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Enhancing the Safety of People Who Inject Drugs:  
A Program Evaluation of a Syringe Services Program in Atlanta

by

Megan Sarmento

Under the Direction of Kathryn A. Kozaitis, PhD

A Thesis submitted in Partial Fulfillment of the Requirements for the Degree of

Master of Arts

in the College of Arts and Sciences

Georgia State University

2021

## ABSTRACT

A syringe services program (SSP) is a public health initiative designed to combat the spread of HIV and other infections among populations of people who inject drugs (PWID). These syringe exchanges adhere to a model of care called harm reduction. A common goal of these initiatives is to reduce risky behaviors by providing health care resources that are necessary for PWID to avoid disease transmission, including sterile injection equipment and much more. These treatment systems contrast practices like forced abstinence, detoxification, and rehabilitation, which are standard ways to treat PWID within the dominant Western biomedical system. This thesis research utilizes ethnographic methods to provide a program evaluation of a SSP in Atlanta, Georgia. It relies on praxis principles to highlight and synthesize the ideas of participants in order to ultimately make recommendations for the development of SSPs in Atlanta and throughout the United States.

**INDEX WORDS:** Syringe services program, Harm reduction, Health care, Drug policy, Program evaluation, Praxis

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2021

Enhancing the Safety of People Who Inject Drugs:  
A Program Evaluation of a Syringe Services Program in Atlanta

by

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Committee Chair: Kathryn A. Kozaitis

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Office of Graduate Services

College of Arts and Sciences

Georgia State University

May 2021

## **DEDICATION**

I dedicate this to harm reductionists working in the streets to ensure that their community sees less pain, disease, and death. I dedicate this to those who have lost loved ones due to the inadequacy of health care that is available to drug users in the U.S. I dedicate this to the Atlanta Harm Reduction Coalition, to its founders and all staff and volunteers who have come since, for the incredible impact they have had by providing revolutionary health care and saving lives throughout the city for over two decades. I also dedicate this to my mom and dad, who relentlessly uplift me and encourage me to achieve my greatest goals.

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I would like to thank all of the interview participants in this study for sharing their personal stories, raw experiences, and incredible wisdom. I would also like to thank all whom I met while volunteering at the syringe exchange for showing me joy, gratitude, care, and realness. Dr. Harris, thank you for guiding me into this fascinating world of anthropology and showing me my immense potential. Thank you for always checking up with me, ensuring that I am progressing and doing well, and being an incredibly helpful and encouraging mentor for three years and counting. Dr. White, thank you for seeing me and for making me feel at home in our department before I even started the MA program. Thank you for your compassion, your knowledge, and your quiriness. Dr. Kozaitis, thank you for allowing me to see the impact that anthropology can and should have in the world. My two classes with you were the most engaged I've ever felt in a course, so I thank you for your captivating lectures as well as the space you provided for me to grow as an academic researcher and professional anthropologist.

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## **LIST OF ABBREVIATIONS**

AHRC: Atlanta Harm Reduction Coalition

PWID: People Who Inject Drugs

SSP: Syringe Services Program

## 1 INTRODUCTION

Georgia's largest Syringe Services Program (SSP) is situated in metropolitan Atlanta, with only two fixed outreach sites. The organization that maintains this program is called the Atlanta Harm Reduction Coalition (AHRC). People who inject drugs (PWID), as well as people who do not use drugs who are committed to helping that community, walk or drive to the outreach site on Mondays, Thursdays, or Sundays to drop off their used needles and receive new, sterile ones in return. Clients are often friendly and grateful. Occasionally a dispute between clients will break out, but that is to be expected when one's life revolves around making enough money to sustain addiction to heroin. People of all colors, ethnicities, and incomes are addicted to injection drugs. AHRC's SSP has seen a white, business-casual, middle-aged woman pull out several hundred needles from the back of her minivan, as well as a limping, intoxicated, and homeless old black man drop off only two used needles that he walked with in his pocket. This thesis provides an ethnographic account of those who engage with this local SSP and contributes to the growing anthropological literature on harm reduction practices in the U.S.

Harm reduction is a model of care that gained popularity in the 1980s as a response to the poor health status among PWID who were heavily impacted by the AIDS epidemic. Contrary to harm reduction practices, drug treatment in the U.S. typically includes detoxification, behavioral therapy, and then a commitment to sobriety via modalities like self-help groups (Recovery Centers of America 2020). The harm reduction model instead recognizes that "abstinence is not the only acceptable or important goal" (Pates and Riley 2012: 10). Rather, the priority for harm reductionists is to reduce the negative consequences of drug use. In understanding that abstinence is often not a realistic or feasible goal, at least not immediately, these strategies are focused on public health interventions and discourage the criminalization of drug use. SSPs were

founded alongside the development of harm reduction principles. They are designed for PWID to safely dispose of used syringes and then acquire sterile, new ones to reduce the transmission of HIV and other blood-borne infections, as well as other health issues associated with injection. These programs typically entail more than just a syringe exchange; they also provide connections to many other intervention services.

PWID in the U.S. generally lack adequate public health services due to policies and practices associated with the War on Drugs. The United States War on Drugs is infamously tied to the Nixon-era of the 1970s. It introduced strict punitive drug policies based on abstinence which still persist today and disproportionately incarcerate people of color. While Black and Latinx populations are a minority in the U.S., “nearly 80 percent of people in federal prison and almost 60 percent of people in state prison for drug offenses are Black or Latino” (Drug Policy Alliance 2018: 1). The excessive incarceration rates of people of color are a direct result of War on Drug policies that persist today (Drug Policy Alliance 2020b). Although the focus on drug criminalization began to shift during Barack Obama’s presidency, the drug policy budget under his administration still had “twice as much money going to the criminal justice system than to drug treatment and prevention” (Tiger 2013: 22). Proponents of harm reduction advocate for criminal justice reform in response to this policy and the fact that “over 1.6 million people are arrested, prosecuted, incarcerated, placed under criminal justice supervision and/or deported each year on a drug law violation” (Drug Policy Alliance 2020a). These data expose the consequences of the War on Drugs that are highly prevalent in the U.S. today.

My research specifically investigates the strengths and areas for improvement at AHRC’s SSP using ethnographic techniques. With the support of literature revealing the efficacy of SSPs in reducing HIV transmission and connecting drug users to further care and treatment, my

research investigates how AHRC's SSP benefits the community and in what ways it may be developed. The research questions are as follows:

1. What aspects of the SSP are particularly successful at reducing community harms?
2. What barriers exist in getting resources to clients?
3. In what ways may the SSP be expanded to reach more people?

This thesis continues by addressing the theoretical considerations that inform this research project. It then describes the methodology used to design and carry out the research. Then, three sections synthesize the ethnographic findings that have been collected and analyzed for this project. First, I provide examples for how harm reduction is practiced and defined by program staff and volunteers. The second section acknowledges the strengths of the program as identified by staff and volunteers. The third section explores stakeholders' ideas and concerns about the expansion of the program. It then provides recommendations for program development based on my ethnographic analysis. Finally, I discuss the insights that my ethnography contributes to the extant body of literature on this topic.

## 2 THEORETICAL CONSIDERATIONS

In this work, I employ a critical medical anthropology framework (Singer 1990; Scheper-Hughes 1990) and join other anthropologists and public health officials who argue that the U.S. still lacks adequate support for health services for people who use drugs (PWUD). My work follows this theoretical model by examining both the strengths and limitations of a health care system and then offers “suggestions for advancing on an alternative, critical course” (Singer 1990: 179). This thesis uses ethnographic methods to investigate how AHRC’s SSP may be developed or expanded, and then proposes research-informed suggestions for the implementation of programmatic developments.

