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“We as Drug Addicts Need that Program”: Insight from Rural African American Cocaine Users on Designing a Sexual Risk Reduction Intervention for Their Community

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Abstract

This focused ethnographic study examines data collected in 2007 from four gender- and age-specific focus groups (FGs) ($N = 31$) to inform the development of a sexual risk reduction intervention for African American cocaine users in rural Arkansas. A semi-structured protocol was used to guide audio-recorded FGs. Data were entered into Ethnograph and analyzed using constant comparison and content analysis. Four codes with accompanying factors emerged from the data and revealed recommendations for sexual risk reduction interventions with similar populations. Intervention design implications and challenges, study limitations, and future research are discussed. The study was supported by funds from the National Institute of Nursing Research (P20 NR009006-01) and the National Institute on Drug Abuse (1R01DA024575-01 and F31 DA026286-01).

Keywords

focus group methodology; formative research; community engagement; HIV prevention; rural African Americans; cocaine use

INTRODUCTION

Sexually transmitted infections (STIs) including HIV are disproportionately affecting African American communities, especially in the South. Sixty percent of reported AIDS cases among men in the rural South were African American, and 68% were African American women (Centers for Disease Control and Prevention, 2008). The primary risk factor for HIV transmission among rural African Americans in the South is unprotected sex (Centers for Disease Control and Prevention, 1998, 2007; Fleming, Lansky, Lee, & Nakashima, 2006). Yet, many rural African Americans do not consider themselves at risk

for HIV and see little need to use condoms (Brown & Hill, 2005; Leukefeld et al., 2001; Wright, McSweeney, Frith, Stewart, & Booth, 2009).

Drug use is a major contributing factor to the increased HIV risk for African Americans (Adimora, Schoenbach, & Doherty, 2006; Aral, Adimora, & Fenton, 2008; Farley, 2006; Fleming et al., 2006; Reif, Geonnotti, & Whetten, 2006). Stimulant use, in particular, has been associated with high-risk sexual behaviors such as inconsistent condom use, multiple sexual partners, and trading sex for drugs and money (Wright et al., 2007). Theory-based, culturally-tailored sexual risk reduction (SRR) interventions are needed to effectively address HIV risk in this population. Interventions using community-based participatory research (CBPR) approaches are most helpful in designing culturally appropriate and sustainable programs (Israel, Eng, Schulz, & Parker, 2005). Although calls for more CBPR-based programs exist, drug users are typically passive recipients of a program developed for them, not partners actively engaged in developing the program (White, 2009). In fact, many rural African Americans have expressed reluctance to participate in education programs provided by health care professionals because of stigma (Preston et al., 2004; Wright et al., 2009), suggesting that intervention development must overcome additional social challenges in rural populations.

Most behavioral interventions for HIV/STI prevention among African Americans focus on teaching skills in negotiating safer sexual behaviors with partners, building self-efficacy for condom use in challenging situations, using condoms correctly, or offering safe sex alternatives to condom use (Scott, Gilliam, & Braxton, 2005; Sterk, 2002). However, not all interventions are equally effective. In programs, which are specifically for African Americans, those that use gender- and culture-specific materials have demonstrated greater efficacy. Interventions that are delivered by persons of the same race and gender as the study population and include skills-training and role-playing to teach negotiation skills are more effective (Crepaz et al., 2009). Research also demonstrates the value of peer or community leaders in prevention (Latkin, Sherman, & Knowlton, 2003; Latkin et al., 2009; Weeks et al., 2009). Despite the demonstrated importance of community engagement and participatory approaches to program development, few published studies have described the process of engaging a high-risk community in program development and incorporating community concerns into the resulting intervention.

This manuscript describes our formative research in the development of a SRR intervention for rural Southern African American cocaine users, using a community-engaged approach. Our objectives were to (1) determine the feasibility and acceptability of a SRR intervention for this high-risk population, and (2) identify preferences for intervention content, structure, and activities.

METHODS

Study Context

All focus group (FG) activities took place in the rural Mississippi Delta region of Arkansas. For several years prior to these FGs, one of the authors (Booth, B.M.) led a natural history study of drug use in this region, the Rural Stimulant Study (RSS). The RSS team spent considerable effort establishing study sites that community members perceived as safe and welcoming. Trusting relationships and secure confidential locations were believed to enhance the quality and trustworthiness of the data collected. FGs took place at RSS program offices, which were centrally located, discreetly positioned, and provided easy access for those with and without their own transportation. All study procedures were approved by the University of Arkansas for Medical Sciences' (UAMS) Institutional Review Board.

Sample

Lee and St. Francis counties, two predominantly African American counties in the Arkansas Mississippi Delta, served as the study location for the FGs. Like many rural Southern towns, both counties have suffered due to the loss of agricultural and manufacturing industries, which has led to a lack of economic and educational opportunities, social services, and medical care (Gamm, 2004; Robertson, Sloboda, Boyd, Beatty, & Kozel, 1997). The percentage of individuals living below the poverty line in both counties is twice the national rate (U.S. Census Bureau, 2010) and nearly twice the rate statewide (Arkansas Division of Health, 2010). Only 56% of adults in Lee county and 65% of adults in St. Francis county graduated from high school (U.S. Census Bureau, 2010). The employment rates in these counties are between 42% and 50%, which are far below the national rate of 64% (U.S. Census Bureau, 2010). Likewise, many FG participants report unstable housing, unemployment, and low high school graduation rates (see Table 1).

