HIV Risk Perception in High-risk Populations: Drugs and Sex Work in North Philadelphia

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Abstract
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HIV RISK PERCEPTION IN HIGH-RISK POPULATIONS: DRUGS AND SEX WORK IN NORTH PHILADELPHIA

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In: Anthropology

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Department of Anthropology
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ABSTRACT

In America, HIV/AIDS disproportionately affects groups that are socially, economically, and politically marginalized. This study investigates the concept of risk and HIV risk perception by at-risk individuals, or socially, economically and politically marginalized peoples of North Philadelphia. The goal of this study is to understand how high-risk individuals such as intravenous drug users and individuals who engage in sex work perceive their own risk to HIV infection and subsequently, how this self-perception affects or complicates successful intervention and prevention strategies. This study suggests that high-risk individuals are aware of the main modes of HIV transmission and are aware that the activities they partake in can potentially lead to infection. Drug users and sex workers construct a subconscious risk-taking hierarchy, which is strongly influenced by their social and economic environments, as well as their physiological and mental states, which drives their high-risk habits. Lastly, this study suggests that educational intervention strategies on modes of HIV transmission should not be the main focus of intervention and prevention strategies because they are not relatable or accommodating to the user and/or worker's risk-taking hierarchy or habitus.
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INTRODUCTION

In America, HIV/AIDS disproportionately affects groups that are socially, economically, and politically marginalized. From a racial perspective, the majority of these individuals are people of color, and from an economic perspective many of these individuals are in poverty. The main modes of HIV infection are unprotected sex and injection needle sharing, both of which are behavioral activities. To understand why certain demographics have higher HIV frequencies, one must look at why these individuals are continuously participating in high-risk activities.

My study investigates the concept of risk and HIV risk perception by at-risk individuals in North Philadelphia. My goal is to understand how high-risk individuals such as intravenous drug users, individuals who engage in sex work, and more generally socially and economically marginalized individuals perceive their own risk to HIV infection and subsequently, how this self-perception affects or complicates successful intervention and prevention strategies. The questions I pose are: how do intravenous drug users, sex workers, and other socio-economically marginalized people interpret their own risk to HIV infection, what factors influence a high-risk individual’s continuation of partaking in high-risk activities, and lastly are intervention and prevention strategies that are currently taking place effective given the high-risk individual’s self-perception? This study serves to debunk common misconceptions of an expert/lay dichotomy approach to risk perception, challenge the usefulness of total objectivity in risk assessment analyses, and to give insight into new tactics for future HIV interventional work.
My study suggests that high-risk individuals are aware of the main HIV modes of transmission and are aware that the activities they partake in can potentially lead to infection. Drug users and sex workers construct a subconscious risk-taking hierarchy, which is strongly influenced by their social and economic environments as well as their physiological and mental states, which drives their high-risk habits. I will later discuss this hierarchy in relation to Pierre Bourdieu's habitus theory. Finally, my research suggests that educational intervention strategies on modes of HIV transmission should not be the main focus of intervention/prevention strategies because they are not relatable or accommodating to the user/worker’s risk-taking hierarchy or habitus.

BACKGROUND TO PROBLEM

The term “health risk,” and “at-risk populations” comes out of public health doctrines that help public health officials identify a health issue, and plan a way to intervene and/or treat the issue. Because individuals who study health problems on a macro-scale for a living construct these terms, and because these terms are then placed upon individuals who did not participate in the creation of their “high risk” label, these descriptions are argued to take on an expert perspective of risk. Influential organizations such as the World Health Organization, National Institute of Health, and the Center of Disease Control, are the leaders and forces that disseminate risk-knowledge into the surrounding American communities. In the way Foucault describes, the dissemination of knowledge and its strong influence on populations give power to the knowledge producers and disseminators, making
them the official authorities of a given field, while simultaneously making it extremely difficult for other point of views to take hold (Foucault, 1978). This knowledge-power theory explains why our society looks to the WHO, NIH and CDC to understand health crisis’s.

When it comes to HIV transmission, public health officials often explain risk of infection in terms of the direct pathways that lead to the disease, although macro-structural determinants such as poverty, gender inequality, racial oppression and socio-economic status are essential to understanding how HIV works particularly in black and urban communities (Ziff et al., 2006). Looking only at these direct pathways to the biological infection can misleadingly explain an at-risk population’s participation in risky behavior as acts of ignorance. This is not to say that there are no individuals in need of HIV and STI transmission education, but rather to say that assuming educational interventions will give at-risk individuals the tools to change their risky ways misses the underlying issues that causes and perpetuates risk-taking habits. Many interventions that currently take place to decrease HIV transmission rates serve to educate individuals about modes of infection, offer condoms and promote safe sex, and distribute clean syringes in exchange for contaminated ones. These educational and harm reduction approaches to HIV intervention targets the direct, biological issue that promotes infection (un-safe sex and needle sharing). However, it is important to realize that HIV can biologically infect anyone but disproportionately affects blacks, Latinos, and socially marginalized groups because the disease is transmitted with a social bias.
Many traditional risk theorist argue that a lapse between expert and lay perceptions of risk complicate addressing health issues because the lay may interpret their risk exposure differently than the expert-tailored intervention strategy. However, my ethnographic findings in part with urban ethnographic studies have found that many high-risk individuals are aware of HIV modes of transmission and have knowledge of ways to lower their risk of becoming infected. In this respect, the injection drug users and street dwellers are not ignorant to the biomechanisms leading to HIV infection; therefore they are participating in risky behaviors for some other reason. Individuals that are consumed in drug and street cultures are not only on the extreme periphery of mainstream society, they are also the same individuals that are most affected by HIV/AIDS. The way these individuals participate within their social surroundings is powered by their habitus, or socially constructed preferences, ideologies, and habits (both conscious and preconscious) given their class upbringing (Bourgois, Schonberg, 2009). Mainstream intervention strategies or initiatives driven by biopower are impractical to adopt for many people at high-risk for HIV infection because their habitus is not accounted for during the creation of these strategies. To effectively implement strategies that will lower HIV transmission rates amongst high-risk groups, public health officials need to recognize the habitus’ of these individuals and incorporate structural changes that mitigate social risks, such as needle sharing, crack related sexual behaviors, and criminal culture, all of which perpetually put individuals in high risk situations.
LITERATURE REVIEW

Risk Theory, The Expert

The term risk is a common and reoccurring word throughout public health, medical, and clinical studies. In many of these studies, however, “risk” is rarely elaborated on as a constructed entity and it is often limited to models of cause and effect. An understanding of risk is not only critical to healthcare and treatment, but also intervention and prevention strategies as well as the formation of public health policies (WHO, 2002). Healthcare systems adopt definitions of risk created by scientific and public health authorities. This expert risk perception may create a rigid frame, which in turn may confine a treatment or intervention approach to a narrow and linear action that often disregards non-medical barriers such as a person’s cultural and social surroundings, and how they act in certain situations. These non-medical barriers are often difficult to organize, and seemingly impossible to categorize. Regardless of this difficult task, non-medical barriers can have a tremendous influence on one’s risk to disease. Treatment and intervention could be even further misguided if there is a conflict or disconnection between the habitus of at-risk people and the intervention strategy that is developed for their perceived needs.

The World Health Organization explains that understanding risk to health is the key to prevention, however, many of our health resources go towards treating diseases rather than preventing them in the first place (2002). When it comes to the sector of prevention, it is important to implement preventative strategies that are specific to the local and social context of the targeted individuals. I would argue that
these risk perception models used by public health officials still fail to fully “view such risks in their local context...[and examine] daily threats, such as poverty, food insecurity, and lack of income” as contributions to risk (WHO, 2002).