This research project is based on the anthropological praxis paradigm that constitutes “partnered, ethnographic, community-based, ethically sound research” (Kozaitis 1997: 2000; 2013a: 134). This ethnographic study is partnered in collaboration with community members who are stakeholders in AHRC’s SSP, namely its staff, volunteers, and clients. It is ethically-sound in that it aims to not only avoid harm but to “do good” for the community (Fluehr-Lobban 2013). Therefore, planned action from this project has the goal of bringing about positive change informed by anthropological praxis theory and research strategies (Kozaitis 2013a). Application of anthropological praxis principles and methods inform planned change to improve conditions for stakeholders in this local SSP.

A praxis framework informs anthropological work that counteracts systems of oppression which limit drug users’ access to adequate health care. Anthropological praxis guides and produces counter-hegemonic realities. My thesis is thus praxis work because it empowers PWID and healthcare workers’ ideas. Furthermore, one goal of this project is “to return decision making, based on theoretical knowledge, to the community instead of conceding this task to the

expert” (Warry 1992:157). My praxis research with a local SSP contributes to building a more just health care model and reveals new ways to expand services for a marginalized community. Incorporating praxis principles into this program evaluation assists in measuring efficacy and ultimately implementing a more effective SSP in Atlanta.

The anthropological praxis framework acts as a guide in this work to develop a program evaluation of AHRC’s SSP. Program evaluations require the examination of all factors affecting the outcome of the program, and context must be considered (Britan 1978). Anthropologist Alexander Ervin describes how a program evaluation is a tool for researchers to document the ways in which any given program is effectively meeting its goals, or not (2008). Program evaluations are beneficial to organizations because they can validate the ways in which they are successfully achieving their mission, and are often used to justify requests for funding and program development. This program evaluation specifically examines a local SSP to demonstrate ethnographically its value as a public health resource for drug users who have been historically marginalized by the U.S. health care system.

This type of program evaluation is defined by David Fetterman (2019) as an empowerment evaluation. He describes how this type of evaluation focuses on problem solving in order to ultimately improve the performance and productivity of the program. A critical aspect of this method, he includes, is that the evaluation is “controlled by program staff, participants and community members” (Fetterman 2019: 138). Likewise, this thesis employs those evaluation techniques by placing stakeholders as the source of data from which suggestion for change may develop. This research design is also guided by Ervin’s suggestion for a collaborative approach in program evaluations in order to enhance the applicability and relevance of research findings to the stakeholders of the community (2008). My role is therefore to synthesize the ideas of

participants, analyze those findings, and then utilize them to inform recommendations for implementing planned change and program development.



### **3 A BRIEF HISTORY OF SYRINGE EXCHANGE IN THE U.S.**

#### **3.1 Harm Reduction for People Who Inject Drugs (PWID)**

Harm reduction for PWID gained popularity after AIDS became a well-established public health crisis in the U.S. The goal of harm reduction programs is to not necessitate recovery, but rather to work one-on-one with individuals to achieve the goals they set for the trajectory of their drug use and treatment. Public health professionals Richard Pates and Diane Riley suggest that, “If harm reduction programmes fail to take all reasonable and available opportunities to connect the population with whom they work with recovery-oriented services from which those same people are likely to benefit, they are squandering opportunities to reduce harm” (2012: 166). In order to ensure they effectively assist clients who express a willingness to detox or go through recovery, harm reduction organizations work with each client independently to create a treatment plan that is most appropriate for their needs. They may refer clients to a variety of services such as medical testing and treatment or counseling.

Two public health interventions in the early 2000’s report on groups of PWUD who engage in harm reduction work: Curtis (2004) examines different organizations of PWUD around the world, beginning in the Netherlands, and Kerr et al. (2006) provide a case study of the Vancouver Area Network of Drug Users (VANDU). Both publications highlight the importance of centering PWUD as agents of change, which reflects a core principle of anthropological praxis, by revealing how stakeholders’ ideas about harm reduction are critical to developing effective public health programs. This research supports the idea that harm reduction efforts are most effective when they are developed in collaboration with PWUD. Similarly, but more generally, I join these authors in arguing that health care systems work better when they are based on the goals and needs of the population in focus.

The ethnographic research and subsequent publications of anthropologist Phillippe Bourgois reveals how the marginal status of PWUD is perpetuated by historical and structural forces (2004; 2009; 2010). The rich ethnography presented by Bourgois and Jeff Schonberg in *Righteous Dopefiend*, based on over 10 years of immersive fieldwork, provides readers with a look into the raw human experience of being a homeless heroin addict in San Francisco. This work reveals the need for a restructuring of health care for the most oppressed populations, and in this case homeless PWID. However, Bourgois is critical of harm reduction. He points out how such efforts are “hegemonized by a naïve conviction that democratic access to ‘objective knowledge’ will drive conscious individual behaviour change, one person at a time, on a population level” (2018: 3). It is dangerous to think of harm reduction efforts as the answer to the health problems that threaten populations of PWUD. Harm reduction discourse has a neoliberal tendency as it expects PWUD to eliminate their individual risky behaviors. Furthermore, it does not necessarily address how the medical oppression of marginalized communities is deeply structural and requires a societal restructuring, not just changes in the behaviors of individuals.

Although harm reduction is a progressive replacement for the dominant abstinence and criminalization paradigm, Nancy Campbell and Susan Shaw similarly argue that within the emergence of harm reduction, “the moral value associated with abstinence under the War on Drugs is fast replaced by a neoliberal emphasis on individual responsibility for health and HIV prevention” (2008: 705). Within the harm reduction framework, neoliberalism plays a role in the way individuals are expected to make changes to their personal risk behaviors as a result of receiving public health interventions and resources. Anthropologist Denielle Elliott’s research at a safe injection site in Vancouver further reveals that even within the progressive frameworks of harm reduction, public health programs are increasingly reliant on “the responsabilization of

citizens” (2014: 10). As the health care system depends on NGOs, religious organizations, research institutes, and private organizations to care for patients, there is an increasing focus on self-care to fix structural problems. Despite these valid criticisms, this thesis provides evidence that builds upon an expanding body of research revealing how harm reduction services have been vital to helping PWUD remain safe on a daily basis.

### **3.2 The Emergence of Syringe Services Programs (SSPs) in the U.S.**

SSPs were formed in different parts of the world alongside harm reduction discourse in the 1980s. By the end of the 1980s and into the 1990s, Hawaii, Connecticut, and Washington took the lead among the first state endorsed SSPs in the U.S. (CDC 1995; National Research Council and Institute of Medicine 1994). At this time, such services were already established in Australia, Canada, the Netherlands, and the United Kingdom. It is important to recognize that non-governmental organizations (NGOs) formed the first SSPs in the U.S. when they discovered a need in their community and therefore took it upon themselves to provide better health care services among suffering communities of PWID. The harm reduction agency on which this thesis research is based is one example of a non-profit group that began because of the efforts of a few compassionate individuals. The CDC now recommends the implementation of SSPs throughout the nation and acknowledges the associated public health benefits among PWID. The federal government now provides grants to SSPs for some resources like Narcan but will not fund the purchase of syringes. SSPs throughout the nation rely on private funding and donations to get syringes, and it is up to state and local governments to approve the development of a program. Most U.S. states now have state sanctioned SSPs, and informal needle exchange services still exist in other areas throughout the country.

