AIDS Prevention Outreach Among Injection Drug Users: Agency Problems and New Approaches*

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Drawing on original field research and agency theory, we examine the operations and internal workings of community-based outreach projects to combat AIDS among out-of-treatment injection drug users (IDUs). We show that even though these projects suffered from a host of organizational problems, the response from IDUs was positive and vigorous. Based on these findings and recent developments in the theoretic understanding of collective action, we describe new approaches to AIDS prevention that build on traditional outreach prevention efforts but rely more heavily on an active collaboration between IDUs and service providers. These approaches fulfill the call by many AIDS researchers for the development of future prevention projects that capitalize on the unexpected responsiveness IDUs exhibited to traditional outreach efforts. Finally, we consider other public health areas in which such interventions might be effectively applied.

Introduction

In June 1981, the first cases of gay men suffering from acquired immune deficiency syndrome (AIDS) were identified, a disease caused by human immunodeficiency virus (HIV) (Shilts 1987). The existence of HIV and its routes of transmission were established in 1983, but the official response to help high-risk groups, such as gays and injection drug users, protect themselves remained stalled for a number of years (National Commission on AIDS 1991). This response by political and public health officials during the early 1980s has been severely criticized by those who feel the opportunity was lost to limit the epidemic (Kuller and Kingsley 1986; Altman 1987; Perrow and Guillen 1990). Yet it is also clear that the AIDS epidemic presented, and continues to present, a challenge of unprecedented proportions. Understanding the obstacles to effective control of the AIDS epidemic has consequences not only for understanding the early history of the AIDS epidemic; it also reveals the constraints under which contemporary efforts to control AIDS must operate.

In this paper, we focus on the control of AIDS among injection drug users (IDUs). We base our analysis on theories of collective action (Olson 1965; Coleman 1990) and agency

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Controlling AIDS as a Collective Action Problem

Olson's (1965) theory of collective action is built on the long-standing recognition that collective interests do not necessarily produce collective action. Here "collective action" is defined as action oriented toward producing a good that is "public" in the sense that it benefits group members, including those who do not contribute to its production. Examples of public goods include services such as fire and police protection, public health, and the social norms that render social life coherent and predictable. Collective action is problematic because groups possessing a common interest frequently fail to mobilize individuals' behavior on behalf of that interest. Many members of a group may be unaware that they share any common interest, so fostering such an awareness is an important element of the process by which collective action is mobilized. In consequence, large but poorly organized groups are frequently controlled by much smaller but better organized groups.

Group size is crucial in Olson's (1965) analysis. In a small group, each individual receives a substantial return from his/her own contribution, and free-riding is highly visible, so collective action is least problematic. For example, if three friends are repairing their group-owned boat each individual's contribution is important, and any shirking is visible. Such groups are described as "privileged," because they can rely merely on the voluntary contributions of their members to guarantee the success of the collective action.

In much larger groups, a very different situation pertains. Each individual's return from his/her own contribution becomes trivial, and the visibility of free-riders is low. For example,
when many thousands of tax payers contribute to public goods such as fire and police protection, the vast majority may see little relationship between their own individual contribution and the provision of such services. Hence, they are unaware of any common interest, so at the individual level participation in collective action cannot be motivated solely by a desire to see the action succeed. Because the impact of each individual's contribution is trivial, each member knows that services will be maintained even if he or she free-rides. As a result, motivating individuals to participate in collective action requires what are termed "selective incentives," that is rewards for cooperators or punishments for free-riders. Their effect is to strengthen incentives to participate in collective action. Selective incentives range from peer monitoring and peer-imposed sanctions that informal groups use to regulate their members, to bureaucratic social-control systems such as formal auditing and policing mechanisms.

Collective action in non-privileged groups is termed "by-product behavior" because it is motivated by the selective incentive system, not by individuals' direct willingness to participate in the production of public goods. Large groups that are well organized, in the sense that they possess effective selective incentive systems, are able to act collectively. More atomized groups remain as "latent groups," because they lack the capacity to act upon their collective interests.

AIDS prevention is a collective action problem because it results from a conflict between individuals' behavior (in this case, sexual and drug use activities that individuals find rewarding), and the frequently unarticulated and unacknowledged common interests of the communities they belong to (in this case, collective enforcement of prevention norms requiring changes in individuals' risk practices). AIDS prevention constitutes a public good because the suffering resulting from HIV infection spills over from all affected individuals to their family members and friends. It also spills over to the community at large, because of the financial costs of treating HIV infections and diseases.

At the beginning of the AIDS epidemic, the large size of high-risk groups, and their lack of organization around public health issues, virtually guaranteed that levels of collective action to combat AIDS would be extremely low. In addition, the rewards of unsafe sex and drug use were powerful and immediate counter inducements; the efficacy of safer practices in preventing HIV infection was uncertain; and the risk from any single act appeared to be small and long delayed — all of which made changing individual behavior more difficult (Lawlor 1990). High-risk groups, therefore, tended to remain latent. Collective action could be expected to arise first in the more organized high-risk groups, such as gays. It might never arise in far less organized groups, such as IDUs.

Thus, at the beginning of the epidemic, high-risk groups were ill equipped to act quickly. In contrast, many low-risk politically or religiously-based groups were already organized around moral agenda related to sexuality and drug use. Such groups, drawn from both white and minority communities, were well situated to redeploy their organizational resources to hinder public health initiatives to combat AIDS (Quimby and Friedman 1989).

In sum, obstacles to containing the AIDS epidemic included the difficulty of mobilizing latent high-risk groups, and overcoming the high level of mobilization exerted by low-risk groups whose moral/political agenda conflicted with effective AIDS prevention measures. These conflicts continue to afflict AIDS prevention efforts. As the epidemic has matured, some high-risk groups have significantly increased their levels of organization. However other groups, in particular IDUs, remain nearly totally atomized in the United States. In addition, the influence of highly organized groups with moralistic agenda remains substantial.

These obstacles could be overcome in large measure if means were found to catalyze or facilitate the process by which high-risk groups mobilize for collective action. Such means would speed the process by which latent groups, such as IDUs, were able to identify common interests and create and enforce AIDS prevention norms consistent with them. Efforts to
accomplish this are discussed in section five. First it is necessary to examine IDUs' potential for collective action, as demonstrated by their responses to AIDS prevention outreach efforts nationwide.

