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A cultural impact of needle exchange: the role of safer-injection mentors

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We examine one way in which needle-exchange services in the San Francisco Bay Area have affected needle-sharing and sexual-risk behaviors for injection drug users. We interviewed, qualitatively and quantitatively, 244 participants. Our analysis focuses on comparisons in HIV/AIDS-risk behaviors for a subcategory of "new" injectors: those initiating after the introduction of needle-exchange services in 1988 (n=57). We found that some new injectors benefited from the presence of "safer-injection mentors." That is, those with someone to teach them harm reduction from their initiation of injection drug use were somewhat more likely to report safer injection practices at the time of interview. We also found that the mentoring process included sharing of information about needle-exchange services. Our results point to evidence of the effectiveness of needle-exchange services in contributing to a culture of harm reduction for injection drug users.

KEY WORDS: *Needle exchange, injection drug use, harm reduction, qualitative, culture.*

There is disagreement over the role and efficacy of harm-reduction education generally, and of needle-exchange programs in particular, within the field of HIV studies. Considerable evidence shows that (a) injection drug users (IDUs) actively seek and respond to health information; (b) IDUs, in some cases, have organized and engaged in high-risk activism to protect the lives and interests of drug users; (c) IDUs have been active volunteers in street outreach and needle-exchange operations, encouraging other users to participate in needle exchange and related risk-reduction programs; and (d) knowledgeable IDUs have provided information about health maintenance and risk reduction to other users outside of the needle-exchange setting.

Prevention studies and assessments of interventions find that even where HIV-risk behaviors are reduced, people continue to engage in them to some degree. It is not difficult to see why some IDUs do this. Illicit drug use is already inherently dangerous, and physically, emotionally and socially destructive. It often costs users their families, homes and jobs, while exposing them to risk of disease, arrest, and violence. The additional, rather vague threat of HIV/AIDS alone is not going to keep IDUs from injecting. Furthermore, many risk activities are actively encouraged by the legal sanctions against drug use. Users cannot afford to be caught carrying injection equipment, so they do not carry clean needles (Murphy, 1987). Increased police surveillance has been associated with higher-risk drug use, while reduced attention to paraphernalia laws has led to greater risk reduction (Case et al., 1998; Groseclose et al., 1995). Clearly, prevention education is not sufficient to eliminate risk behaviors for IDUs. The more relevant question is *Under what circumstances will IDUs inject more safely?*

We are interested in why and how IDUs learn and teach harm-reduction behaviors. We address the complex relationship between needle exchange and changes in risk behaviors from the perspectives of a subset of 57 IDUs. These IDUs all

began injecting after 1988, subsequent to the introduction of needle exchange in the community. The gap between knowledge and behavior change may be at least partially explained by what our qualitative interviews reveal as a developing “culture of harm reduction,” initiated by “safer-injection mentors” and facilitated by the material condition of needle exchange in the community. According to Erickson, “the future of success of harm reduction as a unifying concept will depend on its innovative application . . . and careful evaluation of its effectiveness in a variety of cultural contexts” (Erickson, 1999, 1). We believe our results offer important insights into the qualitative impact of needle-exchange programs and contribute to the understanding of risk perception and risk management for this population.

Needle exchange and cultural activism

Most forms of injecting drug use are felony offenses in the United States. In addition, they are highly stigmatized, inherently dangerous, and harshly punished. These facts, along with the social marginality of many IDUs, contribute to keeping the social organization of drug users limited and underground (Henman et al., 1998). Nonetheless, in the early years of HIV/AIDS many active and former drug users participated in the political and legal challenges that brought needle exchange to this country.