In chapter two of The World Health Report 2002: Reducing Risks, Promoting Healthy Life, WHO explains that a well-defined scope is essential to effective and successful risk assessment (2002). Throughout this chapter, the reader understands risk to be the probability of an adverse outcome. The term probability signifies a mathematical, calculable, and perhaps quantifiable model that can assess risk and attribute precise measurements to characterize “at-risk” populations. Evaluating emissions from a factory or identifying hazardous substances that can promote risk of disease can easily fall in line with WHO’s well-define risk assessment doctrine. However, what happens when diseases are contingent on social interactions that are fundamental to street survival, or influenced by the economy, or even involvement in criminal culture?

Risk philosophers such as Paul Slovic, John Copas, and Sven Ove Hansson explain the western’s perception of risk and some of the misconceptions it entails. In Slovic’s publication “Perception of Risk,” he explains that risk is understood by modeling the impacts of an event in terms of direct harm to an individual. However, he also mentions that the impact of certain events may cause indirect risks to an individual that may be more difficult to map (1987). Copas argues that, “if objectivity of statistical estimates of risk is their strength, then it is also their weakness” (Copas, 1999). Similar to the definition of risk proposed by the WHO, “well-defined” or “objective” measures that assess risk could fail to accommodate
more complexly connected risks that stem from a given social and environmental context. In the article “Debunking the Myths of Risk,” author Hansson makes a provocative and compelling argument which states that society is preconditioned to believe that “risk must have a single, well-defined meaning, decisions on risk should be taken by experts rather than by laymen, risk assessments should be based on well established scientific facts, and lastly if there’s a serious risk, scientist will find it if they look for it” (2005). Hansson’s argument is in dialogue with the theory of knowledge-power as it speaks to the authoritative power that science and public health officials receive from disseminating risk knowledge to the public. It may be difficult or even impossible to detect wide-scale health effects in a given population because there are so many factors that can contribute to how a disease affects a given population. From these theory-based articles, it is clear that “risk” is not always scientifically proven and/or a well-defined entity. If this is the case, what does it mean for a heroin addict, crack smoker, or a sex worker to be at high-risk of contracting HIV?

Margaret Connors, risk management of intravenous drug user researcher explains that risk assessment strategies rarely address indirect effects such as social costs, public distrust of institutions, and the outcomes of risk-taking in different contexts (1992). As I will later explain, the problem of HIV intervention strategies comes along when these strategies neglect indirect risks and build their foundation on educating people about transmission and preventative measures, while ignoring structural issues that lead up to and influence a transmission event.
Drug Policies and Public Health Strategies

Drug using, smuggling, and distributing are not new phenomena in the United States. However, due to the ever-growing HIV/AIDS pandemic, drugs such as heroin and crack are critically looked at in terms of risk to HIV infection and contribution to this pandemic. Traditional classification of policies and intervention and prevention strategies dealing with drug issues are broken down into efforts to minimize initiation of use, programs that cater to drug dependency, and attempts at cutting down drug distribution as well as drug production (Coombs and Ziedonis, 1995). Over the past few decades during the rise of the HIV/AIDS pandemic, much of the federal enforcement efforts have been directed towards cracking down on drug smugglers and high-level dealers, in an effort to minimize and eliminate rampant drug cultures. These efforts, however, only produced little effect on the epidemiological movement (Coombs and Ziedonis, 1995). Because policies that target drug elimination are an impractical solution to drug and health issues, governmental efforts have shifted towards public health strategies in order to address the HIV/AIDS pandemic.

Many innovative public health initiatives originated in various parts of Europe. One such initiative is a harm reduction approach, which targets dependent drug users. The harm reduction pedagogy preaches that interventionists should acknowledge the risks involved in drug use but should provide users with resources to minimize their own health risks and risks to others. Each drug users is recognized as an individual choosing to use, and therefore interventionists should recognize this humanistic decision and place no moralistic judgment to condemn or
support the use of drugs, but to once again offer access to risk reducing resources (Inciardi and Harrison, 2000). Though harm reduction programs serve to target the immediate and most pressing needs of drug communities, they often have a hierarchy of goals. In other words, offering the necessary resources to using populations is often seen as the first realistic step towards risk-free drug use (Inciardi and Harrison, 2000). Although providing resources such as new and unused syringes to heroin addicts is incremental to a successful harm reduction approach, I will later explain some of the complications that come with effectively getting these resources to users in need.

An older work titled *Handbook on Drug Abuse and Prevention* explains that in order to devise an effective prevention approach, it is necessary to understand not only the causes of the disease or condition, but also how various factors fit together to produce the disease or condition (Coombs and Ziedonis, 1995). For example, understanding the proximate mechanisms that cause HIV infection are important, but deeply understanding how sociological factors are pieced together with the biological causes for a disease or condition will yield a successful prevention or intervention strategy. *Care of Drug Users in General Practice* is a harm reduction handbook approach to caring for vulnerable drug users. This handbook, like the previous, promotes the idea of understanding addiction in its entirety (the health and sociological side) in order to address drug related complications effectively (Beaumont, 2004).

Though *Care of Drug Users in General Practice* speaks to drug issues in the United Kingdom, the strategies presented gives insight into public health changes
that could potentially help the United States. Authors Chris Ford and Brian Whitehead argue that individualized care and a well tailored risk assessments for each user is necessary to achieve a successful and widespread intervention. These authors explain that primary care and persistent check ups will not only provide health establishments with a patient profile allowing healthcare providers see the evolution of one’s drug use, but it will also help users to reflect on why they are using, why are they seeking medical help, and how they may need to change their current habits (Beaumont, 2004). In all, Ford and Whitehead believe that through primary and individualized care, health care providers can identify a patient’s health needs as well as social needs, which varies from person to person, to lower health risk associated with drug use (Beaumont, 2004). Though individualized care for users presents an ideal strategy that facilitates a user’s access to persistent health care, as well as provides health care workers with information regarding the user’s sociological background, it is important recognized that users often represent a disadvantaged group with poor access to social and health services and poor awareness of their right to obtain proper care (Robertson, 1998). In this respect, public health officials need to critically question how feasible is individualized care for such a socially and economically marginalized population.

*Sociological Factors that Influence HIV Risk Behaviors*

Though the feasibility for individualized care of users and other marginalized individuals is debatable, understanding the sociological factors influencing and perpetuating high-risk HIV behaviors is still incremental to planning a successful
intervention. Paul Farmer, Margaret Connors, and Janie Simmons’ *Women Poverty and AIDS: Sex drugs and Structural Violence* gives accounts of the social and economic surroundings that put poor women at greater risk for encountering and contracting HIV (2011). This ethnography looks at women not only in urban US centers, but also abroad in areas such as Bangladesh and parts of rural Haiti. Though women in each geographic area suffered from different problems, the underlying theme is the issue of structural violence, or forms of mandated, allowed, or overlooked violence (Farmer et. al, 2011). Whether politically, economically or socially driven, these authors explain how various forms of structural violence can force women into situations where they have little to no autonomy over their bodies.

*Crack Pipe As Pimp: An ethnographic investigation of sex for crack exchanges* explains how the crack era brought upon a new wave of prostitution, one in which a pimp was no longer necessary and where women became more autonomous in their sexual decisions in effort to support their addictions. Though women during this time appeared to be transforming into more sexually autonomous individuals, this ethnography unravels the intricacies of prostitution, drug addiction, and sexual power dynamics between men and women that still subjugates a woman’s decision to take the necessary precautions to lower HIV risk. Similar to the woven theme of structural violence throughout *Women Poverty and AIDS, Crack Pipe as Pimp* alludes to the systematic subjugation of crack addicted women within the peak of the crack culture, and delves into how this subjugation can lead to vulnerability and increased HIV risk. This ethnography also describes a new hierarchy of risk-taking adopted by
women drug users in which they are aware of the risks involved in unprotected sex, but participate in high-risk behaviors anyway to quench the thirst for a high, or to have enough money to get by on a day-to-day basis.