**Community-Based AIDS Outreach**

By 1986, HIV seroprevalence rates among IDUs in New York City and northern New Jersey had climbed to 60 percent, compared to 12 percent in San Francisco (Haverkos 1988). Faced with a rapidly spreading AIDS epidemic, the federal government began seeking ways to reduce high-risk behavior among IDUs beyond the punitive measures that had long been part of the War on Drugs (Wisotsky 1991; Government Accounting Office [GAO] 1992). The new policy addressed the transmission of HIV among IDUs as a *research problem* and assigned it to the authority of the National Institute on Drug Abuse (NIDA 1991a). In 1987, NIDA (1987:1) funded six research demonstration projects intended to study "[t]he use of indigenous outreach workers [OWs] to identify, reach and communicate with i.v. drug abusers and associates in their natural communities" about the risks of HIV, and what steps IDUs could take to protect themselves. OWs were given three fundamental tasks: to recruit IDUs for HIV testing and counseling; to educate them on their own turf regarding AIDS risks; and to distribute prevention materials to IDUs, such as condoms and small bottles of bleach for cleaning needles. NIDA increased the program in 1988 by funding 41 outreach research projects in more than 60 targeted inner-cities with large numbers of IDUs, all part of the National AIDS Demonstration Research (NADR) Project (NIDA 1991a; Brown and Beschner 1993).

Research on the impact of outreach projects confirms the view of IDUs as a latent group, that is, a group with awareness of a common interest but a limited capacity for its individual members to act collectively based upon that interest. Even so, the finding that IDUs are capable of recognizing and, within limited domains, acting upon their interests was something of a revelation. Before the NADR program, it was often believed that IDUs did not care about their health and were unable to regulate their own and others' behavior (Friedman et al. 1987). This claim resulted from the *position* researchers, clinicians, and public health officials traditionally took toward IDUs. It rested on the following assumptions: if people shoot drugs, they do not care about their health; and, if people continue to shoot drugs, they will not change (Rivera-Beckman 1992a). With the advent of outreach projects working directly with IDUs on their own turf, it became apparent that these assumptions had blocked a recognition of both the very real concerns IDUs have about their health, and the changes IDUs are willing to make to protect it, short of "just saying no" to drugs or sex. This has included actions wholly independent of externally organized AIDS prevention programs. For example, Des Jarlais et al. (1985) found in 1983 that, even before outreach projects were initiated, some IDUs in New York City began reacting on their own to reports about the risk of AIDS by reducing needle sharing and increasing the demand for clean syringes. By 1984, IDUs' demand for clean needles was so great that it spawned a new market ripe for exploitation: dealers began repackaging used needles and selling them as new (Des Jarlais, Friedman, and Hopkins 1985; Friedman et al. 1987).

Given IDUs' responses to the arrival of AIDS, it is not surprising that their reaction to outreach programs was positive. Many IDUs began to disinfect their needles with bleach, and to reduce needle sharing. IDUs also increased their use of condoms, though less successfully. For example, in San Francisco during the winter/spring of 1986, before outreach distribution of bleach and condoms began, only 3 percent of the city's estimated 15,000 IDUs reported that they regularly disinfected their syringes. OWs began distributing bleach in the streets in July 1986. One year later,
55.4% interviewed reported using bleach . . . [and analysis of] needle-sharing partners in the past year showed significant shrinkage in the reported size of needle-sharing circles and increased numbers of persons who reported not sharing needles (Watters et al. 1990a:592-93).

Similarly, in 1986, 9.8 percent of IDUs reported not sharing needles, which increased to 21 percent one year later. During that same year, only 4.3 percent of the respondents reported using condoms at least half the time they had sex. By 1987, 32.7 percent reported using condoms in general and "18.6 percent reported using them at least half of the time" (Watters et al. 1990a:593). Watters et al. (1990b:3-4) report that from the baseline measures taken in the winter/spring of 1986, "there was a near doubling of HIV seroprevalence [to] early 1987, from 7% to 13%. After this point the curve is relatively flat" through late 1989. Watters et al. (1990b:4) emphasize that "major behavior change occurred immediately following the implementation of outreach and bleach distribution."

Risk reductions by IDUs in response to outreach efforts in other cities were similarly significant, as NADR researchers reported in New York City, Miami, Chicago, Denver, Baltimore, Cleveland, Hartford, and other sites (NIDA 1991b; Brown and Beschner 1993; Booth and Wiebel 1992; Chitwood et al. 1991; Neaigus et al. 1990; Stephens, Feucht, and Roman 1991; Weeks et al. 1990; Wiebel and Lampinen 1991). Such changes occurred so rapidly following the implementation of outreach projects that secular trends, such as growing awareness of how HIV is transmitted, do not appear to be able to account for them. For example, to control for the effects of secular trends, some studies used sequentially drawn samples, where one group (the quasi-control group) was interviewed for the pre-test at the same time that another group (the quasi-experimental group) was interviewed for the post-test. By comparing variations within the set of pre- and post-tests with variations across the pre- and post-tests, the design provided a control for secular trends such as general increases in the level of HIV prevention information. These studies offer further support for the conclusion that outreach helped to reduce high-risk drug-related behavior. As Stephens et al. (1991:570) report in Cleveland:

For 19 of the 21 measures of risk associated with needle behavior, the "experimental" (post-test) group reported significantly lower levels of risk than the "control" (contemporaneous pre-test) group. Similar contrasts were found in reduction of risk associated with general drug behaviors (See also Neaigus et al. 1990).

Another study, by Booth and Wiebel (1992), provides further evidence of the independent impact of outreach projects. Outreach projects were implemented in Baltimore, Denver, and El Paso beginning in 1987, all designed after the NADR Chicago model (Wiebel 1988). Each project administered an initial and follow-up interview with samples of several hundred IDUs. However in El Paso, due to "agency problems" like those described below, the outreach workers failed both to access IDUs or even sustain a presence in users' communities. In assessing the impact of outreach in the three cities, Booth and Wiebel (1992:285) treated El Paso as a de facto control group in a quasi-experimental design, which led to the following conclusion:

That intervention through outreach could be effective was thus found not only in the significant risk reduction observed among subjects in Baltimore and Denver but in the relative lack of success in El Paso, which for the most part lacked the reinforcing presence of indigenous outreach staff.

In sum, quasi-experiments indicate that outreach projects had a positive impact independent of secular trends such as AIDS education through mass media, or methadone and other drug treatment programs.1

1. The influences of the mass media and methadone clinics must also be noted in prompting the rapid behavioral changes that IDUs exhibited in the latter part of the 1980s. The mass media brought the AIDS epidemic to public
Thus, research on outreach projects has shown that IDUs have made significant risk reduction changes, and that IDUs are far more responsive than experts previously believed. As Des Jarlais, Abdul-Quader, and Tross (1991:1279) conclude, “Intravenous drug users have surprised many policymakers and researchers by exhibiting large-scale AIDS risk reduction.”

