Closer and Closer, Faster and Faster: Grassroots NGOs and the Methamphetamine Trade

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The world is too much with us; late and soon,
Getting and spending, we lay waste our powers;
Little we see in Nature that is ours;
We have given our hearts away, a sordid boon!
—William Wordsworth

The 'sordid boons' of globalisation encapsulate both the best and worst of the innovations and reconfigurations born of the last two decades. For global health, this has meant an increase in equality and positive health outcomes, on the one hand, and a marked decrease of equality and outcomes, on the other. Making such divergent states simultaneously possible are the accelerated, fragmented and intensified forms of transnational communication and mobility that have come to characterise global social networks. These have proliferated amidst the torrent of global opportunism, information and information-sharing technology and desire for social connectivity and belonging. Global social networks, thus, strike at the heart of what former United Nations Secretary-General Kofi Annan has called the "fragility" of globalisation; in other words, a global state absent of centralised control or ethical direction (1999). This "fragility" is manifest through the juxtaposition of two fundamentally incongruous health networks: 'grassroots' nongovernmental organizations (GNGOs) and the methamphetamine drug trade. Whereas, both systems have gained momentum utilising the structures and filling in the niches innovated or reconfigured by globalization, the former is a global network of local civil service actors who provide health and social services to marginalised or underserved communities, while the latter is a global network of gangs, users, and cooks devastating the lives, communities and healthcare systems of millions of the most vulnerable.

Social wellbeing and Global Social Networks

In 1948, “social wellbeing” joined its “physical” and “mental” analogues to comprise the World Health Organisation’s definition of health, thereby officially diverging from antecedent definitions rooted in the biomedical paradigm. Since then, and long before, this issue, of the ubiquitous need for social belonging and connectivity, has fascinated prolific sociologists, psychologists, educators, philosophers and others. Despite the momentous changes that have swept through society since the publication of such monographs as *Suicide* (Durkheim, 1897) and *Toward a Psychology of Being* (Maslow, 1968), the phenomena and derivative implications of “anomie” and “optimal functioning” that they respectively anatomise have not only altered little, but have rocketed in significance (Huynen et al., 2005). For today, the desire, even hunger, for shared social experience and interaction—even if not deep or genuine per se—is suffused in the images and ‘texts’ of our societies to an unprecedented degree (Reid, 2004). No doubt contributing to this, if not driving it, is the foundering of many longstanding institutions of social relations, including marriage, nuclear families and cultural communities, which have engendered feelings of exclusion and alienation (Brown, 2001). Thus, in this globalising world, people—especially those politically or socially disenfranchised—are seeking new connections and interactions to consciously or unconsciously improve their social wellbeing. But whereas social relations were once characterised by their blood bonds and immutability, in the contemporary globalised world, solidarity and social ‘inclusion’ are the characteristics most being sought (Reid, 2004). Global social networks, whether they constitute GNGO employees and volunteers or methamphetamine traffickers and users service this same function. They provide interaction and identification with a web of persons beyond the physical geographies and cultural institutions of one’s environment, and hence engender a sense of belonging.

Global Social Networks and Grassroots Nongovernmental Organisations (GNGOs)

Over the last two decades, global social networks have played a vital role in the proliferation of non-profit nongovernment organisations (NGOs). With roots in religious, political and social agendas, the NGO sector is now the eighth largest economy in the world, with some 37,000 organisations employing more than 19 million workers, and operating on an annual budget of over $1 trillion globally (Elkington, 2003). Such growing stores of capital and community power are testimony to the growing force of NGOs in local, national, and international spheres, wherein they serve as key partners in providing global health services

to communities throughout the minority and majority worlds (Bradshaw et al., 2001). Health-oriented NGOs achieve this by forming structures and undertaking functions most opportune to the niches available, and can be loosely categorised as (a) large, corporate-style organisations that promote global health agendas; (b) intermediary agencies that support grassroots organisations with technical and financial help, and engage in advocacy and fundraising; and (c) GNGOs that provide community-based services, often led by or created for marginalised populations (Sanyal, 2006; Routledge, 2003). While all three contribute in vital ways to promoting global health equality, it is GNGOs that have most proliferated due to the networks born of globalisation.

GNGOs are a relatively new phenomenon, enabled both by the surge in global funding and of the requirement that organisations keep overhead costs to a minimum (Edwards and Hulme, 1995). In this way, GNGOs epitomise the decentralised nodal character of global social networks that vary in structure and function from country to country, community to community. Undertakings of these community-based organisations include training and staff development, organisational capacity building, research and advocacy, information collection and dissemination, networking, peer education, and community development (Sanyal, 2006), as well as healthcare services, health promotion and policy-making (Wamai, 2004). Regardless of the philosophical or activist physiognomy of each, it is common for GNGOs to share resources, information and linkages, and in so doing, to expand their networks. Rare today are GNGOs that operate as independent units, driven by funding acquired without stipulations. More typically, GNGOs are functionally bonded to other such networks. In doing so, they both benefit from social interaction and connectivity and help to build coalitions that link inter-sectoral and international resources for the achievement of a common good (Sanyal, 2006).

