminate the significance of details in policy implementation, which even a clinician like me failed to notice in the beginning. Moreover, the contrast between the numeracy and the needles is intriguing in

that numeracy establishes credibility and objectivity by regarding individuals as numbers while the latter showed the resistance and power of drug users' agentic subjectivity when the CDC proceeded in "the wrong way." Together they clarify a major feature of this top-down harm reduction policy in Taiwan: the co-eval presence of objectifying attempts and subjectifying resistance. Extending the discussion from the previous chapter, I argue here that these examples illustrate the relational characteristics of power: "Where there is power, there is resistance" (Foucault 1976: 95). It is capillary, as Foucault once described, and immanent at every node where *the office* and drug users converge. The subject-shaping effects of these power dynamics are mutual and relational. As the engaged professionals and officials admitted in the interviews, it was not until the implementation of the harm reduction policy that they got to know these users and their culture. Similarly, drug users learned from various harm reduction programs the new entitlements and responsibilities of being citizen addicts. The former will be further discussed in Chapter Four and the latter in Chapter Five.

3.3 The Formation of *the Office*

When the pilot program of harm reduction unfolded in August 2005, many things about *the office* formation were still unsettled. On the one hand, the questionable coordination of the authorities in the central government, especially between the Ministry of Justice and Department of Health, was still a serious problem. On the other hand, the lack of a centrally integrated policy resulted in multiple ways of implementing harm reduction. Different city and county governments were encouraged to organize their own pro-

posals based on extant infrastructure, manpower, epidemic severity, and local demands. These two conditions, manifesting a common theme of coordination, led to a definitional ambiguity as to what constituted *the office*. It was conceptualized as the core group of elements, human and non-human, that formulated, organized, and implemented policy. What then was *the office*, and who/what was in *the office*?

Highlighting the formation of *the office* here has two purposes. The first is to differentiate this site of action from *the street*, which roughly refers to those drug users and their material lives outside the circle and often the target of policymaking (Bourgois 2000, 2003; Bourgois and Bruneau 2000; Dai [1937]1970; Dehue 2002; Fitzgerald 2003; Lindesmith 1947; Page 1997; Preble and Casey 1969; Rosenbaum 1981; Shavelson 2001; Strenski, Marshall, Gacki, and Sanchez 1997). *The street* has long been the focus of concern in drug-related literature: Who are the people that live on "the street"? What kind of lives do people lead on "the street"? What result from their conditions of life and suffering on "the street"? *The office* as an action site related to drug use was not often discussed as policy was simply treated as a stage backdrop against which these users viewed the situation. Stressing the role of *the office* is an attempt to fill a major gap in the broader picture.

The second reason for "studying up" (Nader 1972) the office is that it is immediately concerned with the working of biopower and biopolitics. From a Foucaultian perspective, power is both relational and performative, thus it makes no sense that social scientists should only pay attention to *the street* and ignore the other major set of indispensable players and venues, *the office*, in the formation of a regulatory regime.

To be sure, the making of *the office* is never a simple process. When the CDC decided to implement a pilot program of harm reduction in August 2005, the CDC officials knew that it was not the end point of the created momentum but the start of a policy engine which they needed to continuously fuel. A sense of urgency pushed them to implement the plan as soon as possible. Three counties (Taipei, Tainan, and Taoyuan) and Taipei City were chosen to be the administrative areas where harm reduction would be implemented in August 2005. They were selected for various reasons: higher prevalence of IDUs and HIV-positive cases, greater willingness to participate, and their socio-political significance.

To make this pilot program work, two major controversies needed to be solved at the central government level. Among the three arms of proposed harm reduction measures, only the needle syringe program and the drug maintenance treatment were new to the public. The last one (information, education, communication, and screening) was merely extension or intensification of past strategies. However, different opinions emerged with regard to the two new measures.

The first controversy, and the easier one to resolve, concerned the choice of drug to be used in maintenance programs. From the outset of organizing and planning, methadone and buprenorphine, both recommended by WHO, were considered. When local health authorities submitted their proposals, Suboxone® (a mixture of buprenorphine plus naloxone) and methadone were both listed as possible candidates for substitution therapy. Suboxone® was a newly developed medication with a better treatment profile while methadone had a longer history of clinical use and a cheaper price. For CDC technocrats, their tasks are multiple, and both ends and means mattered. Not only did they

have to keep the policy socially, morally, and politically defendable, more importantly they also had to make it economically feasible. In other words, the goal was both to control the epidemic HIV/AIDS in the shortest time possible and at the lowest cost. As this epidemic HIV/AIDS was a novel issue, only temporary funding could be allocated. If this strategy failed, the program would be cancelled and the director might even need to resign because of its failure. Many things were at stake. As a result, methadone became the drug of choice because of its low daily cost per person (less than 1 USD per person-per day for methadone versus 10~15 USD per person-per day for Suboxone®) and because of the abundant experience with its use in other countries.

For advocates of Suboxone®, however, this decision was disappointing. Led by some psychiatrists specialized in addiction treatment and even by major officials, including Director Lee Chi-Heng, of the National Bureau of Controlled Drugs (NBCD), they contended that buprenorphine was a Schedule Three Controlled Drug to which a looser legal standard of clinical use applied. Moreover, it was newer, safer, and more effective. It could also be used in office-based services. While methadone was indeed cheaper, it was listed as a Schedule Two Controlled Drug and therefore subject to stricter regulation. “Why use an old drug that needs more regulation but not a new drug that is safer and easier in clinical settings?” In their opinion, Suboxone® was a superior choice to methadone or even buprenophine monotherapy (Subutex®).

Eventually the CDC maintained its position despite some compromises. It allowed both medications to be used in the pilot program but generally restricted the funding for Suboxone® or Subutex®. “We were in the driving seat,” said CDC Director Steve Kuo, implying that the power to decide resided in the person who had official approval

and administrative resources. The purchase of Suboxone® by the government was seriously delayed because of its high price. Methadone was gradually adopted in a great majority of hospitals as the only treatment available.

The second controversy was much more difficult. It involved the law. As there was no precedent in Taiwan's history for distributing free needles, syringes, and substitutive medicine to drug users, those who were engaged in the programs, be they service providers or users, could be arrested or harassed by the police and indicted by a prosecutor. Once drug maintenance was defined as a "treatment" for an addicted person, it could be covered by existing laws that regulated medical practices. Nevertheless, things got much tougher when the CDC set out to implement the needle syringe program, because the police were accustomed to capturing drug injectors when they bought needles and syringes. Although selling and buying needles and syringes in registered places such as pharmacies, even without a prescription, are legal and easy in practice in Taiwan (a policy where Taiwan differs from the US), drug users were afraid to purchase them as they would become easy targets for the police who wanted to have a good record of arrests.

For the pharmacies participating in the needle syringe program (NSP), fear and resistance came in many shapes and from multiple sources. On the one hand, the anxiety of knowing that the police were watching prevented many pharmacies from promoting the distribution and exchange of needles and syringes. On the other hand, their participation also meant that they had to manage more drug injectors and deal with their public misconduct. To reassure hundreds of pharmacies island-wide that they would not be harassed, the CDC, or even the presiding Minister of Health, needed to improve coordination with both the National Police Agency under the Ministry of the Interior (see Figure

1-1), which oversees police actions, and the Department of Justice, which supervises prosecutorial agencies.

Addressing this problem was often cited by many of my interviewees as indispensably vital in the early stage of harm reduction. As I suggested to them that this could be a good example of inter-organizational coordination, my interviewees openly revealed their doubts. To them, the solution was not organizational at all. It was purely interpersonal and surreptitious—because the ministers of the Department of Health and the Ministry of Justice had been classmates in high school. This was not the case when harm reduction was first proposed in early 2004. The then ministers of both departments just did not get along well. For many participants in *the office*, the establishment of *guanxi* (關係), a Chinese term that can roughly be translated into English as "relationship", mattered most. What is more important here, the establishment of *guanxi* is itself part of *the office*.

However, even such a seemingly personal reason has certain sociological connotations, because the interpersonal connection was not an incidental given but a purposeful creation. Professor Hou Sheng-mou, then Minister of Department of Health, told me that the schoolmate relationship was pointed out intentionally to create a sense of intimacy and facilitate the negotiations. In a word, *guanxi* is a social bond that needs to be created.

Guanxi is a Chinese term that begs a clear definition but is frequently used across divergent literatures, indicating not a simple, reciprocal exchange of favors but a persisting interpersonal relationship with some elements of commitment and sentiment, or *ganqing* (感情) (Kiplis 1997; Provis 2008). It reaches far beyond organizational barriers and may sometimes imply some kind of "backdoor politics" (Langenberg 2007). In recent literature on China's commerce and society, *guanxi*, along with its ethical implica-

tions, is occasionally invoked to explain certain aspects of Chinese social or business networks (e.g., Gamble 2007; Langenberg 2007).

Retrospectively, their classmate relationship was surely a lubricant for the two ministers concerned, and the significance of *guanxi* in bypassing departmental barriers and informally enhancing organizational coordination is beyond doubt. However, the intentional establishment of interpersonal *guanxi*, or "strong ties", is not without contention. It may "breed local cohesion" at first but, on the other hand, may "lead to overall fragmentation" in the long run (Granovetter 1973: 1378). Hou Sheng-mou and Yen Chun-Zuo, two major promoters of harm reduction policy, expressed a similar strategy—establishing *guanxi* by *Bua Ganjing*. *Bua Ganjing* is a phrase in local Taiwanese which means, not exactly but approximately, "appealing to sentiment." *Ganjing* in Taiwanese is *Ganqing* in Mandarin. However, it should be noted that the term also implies partnership or camaraderie that can only be earned with great efforts by creating true sympathy and mutual devotion.

While Max Weber (2003) argues that modern bureaucracy embodies the rationality that finally turns into an iron cage, *guanxi* obviously represents a precarious facet of the bureaucracy in Taiwan that infuses flexibility and unpredictability into organizational structures. The sophisticated working of *guanxi*, with its polymorphous faces, further reveals the variability and contingency of *the office* as an assemblage.

Another feature of Taiwan's harm reduction policy is that it lacks an integrated program. Thus there are no standardized ways of regulating methadone maintenance treatments and needle syringe programs across different sites. These responsibilities were devolved to each local health authority while the CDC merely suggested some overarch-

ing principles and guidelines. In the name of "tailoring policy to local needs," local health authorities were forced to come up with locally doable plans. For the CDC, this orientation was intended as much to facilitate the diversification of harm reduction measures as to circumvent the vacuum of knowledge about implementation. Although in the eyes of some local health officers, the practice of minimal intervention taken by the central government seemed a way of shunning responsibility, the CDC had its perspective, too: Everything about harm reduction was known from books and journals mostly focused on other places. Very little know-how could be harvested from the extant literature to produce a working plan for Taiwan.

I will leave these knowledge issues for the next chapter, and here concentrate on the consequences of this devolution. Local health authorities, troubled by the lack of knowledge about how to proceed, resorted to non-governmental resources to design preliminary plans. I was told by a local health director that in order to get some funding for overseas visits, the official contacted Taiwan Urbani Foundation, an NGO established in memory of Dr. Urbani who discovered SARS and died of it. With the NGO's help, this local bureau of health sent several psychiatrists and health workers to Hong Kong to learn about its methadone treatment system, thus gaining valuable information, assistance and contacts. Later a computerized system for the registration and management of drug users was created by Dr. Chou Sung-Yuan, a psychiatrist at the Taoyuan Psychiatric Center, and subsequently was adopted by the CDC as the shared platform for all participating methadone clinics. The treatment approach and facilities of the Taoyuan Psychiatric Center were soon replicated with various modifications by other hospitals. Thus what was initially local gradually became national.

While local health authorities lacked sufficient governmental resources, they had administrative flexibility that helped achieve a diversity of harm reduction approaches. For example, Tainan County stood out with regard to clean needle/syringe distribution. With the strong advocacy of Deputy Magistrate Yen, not only pharmacies and health stations but also some 24-7 convenience stores in Tainan County offered this service. This greatly improved accessibility so that the incidence of new HIV/AIDS cases dropped rapidly in the following years. It was also the first region to utilize a "postponed prosecution" system in which arrested drug offenders are offered a compulsory treatment program (usually with methadone maintenance) in place of direct imprisonment.

These innovative measures in many ways contributed to the success of harm reduction in stopping progression of the HIV/AIDS epidemic. They also illustrate the complexity of delineating the boundary of *the office* because it is not, as many would expect, limited to a circumscribed group of people in the central government. Rather, it refers to a plurality of widely dispersed and loosely connected human and nonhuman actors (such as the needles in the previous section) that somehow converge through this project. For nonhuman actors, their presence (be it in a material form, in a graphic shape such as statistical presentations, or as a portion of larger infrastructure such as a bureaucratic structure) is analytically vital though frequently ignored. Nevertheless, along with human actors, they make up the *office* that makes it possible to work out a harm reduction plan. Some of the human actors were included not because they already had expertise but also just because they were there. Dr. Chou Sung-Yuan, the designer of the computerized system mentioned above, expressed this accidentality during an interview. He had previously specialized in forensic psychiatry but was recruited by his superintendent to do this

job. Starting from scratch, he gradually built up the system and accumulated experience in treating heroin users. However, for these IDUs who were seldom if ever consulted, their voiceless presence in *the office* was at most unintelligibly marginal yet obviously undeniable. Moreover, they were often discursively re-/constructed for the participants' divergent purposes. In other words, injection drug users were implicated actors in the arena of harm reduction policy (Clarke and Montini 1993; Clarke 2005).

In the end, who or what constitutes *the office*? This question begs a clarification of the meaning of harm reduction, as different people and elements come and go, giving different definitions of what harm reduction actually entails. The difficulty in delineating *the office* is not so much in who or what has participated in the policymaking process as in how the process itself is defined. To wit, what do we mean by "making" a policy? Even though the project started with a clearly defined purpose, it ended up with so many variations that one could no longer identify who contributed what. Devolution of the responsibility for integrated policymaking resulted in a multiplication of creative improvisations and decentralized strategies. The assemblage formation was apparently task-oriented and the intention was eventually achieved under a particular "condition of possibility."

But what is this condition of possibility? Many interviewees in either central or local government expressed the same opinion—"this policy can work only when it sells." Implied in the saying is a presupposition that there is a "market" for governmental action. This point of view is echoed by Hilgartner and Bosk's article (1988) on the rise and fall of social problems, mentioned in Chapter Two. A policy can exert its desired effects only if the "customers" buy it. Even if this is not an ordinary market where capital and labor

interact, it nonetheless has a similar structure where power and conduct are negotiated on a basis of exchange. However, the workings of this "market" are quite distinct from the old ideas of Rousseau's social contract or Hobbes' Leviathan. In many ways, this feature, echoing the way that *the office* is made, represents a liberal governmentality that characterizes Taiwan's policymaking. This finding in turn concerns a central issue in Foucault's formulation of biopolitics, that is, what does it mean to be a subject under a liberal governmental regime?

3.4 *Homo Economicus* and *Homo Juridicus* in a Liberal Governmentality

A brief review of Foucault's critiques of political reason is necessary here. After the 1970s, Foucault turned to genealogical studies of political rationality, broadly defined, with an emphasis obviously in opposition to Marxist perspectives on the role of the state. He highlighted government as a domain of inquiry and criticism in the hope of illuminating the maneuvers of power as capillary and relational (Foucault 1976). In his works on biopolitics and governmentality (Foucault 1978b, 1997a, 2003b, 2007, 2008), the rise of modern nation-states vis-à-vis subject formation is clearly shown. While various forms of sovereign power with all their armors were superimposed by more technologies of either intimate or distanced surveillance, this bodily disciplining that focused on individual subject formation, or anatomo-politics in Foucault's terms, was put in sharp contrast to the creation of political economy to bring about prosperity for the masses, highlighted as a salient feature of biopolitics that aimed at the entire population. In addition to this bipolar combination of individualizing anatomo-politics and collectivizing

bio-politics (Foucault 1976), Foucault extended his concerns to the formation of governmentality or, in his opinion, the governmentalization of the state. In his works and lectures such as *Discipline and Punish* (1975), the first volume of *History of Sexuality* (1976), *Society Must Be Defended* (1976–1977), and *Security, Territory, Population* (1977–1978), Foucault illustrated step by step, in a way that he calls a "history of the present" (Foucault 1978), the formation of modern nation-states and the forms of power that gave birth to the society and subjects as we know them today. Roughly speaking, he delineates a process as well as a mosaic of political reasons that superimpose on, yet also co-exist with, previous ones. From sovereign power to pastoral power to biopolitics and later governmentality, the genealogy that he portrays situates "modern man" in closely knit webs of power that contribute to his subjection and subjectivization (Dreyfus and Rabinow 1982).

Harm reduction policy as it is now organized in Taiwan may be conveniently described as a biopolitical project in which drug users fall into the purview of government and become subjects of policy implementation. It is true that the policy aims at the improvement of population health and tends to enlarge the domain of previous surveillance by making visible and disciplining drug users in various sites (methadone clinics and needle/syringe-distributing pharmacies, for example). However, the question here is not how well this policy fits with Foucaultian framings of biopower. The question, instead, is how the subjects (i.e., drug users) of this policy are imagined and fashioned in such a neoliberal type of regime.

In his latest published work, *The Birth of Biopolitics* (2008), which contains his lectures at the Collège de France from 1978 to 1979, Foucault further discusses the emer-

gence and incorporation of liberalism in the government rationality, which began in the eighteenth century and has progressed to this day. He distinguishes this form of government from the previous one whose *raison d'etat* needed to be restrained by the law. The market specified by liberalism then was understood as capable of acting as another test for too much government. It was thought that nature, which underlies the functions of the market, would effectively counterbalance excessive administrative intervention. In the face of a market economy, the government in classic liberalism was relatively passive.

Newer versions of liberalism, or neoliberalisms, no longer treated the market as operating outside the government as a check on governmental over-involvement. Instead, the market was seen as internal to the government that needed to be "actively instituted, maintained, assessed and, if need be, reinserted at all levels of society" (Hamann 2009: 42). In Germany, this thread of neoliberal thought was stimulated in the 1930s by scholars of the Freiburg School (or in Foucault's terms, Ordo-liberals) who, while offering their critiques of Nazism that expanded state power over the market, overturned a long-held question. Foucault explains their theoretical stance:

> Our [Ordo-liberals'] question should not be: Given a relatively free market economy, how should the state limit it so as to minimize its harmful effects? We should reason completely differently and say: Nothing proves that the market economy is intrinsically defective….So, let's do the opposite and demand even more from the market economy than was demanded from it in the eighteenth century….This is not enough, the Ordo-liberals say. Since it turns out that the state is the bearer of intrinsic defects, and there is no proof that the market economy has these defects, let's ask the market economy itself to be the principle, not of the state's limitation, but of its internal regulation from start to finish of its existence and action (Foucault 2008: 116)

In the American version of neoliberalism, not only does the state have to protect the market, but the market expands to the formation of a modern subject and defines one's limit of freedom. The market portrays the individual not as a passive subject but as an active entrepreneur. An individual does not only sell his labor power, as Marx portrays; he accumulates human capital as well, by, say, investing in his own education or participating in a drug maintenance program. This image of *homo economicus*, the man of economy or exchange, contrasts with *homo juridicus*, the man of right, who defends his own subjectivity against sovereignty or government through legally endowed entitlements. Thus in this scheme, a man possesses two sets of identities, economic and legal, which is a significant feature of man in modern liberal governmentality.

For drug users in Taiwan as configured by this harm reduction policy, both identity formations are present yet conflicting. On the one hand, drug users are subject to legal-administrative regulations and therefore endowed with certain rights and responsibilities. According to the policy design, they are required to show up daily at methadone clinics and be assessed for their drug use and disease transmission potential. In spite of the fact that they are now entitled to inexpensive methadone and are free from the control of heroin, they are still monitored and disciplined for the sake of better socio-occupational performance. They are, in the words of Foucault, made visible in the panopticon of national public health that in this case, bears the name of harm reduction. On the other hand, drug users are not simply governed as passive objects of this omnipresent web of surveillance. Harm reduction, as I have illustrated above, is a cooperative project in which drug users are implicated everywhere. Although they have to date created no formal organization or advocacy group to put forward their demands, their voices are transmitted via many

channels and make a difference in final decisions. Their subjectivity as fashioned in the form of citizenship in this neoliberalism-informed policy is to be elaborated in Chapter Five, but traces of their subjectivity are in fact everywhere. Refusing wrong needles and syringes, as I have highlighted earlier, is one of the many examples. From my field observation, I also found that drug users were mostly agentive and calculative (and sometimes even *too* calculative) individuals who knew how to effectively bargain and behave. What is theoretically noteworthy here is that drug users are explicitly or implicitly expected to be, treated as and finally acting as rational, interest-based entrepreneurs. This neoliberal ethos is written into the fabric of Taiwan's harm reduction policy. Moreover, the success of this policy is understandably predicated on whether these drug users "buy" it or not.

In sum, Foucault's characterizations of *homo economicus* and *homo juridicus* are helpful in illuminating the immanent conflicts residing in the formulation and implementation of harm reduction in Taiwan, because for a polity such as Taiwan that adopts neoliberal logic, how to accommodate the two identities of drug users within a single policy is a major and unavoidable issue. From the right, we hear voices like "let the rules be clear and the drug users be subjected." However, from the left we have arguments like "let the drug users define what they like and the rules be flexible." From center to periphery, from *the office* to *the street*, these two contrasting discourses define the space of problematization in which the policy orientation oscillates incessantly. Some questions are thus repeatedly being asked: What is harm now? And reduce harm for what, and how? These problematizing questions on the one hand have an impact on the policy that is constantly metamorphosing and, on the other, correspond to component changes of re-

territorialized policy assemblages. Intriguingly enough, the oscillation eventually contributes to the present outcome of this policy, which I will discuss in later chapters.

3.5 Conclusion:

In this chapter I have illustrated some vital elements of harm reduction as a biopolitical project, especially how different technologies are utilized and resisted. From these examples I demonstrated the various ways in which objectivity is constructed and subjectivity is manifested. These cases characteristically embody the deployment of power that is decentralized and metamorphosing. However, Foucault fails to tell his readers what happens to the state analytically if it is not treated as a singular institution with centralized power. To address this theoretical lacuna, I offer the concept of *the office*. It serves multiple purposes. First, it allows the analysis to focus not on the abstract structure ("the state") but on the actors working in, for, or with governmental organizations. Second, a methodological individualism that emphasizes agency is not necessarily capable of addressing collectivity and structure. Instead, I tend to aim at the meso-level analytically so as to situate these actors within their social groups. Third, the actors within *the office* are constantly changing, and so is the task of harm reduction that constitutes the cause for their presence in the policymaking process. For example, the office initially includes the people of law and order (policemen, prosecutors, and so forth) and health bureaucrats. Later, however, law and order actors and entities were gradually phased out from the scene of harm reduction planning. Drug users were consulted once in a while but most of the time they remain only implicated actors in policy formation. By contrast, CDC offic-

ers, local health organizers, psychiatric workers, and HIV professionals have persisted in the picture, although their significance waxes and wanes. Together, all these people constitute an assemblage as proposed by Deleuze and Guattari (1987) and later elaborated by Ong and Collier (2005) and DeLanda (2006). The notion of an assemblage better suits the analysis as it allows a more fluid characterization of the ensemble that houses different people, things, and even infrastructures (Collier 2006; Ong and Collier 2005). In addition to people, elements such as needles, statistical numbers, and the web of *guanxi* among governmental departments are present as well. The feature of continuous de-/re-territorialization characteristic of assemblages is clearly evident in the case of Taiwanese harm reduction policy.

Last, a few more words on Foucault's work in relation to drug policy. In *The Birth of Biopolitics* (2008), Foucault briefly discusses the neoliberal logic applied to the case of drug policy. He first delineates the history of supply reduction efforts up to the 1970s and then introduces a revised point of view that categorizes drug users as heavy addicts and small consumers, the former of which presenting a rather inelastic demand while the latter responding better to price variations. This perspective on the one hand contributes to the "anthropological erasure of the criminal" (Foucault 2008: 258). That is to say, the intrinsic differences once believed to exist in criminals (Foucault 2003b) no longer matter. Drug users, heavily addicted or not, today somehow respond to environmental interventions. On the other hand, the emphasis on environment also diverts the level of intervention away from the subjugation of individuals.

Does Foucault mean that the attention shifted onto the environment will push the liberal governmentality away from a disciplinary panopticon and towards a game of loos-

er rules? If so, does harm reduction count as such a game? While this chapter has highlighted the connection of harm reduction with liberal governmentality, in the following chapters, I pursue the implications and ramifications of this connection analytically.

Chapter Four

Assembling Harm Reduction Expertise

4.1 Introduction:

Expert (n.) *A Person who is very skillful or highly trained and informed in some special field.*
Expertise (n.) *The skill, knowledge, judgment, etc. of an expert.*
(Webster's New World 4th Collegiate Dictionary 2007:500)

This chapter does not delve into Taiwan's harm reduction policy chronologically. Instead, it addresses important issues concerning experts and their expertise in light of policymaking. These issues link to important recent debates in science and technology studies (STS), and are also pivotal to Michel Foucault's thesis on power and knowledge which I directly engage in this project. In addition, questions relating to experts/expertise are central to the transfer of knowledge and governmentality implicated in this "trans-planted" policy for a globalizing state like Taiwan. However, this chapter simply concentrates on how local experts and their respective expertise came about after harm reduction was put into practice. I leave the transfer question for Chapter Six.

From the outset of my research, I was constantly puzzled by one question: "Who are the experts I should talk to?" The presupposition of this question was simple and straightforward: There had to be a certain group of people whose knowledge related to this policy along with its concepts and practices was established and sophisticated. These

people "who know more and better" might have participated as experts during the policymaking process and were consulted by policymakers for their informed suggestions. What I had in mind initially was a clear-cut consultation model, so to speak.

However, an interview with Professor Chen Yi-Ming soon demonstrated that the model was untenable. With an M.D. degree from National Yang-Ming University (NYMU) where he teaches now, he is also a Harvard-trained molecular epidemiologist dedicated to HIV/AIDS research in Taiwan. I was told many times, "he is the expert you should talk to." My hopes were dashed right after I explained my intention. Professor Chen appeared somewhat upset, paused, and said, "To be frank, I have never been in the core of this policy design." I almost panicked—If not you, then who could I be looking for?