However, in examining the organizational dynamics of outreach projects nationwide, it has become clear that IDUs responded impressively to very unimpressive and uneven outreach efforts that drifted toward inertia, and that suffered from high levels of mal- and non-performance of OWs. These findings, reported below, suggest that a new approach to AIDS prevention among IDUs may be feasible, one that relies on a more active and direct collaboration between IDUs and service providers.

Agency Problems in Outreach Projects

Ethnographic research has accumulated on the inner workings of outreach projects, including how OWs have performed in the community in reaching IDUs (NIDA 1991a; Longshore 1992). Our analysis draws on this literature. Our analysis is also based on an ethnographic study of the San Francisco outreach project conducted by the first author. The ethnography consists of a year and a half of participant observation, beginning in June 1988, during which time the first author and two full-time associate ethnographers were trained as OWs and deployed as members of various outreach teams in targeted areas of San Francisco. It also includes interviews with 24 of the 33 OWs employed by the San Francisco project between July 1988 and January 1990. All quotes that lack citation come from these interviews. In addition, in October 1989, the first author and an associate spent two weeks on the streets with the NADR outreach project in New York City at two different sites, Brooklyn and Queens. The observations of San Francisco and New York, and the literature on outreach in other cities, reveal a high degree of commonality in the manner in which outreach projects functioned across the country.

If collective action always succeeded, individuals at risk of contracting HIV would act collectively to neutralize that threat. However, in reality, collective action frequently fails, hence the need for AIDS prevention projects. Agency theory (Jensen and Meckling 1976; Eisenhardt 1985; White 1985) provides a useful conceptual framework for understanding the inner workings and problems of these projects. The theory focuses on informational asymmetries between individuals who contract for a service (principals), and those who enlist or are hired to provide that service (agents). For example, in the relationship between patients (principals) and physicians (agents), the latter’s vastly greater access to specialized medical knowledge creates opportunities to control the patient through evasion, dissimulation, mystification and many other deceptive practices (Waitzkin 1991). Similarly, in the relationship between clients (principals) and lawyers (agents), the latter’s use of specialized legal knowledge can mislead clients to act against their own interests (Bok 1978). More generally, any bureaucracy can be seen as a chain of principal-agent relationships that link principals awareness and disseminated information about the major routes of HIV transmission. However, they have been criticized for failing to provide practical information on safer sex and needle practices, and for primarily playing to white middle-class heterosexuals who were least at risk of contracting HIV (Altman 1987; Shilts 1987). Methadone clinics also served as sources of HIV prevention information. However, their impact was reduced by several factors. They worked with fewer than 10 percent of drug users (Schuster 1988), and they ignored cocaine and methamphetamine injectors (Wiebel and Lampinen 1991). In addition, many did not offer IDUs practical advice and instruction on safer injection techniques or sterilization of syringes using bleach because they focused instead on promoting abstinence from drugs. As Stern (1992:124) notes about the treatment system in New York City, “Although NYC claims belief in a disease model of addiction, addicts are not taught even the basics of IV injection.”

2. Some of the OWs were interviewed during and after their tenure with the San Francisco project. The names of project staff members appearing in the text are pseudonyms.
("superordinates") to agents ("subordinates") charged with fulfilling their delegated responsibilities. However subordinates' differential control over information frequently enhances their power and provides the opportunity to manipulate their superordinates.

Outreach projects could be analyzed at any of several levels, including that of NIDA officials as principals and research investigators as agents; or research investigators as principals and outreach supervisors as agents; and supervisors as principals and outreach workers as agents. In this paper, we limit our analysis to the latter relationship, because it is the closest to the street-level at which outreach interactions occur with IDUs, and because analyzing higher-level agency problems would exceed the scope of this paper. However, it is important to note that the problems identified in the performance of OWs may derive from agency problems higher in the organization (eg., see Broadhead and Margolis 1993).

**Outreach and the Problem of Adverse Selection**

According to agency theory, two fundamental types of problems inevitably arise when the agent's interests fail to coincide with those of the principal. The first problem occurs ex ante, before the agent's services are retained. It is termed adverse selection, because the agents with the strongest incentives to offer their services to the principal tend to be those who are least qualified or motivated. For example, when advertising for a job, the applicants who respond do not come from a random sample of all people who are qualified for the job, because most such people are satisfied with their current employment. Instead, most responses come from people who are unemployed or are in the process of losing their current jobs. This group contains a larger proportion of workers with problems in competence or reliability than does the working population at large. Identifying the true suitability of candidates for a job is especially difficult, because applicants who are least qualified have the greatest incentive to withhold information that reveals their deficiencies.

Adverse selection problems arise to varying degrees in all organizations, because available information on applicants is often fragmentary and lacking in reliability. Consequently, much organizational energy is devoted to overcoming this problem. For example, well-managed police departments now employ psychological tests in an effort to eliminate bullies and sadists who are attracted by the opportunity to use force. Similarly, financial institutions employ background checks in an effort to eliminate con artists who are attracted by the opportunity to control other people's money. Such screening devices are, at best, only partially effective. In this respect, outreach projects faced especially severe difficulties. Studies of outreach have found that the credentials projects looked for in hiring OWs were the kind that often keep people from getting a good job, e.g., a former drug habit, a prison record, socialization to lower class culture, street-smarts about hustles and con jobs, previous gang membership, or a former career in prostitution. Thus, some people hired as OWs had conventional credentials, such as college degrees and journeyman skills, but they all had to have street credentials (Broadhead and Fox 1990). That created problems. As Stephens (1991:47) explains, among street cultures, "[h]igh status is conferred on those who are most adept at conning." Obviously, in actively recruiting people with strong street credentials, outreach projects set themselves up to attract some applicants who were prepared to use their hustling experience and pull a con job on the projects themselves. As a practical matter, it was virtually impossible to distinguish such applicants from others who were equally experienced.

The ethnographic field research revealed problems of adverse selection. The most frequent and simplest problem occurred during employment interviews when applicants expressed a heartfelt desire to help drug addicts protect their health. After being hired, it

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3. It should be noted that adverse selection problems are symmetric. Job candidates do not have a monopoly on deception or incomplete disclosure. For example, in order to attract highly skilled candidates, employers sometimes make promises regarding opportunities for advancement that are not subsequently honored.
became apparent, sometimes slowly, sometimes immediately, that their heart was never in the job. Thus, for example, “going into the field” came to include visiting the mall and shopping, goofing off with clients, chasing around, hanging out in bars, drinking beer, playing pool, and getting high. As one outreach supervisor noted, “All the problems that we deal with on the street, we have in our very own agency.” It was inevitable that such problems included varying amounts of what Agar (1973) aptly called “ripping and running,” because many OWs came from, and all worked in, drug-using and other hustling scenes.