Many rural counties like Lee and St. Francis counties have also been affected by increases in illegal drugs, which has been associated with concomitant increases in violence, crime, and STIs (Booth, Leukefeld, Falck, Wang, & Carlson, 2006; Thomas, 2006; Thomas & Thomas, 1999). Yet, many of these counties do not have the infrastructure or resources to address these issues (Fluharty, 2002; Gamm, 2004; Reschovsky & Staiti, 2005). Consequently, HIV risk among rural African American cocaine users is greater because they may exchange sex for drugs, money, shelter, or food (Falck, Ashery, Carlson, & Wang, 1995; Probst, Moore, Glover, & Samuels, 2004; Wright et al., 2007). Specifically, in Lee and St. Francis counties, the homicide rates are higher than rates statewide (Arkansas Division of Health, 2010). The rates of Chlamydia, gonorrhea, and HIV are nearly twice as high as the statewide rates. The HIV rate in St. Francis county is among the 10 highest rates in the state (Arkansas Division of Health, 2007a, 2007b).

Sampling and Recruitment

FG participants were recruited as part of a pilot study intended to understand correlates of sexual risk and preferences for sexual risk interventions. Participants were drawn from RSS participants who indicated during the RSS consent process that they would be willing to be contacted for future research studies. Participants were recruited using a stratified sampling strategy, which reflected established age (younger than 30 years and older), gender (male and female), and county (Lee and St. Francis counties) differences in types of drug used and sexual experience (Wright et al., 2007). All participants met the inclusion criteria: (1) were at least 18 years old; (2) self-identified as African American, Black, or of mixed racial descent; (3) reported using cocaine in the past 30 days; (4) reported engaging in oral, vaginal, or anal sex in the past 30 days; and (5) reported residence in a study county. There were 32 participants recruited and 31 participated in the four FGs. Each FG had at least seven participants.

Focus Group Instrument

A semi-structured, open-ended FG interview guide was developed by the research team and was designed to capture participants' general impressions of the feasibility of a SRR intervention program for African American cocaine users living in the rural South and their opinions about appropriate program content and delivery procedures. The guide questions were broad enough to accommodate a variety of responses and ensured that the language used in the questions was appropriate. All participants were asked the same questions, modified only for the gender of participants where necessary. The FG guide standardized the questions for these areas: SRR intervention preferences, opinions about intervention structure and content, and perceived sexual risk and risky behaviors.

Procedures

All participants provided written informed consent prior to beginning the group. To protect participant identities, each participant provided any name they chose, be it their first name, nickname, or false name. Facilitators used the FG guide to lead each of the four digitally recorded FGs, which were scheduled for 2 hr, including a 20- to 25-min break. Facilitators had extensive experience working with vulnerable African American populations and were gender-matched with the FG. A note-taker also attended each group. Participants received a \$35 reimbursement for their time and travel expenses, and were provided with food and beverages. In addition, condoms were available at the conclusion of each FG.

Data Analysis

Recordings of each group were transcribed verbatim, checked for accuracy, and entered into Ethnograph. Data analysis was performed using content analysis and constant comparison. Coding decisions and data interpretation were recorded in a detailed audit trail to enhance the rigor and auditability of the qualitative findings. We identified core concepts and assigned codes using content analysis. A list of codes that emerged from the interviews was constructed and served as the basis for a codebook, which included codes and definitions. The codebook was reviewed by members of the team. Ethnograph was used to organize and manage the qualitative data by numbering the lines and labeling coded segments. Files were created to separate the raw FG data based on codes.

Once the data were segregated by codes, constant comparison strategies were employed to contrast and compare interview data across FGs and across codes. The research team identified similarities and differences and identified relationships in the data that were aggregated into factors of a single unit of meaning. Final practice recommendations also emerged from the data through the process of constant comparison. Differences and similarities in identified units of meaning (i.e., factors) were discussed among co-authors until consensus was met throughout the coding and comparison process to improve the integrity of the research findings and reduce risk of investigator bias. In addition, results were reviewed and sub-stantiated by community members and field staff to enhance the credibility and authenticity of the qualitative findings.

RESULTS

The following section discusses the findings related to our objectives and the factors that emerged from the participants' responses.

Opinions About the Intervention

An important aspect of community-based research is local relevance and appeal (Israel et al., 2005). Therefore, gaining FG participants' opinions about the feasibility and acceptability of a SRR program for their community was critical. Although several participants recognized that many individuals were engaging in risky sexual behavior and that STIs were becoming increasingly prevalent in their community, three of four groups described reasons they believed a SRR intervention for rural Southern African American cocaine users would not be successful. Three factors emerged from the reasons provided: impairment due to drug use, difficulty with recruitment and retention, and fear.

Impairment due to Drug Use—Across FGs, drug addiction was consistently regarded as a major barrier to intervention implementation. Drug use among the study population was described as an all-consuming force that could impair potential participants' ability to take part in an intervention. An older male participant remarked, "I can't think of nothing you can put on their [drug users'] mind as long as they're on drugs." Similarly, another older

man said, “On them drugs, I don’t think nothing’s going to work because they know what’s going on.”