Health equality and GNGOs

Some of the greatest health boons to emerge from the contemporary globalising world have come through the individual and collective efforts of global GNGOs, such as the provisioning of health and social services to marginalised and disenfranchised populations, building coalitions that can assume responsibilities typically relegated to the state, and through participatory development and community empowerment. Due to their (ideological, if not operational) independence from national governments and regional political processes, GNGOs have enormous capacity to improve the quality of life for those who are most

marginalised by dispensing welfare in the form of foodstuffs, clean drinking water and healthcare, as well as by operating capacity-building programmes (Bradshaw et al., 2001; Wamai, 2004). But not only have GNGOs involved with issues like HIV/ AIDS, sexual and reproductive health, and drug rehabilitation provided instrumental support, they have also played a vital role in managing the quality of information about diseases, sexuality and substance abuse that is disseminated to (especially) vulnerable populations (Misra, 2006). Moreover in many countries around the world, GNGOs are woven into the fabric of health policy-making, being recognised as critical advocates on behalf of marginalised communities (Wamai, 2004). GNGO coalitions have also yielded great health benefits to their communities and states, such as in the case of the AIDS-NGO Network founded in Nagar, India, which grew out of a union of seven GNGOs. Despite their own agendas and ideological histories, these organisations rallied around their shared a commitment HIV/AIDs advocacy and service provision (Misra, 2006). By linking services, they were able to support their community beyond what one or two of them could have achieved (Misra, 2006). Such collaboration that is absent of profiteering has positioned GNGOs to take on responsibilities previously belonging to the state, such as population-based health promotion and health services schemes. In Kenya and Finland, for example, health GNGOs direct and finance larger health promotion campaigns than those coordinated by the state.

Not only are the GNGOs working to deliver community-based services, but they are also committed to understanding how the processes of globalization can be harnessed to create and distribute greater social and health benefits. The increasing number of GNGOs, and the competition, even conflict, that has arisen between them over limited resources or differing agendas, albeit petulant and disruptive at times, has also been crucial for maintaining quality control of funding and programming resources (Edwards and Hulmes, 1995). More often, though, GNGOs have linked formerly disparate groups together, such as trade unionists, environmentalists, indigenous peoples, feminists, and health workers by bestowing a sense of belonging and “warm glow” on all participants alike (Bradshaw et al., 2001). Through the global social networks of GNGOs, globalisation has provided the context for health and health equality improvement, participatory democratisation and increased positive social interaction.

Global Social Networks and the Methamphetamine Trade

Concomitant with the global proliferation of GNGOs has been the expansion and diffusion of the methamphetamine trade, which too has been enabled and fuelled by the vital force of global social networks. Today, the global retail market for "P", as the central nervous system stimulant is known in New Zealand, is worth approximately $US 28 billion per year, with some 15-16 million people worldwide smoking, snorting or injecting the white powder each year, and with more than 50 million having consumed the drug at some point in their lifetime (United Nations Office on Drugs and Crime, 2007). Yet while the methamphetamine trade has expanded, markets for cocaine, opium and cannabis have markedly waned (United Nations Office on Drugs and Crime, 2008). What is it about the synthetic admixture of pseudoephedrine, phosphorus, iodine, and battery acid that has proven more compelling to manufacturers, traffickers and users than the 'traditional' illicit drugs of the past?

The significance of this answer lies tucked away in the same forces that underlay the growth of global health GNGOs and other global social networks: namely, communication technologies, increased migration and mobility, and opportunism to fill the niches pried open by globalisation. Setting aside the first two, whose emergent properties are more explicit, and turning to third, the successful diffusion of methamphetamine reflects the degree to which adaptability is a central feature of the globalised world. Whereas GNGOs evidence their internal malleability through providing services or developing programmes according to available funding, community needs or staff capacity, methamphetamine cooks and traffickers do the same (Fisher, 2007). When the "war on drugs" led to global policing efforts aimed at obliterating illicit opium, coca and cannabis production, these highly adaptive networks shifted to manufacturing methamphetamine, which, because it is synthetic, is neither perishable nor traceable, and so could be produced in metropolis centres and wayside towns alike (Shoptaw et al., 2006; Fisher, 2007). Moreover, when law enforcement began locating and shutting down centralised "super labs" that produced more than 200 kilograms of the powder a day, which were operated by biker gangs like the Hell's Angels and Mexican drug cartels, "mom and pop" labs began springing up in Canada and Kenya, Thailand and New Zealand. Even though these motel room labs only produce 500 grams of "P" at a time, they are highly mobile and situated close to their markets, two compelling benefits (Fisher, 2007; Kobori et al., 2009). Improvements in communication technologies as well as expanding global immigration, tourism and travel have contributed to "P" proliferation as well.

