

Ethnography of Substance Use

The Moral Economies of Homeless Heroin Addicts: Confronting Ethnography, HIV Risk, and Everyday Violence in San Francisco Shooting Encampments

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ABSTRACT

Ethnographic immersion among homeless heroin addicts in San Francisco documents far more risky practices than the public health literature routinely reports. The logics of street-based income-generating strategies and the moral economy of social networking among self-identified "dope fiends" results in almost daily shares of drug preparation paraphernalia. Public health researchers need to reconceptualize their psychological behaviorist paradigm of "individual health risk behavior" because the pragmatics of income-generating strategies and the social symbolic hierarchies of respect, identity, and mutual dependence shape risky behavior. The explanatory potentials and the applied interventions that participant-observation anthropological approaches could bring to epidemiological public health research have not been utilized effectively in the field of HIV prevention and substance use. The accuracy of quantitative public health databases and our understanding of the who/why/how/where of HIV infection could be improved by a cross-methodologi-

... dialogue with participant-observation fieldworkers and by a greater theoretical sophistication with respect to power, violence, and extreme social marginalization.

Key words. Heroin injection; HIV risk; Homelessness; Everyday violence; Ethnography; Gift-giving economy; Moral economy of sharing

I ran into Max in the Burger King parking lot where he was washing car windows. The sun was just about to set, and he had only managed to raise \$5 since his last injection at midday. He asked me urgently for \$2, explaining that Scotty and Butch, the dealing partnership currently dominating heroin sales in the network, were insisting that \$7 was the minimum amount they would accept for splitting a \$20 bag three-ways with him.

Scotty and Butch stop selling right after sunset and this was going to be Max's final opportunity to purchase heroin for his bedtime supply shot. If he missed this opportunity he was going to be awakened at midnight with hot flashes, dry heaves, intense body cramps, and emotional turmoil from heroin withdrawal. I apologized diplomatically for not being able to help him but opportunistically followed him as he rushed down the street to search for Scotty and Butch, or whoever else might be around to lend him \$2.

We soon found Scotty and Butch, the dealing partners. In an ambiguous tightrope between begging and cajoling, Max somehow managed to persuade them to allow him to share a third of a bag with him for only a \$5 contribution. He promised to pay them the next day the remaining \$2 at 100% interest.

The deal done, we all hurried to the shooting encampment where Scotty and Butch sleep. On our way I heard Max cursing under his breath that he did not have a "clean rig" on him. His sleeping encampment where he keeps his syringes hidden in the bushes—in anticipation of police searches or theft by fellow addicts—is located on the other side of a mound of rocks. He could not insist that Scotty and Butch wait for him to run to obtain a clean syringe at his camp because they were already doing him the favor of allowing him to be \$2 "short" on a third of a bag of heroin. Furthermore, he did not want to let them too far out of his eyesight for fear that they might conspire to shave off a portion of the black tar heroin that they were supposed to be sharing in equal thirds with him.

Immediately upon arriving at the camp, Scotty, Butch, and Max huddled around the wide-mouth Mickey's malt liquor bottle cap with the

plastic lining removed that was going to serve as their cooker for heating and dissolving the black tar heroin in a water solution. (See Fig. 1.) Pete, another one of the injectors who sleeps in the encampment, came running over eagerly with a Styrofoam cup of water for them to use in the hope of earning the rights to the residue on the cotton they were going to filter the dissolved heroin solution through while drawing it into their syringes.

Hogan, another addict splayed over a wet mattress, propped himself up hopefully to watch the reaction to Pete's attempt to earn the rights to the used cotton. Scotty merely asked Pete tersely, carefully avoiding eye contact, "Got any money? I can't loan you anything. The cotton belongs to Max."

Pete stomped off cursing, and Hogan dropped back onto his mattress moaning softly. They had both spent all their money drinking Cisco

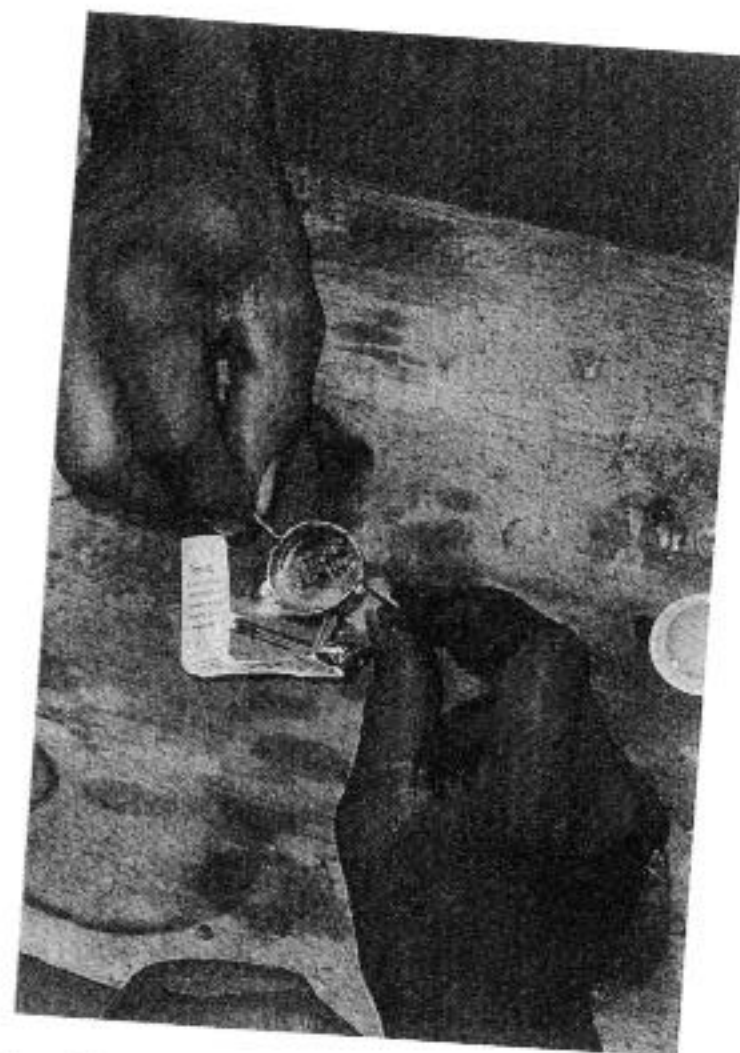


Fig. 1. Dissolving heroin in a cooker (courtesy Mark Lettiere).

Berry fortified wine that afternoon and had nothing left for their crucial bedtime shots. This worried me because Pete often becomes unpredictably violent when he has drunk too much and is refused a fix of heroin.

Meanwhile, Scotty and Butch were cursing because someone had stolen their stash of clean syringes. Scotty rummaged through some foul looking rags, and pulled out three previously used syringes. Before I had time to protest that they should at least bleach and rinse these dirty syringes, Scotty had already filled one with water from the Styrofoam cup Pete had left on the ground and squirted it into the cooker where he had placed the \$20 hunk of black tar heroin, about half the size of a pencil eraser. I tried to remind Max that he should at least rinse the dirty syringe Scotty had just handed him, but he ignored me. He was intently watching every movement Scotty was making in order to ensure that he knew exactly how much water was being put into the cooker since that determines how much heroin solution is allocated to each person involved in the three-way share.

Max had to be very careful because Scotty and Butch were running partners. He was the outsider, and they might collude to rip him off. There was no way under these conditions that he was even going to think of diverting his attention from the preparation process to rinse a dirty needle let alone go search for a clean one.

Loud poundings erupted behind us. Pete, who had been refused the cotton, had grabbed a crowbar and was smashing a wooden pallet that someone had brought to the camp for firewood. Chips were flying and Scotty was forced to cover the cooker with his hand as he heated it over a candle. This made Max even more nervous lest Scotty take advantage of the confusion to draw out water from the cooker on the sly and set it aside while no one was looking.

When Scotty began cursing that he had no cotton to use as a filter, Max refused to go fetch some. Instead, he picked up an old cigarette butt from the mud at our feet—permeated by the smells of feces and vomit—and pulled a piece of the filter out with his teeth, all without taking his eyes off of the cooker. Hogan meanwhile had arisen from his mattress and shuffled painfully up to us, politely holding out a tiny pinch of cotton. They ignored Hogan lest he think that this would give him the right to share with them.