Later, I realized that his emotional comment was not entirely correct. Nonetheless, it led me back to a series of debates around experts and expertise in STS as exemplified by Collins and Evans' notion of the third wave of science studies and its critiques by other STS scholars (Collins and Evans 2002, 2003, 2007; Jasanoff 2003; Rip 2003; Wynne 2003). Collins and Evans' claim was rooted in a long-held interest in the opposing roles played by expert and lay knowledge in the formation of public decisions. In the post-WWII period, Robert Merton's characterization of the ethos of scientific communities reflected the hope that was invested on scientists because their shared value orientations (universalism, communism, disinterestedness and organized skepticism) might produce better scientific knowledge to guide the public (Merton [1942]1973). In other words, "ideal" science was portrayed as not only true but also good for public well-being. However, the functionalist underpinnings of these norms were later questioned by sociol-

ogists of scientific knowledge, as these principles were not always useful or accurate in portraying the actual beliefs and practices of scientists (Sismondo 2004). Empirical approaches to expertise then emerged based on the presupposition that science is a part of human activity, subject to certain bounds and rules just like other social phenomena. In this respect, Schaffer and Shapin's *Leviathan and the Air-Pump* (1985) is a brilliant illustration of the socio-political conditions that led to the eventual success of Boyle's experimental method that paved the foundation of modern science. Their work clearly shows that science is not outside society. It belongs with society, and furthermore, it transforms the social. Just as Foucault has demonstrated in the birth of clinical medicine (Foucault 1994), science has become a way of seeing, knowing and living. Overall, we may say that science is no longer impermeable to social, political, and cultural critiques. On the contrary, it is now a major field of inquiry for those disciplines which were forbidden to raise questions about science in the past. While it may be true that Mertonian norms uphold certain scientific activities, the actual practices and their consequent products—namely "science"—are embedded in specific spatial-temporal milieus that warrant detailed socio-cultural investigations. As a result, even if it is debatable whether there are "two cultures," science and non-science (Golinski 2005; Snow 1959), science is never immune to social critique. Sharon Traweek's depiction of a "culture of no culture" among particle physicists points to the situatedness of scientists despite claims to objectivity and neutrality (Reid and Traweek 2000; Traweek 1992). Donna Haraway's notion of situated knowledge highlights the embeddedness of their products (Haraway 1991).

As science was questioned in these debates, so too were the notions of experts and expertise. Since the late 1980s, there has been an enormous array of STS studies that ex-

poses the disquieting and sometimes catastrophic discrepancies between expert knowledge and lay understanding in terms of public decisions. A shared perspective of these studies is to deconstruct the formation of expertise, explicate its constitution and demystify its effects on public decisions. Collins and Evans (2002) see this critical attitude as a salient feature of the second wave of science studies, as opposed to the glorifying orientation of the first wave represented by Merton's work. According to them, Bryan Wynne's work on Cambrian sheep farmers and Steven Epstein's work on HIV/AIDS activists are two illustrative examples of the second-wave science studies (Epstein 1996; Wynne 1992). In Wynne's case, government-approved scientific expertise was seriously questioned by local sheep farmers and later compromised by its own failure to predict and minimize the hazards of nuclear fallout. In contrast, in Epstein's case, intensive interactions between experts and non-experts resulted in initial conflict and suspicion regarding clinical trials and standards of care although mutual understanding and transformation subsequently followed. In both works, the shortcomings of expert knowledge were exposed. Either lay knowledge was given undeniable significance or the emergence of a new genus—the lay expert—was highlighted.

Yet, even though the legitimacy of expert knowledge is cast in serious doubt, the second wave of science studies never denounces expert knowledge as utterly useless in public decisions. However, *how useful* it is in terms of public decision making now becomes the new question. Collins and Evans (2002) call this "the problem of extension," that is, the extent to which expert knowledge should be employed to reach public decisions. They try to solve this normative question by building a new taxonomy upon established scholarship of sociology of scientific knowledge. They call their own attempts "the

third wave" of science studies. Instead of deciphering and deconstructing scientific experts and expertise in practice, Collins and Evans propose a typological diagram of experts, also a nuanced and even hair-splitting classification of expertise, in their co-authored book, *Rethinking Expertise* (2007), in hopes that a better differentiation of experts is helpful to clarify the problem of extension.

A major contribution of Collins and Evans (2002, 2007) related to my study is their differentiation of contributory experts/expertise and interactional experts/expertise. Contributory experts refer to those who are dedicated to the research of esoteric knowledge that can only be obtained after immersion in the field for some time. In contrast, interactional experts are those who are less specialized and immersed than contributory experts, but they are able to communicate scientific findings with common people. The taxonomy is both epistemological and practical. Collins and Evans (2002) suggest that social researchers of science consider themselves interactional experts in that special field and therefore their participation in public decision making is legitimate.

Let me recap how Collins and Evans define the three waves of science studies: The first wave accepted Mertonian norms of science as practice and took scientific findings as true and real. The second wave challenged that positivist perspective. It was, instead, rooted in empirical approaches to seeking out what an expert or expertise *really is*. The third wave asks, again, what an expert or expertise *should be*.

Their characterization has incited vehement criticisms. For example, Brian Wynne (2003) argues that Collins and Evans' definition of the third wave is just a masked reincarnation of Wave One. Jasanoff (2003) criticizes Collins and Evans for misrepresenting the intellectual history of science studies and misinterpreting the contemporary trends of

participatory politics, thus weakening or even invalidating their classification of experts and expertise.

Even though I agree with Jasanoff (2003) that this framing of science studies as successive waves is both misleading and reductionistic, the periodization has its own value in addressing potential conflicts of expertise and democracy in terms of public decision making, which Jasanoff (2003: 397) clearly points out. However, the framework proposed by Collins and Evans (2002) and even its critics fail to discuss the process of expertization vis-à-vis the immediate urgency of policy demands. Their formulations all treat experts and expertise as categories that are already made, not categories that are becoming.

To be clearer, throughout the designing and implementation phases of Taiwan's harm reduction policy, relevant experts were always strongly needed because harm reduction was such a novel concept that not many people in the government really knew how to implement it. Given the urgent demands for useful expertise, those who were consulted had to offer, upon request, something even they did not know too well. My own critique of Collins and Evans' thesis of experts and expertise, then, is that all three waves fail to adequately address the possible disjunction of expert status and its alleged expertise. More specifically, there were addiction specialists, HIV/AIDS professionals and researchers, and concerned technocrats, but who in the world deserved the title of harm reduction specialists that were qualified to advance suggestions about policy details? When this policy first took form, there were no harm reduction specialists. This absence is central to my research concern, and it is also the point of departure from my original naïve consultation model.

From both my field work on harm reduction policy and my own experience of being asked to draft a governmental health prospectus on drug abuse,[12] I am able to empirically state that someone may be recruited into a policymaking group because his knowledge is deemed relevant to the issue. In this process, the knowledgeable person may be transformed into an expert with specific domain(s) of expertise. Moreover, the recruiting is often based on either long-existing or nascent *guanxi*, and the networks of expertise knowledge thus formed are, in a sense, networks of social closeness: The knowledgeable individual recruited may be sought out because of familiarity and/or their established positions of authority and/or knowledge of related fields. In addition, this relevance is not usually judged on the basis of consensus. That is, an expert may be consulted not for his established expertise in harm reduction per se (because there is not yet such a thing), but for his cognitive authority or familiarity with HIV or drug-related issues, problematics, or institutions that are thought to be "close" to harm reduction. This does not mean that these experts consulted have no expertise at all, but questions remain, on the one hand, about the extent to which their own expertise can be applied to policymaking, and on the other, about how they respond when their expertise can not be applied.

The first part of the question corresponds to Collins and Evans' "problem of extension." However, I complicated their inquiry by asking about the second part, which concerns the actions of experts in the face of knowledge insufficiency and/or mismatch.

[12] This personal experience, though an entirely unexpected one, is in many ways illustrative of the ways that so-called experts were recruited in the activities of harm reduction policymaking. It happened right after I returned to Taiwan to undertake my field work in July, 2007. I was asked by Director Lin Keh-Ming of the Division of Mental Health and Substance Abuse in the National Health Research Institute to participate in the drafting of a governmental health prospectus, *Taiwan Healthy People 2020*, which includes not only administrative strategies on drugs and illnesses but, more broadly, on health promotion and health planning. I was, however, assigned to the part on prescription drug abuse even though I expressed no expertise or interest in this area. The response I received was quite intriguing and furthered my determination to understand the process of expertization in light of policymaking—"How do you define an 'expert' of such a novel notion? You can be one if you want to."

Obviously the second part of the question can only be answered with empirical observation. It therefore diverts me from Collins and Evans' normative stance and allows me to move towards a process-based analytic. In the rest of the chapter, I discuss two major kinds of local experts and expertise that the Taiwanese policymakers consulted: 1) HIV professionals, and 2) addiction specialists (mostly psychiatrists). They were consulted by the government because harm reduction policy was predicated on the unfortunate convergence of HIV/AIDS and illegal drug use, as the statistics showed (see Chapter Three). However, all of these experts did not necessarily possess knowledge of harm reduction. Even regarding the parts they did know about, they did not entirely agree on meanings and practices. These disagreements were echoed in their subsequent pursuit of different goals. In the end, the title "harm reduction expert" is always a misnomer, as the virtual group of such "experts" was nothing more than an assemblage that existed only ephemerally. It had a vaguely defined territory but then lost it again. "Who is the expert?" Even after I followed these people for some time, the question again rang in my ears. The following records my pursuit of the answer.

4.2 Who Is an Expert?

From the outset, there has been no sharp line between those who know and those who do not know in the case of Taiwan's harm reduction policy. In addition, the majority of those involved in policymaking might not call themselves experts even if they are regarded as such by others. Certainly some of my interviewees reported they had previously been acquainted with this idea to some degree, but none of them wanted to define him-

self or herself as an expert in this field. This is particularly understandable because harm reduction occupies a trans-disciplinary space wherein expertise is hard to define. Furthermore, harm reduction was such a novel concept when it was introduced into Taiwan that the directions and suggestions of foreign experts from both Australia and Hong Kong were introduced.[13] Here, however, I am only concerned with local experts as it is these people who constantly work on the project of harm reduction.

The experts I first encountered in my field work were HIV professionals. As the CDC was the main force promoting harm reduction and HIV/AIDS prevention, these people were naturally enlisted as intramural consultants. However, the level of their participation varied, and the composition of this group was very heterogeneous. There were epidemiologists, clinical researchers, infection control physicians, and non-governmental organization (NGO) workers including representatives from religious and non-religious groups.[14] Their interests were largely aligned with those of the CDC, mainly the control of HIV/AIDS among IDUs and ideally a careful reassessment of current policies regarding the governance of marginalized groups such as prostitutes and homosexuals. Initially, drug users were not their primary concern until the IDUs actually contracted HIV and thus posed a public health threat. The collaborative relationships between this group of health professionals with the prison helped them see the early signs of this epidemic outbreak in 2003. Professor of nursing Ko Nai-Ying (National Cheng-Kung University) and an anonymous interviewee from a local NGO vividly remembered the first signs of the epidemic that occurred in the Tainan prison where several new prisoners were found to

[13] The introduction of foreign experts is discussed in Chapter Six where the questions of knowledge transfer and the globalization of harm reduction policies and practices are raised.
[14] Such organizations include, for example, Taiwan Lourdes Association (Catholic), Operation DAWN (Baptist), Taiwan AIDS Foundation, Taiwan Love and Hope Association, Living with Hope Foundation, and Persons with HIV/AIDS Rights Advocacy Association of Taiwan.

be HIV-positive. This was quickly noticed by my anonymous interviewee, who had visited and talked with almost every HIV-infected prisoner in Taiwan. Before long, more cases were found in other correctional facilities and they spread all the way north. Professor Ko, who had worked in the HIV/AIDS prevention and counseling field for a long time, recalled the sign she noticed of the impending catastrophic trend. It was the noise these people made when they were waiting in line to get treatments at the hospital. “In that year [2003], around September or October, I felt the ‘Kang-Kang’ group was getting bigger. I called them the ‘Kang-Kang’ group because their shackles would clatter, making the noise of ‘Kang-Kang’. The larger the group, the louder the noise.” She was alerted to the danger. If more prisoners were coming to her HIV clinic, it probably meant that the epidemic had spread to injection drug users as they constituted the largest proportion of prisoners. As she had an established collaborative relationship for years with the CDC, she soon reported this finding to that agency.

However, there was no feedback, no response, no action. Nothing.

The SARS scare may largely explain why her findings were ignored. Professor Chen Yi-Ming recounted the chaos that SARS brought to the public and the bureaucracy. He speculated that compared to the perceived social threat of SARS at the same time, the increase in HIV-positive prisoners in 2003 might appear trivial even if their numbers were growing by the dozens. Although it is understandable that this HIV issue was not a priority at that time, a pervasive sense of frustration due to lack of respect given to their expertise is still prevalent among HIV professionals like Ko and Chen. It seems unbelievable to them that the CDC technocrats organized the main structure of the Taiwan harm reduction plan without listening to them. Professor Chen was especially upset about this.

He has been working on HIV/AIDS in Taiwan since 1992, and is one of the founders of the Taiwan Harm Reduction Association. In a somewhat agitated voice, he attributed the lack of adequate consultation and cooperation to the fact that the CDC does not actually have its own HIV/AIDS consultation committee for policymaking. The current committee was established in 2001 as an inter-departmental organization in the Executive Yuan. Its chairperson is the Minister of Health and its members, representatives from major departments in the Executive Yuan. Its predecessor was the AIDS Prevention Panel established in 1986. In 2001, it was renamed as the AIDS Prevention Committee, and the Vice Premier was appointed its chairperson. The committee was then reorganized in 2004 in the form it is now (National Health Research Institute 2009: 5-9). This current committee is intended only to coordinate interdepartmental affairs on HIV/AIDS prevention. In Professor Chen's opinions, its limited role in policymaking leads to ineffective government and results in the CDC's inadequacy in managing novel patterns of disease transmission.

Unsurprisingly, Professor Chen was similarly disappointed with the quality of interaction between the experts and the bureaucracy. He expressed the feeling succinctly, "We were *consulted* but we were *not included*." The meaning of being included, he stressed, is reflected in the offering of resources for professional growth. However, he explained to me, as illegal drug use was new to the CDC, it did not pay as much attention to its long-term collaborators as it did to its new allies—addiction specialists. In addition, the CDC seemed to stick to the outdated consultation model, forgetting that these HIV specialists also needed professional growth. "We [the HIV professionals] were thought to have been equipped with sufficient knowledge." However, it was not true, as Professor

Chen briefly pointed out, “In such a new domain of knowledge as harm reduction, experts need to be educated and cultivated too.”

Consequently, self-help became the path. First of all, Professor Chen organized a course on harm reduction as a platform to invite other experts, including addiction specialists, to give lectures in his class. Second, he mobilized his personal resources and *guanxi* overseas and collected information on harm reduction from other Asian countries. Third, he established the Taiwan Harm Reduction Association with the valuable assistance of these associates. These efforts, he emphasized, were done without formal governmental assistance. It was by way of his personal *guanxi* that brought these people together. Contrary to what was formerly believed, the connecting force was neither the formalization of intellectual scholarship nor the normative effects of shared ethos.

Professor Ko shared similar feelings. Energetic and spirited, she has been at the forefront of care and research on people afflicted by HIV/AIDS for more than a decade. “*Guanxi* is very important, which is perhaps true in the whole world but especially so in Taiwan,” she said and grinned. With a doctoral degree in nursing from the University of Washington, she has been working in this field with multiple identities: She participates in social and students’ movements. She offers counseling in the outpatient clinic. She is also a teacher and researcher at National Cheng-Kung University. Her multiple identities have facilitated her association with people from different walks of life. Instead of actively organizing a course like Professor Chen, she stepped down from the ivory tower and walked into the prisons that were plagued by the increasing number of HIV-positive inmates and growing pressures from correctional workers. In half-jest, she referred to her-

self as “the glue” because she knew exactly what she had been doing, “I have always been a person who transgresses: clinical practice, social movement, and academia.”

However, not every professional treated harm reduction as a necessary extension of their original concerns for HIV/AIDS. Some professionals just bumped into this field by accident. Professor Tsai Tzu-I is a typical example. A young faculty member at the National Yang-Ming University (NYMU), she was originally trained in health behavior and health promotion at UCLA. She had had some anthropological training in graduate school, so she was asked to participate in Professor Chen’s project. She took charge of the qualitative evaluation for the pilot program as well as for the full-scale program of harm reduction policy. In the latter report (Tsai 2007), she analyzed the responses of harm reduction workers (psychiatrists, nurses and case managers in methadone clinics, and pharmacists distributing needles and syringes) and injection drug users regarding their satisfaction levels, knowledge levels, and overall attitudinal changes. With the hope that her reports might provide the CDC with the necessary foundation for behaviorally-oriented policy strategies, she completed the reports with great effort and learned a lot from doing them. To her dismay, however, these reports were met with a lukewarm response.

When I asked CDC officials to name some experts, these people were on the list. However, as I turned to these “experts” and asked them about their participation in policymaking, they usually considered their contributions marginal and inconsequential. I could not help but ask, “Is this policy still an expertise-based one? If so, who are the experts?” Perplexed as I was, I pointed out the discrepancy between their recognized role and self-perceived status. Director Steve Kuo of the CDC explained, “It was not purpose-

ful, but I understand it very clearly. In order to reach a consensus domestically….we still worship foreign things and it is not easy for us to persuade the others. But if there is some super-expert from abroad, things will just smooth out." The policy does still depend on experts and expertise, but the question becomes when it has to do so, and what type of expert or expertise is to be sought and utilized. The policy cannot always depend on foreign experts, but they are necessary to unify the divergent opinions. Local HIV professionals, with their long, established relationships with the CDC, are not always excluded, but their role is sometimes ambiguous.

4.3 Assembling New Expertise

The process by which these HIV professionals came to be regarded as experts of harm reduction leads me to two major questions regarding their acquisition and maintenance of expert status: How do we theorize their attempts to earn the expertise that matched their recognized status? What sociological insights of significance does this reflection produce?

When I analyze the actions of these professionals working on the issue of HIV/AIDS, two mechanisms surface that are vital in transforming themselves into experts: transgression and association. Transgression means stepping across disciplinary or other boundaries and acquiring previously unknown experiences, while association refers to establishing a web of *guanxi* by interlinking interpersonal and epistemic connections. The urgent need for harm reduction knowledge offered these proto-experts an opportunity to break extant barriers, make new acquaintances, and gain insights from those who

knew what this was all about. Take Professor Chen's course on HIV/AIDS and drug addiction for example. He attempted to formulate an integrated sense of harm reduction by inviting psychiatrists, NGO representatives, frontline health workers, counselors and even drug users to teach in his class. The resultant knowledge was thus a patchwork mixture of preexisting local experiences combined with transplanted foreign knowledge.

In portraying the processes by which different types of experts transformed themselves to address harm reduction, I began to question Collins and Evans' formulation (2007). They describe the acquisition of expertise as a continuum from sheer understanding of a certain scientific statement to embodied immersion and creation of knowledge intricacies. This characterization of expertise bears a very strong resemblance to Collins' previous idea of core-set (Collins 1981), by which he refers to one or several small groups of hard-core scientists deeply immersed in the laboratory work and devoted to understanding the esoteric intricacies of the subject matter they investigate, that is, the contributory expertise. Comprehensive as it may appear, as I have pointed out earlier, this expertise classification fails to address, say, how one build on existing expertise and become an expert in another scientific field.

It is likely that readers cannot help wondering what factors contributed to my observation of the limitation of Collins and Evans' framework for explaining expertise formation. One possibility is the differences between hard-core sciences and regulatory sciences, as Jasanoff (2003) contends. Jasanoff (1990) has portrayed the latter, namely regulatory sciences, as a domain of contested credibility and Hilgartner (2000) has, in an analytic way, described them as stage performances. However, the distinction between hard-core and regulatory sciences is arbitrary, insufficient and untenable, because harm

reduction as a form of regulatory science requires contributions from many hard-core sciences as well. For example, the transmission of HIV via needle sharing is not a speculation. It has been already repeatedly demonstrated by laboratory confirmation. In addition, the HIV DNA analysis has confirmed the increased prevalence of certain new strains (CRF07_BC) among IDUs in Taiwan. This is an important finding, for the new strains are the same as those previously found in China and different from older strains (CRF-B and CRF01_AE) that were prevalent among the MSM groups in Taiwan (Chen et al 2001; Chen and Kuo 2007). These findings have allowed the reconstruction of narrative storylines underlying Taiwan's harm reduction: Local drug users went to Mainland China to buy, use and smuggle heroin. They shared needles and syringes, and they contracted HIV in China. With their trajectories of travel they brought the new strain (CRF07_BC) back to Taiwan, which then caused the epidemic outbreak in 2004 (Chen and Kuo 2007).

However, even if the boundary between hard-core science and regulatory science is blurred, what matters here is a defense of the legitimacy of these experts. They should be called as such not simply because of the knowledge they already possessed, but because of their capacity to organize an assemblage that held together various elements and generated its desired effects. Here readers may be reminded of Alan Irwin and Mike Michael's (2003) concept of *ethno-epistemic assemblages*. These assemblages articulate the production of truth, locality, indexicality, and reflexivity by invoking both mechanistic and expressive manners of assembling human and nonhuman actors. They act against a citadel model of science which postulates science as a citadel with differentiation between inside and outside. This citadel model is taken up by the works of many STS scho-

lars including Bruno Latour, even though their purposes are to problematize the boundaries between inside and outside rather than follow the boundaries (Martin 1997). In my case, however, the differentiation is pretty questionable at bottom. By re-assembling knowledge, people and things, these becoming harm reduction experts are not necessarily the opposite of lay people. What is more likely is that they become agents or representatives who speak for implicated actors such as drug users. Such experts may even invite implicated actors to speak for themselves—a most radical act. For example, Professor Ko, conscious of her significant position due to her multiple identities, not only once but twice invited some drug users she knew quite well to join policymaking conferences and hearings on harm reduction.

My depiction here of how experts and expertise are generated both challenges and enriches previous views about the ways in which experts can contribute to policymaking. In an earlier statement, Renn (1995) categorized four main functions of scientific expertise in terms of policymaking, including enlightenment, pragmatic or instrumental, interpretive and catalytic functions. Likewise, Roelke (2007) repeats the theme that science can be and should be an honest broker in terms of policy and politics. Both of their propositions reaffirm the positive effects of science (or the effects of positivist science) on policymaking without questioning. Even if positive effects really occur, the circumstances under which these effects can be observed should be empirically examined. More recently, questioning the spontaneity and self-evidence of these positive effects and contemplating the empowering conditions of science vis-à-vis policymaking, Hellström (2000) challenged Renn's "rationalist" thinking and investigated the ways that scientific expertise is used for policymaking purposes by situating the enabling enactment of exper-

tise in its policy culture. His arguments are further echoed by Jasanoff's (2005) research on comparative biotechnology policies in the US and Europe. In brief, the argument here is that expertise can work only when the cultures of experts and policy fit together. Science too has to be interrogated and negotiated when put into policy. These authors point out the normative and/or situational requirements about how scientific expertise should be used for policymaking, but they tend to focus on the ideal conditions for the utility of scientific expertise and fail to address the processes of interrogation and negotiation of that science. That is, they fail to ask, "How do scientific experts make themselves and their work culturally available and practically useful for policymaking?" Therefore, I contend, conceptualizing the dynamic of experts/expertise formation as an assemblage that is constantly in the making and unmaking is a better way to address this complex process.

4.4 Assembling a New Subspecialty

Another category of experts important to the story are addiction specialists, mostly hospital-based psychiatrists. Designing and executing drug maintenance programs, they are obviously strange bedfellows for the CDC, and vice versa. For the CDC officials, the collaboration with psychiatrists was an entirely novel experience, because they usually worked with infectious disease specialists. For the addiction specialists, the alliance created some never-dreamed-of opportunities that they had long hoped for and now grasped tightly. A new career trajectory for them was thus opened.

Nevertheless, the term *addiction specialist* needs to be clarified here. To be sure, addiction medicine has usually been included in the training of psychiatric residents. Ideally every qualified psychiatrist was expected to provide quality care to addicted drug users. However, this was not always the case. As I discussed in Chapter Two, addiction to illegal drugs was largely treated as a criminal act rather than a psychiatric illness, managed in penal institutions rather than in mental health venues. This led to the underdevelopment of addiction medicine as a subspecialty of psychiatry until the emergence of the harm reduction policy rekindled academic and clinical interest in drug use disorders.

For Drs. Su Lien-Wen and Lin Shi-Gu, distinguished addiction specialists at the Taipei City Psychiatric Center, this was a once-in-a-lifetime opportunity to promote what they had been long working on—addiction medicine. They had conducted several drug trials on the efficacy and outcomes of treatment with naltrexone, methadone and buprenorphine over the past few years. They had accumulated experience and expertise in pharmaceutical treatments for opioid addiction that enabled them to participate as medical consultants in the making of various drug-related policies. They sensed that the harm reduction policy that was implemented in 2005 was a great channel to facilitate the development of this subspecialty. In addition, they believed that it might even become an independent discipline that incorporated specialists from basic sciences and clinical sciences.

Harm reduction as initially defined by the CDC was narrow in scope because their definition only addressed the issue of the transmission of HIV or other blood-borne infections. Despite this, however, Drs. Su and Lin, along with Director Lee Chih-Heng of the National Bureau of Controlled Drugs (NBCD), grabbed the chance to propose buprenor-

phine as a better medication for the substitution of heroin among injection drug users. Even though the proposal failed to become the treatment of choice (see Chapter Three), they "jumped on the bandwagon" (Fujimura 1996) and tried to actualize their long-held dream of a new discipline. First of all, they conformed to the decision of the CDC, accepted methadone as the officially favored medication, and actively participated in the maintenance program like any other professionals in public psychiatric institutes or departments. As more and more methadone clinics were established and psychiatrists became interested in this issue, they began to collaborate with the National Health Research Institute (NHRI), an institute akin to the National Institute of Health (NIH) in the US, to set up the Taiwanese Society of Addiction Science. Director Lin Keh-Ming of the Division of Mental Health and Substance Abuse (NHRI),[15] formerly professor of psychiatry at UCLA, was also a great advocate for the formation of the Society. In an article that addressed this urgent need for subspecialty training, he admitted candidly that understanding the psycho-social and cultural dimensions of addictive behaviors was definitely indispensable, but he considered the biological approach a necessary method:

> We are more than ever stricken by a need for reaching consensus, developing practical guidelines and evaluation standards, and promoting clinical long-term follow-up, individualized medicine, and cost-effective evaluation research. These efforts will make our practice satisfy the standards of evidence-based medicine. At the same time, we should actively seek to cooperate with basic scientists to improve our understanding about a wider array of addiction-related phenomena. (Lin 2007: 353)

[15] As NHRI was modeled on NIH, the Division of Mental Health and Drug Abuse was established as a Taiwanese version of NIMH. Dr. Lin was the one who invited me to his panel that drafted the health prospectus. See also note 12.

The first task of this new organization was to train selected psychiatrists as certified addiction specialists. It was called the Taiwanese Addiction Fellowship Training Program, abbreviated as TAFT (Lin 2007). This proposal for addiction subspecialty training soon attracted many bench scientists as well as clinicians who wanted to contribute their respective expertise. The three-year training curriculum covers clinical and research concerns, ranging from epidemiological knowledge, clinical assessment tools, pharmacological and psychosocial interventions, social and policy analyses, genetic studies and laboratory methods. The initial training course began on October 20, 2008, with 13 trainee psychiatrists (Chen 2008).