Singer et al. (1991) provide a foundational anthropological analysis of SSPs at the turn of the century as a strategy to prevent HIV/AIDS from spreading among injection drug users. Their findings are consistent with other scholars in medicine at the time. In fact, SSPs have not increased the use of injection drugs among the local community and have resulted in connections to treatment and decreases in risk behavior (Singer et al. 1991; Des Jarlais and Friedman 1992). This evidence shows that SSPs do not encourage the presence of drugs in the community. Singer et al. (1991) further advocate that SSPs should be connected to other intervention services and call for increased federal and state support. Des Jarlais and Friedman's (1992) analysis of SSP case studies around the world reveals that the results consistently show a significant decrease in HIV/AIDS risk behavior when PWID had access to safe equipment. Their research has supported the growth of SSPs that the U.S. has experienced in the 21st century.

In 1997, Singer and colleagues published research findings about changes in drug users' risk behaviors before and after having legal access to sterile injection equipment due to legislative changes in Hartford, Connecticut. Participants reportedly began using sterile syringes when they became easily available to them. Furthermore, they found decreased numbers of individuals infected with HIV among those who reported using a newly accessible SSP or sterile syringes from the pharmacy (Singer et al. 1997). Expanding on the foundational examinations of SSPs, this research reveals positive changes in health outcomes of PWID in a case study.

In the late 1990s anthropologist J. Bryan Page contributed a review of SSPs that reveals the opposition that such programs faced in gaining a foothold in the U.S. both politically and socially. Community hesitancy, he argues, is the largest factor contributing to the struggle to expand SSPs in local contexts (Page 1997). He advocates for increased and improved ethnographic research to evaluate SSPs effects on risk behaviors, and identifies the importance of

having a clear understanding of the community's needs in order to plan a successful and coordinated intervention (Page 1997). Shortly after this publication, a PhD candidate in Urban Health at the time, Ricky Bluthenthal (1998), writes about SSPs as a social movement growing alongside aspects of harm reduction. Through this social movement perspective, he acknowledges the widespread stigmatization of drug use, and demonstrates how this context makes SSPs “novel because they advocate for services for IDUs [injection drug users] based on the expressed needs of the IDUs themselves” (1161). Both Page and Bluthenthal at the turn of the 21st century acknowledge the need for community support, and ultimately a social movement, throughout the U.S. to continue the effort of SSPs to prevent infections and other harms among PWID.

To examine the efficacy of SSPs in a large U.S. city, a public health team conducted ethnographic interviews among participants of SSPs in three Chicago neighborhoods to examine their changes in injection practices and settings before and after legal, sterile syringes became available to them (Strenski et al. 2000). The researchers find several positive changes: the location in which users inject shifted away from large shooting galleries into smaller and safer places of residence; the increased endorsement of harm reduction practices by shooting gallery operators; increased secondary distribution of sterile syringes throughout the community; and a more widespread practice of using sterile syringes, not sharing, and returning used syringes back to the SSP. These data are used to recommend an increase in “already existing street-based outreach” (Strenski et al. 2000:434). They also suggest further dissemination of harm reduction information to groups of PWID and the reduction of barriers in getting to the exchange.

Anthropologists Merrill Singer and Susan Shaw (2003) reviewed the struggle to develop and maintain community support for a SSP throughout Massachusetts at the turn of the century.

Shaw (2006) later produced an even more localized analysis of this phenomenon in Springfield, Massachusetts. They use their ethnographic findings to argue that political figureheads must be well convinced of the program's feasibility in order to show support because, due to the U.S. War on Drugs framework, there is a widespread fear of ostracism for supporting programs that aim to improve the lives of PWUD and that does not include abstinence or criminalization. If the community does not support the program or has a problem with it, it will not last. Due to the stigma of PWUD in the U.S., Singer and Shaw demonstrate how critical it is to ensure that the community understands the validity and importance of SSPs before trying to implement a local program (2003).

Singer et al. (2005) published lessons learned from their research on syringe access, use, and discard among illicit drug users in three moderate-sized New England cities. The six lessons include the following: targeting local social contexts; developing ethnically targeted prevention models; assessing local barriers to risk reduction; using research as a source of new intervention approaches; developing local databases; and using research findings as a tool of advocacy to address contemporary public issues. Praxis principles are highlighted in the authors' conclusions, such as the necessity of including all stakeholders, most importantly the primary beneficiaries of these practices. The participation of members of the affected community and their stakeholders in each stage of the research process ensures the effective translation and application of findings into planned changes designed to benefit the local community.

A meta-analysis of primary research articles about SSPs and the associated risk of HIV transmission reveals the need to expand SSPs as well as other harm reduction interventions to combat HIV (Aspinall et al. 2014). The U.S. is relatively behind other countries throughout the world, and particularly in the Global North, in providing these services to PWUD. Surveys with

SSP directors in the U.S. reveal unequal access to such programs among rural and suburban communities (Des Jarlais et al. 2015). In order to provide syringe exchange and harm reduction more effectively, Des Jarlais et al. argue that the U.S. needs “(i) an increased and stable source of funding for the programs and (ii) a national plan for addressing HIV and other health problems among injecting and non-injecting drug users” (2009: 1445). These articles provide supportive evidence that SSPs have been effective at reducing HIV transmission among PWID and, therefore, call for structural change in the U.S. to support the development of harm reduction services.

There is a lack of literature on SSPs in southeastern U.S. cities and in Georgia. This program evaluation of a SSP in Atlanta, Georgia, helps close this gap. The focus of my research contributes to the literature on harm reduction and highlights the need for SSPs as a strategy to reduce HIV transmission and other harms. Additionally, literature on the importance of community and stakeholder involvement throughout the entire research process, both core principles and methods of anthropological praxis, shapes this ethnographic study. Using AHRC client, staff, and volunteer voices to identify program strengths and areas for improvement, my praxis project implements data-driven recommendations for the development of SSPs in Atlanta based off of literature and ethnographic analysis.

## 4 RESEARCH METHODOLOGY

### 4.1 Research Setting

The syringe exchange, often referred to by staff as *outreach*, occurs three times a week. On Mondays and Thursdays, outreach operates in a neighborhood called the Bluff from 1:30 to 3:00 p.m. Located in the Bankhead area of Atlanta just one mile from the \$1.5 billion Mercedes Benz Stadium, the Bluff is infamous for its abundance of illegal drugs and crime. There is a popular movie called *Snow on tha Bluff* which is based off of the life of a drug dealer and robber from the neighborhood, Curtis Snow, who is also the starring actor in the film. My participants confirmed that the film is quite an accurate description of life in the Bluff. One staff member says that “Bluff” stands for “Better leave you fucking fool.” Clearly, the Bluff has a reputation as a dangerous area riddled with drugs and crime.

Despite popular dialogue about the community, the little corner on which the Atlanta syringe exchange operates feels quaint and heartwarming. It is located outside, on the corner of two streets in a residential neighborhood, and next to a public garden whose owner has approved the syringe exchange's operation there. Each Monday and Thursday afternoon, the staff members drive the company van to the site and set up folding chairs and tables, and then bring out the resources available for clients. As heroin users intermittently arrive to exchange out their used injection equipment for new, sterile needles and acquire other harm reduction resources, they often express gratitude for the life-saving support that they receive, as well as the kind and welcoming environment that staff provide at outreach.