Moreover, the effectiveness of an intervention to facilitate sexual behavior change was believed to be contingent on the severity of the potential participant’s drug addiction as the indicator of whether or not they would continue to engage in risky sexual behavior. Severely addicted individuals were considered beyond the assistance that any intervention could provide. An older male stated, “If you’re doing drugs and you want some drugs real bad and can’t get it, he most likely, its all depending on what stage he is on drugs, that he would try to do anything.”

Drug use was also believed to put the entire region at risk and impair the success of any local risk reduction efforts. A male participant in the 30 and over group stated, “I don’t see no program that’s going to help that Delta. That Delta’s all in the drug use. That’s one reason I started using drugs.” Even individuals in the region who were not using drugs were believed to be at risk through their involvement with drug users. Another older man stated, “It’s not only the drug users that do that there. You’d be surprised at the married men running around here messing with these drug addicts, and go home to their wife. I see this every day also. People like, with new homes and new cars and everything, they ain’t on drugs. They’re still messing around with these drug addict ladies.”

Difficulty with Recruitment and Retention

The FG participants also believed that drug addiction and gender issues would negatively affect recruitment and retention. For example, participants in the younger than 30 groups believed that older drug users, particularly crack users, were less likely to be involved in the program. One woman said, “I don’t think they’re [crack users] going to be coming to no program. I think they done gave up.”

Participants also stated that men would be difficult to recruit and retain and perhaps even hostile to the idea of SRR programs specifically for men. As one older man explained, “I don’t think men would come to that kind of program. If you have a damn program and it’s designed just for sexual, and nothing but men’s in there ... I wouldn’t want to come to a damn group with a bunch of damn men.” Women were equally pessimistic about the involvement of men in a SRR intervention. One younger woman flatly said, “You won’t get no males to show up.” Another woman shared, “It would take a lot to get a man to come in to just sit around and talk about sex. That’s wasting their time. You’re going to have to come with something for them to come.”

Fear

Fear of learning about HIV and other STIs was another reason why FG participants thought that other members of their community would not take part in the intervention. An older man stated, “A whole lot of people scared of reality. Scared of the truth. You know, they don’t want to see it. Don’t want to hear about it. They like to play dumb to the true facts of reality.”

Intervention Content

Within the context of community-based research, formative research activities are an opportunity to engage the community and foster co-learning between the researchers and the study community (Israel et al., 2005). Participants were in support of many commonly used SRR topics such as learning the symptoms and treatments for STIs and proper condom use. However, one topic was not well-received. Teaching sexual risk negotiation skills was not recommended because as one younger female participant stated, “if you got to convince

him, he's going to do something to that condom." Additionally, during the four FGs, participants recommended additional topics that were unique to the needs of the community. These topics included hygiene, condoms, and violence in relationships.

Hygiene

All four FGs regarded hygiene as an important topic that should be addressed. Hygiene was viewed as relevant to SRR for two reasons. First, washing and douching were believed to reduce transmission risk. Second, personal hygiene was used as a proxy for disease status in potential sexual partner selection. Group members consistently agreed that hygiene was closely related to severity of drug addiction and sexual risk. Good personal hygiene, which was regarded as frequent bathing as well as regular douching for women, was believed to reduce STI risk, especially for individuals with multiple partners or who traded sex. For example, a female participant said, "women that's tricking and stuff like that, they might do need to take a shower 2–3 times a day ... so they don't pass nothing and made sure they don't get nothing."

Hygiene was also an important consideration in partner selection, especially among men. Male participants strongly believed that women in their community needed an intervention that could teach them how to "keep it clean." Avoiding sex with unclean women was believed to reduce transmission risk. In response to the group facilitator's inquiry about why a man did not believe he needed to use condoms, the participant stated, "I just don't. I don't fuck with them nasty assed girls." However, this view was not unanimously held because another participant replied, "just because they got them curls, they could be clean, smelling like roses and still can be infected though."

Women also acknowledged that males in their community used hygiene and physical appearance as a proxy for risk and agreed that the intervention should address issues surrounding partner selection. One woman stated, "Most men they need to know that everything that looks good is not good." Beliefs about the utility of hygiene for partner selection were so prevalent across the FGs that the concept had become part of the local dialect, particularly among younger individuals. Women who were deemed promiscuous or traded sex for money were commonly referred to as "dirties."

Condoms

FG participants suggested topics related to condom use that should be in the SRR intervention.

Teaching the importance of condom use was considered important because as one younger women mentioned, "They [intervention participants] need to know they can catch something if they don't strap it up." Members of the younger male FG stated similar beliefs about condom use, "If you know that ho going, strap it up." Women wanted to learn more about specialty condoms such as heated condoms and "French ticklers," which they believed would increase female sexual pleasure. They thought that eroticizing condom use would also interest men because "Once they [men] learn how to do something that is neat and they think its going to be something interesting for her that she ain't never had happen to her before, they're going to try that." Men in the younger group expressed ambivalence about condom failure. On one hand, condom failure often resulted in sex that was more pleasurable. Yet, men also expressed frustration that when that happened they had to deal with the sequelae of condom failure.