The scope of addiction medicine is, however, not limited to basic, clinical and social sciences. For some addiction specialists like Dr. Tang Xinbei (Chianan Psychiatric Center), this burgeoning discipline should be capable of stepping out of the clinic and establishing essential alliances with legal institutions. In many ways, addiction medicine is close to forensic psychiatry because most, if not all, addictive substances are under strict state surveillance and addiction specialists will have to work with legal agencies from time to time. For example, Dr. Tang and Chu Chao-Liang, then Chief Prosecutor of Tainan District Prosecutors Office, worked out a plan together. This plan of "postponed prosecution" was to appropriate part of the Office's penalty funds for the biological and psychosocial treatments of arrested drug users. These arrested individuals had to agree to comply with the treatments well enough to be eligible for their postponed prosecution (Tainan District Prosecutors Office 2006). Quite to their satisfaction, the treatment outcome was proven superior to that of self-motivated treatment seekers (Tang 2008). This intimate collaboration between psychiatry and the law successfully led to the later forma-

lized codification of “postponed prosecution” as a policy for treating recidivist heroin addicts when they were arrested for the second time (see also Chapter Three). By transgressing original disciplinary boundaries and associating with more potential allies, addiction medicine was becoming a multi-faceted interface between basic research, psychiatric medicine, legal regulation, policy design, and targeted drug users.

In addition, addiction specialists were not satisfied with the current treatment in which methadone was the only medication available. In order to address different patient needs and advance the profession, they needed to have more treatment options. As mentioned, Suboxone® was not favored as the officially adopted treatment because of its comparatively steep price. However, it still tried to make its way into the market by its pharmaceutical producer, Reckitt Benckiser Pharmaceuticals. I attended some conferences where the advantages of Suboxone® were especially highlighted. The invited speakers claimed it had a better safety profile and greater convenience of use which made it a superior choice despite its high price. As a result, Dr. Lin Shi-Gu was quite optimistic about its use in the future. “Considering the limited number of places that distribute methadone, people often spend lots of time and money everyday getting to the hospital just for a sip [of methadone]. I think some people will want to shift to Suboxone® even if it costs more, because time is money and they do not have to come to the hospital everyday. Once they are stabilized on Suboxone®, they will feel it worthwhile.”

Viewed analytically, this comment is obviously based upon the premise that these drug users are neoliberal subjects who make choices with an economic rationality. In contrast with the inexpensive but government-offered methadone, Suboxone® caters more suitably to those *homo economicus* who value liberty and autonomy more than any-

thing else and who can afford it. As of this writing, it is said that the license for the dispensing of Suboxone® is forthcoming. In addition, Dr. Su agrees with me that there will be a stratification phenomenon among drug users: Those who are able and willing to pay for Suboxone® may get a multi-day supply at the clinic and take it home. In contrast, those who cannot or will not pay for it must go to the hospital for methadone every day, rain or shine. He sees no problem in this prospect, I speculate, because pharmaceutical pluralism seems most compatible with the "liberal society." Moreover, addiction per se is excluded from the current National Health Insurance in Taiwan even though addiction-induced illnesses are covered. Thus, the introduction of Suboxone® means a new market outside the National Health Insurance, which has been rather shaky lately due to a serious financial strain on the program.

However, not every addiction specialist jumped onto the specialty bandwagon on purpose. Some just wandered into this field accidentally and even somewhat reluctantly, at least initially. Dr. Chou Sung-Yuan, the psychiatrist who created the computerized system for user registration in the methadone maintenance program, entered this field completely by chance. He recounted this participation process as a detour in his career path. As a young attending psychiatrist, he was initially determined to specialize in forensic psychiatry. However, when the institution he was working for, Taoyuan Psychiatric Center, was designated as one of the lead hospitals in drug maintenance treatment, the organization requirements of the new designation fell into his lap. "At first everyone was scared," he remembered. Fear and resistance seemed to be the initial response of the psychiatrists there as drug users were definitely not their favorite patients. They were afraid the new obligation would cause unwanted changes in the already overloaded clinical

work. In addition, this measure would very likely turn the already packed outpatient department into a battle zone where drug dealing, shooting drugs and other illicit conduct might occur.

These fears were not groundless. As the pilot program expanded into a full-scale program, the registered drug users at the Taoyuan Psychiatric Center multiplied in a very short time. At present, the Center serves over one thousand users per day. Drug dealers soon noticed this. They came there to conduct their business, seeking potential customers. Subsequently, the police came along too in search of any and every sign of probable criminal activity. The hassle from both drug dealers and police officers bothered the hospital staff so much that the hospital asked for help from the local Bureau of Health, which in turned reported the problem to the CDC. In the end, the Department of Police Affairs finally issued an administrative order demanding local policemen not to execute "searches without targets" near these methadone clinics.

Trouble aside, this whole process of setting up methadone clinics was an important eye-opening experience for everyone involved. For example, the Bureau of Health in Taoyuan County turned to Taiwan Urbani Foundation for financial sponsorship to make their educational tour to Hong Kong possible. Dr. Chou joined that tour too, and he found the experience comforting. "Actually the main effect was to lower our anxiety….And we asked for many forms and charts from them. We transplanted them all."

Yet, the transplantation of knowledge, experience and structure was certainly not complete, as I have implied. Nonetheless, I will leave this issue for Chapter Six. In the rest of this chapter, I will dwell on the self-making process of certain addiction specialists like Dr. Chou.

I have found from my interviews that these self-made addiction specialists had several things in common: They were relatively young attending psychiatrists who, because of their lower rank in the hospital hierarchy, were appointed to take charge of this new task given that no senior psychiatrists wanted to do so. Unlike Drs. Lin and Su, they needed to leave behind their previous professional interests to start the new job. Most of them were fraught with uncertainty as they began with almost nothing. Creativity and innovation would be their cherished assets. For example, Dr. Chou's talent in computer science not only led to his design of the foundation for the later nationalized registration system but also established a valuable database that accumulated reliable information for further study. He was later awarded for his devotion to harm reduction and invited to give lectures on various occasions. Dr. Huang Cheng-Yi, another young psychiatrist who works in the Bali Psychiatric Center, followed a similar trajectory. They had to learn textbook knowledge by themselves and experiment with specific know-how on the first patients who came to the clinic, and their main official reference was a translated methadone prescription guideline distributed by the CDC.

But the clinical guideline does not give clear instructions as to how methadone should be dispensed administratively given the practical limits of time and space. Most of what they really needed was local knowledge and embodied experience: Should methadone be offered 24-7? How do we design the clinics to make sure personnel safety will be maintained? How does the clinic prevent diversion, that is, smuggling and distributing legitimately offered methadone for illegitimate street use? Problems have to be worked out one by one, and the solutions must depend on the limitations of each locale. Contrary to the rigidity of formal rule and codified law, clinical practice is quite flexible and some-

times improvisational. Initially, due to some infrastructural limitations, methadone was offered during office hours only, that is, from 9 a.m. to 5 p.m. However, many drug users complained that the hours were not good because their jobs would not allow them to visit the clinics. As a result, the hours were extended. In some places, a 24-hour service became possible as the dispensary was simply located in the emergency room. Furthermore, there was a need for a standardized procedure that everyone takes the methadone syrup properly so as to prevent diversion. From what I saw in the field, drug users would first be identified by their fingerprints, or, amazingly in some places, by iris scanning. Then they were asked to mix the methadone syrup with a certain amount of water and drink it in front of the workers. Only after they opened their mouths and showed there was no residual medication could they leave the clinic. The entire process could take merely 30 seconds.

These young psychiatrists also mobilized the resources, financial and otherwise, of their own hospitals to provide better care for these drug users. Some even found this experience greatly rewarding, because the social and occupational effects of giving methadone to their "patients" were much more gratifying than their previous practice of treating, say, chronic psychotics, whose improvement was relatively slow and intangible. Regular conferences and seminars on harm reduction became the platform of knowledge for them to present their findings and learn from each others' experiences. It was, for many, more enticing professional work.

In some sense, their expertise is also a patchwork that takes its elements from formal textbooks, guideline manuals, published journals and more importantly, infrastructural limitations and adjustments. They also went through the processes of transgres-

sion and association, though in different ways, to become experts. Similar phenomena were found among other clinical practitioners such as case managers, social workers and clinical nurses. A senior case manager qua research staff member who used to be a clinical nurse, Ms. Chang Yung-Chiao, considered the experience of executing harm reduction transforming as it provided her with the opportunity to observe a culture that she otherwise would never have been able to see and to acquaint herself with people who she would never have been able to meet. For example, she mentioned her initial shocked response when she heard of drug users disclosing the illicit ways they obtained money—burglary, robbery, and even complicated acts of bank loan fraud. These harm reduction workers associated and coordinated with other personnel and administrative staff, dealing with the limited resources to maximize the effects of the harm reduction program. They stepped into a field not knowing what harm reduction was but walked out as experts. Just like the HIV professionals, they have eventually become members of a heterogeneous assemblage that constitutes an indispensable part of *the office*, an even larger assemblage.

4.5 Conclusion: Rethinking Expertization in Light of Policymaking

From Wave One to Wave Three, science and technology studies has contributed greatly to our understanding of technoscientific expertise vis-à-vis public decision-making. Some studies give descriptive accounts that refute the claimed features of scientific expertise in the face of uncertainty and indeterminacy which commonly characterize public affairs and policy decisions. Others suggest normative and prescriptive principles as to what constitutes a “good” scientific community or what a “good science” ought to

be. Both of the constructions do not seriously address the becoming process of expertise. All the debates take place as if expertise just existed "out there" from the start. They simply circle around issues of its legitimacy and competence to decide public affairs: Is scientific expertise allowed to enter the core of public decision-making and to what degree (i.e., the problems of legitimacy and extension according to Collins and Evans)? Here, however, I contend that considerations of expertization, so to speak, are integral to the legitimacy and extension of experts and expertise. This is especially true when relevant expertise of the new issue is murky and becoming.

"Becoming" is a catchphrase here. It addresses the ontological status of expertise and experts as an assemblage forming and un-forming in time and space. This reflects a perspective different from the notion of expertise as "already made," but it does not imply that expertise or experts of any kind are not real. Here I take a pragmatist stance and say they are real in their effects (Hacking 1983), but also that the realness of experts and expertise resides in the ways and forms that this assemblage takes shape or dissolves. While the effects of the assemblage become more prominent, its realness is more confirmed. It is not simply a politics of framing questions, as Wynne (1992) once argued, because these experts offer ways of framing harm reduction that are so diverse. As such, cooperation among them and with governmental officials is always filled with ruptures and discontent. In other words, the situation is closer to that of "cooperation without consensus" (Start 2005; Clarke and Star 2007). Nor is an expert a Pasteur-like proponent, as Latour (1988) depicted, enrolling and aligning other parties to accomplish and determine what is true and why it is true.

Instead, the whole picture is much messier because in the assemblage, people from different disciplines only agree on some facets of harm reduction and not on others. For example, some think HIV prevention is the primary goal while others think it is merely the starting point for everything from decriminalization of drug use to radical drug law/policy reform. Some suggest that provisions for methadone prescription should be given to general practitioners to improve accessibility but others contend this medication should be prescribed by specialists (read psychiatrists), at least for now. The ways people organize themselves differ too. As I have illustrated above, HIV professionals tend to empower themselves by associating with other specialists (e.g., HIV-friendly NGOs and practicing addiction specialists) or by representing directly or indirectly the target population of harm reduction (i.e., injection drug users). On the other hand, veteran addiction specialists pursue harm reduction to realize their dream of establishing a recognized subspecialty. Other novice-turned-expert addiction specialists familiarize themselves with the cultures of drug users, improve current systems and seek new niches of clinical practice. As they revise their notions of harm reduction and change their practices accordingly, the assemblage metamorphoses too. This can certainly be called a kind of boundary work (Gieryn 1999). But what is being assembled in this case is not the boundary that differentiates distinct disciplines, but the shifting territories along which the meaning and relevance of what one knows is in-/ex-cluded. In this assemblage marked by associating and transgressing, the constitutive components are exteriorized and interlinked by *guanxi*. In addition, for any given assemblage, the rhizomic connections are constantly challenged, the territories are always contested, and the elements within it shift between crystalization and dissolution (Deleuze and Guattari 1987).

This formulation also sheds some light on a remark frequently made by my interviewees. Once they knew I was working on the expert/expertise issue in policymaking, many people, even the experts themselves, would respond with an old Chinese saying, "The higher positions people occupy, the more powerful their knowledge is." (官大學問大; Guan da xuewun da) This seemingly cynical comment implies at least two things: First, expert knowledge, even if it possesses the secret of truth, may not be as influential as expected in policymaking. For example, administrative authority may sometimes override expert judgments that are based on scientific knowledge. The Chinese saying therefore represents a sense of resentment that scientific knowledge and opinions, regardless of their being neutral, objective and so on, are not generally appreciated as they should be. Similar statements can be seen in many scientists' works such as Gough (2003). Secondly, the saying also indicates the intertwined relationship between knowledge and power. In other words, the potency of knowledge is related to its political position, thus echoing Wynne's depiction (1992) of local farmers' discredited knowledge. Both views share a common theme that the honest broker image of knowledge in policymaking could be seriously flawed if the relation, power and status of the knowledge owner are not taken into account (Roelke Jr. 2007). Nevertheless, the pessimism inherent in this saying can be refuted by my findings that experts or expertise constitutes an assemblage, because the unstable and ever-changing territorialization of an assemblage indicates, as it were, an opportunity for the public to intervene. Collins and Evans' proposed classification therefore appears too rigid to be used in the case where experts are constantly facing the public. It is implied in their framework that contributory expertise and interactional expertise

are mutually exclusive, but this is not always true. In my case, experts like HIV professionals and addiction specialists can just be both.

One special feature of Taiwan's drug policy is that it always lacks the participation of advocacy groups for drug users. Considering the long-term suppression and stigmatization of drug use, it makes sense that no such groups exist. In the case of harm reduction, NGOs that used to advocate for HIV-infected individuals act as proxies for drug users. As HIV professionals in this case are all familiar with these NGOs (some of them even founded or ran these organizations), there is little wonder that they usually act as the spokespersons for drug users on the issue of HIV/AIDS. However, it is not that addiction specialists are not also doing this. They actually have had longer relationships with drug users within the settings of medical treatment. However, as their purposes of partaking in harm reduction policy are not fully congruent with the CDC's intentions, they pay more attention to the other aspects of drug users than the problem of HIV/AIDS per se. In addition, they make the most of the needs for harm reduction as an extension of their previous concern—to strengthen addiction medicine as a subspecialty that warrants more dedication and research as well as to expand the dominance of psychiatrists in a harsh environment made worse by the financially distressed national health insurance system.

To conclude, this chapter delves into the issues of experts and expertise formation. Following the theoretical framework of Deleuzean assemblages of which I made a case for *the office* in the previous chapter, I contend that experts along with their expertise themselves constitute an assemblage that is, as it were, subordinated to *the office*. To conceptualize the grouping of local experts of harm reduction as an assemblage but not a community is to stress aspects of its shifting boundaries, unstable composition, non-

uniform commitments, and varying cohesion. The ethos heralded by Merton is replaced by a set of values extolling the maximization of available resources and the aggrandizement of disciplinary impacts.

The moral economy of experts and expertise in their self-organization warrants scholarly attention not only in light of knowledge production (Kohler 1999) but also in terms of recent discussions on democracy and expertise (Reardon 2007; Thorpe 2008; Turner 2003, 2006). These discussions actually echo the major concern of the second wave of science studies as mentioned above. Even though the issue of democracy is beyond the scope of this chapter, their major concern is relevant: Why should we leave our deciding power to experts if a democratic society should make its major decision based on the opinion of the majority? Although Wave Two of science studies exposes the yoking of power and truth in the domination of expert knowledge over lay knowledge, there is little doubt that most public decisions in modern society too often involve technical details or scientific disputes that common people simply cannot understand. We are left in a dilemma: We need experts, but we do not want them to take over everything.

Nonetheless, as I argued above, expert knowledge does not necessarily conflict with lay knowledge, and experts are not necessarily antithetical to lay people. Chances are they can collaborate and identity boundaries may leak. Instead, the formation of assemblages like *the office* or the expert/expertise cluster may be a way that more effectively foments a certain type of governmentality in or disciplinary impacts on the people involved.

Last, in contemplating the question of expertise and democracy, Stephen Turner (2006) posits the contestation and its resolution in the two vital values of democracy—

equality and neutrality. Recounting some STS studies such as Timmermans' work on CPR (Timmermans 1999), Collins and Pinch's opinion on public understanding of science (Collins and Pinch 1993), and Jasanoff's research on science and law (Jasanoff 1997), Turner (2006:180) insightfully asks, "But are the implications of these studies that expertise is ideological and therefore non-neutral? Or can they be taken differently?" Instead of discrediting expertise altogether or resorting to a new norm, he attempts to reconcile the questionable status of expertise by integrating the claims of constructivism and liberal democracy. Thus he argues in his *Liberal Democracy 3.0* (2003) that the cognitive authority of experts and expertise is itself that which is publicly agreed on. That is to say, it is subject to forces and processes of legitimization as well as de-legitimization.

Recalling Foucault's critiques of liberalism (see Chapter Three), we should note that the legitimization and de-legitimization processes are also part of the liberal governmentality that subjects and subjectivizes individuals, including scientific experts and drug users, at the same time (Foucault 2008). While certain experts and expertise are legitimized, drug users are at the same time confined by the definitions and actions of harm reduction that ensue. The assemblage of *the office*, including the one of experts/expertise, is also the assemblage where drug users are governed and disciplined. In the following chapter, I will portray how drug users were treated differently from the perspective of citizenship when harm reduction policy was implemented.

Chapter Five

Governing Citizen Addicts

5.1 Introduction

While previous chapters dealt with the historical, organizational, and ethno-epistemic aspects of *the office* that constitute and produce harm reduction policy, this chapter seeks to characterize the citizenship of injection drug users (IDUs). IDUs are often implicated in policy design but seldom if ever have the chance to speak for themselves. Nor does harm reduction de-stigmatize them but rather subjugates them to new webs of surveillance by making them distinctively visible and governable in methadone clinics (Bourgois 2000) and needle-distributing sites (Strathdee et al. 1997). However, drug users are not entirely reluctant, passive, or suffering subjects. On the contrary, many of them benefit from the program and feel better about themselves. According to Tang Xinbei (2008), preliminary statistics from Chianan Psychiatric Hospital showed that the employment rate increased from 32% before the intervention to approximately 70% after the intervention. The subjective reports of participating drug users also revealed high satisfaction rates in family relations, physical conditions, and occupational performance.

For this reason, following the suggestions of Fischer and his colleagues (2004), I discard a simple dominator/dominated dichotomy and argue that harm reduction measures should be conceptualized as various forms of governmentality. I contend that harm reduction helps to foster a manner of minding one's own conduct which is conducive to a

neoliberal morality with its emphases on autonomy, liberty, and responsibility, among other values. In the case of harm reduction policy, we can see vividly the transactional nature of this governmentality. That is to say, by conducting themselves in desired ways, drug users are entitled to the benefits of harm reduction policy. In a nutshell, what is expected to result on the individual level is a specific technology of the self that embodies neoliberal values. Those who comply with the policy are seen as having a citizenship that entails new entitlements and responsibilities, and those who do not comply, either because they drop out or never drop in, still contribute by making this citizenship viable. The fact that some drug users are absent from harm reduction programs does not mean they are irrelevant. On the contrary, as we shall see, those non-compliant, unruly drug users are still accountable for the success of the harm reduction policy in Taiwan.

This chapter is organized both thematically and chronologically. It is based upon my field observations from July 2007 to January 2009. For the sake of descriptive clarity and theoretical elaboration, it is divided into two sections. The first part deals with changes in the ways that these drug users were treated and understood. An episode of legal commutation in July 2007 is presented as a revealing test for both the harm reduction policy and the pardoned drug users. From that description I theorize the making of citizen addicts by stressing the intricate intertwining of many techniques and interactions that shape their potentially renewed socio-political membership. In addition, along with the rise of this new citizenship came the decline of detoxification regimens and altered physician-patient dyads. By illuminating this dimension I intend to point out that the transformation of drug users' citizenship does not occur *ex nihilo.* It takes place at the same time that certain practices, skills and interactions diminish and/or emerge.

The second part of the chapter addresses the theoretical implications of changing citizenship. I argue that the recent analytic emphasis on citizenship supplements Foucault's biopolitics discourses. On the one hand, it completes Foucault's shift of analytic focus from the state to government by depicting power, which is in his view relational and capillary, as a way of organizing that bears institutional impact. On the other, it enriches the last lecture of *The Birth of Biopolitics* (2008) in which Foucault tackled the long-held antagonism of political society and civil society by focusing on the perspective of government in a liberalism-informed era (i.e., from the eighteenth century onward). Civil society, he argued, is not a concept or entity intrinsically antagonistic to the state. On the contrary, civil society became possible when governments took up liberalism and decided to arrange things in a "natural", market-oriented way. Foucault further elaborated,

> Civil society is, I believe, a concept of governmental technology, or rather, it is the correlate of a technology of government the rational measure of which must be juridically pegged to an economy understood as process of production and exchange….An omnipresent government, a government which nothing escapes, a government that conforms to the rules of right, and a government which nevertheless respects the specificity of the economy, will be a government that manages civil society, the nation, society, the social (Foucault 2008: 296)

On the same page he explained the inseparability of *homo economicus* and civil society,

> Homo œconomicus and civil society are therefore two inseparable elements. Homo œconomicus is, if you like, the abstract, ideal, purely economic point that inhabits the dense, full, and complex reality of civil society. Or alternatively, civil society is the concrete ensemble within which these ideal points, economic men, must be placed so that they can be appropriately managed. So, homo œconomicus

> and civil society belong to the same ensemble of the technology of liberal governmentality (Foucault 2008: 296)

From this perspective, citizenship, a modern form of socio-political membership that entails not only entitlements and rights but also duties and responsibilities, becomes part of the technology of government. Entangled in power struggle and identity pursuit (Tilly 1995), citizenship is not indicative of a spontaneous evolution of human society (Marshall [1950]1992), nor is it a victory of civil society over political society, or the state.

Bryan Turner (1990) urged his readers to return to T.H. Marshall, a British sociologist who first proposed a theory of modern citizenship. In the now classic essay, *Citizenship and Social Class* ([1950]1992), Marshall distinguished three types or dimensions of citizenship—civil, political and social, the last of which was quite an original concept at the time. He described the acquisition of citizenship as a serially staged process, in which the formations of civil, political and social citizenship were assigned to the eighteenth, nineteenth, and twentieth century, respectively.

Turner (1990) suggested that Marshall's discourses on citizenship were greatly inspired by liberal thinkers such as J.S. Mill, and his discourses were intended to address a major problem in capitalist society. In Turner's exegesis,

> At the heart of Marshall's account of citizenship lies the contradiction between the formal political equality of the franchise and the persistence of extensive social and economic inequality….Marshall proposed the extension of citizenship [i.e., social citizenship] as the principal political means for resolving, or at least containing, those contradictions. (Turner 1990: 191)

Although this Marshall perspective was seriously criticized, his ideas partly formed the theoretical foundation for later welfare states (Turner 1900, 1997) because citizenship implied what the state should offer its citizenry. However, it is important in terms of my current study and Foucault's biopolitics discourses because citizenship acquisition also represents readjusted (bio-)power relations between the government and its people. Thus I contend that the theoretical integration of citizenship and biopolitics may offer immense insight into the working of contemporary biopower, such as new forms of biosocialities, ethical techniques of the self, and renewed strategies of governance.

This governmentality perspective also informs a more sophisticated view of power that defies a simple "state versus people" relation and turns to those amorphous power maneuvers outside state politics. In this regard, I contend, the concept of citizenship better suits the analytic purpose of understanding how people live and legitimize their lives as members of certain socio-political groups. It is not without recent precedent to find new ways of organizing people. For example, Paul Rabinow (1996, 2007b) put forward the idea of biosociality. Moreover, such concepts as genetic, therapeutic and biological citizenship share the same analytic edge in illuminating how biopower works between individuals and collectives through biomedical developments and technologies (Miller and Rose 2008; Nguyen 2005; Ong 1999; Petryna 2002; Rose 2007b; Rose and Novas 2005). What matters, then, in this perspective is how (bio-)power is played out in the ways that people interact with each other. It directs the focus of analysis from concrete institutions to dynamic interactions, from centered proponents to decentered assemblages, from fixed arenas to amorphous and transitory problem-spaces (Collier and Ong 2005).

Citizenship issues for drug users particularly concern representation and practice. In the following discussion I attempt to embed the making of citizen addicts in the specific temporalities and spatialities that contribute to the configuration of drug users' conditional citizenship. The term *citizen addicts* is adopted here to refer to their double-bind situation: They are given certain entitlements and rights insofar as they are considered dangerous addicts. That is, this new citizenship is both cause and effect of their stigmatization. Certain factors are highlighted here as contributing to the conditions of possibility for the formation of this new citizenship.

5.2 Diminished Old Practice, Emerging New Conduct

A series of findings appeared in my field work from the outset. In July 2007, I started field observation at Ju Shan Hospital, a site where I used to work that offered detoxification treatment to hundreds of drug users from Taipei and Taoyuan. I was immediately surprised to note the rapid decrease in numbers of its visiting drug users. As a rural psychiatric institute designed mostly for chronic psychotic patients, Ju Shan Hospital's outpatient clinic was not a busy one, but there were always intravenous heroin users, usually a dozen a day and sometimes more, who came to ask for "detox meds." Diversion of these meds to those who were not adequately assessed was often seen although it was also routinely discouraged.

For heroin detoxification, the typical regimen often consists of two major components, tramadol and clonidine, along with many supplements. Tramadol has been used clinically as a painkiller for decades. Its pharmacological properties are not well unders-

tood, but the fact that it involves opioid receptors makes it a proper substitute to relieve discomfort during opiate withdrawal. For this reason, it was widely used in abstinence settings in Taiwan although its importance in treating opiate withdrawal was not valued in the US until very recently (Tamaskar et al. 2003; Threlkeld et al. 2006). On the other hand, clonidine, originally used as a centrally acting anti-hypertensive medication, has been repeatedly demonstrated to be an effective anti-craving agent that relieves withdrawal symptoms (Fishbain et al. 1993). The rest of the regimen consists of supplementary medications for associated symptoms of heroin withdrawal: runny nose, diarrhea, goose bumps (piloerection), and joint soreness, to name a few.

The regimen works quite well, but acute detoxification does not equal sustained remission. Without adequate care to prolong the drug-free period, drug users just relapsed and came in again and again. If a drug user failed to show up for some time, he was either dead or imprisoned. Providing detox services thus became a frustrating job, but it would be called a prototype of harm reduction because it did help to decrease the chance of transmitting diseases by injecting drugs.