During one of my visits to outreach, a soft spoken and friendly black woman walked up to the syringe exchange wearing a blush-colored dress and a shawl with matching sandals. She warmly exchanged hellos with all the staff and volunteers, who all know her or at least recognize



her. She regularly attends outreach to drop off the syringes she has already used to inject herself with heroin. On this day, the staff member who collected needles in the biohazard waste bucket teased her about how she never has her works ready, as she pulled a liter of soda out of her small drawstring bag and dug at the bottom to find the syringes. She defended herself saying she had to rush out of the house because she almost missed the MARTA bus, Atlanta's public transportation system, which dropped her off right down the road from the site. After receiving sterile syringes in exchange for her used ones, the client stepped over to the next volunteer to get some free condoms. She explains how she always needs them for her job. After a pleasant and quick transaction, she said her goodbyes and walked back towards the bus stop. This scene reveals the regularity, simplicity, and ease with which clients receive essential health care resources at outreach.

On Sundays from 11:00 a.m. to 12:30 p.m., staff members set up their outreach site in another neighborhood that has high rates of injection drug use, called Little Five Points. The same set up occurs here; however, rather than being in a residential neighborhood, this site was situated in front of a row of businesses and restaurants in a busy, commercial section of the city. There are several outside vendors also lined down the sidewalk. However, towards the end of 2020, the police raided the site and asked them to move because they supposedly did not have the necessary approval to be there. The site was moved to a nearby parking lot, which is much more hidden than the previous spot.

## **4.2 Data Collection Methods**

This ethnographic study consists of qualitative fieldwork methods, including participant observation and semi-structured interviews. These methods rely on praxis principles to document participants' experiences, ideas, and needs related to risk reduction as practiced by this Atlanta

agency. Analysis of ethnographic data informs the evaluation of this program and informs recommendations for further developments and improvements in the delivery of services.

#### ***4.2.1 Participant Observation***

In February 2020 I attended the harm reduction agency's volunteer orientation and began regularly volunteering with their outreach program until February 2021. This yearlong field research, intentionally designed as participant observation, provided a substantial amount of data to this thesis. I participate in several different tasks at the syringe exchange. My job of the day depends on what help the staff needed. Some days were busier than others, and active participation took the forefront to attentive observation and note taking. When the pace of the SSP was slower, I was able to focus more on observation and jot down fieldnotes on my phone. Anthropologists have recognized this precarious nature of doing both participation and observation. For example, Spradley (1980) suggests that a spectrum ranging from nonparticipation, moderate participation, active participation, and complete participation describes the continuum of how participant observation may be enacted. To expand on this point, Kathleen Musante supports the idea that "there is no absolute right way to balance participation and observation" (2014: 248). Remaining cognizant of the degree of participation and observation appropriate in my research was essential to my commitment to the agency as a volunteer first, and researcher second.

The majority of my volunteer time was in the Bluff, with three days of fieldwork in Little Five Points. Each day that I attended outreach, I wrote very quick raw fieldnotes on my phone using the Notes app. I typically made a list of data points, like quotes from conversations, questions I had, new insights that I learned that day, or events that stood out. These fieldnotes were elaborated on when I got home later in the day to include more detail and interpretation. I

used Microsoft Word for quick typing and easy coding. These notes are a significant source of qualitative primary data on the cultural aspects of the syringe exchange at both sites.

#### **4.2.2 Interviews**

In addition to participant observation, interviews with AHRC staff members and volunteers serve as a primary source of data for this research project. These semi-structured interviews are led by an interview guide (See Appendix A) aimed at discovering staff and volunteers' ideas about the outreach program's strengths as well as areas for development. I used the same interview guide for all interviews in order to "increase the likelihood that all topics will be covered in each interview in more or less the same way" (DeWalt and Dewalt 2002: 122). Interview questions were open-ended as to avoid prompting specific answers, to provide focus on an explanatory investigation, and to allow for free-flowing conversation (LeCompte and Schensul 2010). A total of five interviews took place. Participants include one former volunteer, one current volunteer, and three staff members.

#### **4.3 Data Analysis**

Fieldnotes as well as interview transcripts were uploaded to the qualitative database, NVivo. All data were coded to find emergent themes among participants' thoughts, experiences, and ideas. These themes inspire the ethnographic analysis that is presented in the following sections of this thesis.

#### **4.4 Ethical Considerations**

This research was approved by Georgia State University's Institutional Review Board (IRB) in July 2020 (See Appendix B). All interview participants were provided with a consent form, outlining the conditions of their involvement in the project (See Appendix B). Each participant gave their informed consent by reviewing the information and signing the form

before participating in the study. Additionally, I made sure to verbally review the consent form with every participant before starting the interview. All participants' real names are replaced with pseudonyms throughout this thesis, and all identifying information has been removed in order to protect the anonymity of all involved.

#### **4.5 Limitations**

I want to briefly expand on the interruption of AHRC's operations, as well as my research plans, due to the COVID-19 pandemic. Outreach was forced to stop operating, and, therefore, participant observation was prohibited beginning the third week of March 2020. The syringe exchange opened again with limited hours on April 11, 2020 and operated for half of the time they worked before the pandemic. Furthermore, the director of AHRC suggested that outreach remain a staff-only operation during that time as to limit the extent of human interaction. I secured IRB approval during this time. My research was put on hold until July 2020 when a staff member reached out to me and said that the agency could use some extra help. I attended outreach intermittently since then, following CDC recommendations and AHRC protocol to protect against the coronavirus. The outreach staff finally returned to their full schedule in the middle of September 2020. Announcements on AHRC's Facebook page kept all of the platform's followers, including myself, up to date with these adjustments.

In addition to the pandemic's interruptions on my field research, it also forced cancellation of my plans to volunteer at the Southern Harm Reduction Conference. AHRC organized the annual event this year, which was originally scheduled for March 26-28, 2020. Instead, it was postponed for a while, and then eventually cancelled and transformed into a virtual event that went live August 27-29, 2020. One perk of this happenstance is that the conference was recorded and is still available online. The conditions of the pandemic also

limited my interview plans due to lack of access for several months to those involved in the SSP. Furthermore, all communication shifted to virtual platforms, invitations got lost in an unread or ignored email, and people had significant new stresses and other personal constraints.

## 5 ETHNOGRAPHIC ANALYSIS OF HARM REDUCTION APPLICATIONS

The main page on AHRC's website lists the agency's vision of "a world where all people are accepted, valued, and have access to healthcare and support that leads to a fulfilling life." This vision reflects the critical medical anthropology framework which acknowledges that marginalized communities, and in this case PWUD, have unequal access to healthcare, and therefore specialized support is needed to combat these injustices. Also listed on their website's main page is the mantra, "Meeting people where they are," which I have also heard consistently throughout my volunteer experience. Ethnographic data reveals how AHRC consistently practices this mission with clients.

When I asked a staff member and one of my interviewees, Tristan, what harm reduction means to him, he quickly replied, "To help people where they at," reflecting the mantra posted on the agency's website. During this interview, I also naively asked if, in his experience, he has noticed clients stop sharing syringes all together, and he replied:

You meet 'em where they at. So, wherever they at, that's where you meet 'em at. Some of 'em stop. Some don't, some just keep going. But they come because they know they gettin' clean needles. That's what we there for to help 'em get clean needles. You know, we there to help them to get help if they need help. But you know?

In response to my abstinence-based question of whether clients quit sharing, Tristan reminded me that AHRC's mission, and his job specifically, is not to judge whether a client has completely quit risky behaviors, but instead to be there to help minimize whatever risks they may be engaged in without our resources. His response also indicates a readiness to connect the clients to further help if they ask for it. Most importantly, his job is to meet the clients where they are, that is, focus on meeting their needs and wants at the time of service, not to aim at completely eradicating risky behaviors.