One other ethnography looking specifically at crack-addicted women also uncovered a risk-taking and decision-making scheme women developed in order to satisfy their addiction. Tanya Sharpe explains that when addicted women were asked if they were concerned with contracting an STD during unprotected vaginal sex, many women admitted yes, however, they engaged in the high-risk activity regardless to support their addictions. Sharpe also encounters a number of women that believed douching after unprotected sex minimizes the chances of contracting an STD (2005). Though there seems to be a lack of education in Sharpe’s correspondents in regards to douching and reducing STD risk, women understood that using a condom lowers the risk of sexually transmitted diseases. Though Sharpe does not discuss the women’s initial decisions in using or not using a condom during unprotected sex, I believe these women were not choosing to participate in unprotected sex simply because they knew that douching was an option to reduce risks, but also because of the structured sexual dynamics taking place between women users, and men clients and/or drug dealers, that heavily influenced weather or not a condom would be used in the sex-for-crack/or money exchange.
METHODS

This study has been conducted over the course of four months in three main field site locations: the Kensington Stroll, Prevention Point needle exchange on Lehigh Avenue, and the mobile needle exchange on 3rd and Girard. Data was obtained through creating a network of main informants and conducting informal interviews with these individuals, as well as making socio-economic environmental observations of the general area. Many of my early days walking the stroll were spent observing the interactions and relationships between people I encountered. I took great note in observing different reactions to my presence in the community. On the Stroll, I also conducted a few resource-situational experiments, in which I set out to find a resource in the field and analyzed how accessible this resource was. For example, one resource I set out for was a condom, and its accessibility was measured in cost, location, and positioning within the store. As time progressed and my level of comfort in the Kensington area rose, allowing me to converse heavily with many community members. These individuals held social positions ranging from drug users, community outreachers, and drug dealers.

My time spent at Prevention Point took the form of volunteering as well as conducting informal interviews with staff members, clients, and other volunteers. My duties as a volunteer consisted of making 10-packs, which are ten newly packaged needles that are rubber banded together, and creating 100-packs, which are 100 newly packaged needles stuffed inside a paper bag. These packages were used for exchanging with registered Prevention Point clients who brought in needles for exchange. Making connections with other volunteers was extremely
helpful in gaining insight into HIV risk perception as seen through the lens of a high-risk individual because many volunteers were recovering users or had previous experiences in the sex work industry. The staff members, on the other hand, offered a public health and harm reduction interpretation of risk, which was useful for assessing possible discrepancies between the two groups of individuals.

Information from these observations, experiments, and encounters was retained by jotting down keynotes on my cell phone with an application called S-Memo. These note highlights were then used to create more in depth and elaborate field notes. Observations were also documented through photos to capture the environment of the Kensington area. Lastly, information from various prevention point clients was obtained by distributing and collecting a few surveys that allowed participants to share information on past and present drug use, habits of needle sharing, use of condoms, and knowledge of HIV modes of transmission.

DESCRIPTION OF FIELD SITE(S)

_The Kensington Stroll_

Exiting the Somerset station in North Philadelphia for the first time was like entering into a completely different world. Drawing comparisons between University City in West Philadelphia and Kensington in North Philly is near pointless. However, entering North Philadelphia gave me an overwhelming sensation of realness: real people, hustling people, hurting people, happy people, and high people. In Kensington, there is no room for struggles and conflicts about meeting times, paper deadlines, exams and etcetera, which my fellow peers and I
revolve our lives around. In Kensington, every struggle, conflict, and act of day-to-day living is directly related to that person's life and physical existence.

The Kensington Stroll, or simply stroll, is well known as an area for two main black market industries: drug retail and sex work. Throughout this study I will elaborate on how these two industries are intimately and inevitably related. Walking down the stroll as a young, black woman on a fairly pleasant day can yield a variety of interesting observations and brow-raising encounters. The streets and few vacant lots along Kensington Avenue are cluttered with empty beer bottles, miscellaneous trash, articles of clothing, and prescription pill bottles, as well as used syringes. Lying at the bottom of many sidewalk/crosswalk slopes were broken or dirty syringes, indicating the prevalent use of injection drugs in this community (see figure 1).

It is incredibly easy to find and buy drugs in Kensington. Between the Somerset and Alleghany SEPTA stops, any individual will encounter numerous dealers and witness many transactions. Shortly after leaving the Somerset station for the first time, a drug dealer looked me in my eyes and asked did I need anything. I replied “No, I’m good,” and he responded with what I believe was “you know of anyone with something superior?” I wasn’t prepared to pursue a conversation with him and wasn’t sure what I could possibly ask, or respond with so I kept walking. Later I observed him and his selling partner from the other side of the street making plenty of transactions with locals. This guy was Latino, and was probably in his late 20s to early 30s. His selling partner on that block was a black woman who appeared to be a lesbian, which was indicated through her men’s clothing attire. Walking
down a side street off Kensington, there was another drug dealer, a black woman, also dressed in men's attire. I saw her from across the street yelling out the products she had for sell and talking to whoever passed her way on her side of the street. The last drug dealer I saw that day was an older white man making a drug transaction with a middle-aged black man. The transaction was pretty obvious as I could see them money and the product. Their interaction with each other seemed very amiable, perhaps the costumer is one of the dealer’s regulars. Although I noticed the police riding around the area, local drug dealers and users did not seem phased by their presence.

As my time spent in Kensington progressed, I began noticing a hand full of men that were walking in my direction would attempt to make eye contact with me, or stare my way. Some wouldn’t say a word as they tried to make the eye connection, while others would shoot me a flirtatious greeting. This same phenomenon occurred with men in vehicles. As I walked down a side street toward Lehigh Avenue, a car coming in my direction slowly approached me. The guy in the vehicle was a young, black man, perhaps late 20s to early 30s. He rolled down his window, grinned at me, and softly mouthed, “how much are you chargin’?” I responded by shaking my head smiling and saying “no” and kept walking. As I continued walking down this street, I noticed that other cars would slow down and try to get a glimpse of my face or make eye contact with me before they passed by. A few cars even beeped their horn lightly to get my attention. Clearly, on multiple occasions I was mistaken for a prostitute. Not because of my attire (I was wearing a winter coat and boots) but perhaps it was because I was identified as a female,
walking on a random residential side street alone. Being mistaken for a prostitute numerous times in broad daylight breaks apart common misconceptions that “hookers” stay on corners, at night, dressed provocatively while flagging down cars (none of which I was doing). This short account also indicates the rather frequent and vast sex work market that takes place in this North Philadelphia community.

*Prevention Point*

Prevention Point needle exchange is located on Lehigh Avenue in North Philadelphia. This is their home site location, which offers clients health screenings, vaccinations, clean works or syringes, warmth, bathroom access, free clothing, and a number of other services. The main entrance of Prevention Point is on the side of a large multi-purpose building, which is situated on a side street. In this alley there are multiple users and homeless people congregating and talking to each other. No one seemed particularly phased by my presence, in fact many of the people were amiable, and showed me to the side door entrance. Walking in for the first time I was immediately hit by a sharp odor of alcohol. Despite the unwelcoming smell, it was very warm inside, and it felt great compared to the cold February wind. There was an array of races and ages in the center, however, no one quite as young as me, though there were a few younger Latina women. The woman that pointed me toward the entrance in the alley walked in a few minutes later after smoking her cigarette and exclaimed, “Boy it sure does smell like straight alcohol in her!” as she waited for people to agree with her.
The space inside Prevention Point is very limited. The entrance leads into a narrow hallway, where many clients hang out and talk to each other. The first door off of this narrow hallway is the staff offices and a couple of medical rooms. This small area reminds me of a small doctor’s office. The main area of Prevention Point is a lobby/lounge like are with a many chairs and a small TV for the clients. At the back of the lounge are a desk, multiple file cabinets and folders, and a frantic receptionist. The receptionist is often challenged with bringing up client health records, answering questions, while simultaneously keeping order amongst the lobby area. Off of the main, narrow hallway is the storage room where Prevention Point staff keeps their supply of syringes, materials for crack cookers, donated clothing, and other drug related paraphernalia for their clients. When I volunteered at this site, the storage room was main workstation. Because of its secluded location away from the main client area, I unfortunately had little access to talk with current users. However, volunteering in the storage room gave me the opportunity to have intimate and thought provoking conversations with fellow volunteers who were recovering users and past participants of the sex work industry.