Research indicates that despite the risk of arrest and even targeted harassment by police for participating in organized HIV/AIDS risk-reduction activities (Case et al., 1998), IDUs are not significantly more antisocial than others or less able to learn and change. But it was this public perception that initially led to the development of drug-user organizations. It has been recognized that these user organizations contributed in many countries to more effective HIV-prevention policies for drug users (Friedman et al., 1993). IDUs in Amsterdam

organized the world's first needle exchange. Prior to the establishment of the needle-exchange waiver system in the state of New York, and to a lesser extent since then, IDUs have participated in the operation of "underground" needle exchanges. Each of the five initial needle exchanges in New York City to receive state waivers had begun as an underground exchange program, managed by users and needle-exchange advocates without support from public health officials. Since that time, IDUs have participated in the advisory boards of many of the existing needle exchanges, and their participation is presently a requirement of the state health department in New York (Henman et al., 1998). Implicit in this work has been the collaboration of IDUs with the public health sector. Public health interventions have taken the form of prevention campaigns employing the media, educational groups or seminars, and street outreach workers. However, it has been amply demonstrated that an individual's knowledge of high-risk behaviors alone is insufficient to ensure cessation of risky activities (Davis-Berman and Brown, 1990; Friedman et al., 1992b; Inciardi, 1990; Murphy, 1987; Murphy and Waldorf, 1991; Otomanelli et al., 1990; Page et al., 1991). IDUs and their advocates have been on the cutting edge of initiatives to change the behavior of other drug users.

One of the extrainstitutional innovations generated by needle-exchange participants is satellite, or secondary, exchange. Key IDUs may identify themselves to the program as representatives of a user collective and thereby make special arrangements to exchange needles in quantities of one or two hundred at a time (Grund et al., 1992). Although secondary exchange is formally restricted by the one-for-one policies of most United States exchange sites, users purchase or collect used needles from their associates in order to increase the number of clean needles available to them (Guydish et al., 1998). Almost 10% of the regular participants at a Baltimore needle exchange were characterized as secondary exchangers.

The Baltimore study concluded that “satellite exchangers provide a natural extension of [needle-exchange programs] that further their outreach into otherwise underserved groups” (Valente et al., 1998, 95). Studies of San Francisco’s Prevention Point found that over one-third of participants surveyed were involved in secondary exchange (Guydish et al., 1998; Murphy et al., 1996; Murphy et al., 2001).

In a more formally constituted initiative in New York, researchers and advocates for drug users operated a project from 1988 to 1989 to support self-organization against HIV/AIDS among drug injectors. Although the organizational efforts did not achieve stability, a follow-up study found that those injectors who had participated in group meetings not only significantly reduced their own risk activities, but remained active in encouraging behavioral change among others (Friedman et al., 1992a).

Research into needle-exchange operations has affirmed the role of an active minority of IDUs as organizers, activists, and outreach workers (Abdul-Quader et al., 1999; Centers for Disease Control and Prevention, 1995; Henman et al., 1998). IDU volunteers attempt to form a “bridge” to health services for needle-exchange participants. A study of 55 needle-exchange programs in the United States identified a variety of behavioral and health benefits sought by participants from the programs, including provision of latex condoms (82%), HIV counseling and testing (42%), tuberculin skin testing (22%), primary health care (18%), and directly observed tuberculosis therapy (11%) (Centers for Disease Control and Prevention, 1995).

Needle-reuse etiquette

There is a long-standing sociological tradition of examining induction to drug use that highlights the strong social and interactional elements of learning to use drugs (Becker, 1953;

Coggans and McKellar, 1994; Crisp et al., 1997; Hirsch et al., 1995). The norms of using drugs and sharing needles are differentiated by situation and social category of the user (Crisp et al., 1997; Murphy, 1987). Social and political structures have been found to have profound effects on the physiological experience of drug use (Bunce, 1979). Two important cultural factors that help determine order of injection are who owns the injection equipment and who paid for the drugs, though individual assertiveness and other social relations are able to overcome these prioritizing factors (Crisp et al., 1997). Cultural belief systems influence both the learning of technique and motivation (Becker, 1953), and these belief systems are well understood by members of the group.

Cultural interpretations may minimize or overlook practical considerations, since patterns of equipment sharing are more complex than serving as rituals of power. Even the term "sharing" when referring to the reuse of others' equipment implies that users freely chose when and with whom to share. Underlying this decision process, however, is the fact that "syringes are shared because they are scarce, and they are scarce because they are illegal to possess without medical justification" (Koester, 1994, 287). Needle exchange is one material condition that facilitates a new etiquette of safer injection because it addresses this scarcity of needles. Given both the social and the legal dimensions of syringe reuse, we examine the new etiquette of injection drug use and the activism of drug users in teaching safer injection.