Before I had any interviews or even attended outreach for the first time, I was introduced to the idea of “meeting people where they are” at the agency’s orientation for volunteers. The staff member who led the orientation was involved in the formation of AHRC and thus is well-versed about the program and highly knowledgeable about harm reduction work. They made it clear to those of us who attended the orientation that our role as volunteers for the harm reduction agency is not to tell people what to do, but rather to start by asking what we can do to help. She handed out a sheet of paper that references harm reduction worker Edith Springer (1996) and outlines best practices for harm reduction workers. Important suggestions include acknowledging that their role is not to “fix” anybody, and to understand that “usually long-lasting changes are achieved through incremental baby steps.” Furthermore, it recommends “concentrated listening,” which is not neutral, but rather active, positive, caring, and ultimately healing for the participant (Springer 1996). This explanation guides AHRC’s definition and application of harm reduction.

These principles were echoed at the 2020 Southern Harm Reduction Conference in a presentation by an AHRC staff member titled “The Role of Peers in Harm Reduction.” The speaker advises harm reduction workers to not try to fix anyone, but instead to be a cheerleader. She encourages them to always praise and reward the people they serve, and to consider that they could be future employees who continue the important harm reduction work within their community. She believes that empowering peers in this way, and perhaps putting them in charge of something, provides them with opportunities as well as hope for upward mobility. Most importantly, she emphasized that harm reductionists should “act like a respectful, dignified guest” (Bennett 2020). In other words, enter the field with respect and a curiosity to learn from the people you serve. This, she says, is an essential attitude to have in harm reduction work.

An interviewee who is a former AHRC volunteer, Ellen, indicated that harm reduction can express itself in a variety of ways. Its relevance to SSPs, as discussed above, are to reduce HIV transmission and other infections. However, harm reduction in practice is understood more broadly and exists in many ways. Ellen described it well in reference to her first job at a SSP in California:

From my perspective and [the director of homeless healthcare's] perspective it was like, just getting someone who's a part of this extremely marginalized population to come inside for a couple hours is harm reduction, because being on the sidewalk out here all day, like, you're at risk of lots of things.

Harm reduction from this perspective takes the form of providing a safe and comfortable social space. AHRC has a similar view, as their SSP takes the opportunity to provide relief from as many harms as they can with what resources they have available.

The van that drives all of the staff and volunteers to outreach is always stuffed full of necessary resources. In addition to addressing the harms associated with the exchange of syringes, all of the resources the van brings to outreach also ameliorate harms like overdose, unprotected sex, the sharing of other injection supplies like cottons and cookers, and hunger and thirst. When it is cold, the outreach team has brought knit hats to combat the harm of having inadequate clothing in bad weather conditions. At the feet of those sitting in the middle row of the AHRC van sits a big orange hazardous waste bucket where clients' used syringes are collected, a tote bag full of Narcan kits and condoms, a trash bag full of safety kits, another trash bag full of lunch/snack bags, clipboards, and personal belongings. The trunk of the van is also full, with a fold-out table, chairs, a big water cooler, and other items that we may need and have room for that day.

On one very rainy day with a packed AHRC van, several staff members and I rearranged



seats in order to give one client a ride from the office to the site in the Bluff. It is only about a 5-minute drive. An excerpt from my fieldnotes describes the encounter, which reflects a typical interaction between a staff member and client:

The woman was very nice and apologized way too many times to everyone. To Robert, [the driver], Tristan, who gave up his seat and moved to the back, and everybody else in the van who she felt had accommodated her. It was very sweet, and I was blown away by how grateful and appreciative she was. Robert told the client a couple of times, "It's OK, that's what we do, we help each other out."

This interaction may be considered harm reduction in practice because when they were able, the outreach team did what they could to help the woman avoid walking in the rain alone in the Bluff. A key practice that AHRC staff and volunteers follow, and that this incident highlights, is demonstrating dignity and respect. Research supports the concept that treating drug users with attitudes of dignity and respect is critical within a harm reduction framework, as well as in medical systems more generally, to build towards a better health-care system in the U.S. (Des Jarlais et al. 2009). This principle was introduced to me on the first day that I visited AHRC for the volunteer orientation and continues to present itself in situations like the staff and client encounter described above.

## 6 STRENGTHS OF THE PROGRAM

### 6.1 Community

Building rapport with research informants is critical for ethnographic projects in order to develop trust and ensure engaged participation in the project (Spradley 1979; Musante 2014). It was refreshing to see these principles also valued by the agency staff, all of whom have a well-established rapport within the community. Some of my research participants have admitted to drug use before their involvement with this syringe exchange, and some have been doing harm reduction work for decades in the local community. All of them, even those who are new, or from an outside community, practice dignity and respect in order to build rapport, trust, and relationships with clients. One day at outreach, Robert, a staff member, repeated, “We need to take care of our people,” demonstrating how the people they serve are treated as friends and neighbors first, rather than as clients. Accordingly, all those who work at the syringe exchange are encouraged to view clients as “our people.”

An interviewee and former AHRC volunteer, Hailey, feels that one reason this syringe exchange has been more successful than others that she has been involved with across the country is that many of the staff are “literally a part of the community.” She continued,

It's not like this dichotomy of— if that's the right word— of people being like, oh we're like these professional people and we come from the suburbs and we come in here and we try to tell you what you need or whatever, which doesn't work for a few reasons. But it's people who are literally like, no, I live here, these are my neighbors, I know what people need, or I'm a user myself and so I have an opinion on this.

Additional ethnographic data collected for this thesis backs up Hailey's statement. Three individuals who are either a staff member or volunteer with outreach have confessed to me at different times that they were once a PWUD themselves. When asked how they would describe their relationship with clients, one interviewee said this:

I would like to think that because of my experience of having been an addict, having been on the streets, having been to jail, like I've been through some shit. Not as much as a lot of the people that I see, but I would like to think that because of those things I'm more able to relate to people and better able to support them because I'm not coming from a judgmental place. And I really genuinely look forward to seeing people, like the people that I know that I see every week. I look forward to coming and being like you know, how was your week? How are you feeling today? I genuinely care.

These two revelations by study participants indicate how a model of care in which the hierarchy between service provider and client is less obvious and instead mutual respect is free flowing. This framework of egalitarian interactions, as practiced by local syringe exchange workers, is a successful alternative for treatment than the usual structure of Western medical treatment centers. A master's thesis by Heather Henderson (2018) at the University of South Florida provides an ethnographic account of stigmatizing experiences that drug users face in a hospital's emergency care. Her research participants described "a combination of feeling shame for their addiction and not feeling worthy of care due to stigmatized experience in acute care settings," as the leading concern with seeking emergency care (Henderson 2018: 65). This dominant model of health care for PWUD in the U.S. is shifted in the field of harm reduction, as respect is a core principle.

According to a staff member, Riley, another important method that AHRC practices to stay connected to the community is to "listen to the people you serve." She continues to explain this theory:

Because you know since I don't inject, I'm not an expert. But I serve the expert, so I should be listening to the experts. And I do. And that's when we started listening to the people we serve, like, to make the program decisions, because it's not a good program if it's not useful to anyone we serve.

In other words, their program is designed to benefit the community first. Riley's method aligns with the praxis paradigm in that her method of care is centered on what the stakeholders in the program, and principally the clients, need and want. The importance of these praxis principles

was also emphasized by an AHRC staff member at the 2020 Southern Harm Reduction Conference, whose presentation was titled “The Role of Peers in Harm Reduction.” She defines *peers* as the people whom they serve, “those who have substance use experience, the true experts in our harm reduction program” (Bennett 2020). This dialogue rejects a top-down approach to health care and instead highlights the critical insider knowledge that PWUD have. She encourages harm reductionists to keep asking questions, to learn the language of the people they serve, to be interested in the people and the community, and to “keep being a student” (Bennett 2020). This reflects anthropological praxis in that it centers program participants’ knowledge as the point of reference for how to make the program as effective as possible for those who utilize it. Biomedical systems of care do not follow this same design, as profit and income are central to the function of that structure. On the contrary, syringe exchange programs respect and listen to the people they serve and then provide care based off of those expressions.