Pete redoubled his pounding. No one showed any emotion. Max merely squinted especially intently as Scotty filled the three syringes for each injector. To warn Scotty and Butch against trying to hustle him, Max launched into an argumentative tirade, insisting on holding each

syringe up to the firelight to reverify its contents. He obliged Scotty to empty 10 units from Butch's syringe back into the cooker, claiming it had been overfilled. They then redrew Butch's 10 excess units into the other two syringes, thereby introducing yet another potential HIV vector since Butch's syringe was also dirty, but also fairly ascertaining that each person had been allocated his precise share of 45 units.

Max was also worried Scotty and Butch might collude in executing a "finger roll" or "two finger dip trip," whereby the person drawing the heroin solution out of the cooker maintains several drops of water balanced on their fingers which they then discretely drop into the cooker once their syringe has already been filled, thereby diluting the remaining amount that the others will be sharing. I realized that it was impossible under these conditions for Max to pay attention to my HIV prevention slogans. More immediately pressing concerns than HIV were consuming him. Indeed, even I had forgotten all about HIV as the primary risky behavior taking place at that very moment. I was focusing on Pete's crowbar which was more immediately dangerous to our health than anything else taking place. Pete kept pounding away the entire time, furious at being excluded from the sharing. (See Fig. 2.)

In his overeagerness to inject, Max fumbled the syringe loaded with 40 units that Scotty was handing him and dropped it into the mud. He



Fig. 2. Max drawing heroin solution into his syringe while Butch injects (courtesy Jeff Schonberg).

quickly picked it up, wiped it on his stained blue jeans, licked the needle tip clean, and injected. No one flinched except me. Scotty called over to Hogan (who had remained standing on the periphery politely coughing and groaning and thoughtfully positioning his body between the injectors and Pete's crowbar and flying wood chips), "You want the cotton?" Hogan hopped over, grabbed the cooker with the leftover cotton in it that Scotty was holding out to him, and waited for Max to finish injecting to borrow his syringe. As he dipped Max's still warm unrinsed needle into the same cupful of water that had probably been used all day in the shooting encampment, I lamely warned him that he should bleach both the syringe and the cooker. He looked at me blankly before eagerly crushing the dirty cotton in the cooker with the back of Max's dirty plunger. I realized yet again how absurd my public health message must have sounded to him. There is no safe way to "pound" a begged cotton when you are "dopesick." Cottons and cookers with residues of heroin obviously cannot be bleached if one is seeking to inject their residue. Worse yet, whatever heroin residue might be mixed in with the blood trapped in the point of Max's needle would be lost if Hogan bleached it. My public health righteousness was rendered even more incongruous when Pete slammed his crowbar into the bushes next to me, sending me sprawling on the ground, my adrenaline rushing at what I was convinced was a near miss. Everyone giggled at my overreaction—even Pete. I just blinked stupidly and said nothing more, hoping my conspicuousness unstreetwisedness would soon pass.

Hogan was calm now. He was confident the cotton shot would mollify his heroin withdrawal symptoms. He no longer had to dread being wrenched awake in the middle of the night with heroin withdrawal pains. He eagerly walked back to his stinking wet mattress and lay down, sighing contentedly. Pete kept on cursing, but not quite as loudly, evidently pleased at himself for precipitating comic relief at my expense. I stared at the feces and vomit caked in the dirt that I had just dived into—and threw up.

Fieldnotes, March 1995

This fieldwork excerpt is one of hundreds of pages of notes I have collected with ethnographic colleagues since November of 1994 when I began conducting participant-observation in the shooting galleries and homeless encampments of a network of heroin addicts living in the bushes of a public park in downtown San Francisco. After over 3 years of frequent visits and occasional overnight stays, I have developed a warm, respectful rapport with some two dozen homeless addicts who allow me and my ethnographic colleagues around-the-clock access to their shooting encampments with full permission to tape record, pho-



Fig. 3. Sunrise at an encampment (courtesy Jeff Schonberg).

tograph, and videotape.* (See Fig. 3.) We are documenting through direct observation the complex dynamics of intensive heroin addiction among one of the most socially marginal cohorts with elevated HIV risks in the industrialized world. We are exposed to the subtle interpersonal power hierarchies, hidden income-generating strategies, and repeated mutual personal betrayals and everyday violences that organize the precarious lives of street-based substance misusers in the inner-city United States. This has led us to critique many of the oversimplified understandings of drug use and HIV infection that rely primarily on quantitative epidemiological surveys and/or qualitative self-report interviews conducted outside their indigenous context. These traditional public health research modalities tend to focus on discrete behaviors that can be counted or communicated in a traditional question/answer format when, in fact, the social practices of people living in settings of extreme social suffering and HIV vulnerability are much more contradictory and complex. It would be difficult to summarize their lives in a standardized interview protocol.

THE MORAL ECONOMY OF DOPE FIENDS

As illustrated in the opening vignette, the street addicts we befriended share ancillary paraphernalia almost every time they inject heroin. They rarely accu-

*This research is protected by a Federal Certificate of Confidentiality and all identifying names and locations have been changed.

multate enough money to purchase an individual "bag" of heroin alone. Usually their sharing is limited to ancillary paraphernalia, water from the same cup, the same heating/mixing container (known as the "cooker"), or the same cotton filter through which the heroin solution is drawn once it is heated and dissolved.

Initially I suspected that the middle-aged, primarily White and male network of homeless addicts we were studying might be an anomaly because of the extent of the risky ancillary sharing practices they engaged in. Despite identifying themselves as "dope fiends," they virtually all consume large quantities of fortified wine (Cisco Berry brand) and occasionally binge on crack when they have surplus cash. Furthermore, panhandling generates a disproportional amount of their income in combination with recycling, day labor, and petty crime (primarily shoplifting, car and warehouse burglary, and street-level heroin selling). (See Fig. 4.) To the general public they present themselves as helpless, broken down winos in need of spare change, willing-but-only-marginally-able to work at odd jobs.

After further contextualizing the economic, emotional, and biological imperatives for why they share ancillary paraphernalia so regularly, however, and after consulting comparative literature, it has become evident to me that fragile income-generating strategies and tenuous social networks of street addicts mandate risky practices (cf. Koester, 1996; Page et al., 1990; Connors, 1994). Until 1996 when prices dropped threefold on San Francisco streets, heroin was sold primarily in \$20 bags of Mexican black tar which were approximately half the size of a stan-



Fig. 4. Burglarizing a construction site (courtesy Jeff Schonberg).

dard pencil eraser. The awkward consistency of black-tar heroin makes it a difficult substance to partition accurately with a knife or razor blade as it is brittle when cold and gooey when warm. The only precise way to divide a bag of Mexican Black tar is to dissolve the entire portion that is being shared in a communal cooker using a measured quantity of water, as described in the opening vignette. Each injector then jealously receives the precise number of liquified units proportional to the amount of money he or she contributed toward the purchase of the bag.

Homeless street injectors are usually unable to accumulate the price of a street bag (\$7 to \$20) before they are overwhelmed by physical and emotional urges to inject heroin. Furthermore, sharing incurs economic and moral debts for future exchanges of heroin (Murphy, 1987). It is best understood as investment in the complex gift-giving economy (Bourdieu, 1996) that addicts construct among their mutually dependent colleagues in order to minimize the chance of finding themselves dopesick and isolated 6 hours from their last injection. Consequently, many—if not most—of San Francisco's homeless injectors (like Max, Scotty, and Butch in the vignette) pool resources with one or more street partners to share a bag several times a day. The other way of saving a portion of a newly purchased bag would be to draw the dissolved contents into a syringe, recap it, and hide it for future use—usually in one's sock. In addition to placing addicts at risk of arrest should they be stopped and searched by the police, storing heroin in ready-to-inject form is difficult for people with intense cravings for drugs. In short, risky needle practices emerge out of the microstrategies that street addicts utilize to avoid dopesickness, minimize risk of arrest; and construct supportive social networks. Most importantly, they cannot survive on the street with dope fiend identities without engaging in risky sharing practices.

Judicious addicts attempt to dose themselves in small enough portions so as to maximize the efficient absorption of heroin into their bodies without raising their habits. They frequently discuss the status of their physical addictions and criticize "greedy" associates who increase their body's physical tolerance by injecting alone. Most of the addicts in my network can keep the physical and emotional pains of heroin withdrawal at bay by injecting only half, or even a third, of a street bag of heroin. By sharing, consequently, they wittingly or unwittingly ensure that 4 to 6 hours later they will still have money (or a debt obligation from an associate) that will enable yet another share of heroin. In contrast, when they inject an entire bag alone, they often go into a heavy heroin "nod" for 3 to 4 hours, thereby reducing their capacity to hustle effectively and leaving them 6 to 8 hours later with intense cravings but no money or reciprocal debt obligations. (See Fig. 5.)