Selection problems were aggravated by the wealth of hustling opportunities available to OWs in the community. Identifying OWs who could work in, but not join, the hustling/drug scene was difficult and fundamentally problematic. To paraphrase Stephens (1991), as interaction with street-based drug and hustling scenes increases, the greater becomes the likelihood of persons’ commitment or attachment to them. Thus, some OWs used their jobs as a cover for running various street-based hustles. As one OW observed while working a neighborhood in San Francisco: “This job would be the perfect cover if you wanted to run a scam.” Later he was discharged by the project after he was discovered fencing stolen merchandise on the job. Another OW was confronted several times by the project directors over rumors he was orchestrating the sale of drugs while distributing bleach and condoms. But such schemes were difficult to prove. In this case, the OW was also a team supervisor and, in observance of the strong street ethic never to “snitch,” the OWs under him refused to tell what they knew to the project directors. In encouraging OWs to use constantly their street-based experience, outreach projects provided opportunities to tap into a complex and lucrative black market that offered goods and services in high demand. If OWs chose to take advantage of the opportunities they cultivated, as some did, they were in a good position to dabble and make a quick return on an investment, or to get more intensely involved.

Yet, it must be emphasized that there were many OWs who remained committed to their jobs and wished to perform like professionals. Studies of outreach projects throughout the country have revealed that many OWs worked hard at accessing IDUs and at promoting risk reduction (see Johnson 1988; Margolis 1990; Rivera-Beckman 1992b; Broadhead and Fox 1990). For those OWs, however, the most deflating and demoralizing experience was having to tolerate the shirking and con jobs of their colleagues. Such demoralization was a major occupational risk for those OWs who were well-meaning and highly motivated (Broadhead and Fox 1993). Thus, a very sincere OW who was able to stay with the San Francisco project for only a few months explained:

When I worked with a volunteer agency, the volunteers worked harder and longer than we did . . . So here is an agency where everyone is paid, but so little is happening, at least with the team I was with. Eventually I just felt like I was wasting my time. I even started to schedule personal things into my own work time, which I didn’t think was right.

In contrast, an OW who constantly had to deal with his partner’s large-scale con job eventually quit in desperation:

I hate Sam, man, I just want to kill that dude! I’m just ready to say “Screw this job!” . . . And Sam, he’s still dealin’ on the job! He’s got four guys that I know of workin’ for him. And they [clients] ask me if I “use,” and I tell them, “No man, I don’t anymore” . . . The reason it bothers me is that it makes me look like a fool. I’m out there trying to do something about this epidemic. So what does Sam do? He tells the guys on the street not to say anything to me.

**Outreach and the Problem of Moral Hazard**

A second type of agency problem occurs *ex post*, after an agent’s services have been retained. If a principal lacks the means effectively to monitor an agent’s performance, the latter may act in ways that serve his or her interest at the principal’s expense. This risk stems from
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Problems of moral hazard arise to some extent in all organizations. Businesses lose far less money to robbery than embezzlement, for it is impossible to watch all employees all the time, especially those in positions of trust. Similarly, no reliable means for preventing corruption among police or truck drivers have been found, because much of their work occurs out in the field (Friedman 1982; Manning 1977). According to Lawlor (1990:154), problems of moral hazard are prevalent in the administration of social services. But the monitoring problems afflicting outreach projects are especially severe for two reasons.

First, OWs enjoyed considerable autonomy in the field for long periods of time, largely free of supervision or colleague control. Such autonomy is a generic feature of occupations at the "street-level" (Lipsky 1980), and many OWs regarded it as a major prerequisite of their job. Once in the field, OWs had many opportunities to shirk. Consequently, OWs frequently organized their days to accommodate personal matters, such as educational programs, artistic pursuits, avocations, and even part-time jobs. Some OWs kept "banker's hours," as a director of the San Francisco project acknowledged.

A second factor that impedes monitoring of OWs derives from local norms. In conforming to the ethics of the street, OWs were loath to "snitch" on one another, which made project monitoring even more difficult. For example, in joining an outreach team, one OW was given the following advice by her new teammates: "I was told, whatever happens in the team, stays in the team. Don't bring problems out in the staff meetings that are our business. We keep our own problems to ourselves."

Given the lack of effective monitoring, OWs had extensive opportunities to act in ways that conflicted with the official aims of outreach projects. These divergent actions resulted from (1) political conflicts, (2) conflicts between local culture and the goals of outreach, (3) the status needs of OWs, and (4) OWs' reactions to the occupational risks of outreach.

Political conflict. Political conflicts between OWs and outreach projects adversely affected AIDS prevention efforts. Minority communities in the United States have been for some time disproportionately at risk of contracting HIV (National Commission on AIDS 1991). In addition, minority communities, especially African-American and Hispanic, tend "to see AIDS in the context of broader problems of poverty, drug addiction, inadequate education and unemployment" (Quimby and Friedman 1989:405). As such, in 1990, at nearly the same time that the Centers for Disease Control was announcing the success of outreach services, members of the Black Leadership Commission on AIDS in New York City were holding their own press conference to announce the opposite: from their perspective, the national AIDS outreach effort was a cop-out by the federal government that reflected a failure to deal with the pervasive problems afflicting minority communities (Broadhead 1991). As reported in the New York Times (1990:N14), the Black Leadership Commission "criticized public health officials in New York City for the bleach distribution, saying they were giving the poor a sop rather than real help;" and, "[b]leach distribution amounts to endorsing inexpensive ways to stop AIDS from spreading among users but failing to come up with the millions of dollars needed to help users get off drugs."

OWs who shared this position with their communities, and brought it to their job, had difficulty remaining committed to their work. Thus, for example, a young Latino OW felt

4. The problems of adverse selection and moral hazard are conceptually distinct. However, they are sometimes difficult to discriminate in particular cases because they become intertwined. For example, inadequate monitoring of agent performance can lead to postcontractual opportunism (moral hazards) such as running con jobs on the project. Subsequently, the prospect for con jobs can serve to attract recruits who are on the lookout for opportunities to exploit, thereby creating a problem of pre-contractual opportunism (adverse selection). In either case, agency theory locates the source of the problem in informational asymmetries.
compelled to quit after struggling for approximately six months, during which time he resumed a cocaine habit:

I just couldn’t handle it anymore. There was something kinda weird about going up to old dope fiends and saying, “Hey man, want some bleach?” when it’s like, “Well, you won’t die from AIDS but, man, you might OD in two weeks.” The project didn’t even address that! It’s like, “Oh, sure, we want to help you, so here, take some free bleach,” you know (pointing his finger to his temple indicating that this is crazy). . . . What about the real problems? It doesn’t address the problem that all these kids in our community are dying from crack and from violence about drugs.