3rd and Girard

Every Saturday from 10:30am to 12:30pm, Prevention Point sets up a mobile health clinic on 3rd and Girard in front of the community’s public health building (see figure 2). Girard is a bustling street that seems to be gentrifying. Along this street, one could find stores ranging from small business retail shops, corner stores, to dog grooming companies and health spas. Many people in the neighborhood are
aware of Prevention Point’s presence in the community Saturday mornings. At the mobile exchange site, there are two trailers: one for holding the needle exchanging supplies, and the other for the free health clinic. The health clinic is run by current Jefferson medical students who named their clinic and services “Jeff Hope.” On the sidewalk there are usually two stations where volunteers are placed to package items such as 10 packs, 100 packs, and cookers. At this site, volunteers range from graduate students, and Americorps service members, to local homeless people.

Any individual walking through this site is subject to hearing Clayton, Prevention Point’s Street-Side Health Project Coordinator yell, “Free doctors, we have free doctors today! Condoms, free condoms here!” Most individuals continue walking pass trying to make as little eye contact as possible, while others shake their heads and say, “no, thank you” or “yea, I’ve heard.” The main clients that come to the area for clean works are familiar with Prevention Point and are most likely older clients. Those who are not familiar with Prevention Point and the services they provide have a range of reactions once they find out its harm reduction methodology. On one occasion walking to the mobile exchange site, I came across a group of young guys that just passed through the site. They were a racially mixed group of guys in their mid-twenties, loudly expressing their opinions about Prevention Point. One of the guys exclaimed, “So they’re giving away needles for drug use? Why the hell are they doing that?” and his friend explained, “No, see that’s good! Its for HIV, you know so people on dope wont have to share and get diseases like that.” This brief encounter speaks to the strong opinions encompassing harm reduction intervention strategies that will be discussed more thoroughly later.
ETHNOGRAPHIC FINDINGS

Black Market Industries and a Culture of Hustle

Pursuing fieldwork in the Kensington area of North Philadelphia gave me the opportunity meet and interact with locals who experienced or witnessed drug and prostitution related issues in the area. One warm March day walking down Kensington, I noticed a guy walking about a foot behind me at my pace. It seemed like he was attempting to walk with me but he wasn’t quite sure if his company would be invited. Eventually we were walking side by side and he asked me how was I doing. I replied that I am good, and asked him the same. He was black, probably in his late twenties or early thirties and he was smoking a very long hand wrapped joint. At first I wasn’t sure about what he was smoking, but after he released his deep inhalation, I knew it was marijuana. We both approached a street corner where I was planning to cross and he was planning to turn, however, before he made his turn down the street he asked, “Can I walk with you?” His quick decision to change up his entire route let me know that his schedule that day was pretty open, as he didn’t seem to be in a rush anywhere.

We started talking at the corner, and shortly into our conversation I found out that his name was Sean. He asked me where I was from and what I was doing “this way,” and I responded by letting him know that I am a student, studying drug culture in Philadelphia. He immediately replied with a grin, “As you can see, I’m pretty familiar with that subject” as he held up is joint. I chuckled a bit, and asked Sean about some of the things he has witnessed in the area that were related to drugs. He responded, “Man, what haven't I seen. I’ve seen some crazy shit man. I
don’t know if you heard about it, but not too long ago this man was all doped up stripped down, he was butt naked, and jumped in front of a SEPTA bus! That dope make people do some crazy shit.” He told me that during the summer months the stroll gets worse because the heat brings more people to the area. “During the summer, you know when it gets warmer, out here looks like a scene from ‘The Walking Dead.’” From my personal observations I have witnessed on numerous occasions people under the influence as well as drug deals and exchanges on colder days. Sean’s “Walking Dead” description allowed me to extrapolate the magnitude and increased frequency of black market activities taking place on the stroll during the warmer half the year.

Sean was not only deeply familiar with drugs in Kensington, he also gave many accounts on how drugs and the sex work industry are intimately related. I told him that in many areas with high concentration of drugs, prostitution is also prevalent in those areas then asked if he felt that was true for the Kensington area. Sean explained that on multiple occasions women have asked him if he wanted to go to their house, insinuating that they were sex workers looking for clients. He explained that prostitution in the area is dying because the police are cracking down on the drug industry. “Ever since SEPTA’s been puttin’ out their cops, the dealers and prostitutes been movin’ further and further down [Kensington]. They try to stay in between the two [SEPTA] stops though.” Sean’s account of the high frequency of sex workers in this drug market area reminded me of the many times I had been mistaken for a worker when I casually walked down the street. It is clear that both markets are intimately and intricately related, and this relationship, as I will later
explain, is one of the major factors influencing an at-risk person’s hierarchy of decision-making.

The cornerstone of any black market industry such as the selling of drugs or the solicitation of sex is that the item or service being sold is illegal. Because the selling of sex, drugs, and needles is so vital to the Kensington local economy, hustling by any means necessary is deeply rooted into the Kensington culture. Though local businesses in the area seem to be thriving, many of them are family owned and run, leaving little opportunity for local residents to obtain a legitimate job in their own community. Many individuals I came across found difficulty in finding work, or found difficulty in maintaining steady work due to an addiction. Because this area is a breeding ground for endemic poverty, many locals have entered (I would argue forcibly entered) into hustling in order to support themselves.

TY is a 21-year-old, African American drug dealer. I met him in the middle of one of his drug transactions on Kensington Avenue with a group of guys. He noticed that I was not from the area and wondered why I was in North Philly. I gave him my standard “student studying Philadelphia’s drug culture” routine and he responded with a chuckle saying, “well there’s a lot of that”... around the same time one of his group members approached us and interjected telling TY, “He ain’t want no dope” and updating him on a drug move. His friend was fumbling with a pill bottle in his hands during this time. TY explained to me that he entered into drug selling a few years back and feels that it is always there just in case he needs extra money. At the time of this first encounter I thought that dealing for him was more of a side-hustle,
but running into him again, I got the perception that selling drugs was is main
source of income. On a separate occasion I ran into TY after shortly parting ways
with Sean. I was ecstatic to see a familiar face and immediately greeted him and
asked how he was doing. TY responded, “I'm just staying out of trouble, looking for
work you know.” His response informed me that he was currently unemployed with
a legal job. The deepened tone of his voice made him seem somewhat sadden by his
situation but by the shrug of his shoulders it also seemed like this situation was out
of his control due to the little hiring opportunities in the neighborhood.

I told TY about the story of the doped-up guy that Sean just told me and
asked TY if he knew of it or heard of any other incidents of drug users. He said he
never heard of that particular story but gave me a general answer saying, “Some
people take drugs occasionally, like they may be into xannies or somethin' to relax
and chill, and then there’s other people that just take it to another level and OD, or
get hooked like on dope or something...I've seen all kinds of sick people, dope sick,
health sick, and yea I’m sure a lot of them have STDs from doing the things they do
because of the drugs.” Here TY explained the spectrum of drug use and addiction in
Philadelphia, framing the pills or xannax using as less detrimental to your overall
wellbeing than something like heroin. He also gives an account of drug use and
sexual health awareness that I will later discuss.