In short the desperate income-generating strategies of homeless heroin addicts, and the fragility of their networks of trust, which are hinged on tightropes



Fig. 5. Pete dopesick (courtesy Jeff Schonberg).

of betrayal and generosity, mandate on an almost daily basis the kind of risky injection behavior described in the vignette. The importance of the moral economy of sharing was drilled home to me when the price of the average bag of heroin dropped in January 1996 from \$20 to \$7 (the former price of a three-way share). Despite the drop in price, sharing remained a vital, daily practice for virtually all the addicts in the network. This is not because it represented a symbolic interactional ritual practice of bonding (Des Jarlais et al., 1986), but because of the political economy of survival in fragile networks and marginal communities (see critique by Koester, 1994). Another more straightforwardly practical incentive for injecting in social groups is the high risk of overdose caused by the variable quality of illegal street heroin. Only after I was forced to provide mouth-to-mouth resuscitation to the victim of an overdose did I begin to understand the survival imperative of the street dictum "never fix alone." (See Fig. 6.) This dictum is often ignored, of course, precisely when one wants to avoid having to share, because injecting in front of a street associate without offering a "taste" or a "cotton" sparks violence and/or moral recrimination as revealed when Pete pounded the wooden pallet in the opening vignette.

THE SYMBOLIC VIOLENCE OF HARM REDUCTION

The absolutist public health messages put forward by even the most sensitive, street-based outreach programs usually miscalculate the prevalence of risk-

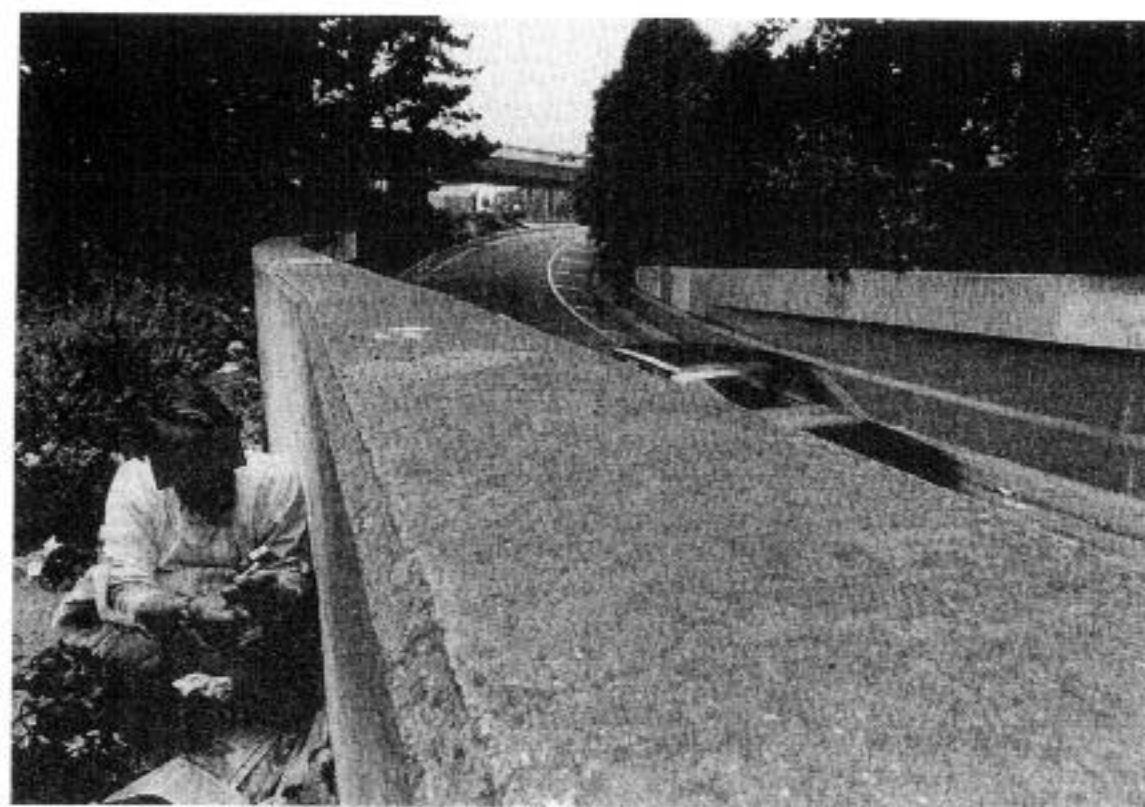


Fig. 6. Injecting at the margins (courtesy Jeff Schonberg).

taking among street addicts. Syringes and paraphernalia are shared in homeless street scenes on such a routine basis that risky HIV practices become normalized even by clients of needle exchange who are polite to community health outreach workers—as are the addicts in our social network. We have witnessed network members succumb to extraordinarily painful seizure-like vomiting, which they casually refer to as "fish-flopping" or "doing the tuna." In fact, every morning many of them wake up to paroxysms of gut-wrenching coughing and dry heaving. The everyday violence pervading their conditions of physical and emotional stress renders it impossible for them to obey the dictates of sanitary medical practices. Few, if any, would refuse a syringe-full of heroin no matter how obviously dirty or potentially HIV infected it may be when feeling dopesick. Virtually all the core members of our network admit that when they are suffering from heroin withdrawal—or even anticipating it—they use "Any old needle; hell! Even a Bic pen if it's around." Sometimes up to four people are obliged to pool resources in their desperation to ward off withdrawal symptoms, especially at early morning or late evening injection sessions such as the one in the vignette. Furthermore, when withdrawal symptoms are especially severe, sick addicts are sometimes unable to prepare their own syringes because their hands become too unstable. (See Fig. 7.)

On the street, the standard public health outreach messages of "bleach it," "never share water, cookers, cottons or needles," and "always wear a condom"

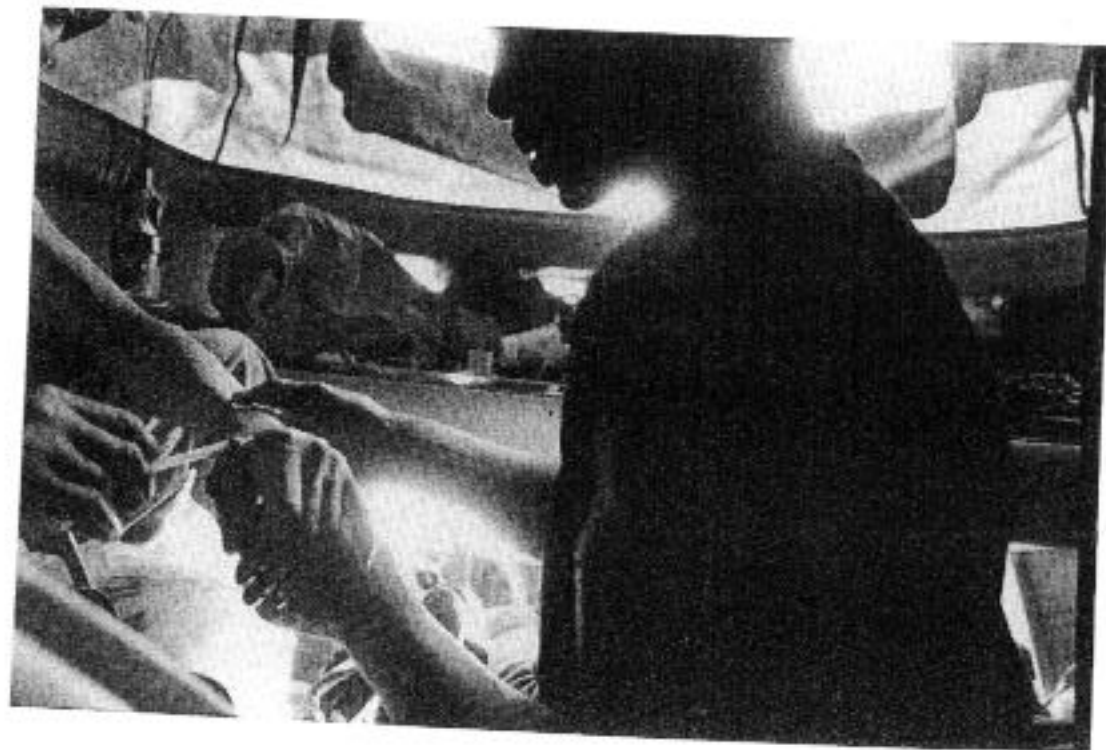


Fig. 7. Helping with an injection (courtesy Jeff Schonberg).

insult dope fiends or push them into a defensive denial. For example, the indiscriminate blurring of sexual risk messages with injection risk messages confuses heroin addicts—who often have not engaged in voluntary sexual relations for years. Ironically, one of their denial mechanisms is to latch onto the safe sex rhetoric foisted onto them by well-meaning outreach workers in order to minimize their awareness of the much greater risks they engaged in of daily needle use in shooting encampments:

Philippe: Do you worry about becoming HIV positive?