Interviews with this OW’s team members revealed that they agreed with his position but felt that there was nothing they could do about it, which increased their frustration. For example, one exclaimed:

I mean, I could relate to Julio a lot, but at the same time, I’ve got kids and a wife . . . You know, I hate the fucking system but what could I do, right? I’m stuck. At least Julio is willing to rough it and that’s why [he quit]. He said, I don’t give a shit, I’ll rough it because the contradictions really got to him.

Instead of quitting, such OWs put in their time but adjusted their efforts downward according to their reduced commitment to the job.

Conflicts between local culture and outreach. Some OWs’ indigenous identities in the community undermined their prevention efforts. Two examples from the San Francisco project suggest the complexity of the problem. One OW, who acknowledged having been a prostitute and hustler years earlier, joined the outreach project after becoming a born-again Christian. Her identity conflicts with the project were twofold. In being asked to work with prostitutes, her job as an OW constantly drew attention to a former identity she wanted to forget. In addition, by requiring OWs to be nonjudgmental in working with IDUs, she was prohibited from spreading the religious message closest to her heart, for which she wore a large, glittering pin that said “THINK JESUS.” Her tenure with the project ended after several weeks of erratic performance. As Stephens (1991:53) explains,

...a person is more likely to adopt new role identities (or roles) when these are compatible with existing roles and self-concepts . . . When one of these new role identities does not fit, it is “sloughed off.”

A second OW exemplified the kinds of identity conflicts that “streetwise” community members commonly experienced in becoming OWs, even though outreach projects sought to hire members with extensive street experience. As an OW exclaimed in an interview, “I’m a homeboy, and I’ll be a homeboy ‘til the day I die.” As evidence of this he emphasized, “I only talk to people that I’ve been introduced to.” To be a homeboy was to be “cool” and “in the know.” Some homeboys placed a premium on being seen as a “badass” (Katz 1988). Thus, it was hard for some homeboys to don a friendly demeanor, and talk to strangers about AIDS, or work the streets distributing prevention materials. They worried that handing out bleach and condoms made them look uncool, like they had sold out and become a “do-gooder.” Thus, as an outreach supervisor pointed out, “Homeboys can get the best contacts, but they’re guilty of ‘going native’. . . They have trouble distinguishing between when they are working and just hangin’.” Thus, as one OW quipped, “I can’t go native. I am a native.”

In general, OWs worked best with clients who were most like themselves. This meant that, for any OW, there were many types of clients with whom they were unprepared to work. Specifically, OWs’ indigenous ingroup/outgroup alignments often reflected the same narrow attitudes and prejudices current among their peers. Thus, for example, a straight Latino OW, perhaps a former heroin addict, may feel confident about accessing and relating to people like
himself. But he may be at a loss in having to work with Latina IDUs, or gay Latino or transvestite cocaine injectors, speed-using male or female prostitutes, black crack addicts, non-drug-using Latina or black sexual partners of IDUs, and white, runaway drug-using youth. Outreach projects specifically hired indigenous members of targeted communities to work as OWs, but much of what OWs brought to the job compromised their performance on the job.

Status needs of OWs. In successfully establishing themselves in specific communities, OWs found that they enjoyed a kind of popularity and kinship with user populations; being well known and admired was a powerful reward. Yet becoming established created inertia. OWs found the prospects of having to break into new drug networks stressful. OWs found their work more satisfying if they stayed with clients who knew and respected them, instead of going into situations as strangers to face IDUs' deep-seated distrust. Thus, OWs tended to restrict their work to areas in which they were well known and felt comfortable, at the expense of breaking into new territories. So, their outreach efforts bogged down.

Status conflicts also arose between the clients of outreach and OWs. Outreach projects asked OWs to maintain a nonjudgmental attitude toward their clients' lifestyles and practices. Yet, some OWs were resocialized by drug treatment programs to attitudes that were highly negative toward drug use and addicts, especially in New York City. As reported by Rivera-Beckman (1991), almost all of the 23 OWs who staffed the AIDS outreach project she studied in New York identified themselves as recovering addicts and members of Narcotics Anonymous (NA). In turn, the philosophy of NA toward active users was highly disparaging: drug use per se was a repudiated activity that must not be tolerated; users were denigrated; recovering addicts in NA who "slipped" were denounced by other members and stripped of rights and entitlements that could only be earned back through humiliating submission to the strictures and control of NA. As a result, given their local membership in NA, most OWs in New York had an aversion to working with IDUs and, as reported by Rivera-Beckman (1991), they refused even to place bleach in IDUs' hands. Instead, IDUs had to approach OWs, whose modus operandi was to stand behind portable tables set up on the street:

In this process, then, the outreach workers' presentation of self asserts a superior status to the user. As a direct consequence, few users are being reached. Few users will walk up to the table, fewer still will stand and talk to an outreach worker whose demeanor, if not message, denigrates their status. Thus, supplies of bleach and condoms needed by users remain on tables instead of reaching their hands (Rivera-Beckman 1991:45).

Due to the OWs' perspective in New York as members of NA, during a ten-month period from June 1990 through April 1991, only 1.02 bleach bottles per OW were distributed on average per day (Rivera-Beckman 1991).

Reactions to the occupational risks of outreach. OWs entered communities and worked directly with IDUs, which generally entailed walking the streets of blighted, crime-ridden neighborhoods. Individuals were hired as OWs, in part, because of their personal knowledge of the areas in which they would be working. Yet, as several OWs noted, they sometimes avoided those very areas in the past because of what they knew about them. As one OW reported, "when they said I was going to work down there as an OW I said, 'Oh no, that is not where I want to be!'"

Most inner-city areas containing large concentrations of IDUs have high predatory crime rates, and many OWs initially felt anxious about being assaulted while working in them. On a day-to-day basis, it was not uncommon to see people involved in confrontations and shouting matches; or undercover police running people down, hassling and rousting people in various locations, and making arrests. In such areas, the threat of physical violence was palpable and ever-present. Besides physical assault, the risk of being psychologically and emotionally assaulted was also high. OWs' clients lived in extremely deprived circumstances, the
vast majority were homeless, addicted, unhealthy and impoverished. OWs spoke often, and with considerable emotion, of the psychological and emotional assaults they experienced in witnessing their clients' suffering and deprivation (Broadhead, Fox, and Espada 1990; Margolis 1990).