An interesting finding with conflicting implications I found was the
prominent selling and re-selling of needles or works. Anyone who comes to
Prevention Point that is in need of works but has nothing to exchange will
automatically get a bundle of 10 needles maximum. Clayton explained that PP
advocates for clean drug use and does not want to turn anyone away. People who come in with under 50 needles get their number of exchanged back and with over 50 needles they get that number back plus 2 works for however many they are over. One of the staff members explained that some people come in with a lot of needles to exchange because they are community distributors, “that’s what we want, people out in the community doing our job for us.” His statement was interesting given that people in the Kensington area are known for going to exchanges, exchanging needles and then selling them for profit on the streets. Many dealers may yell “Works! Works!” to let others know they have needles for sell.

Alonzo, a middle-aged, homeless black man, and also a recovered crack addict and a fellow Prevention Point volunteer, explained to me his personal encounters with the needle hustling culture and some of the politics taking place within the PP exchange system. Alonzo claimed, “I don’t know if these people are running shooting galleries or what, all I know is that I am not the one to give them extra supply hook-ups.” Shooting galleries, Alonzo explains, are similar to crack houses, where users can come buy, sell, shoot, and nod or get high. Alonzo explains that on many occasions other homeless people/users have stole needles from him (he apparently had some on him with the intention to sell as he was very adamant about never “shooting up”). Alonzo also notified me that other PP volunteers often steal multiple boxes of needles. He said, “One day I caught that Spanish woman with all these boxes packed away, I just didn’t say nothin’, but she knew she was wrong.” I asked Alonzo why he thought the one volunteer was stealing so many works and he explained, “She probably will sell some, buy some dope, then use the others, I
think its messed up. I ain't supportin’ her habit.” These accounts show that the needle exchange itself as a harm reduction intervention has been manipulated by Kensington’s culture of poverty. The fact that people exchange needles and sell them for a profit speaks to many of the underlying economic and structural problems that prohibit or limit sources of income for people in the surrounding neighborhoods. More interestingly, although PP advocates clean needle use for all users, the stipulations PP enforces make it difficult for all users in need to have access to clean works.

Risk Taking in High-Risk Groups

Throughout my population of correspondents, many individuals seemed to be aware that unsafe sex and needle sharing can drastically increase risk to HIV infection. On many occasions Clayton downplayed “educational” initiatives to HIV intervention as he explained many people who show up to PP know that sharing needles is bad, and understand the risks involved with doing such activities. My personal experiences with the few surveys I received showed that all survey participants (7 in all) believed they understood the modes of HIV transmission and all of them recognized various forms of unprotected sex and needle sharing as ways that HIV spreads. Although my survey population size is small, I believe there is a general awareness that sex without a condom and needle sharing increases HIV risk within the North Philly drug using/high-risk community.

When asking Sean about his thoughts on drug use and decision-making, he was quick to explain that, “People on dope get caught up in the moment, they think
in the moment, they make their choices in the moment. I mean, when I smoke (marijuana), you know I’m like more aware, I think straight, but when you’re drugged up and high, you gonna make what ever decision you feel is right at the moment.” Sean is articulating the way a person under the influence of drugs, namely dope or crack, makes decisions is strongly influenced by his or her physical and mental state at that given point in time.

The first time I volunteered at Prevention Point’s home site, I was placed in the back storage room to make 100-packs of needles for future exchanges. Back there I met and worked with Larry and Lamont. Larry is a middle aged black male who is also a recovered crack addict with a daughter. Lamont is a younger black male, he is currently in school, and he explained that he is a recovered sex addict and ex-male prostitute who catered to women clientele. Initially, Larry and I were working alone in the back room; he was sorting donated clothing while I continued making bags of 100 needles. Larry and I conversed for a few minutes about superficial topics such as the weather, but shortly our conversation took an intellectually stimulating turn when he asked what I was studying in school. I explained to him the study of anthropology and my focus of medical anthropology and added my interest on how drug users or prostitutes see their own risk to HIV infection. Larry questioned me, “What do you think the issue is? How do you think they see themselves?” He seemed to be picking my mind to see if my thoughts aligned with his experiences. I quickly came up with a hypothetical case of prostitution and told him, “For example, if a woman is addicted to heroin and is going through crazy withdrawal symptoms and she has an opportunity to fix that by
engaging in sex work, and her client at the moment is totally against wearing a condom, she’s put in a predicament that could strongly persuade her to knowingly engage in high HIV risk activity.” Larry was very pleased with my answer saying,

— that’s what I was looking for. People on drugs don’t behave like everyone one else. When you in the moment you ain’t thinking about risk. You make the decision based on what you currently need. Now me, I was addicted to crack, that’s more mental. I ain’t never been addicted to dope but that’s physical. Crack will already make you do some crazy things for the high, but add a physical part to that, and your body’s hurtin’, what do you think is gonna happen?

Larry also explained, “A lot of these programs out here they don’t reach the people. You got to understand how they think if you want to reach the people.” I asked Larry if he thought men and women in general had different factors that influenced risk to HIV. He thought for a moment then said,

Now say for instance, I’m in a crack house and I don’t have no money. I’m not smoking crack that day. But if a woman is in that same house, and she don’t have no money, she can and probably will use sex, perform x, y and z, and smoke crack that day. And like I said, if you really are trying to get your fix, the first thing on your mind is not where’s the condom, and if it is the woman doesn’t have that much control. Because they can use sex, I think women have a little more risk than men.

At this point in our conversation, Lamont started volunteering with us in the storage room. Lamont is not ashamed of his past and is very upfront about his personal experiences, which was shown by his quickness to add his opinion about vulnerability in the sex work industry. Though he acknowledged Larry’s argument that women are more prone to violence during sex-for-money exchanges, Lamont explained that many women take advantage of male prostitutes illustrating his point
by a personal rape anecdote. Lamont also explained that there are still a lot of politics that go into condom negotiation for men sex workers. I asked him, “As a prostitute, was contracting STDs at the forefront of your mind?” He answered, “Getting infected with something is definitely at the forefront of your mind but weighing the risk, and the money, and how bad you want it affects whether or not a condom is gonna be used.” Silvana, a PP staff member interjects with the idea of charging more for “bareback” (sex without a condom). Lamont agrees, “Using a condom protects you and myself. I would charge more cause I’m putting myself at a higher risk. Getting something like HIV affects not only me but my family too.” The point of charging more for unprotected sex is to encourage the condom rate therefore encouraging condom use.

On a separate occasion, Clayton also explained that PP suggests that women (or more generally prostitutes) should charge more for unprotected sex or turn down clients that do not want to use a condom. This harm reduction suggestion seems simple enough in theory, but conversely, the social, economic, and addiction factors of the sex worker complicate this simple solution. After Silvana left the storage room, Lamont opens up a little more, expressing the conflicting emotions that occur when deciding whether or not to take a sexual health risk. “I mean say one of my clients tells me she wants me to hit it raw, no condom no nothing, and she’s willin’ to pay that 20 or 30 more dollars… Yea we probably won’t be usin’ a condom.” I think it is important to keep in mind that Lamont’s drive to participate in prostitution was his addiction to sex and the money that could be obtained, not a physical dependency, although sex addiction would be classified as a mental
addiction. Though Lamont did not have a drug addiction he was trying to sustain, his personal risk analysis showed that condom use during sexual encounters was preferred only if the monetary benefits were low. His accounts showed that there is an active awareness of risk involved in unprotected sex, yet taking that risk and engaging in high sexual risk activities is not uncommon for many sex workers. Lamont’s accounts however are reflections of past experiences and are his attempts to construct a rationality of risk-taking. However, when individuals such as Lamont are in that moment before high-risk activity, it is difficult to gage just how conscious an individual is when deciding whether or not to engage in the activity. For this reason, I will later argue that risk-taking in the moment happens at a subconscious or perhaps unconscious level of thinking, where the individual is knowledgeable of involved risks, but is not actively thinking about the risk itself when making the decision to have unprotected sex or share works.