## **6.2 Cultural Congeniality**

A former AHRC volunteer who later worked with harm reduction agencies in California provided insight into an essential characteristic for SSPs during her interview. Ellen told a story of how one “authoritative and kind of verbally aggressive” staff member left the team, and those who remained “changed a lot of things around to make it more welcoming, more low-barrier, more inclusive.” For example, that former staff member used to keep the front door to the agency’s office locked at all times, but the new team removed it to make clients feel more welcome and make the space more inviting. While clients were less inclined to hang around the agency while the environment was more exclusive, she explained that there was a significant shift once that staff member left, and clients were able to feel more comfortable.

When I started volunteering at AHRC in February 2020, the office felt small and was

dimly lit, but it was often crowded and lively. The agency renovated the office towards the end of that year, making it brighter and tidier. Clients appear to be comfortable there, and many decide to become volunteers themselves. The money that is spent to make the office look nice is certainly not the main factor in making clients feel welcomed, however. Rather, the office's location in the Bluff, where drug use is most prevalent in the city, makes it accessible to those who need harm reduction services the most. A staff member emphasized the importance of site location in a presentation at the 2020 Southern Harm Reduction Conference when she encouraged harm reduction workers to consider, "Are you on their turf? You should be" (Bennett 2020). AHRC's outreach site locations resemble this sentiment as they have shifted over time to follow where the drug using community is centered. Furthermore, the agency's insistence on being led by community members and people who can empathize with those use drugs makes the environment less hierarchical than biomedical health care practices that center around the stratified doctor-patient relationship. Lastly, the practice of dignity and respect is a vital contribution to the welcoming feeling one gets at AHRC.

### **6.3 Not Just A Syringe Exchange**

Today, the Centers for Disease Control and Prevention (CDC) recommends the implementation of SSPs such that "they provide access to sterile syringes and should also provide comprehensive services, including help with stopping substance misuse; testing and linkage to treatment for HIV, hepatitis B and hepatitis C; education on what to do for an overdose; and other prevention services" (CDC 2016). In alignment with these guidelines, the SSP at AHRC is not just a place to exchange syringes; it is also a place for people to get water, snacks, a hat on a cold day, condoms to prevent sexually transmitted infections, and Narcan to

protect against opioid overdose deaths. The comprehensive services provided in this SSP reflect the CDC's recommendation for such programs to provide a range of health services.

As a harm reduction agency, and in addition to the SSP, AHRC has a plethora of other programs that seek to diminish harmful behaviors associated with drug use. The Connection to Care Clinic (C3), the Linkage to Care program, and Direct Client Services each provide assistance and intervention based on individual needs, including testing at the agency and referral to outside services. The pre-exposure prophylaxis (PrEP) program provides a medication that is 90 percent effective at combating HIV when used daily and with condoms. The need to protect sex workers from harms they are particularly at risk for led the agency to form a program called K.I.S.S (Keep Individual Sex Workers Safe). Another program called Mothers on the Move is designed to provide assistance to single mothers via education, counseling, and assistance. Job readiness, training services, and legal aid are all available as well. The Healthy Meal Initiative is a program connected with the Atlanta Food Bank that works to combat the harm of hunger. Depending on a client's short-term and long-term goals regarding their drug use, they also have access to Harm Reduction Therapy services or Prevention services. All of the above programs are free of charge for AHRC clients. Furthermore, AHRC has a research team which explores avenues for further program development. For example, one project surveyed clients about their thoughts about the potential of adding a health care service in which they may be prescribed Suboxone for medicated assisted therapy treatment

Another impactful sector of work within the agency is its policy program, which works to advocate for changes in legislation to better accommodate improvements in health care for PWUD based on harm reduction principles. AHRC's efforts to improve public policy has made substantial impacts for Georgia state residents. One such story was told in a presentation at the

virtual 2020 Southern Harm Reduction Conference titled “Overdose Prevention in Georgia.” The panelists explained that in August 2012, a group of six individuals met in Piedmont Park to discuss taking action to propose a bill designed to protect people from getting into legal trouble when seeking medical attention in overdose situations (Elliott et al. 2020). One of AHRC’s founders was an individual who met that day and was a speaker in this presentation. Some of the other individuals involved in this meeting were parents who had lost a child to overdose and were thus motivated to prevent others from going through the same loss. This meeting and the group’s shared goals resulted in the formation of a volunteer organization called Georgia Overdose Prevention (GOP), which remains close partners with AHRC. In April 2014, the efforts of this small group resulted in the passing of Georgia’s 9-1-1 Medical Amnesty Law. Within the state, people are now able to seek medical attention when one is experiencing a drug or alcohol-related overdose without being at risk of punitive legal repercussions. This is only one significant example in which AHRC has made substantial advancements in public policy regarding better health care for drug users.

### ***6.3.1 Naloxone***

One of the most essential life-saving resources provided to clients at outreach is a medicine called naloxone. It is used in emergency situations to save someone who is overdosing from an opioid. During AHRC’s volunteer orientation, the leading staff member pulled out samples of naloxone and explained how it works. Essentially, the medicine attaches to the brain’s opioid receptors and blocks the drug from working to its full strength and killing the person. The CDC recommends the widespread distribution of naloxone in order to combat high rates of opioid overdoses throughout the country (CDC 2019). In understanding the importance of this initiative, AHRC teams up with an organization called Georgia Overdose Prevention to

distribute the medicine, as well as to educate people about its life-saving effects and how to use it. During an interview, Riley described a few examples of how they do this:

We trained a group of tattooists, a group of tattoo and piercing artists, and I know there have been documented reversals from that distribution so... we're all over state. Also, we're making sure that methadone clinics get— clients get the naloxone in some form. I believe they get the lot. I know that's especially going on in North Georgia, near the Tennessee and North Carolina borders. Yeah, we're just trying to get it out everywhere and educate people about overdose reversals and how to use Narcan and don't run, call 911, all that good stuff.

Riley has seen the distribution of naloxone transform over time and has played a significant role in ensuring its expansion.

During the interview, Riley also informed me that AHRC has access to naloxone because of a grant they were awarded. They now carry two forms of the medicine: one comes as a filled syringe that is injected into the muscle, and the other is a nasal spray, often referred to by its brand name, Narcan. Riley explained that there is an individual who works at a pharmacy in Little Five Points who “stocks nasal Narcan that he gives out for free to anyone in the community who requests it because there were a lot of opioid overdoses going on in Little Five Points.” She said that the pharmacy staff have reversed about seven and likely more overdoses since AHRC has started to provide them with Narcan.

One interviewee, Hailey, who has volunteered at SSPs in three other states, was able to testify that Narcan is more available at AHRC than it was in other places, perhaps because of that grant Riley had mentioned. Furthermore, the volunteer said that when she first got involved with AHRC about four years ago,

We didn't have a ton of Narcan to give out, it was kind of sporadic. And I remember hearing at least two people would die every week. Every week we hear about multiple deaths and then lately like I never hear about people dying anymore. Sometimes I hear about people you know getting shot or something like that, but I almost never hear about people dying of overdose.



I responded by sharing that in my short experience of volunteering at AHRC for less than a year, I have heard few mentions that someone in the community, or their friend or family member, had recently overdosed and died. Instead, I have heard clients report dozens of successful overdose reversals, and thus, lives saved, while distributing Narcan as a volunteer. It is important to note here that the first responders to drug overdoses, and the ones who are saving lives, are also PWUD.