Max: Nah . . . I haven't had sex in years. I'd hate to be young out there today. I'd be scared.

Philippe: Do you know how your sister got AIDS?

Butch: Yeah I do. It was this scumbag cop who used to make her have sex with him whenever he caught her with dope on her—motherfucker!

Philippe: How long was she a dope fiend?

Butch: All her life—like me.

Unrealistic hypersanitary outreach messages exacerbate the marginalization of street addicts. On several occasions we offended network members with the mildest of outreach messages:

Philippe: What about sharing? You know of the risks?

Hogan: Ain't no dope addict out here gonna turn down no 40 units [a

syringe filled with 40 units of heroin] if he's sick. I mean, I'm serious, he just ain't gonna fuckin' do it.

Philippe: But don't you worry about HIV?

Hogan: Yeah [pause] . . . But fuck no! [Silence]. You give any motherfucker out here a motherfuckin' taste of 40 units, and even if the man has any kind of knowledge about you having AIDS or something, he ain't gonna give a fuck. If he's sick, he's gonna fix that motherfucker. I'm sorry, that's the gospel fuckin' truth.

When I asked Butch, who was listening in on the conversation "Has that happened to you," he burst out angrily:

Butch: Oh, c'mon, man, you know! Don't ask me that question. You know damn well it has, man! Happens to everybody a million times. Okay?

Philippe: Okay, okay I'm sorry, man . . . didn't mean to offend you. We were just trying to get our AIDS prevention rap out. Sorry.

Butch: (putting his hand on Philippe's shoulder and calming down): Yeah, yeah. I'm sorry; that's cool. We know you're in the health AIDS business and all. It's okay. I mean most of us try to be careful most of the time.

The extreme marginality imposed on addicts who become full-time homeless dope fiends confines them to a social universe of mutual betrayal and autodestruction that well-intentioned middle class harm reducers cannot empathize with—or perhaps do not want to believe exists. Although individual heroin addicts—like everyone else—construct complex visions of their own moral authority, they virtually all recognize that when in withdrawal, a "righteous dope" will obtain a dose of heroin by any means necessary. "Running partners"—even lovers—regularly rip one another off on the street. Such behavior is considered intelligent streetwise prowess.

For example, when Pete stole a loaded syringe that Max had left unattended at one of the shooting encampments, Max subsequently admitted to me, "Hell, I might'a done the same thing if I was sick." His first reaction was to attempt to beat Pete with an axe handle, but he allowed the other members of the network to restrain him while Pete hobbled away. The network members considered Pete's theft to have been legitimate because Pete was suffering from two painful abscesses on his buttocks that prevented him from walking around and panhandling effectively on the street. In fact, they admired Pete for having executed the theft successfully while dopesick without even leaving the encampment. The fact that the syringe Pete stole had previously been used, and may have contained traces of Max's blood, was irrelevant. Dope fiends do not have the luxury of refraining from stealing a carelessly waylaid syringe out of fear of HIV infection or out

drawal pains. In the opening vignette, Butch did not even curse or pause when he dropped his loaded syringe in the mud prior to injecting its contents.

Most members of the network will take pity on "running partners" suffering from intense withdrawal pains and will treat them for free to the kind of "cotton shot" that Hogan received in the opening vignette. Cotton shots are especially risky. They consist of the heroin (and blood residues) that are "pounded" out of a cotton remnant or old cigarette filter left over from a previous injecting session. As demonstrated by Hogan's actions in the vignette, the water used to rewet a cotton and to redissolve whatever heroin and blood residue may still be clinging to the bottom of the dirty cooker and the used cotton may already be contaminated. Indeed, water containers in shooting encampments are sometimes tinged pink from being used indiscriminately as both rinsing and drawing solution.

IN SEARCH OF RESPECT... AND ECSTASY

The medical control over syringes (Koester, 1994; Carlson et al., 1994) and the precariousness of underground economy income-generating strategies are the easiest dimensions of structurally mandated HIV risk for outsiders to understand. Notice in the vignette the infectious precision with which Max obliged Scotty and Butch to redivide minute quantities of the heroin solution they were sharing. Furthermore, Max's failure to carry a syringe while hustling was due to his fear of police search. His refusal to fetch a clean cotton was out of a concern that he would be hustled during the cooking process. Finally, Scotty and Butch's selection of three formerly used syringes to initiate the sharing process was forced on them because a fellow addict had stolen their scarce supply of clean ones in order to resell or hoard them. The puritanical paranoia that curbs needle exchange programs converts syringes into a scarce commodity that artificially inflates their monetary value on the street and logistically encourages addicts to share them and/or steal them.

A much more, complex, almost nebulous, but nonetheless crucial nexus for infection patterns revolves around the notions of personal respect that organize social interaction on the street. Indeed, the search for respect, as well as economic security, is a central organizing dynamic of street culture that consequently shapes the propagation of HIV (Anderson, 1978; Bourgois, 1995; Finestone, 1957; Hughes, 1977; Wacquant, 1997). For example, not all members engage in high-risk cotton shots with the same frequency. Only a low-prestige, economically unsuccessful member like Hogan will be reduced to begging cotton shots regularly. (See Fig. 8.) Notice how in the vignette Hogan earned the cotton through deferential behavior in contrast to Pete's unsuccessful attempt to violently intimidate a "taste." Addicts with more successful income-generating strategies claim

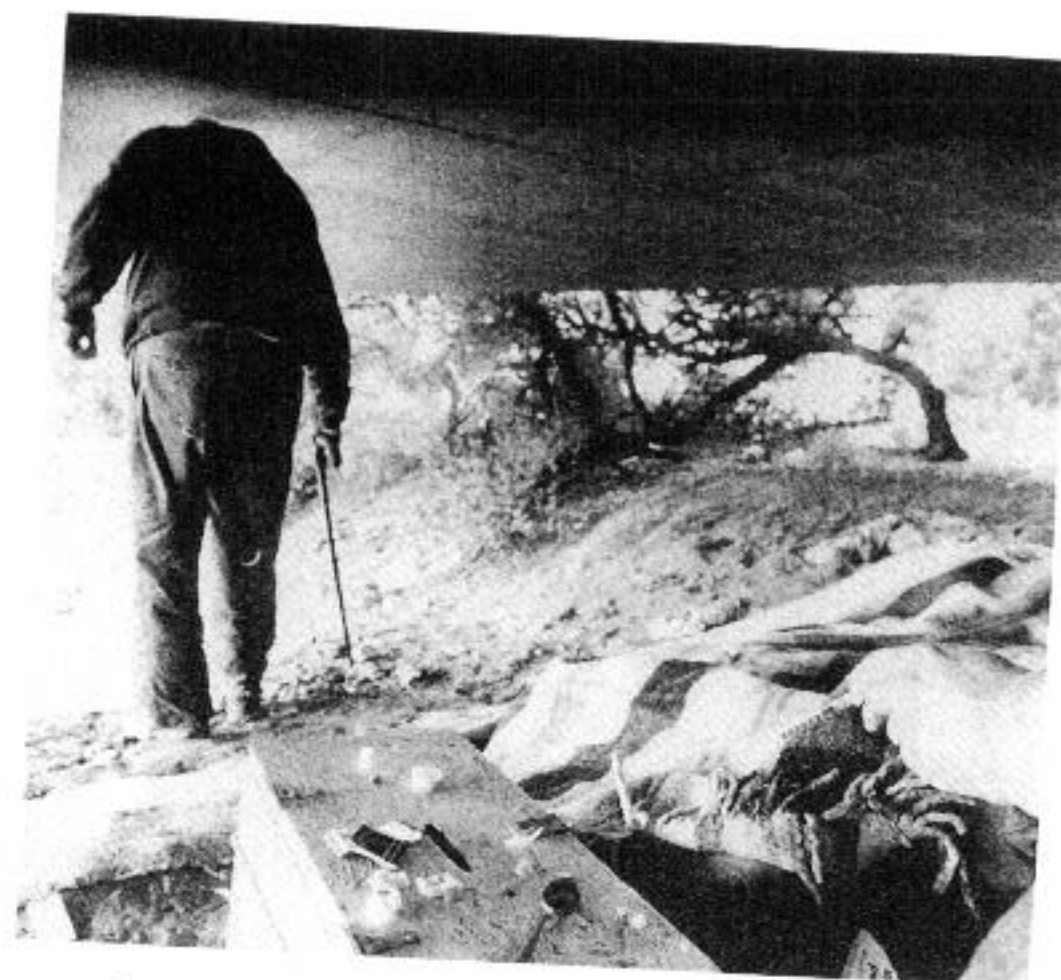


Fig. 8. Hogan leaving his encampment (courtesy Jeff Schonberg).

they never "pound cottons," and they often humiliate those who are regularly reduced to "begging cottons." In fact, Hogan, who is the lowest prestige member in the network, is frequently referred to disparagingly as no-hustle-Hogan, the cotton bandit. The fieldwork vignette illustrates how Hogan is effective at eliciting gifts of dirty cottons by obligingly groveling for the other network members. It is his primary hustling strategy. (See Fig. 9.)