Considering the large number of drug users that Ju Shan hospital once served, I could not help asking, “Where have all the users gone?” As time went by, I gradually found out from my field work that most of those drug users previously seeking detox treatment had probably shifted to the methadone maintenance program. However, there were still a few who came for detox meds. When asked why they came, they either expressed their dislike for the idea of maintenance or admitted their fear that the withdrawal from methadone would last longer. One thing they all agreed on, though, was that the me-

thadone maintenance program indeed offered an inexpensive choice for managing addiction, as shown below:

METHADONE: around 30 NTD a day, or 1 USD a day.
DETOX REGIMEN: 300 to 400 NTD a day, or 10 to 15 USD a day.
HEROIN: 3000 to 10000 NTD a day, or 100 USD to 300USD a day.
(NTD: New Taiwan Dollars. USD: American dollars.)[16]

The ratio of their daily self-paid expenses for drugs or meds alone can be roughly expressed as 1:10:100. Methadone is obviously a choice that saved money, but its use in clinical settings can be tricky. In a CDC-distributed prescription manual translated from an Australian guideline (see Chapter Six), methadone is defined as an agent with both maintenance and detoxification purposes. That is, it may be tapered step by step for the sake of detox, or it may be used as a life-long maintenance medication.

The different options might not be revealed to the help-seeking user in the beginning. As Dr. Chou Sung-Yuan told me, he tended to avoid the explanation and just recommend drug users take methadone for several months before they considered tapering it. Certainly, there was no guarantee that everyone could get off the hook, but the hope of getting clean, however remote and slim, was always there.

[16] These estimates are based on my own clinical experience and interview data. In Taiwan, methadone is distributed for free by the government, so drug users only have to pay a "service fee," which ranges from 20 to 50 NTD depending on the administrative policy of each hospital. The price estimate for daily detox meds is based on the practice of Ju Shan Hospital. The estimated price of daily heroin use is based upon my clinical experience and also that of Lin (2004). Most visiting heroin users spend 3000 to 5000 NTD, sometimes up to 10000 NTD a day for their consumption of heroin. The high cost of using heroin distinguishes them from the IDUs in the US where heroin is sold in bags with relatively cheap prices.

However, some drug users from Ju Shan Hospital who preferred to take detox meds told me that occasionally the withdrawal symptoms from methadone were stronger and lasted longer than heroin withdrawal. Methadone could make it even harder for people to get opiates out of their systems even if they wanted to. The expectations that people bring into the program when they receive methadone have not been fully studied, but a clinical psychiatrist-researcher, Dr. Wang Sheng-Chang, told me that the enrollment criteria for methadone maintenance were sometimes simply too loose. Ideally, maintenance treatment should be reserved only for those who have met the defining criteria for opioid dependence in DSM-IV and who have failed several times in previous detox trials. As methadone use is becoming more prevalent, heroin users who never tried detox are being included in the program. The new option of methadone maintenance treatment (MMT) soon divided heroin injectors into two kinds—those who participated in the program and those who did not. Given the fact that people might have to take methadone for life, this indiscriminate treatment of giving methadone suppressed the "traditional" way of practicing detox and the pharmacological knowledge behind it. In fact, MMT eliminated private detox centers that were mostly scattered and unregulated, unifying the available treatment by lowering drug-related expenditure. In short, MMT encouraged heroin injectors to visit officially recognized venues where they could be seen and monitored. In these places they received not only an ID check and a physical examination, but also a long list of "must-know" information. The information read like a pamphlet for re-education about adequate conduct in the program. For example, the informed consent form for methadone maintenance treatment from the Taoyuan Psychiatric Center (2007) included the following (all emphases are mine):

> [3. Content:]….You should go to the hospital everyday and take methadone as prescribed by the physician. Your absence means you voluntarily give up your rights. Your medication is given by your case manager and has to be taken immediately right there. You cannot take it away from the site of treatment, where camera recording operates all the time….
> You need to visit the physician periodically and obtain your prescription from him/her so as to continue your eligibility for methadone….Also, urine screening is mandatory for every physician visit….
> If you are absent without informing us beforehand, our case manager will contact you by phone first. If your absence persists longer than four weeks, our hospital will discontinue your treatment plan. (Taoyuan Psychiatric Center 2007, not paginated)

Obviously, with free methadone and inexpensive medical care came a long list of responsibilities. In addition, while some regulations were designed for both patient safety and management convenience, they read more like some kind of warning. For example:

> Your information collected by our hospital will be kept in paper and electronic forms. It will also be uploaded to the Department of Health as demanded. People who take methadone in two different hospitals will be excluded. (Taoyuan Psychiatric Center 2007, not paginated. Emphasis added)

Methadone users were asked to apply for medical records transfer if they wish to travel or move elsewhere, and this procedure could be difficult because of the limited service capacity of the receiving institute and the time-consuming paperwork. According to an anonymous psychiatrist, this management style echoed the fear of other psychiatrists because from the outset they felt methadone was merely a chemical "dog leash" for drug users. In fact, their liberty of movement was limited by both methadone and the inconvenient transfer system. Nevertheless, we must consider that perhaps this undesired effect on drug users was the desired effect for policymakers. A retired parole officer who served hundreds of drug users in the postponed prosecution system (see Chapter Four)

speculated that the pharmacological effects of methadone made it a perfect med because users usually had to take it once a day. And, as Dr. Chou told me, even the syrup form of methadone served the purpose of control because it made oral cavity inspection easier. The possibility of diversion was then minimized because users simply could not "save" a mouthful of liquid easily.

Furthermore, the surveillance of conduct resides not only in paperwork and drug forms, it is physically everywhere, including, for example, fingerprint identification machines and iris scanning techniques, along with the cameras used in the drug dispensary. However, things can be very different in different places, and the spatial arrangements may have distinct shaping effects upon drug-using individuals (Fischer et al. 2004; Measham 2004). Every methadone clinic is in fact an example of heterotopia, à la Foucault, which serves unexpected but often multiple purposes (Foucault [1967]1998).

Figure 5-1 A fingerprint machine in a methadone clinic (Chunghe City Clinic, Bali Psychiatric Center), located next to the registration desk. Not all places use the same type of machine, and not all sites design their settings like this one. The instructions on the sign beside the machine read: "1) Enter your 4-digit code of methadone use and 2) then submit your fingerprint for identification. Thank you." (Photographed by the author)

5.3 Why Is Harm Reduction Effective?

Even though they showed up in methadone clinics or NSP sites, these citizen addicts had mostly been invisible to the public because most were incarcerated or hidden. But as time went by, something changed. On July 16, 2007, almost ten thousand prisoners were pardoned and released due to a recently passed commutation act that commemorated the twentieth anniversary of the abolishment of martial law in Taiwan and the sixtieth anniversary of the 228 event.[17] Despite its political underpinnings, the CDC interpreted this as a huge event for public health because most of the pardoned prisoners had committed petty crimes including illegal drug possession and drug use. Many of them tested HIV-positive (see below). Releasing so many HIV carriers back into an unprepared society could be devastating. Certain models have tried to calculate the possible risks of HIV/AIDS plus IDUs under similar circumstances (see Grassly and Garnett 2003 for discussion).

According to the statistics given by newspaper, more than half of the released prisoners on the first day of commutation were drug offenders and 6.7% of the released prisoners were HIV-positive.[18] If they were improperly managed, they could become dan-

[17] The 228 event is a historic moment that marks the blood-stained protest of Taiwanese people against an oppressive regime. It happened right after the Chinese Nationalist government (Kuomingtang, or KMT) retreated to Taiwan after it lost its sovereign power to the Chinese Communist Party. On the evening of February 27, 1947, armed KMT agents hurt a Taiwanese woman when they confiscated contraband cigarettes. Later a Taiwanese man was killed by the agents during the commotion. The act unfortunately spiraled into an island-wide protest after the KMT government resorted to armed force to suppress the angry crowd. On the afternoon of March 8, KMT troops from Nanjing arrived in Taiwan and a bloody "cleansing of the countryside" proceeded. It resulted in the deaths of 10,000 to 20,000 innocent Taiwanese, some of whom were renowned local elites. This event heralded subsequent political silence among Taiwanese people, the so-called "White Terror" period, which lasted until the abolishment of martial law in 1987. To commemorate this special event, the Taipei 228 Memorial Museum was established in 1997. For more details, please refer to http://228.culture.gov.tw/web/web-eng/228/228-1.htm

[18] Total pardoned prisoners on the first day: 9597; drug offenders: 4973; HIV-positive cases: 644 (*Taipei Times* 2007). According to the CDC statistics (2007b), the accumulated number of HIV-positive individuals

gerous sources of HIV transmission through sex with partners or prostitutes and/or through needle sharing. The CDC therefore prepared thousands of "care packages" for pardoned prisoners. Every package contained "a letter from Minister Hou Sheng-mou, condoms, hygiene utensils and a list of hospitals offering methadone programs and AIDS care" (Shan 2007). Yang Shi-Yang, then Director of the Third Division of the CDC, even wrote down the precautions in the form of a *chienshi* (temple poem) for those who were released to heighten their awareness of risky behaviors that may cause overdose or blood-borne infection. Despite all these efforts, two days after the commutation, four pardoned prisoners were arrested again for drug offenses and six were pronounced dead, most likely due to drug overdose (Chuang 2007). As public suspicion soared, President Chen Shui-bian urged tolerance for these people (Ko 2007). However, one week later, a National Taiwan University professor cycling in a riverside park was killed by a pardoned drug offender (Wang, Ko, and Mo 2007).

Even though the social impact of the commutation remained controversial, the most dreadful thing that the CDC worried about—another HIV outbreak—did not happen after all. It seemed as if the harm reduction measures that offered free methadone and syringes really worked. This also meant that the status of citizen addicts could be recognized because this "conditional citizenship" (Porter 1999) did in fact produce expected results. How it worked so successfully remained a mystery.

Although the CDC officially claimed the efficacy of its intervention, some treating physicians, such as Dr. Chou Sung-Yuan and Dr. Wang Sheng-Chang, questioned the cause and effect relationship of harm reduction and HIV containment. This issue also

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in Taiwan was 14246 by the end of July 2007, so the released HIV-positive prisoners constituted about 5 per cent of all HIV cases in Taiwan. .

concerned CDC officials because it was pivotal not just for scientific reasons but also for administrative purposes. According to the CDC statistics (see below; Figure 5-2), the incidence of HIV/AIDS was indeed declining after the implementation of harm reduction. At first glance, it was easy to draw a conclusion about the effectiveness of harm reduction, but these concerned people tried to carry their questions further: Was there any other factor that might also contribute to the decline? And, if harm reduction policy really worked, which of its measures worked best and how? These questions begged more in-depth consideration. First, the coverage rate of the harm reduction policy was relatively low. For example, Dr. Chou Sung-Yuan was quite reserved about the true effects of methadone substitution per se on HIV/AIDS control. He estimated the number of IDUs in the Taoyuan area at the time of interview (September 2007) was around 8000.[19] Of these 8000 IDUs, only 3000 at most had received some sort of assessment, let alone the number of users who actually received maintenance therapy. Anyhow, the real coverage rate was less than 50%. Even on a national level, among the estimated 60,000 to 80,000 IDUs, fewer than 10,000 were actually treated on a regular basis. A methadone coverage rate this low was unlikely to account for the rapid decrease in newfound HIV-positive cases (Figure 5-2).

[19] The estimate of real heroin users has always been a mystery, and I was curious how Dr. Chou got this number. He said that his estimate came from his colleague, Dr. Chiang Shu-Chuan. I wonder if he was referring to Dr. Chiang's study in 2002, which estimated 17713 drug users of all kinds in 2001, or 2.7% of the total population in Taoyuan County. The thesis also showed that the prevalence of heroin abuse was 0.48% in Taoyuan in 2001 (Chiang 2002).

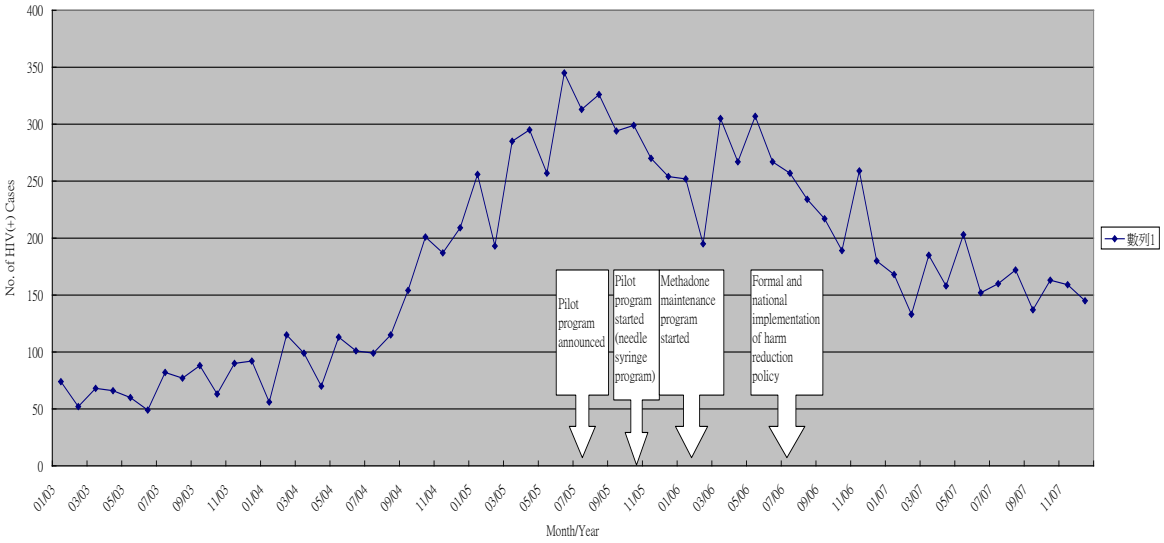

Figure 5-2 The number of monthly newfound HIV-positive cases from January 2003 to December 2007. Note the timing of major events of harm reduction. (Adapted from CDC, n.d)

More persuasive evidence of "reasonable doubt" was the curve change of HIV incidence in relation to the major events in the implementation of harm reduction policy, shown in Figure 5-2. Here we can see that the monthly incidence of HIV decreased about the same time, namely August 2005, when it was announced that the pilot harm reduction programs would be implemented in Taipei City, Taipei County, Taoyuan County, and Tainan County. The incidence curve inverted downward after that time and stabilized at around 150 cases per month by the end of 2007. An epidemiological question immediately arises: Why did the number of new HIV cases drop when the government *announced* its determination to implement harm reduction? The drop simply could not be attributed to any realized harm reduction measures (i.e., MMT and NSP) because at this time no such measures existed. Instead, either the infection reached a state of saturation where it had already infected all those who shared contaminated needles or practiced unsafe sex,

or something else about drug users or use did change, given the same social and administrative conditions (e.g., HIV screening remaining the same).

Many people I interviewed recognized this enigma. Most agreed, though without much solid proof, that the governmental announcement of harm reduction policy itself propagandized the dangerousness of shared injection and the necessity of using clean paraphernalia. They believed that this information mattered more than anything in transmitting the message that one should start taking care of oneself by adopting a new and clean manner of drug use. In other words, this announcement was itself an act of health education, Dr. Chou reminded me. From his own experience, methadone was, in a manner of speaking, a channel for drug users to realize how risky their behaviors had been and how they could live more safely by changing them. After all, not all methadone users stopped using heroin. According to Dr. Tang Xinbei (2008), about one third of them kept on using heroin, only to a lesser extent or frequency. Deputy Magistrate Yen Chun-Zuo of Tainan County put it in a more straightforward way, “Once the word is out, the effect is there before anything gets done.”

5.4 The Making of Citizen Addicts

However, drug users learned to behave not only from MMT but also from their encounters with the needle syringe program (NSP) sites. These sites were also major places where citizen addicts could enjoy free entitlements without worrying about the risk of arrest. An anonymous CDC officer told me that around 200,000 needles and syringes were distributed per month, and the return rates at different sites were around 40 to 60 %.

The budget confirmed her statement. By the end of 2007, there had been 3.93 million needles/syringes distributed nation-wide and the return rate was around 53% (Centers for Disease Control 2007: 89). The distribution points expanded from pharmacies to health stations, convenience stores and health examination centers.[20] However, people (even pharmacy owners themselves) told me that many pharmacies actually sold the needles they received from the CDC to visiting drug users rather than distributing them for free. In addition, sporadic cases of injury due to randomly discarded needles were noted. In a word, the NSP left much to be desired.

In January, 2008, I visited a pharmacist enthused about promoting NSP. I wrote in my field note:

> Ms. X (who prefers to be anonymous) is a short, plump female in her late fifties, and she's been running this local pharmacy for three decades. She says it [participating in the needle syringe program] is totally out of a desire to re-pay society after 30 years of service….Her pharmacy is 8 or 9 Pings large [about 300 square feet]. Beside the small passageway from the gate to the counter are closets filled with medications, sanitary products and medical equipment. The whole space is packed and somewhat dim, which is typical of "traditional" drugstores in my memory.[21] "I run a community drugstore and I treat them as if I was an auntie next door," she said.
>
> Ms. X has always been active in the local pharmacist association. When she knew there would be a needle syringe program for the ever-increasing HIV/AIDS cases, she volunteered. "On the one hand, I learned from many training courses that HIV/AIDS was such a serious problem and on the other hand, around that time, I noted on several occasions used needles on the play-ground where I jog everyday," she recalls.

[20] Health examination centers offer facilities for medical examination such as blood counts and chemistry, urine and stool screening, and so on. Run by non-physicians, they either offer self-paid services or they collaborate with private practitioners.

[21] I wrote this because there have been more and more modernized chain drugstores in Taiwan that are quite similar to CVS and Walgreens in the US. Ms. X obviously ran her pharmacy in an old-fashioned way. Most NSP-supporting pharmacies belong to this "traditional" type.

> In the beginning it was not easy to win drug users' trust as they were often guarded. "They just come and go and grab the needles, never willing to stop for a second." She thought that it was useless if she could not offer them health education and treatment information, so she decided to place the needles and syringes right at the end of the passageway rather than outside the door. The return box is placed on the right of the distribution box. Her intention is all too apparent: If drug users need to get them, they need to walk through the door and pass by the counter. Then maybe she can say something to them.
>
> She continues introducing me to her findings of optimization: You always keep 5 to 10 needle-syringes in the box for take-out. If there are too many, the free needles and syringes will run out soon. If too few, then they will come back shortly. The free needles are distinct from those used by ics.[22]….This difference in some sense helps her distinguish needles for sale from needles for distribution. I ask, "What about the return rate?" "Not much, about 50 to 60 per cent, in my estimate. These users are still afraid to walk around carrying used needles," she answers and grins.
>
> She is interested in observing those who come to take, and sometimes exchange, needles. A gross estimate of her "customers" is ten to thirty persons per day, mostly young males. But more and more middle-aged men and women dressed fashionably appear in her pharmacy these days. The winter is usually the "bad season", because it is around the advent of Lunar New Year when the police routinely need good arrest records and most drug users just hide out.
>
> "I am not looking for material gain, and I hope there will be vendor machines. Thus I do not need to organize my space like this anymore." She points to the camera monitor on the corner of the room. She set this up after the last burglary. Over the past two months she has been burglarized and robbed twice. (Field note, 01/16/2008)

This vignette, along with the above discussion, points to an often neglected dimension of harm reduction—health education, or in more official terminology, information, education and communication (IEC).

Two points are worth mentioning. First, a recent review (Aggleton, Jenkins, and Malcolm 2005) has shown that IEC alone is rarely effective, a fact well known to HIV

[22] The differences are discussed in Chapter Three. It is actually Ms. X who reminded me for the first time of the importance of getting the right tools for the job (Clarke and Fujimura 1992). I thus thank her for this insight that even she does not recognize as a kind of "expertise".

professionals and addiction specialists. However, as the authors pointed out and many of my interviewees did as well, the effects of health education are greatest when it is combined with other harm reduction measures. As a result, even though MMT and NSP may serve only a limited portion of drug users, they play an indispensable part in the achievement of disease control. In the words of Yang Shi-Yang and Tsai Shufen, two ex-directors of the CDC, it is a "platform" on which many other agendas can play out. These agendas may on the one hand include globalization imaginaries, discussed in the next chapter, and on the other, they may provide drug users with a condition of possibility to know more about themselves and know more about how they ought to behave.

This leads to the second point. As I have shown above, the tremendous decline in HIV incidence implies that either a great number of drug users changed their risky behaviors or the population of drug users had been saturated by HIV. Given the absence of ethnographic or behavioral studies of drug users in Taiwan, it is hard to determine which is more likely, even though the CDC, quite understandably, prefers the former possibility. Regardless, it is equally undeniable that drug users were given more opportunities to choose their ways of living. They were entitled to things that they never had had a chance to have, even at the expense of the newly added responsibility to make themselves less dangerous to the public and more productive to society. The so-called IEC in this case refers to both the cause and effect of a novel social citizenship. It delivers knowledge and equipment to a specific population as a form of social right, but at the same time it also indoctrinates this population to behave as responsible citizens. It not only produces the effects of equality provision in the Marshallian sense of citizenship, but it also constitutes a major step in the fashioning of desirable citizen addicts.

For harm reduction workers, drug users may be unruly, rebellious and offensive, but contrary to common belief, they are never uneducable criminals. Nonetheless, it took some time for CDC officials to learn this lesson. For them, the lives of drug users were initially a source of shock and dismay. They had thought the HIV patients they had been dealing with were marginalized enough. For example, a CDC interviewee told me,

> [T]hese IDUs have been neglected by our society for too long, and not until this [harm reduction] did I acquaint myself with these people….When we interviewed these people, [we found that] about one quarter of them reported that they were not covered by national health insurance….It is said that the coverage of our national health insurance is over 90%, but these people are just ignored. Resources are not invested in them. (Interview, 10/23/2008)

This long-term neglect and marginalization led to feelings of frustration not only among drug users but also among those who tried to approach and support them. A shared feeling among CDC workers who encountered IDUs was exhaustion. "It is not that I dislike them, but simply that it takes so much energy to *really know* them," one respondent told me (my emphasis). Another interviewee told me about a case she remembered clearly: "There was this 23-year-old girl with three kids—no one knows where they are now—and she was raped by her uncle at 18. I did not know how much I could help her, and she did not know either." Dr. Yang Chin-Hui, now Director of the Third Division of CDC recounted her past experience with HIV-infected IDUs and concluded, "They did not seem to really take care of their own lives."

Perhaps in an amorphous yet existent space of social abandonment, frustration and depression are often the rule (Biehl 2005). However, hope lurks even there. While the CDC workers feel frustrated and exhausted, some NGO workers see a positive light.

Take an anonymous interviewee of mine as an example. Her NGO association has been organizing group therapies for HIV-positive individuals, both for MSM and later IDUs. She took the unpredictability of drug users' behavior as a reasonable response to long-term deprivation of self-esteem and social recognition. But she did not lose faith in these people's rationality, even if theirs might not be congruent with traditional values of abstention. In her mind, harm reduction is the way these drug users can regain their sense of entitlement. For example, drug users used to be afraid to seek a job because of their feeling of inferiority. Life was simply a torture for them. Nonetheless they can now express in the group that, with the treatment of MMT, they can take time picking better heroin. "[They said] now it's enjoyment, not something you do because you need to." In her eyes, harm reduction policy offered these IDUs a reason not to abandon drug use, and even allow them to enjoy themselves. And they grabbed it.

Comparing the impressions of CDC workers and this interviewee, we are able to see the changes in citizen status over the course of policy implementation. Even though this policy was imposed upon them without much of their participation, IDUs came to grips with the opportunity. To survive the threats of HIV/AIDS, they were expected to become the active and interested entrepreneurs that American neoliberalism hopes for (Foucault 2008). In this sense, the way they were treated and the way they behaved were both transformed.

This is a significant move for drug users. They do fit the depictions of dangerous individuals of Michel Foucault (1978a). But instead of relentlessly subjecting them to public condemnation, incarceration or intensive re-education (Foucault 1978b), they are now allowed to live a certain way of life that fits the ideals of neoliberalism. Ideal drug users

have now become those who are hoped to be responsible, productive and autonomous — responsible for their meds supply by visiting hospitals everyday, productive in work, school, family and social activities, and autonomous in the sense that they opt for a more liberal and less expensive way of relieving their craving and satisfying their needs as heroin addicts. Dangerous as they were before, they are now bestowed with new social rights, such as free methadone, needles and syringes. But at the same time, they are also asked to take more responsibilities, including regular hospital visits and adherence to the treatment regimen. Further, the policy aims at addressing not only those who show up but also those who do not. The fact is all too easy to see: If MMT and NSP reached a limited number of IDUs, the claimed success of the harm reduction policy could be attributed only to the impacts of IEC on those IDUs who did not ever show up at the MMT or NSP sites but somehow obtained the knowledge through their networks and changed their behavior. As I have argued, IEC might better change risky behaviors in general if it was included with the other measures. In the end, all drug users, whether they were included in the program or not, participated in a government project that entailed a rearrangement of citizenship. Thus there emerged a new class of citizenry: citizen addicts.

5.5 Citizenship and Governmentality

The making of citizen addicts is on the one hand fashioned by the discourses of harm reduction, and on the other engineered by its disciplining interactions. In other words, drug users are made into citizen addicts by means of both words and deeds. Moreover, this citizenship entails not only rights and entitlements but also responsibilities

and duties (Barbalet 1988; Faulks 2000). However, from a Foucaultian perspective of government, this citizenship signifies a salient feature of neoliberal governmentality (Dean 1999; Foucault 2003b, 2007, 2008; Rose 1993, 1996, 2007a; Rose and Novas 2005). Specifically, drug users are treated as autonomous entrepreneurs even though they are subject to governmental surveillance. In place of the previous up-close forms of monitoring such as police interrogation or penitentiary incarceration, this new way of governing drug users is characterized by its physical flexibility and remoteness. In other words, they are subjected and subjectivized no longer by close surveillance but by freely distributed re-education and guidance from multiple local platforms that offer free medications and paraphernalia. As physical proximity is no longer mandatory for the government to have an impact on its governed individuals, this new method is aptly termed "governance at a distance" (Miller and Rose 2008: 16).

But how does this "conditional citizenship", an insightful term that Porter (1999) uses to refer to the transactional nature of citizenship, make sense in terms of this new policy? To be sure, the concept of citizenship has over and over again been highlighted, revised and problematized in social science literature. As I have noted earlier, T.H. Marshall's discourse of citizenship constituted the basis of discussion and criticism for later scholars. However, it was solely based on the history of British society, so its theoretical applicability was rather limited. Bryan Turner (Turner 1990, 1997, 2001) also astutely commented that the Marshallian conception presumes a uniform direction of evolution and therefore ignores the heterogeneity of citizenship formation. I agree with Turner and Porter in terms of this situatedness and conditionality of citizenship. As Keith Faulks (2000: 13) contends, citizenship should be seen as "a membership status, which contains

a package of rights, duties and obligations, and which implies equality, justice and autonomy." It reflects the end product of a wide array of local factors that over-determine its content and form, and it implies the identity formation of individuals that results from the acquisition of socio-political membership, as Marshall's original definition of citizenship suggests citizens' full participation (van Steenbergen 1994). This has been especially visible since the genesis of modern nation-states (Tilly 1995a). Charles Tilly (1995b) recognized the transactional nature of citizenship and classified it into two types, thin and thick, based on how many transactions were involved between the state and its people. He also suggested the differentiation of "passive" and "active" citizenship to indicate the level of activity that people demonstrated to earn their rights. In addition to top-down endowment by the government (so-called passive citizenship), citizenship can also be actively earned through engaging in interactions and struggles that involve multiple actors, human and nonhuman (Turner 1997).