Violence in Relationships

Participants believed that violence in relationships was prevalent in their community and, therefore, was important intervention content. They felt that community members, particularly women, were vulnerable. They believed that drug use caused mental impairment, which resulted in frequent violence. An older woman noted, “See the men these days who smoke crack, its ate their brains up to where they want to fight who they love. And they don’t even trust their own damn shadow, let alone somebody else’s.” The paranoia associated with cocaine use was believed to be the primary cause for the violence experienced in their relationships. Male participants also described several violent encounters with their sexual partners that they believed were caused by drug use. An older man said,

Drugs alternate your thinking ... You’re broke and you wanting you some dope, and you know [your partner] done got paid, she got some money ... Before you know it, you done got off and took the money and whipped her and went on and bought you some dope.

Intervention Structure

Effective community-focused intervention development is collaborative (Israel et al., 2005). Developing an intervention that has local relevance is an iterative process that should clearly incorporate the values, preferences, and attitudes of the study community. Five factors emerged from the FGs about participants’ preferences about the proposed intervention design.

Confidentiality

All groups discussed the importance of confidentiality, a well-understood concept that participants believed was beneficial. An older man explained, “That’s why I’m keeping it real, because I like the confidentiality. Because I wouldn’t want to say nothing to go and incriminate myself ... If you ain’t got that confidentiality, see they could pass this on to some kind of law enforcement.” Most recognized the importance of maintaining confidentiality and reiterated to fellow FG participants “what goes on in this meeting today should stay right here.” Participants felt that intervention staff members who broke confidentiality should be fired.

Professional Versus Lay Interventionists

An important aspect of any health promotion intervention is the intervention staff. Participants expressed frustration with the prospect of a SRR intervention that employed only professional health educators who were unfamiliar with drug use because they would not understand the intervention participants. Professional health educators were believed to be less credible teachers because their lifestyle would greatly differ from the intervention participants. More importantly, FG participants felt that professional health educators would not be able to understand or sympathize with the situations that increase sexual risk among local users. As one younger woman stated:

You know, she’s [a crack-using intervention participant] on the bricks ... But when she looks at somebody [the health educator] else that be telling her, “Girl, it’s going to be alright.” This woman [the health educator] got a bank account. She could pay my bills if she wanted to ... You got a job. Write the check. Other people, they have to do what they do to get by.

Lay intervention staff that were familiar with the local cocaine-using community were a more credible option to some of the participants. Another younger woman said:

If a crackhead was listening to you, she would be like, "Well you got everything. You got a house and a car and a job." But if she's listening to somebody else who done been there and they're just starting to get better, she'd be like, "Well she's been the same place I been." ... They'll listen to that. But they can't take it from somebody who never, who ain't never been where they been.

Similarly, an older woman said, "You got to be able to live the life and know the life in order to teach the life."

Participants mentioned additional benefits associated with having local lay interventionists involved, as they were considered more trustworthy because participants would "know if he [the lay interventionist] be telling the truth or not because they know him. They know him, they'll see he's keeping it real." This prior knowledge was viewed as a major benefit, especially to an intervention where very sensitive and personal topics would be discussed. Another benefit of a local lay interventionist was their ability to keep the intervention group honest. An older male explained that with a nonlocal intervention leader "I can sit there and tell you [the non-local interventionist] anything. You don't know nothing about me." When asked by the FG facilitator if having someone well-known in the community leading the group would make the intervention participants uncomfortable, an older man replied, "We know each other real well. Everybody's free. We been in jail and everything, all of us pretty much know each other." Another agreed and added, "We feel comfortable talking to each other."

Conversely, younger FG participants were relatively uncomfortable with having lay interventionists and preferred having professional health educators. Members of the younger male FG were apprehensive about someone from the local community leading intervention sessions. When asked the reason, one said, "Cause they from the hood ... It needs to be somebody we don't know from around here. Mess around and start a fist fight. He [the lay interventionist] thinks he knows more than me, and we're doing the same thing." A young female expressed a similar opinion when she said:

If we had somebody that sat right there that's running the group that I see every day, that does the same things, I'm not trying to hear what she's talking about, because she ain't going, when she leaves here, she's going to be doing the same thing she just told us not to do. You can't take advice from a person that's under you ... But if you listen to somebody who has been to school for it or they know something about it, you can ... if you get somebody from here, they most likely, you can't listen to them.

Another concern about having local interventionists was that confidentiality may be compromised through their involvement. FG participants believed that a local interventionist would tell community members not involved in the intervention information shared by intervention participants. In short, lay interventionists would "run their mouths." As one participant stated, "most likely you going to hear about it after the session." Another said "the same people from around [city name], I wouldn't trust them." Lastly, an individual who was actively using cocaine was collectively viewed as a poor choice. Even participants who were particularly supportive of having a lay interventionist felt that current cocaine users could not serve in that capacity. An older female exclaimed, "What can another dope smoker tell me? Nothing!"

After much discussion, most FGs agreed that having both professional health educators and lay interventionists would be the best option. An older man remarked that with both "you got the scientific terms and you've got the street terms. You've got both knowledge." It was generally well-regarded that the combination "can't fail" and would improve the overall relevance and quality of the program.