However, OWs' adjustments to their work situation went far beyond merely protecting their physical safety. To reduce their exposure to disturbing situations, OWs tended to restrict themselves to open, public spaces. Thus, for example, an OW reported in a staff meeting, "This week we went into the City Hotel and I want to tell you, I've never seen five floors of such absolute filth in my life like we saw there." The staff agreed that OWs were better off staying out of such places and positioning themselves to hand out prevention materials to clients as they came and went. OWs typically positioned themselves where they hoped community members would know where to find them (Johnson, Williams, and Kotarba 1990). Thus, for OWs in New York City, as described by Rivera-Beckman (1991:40):

> A typical day consists of setting up a table in front of a neighborhood park, by a methadone maintenance clinic . . . or soup kitchen and waiting for interested clients. This sedentary approach may be combined with a limited amount of outreach worker movement around the vicinity of the table.

OWs in San Francisco and Chicago worked the streets much more often, but their objective was similar: to maintain daily routines such that IDUs would know where to find them if they wanted to, rather than OWs feeling obliged to track down IDUs (Wiebel 1988; Rivera-Beckman 1992b; Johnson 1988). Thus, OWs' efforts became highly circumscribed and routinized. The strategies OWs fashioned to minimize the risks of outreach generally led them to cover only a small part of the territory they were supposed to serve.

In addition, OWs learned that in working to be accepted and trusted by IDUs, it was streetwise to copy IDUs' street demeanor. Members of drug using scenes try to avoid drawing attention to themselves and their activities. As a veteran OW remarked, "All those guys that seem to be just standing around out there are not just doin' nothin'! They're workin', watchin' what's goin' on, keepin' track of business: sellin', coppin', makin' connections." Thus, OWs strove for a demeanor that was equally low-profiled and muted. They dressed down in keeping with street styles and worked to be seen as cool and part of the scene. As Johnson (1988:33) notes of OWs in Houston, "Doing 'hanging-out' is an attempt to blend in. Clothes are a means of camouflage. Actions are a method of concealment." Thus, even handing bleach to IDUs followed street etiquette, as one OW explained in San Francisco: "I just hold it in my hand and pass it to them, just like it was a drug deal." Being low profile and cool helped OWs allay IDUs' suspicions and forge trusting relationships with them (Broadhead and Fox 1990). But the style worked against aggressive and widespread distribution of AIDS prevention materials.

The Role of IDUs in Outreach Efforts

The general picture of outreach that emerges from the research literature is that OWs adapted rationally to a risky and stressful work environment in ways that reduced both the number and diversity of IDUs they served. OWs' adjustments were also the result of working in projects that were bureaucratically organized, but that operated under conditions which allow hierarchy and supervision to break down easily, resulting in organizational drift and inertia. Yet, as documented earlier, IDUs made significant community-wide risk reductions in response to the outreach services they received. Indeed, this is only half the story: IDUs' responsiveness went beyond risk reduction changes per se. Specifically, in outreach projects throughout the country, OWs found, and ethnographers documented, that IDUs volunteered and helped OWs carry out AIDS prevention efforts in many ways (Broadhead and Fox 1990; Rivera-Beckman 1992b; Johnson, Williams, and Kotarba 1990).
IDUs frequently introduced OWs to other users, and vouched for OWs in new communities. IDUs commonly helped OWs fill and prepare bleach bottles, and helped OWs distribute bleach, condoms, and prevention information. It was also common for IDUs to aid OWs in locating users to be interviewed, or to find users who needed to return for follow-up interviews. As the directors of the San Francisco outreach project reported:

In short, the IV drug users became deeply involved in helping us gather health information regarding AIDS and its means of transmission. They generally looked favorably on such efforts to involve them voluntarily and encouraged their friends to cooperate in a similar fashion (Feldman and Biernacki 1988:31-32).

Similarly, in New York City, the Association for Drug Abuse Prevention and Treatment (ADAPT n.d.:3) reports that, "users will often volunteer to help you set up your table and to bring their friends to it or distribute literature on the street . . . " Ethnographers have even found operators of high-volume shooting galleries enforcing risk-reduction norms, as Ouellet et al. (1991:80) describe in Chicago: "Although Slim allows syringe sharing, he said, 'I discourage that,' and he makes sure everyone who needs bleach has it . . . To share a syringe in Slim's gallery is unusual; to share without first cleaning it with bleach violates gallery norms." The Chicago outreach project concludes: "In fact, we have found that, as addicts become aware of the threat that AIDS poses, they are quite capable of assimilating a strong sense of social responsibility which can be readily channeled to include an assumed role of prevention advocacy" (Wiebel 1988:147).

In sum, while it appears that outreach projects in many areas sparked risk-reduction changes, IDUs and other drug-scene members clearly augmented those projects substantially. In the course of doing so, IDUs further disseminated and reinforced the strength of prevention norms within the larger IDU community. What is now known about both the limitations of traditional outreach and the unexpected responsiveness of IDUs, suggests the potential for a new approach to AIDS prevention that relies on, and works to strengthen, the capabilities of drug users to promote risk reduction among their peers.

**Augmenting the Capacity for Collective Action Among IDUs**

If means could be found for augmenting the cohesion of high-risk groups, that would increase their capacity for collective action and facilitate the emergence of AIDS prevention practices and norms. Such a development would enable public health officials to pursue a different strategy than has been typical in combating infectious diseases. Instead of providing direct services to at-risk groups based on a "provider-client model," like traditional outreach to IDUs, an alternative approach would be to facilitate the creation of indigenous networks of mutual influence and control within at-risk groups themselves. A relatively new development in the theory of collective action, the *theory of group-mediated social control* (Heckathorn 1988, 1990), shows how this might be done. The theory establishes a conceptual bridge between the organizational terrain to which agency theory applies, and the peer-group norms to which collective action theory applies, to suggest means by which organizations can foster the development of appropriate systems of peer-group norms. Such an organization might provide not only direct services, it might also encourage its clients to provide services for their peers, thereby enhancing the organization's effectiveness and efficiency.

According to this theory, relationships of power are never strictly dyadic. Virtually all individuals are members of groups with whom they are interdependent. These include groups of family members, friends, neighbors, co-workers and others with whom individuals interact regularly. To the extent that members of a group are interdependent, sanctions or other means of control directed at any individual have consequences that extend to other group members. For example, when one person is promoted on the job or fired, the sanction
spills over and affects family members and friends. Except in the limited case of social isolates, almost all social sanctions targeted at an actor generate collective rewards or punishments that impinge on his or her primary group. Imprisonment is an example of a punishment that spills over. It is not merely a personal calamity, it frequently drives the families of inmates into poverty. Similarly, rewards spill over to peers. For example, when a family's major bread winner earns an important promotion, the life chances of all family members may improve. Due to the spillover of an individual's rewards and punishments, social sanctions are seldom strictly individualized. Instead, they give rise to collective rewards or collective punishments.