My last significant accounts of risk-taking came from two gentlemen that run a community-based HIV rapid testing facility called “Get Up”. The “Get Up” testing site is located on Kensington not too far from the Somerset Station. Will and Mr. Right, both who are African American males that identify themselves as gay run this small non-profit storefront. After entering into the site and introducing myself, we immediately delved into topics regarding IV drug use, risk taking, risk perception, and sex work. I asked the men their thoughts on how drug users and their other clients interpret HIV. Mr. Right explained,

These users and risk-takers are not understanding how HIV works. Yes, they may understand most of the ways it is transmitted, but see HIV is not what is use to be. People think HIV is like syphilis now and live by ‘one pill
a day, and I will be okay.’ It’s a lifetime disease and people out there just aren’t understanding the consequences.

Mr. Right’s response was the first to address an HIV misconception noting that its not necessarily the lack of information on how to contract the virus, but rather a false understanding that living with HIV is easier now because of the medicine that is currently available. This is an interesting take on HIV knowledge in at-risk communities, however, I do question how widespread this notion is considering that HIV is still heavily stigmatized in mainstream cultures.

I then asked the gentlemen, “Do you think the physiological effects of say dope promote the urgency of needle-sharing, even if they know HIV is a potential risk?” Will answered,

If an IV user doesn’t have access to a needle in that moment of needing that high, or doesn’t have the cash to buy works off the street, and if they’re not packaged who knows if they’re even really clean, some do pick them off the ground or use with their friends, yes it definitely happens... one of our clients told us that a person they shared with told him he was HIV positive well after that day they shared needles... places like Prevention Point are great for promoting less needle sharing, but at the same time these places are not 24hrs, they can’t be. And drug cravings don’t stop when these places close.

I then asked, “I heard people can sometimes get residual highs from a needle that has just been used by someone else, can that influence the urgency to share?” Will responded, “Back-blooding! Oh that’s really high-risk, but yes it happens too unfortunately.” At that moment I recalled asking Clayton his opinion on needle sharing due to residual highs that could be obtained and he responded by giving me the same harm reduction statistics he gave me on a previous occasion stating that it
is proven that when users have access to clean needles it increases their chances of not sharing. Will’s comment on the accessibility of clean works through all hours of the night poses a question of efficacy to Clayton’s harm reduction doctrine. Though the distribution of clean needles is helpful, clean and free needles are not always available, thus putting dopesick users in a quandary of paying for works, or sharing works.

I transitioned the conversation to sex work and how risk is perceived in that industry. Mr. Right said,

> We give out free condoms, but I’ve seen people selling these same exact condoms for $2.25! Who has $2.25?! And if you’re addicted to something now you have to decide whether to spend money on a condom or to get high?

Will interjected,

> —same with the needles, some places like us offer free condoms, but if its 9, 10, 11 or 12 o’clock at night and places like us are closed, you have no condom, and closest store selling some at a decent price is blocks away, many people will just do what they do without it.

I then asked, “Do most clients of the workers prefer to use condoms?” Will answered,

> Many of our clients that are prostitutes do carry condoms with them, but if one of their clients is offering 20 or 30 more dollars above the average rate to do with out, that condom may just come off! Especially if that person is trying to support a habit. Sex and drugs are just related like that.

Here Will expresses some of the same dilemmas explained by Larry and Lamont.

Again, letting a client “walk” because the worker refuses to have sex without a
condom is a tough thing to do, especially when there is a physiological, financial or physio-financial force influencing their ultimate risk-taking decision.

From my various encounters with individuals of Kensington, it seems that certain drugs like heroin, which causes a physical addiction, or crack and even sex, which cause mental addictions, puts an individual in a variety of temporary physical and mental states, which will dictate how a person acts. These temporal states make it difficult for risk-takers to think about the implications of their decisions or future repercussions because they are focused on making decisions that will impact themselves at that given moment in space and time.

**Intervention and Prevention**

Clayton advocates syringe exchanging is like putting on a seatbelt.

What’s the first thing you do when you get into a car, put on your seatbelt right? When we drive heavy machinery we put ourselves in danger each day, that doesn’t mean we are going to stop doing it, we need to take the necessary precautions to make sure we are the safest we can be. The same goes for needle exchanging.

Clayton’s metaphor of PP as the drug user’s seatbelt is efficient to the extent that drug addiction and lack of financial resources, both social and structural obstacles, can strongly influence users to not put their metaphoric seatbelts on during any given day.

While chatting with Clayton in his office one day, Silvana popped in with a brief anecdote to share. She said that some politician was talking with her and asked, “Whatever happened to that saying, ‘hugs not drugs’?” she chuckled and said to Clayton, “yea that never really worked did it?” The politician’s statement hints at some of the criticism around needle exchange efforts as some people view harm
reduction as promoting drug use. Clayton then explained to me that both community members and politicians often view harm reduction interventions as destructive, and many believe that more prohibitory policies should be implemented to eliminate and severely punish drug use. Clayton posed the question, “Would it be worse for a child to see syringes in Needle Park and ask his parent what is that? Or see a bio hazard bin for users to dump their needles and ask their parents what is that?” Needle Park is Mc Phereson Park, close to the library where I saw an anti-drug using mural (see figure 3). This makes for an interesting dynamic between community anti-drug sentiments and the harm reduction approach embraced by the liberal activists.

On the one hand, one must look into past drug prohibition policies and their effect on minimizing drug use. For example, at the peak of crack’s moral panic, drug policies that were put in place to lessen the crack epidemic also put a huge number of young black men into long prison terms, and even then still the crack culture did not cease simply due to harsher drug laws. On the other hand, one must question the optimal efficacy of harm reduction strategies, which are praised for their efforts to get users the supplies they need. As Alonzo explained, no clients of prevention point are allowed to get extra works even if they are guaranteed to be in the hands of the head of a shooting gallery. Although there is a fear of abuse where PP clients may turn their exchanged needles for a profit, street works sellers are the main clean needle disseminators to the widespread public. Similar to Will’s point, what happens if a user in need and cannot make it to 3rd and Girard before 12:30pm on Saturday?
Along with needle exchanging, Prevention Point also offers medical help to its clients. Clayton explained,

> We have a relaxed environment, therefore our clients trust us. We may have a few people come through the main facility and hang out there for about a month, getting to know others, warming up from the cold weather, and after a while they may feel comfortable enough to ask for some of our services.

He explained that many clients, even if by chance they had a primary care physician probably would not divulge information such as drug use to them, or outreach for screenings in fear of judgment. He says the PP’s relaxed atmosphere facilitates constructive and trusting interaction between client and staff. This approach to health care seems similar to individualized care systems where each client has his or her own medical history with Prevention Point. Though PP keeps medical records for all of their clients, the student doctors reinforce patients to seek primary care help and make follow health visits. While volunteering at mobile exchange, I encountered a Jefferson medical student explaining the importance of following up with a primary care physician. The PP client went by the name Moose. Moose was an older white veteran who has been having trouble with a replaced hip. The medical student asked Moose when was the last time he had his hip checked out after his surgery. The veteran was unable to give a decisive answer because he admitted that he doesn’t go to the doctor often, in fact he was only being seen today to get works and vitamins. The medical student then stressed the importance of doctor visits, “even when you’re feeling well.” Alonzo also gave numerous accounts of going to the emergency for medical help, his usual spot was the Penn emergency medical center, but never mentioned regular doctor visits. Moose and Alonzo’s
difficulty in obtaining persistent primary care is not at all uncommon within the
drug using, sex working, and homeless cultures. The environments of these
individuals, in part with their temporal physical and/or mental states, make the act
of seeking primary care low on the individual’s daily survival acts.