Characteristics of a Good Interventionist

The quality of intervention leadership was emphasized as critical to the success of the intervention in three of the four FGs, who believed that certain characteristics would make individuals in these positions “worth listening to.” An example of a qualified interventionist was “somebody here that’s got sense and they’re going to talk right. They’re going to explain everything to you, everything’s going to be out in the open.” Other characteristics included “knowing the life” but no longer being an active user and not “running their mouth.” One participant surmised that intervention participants needed, “Counselors that is comfortable enough for that person to come to you to talk to you, to open up to talk to them. If you’re not willing to listen to them, without criticizing them, it ain’t no use.”

Group Composition

Despite the homogeneity that might be expected from a study group defined as African American cocaine users living in the rural Arkansas Delta region, there is great diversity based upon age and gender. This was one of the reasons that the FGs were grouped by gender and age. FGs provided insight about how intervention groups should be composed. Segregating participants during intervention sessions by age was not recommended by most FG participants. A benefit of mixed age groups was having “both sides of the opinions, from the young group and the older group.” In addition, older participants were hopeful that older intervention members would share their drug-related life experiences with younger participants and thereby motivate them to change their current risky behavior. An older man stated, “Younger people listening to the life experiences of the older people may have the light jump on so they will change the way they are living so they don’t end up like the older folks.”

Participants felt that there were distinct advantages and disadvantages to having mixed-gender intervention groups. In general, men preferred mixed-gender groups while women wanted single-gender groups. A distinct advantage of mixed-gender meetings was improved recruitment and retention of male participants, generally believed to be a difficult population to involve in a SRR intervention as previously mentioned. One older man stated:

I don’t think you would get more people to participate in a program with it just being men as well as if you had men and women. Because most of the men, they’re going to come just to see what kind of woman comes in there anyway. And that would attract more men.

Other advantages of mixed-gender groups included having “better responses” and participants “being more open.” One man stated that a benefit to the researchers would be:

You’ll get a lot more information on how a person really feel, you know. It’ll be more open. Because a lot of them [females] are going to get right here and bust you [the men] out and say, “What?” And you’re going to bust her right back, “Uh-huh, you know.” You’ll [the researcher] get the true facts out of it.

Yet, with these advantages came several disadvantages. In direct opposition to the perceived advantages mentioned above, younger men and women believed that mixed-gender groups would reduce the integrity of the information gathered during the intervention sessions. A male participant remarked, “You got them hos that going to say ‘we don’t do this. We don’t do that’. Everybody don’t do nothing now. But let them doors close, [women] sucking everything.” A female participant with similar concerns asked the facilitator “If your spouse was here, just think, would you make the comments that you’re making now if your man was sitting here with you?” The women thought that the quality of the men’s data would also be compromised in mixed-gender intervention groups. One woman said that “they’d [men] be quiet. They’d be trying to see what the other person going to say.”

Another disadvantage became clear during discussions between male FG participants. Some men supported mixed-gender intervention groups because the sessions could be used as an opportunity to meet cocaine-using females. One young man even suggested that researchers should forgo the educational sessions because “it’ll be better if y’all set us some hotel rooms out there and then you know go on and get the rocks out.”

Additionally, younger men and women believed that mixed-gender intervention sessions could have violent repercussions. One man remarked, “I feel it’s [mixed gender intervention sessions] going to start a fight. We’re [men] going to be up here talking so bad about them [women], and they going to be up here fronting, and then there goes one thing, and then hos going to be knocked out.” Females shared the concern that mixed groups might cause conflict for the intervention participants. One woman explained that information shared during the session in the presence of a sexual partner “might start an argument or something, somebody might go, and then they [the sexual partner] get home and it’ll be a whole different story.”

Fair Reimbursement

Fair reimbursement for intervention participants is a major concern in all facets of human subject research. Finding the amount that adequately reimburses participants for their time and travel without becoming a coercive inducement may be especially difficult when working with impoverished populations. Input from the FGs was critical.

They gauged fair reimbursement based on the amount of effort and cost it would take to get the intervention location and the amount of money that could be earned during that time period from “hustling.” For example, the suggestion of \$5 per intervention session was rejected because “I can get out there and hustle that” and “that ain’t enough for gas.” Younger males were especially adamant that lower reimbursements would only be of interest to “crackheads,” a derogatory term used to describe crack cocaine users, particularly severely addicted older crack cocaine users. One younger man said, “Y’all need to go get y’all some crackheads. We just bake heads and weed heads in here. We don’t smoke rocks. Now, y’all need to go get some rockstars if y’all want some motherfuckers to come up here for \$5.” Conversely, offering larger sums of money such as \$55 could result in ineligible individuals trying to get into the program. “Y’all have got a reasonable price now, \$35. But a good price, a good \$55, you’d have to open up a coliseum, [intervention participants] wouldn’t have to go out and hustle no more the rest of that day if they got \$55.”

Many FG participants were willing to join in the intervention without reimbursement under certain circumstances. To express his desire for mixed-gender groups, an older male said, “I would do the co-ed group you were talking about for nothing.” Other reasons were provided for why participants would be willing to attend the intervention without reimbursement. Several women were willing to attend the groups for free because they wanted to serve other individuals in their community. One woman said, “I would come without condoms or whatever, because I have a mom that’s in that situation [trading sex for drugs] ... and I would want to help other people.” Some men said they would participate without monetary reimbursement “as long as it’s worth me coming up here.”

