

# PRACTICING ANTHROPOLOGY

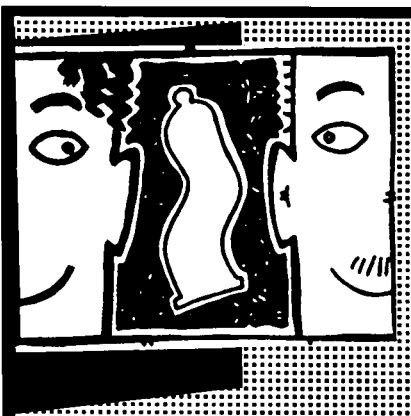
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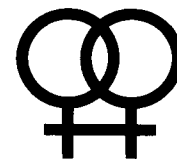
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AIDS Outreach,  
Education,  
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Anthropological  
Contributions

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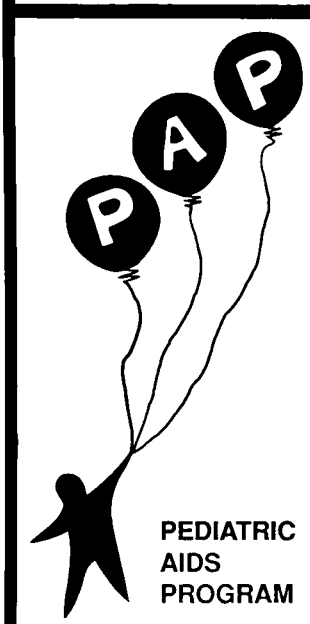


SAFER SEX  
WORKSHOP  
FOR LESBIANS AND  
BISEXUAL WOMEN



## Project COPE

Community Outreach Prevention Effort

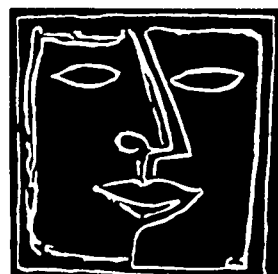


PEDIATRIC  
AIDS  
PROGRAM

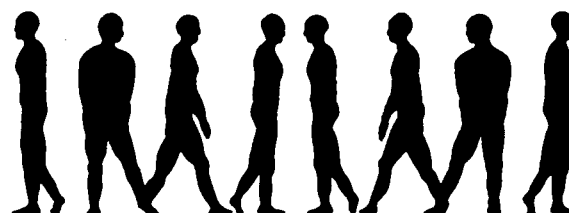
## NO/AIDS TASK FORCE



*Life is Precious*



BLACK HIV &  
AIDS FORUM



## BLACK MESMAC

# A SMALL TOWN MODEL FOR HIV/AIDS PREVENTION

By James M. Potter Jr.,  
V. Davis, George S. Gotto IV,  
Anthea V. Hajjar,  
and Robert T. Trotter II

The epidemiological characteristics of the AIDS pandemic have created a need to locate high-risk members of drug-using populations and provide them protective information. The Flagstaff Multicultural AIDS Prevention Project (FMAPP) is one of twenty programs funded by the National Institute on Drug Abuse (NIDA) to create, test, and apply culturally appropriate methods for HIV and drug abuse intervention. Each project is evaluating innovative approaches to reducing HIV risk behavior among active drug users and thus slowing the spread of AIDS. Our project is designed as a small town model for HIV prevention, in contrast to the predominantly urban models being tested at other sites. We work in north-central Arizona with active injection drug users (IDUs) and cocaine smokers from four cultural groups: African Americans, Anglo Americans, Hispanics, and Native Americans.

The FMAPP project was designed to test a number of current theories about HIV prevention and intervention strategies drawn from anthropology and other social sciences (predominantly psychology). The primary ethnographic and anthropological contributions to the project fall into four areas: outreach activities (how to find hidden populations); base line descriptive information (such as cognitive models of HIV infection and drug abuse); development of culturally specific elements of our enhanced intervention (including social network approaches to risk reduction); and program monitoring and evaluation tools (including testing changes in people's knowledge, beliefs, and behaviors).

The standard approach for finding high-risk individuals and high-risk areas



Photo by Stephen Schweitzer

V. Davis, George Gotto, Anthea Hajjar, and Jim Potter  
(Left to Right)

was initially developed and proven effective in the National AIDS Demonstration Research projects (NADR), funded by NIDA's Community Research Branch. This is an urban street-based model involving a process called "targeted sampling." (See John K. Watters and Patrick Biernacki, "Targeted Sampling: Options for the Study of Hidden Populations," *Social Problems* 36,4[1989]:416-430.) Information on drug arrests, sexually transmitted disease (STD) rates, drug treatment participants, and other available secondary data is combined with ethnographic information about areas of open drug activity to produce a map of drug use. The approach was introduced as the standard procedure for new cooperative agreement projects such as ours. This article discusses the changes we have made in this and other urban-oriented procedures to adjust to the reality of rural communities.

## Mapping Drug Use

Before we could create a targeted, rather than a generic, AIDS prevention model in northern Arizona, we had to discover how people in our area used drugs. We employed ethnographic interviewing, freelisting, and ethnographic network analysis to assist in the development of the map of HIV/AIDS risks in our community.