Methods and procedures

We conducted a three-year process evaluation of Prevention Point, the needle-exchange program in San Francisco.¹ Prevention Point began illegal distribution of needles and other harm-reduction materials in San Francisco in 1988.² Rapid expansion and community need led Mayor Frank Jordan and

San Francisco's Board of Supervisors to declare a state of medical emergency in March 1993, allowing the city to circumvent California's prescription and paraphernalia laws, although it did not minimize the illegality of possession of syringes. It also allowed San Francisco's Department of Public Health to fund Prevention Point and allow needle-exchange volunteers and staff to exchange syringes. At the time of data collection, Prevention Point operated eight sessions, Monday through Friday. Program staff at all sites dispensed needles, cotton, alcohol wipes, and condoms. In addition, treatment and medical referrals and HIV/AIDS information were available upon request. The program model was one of low centralization and low formalization (Murphy et al., 1996; Wenger et al., 1996). Providers participated in the development and management of the organization. They required very little from clients in terms of their continued participation.

We use multiple data sources to triangulate on the key variables. Data collection included participant observation, in-depth life-history interviews, and a closed-ended quantitative instrument. Here we use the quantitative data to define the phenomena and the interviews to explore their meaning to the people who are engaging in making these decisions about risk. We completed data collection in September 1995 with a total of 244 study participants recruited from eight needle-exchange sites. We selected our study participants using maximum-variation sampling, which aims at capturing the central themes that cut across a great deal of participation variation. The logic of maximum-variation sampling presumes that any common patterns emerging from great variation are of value in understanding the core experiences of program participants (Patton, 1987). Our sampling strategy was informed by intensive field work at all participating needle-exchange sites, for the reason that "by including in the sample individuals the evaluator determines have had quite different experiences, it is possible to describe more thoroughly the variation in the group and to understand variations in experiences" (Patton, 1987, 54).

We sought to maximize variation in age, sex, and race. We also used this method to maximize variation in drug of choice by recruiting heroin, speed, and cocaine users. The demographic variables were not necessarily predicted to explain differences in outcome measure of harm-reduction activity. All subjects were similar in key ways: They were regular injectors of illegal drugs; they had either participated in a needle exchange or knew of needle exchange. Many kept a schedule to exchange needles for their own safety and the safety of others. But they were not all from one neighborhood, one ethnic background, or one supposed drug "subculture."

Experienced field workers approached needle-exchange participants and screened volunteer respondents for inclusion in the study. Interview appointments were made with those who met the criteria. Interviews took place either in the field office or out in the field, depending on which was more convenient for the study participant. Interviews were tape recorded and lasted two to four hours. Participants were paid \$50 for their time. All participants were informed about their rights and protection of confidentiality.

We identified those study participants with mentors from the interview transcripts during content analysis. Many questions were asked about the process of becoming an injector and the people involved in the transition. Safer-injection mentors were friends or relatives of injecting drug users who taught them safer methods for injecting drugs and influenced their attitudes about reducing drug-related harms. Mentors were experienced injectors who were knowledgeable about HIV-prevention techniques and took the time to share this information with less knowledgeable and less experienced injectors. This knowledge consisted of more than the logistics of injecting. Rather, it consisted of techniques of *safer* injecting. Those without mentors were not social isolates, but they did lack a personal relationship with someone who was willing and able to share information about HIV prevention. We adopted the

term “mentor” from the words of Tim, a 35-year-old white man, as his experience captures that of many others:

Well, both my brothers use drugs. Michael, my brother on the West Coast, has always in many ways been kind of like my mentor. He and I are very close, and he taught me a lot about my attitudes and thoughts. And we discussed injecting one time. And in fact, if you're going to use heroin, that's probably the easiest way on the body to do it, as long as you know what you're doing. About a year and a half ago, I started using that as my way of choice of doing it. (322)

Study participants were classified as having a mentor based on their initial injection experience. These mentoring relationships were usually defined as ongoing affiliations, with participants continuing to have contact with the person who mentored them through the time of data collection.