In many ways the recently rekindled interest in the study of citizenship reflects dilemmas of globalization. The transnational flows of capital and labor on the one hand contribute to the birth of a new form of cosmopolitanism in which a person may frequently possess multiple and flexible citizenships (Ong 1999). On the other hand, it gives rise to increasing tensions in countries where new immigrants-turned-citizens pose serious threats to the original residents in terms of cultural incompatibilities, occupational opportunities and social rights (Kymlicka 2001). In short, many if not most contemporary disputes concerning citizenship arise out of this transformation of global political economy and the consequent blurring of national boundaries.

However, aside from global political economic changes that feature the age of "advanced liberalism" (Rose 1993), science and technology have also contributed to the elaboration of citizenship debates and become an indispensable part of it (Jasanoff 2005). It has been long discussed that biomedical knowledge may contribute to the formation of new forms of sociality, or biosociality usually based on diagnostic categories or biomedical classifications (Rabinow 1996). This idea has recently expanded in different guises to depict the refashioning of people's membership vis-à-vis the government or each other. For example, biomedical knowledge and resources have become a valuable leverage point on which new organizations for genetically- determined rare diseases fight for more rights in terms of treatment and benefits (Heath, Rapp, and Taussig 2004; Taussig, Rapp, and Heath 2005). In another case, the medical criteria for monetary compensation for the impact of a nuclear accident after the Chernobyl event turned into a point of convergence where medical practitioners work with diagnostic ambiguities and suffering patients claim their eligibility (Petryna 2002). In a third example, the citizenship disputes lie not in the knowledge domain but in the provision of therapy. The right to antiretroviral therapy for HIV infection has to be sought through organizations that can effectively argue for international recognition and the funding and medicines that follow (Nguyen 2005). The triggers for these citizenship issues imply the potential to reshape or reconfigure the ways that people are able to identify and organize themselves (Turner 1997). It also gives rise to a novel mode of government, multifarious as it may appear, in which citizenship refers to the norms and ranges of what Colin Gordon terms (1991:2) the "conduct of conduct." By this Gordon (1991:2) means "a form of activity aiming to shape, guide, or affect the conduct of some person or persons." At the same time, I argue, citizenship is the link be-

tween the technologies of the self and those of government (Foucault 1997). As Foucault's approach to political reason attempts to de-center the state by turning to an analysis of governmentality, it is quite understandable that citizenship, at least the Marshallian version, does not really enter his discussion. Indeed, the classic, Marshallian definition of citizenship is originally a concept based on the presupposed (and inherently classist) opposition of state and citizen (Marshall 1992). However, from Foucault's point of view, this antagonism is sterile, and the power struggle is better understood through the technologies and strategies of government. Moreover, as the *raison d'etat* no longer resided in the state itself but in the prosperity of its people, the resultant biopolitics emerged not because the men of rights in civil society stood against the state in political society with their claimed or codified citizenship. The opposition between the two is not a natural given because, in Foucault's opinion, even civil society itself is a fabricated "space." It is, instead, a transformation of governmentality that created, especially when liberalism was added to the rationality and technologies of government, a form of civil society as we know it today (Foucault 2008). If civil society is a manufactured idea informed by liberalism, then the citizenship that develops out of it should be seen as a co-evolving product of governmentalization. Thus, discussions around citizenship do not have to center on the state, as the state is no longer the only political community from or through which citizenship can claim its legitimacy (Barry, Osborne, and Rose 1996; Foucault 1991, 2000a, 2000b; Rose 1993). Take Nguyen's (2005) research in Côte d'Ivoire for example. In his study of therapeutic citizenship, the requests for more treatments and opportunities were not made to a given state but to the wider international philanthropic community. Notably, in the name of universal human rights, the absence of the state did not alter the iden-

tity and solidarity shaped by this citizenship (Turner 1997). It thus calls for a perspective not fixated on the state as the sole source of entitlements but rather attending to strategies, practices and maneuvers of power between government and citizens that rearrange rights and obligations.

5.5 The Double Bind of Citizen Addicts[23]

However, citizen addicts are still trapped in a double bind. They are given free needles and syringes because they are dangerous persons prone to transmit diseases. They are guaranteed more work opportunities and less expensive medical treatment but are subjected to more surveillance and less liberty at the same time. While they are no longer incarcerated as they used to be, they are still hooked or bounded—not just by now legal medications (i.e., methadone) but also by all the institutionalized ways of life.

The double-bind situations of citizen addicts are interwoven with their subjectivity, which can be illustrated in a few examples. To begin with, citizen addicts are certainly not a homogeneous group. Consequently, some addicts are worried that the implementation of harm reduction measures may be hampered or even halted by the misconduct of some of their cohort. Director Kuo showed me a hand-written letter from a drug user who was eager to offer his opinions about preventing drug dealing around methadone clinics. Expressing his appreciation for the program, he asked the CDC to pay "extra attention" to

[23] An earlier theory that tried to explain the pathogenesis of schizophrenia attributed the origin of this illness to the conflicting communications and emotional expressions among family members. The puzzled kid would withdraw into a psychotic state to escape from confusion and disorientation. The double-bind theory was forwarded in 1956 by Gregory Bateson and Donald Jackson, the former an anthropologist and the latter a psychiatrist (see Sodock 2007). However, the theory was unable to be validated by empirical studies. Now it is used only as a descriptive term. I adopt it here to indicate the immanent contradictions and controversies in the new yet no less perplexing citizenship that is endowed upon drug users.

how some clinics ran their businesses because their lack of adequate cooperation with the police might result in public safety concerns. These concerns, he feared, would lead to the cancellation of such services. His apprehension was not without grounds. During my fieldwork in the summer of 2008, I was told that some methadone clinics were about to close for various reasons: harassment of visiting drug users, objection from local neighborhoods, financial strain, and so on. The one in Chunghe City, run by the Bali Psychiatric Center, is an example. Located next to an elementary school in a relatively densely populated region, it was also the place where the letter's author received methadone. On the day of my visit, I saw drug users waiting in the clinic for their transfer documents and grunting their discontent and confusion. The clinic was located on the fourth and fifth floors of the local health station, very close to Chunghe City Hall. Thus the lingering drug users were actually mixed in with the common people in this vicinity who came for either business or health issues. Outside the gate of the neighboring elementary school were some casually dressed parents waiting for their children. They cast their fearful eyes upon the people coming in and out of the clinic, who might accidentally expose the tattoos on their arms or legs. It was in broad daylight, so I did not see any overt drug dealing or panhandling. However, tension did exist. My interviewee, Dr. Huang Cheng-Yi, worked there on that day. He told me that local representatives requested that the clinic be moved somewhere further away and less populated. It was a predictable NIMBY response,[24] but it was equally predictable that the availability and accessibility of the MMT service would be seriously jeopardized.

[24] NIMBY stands for "Not In My Back Yard". It has been used to describe a public dilemma where people do not want any potentially hazardous facilities located near them even though they admit these facilities are indispensable. For a US harm reduction example, see Davidson (2009: 239).

In this case, the drug user who wrote the letter was obviously aware of the dangerousness of his cohort, who might well get involved in drug dealing or other misconduct around methadone clinics. But he wanted to defend his entitlement to accessible MMT by offering his insider's tips for managing "dangerous individuals" (Foucault 1978a; Foucault 1978b). Given the limited but needed resources of MMT, he had to label, or "rat out," his cohort, along with himself, as legitimate subjects of government in order to get what he thought he deserved. Thus the double bind not only involves how drug users see others but also how they think of themselves. I was told of another example from NGO-organized group therapy sessions for HIV-positive drug users. When the participants were asked if drug users were supposed to take care of their own children, my interviewee was surprised to learn that their answer was unanimously negative.

In other cases of citizenship transformation, organizations play an important role. These organizations can be governmental, such as public medical units that decide the criteria for compensation (Petryna 2002), or they can be non-governmental or self-organized, such as patient advocacy groups or international humanitarian groups (Biehl 2007; Heath, Rapp, and Karen-Sue 2004; Novas and Rose 2000). A number of successful examples of self-organized groups of drug users that contribute to better design of safe environment have been documented (Inciadi and Harrison 2000; Kerr et al. 2006).

However, two salient features shape drug users' citizenship in Taiwan. First of all, there are no advocacy groups whatsoever in Taiwan. It is an understandable fact considering the historical trajectories of drug policy, as I have illustrated in Chapter Two, and Taiwan's socio-political development since 1945 (Roy 2003; also see note 17 on the 228 event). Obviously, drug users were too suppressed and stigmatized to organize them-

selves formally. They had neither the ideological support nor recognized interest to unite themselves. As can be seen even now, if they want to have their voices heard in public decision making, they either resort to the experts who are acquainted with them (see the previous chapter) or simply do it themselves (e.g., writing to the director of the CDC). The points of resistance, as a result, are dispersed.

Secondly, universal human rights have never become the theme of any governmental measures related to harm reduction. The lack of human rights discourse makes this citizenship a passive one, not an active one. In other countries, harm reduction may be seen as a humanitarian effort to provide drug users, often disfranchised and marginalized, with the equipment to improve their health and enhance the quality of their life (Inciadi and Harrison 2000; Wodak 2006). However, in Taiwan, the dominant rationale underlying harm reduction measures is simple—harm reduction is done not out of respect for drug users' human rights or concern for their well-being, but for reasons of public safety. Not unlike Quirion's (2003) observation of harm reduction policy in Canada, it can be a purely utilitarian and risk-based move that aims for the maximization of security, longevity and productivity. While human rights as a morally enabling discourse "matters" in other places, it simply does not sell in Taiwan, as Director Kuo told me.

The double-bind situation, the lack of advocacy organizations, and the utilitarian policy orientation constitute the major conditions of possibility for the forming citizenship of drug users. It is not earned, but more or less imposed. Moreover, it is a citizenship endowed conditionally, a citizenship realized in transaction again and again.

The transactional characteristic of this citizenship somewhat contradicts Foucault's portrayal of *homo juridicus* and *homo economicus* in the evolution of neoliberal govern-

mentality. In a US-style neoliberal government, modern subjects are both juridical and economic beings who can protect themselves with the law and act on their interests just like autonomous entrepreneurs. Although a liberal government still needs to manage the issues of territory, population and security (Foucault 2007), the new art of government lies in the endeavor of maintaining an adequately functioning market where these entrepreneurial citizens may strive and compete by the "rules of nature." Apparently, this is not the way it goes in Taiwan.

As a matter of fact, the transactional feature of this conditional citizenship aptly illustrates the ways in which harm reduction policy in Taiwan, taken as an exemplary biopolitical project, fosters a kind of neoliberal governmentality that is distinct from its Euro-American counterparts. Contrary to the well-developed American neoliberal governmentality as described by Foucault (2008), the ways that citizens' conduct is managed in Taiwan quite notably allow less room for entrepreneurial activity but more room for behavioral disciplining. This comparison is intriguing because it reveals the peculiarity of Taiwan.

In Chapter Three I described Foucault's elaboration of the impact of neoliberalism on drug policy. In the trend described by him continuing since the 1970s, addicts are divided into heavy users (whose use of opiates shows great inelasticity to price change) and light users (whose use can be decreased by manipulating the environment of supply). "Low price for addicts and very high price for non-addicts," says Foucault (2008: 258). In this sense, harm reduction strategies, aside from their tolerance, actually act as an art of neoliberal government that manages the inelasticity of opiate use for heavily addicted users by providing them with cheaper methadone. On the other hand, the supply reduc-

tion approach that aims to obstruct the sources of illegal opiates and elevate their price is expected to be effective for light users or non-addicts.

These differential treatments for heavy and light users are not, however, a salient feature of Taiwan's current harm reduction policy.[25] As I have described, the provision of MMT has marginalized if not eliminated traditional detox services. Drug users, heavy or light, now swarm into methadone clinics for free meds and health care. Dr. Wang Sheng-Chang, as I have mentioned earlier, was clearly aware of the indiscriminate use of methadone among prescribing physicians. He was concerned that those drug users who should have received detoxification or other abstinence-oriented treatments (that is, "lighter" users) were inadvertently placed in MMT, which might have been unnecessary but unfortunately now might be life-long for them. Considering the fact that the DSM-IV criteria for opioid dependence do not necessarily correspond to the severity of drug use à la Foucault, there is almost no telling how many people in the MMT programs are or were actually "light users." However, their mixing-up reveals the likelihood that drug users are to be placed under surveillance no matter how heavy their drug habits really are.

This makes perfect sense for the CDC. As disease control is its ultimate goal, the provision of differential treatments based on the severity of drug habits is never its concern. This feature contributes to the foundation of the political reason upon which Taiwan's harm reduction policy is not only put into practice in a top-down manner but also shapes the citizenship of drug users into a form so different from that produced in other countries where the initiative moves from the bottom-up in the community itself (Inciadi and Harrison 2000; Stimson 2007). To be sure, it will take comparative studies to know

[25] Ironically, it is compatible with the regulatory principles of opium control in the colonial period of Taiwan. See Chapter Two.

whether this is the case in the other Asian countries where harm reduction policy has also been initiated by the government. However, if rekindled interests in citizenship originate, at least partly, in the debates about globalization, then it is legitimate to ask how these globalization debates, including their knowledge dimensions, matter to this policy. This is the theme of the next chapter.

Chapter Six

Rethinking Policy Globalization

6.1 Introduction

In every way, harm reduction is a good example of globalization (Stimson 2007), not just in a traditionally defined economic or geopolitical sense, of course, but in the spheres of health and culture that pertain to collective well-being beyond a circumscribed body politic.[26] Its major proponents include, quite obviously, international organizations such as WHO, UNAIDS, and UNODC. Such organizations influence each locality either by way of the government or through a considerable number of intermediary non-governmental organizations (NGOs), such as the AHRN (Asian Harm Reduction Network), that devote themselves to the promotion of such a strategy.[27] In addition, the globalization process is also enacted by other actions or components that often escape ordinary discussion on this theme. Two instances are given here: published materials and conferences. When more and more people read related publications and/or attend related conferences, harm reduction has a greater chance of being implemented. Thereby, it is "globalized."

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[26] Much discussion has been devoted to the intertwining relationships between drugs and globalization. Drug prices, smuggling routes and globalizing anti-drug campaigns are some examples. See, for example, Ciccarone (2005), Reid (2005), and Stimson (2007).

[27] The tasks and goals of these international organizations on harm reduction can be seen on their websites: WHO: http://www.wpro.who.int/health_topics/harm_reduction/ ; UNAIDS: http://www.unaids.org/en/PolicyAndPractice/KeyPopulations/InjectDrugUsers/ ; UNODC: http://www.unodc.org/unodc/en/hiv-aids/index.html ; AHRN: http://www.ahrn.net/

Certainly, harm reduction as a concept or an action is neither homogenous nor unanimous. People explain and practice harm reduction in different ways. It is often not easy to define what "harm" or "reduction" is, nor is it straightforward to decide which practical strategies this notion should entail. The ambiguity may lead to tremendous confusion when it comes to the meaning of "globalized/globalizing" harm reduction. However, this confusion leads to a fundamental question: In what sense do we say this project is "globalized"? To what degree is globalization, along with its literature, relevant here? Or, in my case, as *assemblage* is used as a conceptual tool to understand the formation of a biopolitical project like harm reduction, how does it pertain to the ways we define globalization on a policy level?

6.2 Three Questions about Globalizing/Globalized Harm Reduction

These questions are important not just because they touch on the globalization of health and medicine but also because they lead us to scrutinize what processes substantiate globalization from an empirical perspective. Even though globalization in most cases refers to transnational capital expansion and labor flows which often attenuate state power (Busfield 2003; Held 2000), it has recently been fervently debated in terms of the spread of scientific biomedicine (Fischer 1999; Gordon 1988; Kuo 2009). The shift of globalization from an indicator of diverse phenomena to a process of multi-directional transmission leads scholarship to the analysis of concrete practices rather than the discussions of abstract categories. Notably, this processual perspective brings about methodological breakthroughs. On the one hand, the expansion may be traced back to colonial

times, as medicine and public hygiene are always held to be gems of modernity that were brought to the colonies (Anderson 2004, 2006; Arnold 1993, 1994; Chakrabarty 2004; Prakash 1999). Entangled with the desires and dreams of modernization, medicine and public hygiene are often integrated into the biopolitical regimes of post-colonies in spite of the ambivalence they provoke (Anderson 2002; Nandy 1988; Rogaski 2004; Visvanathan 1990).

On the other hand, the technoscientific expansion creates a new landscape of health, or "healthscape" (Clarke, forthcoming), in which novel transnational associations among things and people are made possible in the forms of, say, the Human Genome Project or a transnational health social movement (Rabinow 2005; Rodriguez-Ocana 2002; Roemer 1994). Science and technology studies have contributed to the understanding of knowledge transmission by pointing out the hidden mechanisms that enable the birth of such a new healthscape, but the globalization discussions add to it greater insight into the implications and ramifications of these transnational processes, such as the US-Mexico cooperation in bio-prospecting (Hayden 2003) and the venture capital hype about biotechnology in India (Sunder Rajan 2006). Scholars have recently illuminated that the propagation of scientific knowledge or technological innovation comes along with a stronger and faster flow of capital and labor (Lakoff 2006; Petryna, Lakoff, and Kleinman 2006; Shah 2003; Sunder Rajan 2006). The trend has pushed researchers to go beyond the laboratory and to ambitiously problematize "the social", "the local" and "the global" by engaging with other topics that converge on the globalization issues (Latour 2005; Ong and Collier 2005; Raz 1999; Rose 1996). A number of studies have shown us the value of such inquiry. For example, it is a common practice for big pharmaceutical companies to conduct

multi-national multi-center drug trials, but their probable social and ethical implications and ramifications have not been fully understood and discussed until very recently (Kuo 2005, 2009; Petryna, Lakoff, and Kleinman 2006). Moreover, the expansion of pharmaceutical products and power also contribute to the readjusted significance of scientific knowledge in daily medical practice. This can be seen in Lakoff's (2006) excellent work on the impact of a DSM-based diagnostic system on Argentinean psychiatry. Aside from the transformations of diagnostic and therapeutic paradigms, the institutions and structures that carried out the care plans of mental patients changed accordingly.

At first glance, it may well be argued that the problematic of this case is somewhat different, and that policy is distinct from all the factors of globalization I list above—science, technology, capital and labor. However, a policy like harm reduction simply cannot travel without its scientific knowledge and practical know-how. With its successful outcomes in various countries and localities, its scientific robustness is a major reason for its global expansion (Stimson 2007; WHO 2008) and also distinguishes it from many *ad hoc* local policy options that have not been scientifically validated.

Thus I contend that the approach to scientific transmission can be appropriated to see how a knowledge-dependent and knowledge-intensive policy, such as harm reduction, travels. In addition, from the Foucaultian perspective of governance (Barry, Osborne, and Rose 1996), which I have adopted in this dissertation, harm reduction as a transplanted policy is not that different from transferred science and technology. They all create or rely on truth, from its making, materialization, and application to its politicization. From the history of Taiwan's harm reduction policy, it is easy to see that this policy was adopted not out of idiosyncratic reasoning or irrational preference (CDC 2005). On

the contrary, it was chosen despite social distrust and political antagonism because it was backed by its claimed scientific robustness and practical usefulness. Without scientific figures and numbers that support the efficacy of harm reduction, this policy might never have been made into a real project. Since it involves how truth claims are accepted by different people in different places, I suggest that existing explanations about how technoscience travels can usefully and provocatively be applied as a template to the policy case.

However, modification is definitely mandated. Transmission of technoscience as well as policy is never a process of homogenization. It creates heterogeneity, but we need a useful and flexible framework to depict this heterogeneity. The botanical metaphor of transplantation implies the organic, adaptable features of policy travel as opposed to the immutable mobile thesis of Bruno Latour who asserts that scientific truth is directly transmitted and accepted (Latour 1986, 1987). In other words, in addition to associating the travel of science and technology with the appearance of harm reduction policies in places like Taiwan, what has changed and what has not during the transplantation process also need to be explicated.

In his immutable mobile thesis, Latour (1986) attributed the transmission of scientific findings to the effects of "immutable mobiles" which, like the black boxes that seal up messy practices and tacit details, may both move to distant places and augment the degree of truth they carry, sometimes with the aide of scientific inscriptions. In contrast, Shapin and Schaffer (1985), representing the sociology of scientific knowledge (SSK) approach, argued that it is the "local" social milieu and social technologies that make a scientific truth accepted. They gave as an example Boyle's experimental method. The

political conditions at the time when Boyle deployed physical demonstration as a way to establish witness and belief constituted wonderful leverage for his experimental method and allowed him to triumph over Hobbes' more speculative contention. Here, it was not black-boxed truth that traveled and spread, but demonstration-produced credibility, along with contemporaneous socio-political conditions, that created a social situation conducive to Boyle's success. Latour's explanation emphasizes the autonomous potential of a scientific object to move beyond its site of creation, while Shapin and Schaffer focus instead on the social conventions and contingencies (on both the producing and receiving sides) that make a scientific argument "true."

Then come my questions. In explaining this case of policy transplantation, which of these two approaches works better? If neither is satisfactory, what other conceptual and methodological tools offer better insight into the working of policy/knowledge travel as a process of globalizing? I have used the Deleuzean concept of *assemblages* to conceptualize the formation of harm reduction policy as a biopolitical practice and explicate its associated *office* and expertization. How useful is this concept in understanding how harm reduction policy/knowledge (as a package for the sake of analysis) gets globalized?

To reiterate, three questions await our attention:

1. What does "globalizing" harm reduction mean if the process is not regular and homogeneous?
2. How does a policy/knowledge package travel or, to borrow the botanical metaphor, get transplanted?
3. Empirically, in this specific case, what changes and what does not during the process?

Leading here with the concept I have used in previous chapters, I use the assemblage formation thesis to address these issues. My argument is that the Latourian idea of immutable mobile as a traveling encasement and the SSK approach to social technologies of truth making each portray only part of the story. Transplanting a policy from elsewhere involves not only the transplanted entity itself but also local performances on both the offering and receiving sides. In other words, neither Latour's nor Shapin and Schaffer's perspective accounts for both the "machinic" and "enunciative" dimensions of assemblages (Deleuze and Guattari 1987: 88).[28] An assemblage is a multi-faceted as well as ever-changing process. Assemblage formation intends to take into account all these ephemeral factors as assemblages are themselves heterogeneous, changeable and frequently short-lived. Simple causality is not functioning. What is at work is, instead, a relation of nonlinear over-determination. My idea of assemblage formation, drawn in part from Ong and Collier's (2005) notion of global assemblages, allows space for those unchanged elements (or immutable mobiles in Latour's terms), of course. However, my analytic emphasis is placed more upon the sophisticated interactions among the elements in the forming of an assemblage that modify old ways and generate new ways of knowing, living, and doing things. Further, I venture the question: Can we offer a way to rethink the global and the local not as a matter of different scales but rather as a way of forming assemblages? If so, then policy "transplantation" will signify a manner of re-

[28] Deleuze and Guattari (1987: 87) explain that [elements] in an assemblage may "function either as a body that acts and undergoes actions or as a sign constituting an act…." However, the two functions or lines in their terms are co-constitutive yet independent. Thus on the next page (p.88), they say, "On a first, horizontal axis, as assemblage comprises two segments, one of content, and the other of expression. On the one hand, it is a machinic assemblage of bodies, of actions and passions, an intermingling of bodies reacting to one another; on the other hand it is a collective assemblage of enunciation, of acts and statements, of incorporeal transformations attributed to bodies." Thus we may see that the idiosyncratically coined descriptive "machinic" refers to the corporeal dimension of an assemblage, while the term "enunciative" means a collective dimension that is incorporeal but hinges on corporeality. They are not identical with the binaries such as "representational" and "performative", "individual" and "collective", "agential" and "structural'.

arrangement that is best not portrayed as a mechanistic displacement but rather as an organic re-/formation or re-/invention.

During my study, I asked many interviewees questions about globalization and harm reduction policy. Many of them gave quite surprising answers regarding whether this policy was "transplanted" or "globalized," what is meant by "policy transplantation," and what implications this choice of concept entailed in terms of future policy design and implementation. The theoretical reflections presented above are based upon these collected data. In the following sections, I will disclose how the three questions arise, unfold and get answered.

6.3 Globalization as an Effect of Transnational Transplantation

For many CDC officials I interviewed, harm reduction was simply a domestic policy. The word "global" never rang a bell when they designed or implemented it. However, this was not the case for Director Kuo, who always thought that harm reduction policy was global because it was in accordance with the suggestions of international organizations, such as WHO, on HIV/AIDS control, and it could be used as leverage for Taiwan to re-enter the global community as a formally recognized country. In this sense, Taiwan's harm reduction policy as a global one was founded in ways that both re-claimed Taiwan's sovereignty and followed international guidelines.

On the other hand, ex-director Yang Shi-Yang of the third Division of the CDC gave the policy's global nature more epistemological reasoning:

> In the process of globalization, Taiwan is susceptible to the influences of its surrounding countries. Imported goods, increased traveling, or even the opening up of across-strait communication poses tremendous impacts upon the prevention of epidemics. I wrote in the past about 'the epidemics prevailed prior to the across-strait communication'. SARS is a glaring example, too. In fact, our HIV strains are the same as those in Mainland China, the B/C subtype. They came into Taiwan practically in 2002 or 2003. (Interview, 01/30/2008)

Since epidemic diseases like HIV/AIDS or SARS are globally transmissible, the coordination of health promotion by international health organizations is all the more important. However, Taiwan is officially helpless in this respect. Yang gave his opinion:

> Let the political remain political, but health is a human right….When WHO becomes a political organization, it is relatively unfair to Taiwanese people. Why should we be treated like this? Somewhat like a colonized land, but it's worse than the status of a colony. A colonized land has at least a ruling master, but we have nothing. We simply lack an identity to participate…to gain vision for Taiwan, to connect with the international community. Director Kuo hopes our program can achieve that goal [of re-entering the international community]. Anti-TB or anti-AIDS, it does not matter. (Interview, 01/30/2008)

In addition to the diplomatic-political and epidemiological reasons, Tsai Su-Fen, also an ex-director of the Third Division of the CDC (prior to Yang Shi-Yang), identified the third dimension of harm reduction being global: the entangled package of policy/knowledge. She especially emphasized the significance of transplanted know-how in making this policy work. She talked about a learning trip to Australia with the guidance of Dr. Alex Wodak:

> He was very enthusiastic, and he scheduled our trip to NGOs, religion-based detox programs, safe injection rooms, and STD (sexually transmitted diseases) prevention stations in red light districts. Everything. A whole package. When

> we returned, we invited a professor from the University of North Wales[29] to train our people who would carry out the pilot program of harm reduction. We had seven or eight modules and ways to evaluate these things. (Interview, 10/08/2007)

From her and the other interviewees' remarks, I summarize three major ways by which the fundamental knowledge and know-how of harm reduction can be transplanted to Taiwan. Overall, the package is carried into Taiwan along various informal, non-governmental channels. First are the online resources of international organizations such as WHO, UNAIDS and UNODC. Quite like scientific inscriptions such as the articles in professional journals (Latour 1986, 1987; Latour and Woolgar 1979), these materials are directly downloaded and studied. This is important because Taiwan is not a member of these organizations and thus has no legitimate access to their formal and practical assistance in programming the project. The second channel includes international conferences, educational tours, and invited foreign experts that aim to strategize harm reduction, exchange local experiences and facilitate policy implementation. The third channel involves the translation of written materials about harm reduction, including prescription manuals, self-help guidebooks, and even clinical forms, files and protocols.