While Hailey and I continued our conversation, we agreed that it is heartbreaking to think about all of the people who would still be alive had Narcan been accessible to them at that time. She pointed out that “it really is life changing to be able to have Narcan and to be able to give it to people so freely.” AHRC reported distributing 10,377 naloxone kits and administering 950 successful overdose reversals in 2019 (AHRC 2019). It is safe to assume that these numbers are lower than the true impact that naloxone has had, because they are based on only those which have been voluntarily reported and recorded.

## 7 RECOMMENDATIONS FOR DEVELOPMENT

### 7.1 Considering How to Reach More People

Atlanta is the most populated city in Georgia, and the 37<sup>th</sup> most populated city in the United States. AHRC is the biggest SSP in Georgia with only a couple of other smaller programs in the state. It surprised me to learn, then, that the office is small and often crowded and the SSP only serves about a 100 people a week. I was unable to obtain records about clients, so this number is an estimate based on my experience in the field. The staff is a small team of dedicated and underpaid individuals, and there are only two sites available through this agency for clients to safely receive sterile syringes and other harm reduction resources vital to their health. A survey of IDUs in Atlanta finds that only 38% of their sample reported using a SSP (The Georgia Department of Public Health 2015). This report does not specify how much those who use an SSP depend on those services, so we cannot be sure that they all attend regularly, or that it is their only source for syringes. Although AHRC's SSP provides life-saving resources in neighborhoods that are very much in-need, this research supports my hypothesis that many PWID (over half) do not have easy access to the two sites that are currently offered.

Several interview participants confirmed that there is a need to establish additional outreach sites in order to reach more people, reflecting a demand for the expansion of SSPs even just within Atlanta. Tristan quickly came up with a list of neighborhoods that would benefit from having a syringe exchange; he noted that, "It's not only in the Bluff and Little Five Points," but also in College Park, Bankhead, Northside Drive, East Point, and Cobb County. On one day of volunteering at outreach, a woman restocking her supply of Narcan mentioned a dire need for a SSP in Lakewood. However, one staff member, Neil, reminded me of an important challenge when considering adding more sites. He reported that about a year ago the outreach site in the

Bluff moved a few streets down from its old location due to rapid gentrification that affected the area. He also said that they lost a lot of clients as a result and it took some time to build back their base. Because the two sites are so connected to the community of users, he warns that the expansion of SSP services might lose touch with those close ties.

In addition to adding more sites, Ellen provided another good idea for how to reach more people. Her first syringe exchange job in California was part of a homeless healthcare program in which she was paid to staff their fixed site three days a week. In addition to her work at the site, she ran a mobile exchange in which PWID could call a number available in a local phone list. The caller would express a need for new syringes, share their preferred meeting location, and then she would drive to deliver the syringes and other harm reduction supplies she had available to the client. Her time was unpaid, although she was compensated for the gas and mileage, and the supplies were provided to her by the agency. Furthermore, when I asked if a team member accompanied her, she replied, “No; I was just by myself like a crazy person [laughing]. Nobody wanted to do it with me!” Although Ellen’s mobile strategy is intriguing, it was only effective because of her personal dedication. For such a program to work at AHRC, it would need people to drive, which means more staff or volunteers, and more funding to compensate for gas, mileage, and of course ideally, time.

## **7.2 Resources**

During my first few months of volunteering at outreach, I only saw the team run out of syringes once at the very end of the shift, so it was not a big problem. At the end of summer 2020, there were a few weeks in which the agency staff noticed that they were running out of syringes, so they were forced to limit the number they gave to each person. Some clients expect to exchange several hundred syringes, so it can be disappointing and a hinderance to using safely

when they are not able to receive an even trade. On July 8, 2020, we were giving out a maximum of 100 syringes per person and putting the rest “on the books.” In other words, we would record how many syringes were owed to the client based off the number of used ones they brought versus the number they were not able to receive in exchange. That way, those who brought more than 100 used syringes would receive the remainder the next time they visited, and supplies were restocked. One staff member explained that they were waiting on a shipment of syringes to come in.

Another discrepancy I observed related to the syringes provided at outreach is the quantity of short vs. long tip needles. A few times throughout my year in the field, AHRC ran out of short tip needles and many clients were disappointed. Only a few clients actually preferred the 1/2cc long tip syringes. Staff members explained that sometimes there is a delay in shipping and there is nothing they can do but wait to receive more. All needles are privately funded by different organizations who are willing to donate. Riley explained that sometimes people will donate the extra syringes that their sick or elderly relative did not end up using. Evidently, syringes come from a variety of sources, so their intake can be inconsistent.

During the outreach session right before Labor Day 2020, when they would not be operating, the supply of syringes was so low that the general rule was to collect 30 from each person and give out 40. This was significant because the first precaution the staff took was to at least collect all of the syringes that clients brought and only limit the number we gave out. But because the supply was getting even tighter, the limitations became strict. Many clients that day were upset and gave a little bit of pushback. One regular client was fairly disappointed even with the negotiation to give him 50, an extra 10, than what was given out to some clients because outreach would not be functioning on Labor Day. He seemed calm but upset, noting that, “It’s a

long way to drive just for 50.” The boss decided to give him an extra 50 in addition to the first 50, presumably because he is a kind and consistent client, and they did have just enough syringes in stock at the time.

In addition to having a scarcity of syringes that day, we also ran out of the citric acid and cottons which normally go in safety kits for those receiving injection equipment. Citric acid is provided to anyone getting syringes because it can be used to dissolve clumps and dilute the heroin. The small cotton rounds act as a filter between the drugs and the syringe. Like the citric acid, a filter acts as a second barrier preventing insoluble particles from getting into the syringe. When the drug is not diluted enough, the user risks inflammation of the vein walls, phlebitis, as well as contracting a lung disease that is common among PWID, talcosis (Keijzer and Imbert 2011). Therefore, AHRC clients who normally depend on those resources to inject safely are more at risk of health complications when they are no longer able to attain them.

Safe injection equipment is not the only discrepancy of resources that has been revealed in my ethnographic data. One interviewee explained that if she could expand any service that outreach provides, it would be to consistently provide a wider variety of food. Although there have always been some snacks to hand out at outreach, Hailey explained that the food is not always good, and “it’s kind of just like whatever we have that week.” She was quick to defend AHRC because it is the lack of available funding which prohibits the agency from extending the provision of food to its clients. However, Hailey expanded on her desire to provide more high-quality foods or snacks to clients:

I don't feel this way from AHRC, but I have definitely worked in places where there's a very big disparity between like the volunteers and the people who access services where it's a very weird and uncomfortable dynamic where it's like “oh these like, you know, poor people, like we're just going to give them scraps and they'll be happy for it,” and it's kind of gross. And I don't think anyone at AHRC feels that way and I've never seen anything like that thankfully, but I always am aware of that. I'm always thinking about

that when I'm giving somebody something that I don't feel good about where I'm like, I wouldn't be happy if somebody gave this to me, and I don't want somebody to be like, "oh you know, I'm poor, I don't have resources, so I'm supposed to just be happy with like whatever garbage they have." That sucks.

Hailey admits here that clients are in need of more substantial foods and it is stigmatizing to only be provided what one can get their hands on, especially when it is low quality or seems like "scraps." Still, AHRC provides whatever food they can by collecting donations and often staff volunteer to make food, like soup or sandwiches. One day in Little Five Points, we had a box filled with different kinds of pita bread. Although most clients were not intrigued, many still decided they could use the food. One day when a staff member brought in soup to give out at outreach, a few clients teased about how it tasted too salty. Regardless, several people asked for seconds and there was certainly none left by the time the staff and volunteers packed up to leave. Clients are generally grateful for whatever they are provided, but it is not uncommon to hear a complaint when the food is not desirable.