In the following we use the quantitative information to summarize the risk behaviors for the subsample. While we report the results of some significance tests (including non-parametric tests and odds ratios), we realize that these are preliminary, considering the small quota sample. Because our focus is on the qualitative nature of the relationships, we weave in the qualitative results to provide context and meaning of these behaviors. Our analysis is limited by the nature of the data collection. Therefore our results are only representative of the population under study.

Findings

Description of the study population	We compared risk behaviors for those with and without mentors for only those injectors who initiated injection after needle-exchange services were made available in the community. The two groups did not differ significantly by demographic characteristics. There were 24 women and 33 men in the subsample. Of these, females were less likely to report having a mentor. The overall average age was 28.3. The
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majority of both groups were white, followed by African-American and other ethnicities. The respondents reported an average of 12.5 years of education. Two-thirds of those with mentors used heroin as their drug of choice, while 47% of those without mentors reported heroin as their primary drug. Speed was the next most common primary drug, followed by cocaine. The overall average period of time for injecting was 2.26 years.

The overall serostatus rate was quite low for the subsample of new injectors, with only three reporting as positive (11 had not been tested or did not know the results). However, because rates often follow risky behavior, we can learn a lot about potential conversions by examining other risk behaviors. We next review needle-sharing behaviors and sexual-risk behaviors for the subset of new injectors, comparing those with and without mentors. Part of this review is spent examining the context of needle sharing, including the makeup of sharing partners, and needle-exchange participation. We then describe in detail the experience of mentoring and conclude with a discussion of the implications of our findings about the nature of mentoring for this at-risk population.

Sharing needles and other injection equipment

The following table provides the results for comparisons of recent risk behaviors by mentor status. Slightly fewer of those with mentors reported having shared needles in the six months prior to the interview. Of those sharing in the past six months, there was a significant difference in the mean number of times shared, with 8.8 times for those with mentors compared to 27.4 for those without mentors. There was also a significant difference for having shared in the past 30 days, with those without mentors being over three times as likely to have shared a needle (OR 3.50, 95% CI 1.102–11.116).

In addition to sharing needles, there are other high-risk injection behaviors, such as sharing cookers, failing to clean injection sites, and going to shooting galleries. Our most interesting finding is that those with mentors reported more often clean-

Recent risk behaviors by safer-injection mentor status (past 6 months)

	Mentor n=27	No Mentor n=30	Significance
Shared Needle	55.6%	60.0%	NS
Mean Times Shared Needle	8.8	27.4	$p = .067$
Shared Needle (30 days)	22.2%	50.0%	Cramer's V=.288, $p = .030$
Shared Cooker	59.3%	63.3%	NS
Used Shooting Gallery	7.4%	13.3%	NS
Cleaned Skin	88.9%	69.0%	Cramer's V=.243, $p = .069$
Mean Days Shared Heroin	30.3	52.0	NS
Mean Days Shared Cocaine	6.0	37.0	NS
Mean Days Shared Speed	10.4	45.6	$p = .049$

ing their skin before injecting (OR 3.45, CI .819–14.525). Supplies for cleaning injection sites were available at all needle exchanges. Overall, very few new injectors had used a shooting gallery in the past six months. Finally, those without mentors shared more days for all types of drugs. The only significant differences in sharing needles were when injecting speed. Many of the non-significant findings were due to small cell sizes, but they are in the expected direction. For example, while days injecting heroin were nearly the same for those with and without mentors, those with mentors shared fewer days (30.3 compared to 52.0).

Interviews with IDUs in our study population revealed reasonably consistent knowledge about HIV/AIDS and differences in the use of that knowledge. As expected, the new injectors in general had high knowledge of risk behaviors and of how to reduce personal harm related to drug injecting, likely resulting from the growing availability of information about needle exchange and risk reduction. Many of our study participants reported that they did not share needles at all. Others shared only with their current sex partner. For example, Jessica (344), a 20-year-old white woman, left home

when she was 17 and found her way to New York City. While there, she started snorting cocaine and heroin, eventually transitioning to heroin injection. She had learned about AIDS while in high school and already knew she should not share injection equipment. However, she did share with her current boyfriend.