In some sense, these three channels are listed in an order that corresponds to the increasing level of local engagement in the policy transplantation process. The downloaded materials are used for one-sided absorption of strategies and tactics. They are the least directly engaged channel. In comparison, conferences, learning tours and introducing foreign expertise are more engaging. They do not signify unidirectional absorption as much as mutual communication. They also represent three methods of learning and integrating policy from elsewhere into the existing infrastructure of Taiwan's healthcare system.

[29] This should be the University of New South Wales.

However, this kind of integration does not necessarily lead to the best fit. A more solid foundation is needed upon which practical measures can be built, and the foundation itself requires translation.

Here I mean translation in both its literal and figurative senses. Literally, the official guide for methadone prescription distributed by the CDC (see Chapter Four) was translated by Dr. Yang Chin-Hui, current Director of the Third Division of CDC. She translated them from the guidelines for prescribers issued by the Victorian Government, Department of Human Services, Australia (Department of Health 2007). However, Taiwan's HIV/AIDS statistics were appended to the translated guideline, making it appear more "local." Similarly, another translated book, *Over the Influence: The Harm Reduction Guide for Managing Drugs and Alcohol* (Denning, Little and Glickman 2004), was retitled in its Chinese version as *Challenging the Addiction Perspective* (挑戰成癮觀點; Tiaozhan chengyin guandian) and enriched by a long list of local addiction treatment institutions.

These examples of translation in many ways illustrate the differences, and perhaps very necessary ones, in a postcolonial condition vis-à-vis global knowledge. Translation did not mean sheer replication but rather creative hybridization. It sought to unify opinion as well as to accommodate diversity. In the end, it both ended and started debates.

Translation is often depicted in STS as an important manner of establishing scientific truth by aligning actors' interests. It is a central concept of Actor-Network Theory (ANT) developed by Bruno Latour and Michel Callon and many others (Callon 1986; Callon and Law 1982; Latour 1988, 2005). Latour (1988) elaborated this notion with the example of Pasteur. In his case, translation is a major way of strengthening the network

and making the network-supported knowledge claims ring true. With the notion of translation, Latour reversed the order of cognitive authority and social authority regarding truth formation. That is, farmers believed in Pasteur's discovery of anthrax bacilli as the pathogen responsible for their diseased crops not because it was truth. On the contrary, it came to be true only when Pasteur successfully persuaded French farmers that the cause for anthrax could be found with his microscope in the laboratory that was itsy-bitsy compared to the enormous farms that suffered. Cognitive authority for this scientific "truth" thus came *after* the social authority engineered by Pasteur was established. In addition, the scale and focus of science and society changed at the same time or, in Latour's own words, the social (as well as the scientific, I suppose) was reassembled (Latour 1993, 1999, 2005). Notably, along with Latour's earlier notion of immutable mobiles (Latour 1986, 2005), this process may account not merely for how scientific truth stands out but also for how it is accepted and promoted in different places.

Even though translation in this case of harm reduction guideline literally referred to the practice and product of turning one language into another, this linguistic shift also signified a socio-semiotic translation (Callon 1986). As I have argued elsewhere about translating "burnout" (Chen 2007), a translation is judged to be successful not only by the accuracy of wording but also by the compatibility of signification, which involves a realignment of the interests of the potential readers and the intentions of the translator. This realignment is the key to Latour's notion of translation, and in the case of harm reduction, the translated materials, including prescription guidelines or self-help manuals, became the carriers that informed the modes of clinical practice and self care.

However, the insufficiency of Latour's thesis of immutable mobiles and the need to complicate his use of translation become apparent when they are applied to my work. Translation here involves the enrolment of allies and re-alignment of their interests, but the medium or material for translation is not so much used for persuading and recruiting allies as offered for reference and regulation. In other words, translated materials such as treatment guidelines are more often a starting point where local variations emerge, rather than a consensual text where controversies end. They are, in other words, more like boundary objects (Star and Griesemer 1989) in the sense that they allow a number of actors and social worlds to converge and collide through them even in the absence of complete consensus. As a result, the meanings cast upon these boundary objects are thus multiplied. For example, a young psychiatrist told me how she started this service from reading the guidelines:

> As a matter of fact, CDC hardly offered any [educational materials] in this respect. Wasn't there a treatment guideline manual? Yes, we read it along with our case managers. That was just the basic stuff you had to know….Now I still do not feel I am as knowledgeable as those addiction specialists. All I can say is I accumulate some clinical experience….This is a Grade-F policy, but it is better than doing nothing. We just learn by doing, and then we modify. If, by this policy, we gather up people and reach a consensus that medical intervention is effective, then we can gradually figure out what form of medical intervention works best. (Interview, 03/03/2008)

A translation does not offer closure but rather a space of contestation, where inherent ambiguity makes allowances for the flexibility of local practice and the adaptability of the whole program. Therefore, for a transplanted but science-based policy like harm reduction, the Latourian formulation of translation appears to neglect necessary reconfi-

gurations of social structure and alterations of human practice on the receiving end where the ambiguity arises and where actors' interests are translated.

In addition, the transmutability of the translation phenomena also contradicts the idea of *immutable* mobiles. From the perspective of boundary objects, how the transplanted policy/knowledge package may remain an immutable yet mobile entity is quite questionable and actually appears untenable. For this reason, my criticism in some sense echoes SSK's discontent with Latour's theses (Bloor 1999a, 1999b).

While I agree with the central doctrine of methodological symmetry in the SSK approach, and I think we should not attribute technoscientific recognition and expansion merely to the agency of the object but to the society as well, I am not completely comfortable with the SSK claim that scientific truths are produced and accepted "through their [scientists'] shared conventions and institutionalized concepts" (Bloor 1999a: 90). I think that the idea of "the social", or the "shared conventions and institutionalized concepts," warrants more analysis when we try to explain the acceptance and transmission of science. That is to say, I urge a more fluid approach that allows the social not to be an invariable defining feature. Taking a constructivist stance but not taking the social for granted, I argue that it is necessary to start from an assemblage perspective and ask how this approach leads us to the issues that are featured by drastically enhanced flows of people and things—capital, labor, knowledge, and technologies. These are the issues we talk about in terms of globalization. What constitutes the social must be empirically explicated.

Thus we must assess what "globalized/globalizing harm reduction policy" means within established scholarship in STS about knowledge transmission. Policy travels as its

knowledge travels, but the process needs comprehensive scrutiny. Here I draw on inspiration from postcolonial science and technology studies (Adams 2002; Anderson 2002). In the historical literature on colonial science and medicine, the global transmission of knowledge and infrastructure is made possible by the movement of colonists, especially scientific specialists, and the imposition of colonial power (Anderson 2006; Arnold 1993, 1994). However, in traditional diffusionism, it is often supposed that things are transposed unchanged (Basalla 1967). But quite obviously, the transplantation of science, perhaps especially but not only when it is conjugated with policy, is never undertaken *en bloc*. Local variations and new measures tailored to the use of particular colonies, even after these lands claim independence, are always present and requisite (Arnold 1994; Prakash 1999). A significant emphasis of postcolonial science and technology studies is to delineate the contours and range of variability observed in such sites when technoscientific apparatuses are brought in, and sometimes are objects of desire for modernity and progress (Abraham 1999; Anderson 2002).

Significantly, the term "postcolonial" is applied here not simply to refer to those lands which used to be colonized, but also as a figurative space of problematization where power and domination result in the differentiation of marginal states (Aretxago 2008; Hall 1996b). This approach exposes the reasons why the immutable mobile thesis or the traditional diffusionism does not work well in this uneven, post-/colonial situation, and why the Latourian definition of translation needs revision and specification. To characterize the transplantation process, I suggest an *assemblage* perspective may best accommodate the complicated interactions between local infrastructures and global elements that require articulation during the globalizing process.

To delve deeper, we may see that the transplant, if the botanical metaphor stands, should not be treated as arborescent but, again in a Deleuzean manner, as rhizomic. The rhizome, notably, "connects any point to any other point" (Deleuze and Guattari 1987: 21). In this perspective, the spatial and symbolic dimension of global versus local distinction naturally dissolves, as they no longer signify different scales or identities. As a result, the analytic focus may turn to the practices of connectivity that constitute the process of transplantation. Echoing Knorr-Cetina's (2007) concept of global microsociology, this helps us better visualize the microscopic interactions and adjustments that make viable what travels (if in an active tone) or gets transplanted (if in a passive manner) instead of conceptualizing the process in a macroscopic and often disembodying, unarticulated way.

6.4 Globalization as a Series of Assemblage Formations

In the previous section, I recommended taking an assemblage perspective to conceptualize associations among heterogeneous elements. In this section I proceed to analyze how policy travels along with technoscience.

There are multiple reasons accounting for the intertwining of policy and its know-how. First, as I have said, CDC workers searched for WHO-distributed materials on line. Staff members were sent to various sites, such as Hong Kong, Australia, Britain and the US, to see and learn. Interestingly, the CDC intentionally avoided copying the US model because the US model was deemed to be a failed one. "Many policies made by the Taiwan CDC come from the US CDC alright, but in the end I was questioning whether we

needed to mimic the US in every possible way," said Director Kuo. The idea that the US experience was a failure came from some harm reduction experts that the CDC invited, such as William Bowtell and Alex Wodak (both are Australians), and opinions gathered at international conferences. As stated earlier (see Chapter Three), Hong Kong soon became another source of policy learning owing to its geographical proximity and its decades of experience of providing MMT. The consequent policy in Taiwan was therefore a hybrid with genetic traces of Australia and Hong Kong rather than a direct descendent of the US.

However, many policy details had no formal references but relied on informal transfer of experience. This "experience talk" immediately related to the formation and legitimatization of certain types of expertise. In terms of policymaking, a decision about expertise is at the same time a decision about privilege and power. For example, should the privilege to prescribe methadone be restricted to psychiatrists or expanded to general practitioners as well? Is the pharmacy-based design of needle syringe programs the best solution for Taiwan? How is it possible to reconcile police actions against drug users with the tolerant attitude needed for the sake of public health?

The second source of policy transplantation involves the personal participation of foreign experts. Considering the lack of official channels, foreign harm reduction experts, especially Alex Wodak (Australia), Gerry Stimson (UK), Yang Ching-Dian (楊慶鈿, Hong Kong) and Chen Char-Nie (陳佳鼐, Hong Kong), to name a few, seemed to be the carriers of technical details and administrative secrets that were central to policy implementation. Their enthusiastic responses soon became the heartwarming force that supported CDC workers. During the presidential election campaign in 2008, Alex even wrote

letters, partly spontaneously and partly upon Director Kuo's request, to both candidates of the KMT and the DPP[30] to express his concerns about the future of harm reduction policy after the election.

In addition to the experts invited by the government, local NGOs that partook in the care of HIV patients, both IDUs and non-IDUs, also embraced the idea of harm reduction. For some CDC workers, these organizations were more receptive than addiction psychiatrists in terms of offering harm reduction approaches to individuals and groups. Following a similar trajectory of self-fashioned specialization to that adopted by local experts, Taiwan's NGOs such as Taiwan Harm Reduction Association and the Lourdes Association resorted to whatever funding resources were available to enrich and update their techniques of care. They jointly invited Patt Denning and Jeannie Little, two authors of the book *Over the Influence: The Harm Reduction Guide for Managing Drugs and Alcohol* (2003), to lead the workshops they had designed for concerned workers. At the one I attended, there were more than one hundred participants, mostly social workers, nurses and frontline workers dealing with HIV-positive individuals. We listened to the invited speakers and learned from them specific techniques of motivational interviewing which constituted the practical basis of harm reduction psychotherapy. Because very few physicians (like me!) attended, the workshop was characterized by non-medical approaches and non-hierarchical exchange of ideas.

In these ways, harm reduction policy in Taiwan as an assemblage is supported by a wide range of international participants but the transmission of its knowledge, expe-

[30] The KMT candidate was Ma Ying-jeou, who was also the Minister of Justice during the War on Drugs campaign around 1994 (see Chapter One). The DPP (Democratic Progress Party) candidate was Frank Chang-ting Hsieh. Ma defeated Hsieh in the 2008 election and became President of Taiwan (or the Republic of China) on March 20.

rience, and design information has been unofficial under most circumstances. The whole process is reminiscent of the webs of *guanxi* mentioned earlier. The packages of knowledge, experience and information were brought to Taiwan via personal, or at best semi-official, connections with individuals and certain NGOs (i.e., AHRN, but not WHO). Retired directors Tsai and Yang of CDC both showed their gratitude for the instructions and suggestions by foreign friends like Wodak and Stimson. Director Kuo, in addition, transformed their friendship and concern into a means of unifying the opinions of local, self-made "experts" (see Chapter Four).

However, aside from these clearly visible pieces of advice and suggestions, there were probably some gossamer lines of association that also helped him move this project forward. Kuo mentioned a training course at the Harvard Kennedy School in 2002, where he learned for the first time about the New York experience with methadone programs in the 1970s. At that time he was chosen by the Taiwan government to attend a series of administrative education courses, and this case study was listed in his teaching materials. It focused on how the policy was pushed forward against local resistance, similar to the situation at the beginning of harm reduction policy implementation in Taiwan. Although this lesson did not come to his mind, according to Kuo, until very late in the implementation process of harm reduction, he felt the association somehow stayed in his subconscious and exerted an impact on the policy. In a nutshell, then, the frame of this policy was a patchwork made from newfound knowledge and information collected online, personal experiences and suggestions from foreign experts, and *ad hoc* improvisations by local bureaucrats. In this way, the fabric of the global was so interwoven with the structures of the local they appeared nearly inseparable.

In this case, policy know-how was actually brought into the decision-making circle at the same time as policy formation. It is almost impossible now to specify where policy ends and where knowledge begins. Just like the modern biopolitics that intertwines discursive formation with power deployment, the intimate entangling of knowledge and policy in this case represents its salient feature as an assemblage that defies a diffusionist explanation but rather demonstrates a rhizomic growth out of the interlinking of knowledge, governance and desire (Deleuze and Guattari 1987).

In sum, regarding the three questions I raise in the beginning of this chapter, my argument is that the idea of globalization, though encompassing, loses its grasp and utility when it comes down to the analysis of ephemeral (and sometimes chaotic) assembling and disassembling of people and things. The scalar perspective distinguishing between the global as the larger and the local as the smaller does not serve the desired descriptive functions well. Instead, assemblages that constantly deterritorialize and reterritorialize allow greater descriptive flexibility and analytic inclusiveness. Transplantation is neither sheer duplication nor en bloc displacement. The connections "from any point to any other point" (Deleuze and Guattari 1987: 21) contribute to the hybridity of translation and thus make the transplantation not one of plants but one of rhizomes.

That said, the remaining issue is how this assemblage of harm reduction evolves and, since it is by definition an ever-changing and transient ensemble, how it then turns into another by deterritorializing and reterritorializing.

6.5 Changtaihua: End of an Old Assemblage, Beginning of a New One

In September 2008, I stepped into the hotel where the ninth Taipei International Conference on HIV/AIDS was held. Although registration was encouraged, the conference was actually open to the public. Finally seated in Excellence Hall, I looked around.

It was a large lecture hall packed with over 500 people. The conference lasted two days and covered many policy-relevant issues, such as the epidemiology and treatment of HIV/AIDS in vulnerable populations (IDUs, MSM, prisoners and women). Invited speakers were mainly from the US: from the CDC, Johns Hopkins University, Harvard University, Yale University, UCSF, UCLA, and NYU. Specialists from Hong Kong and Thailand were also included along with local experts from National Taiwan University, National Cheng-Kong University and of course, the Taiwanese CDC. While international (chiefly American) speakers talked about a bigger picture in which harm reduction occupied only a limited space, the favorable outcomes of harm reduction policy in preventing HIV/AIDS transmission were promoted by the Taiwan CDC as a working project in public health from which other Asian countries could learn. One speaker, Robert Newman (Beth Israel Hospital, New York), praised the successful outcomes of harm reduction policy (mainly MMT) in Hong Kong in his speech on the current HIV/AIDS situation among IDUs. When he finished, Director Kuo of the Taiwan CDC approached the microphone and repeated something he had told me in an earlier interview. He described Taiwan as a "quick follower," but that to make harm reduction a sustainable policy despite the shift in party politics, he needed to make sure the new KMT government would continue sponsorship of this policy. This was also the reason why he asked Alex Wodak to write the letters to presidential candidates of both parties, mentioned earlier. At this conference, he again disclosed his concerns about the future direction of this policy.

As a matter of fact, this was the moment when harm reduction policy was going to be *changtaihua* (常態化), which could be translated into English as either "normalized," "regularized," or "routinized." *Changtaihua*, or *Chengchanghua* (正常化), was a term many health officials used during their interviews with me, by which they meant two things. One was that harm reduction ought to be a sustainable policy regularly applied to people in need. Its *ad hoc* features had to be replaced by long-term arrangements. Even though Director Kuo was somewhat apprehensive about the possible revision of policy details in the face of changed political leadership, he had strong faith in the sustenance of this program. He knew it had served so many people that the government could not easily stop it. Many other CDC officials felt the same way—it was nearly impossible to stop an engine that supplied methadone to over ten thousand drug users every single day. Action speaks louder than words. Their attendance at the clinics in fact constituted the strongest force that could continue the program.

However, the major problem was not *whether* this program would live on but *how* it would live. Kuo was concerned, and so were many CDC officials who had worked on this project for a long time, about the re-assignment of bureaucratic responsibilities for this policy. It seemed to him that the viability of harm reduction as a sustainable policy hinged on bureaucratic adaptations that could ensure the policy's long-term administrative as well as financial support.

In Ong and Collier's (2005) original framework of global assemblages, the formation of an assemblage involves elements that are shared and universal (therefore *global*), at least to some extent, and more local elements that are emergent and contingent. However, as Wodak (2006) has astutely noted, it is this localness that is also shared and com-

mon, to wit, global. In this case, the local elements refer to the necessary adaptations of the policy to fit Taiwan's political culture, as Jasanoff has demonstrated vis-à-vis biotech policies (Jasanoff 2005). However, it is important to mention here that the process often seems so "natural" that it may be taken for granted.

To the CDC, *changtaihua* was the only way to go because its involvement in this project was entirely an accident. Had it not been for the scary HIV statistics, the CDC officials would never have encountered the world of drug users (remember the discussion about "we thought all the needles were the same" in Chapter Three). This serendipitous encounter, on the one hand, certainly brought a new perspective on this long-neglected group that so needed public health attention. On the other hand, once drug users no longer posed a threat to public health in terms of the HIV epidemic, the CDC just wanted to get rid of the heavy burden of their treatment by transferring part of the work to the other units in Department of Health, specifically the Bureau of Medical Affairs (BMA) and the National Bureau of Controlled Drugs (NBCD).

The withdrawal of the CDC from the implemented harm reduction policy was a stepwise action, according to Director Kuo. One month before the September conference, the Executive Yuan held an administrative meeting on the prevention, treatment and rights of people with HIV/AIDS. The theme of this meeting concerned the recently renamed HIV Infection Control and Patient Rights Protection Act (previously AIDS Prevention Act). At first glance, it was nothing but a reconfirmation of services for people with HIV/AIDS such as counseling, health education, free provision of medical treatment, and psychosocial interventions. Director Kuo reminded me that the special emphasis had shifted towards "protection of rights" of people with HIV/AIDS in these revi-

sions, which would become the next goal. For the CDC, the timing of returning to human rights issues was perfect because drug users were no longer the focus. Instead, MSM, the old target population of the CDC, returned to the top of the priority list. In addition, the CDC's intent to *changtaihua* harm reduction also meant that MMT was supposed to be managed by the correct units. If, Director Kuo stressed, addiction was considered to be a relapsing chronic illness just like diabetes or hypertension, the BMA and the NBCD were better candidates for this task as they oversaw medical practice and regulated controlled drugs, respectively. "We have been transgressing for three years," he said and added, "but only this way [*changtaihua*] can this policy sustain itself. The CDC simply does not have the capacity. We have been stretching ourselves." However, this did not mean it would rid itself of all responsibilities. Kuo stressed that the CDC would continue to take care of the NSP segment. However, the NSP was not a big issue, because it cost relatively little. Considering the vast amount of money invested and the scale of the perceived impact, MMT was the battlefield, he opined.

Around the time (August 2008) when the focus of CDC work shifted to the protection of rights of people with HIV/AIDS, it also ceased to reimburse the "first-visit fees," about 4600NTD (or 150 USD) per person, for drug users seeking help from methadone clinics. Because IDUs often sought help at the last minute when they were seriously ill and penniless, serious outcomes might ensue if the government stopped paying for them. Clearly, the withdrawal of financial support from the CDC soon resulted in an elevated treatment barrier. Then IDUs stopped coming to methadone clinics. This trend was shown in Figure 6-1. The decrease in drug users staying in MMT and the withdrawal of

reimbursement roughly took place at the same time in spite of the increased number of methadone clinics.

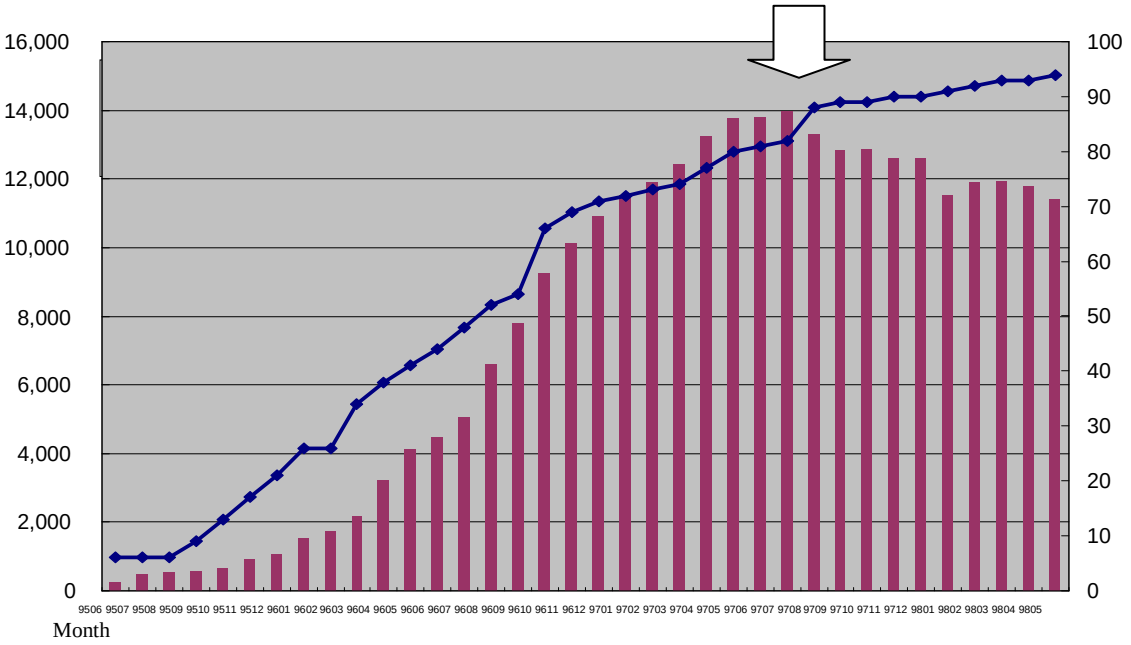

Figure 6-1 The number of drug users in MMT (expressed as bars, number on the left) and the number of hospitals rendering MMT services (expressed as a spotted line, number on the right) monthly from 06/2006 to 05/2009. The arrow indicated the time when reimbursement was withdrawn. (CDC 2009: not paginated)

Certainly, the chart is insufficient evidence to substantiate a causal relationship between the budget cuts and the decreased number of drug users' visits. However, it sounds a warning bell for those who have devoted their time and energy to harm reduction over the past few years. On November 10, 2008, I attended another meeting on the medical treatment of drug abuse and accidentally found, contrary to my expectation, that this meeting was not so much an educational and training course for concerned physicians as an occasion to discuss the future of MMT. Surprisingly, many non-physicians attended this conference to render their opinions. It contained sessions on heroin use and MMT, as

well as methamphetamine, benzodiazepine use and so on. However, the greatest emphasis was placed upon the first session, which was chaired by Deputy Minister of Health Chen Tzay-Jinn (陳再晉) and focused on the future of MMT. In that session, Drs. Su Lien-Wen and Tang Xin-bei reported on the principles of MMT and its medical and social effects. After their presentations, Deputy Minister Chen, MD/MPH and former Director-General of the CDC, showed an overhead slide to the participants that illustrated his conceptual frame, one of gene-environment interaction for managing drug users:

◎ Gene with/without initiators/promoters [original in English]

◎ Supportive environment—social responsibility [in Chinese; the same below]

◎ Life habits—personal responsibility

◎ Medical care—professional responsibility

◎ Juridical management—last solution

He explained in a clear and strong voice the rationales that emphasized several dimensions of adequate management of drug use problems. Among all the factors he listed, he defined medical care as the sole responsibility of the Department of Health. Since genes are beyond administrative control, a supportive environment belongs to "the social" (read "not our business"), juridical issues are left to the Ministry of Justice, and life habits are mostly personal, the Department of Health could concentrate only on the medical care of drug users, or in this case, MMT.[31] However, he stressed that the provision of MMT was not unconditional. Rather, it mandated candid confession. He briefly explained the principle of future MMT services, "I demand that you tell the truth if you want this treatment." In his words, it was a simple and straightforward manifestation of the rela-

[31] As a matter of fact, the NSP was certainly included in the responsibilities of the Department of Health, but MMT in particular was highlighted in this conference because it was the focus.

tions of rights between government and citizenry. MMT was offered on the premise that the government was responsible for providing available treatment insofar as the citizen addict fulfilled his responsibility for telling the truth. Thus it was a new confessional technology that incorporated a globalized project into an art of government focusing on a previously medically unattended population.