Another small cohort within our network who are not necessarily low-prestige members but who frequently engage in cotton shots are the ones who establish independent shooting galleries in their encampments. Unlike New York City where shooting gallery managers charge an officially recognized \$2 admission fee to their clients for access to the premises and for paraphernalia rental (Bourgois, 1992), in the San Francisco Bay Area shooting galleries, or what I call shooting encampments, are less formal (Waldorf et al., 1990). The standard payment is a "taste" of whatever a client happens to be injecting. This taste usually takes the form of a watery cotton. The only advantage managers of shooting galleries have over those members of the network who beg cotton shots is that

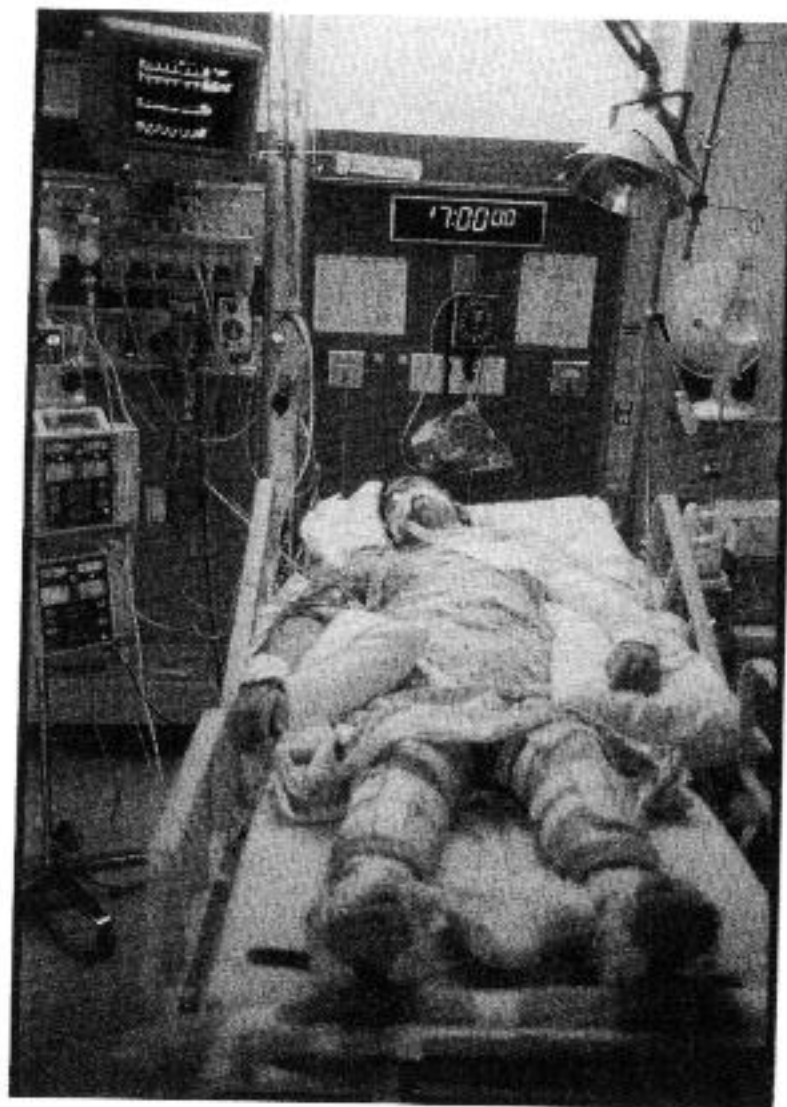


Fig. 9. Hogan in the intensive care unit (courtesy Jeff Schonberg).

well-organized shooting gallery managers can sometimes develop special relationships with outreach workers or volunteers from public health needle exchange programs which allow them to maintain a stash of clean insulin syringes for their personal use, even when only contaminated ones are available for lending to clients. Indeed, this kind of direct needle distribution outreach relationship with a shooting gallery manager was what facilitated our initial entry into this particular network of injectors. It also represents an important HIV-prevention modality. Flooding shooting encampments with clean syringes, especially among cohorts of addicts whose income-generating strategies are fragile, is the ideal way to curb HIV infection. From a humanitarian, public health perspective, needle distribution rather than exchange is the most realistic and efficient HIV-prevention strategy for homeless addicts. They will use clean syringes if they are readily

available, as Scotty and Butch's rummaging and cursing for their stolen stash illustrates in the opening vignette.

Shooting encampment managers often engage in, or even promote, risky practices when clients arrive with bonus supplies of diverse drugs and alcohol to initiate binge sessions. During binges the encampment manager is treated to "tastes" of whatever is being consumed. This sometimes degenerates into chaotic needle use—especially when cocaine or crack is involved. Addicts often engage in bloodier methods of injection during binge sessions as they publicly express their companionship in their search for ecstasy. For example, individuals who normally "muscle" (inject intramuscularly) will often attempt to strike a vein: "direct deposit") during a binge session thereby filling their syringe with exceptional amounts of blood as they probe through their collapsed veins for a swift path to pleasure. (See Fig. 10.) Others who have strong veins often "boot and jack" their injections under the appreciative eyes of their fellow bingers in their communal celebration of ecstasy (i.e., draw blood in and out of the syringe during the injection): "Moby Dick! Thar' she blows! Bingo! [as blood flows into the syringe]." (See Fig. 11.) And "Hit the road Jack and don't come back . . . [as the blood and speedball solution is partially injected] come back . . . come back . . . [as blood is redrawn into the syringe]." Once again, the most realistic way of stemming HIV in shooting encampments where binging regularly occurs is to flood these sites with clean syringes. This would take away their market value and dramatically reduce the risks caused by chaotic needle use as clean ones would no longer be stolen. When clean syringes are available during cocaine binges, some injectors who have difficulties making direct deposits obsessively and even wastefully backload their cocaine solution into new syringes in the middle of probing for a vein because they become hypersensitive to the relative

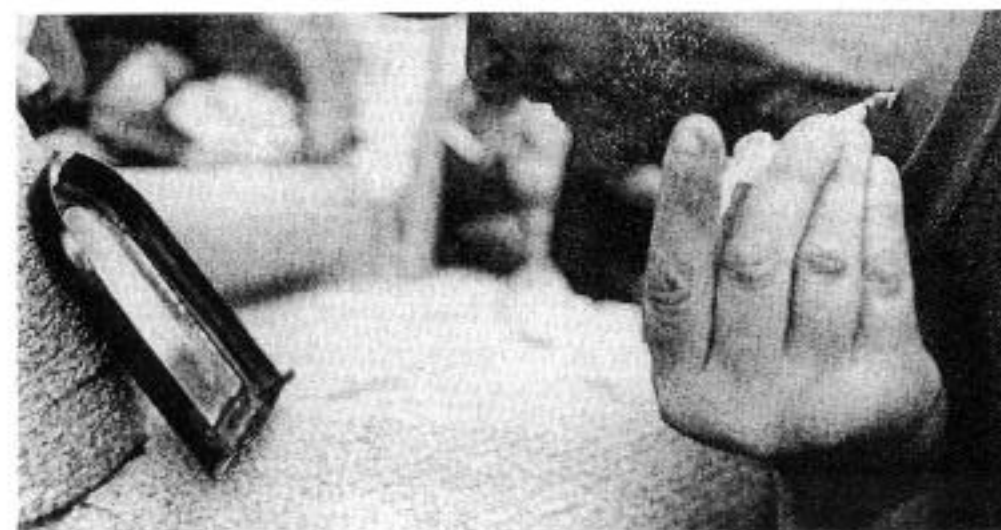


Fig. 10. Injecting into the jugular (courtesy Jeff Schonberg).