Intervention Activities

Developing culturally appropriate health promotion activities is an important aspect of constructing an intervention that participants become interested in and deem worthy of their time and energy (Resnicow, Baranowski, Ahluwalia, & Braithwaite, 1999). Passive learning approaches and active engagement and empowerment were the factors that emerged from FG discussion about activities to be included in a SRR intervention for their community.

Passive Learning Approaches—Several of the participants described traditional health promotion methods such as didactic educational classes, condom distribution, and health promotion pamphlets as ineffective and boring. Intervention sessions that solely focused on sexual health through traditional teaching methods were discouraged. One man characterized his dismay with traditional health education classes when he asked the facilitator, “Would you want to sit around a room with a bunch of men talking about sex?” The participant then responded to his own question with an emphatic, “Hell no! I know I wouldn’t.”

Moreover, the effectiveness of condom distribution, a staple of many SRR efforts, was questioned among participants. An older male remarked that condom distribution could be effective but would not be the key to longterm sexual behavior change. “If you’ve got these [condoms] in your pocket, you’re more likely to use them if you’ve got them. If you ain’t got them in your pocket, it’s just like out of sight, out of mind.” One stated, “You give me some condoms and I could successfully use them or I could drop them down on the corner down there.” Another agreed, “Or you could take them [the condoms] two or three blocks over there and sell them.” Similarly, younger men believed that condom distribution was ineffective because condoms distributed were “cheap” and “white boy condoms, they is too little.”

Additionally, providing health promotion pamphlets was believed to be equally ineffective because “ain’t nobody going to read them.” Participants described pamphlets as redundant because of their extensive use in other public health efforts in the region. One man said, “We done read all that there [booklets on table]. I’ve been to the joint, when you go in they’re going to give you all that there. You know its [the SRR intervention] gonna have to be something they can see themselves benefiting from or they going to get something out of it.”

Active Engagement and Empowerment—Participants agreed that for a SRR intervention to be successful in their community, “there going to have to be some form of benefits.” The prevailing attitude among many FG participants was that passive learning approaches would not provide the perceived benefits necessary to recruit and retain their fellow community members. They posited that activities that actively engaged and empowered participants would be more successful.

Specifically, they were adamant that the intervention activities should cover designated SRR topics in a way that was “active” as well as “fun and exciting.” Suggested activities differed across gender and age groups. For example, females suggested offering intervention participants free STI and HIV testing as well as other medical testing such as “physicals, blood work, and pap smears.” Men recommended role-playing as an effective and entertaining intervention activity. They suggested two types of content for the role plays. The first type of role play was an opportunity for participants to witness how they behave and the risk behaviors they engage in while intoxicated or high. Participants also suggested plays about the consequences of risky sexual behavior among characters from similar backgrounds and circumstances as the community members. As one older man suggested, “A little play like that, I can see where it might put something on your mind ... Might have a few people up here doing a little role playing on different situations on drugs and sex on drugs.”

Opinions about intervention activities were similarly diverse across age groups. For example, younger groups suggested “little get-togethers” or parties where participants play games that teach them about sexual risk. Older FG participants suggested the facilitation of employment opportunities as an attractive intervention activity. Opportunities to work and

be involved in tasks associated with the intervention were highly recommended and widely considered enjoyable activities that they could “see themselves benefitting from.” One described the ideal program as

a program where people was helping somebody, where you could like have a class in the evening somewhere they can go out and work an honest job or something like that, and still come in and where they can come in after that, instead of just coming to a program or lecture, because it would get boring to them, and when it gets boring to them, most of the time when people who do dope, people like me, when you get bored, you go out and do drugs ... If you have a program like that, where they work in the evening, or work in the morning something like that, then they'll see themselves trying to do better.

And, an older woman stated:

Make a dope fiend feel important ... Get them involved. Help in the program like. It's the little things, you know, if it ain't nothing but passing out flyers to tell the other people about the program, or when they come in, take down the names. Just let them do something active to get them in this, you know what I'm saying? Take part in it.

Participation in these activities was viewed as another form of compensation for attending the intervention because these activities offered a chance to have their work valued and their efforts recognized. Participants felt there was great value in having an opportunity to take part in something that contributed to the well-being of their community and enhanced their own sense of self-worth.

DISCUSSION

The purpose of this formative research was to tailor an evidence-based SRR intervention to the needs of the study community. Through ongoing community engagement, the research team aimed to gain community members' insight about potential barriers and program development. Despite stated barriers to intervention success, participants believed that a SRR intervention was needed and were supportive of the proposed intervention. The perceived need for the program was particularly strong among older FG participants. As one woman remarked, “I feel that we as drug addicts need that program ... I am not above the fact of asking for help, because I do need help, because I am sick.” Similarly, a man said, “It might help. I'm saying not a solution to it, but it might help.” Intervention developers and FG participants shared the belief that a tailored SRR intervention could overcome barriers and facilitate behavior change. FG participants provided useful guidance about ways the intervention could be tailored to combat barriers to success. From the cross-comparison of factors, four recommendations arose that offer valuable insight about intervention design, content, and activities and may improve program success and facilitate participant engagement for other research teams working with similar populations (see Table 2).