Similarly, we may notice that *changtaihua* was not just about the CDC seeking to relieve itself of the burden of harm reduction, but also about the integration of an *ad hoc* mission into existing bureaucratic infrastructure of biopolitical government and long-standing suppressive disciplining. One month after the meeting, I interviewed an anonymous governmental official in charge, who was then in the middle of organizing the new structure for MMT, including its provision, finances, personnel and treatment plans.

The official was apparently discontented with the original goal of harm reduction, which he saw at this moment as part of addiction control rather than HIV prevention. Instead of viewing harm reduction as an emergent strategy for preventing HIV/AIDS, he intended to integrate the offering of methadone into existing psychiatric services for drug users and make it one of the options for drug users in the long run. In other words, he planned to change the ways in which elements within this assemblage could associate with each other and intended to re-connect harm reduction with the older yet more established treatment alternatives for addiction, including individual and group psychotherapies and social services that promoted social re-integration of drug users. Harm reduction, in his opinion, was not an alternative apart from supply and demand reduction. It was, instead, a temporary step leading to the eventual goal of getting sober and clean. A re-incarnation of the old spirit of abstinence, so to speak.

In this light, the appropriateness of the allocation of governmental funding for harm reduction was re-assessed. Establishing a web-based database system, creating locally pertinent treatment guidelines, and expanding current MMT-providing sites were his three major concerns—all needed money, and money was always an issue. He clearly expressed his concerns to me:

> You know the retention rate of current MMT is not high enough. We will see what will happen if we improve its convenience of delivery. But funding is a problem. Without funding, all these [improvements that need to be done] are nothing but a bluff. Addicted people will buy drugs whenever they have money, so we need extra funding for these programs. Now we know clearly that the treatment expenses of people with HIV are covered by the government, so they do not have to pay now.
>
> However, how long will the others [drug users who are HIV-negative] pay for themselves? Do we have to pay for them? Medicine aside, how long can we cover their expenses in other treatments? There are two ways of reimbursement: complete and partial. Complete reimbursement means that we pay for everything—psychotherapy, drug therapy and stuff. Partial reimbursement means, for example, that I pay for your expenses for the first month, and if your urine test is negative, then I keep on paying for you. If your urine screening shows positive results, sorry, I will no longer pay for you. This is the more effective way of money management, towards which I am heading.
>
> Among the three components of addiction treatment, that is, physiological detoxification, psychological rehabilitation and social re-integration, emphasis has been placed upon the physiological part the most, less on the psychological, not to mention social reintegration. However, given the varieties of physiological detoxification alternatives, we need to see where the money should be spent. (Interview, 12/25/2008)

In spite of the resurrected abstinence-centered ideology and the re-distributed governmentalization, he emphasized the importance of scientific and consensual guidelines for treatment adapted to local needs in Taiwan: “Now we do not have anything really local. Even if we do, it’s small-scale. Large-scale databases are still lacking. Now we have the

[Taiwanese] Society of Addiction Sciences and I hope we will have a consensual perspective and shared thoughts….” The interview ended when he had to leave for another meeting about making treatment guidelines.

In January 2009, the process of *changtaihua* seemed to be almost finished. Since its inception around 2004, Taiwan’s harm reduction policy adoption has traveled a long and winding road. I would argue that *changtaihua* did not signal its end, but its beginning in another guise, one that was hopefully more integrated and stably funded. At least from what I have seen in my fieldwork, it has been incorporated into the daily lives of many if not most Taiwanese people. All the controversies regarding its compatibility and feasibility have subsided, and the players once active in its policymaking have gone back to their original fields and lives. The old Chinese saying, “an old bottle may contain new wine,” is intriguing here. It means on the one hand that novelty may burgeon from an older form. However, it also means that the novelty may still be restrained by the old form. What we see here is more like the second meaning —an old style of thinking and doing resurrected through a new policy. A public health strategy once based on pragmatism, tolerance and users’ subjectivity has now been transformed into a part of a greater machine that encourages total abstinence rather than safe use. The utilitarian logic and neoliberal governmentality that emphasize the good of the majority, autonomy, responsibility, and cost-effectiveness have re-connected with the older, suppressive, war-on-drugs goal. Maybe we should not treat this as a degradation of the original liberatory spirit of the harm reduction movement. Instead, we may postulate that reterritorialization of the assemblage of harm reduction has taken place once again.

Portraying harm reduction policy as an assemblage with constantly changing territories has a major analytic edge in terms of the travel of policy/knowledge: It addresses the processes, practices and materials of traveling. Transnationalization of scientific knowledge, policy discourses and institutional structures can be depicted as a series of assemblage formations, thus accounting for the motions and variations involved in the temporalities and spatialities of globalization. It is, therefore, distinct from the comparative approaches adopted in some STS studies about globalization.

To illustrate the theoretical implications of this assemblage approach, I give two examples of STS studies about globalization that apply comparative methods, and I explain how they differ from my approach. Then I will show how my assemblage approach is compatible with Herbert Gottweis's (1998) ideals of "post-structuralist science and technology policy studies."

My first example is globalization of the anti-tobacco movement. In *Globalizing Tobacco Control* (2005), Roddey Reid, a veteran STS researcher, conducted a comparative study of discourses, media and representations to address the different trajectories and developments of tobacco control in three different places—California, France and Japan. Trying to avoid the often implied practice of "disqualifying others" in comparisons of policies and societies, Reid intended to go beyond this narrow definition of modernization.[32] He demonstrated that the anti-tobacco movements in these three places were neither pure products of local histories nor the direct outcome of global circumstances, but rather were something in between—which he called "global singularities" (Reid 2005: 244).

[32] See also the "waiting room" metaphor in Chakrabarty (2000:8-9).

While Reid's approach is illustrative and persuasive, I intend to address the entanglement of "local histories" and "global circumstances," to quote his terms, rather than to treat them as separable causes. In my constructivist assemblage approach, scale and causality are not *a priori*, static concepts that precede practices, interactions and associations involved in globalization. On the contrary, they are produced attributions of a series of assemblage formations. Therefore, scale and causality are always changing too.

In the second example, comparing the ways in which biotechnology policies are formulated and implemented in Britain, Germany and the US, Sheila Jananoff (2005) succinctly concludes that different political cultures can account for the disparities in the design and practice of their policies. She defines political culture as the "systematic means by which a political community makes binding collective choices" (Jasanoff 2005: 21). In some sense, the use of political culture shifts the emphasis away from the state and toward the co-production of science and society by exposing the "tacit, but nonetheless powerful, routines by which collective knowledge is produced and validated" (Jasanoff 2005:21). However, through the case of harm reduction in Taiwan, I have demonstrated that Jasanoff's definition of political culture, though effective in explaining how a life science-related policy is somewhat bound up with the plan of nation-building (Jasanoff 2005: 7), fails to note that the life sciences in policymaking could operate more as a transplanted carrier of governmental rationality, rather than as a domestic outgrowth, that needs modification and adaptation. The so-called political community could actually be very heterogeneous. To be clear, I am not opposed to the use of political culture to account for those implicit and immanent values or rules involved in the policymaking, but I also view the concept of assemblages as better capturing the amorphous interactions

among various actors, human and non-human, who are retrospectively clustered as a political "community."

My approach is thus very similar to Herbert Gottweis's (1998) poststructuralist science and technology policy studies. In his great work on the discursive and narrative construction of genetic technologies, Gottweis succinctly recounted the emphases and pitfalls of past policy research approaches. Instead of the long-held realism in policy studies that considered policy formation as the net effect of the struggles between sociopolitical institutions, historical impact, or group dynamics, he stressed the significance of discursive and narrative re-/construction of pertinent issues and possible solutions. Just as I have done here, Gottweis suggests de-centering the subject, focusing instead on the practices of government rather than the reified state, and turning analytically to the re-/drawing of boundaries between science and non-science, or politics and non-politics. With his analysis he even pointed out the potential conflicts between genetic technologies and public perception.

However, I not only try to sharpen my analytic edge by giving a more fluid perspective that captures the motions which constitute the globalized contemporary, not static comparisons or snapshot-like depictions of different locations, but I also expand my analytic width by lending it a postcolonial angle that examines both the advanced "West/North" and the advancing "East/South." In spite of my criticism of Jasanoff's argument, her explorative comparison elucidates the significance of the cultural milieu on the receiving end of globalized knowledge or policy. In my case, in the enthusiasm of implementing such a policy as harm reduction despite long-lasting suppressive ideology resides the conscious intent of the Taiwanese government to propagandize its successful

implementation of harm reduction towards the "global." The global is imagined by the CDC here as a multi-national community which rejected Taiwan's plead to enter its diplomatic field because of China's interference. The postcolonial desires and aspirations of the Taiwanese government to be a globally recognized polity are more than palpable. Foucault once described in his lectures the other side of biopolitics which resides not in the interior management of the population and security but in the exterior territory, including the diplomatic and military arrangements that defend citizens' lives (Foucault 2003b, 2007). In this case we see how these two aspects can become deeply entangled.

In sum, the global transplantation of policy and its accompanying knowledge ought to be analytically considered as a cascade of emergent assemblages in different localities such that internal inconsistencies and external reconfigurations can both be taken into account. However, such assemblages do not take form *de novo* or *ex nihilo*. They are, instead, contingent on existing infrastructures on the one hand, and long-held aspirations and desires on the other. The whole process, along with the formed assemblages, is both productive and destructive. It both generates and pulverizes. It is dangerous as well as hopeful. Harm reduction policy is, after all, already a technology of despair and hope.

For many CDC workers who went to all the trouble to implement harm reduction, the experience was clearly bittersweet. Despite tremendous hardship in the process of making a policy as controversial as this one, many CDC officials still think positively. As one anonymous official sincerely told me, "this is, to my knowledge, the first time that a public health policy based on inter-departmental cooperation should work successfully." Although sometimes messy and sometimes chaotic, the whole project of harm reduction marvelously demonstrated its effects in transforming drug users and stabilizing the

HIV/AIDS epidemic. Instead of the claimed exactness that characterizes hard science, the complex of science and policy that traverses space and time simply defies clarity, stability, and consistency, a *mutable* mobile indeed.

Chapter Seven

Conclusion

7.1 Aftermath—Will the Epidemic Return?

I ended my field work in January 2009 when harm reduction no longer aroused as much public attention as it had, but the *changtaihua* process of administrative coordination had not yet come to an end. Of the three branches of harm reduction policy, the Methadone Maintenance Treatment (MMT) program was allocated to the Bureau of Medical Affairs (BMA) and the National Bureau of Controlled Drugs (NBCD). The Needle Syringe Program (NSP) still belonged to the CDC. The third part, screening and education, was split among the CDC, BMA and NBCD, with different foci and concentrations. Since this division of responsibilities, the CDC's agenda has now shifted back to focus on safer sex and injection practices. The BMA and the NBCD now stress the goal of abstinence with the aid of medical treatment. Overall, the initial ideals of harm reduction have now been subordinated to the long-established goal of abstinence.

From my fieldwork, I can see that the attention invested in harm reduction issues has been diminishing since the end of 2008. The activities of the Taiwanese Society of Addiction Science, which represents addiction specialists and works with the NBCD and BMA, are now separate from the continuing efforts of HIV professionals and CDC officials in the domain of HIV/AIDS prevention. These two groups of people once converged, and now diverge again. The CDC's tolerant attitude has been replaced by the

cost-effective management of the BMA. Infection control and addiction management, two domains once united by the CDC in the name of harm reduction, have now been separated from each other.

This diversion could be alarming. Professor Ko (see Chapter Four) told me apprehensively that she was afraid the HIV endemic among IDUs would break out again in five years if attention on harm reduction waned. “I wish my prediction was not correct, but it often is…,” she sighed. Her apprehension is not without reason. The assemblage of harm reduction policy has metamorphosed or, in a Deleuzean sense, re-territorialized. First, the bureaucrats involved have been re-positioned. Two months after my field work was finished, I was informed that two major interviewees of mine, one of whom used to work in the BMA and the other in local government, were transferred to another administrative unit in the Department of Health, totally unrelated to harm reduction policy. Given their accumulated experience in organizing the policy details, this re-positioning will surely have consequences, most likely detrimental, for a transforming project like harm reduction at this moment.

Certainly the change of the bureaucrats in charge does not necessarily lead to alteration of the project, but the frequency of repositioning personnel implies an instability factor in the remaking of this project. Instability is not necessarily bad; it may simply imply flexibility. Actually, over the course of policy implementation, the third division of the CDC, which is in charge of HIV/AIDS and TB issues, has been led by three different directors: Tsai Su-fen, Yang Shi-yang and Yang Chin-Hui (current). Three directors in five years means something, and concerns about policy continuity may arise. But Director Kuo tended to interpret this rapid transition in a positive light. He stressed that the

three directors' different styles of doing things actually benefited, rather than impeded, policy implementation because the leadership qualities needed in different stages were so different that no one individual could possibly have them all. Changing directors in charge actually contributed to the flexibility of this assemblage that constantly reshapes itself and rapidly adapts to the needs of real-life.

Second, the change also occurs at the institutional level, as I have described in the previous chapter. The original project was coordinated solely within the CDC, but now it has been dissected into several dispersed parts allocated to different units. In fact, harm reduction is not so much a systematic, orchestrated project now as it is an overarching strategy of government that has been put into practice in a fragmented and improvised way. To integrate the available mental health resources, in March 2009 the Department of Health organized a task force, the Mental Health Office, modeled on SAMHSA (Substance Abuse and Mental Health Services Administration) of the US. It was headed by Superintendent Happy Kuai-Le Chen of the Taoyuan Psychiatric Center, and its purpose was to promote citizens' psychological health, integrate mental healthcare, and promote substance abuse prevention (John Tung Foundation 2009; Wang 2009). Whether and how this task force will adequately re-situate the harm reduction policy within the re-organized mental health programs remains uncertain, but it does signal a shift in harm reduction policy from the emphasis on HIV/AIDS back to the control of drug use behavior. I am afraid, and this is becoming more obvious now, that this is a change of direction towards a more conservative, ultimately abstinence-oriented goal.

Third, the assemblage of harm reduction is expected to expand its armamentarium in the treatment of addiction. As I have said in Chapter Four, this expansion echoes the rise

of a new profession — addiction medicine. While this may be a burgeoning psychiatric profession, addiction sub-specialists not only need specialized knowledge and training, but also require therapeutic facilities and tools. Aside from the currently available but government-controlled methadone, they need more profitable medical products. The financial incentive is more than obvious. Addiction treatment per se is not covered by national health insurance (NHI), so it is subject not to the budgetary regulations of the government but to the demand-supply rules of the market. In short, addiction treatment can be a potentially lucrative product for sale. Further, as Dr. Su told me, the market response in Taiwan is considered to be a harbinger of the larger market in Mainland China. This is partly the reason why pharmaceutical corporations are so enthusiastic in introducing another substitutive medicine for opiate dependence, Suboxone®. In addition, it is widely believed that Suboxone® is less dangerous if overused or misused and thus is subject to looser regulation. Drug users taking Suboxone® do not have to go to methadone clinics every day and they can therefore enjoy more privacy and respect. As I suggested earlier in Chapter Four, social class may be reproduced in the choice of substitutive medicine for addiction because the high price of Suboxone® will exert a stratifying effect upon drug-using individuals.

Fourth, the knowledge dimension has been transformed. One interviewee in the government repeatedly emphasized that “local data” should be accumulated and analyzed as soon as possible to build up treatment guidelines that pertain to the needs of “local people” (本地人, *bendi ren*). The current guidelines, adapted from those used in Australia, have to be replaced eventually. These “localness” discourses and arguments are familiar, as the implied ethnic differences have been not only once but twice invoked in either

domestic or international settings (Kuo 2005, 2009; Liu 2009). But their use, generally speaking, is strategically essentialistic for various reasons. That is to say, the distinctions highlighted by scientific evidence are used not only because they represent certain *bio-logically* distinguishable traits and differences, but also because they create or protect a problematized space where sociopolitical factors may serve some end.

A common reason for these localness discourses is nation-building. Liu (2009) illuminates the intertwining relationships of the political definition of "(new) Taiwanese" and the genetic findings of "Taiwaneseness." In another combination, this science-based longing for nation-building merges with Taiwan's political desire for official global recognition. In this sense, the search for "localness" is intriguingly illuminated by Kuo's studies (2005) on international harmonization conferences where each and every Asian country proclaims and pursues, by different means, something unique or useful to itself, either a distinctive racial constitution that warrants re-examination of every incoming medicine (e.g., Japan) or a shared genetic reactivity to drugs that could be calculated by multi-center, multi-national studies (e.g., Taiwan). However, in Kuo's case (2005), the socio-political purpose involves political sovereignty and economic interests in the face of transnationalizing pharmaceutical companies. In Kuo's later elaboration (2009), this purpose also includes a national desire to "go global" that, via bridging with other national milieus and voicing one's own wishes, converges with the ambition of pharmaceutical companies on the platform of the International Committee for Harmonization (ICH). In contrast, in my case, the establishment of local treatment guidelines based upon local data would signify the last stage of policy transplantation, or the terminal stage in which a

traveling policy orientation and its know-how really "go native" and become fully domesticated.

From this stage on, policy is not only transposed; it grows new knowledge. Actually the velocity of local knowledge growth is amazing. I attended the annual meeting of Taiwanese psychiatry in 2008 and found that the most discussed issues in post presentations concerned drug use and drug users. Furthermore, in addition to existing studies of HIV/AIDS and drug use, there have been a number of studies that specifically concentrate on harm reduction. Mostly government-sponsored, they provide the empirical foundations on which future revisions of harm reduction policy can be made. This is another feature showing that knowledge production and biopolitics formation are intertwined.

All of these conflicts and adaptations can be seen as the consequences of inevitable "frictions" (Tsing 2004) when a policy is introduced into Taiwan whose long-held governmental rationality is incongruent with that of the introduced action. These conflicts and adaptations constitute the defining characteristics of what Roddey Reid (2005) calls "global singularities" whose heterogeneity and variation cannot be easily erased even beneath the surface of the unifying trend of globalization. What Tsing means by frictions is inspiring because it casts our attention onto those areas of incongruence and inconsistency that better expose how locals react to the imposition of foreign influences, be they political, economic, cultural, or technoscientific. It shifts our attention from abstract terminology such as *the global* and *the local* to concrete practices that make these transplanted concepts, technologies and/or structures viable. The so-called globalization phenomena are split into diversified and multi-faceted fragments that defy a grand discourse or unifying description. Instead, the global/local dichotomy, no matter what this opposition may

refer to, fractures into problems of transplantation—in this case, how a piece or set of knowledge travels and settles.

Despite the transformations in the original assemblage of harm reduction, this policy has, as many CDC officials hoped, been widely recognized and propagandized. On the website of AHRN (2009), a clip can be played with the title, "Harm Reduction in Taiwan: Showcasing Asian Leadership on Harm Reduction." Besides, an electronic communication by Marwaan Macan-Marker, in the Asian Harm Reduction Network (AHRN), praises Taiwan in the article: "Taiwan is emerging as a beacon of hope for countries across Asia grappling to stop the spread of the AIDS epidemic among injection drug users (IDUs), a major risk group." He quotes Tom Smits, executive director of AHRN, "No other country in Asia can match Taiwan's achievement in launching and sustaining this harm reduction programme" (Macan-Marker 2009, not paginated).

Thus an instant legend is created, a success in public health policy that aims to contain public risks, and one that bureaucrats may hopefully follow when the next threat to the public arises. Interestingly, in this electronic communication, Taiwan's story is fashioned as a moral parable that emphasizes the significance of perseverance in the face of suspicion and rebuke from the media, the parliament or even the public. Salient here is its picturesque title: "Taiwan blazes a trail to help drug users with HIV" (Macan-Marker 2009). The article seems to recommend that policymakers who craft harm reduction should hold onto their beliefs and fight against prejudice, ignorance and resistance. Eventually victory will be theirs.

Human determination matters, but it is not everything. As I have tried to portray in this dissertation, the story is much more complicated than is depicted in the email com-

munication. Moreover, the success it means to different parties reminds me of the story of the blind men and the elephant—each one touches a piece of it but no one has the whole view. For instance, it comes as no surprise that ex-minister of health Hou Sheng-Mou, witnessing the progress of this policy at each stage, considers this policy one of the most satisfying projects in his three-year period of service (Hou's interview). However, which part of it is successful? According to an anonymous CDC official, "…. [T]he biggest thing to learn from this [harm reduction program] is, for me, that we know we can control the epidemic, enhance our relationships with other departments and units, and improve the way we cooperate with others." The extension and depth of cooperation characterized the definition of success. This may not be the case for other people. For example, at the HIV/AIDS convention in September (see Chapter Six), Deputy Magistrate Yen Chun-Zuo even suggested that drug use per se should be decriminalized and that only drug dealing and manufacturing should be punitively treated. His words indicated another new space of discussion successfully opened up by this policy initiative. The idea of decriminalization is being discussed among lawmakers and prosecutors at this moment. Some insight from the postponed prosecution program has been written into legal codes awaiting further implementation. In a nutshell, harm reduction policy, from its generation to its implementation and expansion, has not only produced a number of opportunities for new collaborations but also fostered critical reflections regarding current legal and health systems. That said, how far this policy may go remains uncertain.

Predicting how harm reduction policy may develop is not my intent, and it is actually impossible to do so because there are so many contingencies that may affect its future direction. Nonetheless, some features missing from Taiwan's harm reduction policy do

warrant further observation. First, since universal human rights are not the undergirding principle of Taiwan's harm reduction policy, the momentum that makes it happen and keeps it going is based on the mandate of public health and collective safety. Once the perceived threat of HIV/AIDS declines, the enthusiasm of the government for harm reduction will eventually ebb. As Professor Ko apprehensively predicts, another epidemic of HIV/AIDS among IDUs may plague Taiwan again. In addition, Taiwan's harm reduction policy lacks drug user advocacy group. This makes it even more difficult for the public to understand, let alone accept drug users' demands for human right. Although Turner (1997) argued universal human rights could be the conjoining principle that sustained a global citizenship, it has not been realized in the case of Taiwan's harm reduction policy. Given the few existing channels for drug users to speak for themselves, the influence of experts is even more pivotal for protection drug users' rights. In fact, some of them, like Professor Ko, have intentionally become spokespersons for drug users.

This case study is not intended as a critique of what has or has not been done in terms of harm reduction, nor is it intended to give a bird's eye view in order to guide future government actions. Distinct from most institution-based policy studies, my research does not follow a mechanistic, stepwise pattern of policy progression (Kingston 1995; Bardach 2009), nor does it unquestionably presuppose that the motivating force resides in either the state or society (Birkland 2005). On the contrary, my approach is closer to post-structuralist science and technology policy studies (Gottweis 1998), but my intent is to expand the theoretical repertoire to other domains, such as post-colonialism and science and technology studies (STS). Overall, the result is an analysis of the numerous

processes, emergences, interactions and resistances present, however ephemerally, in the policymaking process over time.

I next need to make clear how this case study of harm reduction policy in Taiwan enlightens us in the domains of STS and, more widely, in social theory. Therefore, I will elaborate on the insights this example offers into the making of the contemporary, to quote Rabinow (2007).

7.2 Theoretical Reflections

To conclude, I offer a synthesis of my findings and arguments in this dissertation and some reflections about the contribution of my research either to STS or to sociology in general.

First is the importance of integrating the discussion of technoscientific knowledge and practice into a Foucaultian critique of modernity. That is to say, it is necessary to combine the scholarship of STS and Foucault studies to fully grapple with the ways in which and the extent to which contemporary life comes into being with the aid of science and technology. To further elaborate this idea, there are at least two points I need to clarify and expand upon. On the one hand, a Foucaultian approach to the contemporary human condition and modern political reason would be unfortunately incomplete without considering technoscience. Foucault himself has repeatedly revealed in his interviews the inter-linking of knowledge and power that characterizes modern subject formation (for example, see Foucault 1982). In *Discipline and Punish* (1978) he delineates a genealogy about how modern institutions such as prisons indoctrinate individuals both physically

and mentally. His work reveals not only the rationality that imbues modern subjects but also the materiality that features this type of forced or self-fashioning. Later in the discourse on governmentalization (Foucault 1991a; Gordon 1991), he stresses the co-extensive and co-constitutive transformations of both government and the governed in ways that superimpose on but do not supersede the previous sovereignty-centered power structure. This governmentalization process is, of course, primarily concerned with political reason and social organization, but it is also about the formation, appropriation and application of certain forms of knowledge and technology. Ian Hacking, for example, demonstrates how the rise of statistics as a science is closely linked with the needs of modern society (Hacking 1990, 1991: Schweber 2006). Other examples include social medicine, public health, and the so-called psi-sciences (psychology, psychiatry and psychoanalysis) (Foucault 1997a; Porter 1999; Rose 1997, 2007). These human and social sciences define what a human being is and should be, and therefore act as ethical grids for forming technologies of the self (Foucault 1997b). In a word, technoscience has come to be an indispensable part of biopolitics and self-fashioning. Thus an analysis of biopolitics vis-à-vis modernity that fails to scrutinize its technoscientific dimension would be insufficient.

On the other hand, as Bruno Latour (1988:229) once pointed out, science is politics by other means. It has been widely accepted in STS that technoscience *is* inherently political not simply because it is often produced and used for political ends but also because it often symbolizes and materializes condensed forms of politics that ironically may wear a de-politicized mask (Hayden 2003; Petryna 2002; Visvanathan 1988; Winner 1986). In fact, technoscience has become part of the apparatus of subjection for biopoliti-

cal purposes in the contemporary world. In the case of harm reduction, drug users are disciplined first of all by prison and by the hospital, and then, given the conveniences brought about by harm reduction policy, they are also asked to use clean paraphernalia and bleach, identify themselves by either iris scanning or fingerprinting before making use of MMT services, and also receive regular psychotherapy with routine screening. Although the measures taken can be compulsory in some cases, there is also a trend that the government's position in terms of harm reduction has been gradually shifting towards a more laissez-faire orientation.

This is not the same as the previous model of criminalization, nor is it the same as the idealizing enthusiasm and supportiveness that was a feature of the initial stages of harm reduction policy implementation. Instead, it divides drug users not by how severe their addiction is but by how much they can afford available treatments. The pricing contrast of methadone and Suboxone® is quite illustrative of the market-driven scenario that may soon befall drug users. In this scenario, the government treats each and every drug user not as an incorrigible felon but as a calculating individual who knows how to keep him or herself safe by adopting desirable health behaviors and choosing affordable treatment modalities. In this model of governance, health becomes part of cultural capital that can be accumulated (Shim, forthcoming), and this cultural health capital (CHC) contributes greatly to the stratification of addiction treatment market. From this perspective, the NSP, MMT and other harm reduction programs are not just constitutive of the technologies that serve political ends for the sake of governance. They are bio-politics real and corporeal to those who participate in the program, be they drug users, researchers, bureaucrats, or medical professionals.