Drug use in both urban and rural areas is always somewhat hidden in order to avoid attracting the attention of law enforcement agencies. The degree to which activities remain under cover depends largely on the orientation (or political economy) of local law enforcement. In urban areas busting single users is inefficient, as is the universal arrest of small dealers. This creates a cultural ecology in which street-based use and small-scale dealing flourish. Conversely, open (street corner) drug

use is virtually absent in small town and rural settings, since local police do conduct arrests at the personal use level. In our site, local drug sellers seldom deal in open areas; instead, they have created an effective home delivery system.

Rural law enforcement officers also treat locals and outsiders differently. They bust higher ratios of out-of-townners who move drugs through the community, especially in some neighborhoods. This skews the data that we would otherwise use to identify high-risk locales.

Data from social service agencies is also biased by the small town nature of our site. Individuals who need community services, such as treatment for STD infections, often fear "everybody knowing their business." This commonly leads them to use fictive names and addresses or drives them to other communities (since they may even be related to the people providing the services locally). Limited drug treatment options and the same confidentiality problems encourage people to go out of town for drug treatment as well.

Because of the small town environment, therefore, many quantitative variables that are highly useful in mapping drug use in urban communities are far less reliable in targeting rural AIDS outreach. This condition caused us to place much higher reliance on ethnographic mapping and key informant interviewing than is necessary in urban centers.

Ethnographic mapping produced a model of both behavioral and cognitive dimensions of rural drug use. Data on drug arrests, STD rates, and drug treatment participants were enhanced by invaluable qualitative descriptions of high-risk areas drawn from community professionals responsible for dealing with these issues (law enforcement, public health, self-help groups, etc.). We then added information from ethnographic interviews and observations within the drug-using community. This combination of quantitative and qualitative mapping produced a list of potentially high-risk neighborhoods which have become the focus of the

project's recruitment, intervention, and research activities.

### Ethnography for Outreach

In the beginning, we mistakenly directed our recruitment efforts towards drug user locations, rather than people. This "on the street" approach to recruitment, which works well in urban

neighborhood do not necessarily know each other beyond their own limited network. When we put "the word" out on the street, it travels in small circles. In practical terms, recruitment of active drug users means gaining entrance into each drug network sequentially.

Two additional themes that emerged from our ethnographic ground work are also employed in outreach. These are

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areas, was met with firm resistance. Our offers of respondent fees and confidential HIV testing were outweighed by the fear of exposure or the fear we were narcs. Further investigation indicated that our approach had been too open; we had to learn how to make more personal connections and to use the same lines of entry into the networks that were followed by new drug users. Once our outreach workers switched to this more culturally congruent approach, we began to recruit people into the project.

Fortunately, our use of ethnographic methods allowed us to make this discovery early in the project. Nevertheless, it was something of a shock to discover that not only drug mapping techniques but also methods of outreach had to be invented on the spot, when we had assumed that the standard approaches from the literature would work.

Our ethnographic information demonstrated the relatively hidden nature of small town and rural drug use. Users, and even dealers, in the same

personal trust and community responsibility. Our outreach workers first approach active drug users with whom they have strong previous associations and then build dyadic trust relationships that can be transferred from person to person through a network. Their mission statement is "we are talking about HIV risks to the people who we know and care about first." Since drug users in our locale maintain a sense of responsibility to their family and community that is not apparent in descriptions of urban drug-using populations, we can extend our contacts by appealing to their sense of responsibility. These approaches include "for your group to be safe, it is important for all members to be tested for HIV and know how to use safely" and "if you're not worried about yourself, how about getting tested for your family and friends."

Our experience has reaffirmed the importance of evaluating social structure in projects like ours. Since our whole approach moves through natural social networks, we have found it

valuable to map social relationships in each group, using ethnographic, ego-centered, and social network approaches. We have explored drug use, drug scoring, long-term friendships, sexual relations, kinship, work relations, and other social activities to determine the overall structure of these networks. We can also map lines of communication on specific topics (AIDS, sex, needle use) and identify taboo subjects within the group. This information is being used in our outreach efforts, and it will also allow us to test theories about the transmission and acceptance of new knowledge and behaviors, including the force and direction of peer and group pressure and the effectiveness of HIV risk intervention at the group level.

### The HIV Intervention Program

Our project is testing two types of HIV risk reduction interventions. The first is the NIDA standard intervention, which is being used by all cooperative agreement projects as an ethical alternative to a project in which an at-risk "control" group is not provided with services that might save lives. The second is our enhanced intervention, developed on the basis of our ethnographic research and designed to be culturally appropriate for our local population. We randomly assign networks to either the standard or our enhanced intervention.

The standard intervention provides all of the information necessary for people to protect themselves from injection or sexually related HIV risks in a format that was proven to be effective by the NADR projects. It consists of two one-on-one client/interventionist sessions on understanding HIV transmission, condom use, and IV needle hygiene. Clients are provided with basic AIDS education, HIV testing and counseling, and practice in risk reduction skills (needle cleaning and condom demonstrations).