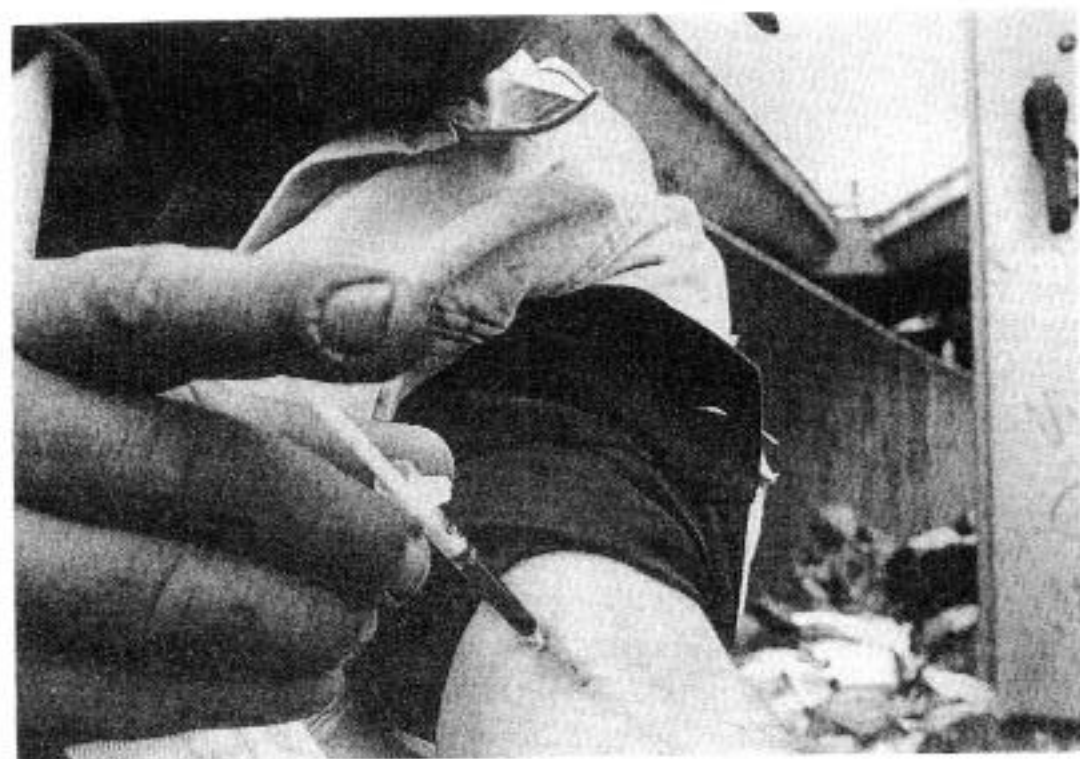


Fig. 11. Direct depositing (courtesy Jeff Schonberg).

dullness of their own used needle points. (See Fig. 12.) They may not be able to incorporate bleach and clean rinse water into their injection practices but they certainly can and will reach for a fresh needle when it is available.

ACCURACY IN SUBSTANCE MISUSE RESEARCH

At the very minimum, participant-observation ethnography can increase the reliability of information collected in large-scale surveys of risky behavior that rely on self-reporting. Strategically focused participant-observation can permit the development of more powerful epidemiological protocols by allowing for focused user-informed questions that respond to more relevant analytical categories. It can also increase the effectiveness of strategic sampling. Currently many surveys are not even asking the right questions; they simply miss the central dynamics that mandate HIV risk. For example, one of the main dealers in our network has been interviewed several times by local epidemiological research projects which attempt to measure the correlation between HIV infection and risky practices. The fact that he is a dealer—and consequently has a heavy “dealer’s habit” with an irregular clientele at a precarious income-generating site that frequently forces him to pool resources desperately—has never been raised in the course of these interviews. Instead, embarrassed by their questions about syringe sharing, the

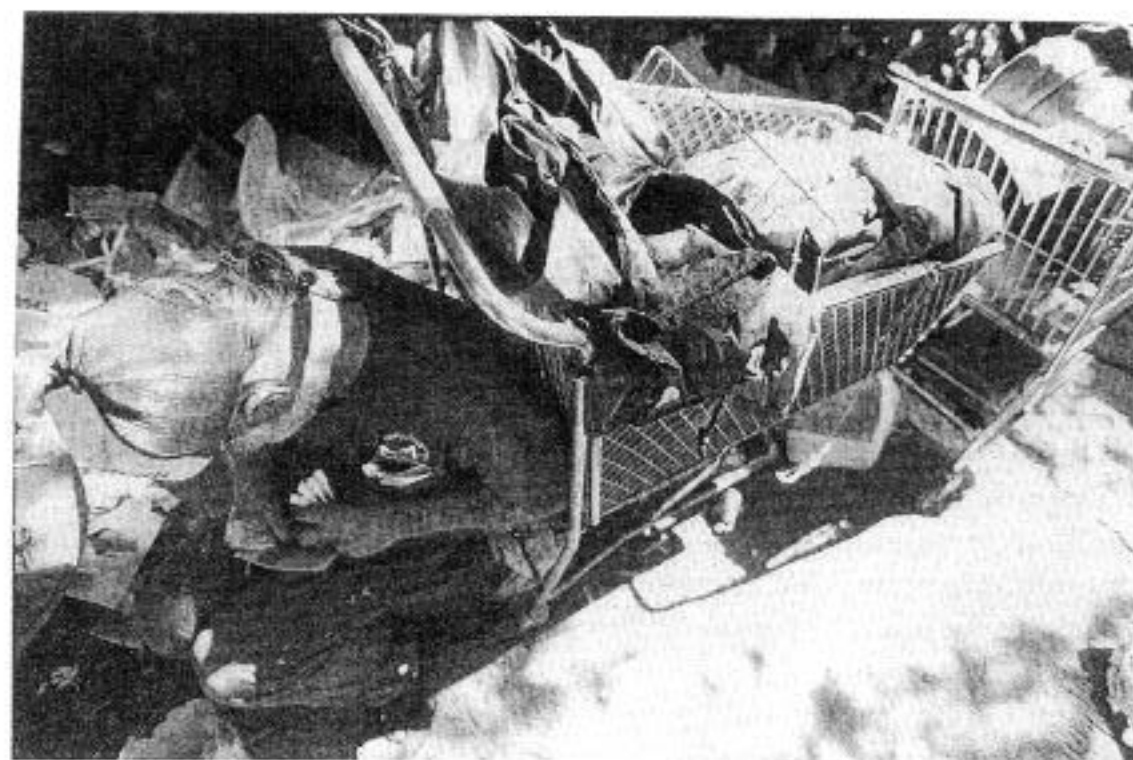


Fig. 12. Counting a stash of needles (courtesy Jeff Schonberg).

dealer soft-pedals his daily risk-taking to qualitative interviewers in their comfortable, field office settings.

Street addicts do not want to appear stupid or offensive to a friendly interviewer; in fact, they have usually internalized society’s normalizing judgments and are depressed, ashamed, and confused over their substance misuse at the same time as proud of being dope fiends. Deep down inside, they *know* they are failures. The confessional context of a paid self-report interview drills this humiliation home (Foucault, 1978:61–64). If street addicts answer cross-checked self-report questionnaires honestly, they are made to appear self-destructive and irresponsible to their interviewer. No-hustle, cotton bandit Hogan, who, as we have seen in the opening vignette, regularly takes more injection risks than any other of his network members because of the ineffectiveness of his income-generating strategies and because of his willingness to assume a low status role, reported to me the outcome of one of these paid, would-be confessional, public health research interviews:

Hogan: I said, yeah, I share rigs occasionally. You know . . . Only if it is somebody I know that is clean—and this and that. I said I went down and took an AIDS test with them, we came back clean; so I said I shared with them.

Philippe: Why did you say that?

Hogan: Well, I thought it sounded good. Which is the truth, you know . . . But not that I could really tell if they were HIV.

As a cotton bandit, Hogan cannot remain a dedicated dope fiend without sharing ancillary paraphernalia every single day, usually several times a day. He often finds himself directly sharing syringes without even rinsing them first with water. He liked the researcher administering the interview protocol, however, so he tried to respond in what he thought was a socially appropriate manner. On another occasion Hogan told an interviewer on an epidemiological research project that he only shared syringes with his "Ol' Lady." When we asked him why he bothered to make up this bizarre detail (he has not socialized with a woman for over a decade), he protested: "Well, it's true. I have been faithful to my Ol' Lady for 30 years. Her name is heroin. I love her." Hogan was not making fun of his interviewer by fantasizing about his Ol' Lady Heroin. He was just trying to celebrate the dignity of his dope fiend identity despite the humiliating context of the self-report protocol.