![Figure 1 - Group Mediated Social Control](image)

The hollow arrow represents individual-sanction-based control. For example, this could involve individualized rewards or punishments targeted at the actor. The solid arrows represent the two steps in group-mediated social control. First, based on whether the actor complies, the actor's group is either promised a collective reward or threatened with a collective punishment. Second, the group responds to that incentive by controlling the actor.

Given that most social sanctioning includes both an individual and a collective component, behavioral compliance can arise from either of two theoretically distinguishable sources (see Figure 1). First, it can arise from individual-sanction-based control that is exercised by an agent such as a teacher, police officer, parent, or neighbor and directed at an actor who is the target of control. For example, an agent may threaten a targeted actor with the threat of punishment or offer the promise of reward. The result is a dyadic power relation of the sort presumed in many sociological analyses of power relations. Second, compliance can also arise from group-mediated control (Heckathorn 1990), as when students obey teachers because punishment administered by the school would be augmented by parents; or when workers hold onto disagreeable jobs because unemployment would inflict hardship on their families. In these cases, the agent of authority's influence is amplified through the group in which the target of control is embedded. For example, recall the OW who explained his decision to continue working despite the severe political conflicts he had with the outreach project: "I've got kids and a wife . . . I'm stuck."

The traditional emphasis on individual incentives in studies of social and organizational control is overdrawn (Heckathorn 1990). Individual incentives alone do not suffice to motivate compliance in complex organizations or communities. Large-scale compliance is much more likely when official sanctions are amplified by internal selective incentive systems. Hence, group-mediated social control is a prerequisite for effective legal, organizational, or normative control. Control based on individual sanctions works by altering peoples' inclinations, that is, their preferences regarding their own personal behavior. It does this by using
what may be termed primary incentives, such as performance-specific rewards or punishments. In contrast, group-mediated social control works by altering peoples' regulatory interests, that is, their preferences regarding how others behave. Group-mediated control does this by using what may be termed secondary incentives, such as rewards or punishments based on the performance of peers.

Collective action of a group can be promoted by using secondary incentives to amplify the regulatory interests that group members may share but are not acting on. If that amplification is sufficient in magnitude, what had been a latent group will begin to act collectively. For example, a latent group at risk of contracting HIV may become capable of creating and enforcing further norms with which to control high-risk behavior. Below, we describe how this can be done in practice.

Efforts to Promote Self-Organization Among IDUs

The responsiveness of IDUs to outreach efforts has encouraged many AIDS researchers to call for future prevention efforts that are based on active collaborations between drug users and prevention workers (Carlson and Needle 1991; Chitwood et al. 1990; Des Jarlais and Friedman 1990; Feldman and Biernacki 1988; Wiebel 1988). However, only one such program has been both implemented and assessed in the professional literature. In the Williamsburg section of New York City in 1988, Friedman et al. (1991) encouraged ex-users to recruit active users into self-help groups. Using a storefront, the organizers initiated weekly meetings of female IDUs for several months with an attendance of 6 to 20, and later, weekly meetings of male IDUs with between 3 and 18 participants. This experiment encountered agency problems similar to those found in traditional outreach projects. For example, the staff of ex-users often sought to prevent active users from encroaching on their authority, and even acted to discourage active users from becoming engaged in the program. Similarly, the staff sought to deny active users any overt recognition for the program's achievements. So, the program fell prey to the status needs of staff. Because of such problems, the experiment was unable to cultivate a durable user-organization in any way similar to the Junkiebonden found in The Netherlands. Given its success in motivating user self-help, the preliminary results were nonetheless encouraging. Des Jarlais and Friedman (1990:143) conclude that, "Public health officials should address the immediate need to reduce the spread of HIV, including advocating prevention programs that involve collaborative efforts with current members of drug use subcultures."

As the above example illustrates, the problem of designing a system to harness the potential contributions of IDUs is challenging. The special demands of IDUs' lifestyle, a product in large part of the War on Drugs (Goode 1993; Drug Policy Foundation 1992), frequently reduce IDUs' ability to perform satisfactorily in traditional organizational roles. In addition, it would not suffice merely to hire IDUs to replace OWs because the same agency problems that hampered OWs' efforts would also afflict IDUs. More creative organizational arrangements are required.

Collectivist organizations (Rothschild-Whitt 1979) provide a second approach to replacing traditional bureaucratic structure with normative regulation. Unfortunately, they depend on the selection of recruits for whom the organization's normative controls will be salient. Thus, they take great efforts to screen out opportunists and others who fail to respond to solidaristic incentives. In essence, this approach assumes that the problem of adverse selection can be so thoroughly solved that subsequent problems of moral hazard will not arise. The problem in applying this model to outreach is that very few IDUs would fit the selection criteria. A more robust approach is required that can accommodate individuals with a broader array of orientations.
An HIV prevention project that is currently operating in southern New England (Broadhead and Heckathorn 1992), illustrates a third approach, one that uses a mix of primary and secondary incentives to promote self-organization among IDUs. Its design employs a two-step process. First, the essential functions of traditional outreach were identified. Second, means were devised for strengthening regulatory interests using secondary incentives, so that group members would undertake those tasks.

The first task of outreach is recruiting IDUs into prevention programs. As in traditional outreach programs, the nexus of a "peer-driven intervention," or PDI, is a facility, such as a storefront, that provides HIV testing and counseling, risk reduction education, and prevention materials. In a PDI, IDUs are motivated to recruit other users for the above services via a coupon system: for each IDU recruited bearing a coupon, the user who recruited him or her receives a modest monetary reward. Only modest rewards are required, because the cost involved in exercising influence over peers is usually small, and there now exists widespread concern about AIDS and its threat to the welfare of peers.

Each recruit, in turn, is also given a limited number of coupons to recruit still other IDUs within their network. Thus, the mechanism coopts user networks to serve as a medium to recruit further IDUs. If adequate incentives are employed, with the number of coupons strictly limited per IDU so that no one single member can monopolize recruiting, the expanding system of chain-referrals may be robust enough to saturate the IDU population. In addition, all members of the IDU community are provided an equal opportunity to participate in the intervention, and to be rewarded. This approach has several advantages. First, it puts the burden of identifying recruits on those with the best current information: active users. Of course, users vary in their centrality within the IDU community, so they can be expected to vary in the success of their recruitment efforts. However, as the network research on the "small-world problem" demonstrates (Killworth and Bernard 1978/79), only a handful of linkages are required to connect even highly disparate positions in real-world social networks. The implication is that peer-recruitment mechanisms can operate virtually irrespective of network structure.