First, interventionists should try to “cover all the bases” that are relevant to the community as it relates to intervention content. Many topics can be deemed appropriate due to the ecological nature of sexual risk. However, it is nearly impossible to address all potential topics. Therefore, community input is critical in determining which topics are most relevant and applicable to sexual risk in that community. Community engagement was immensely helpful in identifying the topics that were the most crucial to address. Members of the FGs suggested that content needed to center around “sex and drugs,” which included challenging issues such as violence in relationships, condoms, and hygiene. As one stated, “Sex and drugs. You cover all the rest of the bases right there.” All groups mentioned the effect that

drug use has on sexual behavior and suggested SRR topics that were unique to their experiences as African American cocaine users living in the rural South.

For example, hygiene was mentioned by all groups as a topic that needed to be addressed. Hygiene is not typically thought of as an important topic in SRR. However, in this community, hygiene serves as a proxy formative disease risk, addiction severity, and partner selection. Few studies address partner selection as a prevention strategy or risk factor for HIV. However, partner selection may be an important aspect of SRR. In a recent study, Eaton, Kalichman, and Cherry (2010) examined sexual partner selection and risk reduction among Black and white men who have sex with men (MSM). They observed that white MSM were more likely to use partner-selection risk-reduction strategies than Black MSM and suggested that this may explain in part the disproportionate number of HIV infections among Black MSM (Eaton et al., 2010).

Similarly, FG findings support the inclusion of violence and abuse risk into intervention content. Participants describe abuse and violence as epidemic within their community and therefore, a relevant topic. Research sub-stantiates this suggestion because experiences of physical, sexual, or emotional abuse have been associated with high-risk sexual behavior and STIs, particularly among women (Logan, Cole, & Leukefeld, 2002). However, without community guidance these important topics could have been overlooked amidst numerous other SRR topics.

Another recommendation was that confidentiality must be maintained. Confidentiality and the potential social consequences of confidentiality breaches were well-understood by FGs. It was widely agreed that any breaches of confidentiality should have serious consequences for staff and would inevitably compromise the reputation of the intervention. Therefore, multiple steps should be taken to ensure confidentiality and staff should be trained to explain these steps to participants at each intervention session in order to build trust and accountability.

FG participants also recommended that both “book smarts and street smarts” be incorporated into the intervention sessions. Suggested ways to help accomplish this were to use “scientific terms and street terms.” Participants believed that including both professional health educators and locally respected lay interventionists would improve program recruitment, retention, and relevance.

Lastly, it was strongly recommended that intervention activities provide tangible and intangible benefits to intervention participants. The perceived benefits of participation that were considered most attractive were beyond monetary reimbursement. Intervention activities that were novel while remaining informative were preferred. However, one challenge was in designing an intervention that would benefit the community while trying to address the differences between subgroups. There were clear gender and age differences in what they believed would be most beneficial. Gender differences were particularly salient to intervention development, given the different preferences for intervention content and design as well as the distrustful relationship between men and women in this community. In addition, age differences were important because younger individuals valued opportunities to socialize over opportunities to work, denigrated older members of their community, and were distrustful of peers.

Ultimately, successful intervention development must reach a compromise that is mutually beneficial across all subgroups. The best compromises address potential barriers to success while enhancing tangible and intangible benefits for members of each community subgroup. For example, FG participants and interventionists decided to include both single-gender and mixed-gender sessions in the intervention. This was mutually beneficial because it

encouraged recruitment and retention among men and provided a time for participants of all ages and genders to socialize while still maintaining the privacy of the single-gender sessions.

Study Limitations and Conclusion

There are important limitations to this study that must be acknowledged. The results of this study may not be widely generalizable. FG research is ideally suited for formative research with exploratory purposes but is ill-suited for conclusive hypothesis testing with generalizable findings (Denzin & Lincoln, 2003). Therefore, this study collected exploratory qualitative data consisting of diverse subjective attitudes, preferences, and beliefs from members of the community. Another potential limitation was that FG participants were selected through their involvement in other local research efforts. Although efforts were made to select a diverse group, they still represent a small portion of the community. Therefore, our results may not represent the entirety of the study population. Finally, despite efforts to reduce socially desirable response patterns, it is possible that some FG participants did not fully express their opinions.

Despite these limitations, our research was highly beneficial. There is an urgent need for relevant and effective SRR interventions for active drug users. This formative research served several crucial functions as follows. First, it engaged potential participants and members of the research team in an important dialog about the needs and experiences of the community. Second, it began an ongoing discussion about sexual risk within the community. Third, it began the process of building trust within the community and between community members and researchers. FGs also gave members of the investigative team important information about intervention preferences and the acceptability and feasibility of a SRR intervention for a high-risk population that is under-researched and under-resourced. Lastly, even though community engagement and local involvement can be a time-consuming and challenging process, it was invaluable to the success of our collaboration. Our investigative team and community partners believe that engaging the community early on can lead to the development of a more relevant SRR intervention by tailoring the intervention to fit the specific needs and preferences of the community, refining evidence-based strategies, and identifying potential barriers and important intervention characteristics.