### **7.3 Discussion**

The strengths and weaknesses of SSPs highlighted from the ethnographic data analyzed in this paper reveal my recommendations for program development. First, AHRC staff and volunteers, as well as clients during field research, have reported a demand for the expansion of syringe exchange sites throughout Atlanta. They claim that there are many more people in need of the services provided at outreach, but those people are unable to access the two fixed sites established near the downtown area of the city. Second, a more stable supply of resources is necessary for the outreach program to consistently provide clients with the tools they rely on to use drugs safely. Most importantly, grant-writing, fundraising, and other means of securing funding for additional supplies or sites is essential to developing the outreach program.

All of the above suggestions would be made possible with more funding. This situation is political, as the state allocates funding for SSPs; however, such efforts are still highly stigmatized, especially in southern, conservative states like Georgia. Therefore, more research needs to be done that focuses on the multitude of ways in which SSPs secure sources of funding and how this financial support may be expanded.

These recommendations are based upon engaged involvement with the agency for one year, as well as five interviews with stakeholders in the program, highlighting the efficacy of praxis work in developing community-based interventions. Ethnographic data, which feature conversations, feelings, beliefs, experiences, and ideas of research participants, are successful in this thesis at indicating strengths of the program as well as areas for development. These data and my subsequent analysis provide a strong case for the expansion of SSPs in Atlanta and throughout the U.S.

## 8 CONCLUSIONS

Anthropological praxis within the domain of critical medical anthropology is employed in this project to document and to analyze health inequities among drug using populations and to apply these ethnographic insights to improve those conditions. This community-based participatory action research is appropriate to document a problem, the analysis and amelioration of which will help to correct a social order that economic and political forces impose on PWUD, subjecting them to precarious conditions in which their health is at risk. Consistent with praxis theory, intervention is most relevant and, therefore, effective when it is grounded in the community's needs and ideas, which are in turn incorporated in program development. This project privileges the participation and contributions to the study by the stakeholders of the SSP in question, including clients, staff members, and volunteers. Utilizing staff and volunteers as partners in this research endeavor reflects the vitality of anthropological praxis that reflects this work, and which may inform similar studies in harm reduction.

The type of planned change investigated and implemented in this thesis is guided by what Kozaitis refers to as “center-outer reform,” a research and development process in which the targets of change become the core agents of change (Kozaitis 2013b). To ensure that recommendations for program development come from the center, the staff and volunteers who are invested in meeting the needs of the community are the reference point of analysis for this program evaluation. Praxis is effective here in empowering stakeholders to co-produce knowledge that is to inform action, and in insisting on collaboration as a tool to implement collective ideas for planned, culturally competent, and socially affirming reforms to the delivery of services. The change suggested by this program evaluation moves beyond the ethical principle, “do no harm,” and reflects an ethical principle of anthropological praxis—to “do



good.” Furthermore, this research is designed to improve the conditions and services of one harm reduction agency to further ameliorate health inequities among a community of PWID in Atlanta, Georgia.

## APPENDICES

### Appendix A: Interview Guide

1. Can you tell me about your role at AHRC and what your work entails?
2. When did your involvement with AHRC and the SEP begin?
3. What motivated you to get involved in the SEP at AHRC?
4. What does harm reduction mean to you?
5. Can you tell me about funding sources for services provided at the SEP?
6. What supplies are in greatest demand at the SEP?
7. Does the agency run out of supplies? If so, which ones and how often?
8. Are there any supplies or services you feel the SEP lacks?
9. Where are individuals referred if they need help that they can't find at outreach?
10. How did the agency choose its original outreach site?
11. Why is "the Bluff" nicknamed what it is?
12. Can you tell me more about the community in general?
13. When was the second outreach site added in Little Five Points and why there?
14. Are there any other sites you know of in Atlanta that have been, or you believe should be, considered for a SEP? If so, where?
15. If more funding were available, what services do you believe should be prioritized in expansion and based on what evidence?
16. What are relationships between clients and service providers generally like?
17. In what ways do you believe the SEP is shaped by clients' needs and ideas about what services are most helpful? Where do you hear their ideas the most?
18. How would you describe the effectiveness of the SEP?
19. What impacts have you seen the SEP have on the community?
20. What other insights about your work with SEP can you share with me?

## Appendix B: IRB Approval



### INSTITUTIONAL REVIEW BOARD

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58 Edgewood  
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July 17, 2020

Principal Investigator: Kathryn Kozaitis

Key Personnel: Kozaitis, Kathryn; Sarmiento, Megan A

Study Department: Anthropology

Study Title: An Anthropological Program Evaluation of a Syringe Exchange Program in Atlanta, Georgia

Review Type: Expedited Category 6, 7

IRB Number: H20777

Reference Number: 361149

Approval Date: 07/09/2020

Status Check Due By: 07/08/2023

The Georgia State University Institutional Review Board (IRB) reviewed and approved the above referenced study in accordance with 45 CFR 46.111. The IRB has reviewed and approved the study and any informed consent forms, recruitment materials, and other research materials that are marked as approved in the application. The approval period is listed above. Research that has been approved by the IRB may be subject to further appropriate review and approval or disapproval by officials of the Institution.

It is the Principal Investigator's responsibility to ensure that the IRB's requirements as detailed in the Institutional Review Board Policies and Procedures For Faculty, Staff, and Student Researchers (available at [gsu.edu/irb](http://gsu.edu/irb)) are observed, and to ensure that relevant laws and regulations of any jurisdiction where the research takes place are observed in its conduct.

## Appendix C: Consent Form

Georgia State University  
Informed Consent

Title: Program Evaluation of Syringe Exchange in Atlanta  
Principal Investigator: Kathryn A. Kozaitis  
Student Principal Investigator: Megan Sarmento

### **Introduction and Key Information**

You are invited to take part in a research study. It is up to you to decide if you would like to take part in the study.

The purpose of this study is to evaluate the strengths and areas for expansion at the Atlanta Harm Reduction Coalition's syringe exchange program [SEP].

Your role in the study will last between 30 to 90 minutes.

You will be asked to do the following: participate in an interview.

Participating in this study will not expose you to any more risks than you would experience in a typical day.

This study is not designed to benefit you directly. Overall, we hope to gain information about how this SEP is benefitting the Atlanta community and in what ways it may be expanded.

### **Purpose**

The purpose of the study is to evaluate the strengths and areas for expansion at the Atlanta Harm Reduction Coalition's SEP. You are invited to take part in this research study because you are currently or at some point have been a volunteer or staff member at this SEP. No more than 30 people total will be invited to take part in this study.

### **Procedures**

If you decide to take part, you will be asked to participate in an interview with the student PI for 30 to 90 minutes at the Atlanta Harm Reduction Coalition office. You will be asked to answer questions about your experience with the SEP, your views on harm reduction, and your ideas for program expansion. You will be audio-recorded during this study. You will be asked to participate once, but a follow-up interview may be suggested if the discussion is cut short or more questions arise.

### **Future Research**

Researchers will remove information that may identify you and may use your data for future research. If we do this, we will not ask for any additional consent from you.

### **Risks**

In this study, you will not have any more risks than you would in a normal day of life. No injury is expected from this study, but if you believe you have been harmed, contact the research team as soon as possible. Georgia State University and the research team have not set aside funds to compensate for any injury.

### **Benefits**

Version Date: 07-16-20

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