Health inequality and Methamphetamine

One would be hard pressed to find such an exemplar of the "fragility" of globalisation, as characterised by Kofi Annan, as the methamphetamine trade (1999). By facilitating the ease of manufacture and distribution of this "Class A" drug, global social networks, in this case, undermine global health equality by diminishing the health of users, placing an excessive burden on the health care system (Singer et al., 2006); causing family and social disorder associated with lost productivity, crime including child abuse, sexual abuse, and gang-related violence (McKetin et al., 2009; Thomson et al., 2009); polluting the environment through the dumping of toxic waste, which is produced six to one, for every pound of "P" produced (Singer et al., 2006; Kobori et al., 2009); and increasing the transmission of infectious diseases as well as the risk of HIV transmission through reckless promiscuity and shared injection needles (Shoptaw et al., 2006).

Further debilitating is the disproportionate affect these harms have on society's already marginalised and disenfranchised, especially in developing countries, where users are likely not only to consume the drug to promote social inclusion but also to increase stamina and energy necessary for working longer hours (Kulsudjarit, 2004). Included among the vulnerable users are school children and street youth (Kulsudjarit, 2004; Cape Argus, 2009); gay, bisexual, and men who have sex with men (MSM) (Shoptaw et al., 2006; Singer et al., 2006); carriers of sexually-transmitted diseases (STDs) and HIV (Shoptaw et al., 2006; Kobori et al., 2009); female sex workers, especially in developing countries (Patterson, 2009; Wechsberg et al., 2008); those with lower education (Wacquant, 2003; Corva, 2008); those with fewer employment opportunities or on government benefits (Kobori et al., 2009; McKetin et al., 2009); and those who are or have been incarcerated (Thomson et al., 2009). To promote use among these populations and to grow their networks, "P" traffickers will often give away free samples of methamphetamine tablets or sell it at a loss when trying to capture a new market by getting would-be customers addicted (Fisher, 2007). Once they have succeeded, they then raise the prices. But because many "P" users cannot afford the drug, they often turn to theft, prostitution, or drug manufacture themselves—whatever it takes. Manufacture and use thus drive further manufacture and use.

The disproportionate adverse health effect of methamphetamine on the poor has led some to theorise about the role that the "War on Drugs" has played in the ''penalization of poverty'' through the promotion of "narco-delinquency" (Wacquant, 2003). As such, not only are

methamphetamine and other illicit drugs contributors to health inequality in the ways described, but so are the global drug laws that render them viable through criminalisation (Corva, 2008). Growing evidence is pointing to the need to regard substances like methamphetamine as "indicators of abandonment", whether witnessed among the wealthiest or poorest segments of a population (Brown, 2001). For some, methamphetamine is a physical expression of powerful human needs for social inclusion that will not be quelled with increased legislation or law enforcement (Corva, 2008; Brown, 2001).

Conclusion

Globalisation has thus simultaneously fuelled the diffusion of health equality and inequality as well as positive and negative health outcomes through the global proliferation of GNGOs and the methamphetamine trade. But while both networks draw on similar outgrowths of globalisation, their aims and outcomes differ quintessentially. Whereas the one works to improve the health conditions of vulnerable people by creating networks of support and empowerment, the other perpetuates further inequality through entrenching the already marginalised and poor into deeper spirals of physical, mental and social deterioration. The juxtaposition of these networks exposes the organic kaleidoscopic character of globalisation, which cannot be reduced, as some activists and scholars have, to a binary, where one is either "pro-globalization" or "anti". For such polarities only further confound the factors driving, and deriving from, this fact. Ultimately, globalisation is not a social policy or a football team that one can root for or stand against. It is a complex, robust system, immune to centralised and premeditated control: it is anything but "fragile". Thus former Secretary-General Annan's claim that "globalization [sic] is a fact of life. But I believe we have underestimated its fragility" is a problematic one, because his perception of "fragility" is rooted in his own inability to define and control the agendas and outcomes of globalisation (Annan, 1999). Globalisation may yield unpredictable, harmful, even inequitable consequences, but society's inability to regulate its processes does not render it vulnerable, rather—like GNGOs and the methamphetamine trade—globalisation is the product of the spontaneous generation of powerful and robust forces.

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