Second, the pay-for-performance design of a PDI rewards the most productive recruiters, thereby reducing problems of moral hazard. As a result, subjects are paid in direct proportion to the success of their recruitment efforts, and those who recruit no one receive nothing.

Third, a PDI offers a built-in accommodation to the cultural diversity in the user population: with IDUs accessing their peers, the recruitment effort is couched in terms appropriate to each user subgroup. Thus, a PDI has built into it a performance-based monitoring system that effectively avoids the agency problems commonly afflicting bureaucratic organization.

Another central task of outreach is distributing AIDS prevention information. Traditional programs educate IDUs both in the field, and through education modules on HIV, STDs, safer injection practices, and so on at a storefront, van, or similar space. In a PDI, IDUs are given incentives to educate their peers in the community. The extent to which IDUs pass on information to those they recruit can be measured through questions added to standard interview schedules, and the reward to the recruiter depends on the knowledge of the recruit. This approach has several advantages. First, it puts the responsibility for educating IDUs on those who are most likely to be influential: their peers. One of the most effective ways of motivating students to invest in a body of knowledge is to have them teach one another (Juzang 1992). Second, it entails considerable repetition. Subjects are first educated by their peer-recruiter, then by project staff, and finally subjects rehearse what they have learned when educating and recruiting their peers. Third, its pay-for-performance design rewards the most effective educators, thereby reducing problems of moral hazard. Fourth, it gives the outreach effort ongoing feedback for assessing the comprehension of prevention messages by users of different cultural and ethnic groups.
The final essential task of outreach is distribution of AIDS prevention materials such as bleach, condoms, and (if legally and administratively permissible) syringes. In a PDI, secondary incentives also can be used to motivate IDUs to distribute materials to their peers in the community. Thus, IDUs can look forward to receiving rewards that they have earned by referring their peers for education and testing, and for distributing AIDS prevention materials and information.

The most durable interventions are those that change community norms. Strictly individualized incentives, which affect only inclinations, tend to have results that are transient and erratic (Andenaes 1974). In contrast, alteration of regulatory interests has more durable effects because it creates a system of supportive norms. When recruiting and educating their peers, individuals draw upon whatever reserves of social influence they may possess. If such norms are consistent with previously existing regulatory interests within the group, they can, so to speak, take on a life of their own (Heckathorn 1988). In relatively cohesive groups, norms can persist long after the external sanctions upon which they are based have withered or been withdrawn. In more atomized groups, the intragroup control resources that are available, however weak, can be harnessed on behalf of the norms. Consequently, changes in norms have the potential to produce more abiding alterations in group behavior.

Financial constraints add urgency to the task of seeking more efficient means to deliver human services to IDUs. Most outreach projects nationwide have been funded by the federal government as demonstration projects for only three to five years. Many are now losing federal funding and are too expensive for many state and local governments to continue. Thus, the San Francisco outreach project was defunded at the end of 1990. When the first author returned to San Francisco in May 1991 to a neighborhood he had served as an OW, some of the IDUs complained that no one was giving out bleach anymore on the streets. The result was, as one IDU noted, "People back doin' some bad shit, 'homes'."

The defunding of outreach projects has caused considerable alarm at the federal congressional level (Weiss 1990). Despite OWs' success at reducing the spread of HIV, outreach projects are now being abandoned in many parts of the country. Other programs have lost funding because of agency problems like those described above (Hartford Courant 1992). Given a PDI's greatly reduced reliance on paid staff, such an intervention would be far less expensive than traditional outreach, by nearly an order of magnitude, and avoid many organizational problems found to afflict such projects.

Conclusion

We have outlined an alternative to traditional AIDS outreach based on a form of secondary-incentive-based organization termed a "peer-driven intervention." Of course, a definitive assessment of the strengths and weaknesses of this approach must await the results of empirical tests, a process that is now under way. Should the results prove positive, similar interventions might be devised to address other public health problems. A peer-driven intervention appears most promising when clear performance measures are available, and any of the following three conditions are met:

1. Individuals cannot be identified using public records, but suitable knowledge exists at the level of the peer group. It is extremely difficult, time consuming, and costly for outreach workers or ethnographers to tap into innumerable local networks. Knowledge is usually highly localized when activities are intimate, normatively suspect, or controversial.

2. Individuals lack strong conventional ties, and rely instead on peer support. For example, the unemployed cannot be reached in the work place, and drop-outs cannot be reached in schools. Yet unless they are social isolates, they can be reached through peers.
3. Individual behavior is subject to peer control. Few individuals will change their behavior at the cost of ridicule from peers, but this problem does not arise when the change is initiated through peers.

A major area of potential application of secondary-incentive-based organization is the delivery of human services. The organization of these services in the United States has long been controversial. Critics from both ends of the political spectrum have attacked “welfare bureaucrats” for remaining distant from the communities they serve and consuming the resources intended for their clients. These reflect the problems identified above as adverse selection and moral hazard.

On occasion, these criticisms have led to organizational innovation. For example, during the 1960s “War on Poverty,” the “New Careers” program sought to deprofessionalize human services (Pearl and Riessman 1965; Riessman and Popper 1968). Indigenous community members were trained to take over many service delivery jobs. The results were mixed because community members, once given newly-created careers as service providers, found that their interests no longer coincided with those they served, or with those who hired and supervised them, so problems of moral hazard recurred. The deprofessionalization of human services was disappointing because it did not grasp fully what needed to be done. It did not address the agency problems that lie at the root of the problem. Creating new occupations is still based on a hierarchical provider-client model in which, as Rivera-Beckman (1992c:1) emphasizes, “the relationship between the ‘helper’ and the ‘helpee’ is seldom equitable, and in fact, is often embedded in a structure of power whose character may in fact be counterproductive.”

A more promising approach in social service programs may be to minimize absolutely the reliance on professionals. This would avoid creating new occupations whose members then strive to increase their power, prestige, and resources at the expense of their clients. An alternative is to provide community members with modest incentives to serve their peers, coupled with clear performance measures. For example, peer-driven interventions of the sort described above may be appropriate in combating an array of public health problems in the community, including accessing pregnant teenagers in need of prenatal care, or parents whose children have not been immunized, runaway/homeless youth, and broad-based hypertension screening and peer treatment support carried out by members, themselves, of high-risk populations. The prerequisite is that individuals must have information regarding, and influence over, others who also live with the same problem.

As conventionally viewed, out-of-treatment IDUs might seem to be the least promising candidates for assistance based on self-help. Yet, their response in helping one another protect themselves from HIV suggests that such approaches should be explored much more extensively. If IDUs can help themselves, other groups may be able to do so as well.

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