My second theoretical reflection involves reappraisal of the global and the local as explanatory terms. In formulating my case of harm reduction, I have found the often cited global/local dichotomy poses more problems than clarifies situations. For example, it is easy to say that foreign experts and international organizations represent (at least part of) the global that fosters Taiwan's harm reduction policy, which represents the local. Nevertheless, this type of characterization tends to suffer the fallacy of homogenizing the global as the backdrop in front of which the uniqueness of the local—policy details in this case—is played out. Viewed in this rigid, dichotomized way, the Taiwan case of harm reduction that I present here is nothing but a "local" version of a universal program, biopolitical strategy, or policy orientation. It is subsumed into the universal, hence it becomes a project that can never be complete in itself. However, many scholars have repeatedly cautioned about the danger of this dichotomizing way of imagining because it not only narrows the range of connotations of global and local but also presents the concepts in an inherently antagonistic manner (Collier and Ong 2005; Knorr-Cetina 2007; Tsing 2004). I do not want to reinforce the already established binary opposition of global/local in ways that imply its connotational closeness to universal/singular or homogeneous/particular. Neither do I wish to conceptualize their meanings solely by the presumed difference of scale or space. The global is not "there"; the local is not "here". Instead, what we need to do is to problematize the dichotomies and question the implicit underlying presuppositions. In this regard, I am greatly inspired by Anna Tsing when she says:

> It is this kind of post- and neocolonial universal that has enlivened liberal politics as well as economic neoliberalism as they have spread around the world with such animation since the end of the Cold War….The specificity of global connections is an ever-present reminder that universal *claims* do not ac-

> tually make everything everywhere the same (Tsing 2004: 1, emphasis added).

Tsing's suggested solution is to study those "frictions" of global connections as they act as reminders of the fact that "heterogeneous and unequal encounters can lead to new arrangements of culture and power" (Tsing 2004: 5). Such an approach therefore resets the analysis of global phenomena not as one that is built on taken-for-granted conceptual pairs such as global/local but as one that empirically inquires into the processes by which these pairs are themselves produced and understood, and that looks into the details for inconsistencies (or in Tsing's words, frictions) when global connections are made. In my reading, this method re-directs the research from abstract definitions to concrete practices. The question "what does the global do to the local?" becomes "what do people and things do in the name of the global and the local so as to make both terms look the way they are now?" This methodological turn means that researchers need to look at how harm reduction is brought into being and how the global and the local are defined, positioned and even appropriated during the process. It was, then, to generate a genealogical inquiry of harm reduction policy in Taiwan as well as a cartographic attempt to re-situate things and events that I turned the question of globalization of harm reduction into one of knowledge/policy transplantation in Chapter Six.

In what ways, then, can we conceptualize the formation of globalizing biopolitics and governmentality with the aide of technoscience without falling into the barren opposition of the global and the local? Here I adopt the notion of assemblage from Deleuze and Guattari (1987) because this interpretive stance addresses my third reflection, *the need for a useful frame*. For example, I introduced in Chapter Three the notion of *the of-*

fice to conceptualize a previously less discussed domain, which was represented by an assemblage of actors participating in the policymaking process. These actors could be humans or non-humans, their associations could be transient, informal, and unstable, and the shape of the formed assemblage could be incessantly changing. Yet *the office* was a producing ensemble that was at the same time transformed by its products—down-to-earth practices, socio-political consequences, users' responses, and generated knowledge. In a word, an assemblage, such as *the office*, and its effects are constantly co-produced. Such a useful frame as *the office* is necessary first to theorize the ways that biopolitical regimes and neoliberal governmentality delineated by Foucault are applied to understand socio-political situations outside their original milieu. Second, they help account for the similarities and differences when they are refashioned in each site of policy implementation or resistance formation.

The use of assemblages as an analytic concept has been found in research of various scholars (DeLanda 2006; Irwin and Michael 2003; Ong and J.Collier 2005), who apply the notion to account for the fluid and often transient encounters of humans and things that are socially consequential. Moreover, because of its propensity to resist and even refute unidirectional causality and ontological essentialism (DeLanda 2006), it is especially suitable for describing situations where co-constitution and co-evolution of science and society are most salient. It also applies to the moment of emergence of biopolitics and globalization, because globalizing biopolitics, expressed in the form of policy, needs to fit the specific locality where it is implemented. The "fitting" implies incessant alterations of construction and destruction, so it is all the more significant analytically to capture the moment when the situation is murky, things are amorphous and associations are

unstable. Even though promoting the prosperity of the population of the nation-state and maintaining its own security remain the central dogma of biopolitics evident in most if not all contemporary countries, the forms and shapes of these biopolitical projects may be very different (Greenhalgh and Winckler 2005; Greenhalgh 2005). Given the fact that the undergirding technosciences of these projects are frequently appropriated globally but the infrastructure with which these projects are made possible is inherited locally, there are surely likely sites of contingencies and "frictions", to quote Tsing (2004), when a Euro-American version of biopolitics becomes indigenous. Therefore, it is my argument that biopolitics, in spite of Foucault's insightful genealogy in the European context, is not isomorphic everywhere.

This heteromorphism of biopolitics has been substantiated by a wide array of scholarship (Stoler 1995), but it seems to me that what matters more is the ways they have become so heterogeneous. In colonial times, biopolitics came along with colonial surveillance and disciplinary action (Anderson 2006; Stoler 1995; Stoler and Cooper 1997), while in post-colonial times, it persists and permeates into the fabric of everyday life in ways that transcend national borders and defy institutional limits (Adams 2002; Anderson 2002; Anderson and Adams 2007; Stoler and Cooper 1997). Sometimes it travels with transnational flows of capital and knowledge (Sunder Rajan 2006), sometimes it is promulgated with the aid of international organizations (Roemer 1994), and sometimes it is learned and mimicked from "the West," purposely appropriated as a short-cut for problem-solving (Bhabha 1984; Lo 2002). Oftentimes there is more than one mechanism at work that makes a biopolitical project take root. Director Kuo of the CDC justified his choice of transplanting harm reduction policy when I asked him about this: "I believe we

are never the first to encounter such a problem [HIV/AIDS transmission among IDUs], so there must be a solution somewhere for us to learn." This actually refers to a framing effect in which a social phenomenon is defined as "having happened elsewhere" so a previously generated solution can be located and transplanted. However, as I have shown in Chapters Two and Three, the framing process cannot occur without its local historical precedents and contemporaneous social conditions. Besides, contingencies abound and participants are hard to pinpoint. Even if these things do factor into the making of harm reduction policy, their presence is mostly dubious and their significance undulating. While HIV professionals stick with the CDC in their collaboration in the fight against HIV/AIDS, addiction specialists proceed to work with the National Health Research Institute (NHRI) to establish the subspecialty of addiction medicine. Citizen addicts exhibited their collective resistance in the rejection of unfit needles and syringes. In the end, however, they have adapted themselves passively to this new citizenship status except for those who, with the help of experts, have found a voice for themselves in conferences or public hearings that involve policymaking. Scientific knowledge as well as biotechnologies are appropriated or applied to serve administrative needs for policy design, patient identification and hazard control. These addicted "patients", too, seek to improve their situations. All these things point to the necessity of finding a conceptual and methodological frame to congeal as well as conjure the ephemeral moment that all actors, human or non-human, encounter and make things work. As this research shows the concept of assemblage serves this end well as it is itself a fluid notion that allows for variation, escape, vanishing, emergence and mutual inclusion.

My fourth reflection, quite related to the third, concerns the de-centering of the Euro-American version of biopolitics, or more specifically, the biopolitical regimes involving not only (allegedly) universal knowledge but also individual conditions. Stoler and Cooper (1997) have insightfully questioned the Eurocentric notion of biopolitics by situating it within the context of colonization in which metropolis and colony stood for two poles constituting each other. If their argument stands true, there are, as Prakash once argued in *Another Reason* (1999), alternative forms of biopolitics and governmentality. These alternatives, frequently combined with nation-building desires and generated in specific trajectories of development, have already been illustrated in some Asian and African countries (Adam 1998; Ferguson 1994; Gupta 1998).

This de-centering, or provincializing in Dipesh Charkrabarty's (2000) terms, of Euro-American biopolitics does not intend to erase its presence; on the contrary, it is to stress its local variations that complicate what we imagine biopolitics would be. As Charkrabarty explains in his introduction to *Provincializing Europe* (2000: 3-4, italics original), " The Europe I seek to provincialize or decenter is an imaginary figure that remains deeply embedded in *clichéd and shorthand forms* in some everyday habits of thought that invariably subtend attempts in the social sciences to address questions of political modernity in South Asia." His approach is deeply informed by the tradition of subaltern studies, totally beyond my scope here. But this idea of provincializing Europe is intellectually provocative because it defies the implicit presumption that there is only one version, and a Euro-American one, of biopolitics or political modernity.

This postcolonial perspective is evident in the studies of technoscience (that is, postcolonial STS) as a refutation of previously prevalent theories of diffusionism. For postco-

lonial STS, the entanglement of science and policy is a vital issue in that the sciences focusing on biopolitics-related issues such as public health, reproduction, and epidemics are often "institutionalized by colonial and early postcolonial state-building projects that appealed to economic and cultural 'progress' as well as 'national security'" (Pigg and Adams 2005: 12). However, my study is not about postcolonial development camouflaged as a scientifically robust plan of national improvement (Abraham 1999; Ferguson 1994; Gupta 1998), because Taiwan has been independent from Japanese colonizers for more than fifty years and is well-established in many ways. Taiwan's harm reduction policy, unlike its earlier family planning and TB prevention policies (Kuo 2006; Chang 2006, 2009), is quite different from the developmental projects for postcolonial states where foreign forces interfere with national planning in terms of its economic strategizing and political functioning (Mitchell 2002).

In this sense, the term *postcolonial* that I use should be seen in light of the above stated reappraisal of globalization debates. In Kuo's case (2005,2009), concerns about racial differences even among so-called "Asian" populations were traceable back to previous colonial memories (see, for example, Wu [2004] on Japanese colonization of Taiwan and the medical-scientific discourses on the "Taiwanese race"). But race was utilized by the Japanese government in the International Conferences of Harmonization (ICH) as a timeless scientific category that allegedly stood for national autonomy and interest vis-à-vis transnational pharmaceutical companies eager to enter the Japanese market. That is to say, by "postcolonial" I mean a perspective that articulates the immanent practices, resistances and strategies that echo power and material issues lingering from colonial times yet also engineer the sustenance of marginal spaces within such a global/local di-

chotomy. In this sense, the way I treat postcoloniality is similar to the broader sense that Begoña Aretxaga (2008) means when she talks about the "altered state" or the marginal status of political madness in post-dictatorial Spain. Her ideas have been expanded by Good and colleagues (2008: 6-7) to cover situations or settings where colonial power dynamics are often inherited and affect the contemporary era in the forms of institutionalized structures, traumatic memories, continued violence and suppressive domination and appropriation.

This approach to postcoloniality, or more specifically in my case, to postcolonial STS, disassembles the long-held assumptions of associations between science, medicine and politics whose shapes have often been homogenized and stereotyped as one—and the one and only one kind—"Europe", à la Charkrabarty (2000). That is to say, instead of glorifying largely neglected indigenous knowledge (Turnbull 2000; Verran 2002) or emphasizing the (mostly asymmetrical) bi-directionality of transmission of technoscience (Anderson 2002, 2006), I endeavor to conceive of this multiplication and its subsequent mutation of a certain biopolitical project that depends on the travel of technoscience as a long and complex *series* of assemblage formations (Verran 1998). This way of understanding is different from the old diffusionist version (and also Latour's [1986] immutable mobile thesis) because it stresses the heterogeneity and completeness of each assemblage and turns the analytic focus to the associations within and between assemblages. The assemblage approach therefore avoids the Eurocentric ideology behind the "not yet" description of Asia (Chakrabarty 2000: 8) and places Asian cases on the same footing as their Euro-American counterparts.

As I have illuminated in previous chapters, the biopolitical configuration of harm reduction policy is different in Taiwan from that in other countries. It is uniquely characterized by administrative dependence on the public health infrastructure which is partly colonial legacy, top-down development of policy planning, piecemeal community involvement in policy processes, informal and unstable channeling with international organizations and knowledge, and a distinctive pattern of expert-making and expertise formation through self-learning and self-organized professionalization. The resultant biopolitics obviously is distinct from its European or American counterparts but perhaps is closer to the situations in other Asian countries.

This leads to another point of discussion: Fu (2007), in a position paper that heralds the publication of the *East Asian Science, Technology and Society: An International Journal* (EASTS), inquired whether East Asian STS studies can be distinguished from East Asian "area studies" that apply Western STS theories. He further criticized the potential of the Latourian network theory to overthrow the dichotomizing, interdependent pair of metropolis and periphery, and he questioned how power inequality in terms of knowledge and politics should be addressed without a center/periphery dyad. What Fu was asking is actually the extent to which emergent East Asian STS may effectively refute the old-time diffusionism and create its own theoretical niche. Though I had not read Fu's article until very late in my field work phase, my project somehow answered his criticism, offering a case study that exemplified an approach to this question of postcoloniality. I hope my study has successfully demonstrated a doable approach for studying East Asian as well as other similarly postcolonial conditions.

My fifth reflection concerns the significance of short-lived phenomena and the significance of studying them. When it comes to the making of harm reduction policy in Taiwan, it should be noted that the duration from its genesis to normalization (*changtai-hua*) is merely five years. Certainly the longue durée method of the Annales School does not apply. Nonetheless, the rapid normalization of this policy still highlights something more persistent and longer in duration. For example, when I asked Director Kuo how and why harm reduction could work so quickly, he attributed its success to "cultural" factors: "Taiwan is culturally characterized as a shallow dish," he said. A shallow dish means that a ripple, once appearing, spreads fast. Later he quoted a Chinese phrase to describe this tendency as "a gust of wind (*yi wofong*)." [33] However, what spreads fast may die fast. Kuo's worries that harm reduction policy might be hampered or halted were neither ungrounded nor simply about changed political leadership. The reason was still cultural, or more exactly, it was that we have no strong cultural bond. Kuo stated,

> We mobilize very fast. During the apex of the SARS epidemic, the foreign supervisors felt the same way. This case [i.e., harm reduction] can be viewed in the same light, probably still related to the notion of *yi wofong*. That is to say, we are not bound by strong cultural or religious belief, so we can move fast. But the momentum disappears fast, too. (Interview 08/15/2008)

Can we say, then, that this "shallow dish" culture constitutes the context in which the rapid implementation of harm reduction policy is made possible? Or should we say that it is the very success of rapid policy implementation that conjures this cultural explanation as a way of making sense? When we approach an issue in a way that emphasizes the ephe-

[33] This saying is sometimes expressed as "a swamp of bees" (一窩蜂), which sounds exactly the same as "a gust of wind" (一窩風) in Chinese. Either way, it means the swiftness of collective action.

merality of an event, how do we treat the temporal dimensions in which the event unfolds?

Eventalization in Foucault's opinion not only provides a specific depiction of the conditions of possibility for a singularity to take place (Foucault 1991b); it also helps to outline the murky context in which the event arises. In Foucault's own words, "'eventalization' thus works by constructing around the singular event analyzed as process a 'polygon' or rather a 'polyhedron' of intelligibility" (Foucault 1991b: 77). In some sense the notion of assemblages formulates an event, along with the ways in which things form, interact and then dissipate that contribute to the event (the "polygon" or "polyhedron"). It is therefore a suitable concept for describing the processes of eventalization. In addition, by observing how assemblages de-territorialize and re-territorialize, the context ("culture" in this case) is enacted and conjured at the same time. In other words, this assemblage approach does not lose sight of the context when it foregrounds the unfolding of the event. Instead, it favors a perspective in which the event and its context are co-constructed and continue to unfold.

Sixth and lastly, as I discussed in Chapter Four, recent STS scholarship has focused on the problematization of experts, especially in terms of public decision making. Brian Wynne's critique of scientific experts in his Cambrian case is a typical example in which experts stand in opposition to the local public just as their scientific knowledge does to the Cambrian farmers' local knowledge (Wynne 1992). In another often cited example, Epstein (1996) traces the historical trajectory of the AIDS movement in the San Francisco Bay Area in which scientific experts and concerned lay people interacted and transformed each other. In his formulation, experts still occupy a position in opposition to

laypeople even though the two positions are transmutable and communicable, hence the newly coined category of "lay experts" (Epstein 1996). These two accounts together shape an antagonism, innocent and alterable perhaps, between experts and laypeople (also see Collins and Evans 2002). As a matter of fact, the distinction between the haves and the have-nots in terms of specialized knowledge constitutes the basis of a vast array of disputes regarding democracy and expertise-based politics (Collins and Evans 2007; Reardon 2008), but it is at the same time often misconstrued (Wynne 2007). For one thing, the distinction of invited and uninvited participation of the public in the policymaking process should be emphasized, Wynne (2007) contends, because the spontaneity of participation reflects whether the frame of the issue is imposed or self-generated. From another perspective, Reardon (2007) echoes and makes more sophisticated Wynne's concerns by arguing that it is insufficient just to include the subjects in the policymaking process. More importantly, she argues, the inclusion of research subjects may inadvertently create a false impression of democratization of a technoscientific project. In fact, it is more consequential whether fundamental questions about the order and constitution of societies are written into the research agendas. In sum, for STS to deal with the expertise-dependence issue in policymaking, several approaches have been advocated—the critical scrutiny of the problem frame (Wynne 1992, 2007), the application of deliberative democracy methods (Cheng and Deng 2007), and/or the specification and introduction of interactional experts (Collins and Evans 2002, 2007; Selinger and Mix 2006).

My own point here is not just to deconstruct expertise, to create new expertise, or to make existing expertise more receptive to and accepted by the public. Instead, it is to highlight a new position, given the present structure of expertise vis-à-vis policymaking,

for relevant experts when they have opportunities to advance their knowledge and suggestions to policymakers, or on some occasions, when they *are* the policymakers. My suggestion is that experts can be, as I have illustrated in Chapter Four, knowledgeable spokespersons for drug users, or more broadly, for those who are too disenfranchised to enter the circle of decision-making about their own affairs. In other words, my study shows that, given the current absence of organized advocacy groups for drug users in Taiwan, experts could and did still stand on the same side as their subjects and were, to borrow Collins and Evans' (2007) terminology, both contributory and interactional experts at the same time. However, this optimistic position is not without its potential problematics. For example, if knowledge is inevitably entangled with power, à la Foucault, and the experts who possess the knowledge/power aptly act as the channels from which their subjects may speak, then how could the experts relate to their study subjects in a more egalitarian and non-dominating way? And what if the claimed image of objectivity as a specialized researcher conflicts with the argumentative posture of subjectivity as a dedicated advocate? Is there really a way to reconcile the two incongruent and potentially opposing standpoints?

In my opinion, the intriguing balance between expertise and democracy in public decision making hinges on these questions, which can only be answered by empirical research. These questions not only reveal the intricate entanglement of knowledge and power, but also point to a previously less discussed issue—the epistemological, ethical and socio-political conditions and implications of transforming an expert in one domain into an expert in another.

7.3 Finale

This dissertation has gone far beyond its original humble purposes and shed light on multiple aspects of a biopolitical regime in Taiwan. It is, nevertheless, partial in terms of descriptive completeness and analysis. I contend that the partiality is inevitable and forgivable for good reason. On the one hand, it is impossible to pursue everything that has been revealed in the formative process of this drug policy. Consequently I opt not to cover issues such as transnational policy comparisons ("What are the similarities and differences of the harm reduction policy in Taiwan compared to that of another country?"), the post-authoritative governmental configuration ("Why do some people think the harm reduction policy would have been impossible if the dominating political party had been the KMT?"), extensive cost-effective analysis ("To what degree and in what way does harm reduction work in terms of invested costs and measured outcomes?"), and ethnographic depiction of drug users' life on the street ("What kind of lives did drug users live before and after harm reduction?").

On the other hand, I do attempt to achieve something useful and valuable from the collected data and observed phenomena. My approach aims to set a research example that complicates rather than simplifies the situations that brought about the birth of harm reduction policy in Taiwan. It defies a linear explanatory model and favors a method of multi-layered and multi-faceted understanding that attends to a vast array of discourses, practices and institutions. The result, I believe, is a composite and inter-linking analysis, chronologically and thematically. It is a way of critical storytelling that serves both descriptive and analytic purposes. Although I refrain from making universal, normative or

prescriptive arguments, this critical analysis is not without its morals. However, instead of telling my readers straightforwardly what implications this research may convey, I would rather leave the joy of interpretation to my readers.

As my interviewed subjects and observed drug users agree, the harm reduction policy in Taiwan is both one point in a long line of governmental and organizational efforts to better manage bothersome drug problems and an aperture of the suffocating structure from which they may see a future of better bureaucratic cooperation and governmental-societal collaboration. The policy is, in a matter of speaking, a mixture of desire and hope, yet at the same time a technology of surveillance and self-making. The internal contradiction, polysemy and ambiguity of the subject matter also add the element of reflexivity to my research. It was not until I was wallowing deep in the muddy field (figuratively speaking, of course) that I began to realize this work could situate itself and me, the author and analyst, among the objects of its own criticism. That is to say, by making itself part of the literature on harm reduction in Taiwan, my dissertation becomes the object of its own analysis. By writing about this policy, I turn myself into a harm reduction expert that my analysis aims to understand.[34] In this sense, I not only situate myself in a "studying up" posture looking into the interplay of government and power (Nader 1972), but also put myself in a position of "studying across" and see my fellow "experts" in a new light (Reid 2000: 119-150). The effects and contradictions of my position actually complicate and problematize the subjectivity of the researcher (me!) and the objectivity of the research itself. I make no effort to neglect or conceal this contradiction but simply point it out here to show the limit of analysis. As a matter of fact, I weave my analysis into the

[34] Interestingly, the test of self-reflexivity emerged right from the start of my field work when I came back to Taiwan with the intent of studying harm reduction but was very quickly treated as an expert in this field instead. Please refer to note 12.

descriptive account not just for the sake of narrative convenience or analytic groundedness but also for the purpose of research reflexivity, which I adamantly contend is the basic value of qualitative study. I hope my efforts are successful enough to illustrate vividly to the readers the power of this self-reflexive style of analysis.

My dissertation ends here but the story does not….

Appendix A Interview Questions (English Version)

(Adapted from the research proposal; CHR approval number: H6577-30835-02)

The interview will be open-ended, encouraging participants to articulate their own perspectives on and experiences with the interactions between science and policy in terms of the development of harm reduction policies in Taiwan. The questions will serve to guide the interview, and not every probe will be asked.

Introduction:

Hello, thank you for meeting with me and sharing your ideas. Before we start, I would like to remind you that you can stop our interview or choose to state your opinion "off the record" at any time during our interview. I will ask some questions about your work experiences in terms of harm reduction in Taiwan. If you feel I have not been clear with my questions, please tell me and I can clarify them for you.

1. **First, would you please tell me about your education and training.**

2. **Would you please tell me how your work is related to harm reduction? [Probe]:** What is it about? What do you do that makes you related to the policy-making of harm reduction?

3. **Would you please tell me the story of your participation in harm reduction? How did you get involved? What did you do? Are you still active in the area?**

4. **(A) Based on all your experiences to date, would you please give me your current views on harm reduction in Taiwan?**
   (B) What do you think is the biggest benefit that harm reduction may bring?
   (C) What do you think is the limit of harm reduction in achieving that goal?
   (D) What adverse effect(s) do you think harm reduction may bring?
   (E) What effect do you think harm reduction will have on the definition of drug use and addiction? [Probe]: in medical, legal and socio-cultural domains?

5. **(A) How do you feel about the participation of scientific experts in the formulation of this harm reduction policy?**
   (B) Please give me your personal suggestions on the best criteria for including or excluding certain experts.
   (C) What do you think are the advantages or disadvantages of recruiting scientific experts in a policymaking process?
   (D) How do you feel about the participation of scientific expertise in public policy in terms of Taiwan's public decision-making in general?

6. **(A) How do you think harm reduction is related to other Taiwanese traditions?** [Probe]: such as colonial legacies or folk beliefs or shared ideologies?
   (B) What do you think are the domestic causes and effects of harm reduction policy?
   (C) What do you think are the international causes and effects of harm reduction policy?

7. **Is there anything else you would like to tell me that I should know about?**
8. **Before we end this interview, do you have any questions for me?**

Thank you for your time.

Appendix B Interview Questions (Chinese Version)

(Adapted from the research proposal; CHR approval number: H6577-30835-02)

會談訪問將以開放式進行，以鼓勵參加者對於減害政策發展當中的科學與政策的互動，清楚陳述他們的觀點與經驗。這些問題將當成是引導會談訪問進行的工具，並不是所有的探測性問題都要提出。

介紹

您好，謝謝您與我見面，分享你的意見。我們開始之前，我想要提醒您：您可以在我們會談訪問的過程中的任何時刻停止會談，或者選擇用「非正式紀錄」的方式陳述您的意見。我將會詢問一些跟您跟減害措施相關的工作經驗，如果您覺得我的問題不夠清楚，請告訴我，我可以為您澄清語意。

問題

1. 首先請您告訴我，您的教育跟訓練背景。

2. 能不能請您告訴我您的工作跟減害措施有何關聯？
[探測性問題]：工作內容是怎樣？你做些甚麼事情以致於讓自己跟減害措施有關連？

3. 能不能請您告訴我，您參與減害措施的整個故事？您是怎麼涉入其中的？您做些怎樣的事情？您現在還參與這方面的工作嗎？

4. (A) 基於您到目前為止的經驗，能不能說說您目前對於台灣減害措施的看法？
(B) 您認為減害措施會帶來的最大好處是甚麼？
(C) 您認為減害措施達到這個目標的限制會是甚麼？
(D) 您認為減害措施可能會有怎樣的負面效果？
(E) 您覺得減害措施對於藥物使用與成癮的定義會有怎樣的作用？
[探測性問題]：在醫療、法律、社會文化的領域裡面？

5. (A) 您對於科學專家參與減害政策的制定有何感受？
(B) 請說說你對於納入或者排除某些專家的最佳判準，有何個人建議？
(C) 您認為政策制定過程中將科學專家納入，有何優點與缺點？
(D) 以台灣一般的公共決策來說，您對於科學專業參與公共政策有何感覺？

4. (A) 您覺得減害措施跟台灣其他傳統有怎樣的相關？

[探測性問題]：例如說殖民遺緒、民間信仰、或者共享的意識形態？

(B) 您認為減害政策的國內原因與效果是甚麼？

(C) 您認為減害政策的國際原因與效果是甚麼？

5. 還有些甚麼我該知道的事情，您想告訴我？

6. 我們結束會談之前，您還有問題要問我嗎？

非常感謝您花時間跟我進行會談。

Appendix C Map of Taiwan (English)

(Retrieved September 30, 2009 from http://www.esltaiwan.com/articles/44/1/Map-of-Taiwan/Page1.html)

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