With a fuller understanding of what takes place physically, socially, and emotionally, in street-based injection scenes, we might be able to untangle the puzzles over the who, why, how, and when of HIV transmission and explain the actual processes that are reflected in epidemiological correlations of differential HIV infection rates across distinct population cohorts (Coates et al., 1990; Laumann et al., 1994). Currently, for example, we simply do not know how risky it is to share ancillary paraphernalia although we suspect that cookers, cottons, and water are not a particularly effective route for HIV transmission as compared to the risk of directly sharing a syringe without rinsing it, or engaging in receptive anal sex without a condom. We know homeless addicts virtually never use bleach to rinse their syringes but almost always do rinse with water. "Always rinse with water several times" would be a realistic and concretely implementable outreach slogan and would be worth promoting if we knew how effective dirty water rinses are. It will be difficult to learn the answer to these important public health questions if paid self-reporting on survey forms remains the standard methodological tool for collecting data on HIV risk-taking behavior to the exclusion of participant-observation data and analysis. From a straightforward positivist perspective, it is naive to expect to generate very reliable databases on the intimate practices of vulnerable people by administering questionnaires which pay addicted respondents to self-report socially stigmatized behaviors.

At the very least, participant-observation data can allow for the development of effective questions for multiple cross-checking and triangulation on epidemiological surveys. For example, individuals who admit to engaging in cotton shots, but claim never to share cookers elsewhere on an interview protocol, are misrepresenting their injection practices. Of course, even a simple question about cotton shots may be problematic since most cotton bandits are probably ashamed of

having such weak hustles. Similarly, individuals who report that they usually inject a dollar amount of heroin that is less than the minimum street value of locally sold heroin are also probably misrepresenting their risk-taking if they claim never to engage in ancillary paraphernalia sharing. Injectors who complain that new needles are "slippery" are also likely to share syringes regularly.

Most epidemiologists are aware that injectors often seek to make socially acceptable responses when interviewed (McNaghy and Parker, 1992; Watters et al., 1992).^{*} Furthermore, many street addicts are genuinely incapable of accurately self-reporting their direct and indirect sharing behavior because the reality of their practices are not overwhelmingly dangerous and self-destructive for them to be able to admit cognitively to themselves—or to anyone else. They could not maintain identities and bodies as dope fiends if they stopped taking risks regularly. Denial or ambivalence should not be understood reductionistically as a psychological characteristic of victims (or politically as an ideological imposition of moralists), but rather as a desperate survival strategy laden with a complex definition of self-respect.

RISKY THEORY AND PRACTICE IN PUBLIC HEALTH

The inadequacy with which we conceptualize the precise behavioral dynamics of HIV transmission among vulnerable people has spawned bitter polemics about how the disease is transmitted and how governments should deal with it (Broadhead and Margolis, 1993; Caldararo, 1996; Duesberg, 1995; Fernando, 1992; Fumento, 1990; Scheper-Hughes, 1993). Ironically, even though applied public health researchers cite individual behavior as the crucial unit of risk analysis, they have trouble explaining or even documenting with confidence the relative risks of specific behavioral practices. Fundamental anomalies in the data abound. For example, there is no definitive explanation for why gay and injector HIV seroprevalence rates are roughly comparable in New York City, while San Francisco's injectors are estimated to have less than one-third of the HIV infection rates of gay men. These differential infection rates may be caused by the organization of male sex work in the gay community or by differences in the prevalence and organization of shooting galleries—but no research has been designed to test these crucial dimensions of street hustling. In New York City, a

^{*}Criminologists have elaborated graphs and equations to represent the greater disparity in crime self-report rates between African-American and White delinquent males. In one study "White males reported 90% of the offenses on their records while Black males reported only 67% of the offenses listed on their official records, a ratio of 1.5:1. Significantly, public health researchers have failed to correct for reporting biases, hence the unexplained anomaly in a San Francisco epidemiological study that noted that African-Americans report less needle sharing, claim extensive condom use, but are more highly infected with HIV than other local ethnic groups (Watters et al., 1994).

large proportion of male hustlers in White gay scenes are Latino or African-American injectors who still live in the inner city and may be sharing needles with heterosexual street users in shooting galleries in their home communities (McNamara, 1994). In San Francisco there is less overlap between male sex workers in the gay community and in the inner city. Furthermore, shooting galleries in New York City are much more formal and salient institutions (Bourgois, 1998; Waldorf et al., 1990). Significantly, most epidemiologists would not even consider the differential infection rates of New York City and San Francisco to be an interesting research question since they understand these processes to be determined straightforwardly by the date of viral introduction. The organization of race, class, and the public spaces for expressions of alternative sexualities, as well as adaptations to law enforcement in the underground economy, does not enter their equations. More dramatic is the inability to explain why approximately 85% of AIDS victims are identified as heterosexual in the Third World, while in the industrialized nations AIDS remains a primarily "gay" disease despite rising seroincidence rates among heterosexual female partners of injectors and bisexual men (Caldararo, 1996).

As this article suggests, much of the problem with the data on HIV risk is methodological. In substance use research there has been little substantial dialogue between quantitative and qualitative researchers even within anthropology. The intimate practices of vulnerable populations have only rarely been rigorously documented in this indigenous, natural contexts through direct observation and dialogue. A more fundamental problem, however, is that mainstream applied public health paradigms ignore power—whether it be the criminal justice system and laws governing controlled substance and paraphernalia; the ideological and social structural enforcement of social marginalization by institutions and mainstream discourses; or the structuring of networks and identities/practices of risk by race, class, gender, sexuality, and geography. By focusing on changing individual behavior in a vacuum, public health researchers obscure and ultimately reinforce the power dynamics that shape risk. They defer to biomedical statistical paradigms and psychological behaviorist-applied intervention models that fail to analyze the prolonged everyday suffering and ecstasy of street addicts. Power relations do not enter the statistical correlations of public health researchers or the moralizing outreach modalities of most HIV-prevention organizations modeled on individual behavior change. In focusing on a methodological critique of traditional public health research, this article has only indirectly scratched the surface of the complex power issues which operate at the multiple macrostructural levels that shape everyday micropatterns of HIV infection. The opening vignette and subsequent analysis is meant to provide a partial demonstration of the potential power of ethnography by providing a glimpse of how these macropower

dynamics play themselves out in daily risk-taking practices inside shooting encampments and how this envelops addicts in a murderous panoply of social suffering.*

Perhaps, once again, a fieldwork vignette best expresses the social misery of the everyday violence contextualizing HIV risk.

Ray overdosed this morning. The panic caused by Ray's shave with death drilled home to me the inadequacy of my applied public health research model of "changing risky behavior." At the moment of Ray's overdose we were filming the precise logistics of how heroin addicts share ancillary paraphernalia—water, cookers, cottons, etc. We missed the opportunity of filming Max while he was stealing the encampment's dirty water bottle to prepare a fresh fix of heroin all by himself away from the rest of the network to avoid sharing with them, because Max grabbed the water right when Ray hit the dirt. Everyone was trying to revive Ray with slaps, arm pumps, body shakes, and massages. His girlfriend Tina was kissing and hugging him. The camp bustled with solidarity—for a moment.

By any objective standard, the most urgent "individual health behavior risk" at this morning's injection session was Ray's overdose—not Max's injection of dirty water. How is anyone supposed to worry about the cleanliness of their water or any other ancillary paraphernalia when they are confronted on an almost regular basis with an immediate, final life and death constraint such as an overdose? In fact, anyone who did worry about the cleanliness of their ancillary paraphernalia in that setting would have to be awfully callous. Thank God we did not have the presence of mind to film Max slinking off with the dirty water to inject during the hullabaloo. We were huddled around Ray, helping revive him and comforting him. (See Fig. 13.)

The personal dynamics around Ray's brush with death are even more complicated: Max, who is White, hates Ray, who is African-American, for having been intimidated and ripped off by him and for being Black. Consequently, he was hoping the whole time that Ray would die. After Ray was resuscitated, Max accused Ray of engineering a fraud for the camera to hustle sympathy and be the star of the show. Luckily, Max refrained from confronting Ray face-to-face with this accusation or Ray would have smashed him over the head with a 2 by

*For a Foucauldian power analysis of some of the same ethnographic data presented here, see Bourgois et al., 1997.



Fig. 13. Scotty ten days before dying from an overdose (photographer unknown.)