Declaration of interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the article.

RESUME

“Nous, comme toxicomanes, avons besoin de ce programme”: aperçu des toxicomanes afro-américaines ruraux de cocaïne sur le plan d’intervention de réduction de risques sexuels pour leur communauté

Cette étude ethnographique concentrée examine les données rassemblées en 2007 de quatre groupes de témoins spécifiques en termes de genre et d’âge ($N = 31$) pour informer le développement d’une intervention = de réduction de risques sexuels pour les consommateurs afro-américaines ruraux de cocaïne dans l’Arkansas rural. Un protocole semi-structuré a été utilisé pour guider les analyses des groupes de témoins, enregistrés en audio. Les données ont été saisies et implémentées en Ethnograph et ont été analysées en utilisant les comparaisons des constantes et une analyse du contenu. Quatre codes avec des facteurs associés se sont dégagés des données et ont révélé des recommandations pour les interventions de réductions de risques sexuels avec des populations similaires. On discute les implications du plan de l’intervention et les défis, ainsi que les recherches dans l’avenir.

Cette étude a été soutenue par des fonds de l'Institut National de Recherche de la Profession d'Infirmière (P20 NR009006-01) et l'Institut National sur l'Abus des Drogues (1R01DA024575-01 et F31 DA026286-01).

RESUMEN

“Nosotros, siendo drogadictos, necesitamos ese programa”: entendimiento de consumidores afroamericanos rurales de cocaína sobre la planificación de intervención de reducción de riesgos sexuales para su comunidad

Este estudio etnográfico enfocado examina los datos reunidos en 2007 de cuatro grupos focales específicos en términos de género y edad ($N = 31$) para informar el desarrollo de una intervención de reducción de riesgos sexuales para los consumidores afroamericanos de cocaína en el Arkansas rural. Un protocolo semi-estructurado fue usado para guiar los grupos focales, grabados en cinta de audio. Los datos fueron entrados en Ethnograph y fueron analizados usando una comparación de constantes y un análisis de contenido. Cuatro códigos con factores adjuntos salieron de los datos y dejaron ver recomendaciones para intervenciones de reducción de riesgos sexuales con poblaciones parecidas. Se discuten las implicaciones del plan de intervención y los retos, las limitaciones del estudio y las investigaciones del futuro. El estudio fue apoyado con fondos del Instituto Nacional de Investigaciones de Enfermería (P20 NR009006-01) y del Instituto Nacional de Abuso de Drogas (1R01DA024575-01 y F31 DA026286-01).

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TABLE 1

Characteristics of focus group participants

<i>N</i> = 31	<i>N</i>	%
Male	16	51.6
Marital status		
Never married	18	58.1
Married or living as married	5	16.1
Separated/divorced	8	25.8
Living arrangements		
Have their own house/apartment	13	42
Someone else's house/apartment	18	58
Currently employed	6	19.4
Annual income < \$5,000	23	74.2
Mean age	31 years	Range (20–60 years)
Mean years education	11.6	Range (9–15)
Mean days used crack cocaine in past 30 days	16.8	Range (2–30)
Mean days used powder cocaine in past 30 days	8.6	Range (0–30)
Mean days used other drug (excluding alcohol/tobacco)	20.9	Range (2–30)
Mean days sexually active in past 30 days	11.7	Range (0–30)
Mean number of sexual partners in past 30 days	1.9	Range (1–6)
Never used condoms with vaginal sex past 30 days	13	48.2
Ever tested for HIV	28	90.3
Sexual preference heterosexual	30	96.8
Experienced violence past 12 months	4	13
Forced to have anal, vaginal, or oral sex past 12 months	0	0

TABLE 2

Summary of qualitative findings

Code	Factor summaries	Recommendations
Opinions about the intervention	<ul style="list-style-type: none"> • Drug use may impair intervention implementation and effectiveness. • Fear may also be a barrier. 	<ul style="list-style-type: none"> • Despite potential barriers, the intervention was considered desirable.
Intervention content	<ul style="list-style-type: none"> • Intervention sessions should include relevant content, including hygiene as a proxy for partner selection and disease status, eroticizing condoms and reducing condom malfunction, and violence related to cocaine use. 	<ul style="list-style-type: none"> • Intervention content must contain topics that are relevant to the community's needs and experiences.
Intervention structure	<ul style="list-style-type: none"> • Confidentiality was valued and well-understood. • Preferable to have both health educators and lay interventionists involved in intervention sessions. • Intervention leaders must have certain characteristics to be deemed qualified. • Lay interventionists should also be well-regarded in the community having recovered from their addiction but still remaining active in their community. • Preferences for intervention group composition varied by gender and age. • Opinions about fair reimbursement were contingent on transportation, other income options, and drug price. 	<ul style="list-style-type: none"> • Intervention structure should heed community recommendations, mirror community preferences, and utilize community assets. • Compromises across differing subgroup opinions and preferences should address barriers and enhance benefits.
Intervention activities	<ul style="list-style-type: none"> • Passive learning approaches were deemed ineffective. • Active engagement was valued and encouraged, but suggested activities differed across gender and age. 	<ul style="list-style-type: none"> • The intervention must be seen as providing both tangible and intangible benefits.