DISCUSSION

*Expert Vs. Lay: Is there really a difference?*

Public health powerhouses such as the World Health Organization, the
Center for Disease Control, and the National Institute of Health are responsible for
creating what it means for an individual to be at risk to HIV infection. As previously
explained, these perceptions of risk would be considered that of the “expert.” When
it comes to HIV, this expert perception of risk often constructs high-risk as being
constituted of engaging in unprotected vaginal and anal sex and sharing intravenous
works. I would argue that the concept of biopower and the western tradition of
holding the medical system as the ultimate health authority makes it difficult to
create a clear cut dichotomy between expert and lay perceptions of risk that
traditional risk theorists once advocated. Throughout my ethnographic findings, I
came across multiple incidences where lay individuals did not necessarily interpret
their own risk to HIV differently than expert individuals or expert writings.
However, I propose that there is a dichotomy that exists between the expert’s
reaction to risk and the layperson’s reaction to risk.

Many of the public health powerhouses also praise objectivity as the key to
effective and accurate risk assessment. However, as Copas critiques, if objectivity is
the strongest part of a good risk assessment, it is also the weakest. Ethnographic data is often difficult to quantify and translate into an objective language. From my time working in Kensington, it is clear that sociological, economic, mental, and physiological factors all play a strong role in a person’s risk to HIV infection. I challenge the authority of statistical data that the public health field often places on analyzing risk. Although I cannot measure the threshold point for a sex worker to enforce condom wearing or to forgo condom wearing and gain an additional thirty dollars, which could equate to $x$ amount of additional drug highs and/or food for the day, who is to say that a sex worker’s physio-financial predicament is insignificant in risk assessment because it cannot be quantified? Risk assessment studies should therefore take on a more integrated form of study that focuses on both objective and subjective data equally as needed.

Needle Sharing in a Culture of Poverty

In Philippe Bourgois and Jeff Schonberg’s ethnography Righteous Dopefiend, Frank, an Edgewater homeless heroin addict explains his needle sharing knowledge with Philippe by expressing, “You know damn well I share needles. It happens to everybody a million times. We always try not to share needles but we still do it...we worry about AIDS, but when you’re sick on dope and you got to fuckin’ get well. You not gonna worry about that shit at the moment” (2009). Frank’s honest response to Philippe’s question on needle sharing illustrates the drug user’s awareness of IV drug use’s role in the spread of HIV and the risk he takes when sharing needles. Similar to this short account, my findings in Kensington (via surveys and
interactions) showed that users are aware of HIV modes of transmission, in the words of the ex-crack user Larry, “People on drugs don’t behave like everyone else. When you in the moment you ain’t thinking about risk. You make the decision based on what you currently need.” From the few surveys I collected, the all heroin users admitted to sharing needles and the most prevalent reason for doing so was due to dopesickness. In Connor’s study on risk perception, risk-taking and risk management among IV drug users, results showed that active drug users often expressed difficulties of putting their HIV transmission knowledge to practical use as they were “…apt to recognize the objective risk involved and do it anyway” (1992). Similar to the Edgewater homeless narratives and my encounters with people of Kensington, these IV drug users know and understand HIV transmission, but this knowledge and preventative actions it promotes still is not accommodating to drug using lifestyles. Another study examining the continuation of high risk behavior by heroin and crack users after gaining knowledge of their HIV status and ways to prevent transmission showed that nearly all users planned to use a condom and planned to use clean needles, but when asked the about their last drug or sex encounter, many of them did not take any transmission precautions (Smith, 2000). Once again, knowledge of HIV transmission and ways to lower risk is not the force perpetuating high-risk behavior within these groups.

This physiological drive to participate in needle sharing is an inevitable barricade to altogether eliminate needle sharing in the drug using culture. As Will, the local HIV testing site manager posed, what will happen to users who can’t make it to the needle exchange in that time of need because its too far away or because its
closed? It may be worthwhile to further investigate the most frequent times of a user’s onset of withdrawal symptoms to coordinate with harm reduction hours of operation. For example, if future studies show that the majority of users experience dope sickness between 7am and 11am but needle exchanging facilities distribute their products between 10:30am and 3pm, users in need may have already found their fix by sharing in that moment of need. Also, because of the high frequency of needle selling, harm reduction organizations such as PP should establish better, or perhaps more formal relationships with local needle distributors. Though there are some anxieties about “abusing” the harm reduction system or as Alonzo put it, “hooking up users with extra works,” making sure works are out in the community at all hours is important to continuing to minimize needle sharing. As illustrated through my accounts, users are not always actively thinking of the implications to their actions. Making sure one has enough works for the weeks on Saturday may not be a viable practice for a user who consistently misses needle exchanging hours because he or she was too high to make it there. By increasing the hours and locations of needle distribution via the already strong and well-established black market industry, works will be more readily available in those moments of need. Individuals in urban drug and street cultures partake in risky behavior not because they are ignorant and not because their perception of risk significantly contrasts that of the expert’s, but rather because they have an intricate hierarchy of risk-taking and decision-making process that has been fostered by their unique habitus.
Habitus

Habitus is a term first proposed by Pierre Bourdieu to explain the differences in natural, conscious, and preconscious behaviors between different social classes (2000). His theory of habitus shows how social structural power influences daily practices which in turn legitimizes social inequalities (Bourgois, Schonberg, 2009). Bourdieu explains that habitus, “occupies a position there which we know is regularly associated with position-takings (opinions, representations, judgments etc) on the physical world and the social world” (2000). Drug users, sex workers, and other marginalized people that partake in high-risk behaviors may not have a different understanding of position-taking than individuals in the mainstream culture of power, but how these risk-taking individuals act out their position-taking significantly differs from the average, middle class American. Going back once again to Connor’s study, heroin addicts were able to easily talk about IV drug knowledge and HIV prevention because they took a position of recognizing needle sharing as risky, however they struggled to incorporate these preventative practices into their daily lives because their habitus acted on their position according their environmental and social context. The drug addict’s habitus motivates risk choices at the expense of possibly contracting HIV and other health conditions. Connor explains that,

This shift in priorities... creates an often overwhelming desire for drugs [and] affects the amount and degree of their involvement with risk... routine risk taking becomes habitual and the degree of risk involved in activities becomes downgraded (1992).
Here we see that routine risk-taking happens quite frequently, turning the expert-perceived dangerous act of needle sharing into a daily and habitual occurrence that comes second nature to addicts.

Looking specifically at injection drug users, heroin addiction shapes the user’s habitus and his or her resulting risk choices. As Frank explains, “People gonna share a needle; they’re gonna share a cooker, they’re gonna share whatever the fuck they got to if they’re sick” (Bourgois and Schonberg, 2009). Also, going once again back to Will from HIV testing site “Get Up,” drug yearnings do not work on needle exchange hours. Because heroin addiction causes extreme physical dependency, a needle sharing culture emerged to buffer against the chances of being sick with no way to get well. Acquiring sufficient drugs and food on a day-to-day basis can be challenging for an individual; to ease some of the challenges posed by street culture, many IV drug users form a running partnership where resource sharing is fundamental to their relationship (Connors, 1992). These individuals are put in a quandary of dope-sickness, few resources, and partnership networks that can mitigate street life struggles. For these reasons, the IV drug user’s habitus allows for risky behaviors to take place because the moral economy of the streets privileges those that share resources. Though needle sharing offers a great example of how drug and street culture affects decision-making, needle sharing is only one dimension of risky behavior that stems from street and drug habitus.

Unprotected sex is still the main cause of HIV transmission and infection. Sexual habits within drug cultures are another area where habitus is taking place in choosing risky behaviors. For example, although crack smoking is not directly
related to HIV transmission because using this drug is non-invasive, sex is a common currency within the crack using and selling drug culture. Epidemiological researchers explain that during the crack era’s peak from 1986-1988, syphilis rates significantly increased in New York City, due to the exchanging of sex for money or drugs in order to sustain the crack habit (Booth et al., 1993). In a study that observed the differences in sexual behaviors between injection drug users, crack smokers, and injection users and crack smokers, researchers found that individuals with the highest risk (or display of risk-taking behavior) related to unsafe sex, were more likely to be black, and they were more likely to be crack smokers who only smoked crack or smoked but also shot heroin. This same study also uncovered a sex behavior trend differing between the sexes. On average, women that smoked crack had a greater number of sex partner than men averaging 11 to 3 respectively (Booth et al., 1993). This study highlights Larry's description of sexual interactions within the crack using culture and the difference in risk between men and women. Though sex-for-crack exchanges in men is something that occurs and perhaps is under-studied, Larry's claim of women having a slightly higher risk to HIV because of the normalization of women using sex as a means for drugs aligns exactly with this study's claims.