Our enhanced intervention consists of the NIDA standard plus two additional sessions developed specifically by and for our site. It is assumed that risk reduction strategies are most

successful when the client's cultural background, gender, social relationships, readiness for change, personal knowledge level, skills, and externally motivating factors are taken into account. The first enhanced intervention session is individually focused; the second is directed at natural social networks.

In the individual session, our intervention counselors work with each client to set goals tailored to their own perception of their HIV and drug risks. This intervention can be sculptured to accommodate differences in cultural and drug use background, along with differences in personal orientation and development, including readiness to change behavior in the areas in which individual changes are needed. To support these individual sessions, our project staff created a community-oriented video that vividly discusses the HIV and drug risks local people have encountered. (See Nancy E. Tongue, Jay Wheeler, and Laurie J. Price, this issue.) The video effectively initiates the self-assessment of risk, which then can be followed up by one of our interventionists.

The second enhanced intervention session is based on the natural drug networks of our clients. Individuals from a particular network meet together with an intervention counselor to explore group risks for HIV transmission. The participants are asked to identify all of the known risks for HIV transmission and to select risks which apply to their own group. The group works through a problem-solving process, discussing the drawbacks and benefits of their risky behaviors and the barriers to changing them. The participants then set group goals to change their identified risks.

After a period of relationship building, we find that many of our respondents feel comfortable meeting with us in groups. This creates a unique opportunity to carry out additional formal network analysis using a matrix of questions we have developed on social, drug, sexual, and intimacy relationships. A mini-focus group is conducted following the completion of

the network matrix, and the group is asked a set of descriptive questions: how did they get together? how long have they been together? how does someone become a member? what is different about this group from others? The resulting information on strong and weak relationships, on the density of the group and central persons, and on the types of relationships that allow the discussion of intimate topics can make a significant contribution to our enhanced intervention, as well as to the analysis of risk factors for HIV transmission in rural drug networks.

Our intervention relies heavily on an understanding of cultural domains. We used freelistings and pile sort techniques to give us a basic picture of drug risks and the barriers to changing those risks in our community. In the freelistings, informants were asked to list the perceived advantages and disadvantages of drug use. The pile sort technique utilized key words and phrases derived from the freelistings and from interviews with members of the drug community; respondents were asked to group cards with these key words on them into self-defined categories. Information acquired from the freelistings and pile sorts allowed us to construct a beginning model of how this population structures their beliefs about drugs and drug-related risks—a model which can be incorporated into problem-solving scenarios for our enhanced intervention. Also, by comparing emic typologies of drugs in two different locations, one rural and one urban, we have been able to identify local subcultures of drug use.

We are also using ethnographic interviews to explore the context of six specific types of drug use: smoking crystal, shooting crystal, snorting cocaine, smoking crack, shooting cocaine, and shooting heroin. We are identifying the ways people learn about drugs and how to use them, where and with whom they use their drugs, and the street view of the differences between drugs. Additional knowledge of the motivations behind drug use and the reasons people favor various modes of using these drugs will help us tailor our

intervention to make it more effective and beneficial to the respondents.

We are currently evaluating the effectiveness of the standard and enhanced interventions. The success of each intervention is measured using

a national problem. In the Flagstaff Multicultural AIDS Prevention Project, anthropological techniques and perspectives have been used to increase our understanding of the high-risk activities of drug users and to apply

[The Flagstaff Multicultural AIDS Prevention Project (FMAPP) is a five-year outreach-based prevention project funded by the National Institute on Drug Abuse, Community Research Branch, Grant #1 UO1 DA07295.]

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variables taken from a pre- and post-measure, Risk Behavior Assessment (RBA), designed by NIDA for the cooperative agreement project, and our own qualitative and quantitative evaluation instruments. Preliminary data from ninety-one respondents (forty-eight standard and forty-three enhanced) show risk reduction through a decrease in the frequency of injections and of needle sharing in both groups. The potential differences in effect between the standard and our enhanced intervention cannot be measured yet, since a power analysis indicates that the information cannot be considered statistically significant based on the number of clients who have completed the program to date. A period of six to nine months is required for a respondent to complete the entire intervention, assessment, and follow-up data collection process, so it will be some time before we have the numbers required for a defensible analysis.

### Conclusions

The AIDS epidemic has generated a need for anthropology and other social sciences to contribute to the solution of

culturally congruent methods of intervention. Our approach has been effective in some areas. For example, our clients are sharing needles less frequently after the intervention than they were before it. Unfortunately, about the same percentage of people are using condoms after learning about sexual risks for HIV as were before they went through our program. This indicates that our clients are lowering their risk of infection in some cultural contexts and not in others.

Our community level research findings support a general shift in the approach to health issues by including the “other,” the people themselves, in the process of program development. Within the boundaries of our own culture, we can apply anthropological methods which enable a better match between the at-risk groups and the services offered. Anthropologists’ ability to explore the community allows us to reach hidden populations and to deal with normally “invisible” behaviors. Understanding these populations allows our risk reduction strategies to be designed to enhance the services offered, and thereby better address the HIV risk in drug-using populations.

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