Having a mentor did not guarantee continued safer injection. Alan (343), a 20-year-old white man, was in elementary school when his uncle died of AIDS and his mother talked to him about HIV transmission for the first time. When he first began injecting drugs, after learning about the risks from his mother, he would buy clean needles on the street. But he occasionally shared them with his girlfriend, figuring that since they were not using condoms, they might as well share needles.

Jack, a 43-year-old white man, shared needles but always made sure his partner bleached them first. His partner of 10 years always injected for Jack first before injecting himself. They both took care to minimize their risk. Jack described the meticulous bleaching process:

He gets out a little thing of bleach, and a cup of water there, he'll take the needle and he'll throw the bleach into the syringe, and squirt it out, and he'll do that about three times, and then he'll rinse it out with water around three times. . . . Usually when he gets through, when we get through, he'll bleach and clean it before he puts it up. But then he'll still go ahead and clean it again before we use it. He's very careful. (305)

Although Jack had not been tested for HIV, his partner had tested negative several times, and they had been monogamous for more than six years.

Matthew (263), a 38-year-old African-American man, had been injecting drugs for four years. Prior to that he dealt drugs and saw many other drug users engage in high-risk behaviors such as sharing cotton, cookers and needles. He

also saw many of them suffer the consequences of sharing when they seroconverted or caught other diseases. He learned about the risks of sharing from his brother and later from educational programs in prison. As a result, he never shared needles, cotton, or water.

These and other stories about sharing point to the complex relationship between risk-reduction measures and the negotiated risk of consenting to share injection equipment, especially with sex partners.

Sexual behaviors

Many sexual-risk behaviors varied but were not significantly different for the two groups. Those with mentors reported fewer partners for both the past five years and in the past six months. In addition, fewer mentored participants reported sharing sex toys or having sex that involved bleeding, but the differences were not significant. In further analyses, when dichotomized as “never” versus “at least sometimes” using condoms or latex protection during sexual activity, those with mentors were much more likely to use condoms. That is, new injectors with mentors were 3.3 times as likely to at least sometimes use latex protection during sex (OR 3.30, 95% CI .91–12.16). It is possible that the advice of a safer-injection mentor, coupled with needle-exchange services, spilled over into reducing risky sexual behaviors.

Kelly, a 26-year-old Native American new injector with a mentor, understood safe sex to mean using a condom. She then explained about her needle sharing and sexual relationships:

I guess I do sort of have a false sense of security. Even with my boyfriend, when we were shooting up, we never shared a needle . . . even though we'd have unsafe sex. But I would never in a million years share needles with somebody. (271)

Kelly compared sharing needles to “playing Russian Roulette.” She believed it was “ten times worse than having unsafe sex,” because she could see the blood involved in the

sharing of needles, and she believed it was statistically easier to get HIV through sharing than through unsafe sex.

Needle exchange

Most of the new injectors with mentors heard about needle exchange from friends or family (77.8%). While the majority of those without mentors were also likely to hear about needle exchange from friends or family, they reported a higher rate of learning about needle exchange from service providers or the media (36.6%). Those with mentors reported overall fewer barriers to needle exchange: 2.4 compared to 3.0 for those without mentors (although not significant). Cara, a 24-year-old white woman, did not have a safer-injection mentor and did share needles with her current sex partner. They did not use the needle-exchange program, for practical reasons. She described their needle sharing:

I'll use it and hand it to him and he uses it. We'll have rigs that either one of us has used that we keep in the same bag and we'll just take one, ones that have been used, before we use again. Because we're so far away from the needle exchange. (120)

All needle-exchange sites distributed information about all kinds of risk involved with drug injection. Respondents reported learning about risks with sharing injection equipment other than needles from needle exchange. For example, Brad, a 26-year-old white man, remembering his first experience with needle exchange, said:

I figured there would be some place to throw your old [needles]. And you would form a line. It was a little different. I didn't expect that they would give out all the accouterments. Bleach and condoms even, and alcohol wipes and cotton, but it's cool. (125)

An emerging culture of harm reduction

Almost half of the new injectors we interviewed explained that when they first learned to inject drugs, they also learned the basics of safer injection practices (n=27). These new injectors with "safer-injection mentors" in our study population were somewhat more likely to be white men less than 44 years old. The new injectors identified friends, family, and lovers as responsible for sharing specific and detailed infor-

mation about reducing risk when injecting. Safer-injection mentoring was most often initiated by other new injectors rather than by someone who had been injecting for a long time. For example, Monique (133), an 18-year-old white woman, learned about HIV-risk reduction and safer injection from her boyfriend. From the very beginning of her injection drug use, she knew how to reduce her drug-related harm by not sharing or by bleaching the syringe if she did share.

Mentors were often friends of the respondents. Richard (226), a 24-year-old white man, learned generally about HIV long before he started injecting heroin. He described how he was taught by a close friend to clean his injection equipment from the first time he injected, and he was also taught not to share needles. He believed this was partly because one of the people who taught him how to inject was HIV-positive. Jeff (113), a 27-year-old white man, explained that some friends taught him the logistics of how to inject properly (measuring the drug, etc.) and also taught him safer injection practices, such as how to mark his syringes and keep them separate from others' syringes, how to bleach his needles, and where to go to exchange his syringes.

There were, of course, some new injectors without mentors who took safety precautions. Marcus, a 21-year-old white man, never shared needles and was irritated by assumptions about IDUs being careless and taking risks. He said:

Most people that use needles that I've come in contact with, contrary to what people think about junkies, they don't share needles. You know, it's mostly the people that live on the streets . . . well, I don't even want to say that, 'cause that's just another stereotype. Most people I've come in contact with just don't share needles . . . it's just an unwritten law. (244)

Shane, a 36-year-old white man, reported that a friend fixed him the first time and insisted on safe practices. He explained:

Yeah. He taught me. And not only him, but another friend of mine as well, who was a nurse, taught me. And I feel like I learned from the best. (280)

These and other study participants who learned safer injection techniques from their friends and family reflect the development of a harm-reduction culture that can be passed on among injector cohorts. Our qualitative interviews indicate that safer-injection mentoring is indeed more than a possibility for drug-injecting populations, and is in fact already happening informally. As shown in other studies, there is an important role for IDUs in teaching each other the skills and methods of harm reduction. As one respondent put it, "You got to have somebody takin' care of you."

One result of the mentoring culture was a change in the etiquette of needle sharing. That is, the process of learning to enjoy the physiological effects of the drug was coupled with users' knowing they were protected from HIV/AIDS and other communicable diseases. Where previous research has found that neophyte users are the most likely to share (Murphy, 1987), we found a new pattern, with new users learning how *not* to share. The learning of risk-reduction behaviors by this population is a positive move toward reducing harm associated with drug injection. Needle exchange does not serve to initiate users, but it can decrease risk among those who do transition to injection drug use. At the same time, the lack of an initial mentor does not mean the respondents were not capable of learning to be safer, as indicated by those who did not share needles in the months prior to the interview.

Discussion

Despite research findings to the contrary, some have implied that drug injectors are not likely to pass on risk-reduction information to their peers. According to Bloor,

[t]he drug-injecting population has previously proved very unstable, future waves of injecting have not been predicted, and there has been limited overlap between successive waves of injectors—implying the lessons of HIV risk reduction will have to be repeated and learnt anew. (Bloor, 1995, 123)

Such speculation about drug-injecting populations may be preliminary, considering that most communities in the United States do not have stable and reliable risk-reduction tools, including needle exchange and other educational materials.³ Other research follows the body of research pointing to the willingness and ability of active drug users being “competent collaborators” in public health programs designed to reduce their risk (Broadhead et al., 1998; Heckathorn et al., 1999; Henman et al., 1998; Sergeyeve et al., 1999). Their increased “legitimacy and sense of personal worth” resulting from organizing create an opportunity to maximize harm-reduction networks (Henman et al., 1998, 397).