Another crack smoking and sexual behavior study that looked specifically at women found that women with the highest smoking frequencies as well as with the most intensities were also the women who had the highest counts of oral and vaginal sex (Hoffman et al., 1999). Looking specifically at oral sex, not only are condoms more likely to not be used in this act, it is not a mutual sexual behavior
which supports the hypothesis that crack smoking women are participating in these high-risk acts as some form of compensation or resource-insurance networking. This same study also found that HIV seropositive status significantly correlated with heaviest crack smoking addicts, totaling to about 78% of the HIV positive individuals present in the study (Hoffman et al., 1999). This information means that the majority of HIV positive individuals had heavy crack smoking habits to sustain, which more likely put them in HIV-related risk-taking situations more often than the other addicts.

Although Connor speaks directly about the complexities of the injection drug culture, her analysis of women HIV related risk-taking speaks to the social networking of sexual relationships dependent drug users must participate in. She explains that women’s participation in sexual bartering and prostitution are a consequence of having unequal access to resources such as money and drugs (Connor, 1992). This risk-taking behavior powered by the user’s habitus can be seen through the story of Tina in Righteous Dopefiend. Before becoming official with her lover Carter, Tina had an extensive network of men in which she had some sort of relationship, most likely based on sexual exchanges, to ensure her survival on the streets and access to crack. Though Tina claims that she uses condoms every time she participates in sex, the gender dynamics that play out in condom negotiation is in favor of the man. Roxanne, a female participant in Connor’s study explained that although she is unsure whether or not her partner is participating in risky needle sharing, she agrees to have unprotected sex with him after condom negotiating because she fears she will lose him as a provider and strives to gain his trust (1992).
Also, when it comes down to straight sexual exchanges for money with clientele, a sex worker must again quickly decide whether to engage in unprotected sex, or let that client walk away and end up with nothing at all.

To say these individuals are not aware that HIV is spread through unsafe sexual contact is to miss the more structurally based problem at hand. People in drug and street cultures are in many ways forced to participate in high-risk sexual acts to ensure resources and survival. Because condom use is predominantly in the male partner’s hands, women can often be forced into risk-taking situations while knowing their sexual partner may potentially be HIV positive. When one of these women is in the moment of a sexual encounter and the male is not in favor of using a condom, her habitus (which again is influenced by her economic and social environment as well as her physiological and mental state) drives her decision to take a sexual risk. A woman from a very different socio-economic background who does not need a man’s financial support, or a woman not in a drug culture where she is trying to sustain her addiction may act quite differently in the same condom-negotiating scenario, and not because she is more aware of HIV and STD sexual transmission. One must really think about how high of a risk a drug-using woman is taking by participating in unsafe sex when she most likely doesn’t have direct access to basic living resources. I believe that it is difficult for our medicalized society to see unsafe sex practices outside of the context of HIV and other STD transmission, which is one of many reasons why women in these cultures are looked down upon.
Current Public Health Implications

While interviewing the two “Get Up” managers I had the opportunity to hear their perspective on public health strategies that governmental agencies should look into. Both men came to the conclusion that education and harm reduction techniques are crucial but they should be intertwined and not separated as they often are. Mr. Right stated that, “People who are at high-risk need that knowledge of HIV being a lifetime illness and they need the prevention methods too. They need to be targeted with both methods at the same place at the same time.” This statement reminds me of one of Clayton’s famous lines, “You cant help someone if thy are dead.” Though harm reduction is looked upon as enabling addictions, if that person dies in the near future due to health related issues that could have been prevented given the necessary resources, that person will never have the chance to undergo rehabilitation and attempt to get clean. Mr. Right explained though a two-pronged intervention is needed,

Its not gonna happen. Funding ain’t what it use to be. But maybe that’s what they want. Its all capitalism... pharmaceuticals are makin lots of money, nothing is gonna change. That’s why HIV rates in Philly have been the same for years.

The two “Get Up” gentlemen have a point here: individuals at high risk for HIV infection may need a way to see the long term implications of HIV infection but I would argue that they need it to be framed in such a way that relates to their current state. As previously explained in detail, harm reduction strategies should work harder to disseminate needles throughout a community instead of restricting clients in fear of system abuse. It is important to realize that there is no magic intervention
or prevention model that will fit a diverse reality and that Drug Policy is often an
attempt at incorporating the “truths” of addiction (Robertson, 1998 and Campbell,
2000). European based intervention strategies of individualized care work well in
theory, but these methods seem very difficult to translate to the urban centers of the
United States. Though it is difficult to propose an intervention or prevention
strategy given the at-risk individual’s habitus, my work supports strategies that are
less educationally based on HIV modes of transmission, and more structurally
based, targeting the economic and social factors that influences the at-risk person’s
habitus before he or she is put in a position of risk-taking.

CONCLUSION

Ethnographic and anthropological studies bring a powerful component to
objective and statistical based studies. Though my work was a brief study, taking
place over the course of four months, I have been able to extract some valuable
information from local Kensington residents in regards to the drug and sex work
culture in North Philadelphia. My ethnographic findings are a compilation of
encounters with different people I met and spoke with for varying amounts of times
and occasions. To further develop my argument of a risk-taking hierarchy by at-risk
individuals, I would need to develop enduring relationships with correspondents,
which would allow me to consistently see the daily decision-making processes at
work and analyze the factors that influence those processes. Though it is difficult to
devise an intervention or prevention strategy to accommodate the at-risk person’s
habitus, I believe further research on economic, social, and structural forces that influence risk-taking is crucial to a better HIV intervention plan.
Works Cited


APPENDIX

Figure 1

Syringe in rubble on the side of the street

Figure 2

Medical van at mobile exchange on 3rd and Girard
Figure 3

Anti-drugs community mural in Kensington
Copy of survey used

Prevention Point Survey

Circle answers

I am:

Male       Female

Do you come to Prevention Point often?

Not often       Once a week       Very often (many times a week)

Services I use at Prevention Point (circle all that apply):

Needle exchange
Pipe smokers
New clothing
Condoms
Health screenings/ vaccinations
Other (please list):

Drugs I have used in the past, or currently use now (circle all that apply):

Heroin
Crack
Pills
Alcohol
Other (please list):

Have you ever shared works?

I always share       I only share if       I only share with       I never share
I am dope sick       I am dope sick       people I know

IF YES- Reasons why I have shared works (circle all that apply):

I am friendly/generous
I felt dope sick
Someone offered me their leftovers
I didn't have a clean needle on me
I knew the person well
Other (please list):

**Do you use a condom during sex?**
Always  Sometimes  Never

**IF NO- Reasons I have not used a condom (circle all that apply):**
I wasn't thinking about it at the moment
I didn't have one at the moment
My partner didn't want to use one
I know my partner is clean
I was raped
Other (please list):

**Have you ever worked as a prostitute/ received money for sex?**
Yes  No

**IF YES- Do/Did most of your customers prefer to use condoms?**
Most did  Most did not  Most didn’t care

**Do you know how HIV spreads?**
Yes  No

**How do you believe HIV spreads (circle all that apply)?**
Needle sharing
Unsafe vaginal sex
Unsafe anal sex
Unsafe oral sex
Sharing crack pipes
Touching blood of person with HIV
Kissing person with HIV