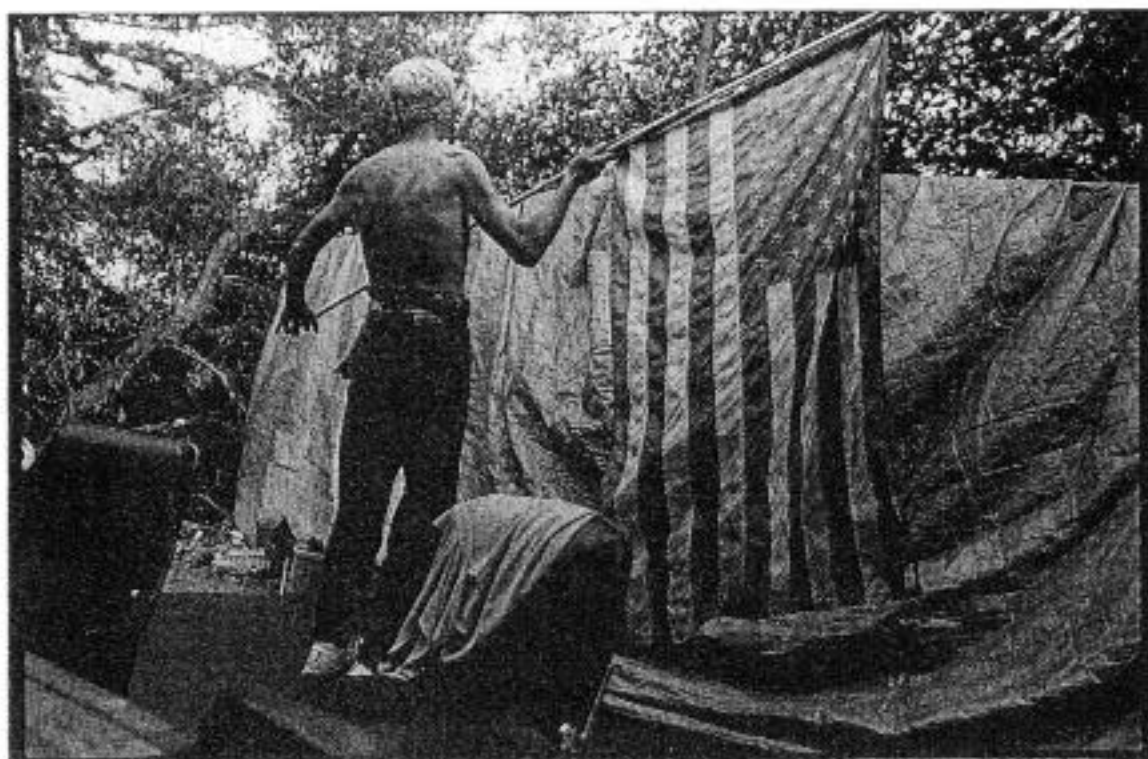


Fig. 14. Pete reminiscing about Vietnam (courtesy Jeff Schonberg).

4—yet another urgent, immediately life-threatening behavior risk at this morning's injection session. I think I'm beginning to understand a bit more concretely why sanitary injection is such a low priority in the everyday struggle for survival and meaning. (See Fig. 14.)

Fieldnotes, May 18, 1996)

GLOSSARY

- Bag - Standard quality of heroin (about half the size of a pencil eraser) purchased on San Francisco streets, usually wrapped in a piece of plastic or a balloon; price generally ranges from \$7 to \$20 depending upon weight, quality, turf control, police repression, and supply and demand.
- Black Tar - Form of heroin generally available in San Francisco: gooey when warm and brittle when cold.
- Bleach, to - To rinse a used syringe with bleach.
- Boot and Jack, to - To alternate while injecting between drawing blood into the syringe and partially injecting the blood/drug mixture.
- Cisco Berry - Brand of fortified wine commonly consumed by street-based alcoholics.
- Cook, to - To dissolve an injectable portion of heroin in water by heating and stirring it.
- Cooker - A metal bottle top, a spoon, or the bottom portion of a crushed aluminum can used for heating and dissolving heroin in a water solution.
- Cotton - Small cotton ball or fragment of a cigarette filter used to filter heroin solution while drawing it into a syringe after heating and dissolving it.
- Cotton Bandit - An addict who maintains his/her habit by begging used cottons.
- Cotton Shot - An injection prepared by rewetting and heating a used cotton in a used cooker.
- Dealer's Habit - A large physical addiction supported by selling drugs.
- Direct Deposit - To inject directly into a vein.
- Doing the Tuna - To collapse in seizures due to dopesickness or overdose (see Fish-flopping).
- Dope - Heroin (not a generic word for other drugs).
- Dope Fiend - Heroin addict.
- Dopesick - Suffering from heroin withdrawal.
- Finger Roll - Deceptive act of adding extra drops of water into a shared cooker after drawing one's own portion of the drug solution in order to dilute other sharers' portions, and fool them into thinking they all received equal portions of liquid heroin.
- Fish-flopping - To collapse in seizures due to dopesickness or overdose (see Doing the Tuna).
- Fix, to - To inject.
- Hustle - Income generating strategy in the underground economy.
- Jack, to - (See Boot and Jack, to).
- Muscle, to - To inject intramuscularly.
- Nod, to - To be heavily sedated (high) on heroin.
- Ol' Lady - Long-term girlfriend or wife.
- Pound a Cotton, to - To recook a previously used cotton in order to inject its residue of heroin.

- Rig - Hypodermic syringe.
- Running Partner - Most trusted associate with whom one hustles regularly as a team.
- Shooting Gallery - Site where drugs are injected on a regular basis and where injection paraphernalia is usually made available.
- Short, to - To discount the price of a drug.
- Speedball - Heroin/cocaine mixture.
- Stash - Hidden supply.
- Streetwise - Effective at surviving the perils of street life and at hustling in the underground economy.
- Taste - A small gift of a drug in return for services, friendship, or future obligations.
- Two-Fingered Dip Trip - (See Finger Roll).
- Unit - Quantified measurement marked on the side of a syringe (100 per standard insulin syringe).
- Watery Cotton - A used cotton in a used cooker with some extra drops of the original heroin solution.
- Weak Hustle - Ineffective income-generating strategy in the underground economy.

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RESUMEN

Una investigación etnográfica de toxicomanos desamparados en San Francisco, California revela más prácticas riesgosas de las que reportan generalmente los investigadores de salud pública. Tanto los académicos como los que proveen servicios a toxicomanos deben repensar el paradigma individualista de "práctica riesgosa" y tomar en cuenta las relaciones sociales de poder y la violencia cotidiana que influyen en la transmisión del VIH. Las estrategias económicas de sobrevivencia en la calle y las jerarquías simbólicas en torno al respeto, la identidad, y la participación en redes sociales contribuyen a que casi todo los días los desamparados que se auto-identifican como "drogados" ["dope fiends"] comparten entre ellos los equipos necesarios para preparar inyecciones. Frente a esta realidad preocupante, aún no se ha aprovechado del potencial analítico y también de intervención aplicada que ofrecen los métodos antropológicos de participación-observación. Un diálogo entre investigadores en epidemiología que trabajan al nivel estadístico y los etnógrafos que hacen trabajo de campo podría arrojar nueva luz sobre el problema de quién, como, donde, y porqué se transmite el VIH. Para entender y prevenir la transmisión del VIH es imprescindible llegar a una mayor sofisticación teórica acerca de la marginación social, la organización del poder, y la violencia cotidiana.

RÉSUMÉ

Une recherche ethnographique dans le milieu des heroinomanes à San Francisco, Californie révèle des pratiques bien plus risquées que ne le documente les pub-

lications de santé publique. Les stratégies de survie dans l'économie de la rue ainsi que les logiques des liens sociaux réciproques et les hiérarchies symbolique de respect entre ceux qui s'identifient comme des camés [dope fiend] a pour conséquence le partage presque journalier de l'attirail pour la préparation de la drogue. Les chercheurs en santé publique doivent revoir leur paradigme de comportement à risque individuel pour mieux situer dans son contexte sociale comment le pouvoir et la violence quotidienne structurent la transmission du VIH. L'efficacité des interventions de santé publique souffrent. L'exactitude des données quantitatives de base ainsi que notre compréhension du "qui-pourquoi-comment-et-où" de la propagation du VIH pourrait être améliorées par un dialogue d'ordre méthodologique entre des chercheurs quantitatifs en épidémiologie et des participant-observateurs en anthropologie. Cela demande également une plus grande sophistication des théories sur le pouvoir, la violence, et l'extrême marginalisation sociale.

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