We began this exploratory and qualitative investigation by seeking detailed descriptions of the experiences of a subset of newer injectors in our sample. We found that their experiences varied by a number of factors, including the presence of safer-injection mentors. Those study participants with mentors reported fewer injection-risk and sexual-risk behaviors. Our contribution to the research has been the identification of an important element in the incorporation of needle exchange into communities. The role of the safer-injection mentor is one that highlights the potential of engaging drug users to spread safer-injection information. While others have reported similar findings about the networks of drug users and the capability of IDUs to participate in formal outreach efforts (Broadhead et al., 1998; Friedman et al., 1992a; Heckathorn et al., 1999; Sergeyeve et al., 1999), our research focuses on the informal sharing of information that IDUs initiate without official incentive—their only motive that of keeping each other alive.

These mentors were instrumental in getting new injectors to utilize needle-exchange services and to implement safer injection practices from the beginning stages of drug use. Knowledge did not necessarily translate into behaviors for our study participants. Although overall new injectors who were trained from their initiation to injection drug use to follow safe regimens regarding needle sharing did demonstrate fewer risk incidents for needle sharing, some risk incidents did occur. We found that some of our study participants congregated in very different social groups, but that others were initiated into the larger needle-exchange circle and taught a new etiquette of safer injection. The presence or absence of mentoring, in fact, might be an indirect measure of social integration for the injectors engaging in fewer risk behaviors.

Respondents with regular and manageable access to harm-reduction tools attempted to use those tools to stop the transmission of HIV. By the time the new injectors reach drug-use maturity, with continued access to harm-reduction measures such as the needle-exchange program in conjunction with education and information opportunities, the culture of harm reduction may be widespread and deeply entrenched in drug-using circles. Based on our findings, we believe that needle-exchange programs, as modeled in the San Francisco Bay Area, facilitate changing norms and actively encourage a culture of harm reduction rather than a culture of risk. In addition, according to our study participants, the Prevention Point needle-exchange program has made an impact on the needle-sharing behaviors of our study population. Those study participants who were new injectors who also had safer-injection mentors exhibited lower risk for both injection-risk and sexual-risk behaviors. The new etiquette, comprised of safe injecting and cultural activism, reflects the culture of harm reduction surrounding injection drug use.

Our findings about the culture of harm reduction among IDUs suggest numerous areas for future research and hypotheses testing. For example, what social mechanisms encourage new

injectors to participate in sharing safer injection practices and information with other injectors? A growing area of research in drug studies focuses specifically on the conditions of transition to injection (Kelley and Chitwood, 2000; Neaigus et al., 1998). This focus should include general network analysis as well as contextual analysis of the process of mentoring. Our exploratory results should be taken into account in future studies intended to solicit deeper understanding of social networks, mentoring, and the negotiation of risk. How do respondents arrive at the point of willingness to commit to safer-injection practices? What are the components of social integration that tie the safer-injecting mentors to other injectors? What is the role of secondary exchangers in expanding this culture? Probably most significantly, what are the social processes that enable IDUs to formally organize around health and safety issues in a political environment hostile to their social status? Many of these questions are already the focus of study in places such as Britain, Australia, and many European countries where needle exchange has long been instituted. These processes should be clearly addressed in research in the United States.

Notes

1. This was a NIDA-funded study, "AIDS Prevention: An Ethnography of Needle Exchange" (RO1 DA08322), Sheigla Murphy as principal investigator, The Institute for Scientific Analysis. As of this writing, Prevention Point has been renamed San Francisco's HIV Prevention Project. The study participants have been assigned pseudonyms to protect their confidentiality.
2. Bleach distribution was begun in the San Francisco Bay Area in 1986 by community health outreach workers.
3. Although continuing to increase in number, at the time of data collection there was a limited number of exchange programs in the United States. In a review of the national profile of needle-exchange programs, it was found that between 1994 and 1996 there was a 54% increase in the number of cities operating a needle-exchange program (a total of 87 programs responded to an inquiry for information) (Paone et al., 1999).

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