

**FINAL REPORT TO THE CENTERS FOR DISEASE CONTROL AND PREVENTION
ON ADAPTING SAFETY COUNTS FOR MIGRANT WORKERS WHO USE DRUGS**

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ACKNOWLEDGEMENTS:

On behalf of The Border Health Foundation's CEO Mr. Albert Moreno, Director of Research Dr. Charles Anderson and Safety Counts staff, we would like to express our deepest gratitude to the Centers for Disease Control and Prevention for providing us with this unique challenge in allowing us to pilot test Safety Counts among Migrant workers along the United States-Mexico border. This project would not have had any chance of succeeding without the encouragement, patience, support and guidance provided by Dr. Jonny Andia, Mr. Nelson Colon-Cartagena, Dr. Charles Collins, Mr. Keith Yamaguchi and Mr. Sam Taveras. A special note of gratitude as well must be extended to Safety Counts Principal Investigator, Dr. Fen Rhodes for his great support.

DETAILED GUIDELINES AND STEP-BY-STEP PROCEDURES

A) Population Identification.

Methodology:

Informal and formal outreach was conducted in the agricultural fields, at low-income housing projects, locations where migrant workers were congregating in large groups (i.e., where several labor gangs met before being transported to the fields), from out of the Border Health Foundation's federally-funded Abstinence Only Program and other projects and places where they congregated that were known drug-using venues unique to the migrant workers. These had already been identified by Dr. Anderson from a previous SAMHSA HIV Planning Grant.

Gas stations, food banks and service agencies were also good for outreach efforts as the pilot test advanced. Gas stations proved to be especially viable for outreach because these were locations where numerous crews from many different companies stopped at the same time on their way to work or going back home at the end of the working day. Anderson and Bletzer made regular trips to Somerton to observe the promotoras in action and to trouble shoot potential snags in outreach and recruitment. These trips included visits to the agricultural fields.

Initially, recruitment went slowly in the fields. The patrons (owners of the fields) were adamantly opposed to our presence because they felt it would compromise the workers' efforts in putting in a full day of work. However, Field Bosses (Foremen) were less opposed because they knew one of our promotoras from her previous days as a migrant worker and this facilitated easier access when the patrons were not around.

After explaining Safety Counts to the Field Bosses and what the project was attempting to accomplish smoother entry into the fields was facilitated for conducting outreach and recruitment activities. Outreach had to be carefully planned to catch the migrants working on those days when the Field Bosses would not have been "pressured" by the patrons to prevent our access. Times of the day and days of the week when we would not expect to see any of the patrons at those sites were carefully noted.

Sample Size:

Forty-two persons (31 men and 11 women) participated in the four-month pilot run of the evidence-based Safety Counts in Yuma County, Arizona. Four cohorts (individuals who participated in activities as a group) comprised the participant sample.

For a better understanding of piloting the intervention in relation to the agricultural season in Yuma County, we divided the four-month project period into first half (February-March) and second half (May to June). Each of the first two cohorts covered the first two months (n=15) and each of the final two covered the last two months of the project (n=27). This represents an increase of 1.8 times as many persons who participated during the second half (May-June) of the project as the first half (March-April). There was an additional four persons who were recruited for the first cohort, but no information was collected from them and they participated in none of the sessions; hence they were not counted in the total sample of 42 intervention participants. The

mean age of the 42 participants was 42.37 years with no great difference in average age of women compared to men. The final three cohorts were slightly older than the first cohort.

In terms of knowledge of risk behaviors, prior to being enrolled in Safety Counts, it was discovered that the knowledge of drug use and needle sharing was moderate for both males and females. Knowledge of HIV/AIDS was low to moderate with females being a little more aware.

Upon advice of Dr. Anderson, the promotoras were not trained or did not use any types of random sampling designs. So, therefore, we did not do any equal probability sampling, stratified random sampling or purposive sampling. Anderson believed at that time it would not be feasible for the pilot. However, see later discussions with respect to recruitment and retention for some recommendations on this issue.

1) Drug-Use Patterns:

Previous NIDA-funded research by Dr. Anderson demonstrated some consistency among migrant workers on injection versus non-injection drug use and types of drugs consumed. This is another rationale why Safety Counts turned out to be a good prevention intervention for this population. As the pilot evolved and more data was elicited from the participants, many of the similar trends that Anderson noted in previous investigations continue to hold true for the Safety Counts pilot.

There was no difference in the proportion of participants who reported injection behavior for the first half of the project (7 out of 15 or 46.67%) compared to the second half (12 out of 27 or 44.4%). Recruitment skills of the outreach team and the "spread" of information by word-of-mouth was evident in a greater proportion of persons who reported injection behavior over the middle two cohorts, compared to the first and final cohorts (15 out of 21 or 71.4% for the middle two, versus 4 out of 21 participants or 19% for the first and final cohorts combined). **This is important because Anderson's past work would indicate that between 70% and 75% of migrant farm workers along the U. S.-Mexico border were injecting drugs. The increase among women farm workers of injection practices is rising both proportionately and geometrically in the region.**

Interpretation of These Percentages:

It may be speculated that a low percentage for the first cohort was due to "warm-up" of the outreach team, "start-up" of the project and/or minimal information on "community credentials" of project promotoras in the local area during a period of large numbers of workers in Yuma County (intensive harvest season).

The Border Health Foundation staff would argue here that the low percentage for the final cohort may have been due to few workers who remained in the county (or possible "saturation" of the available pool of local injectors, after some had departed the area), as well as staff fatigue mixed with a shift in assignments and administrative responsibilities, as another project through the Foundation's Field Office in Somerton was also winding down at this time.

As was expected before the pilot began, it turned out that there was no appreciable difference in the amount of reported drug use across the first three cohorts but there was a slight drop in reported use for the final cohort. The mean number of reported substances used by participants over the previous 90 days ranged from two to three for the first three cohorts to "one" substance per person for the final cohort. **There was an interesting "outlier" in the form of one participant who reported experience with ten substances in the previous 90 days, which gave a mean of 3.11 substances for the first cohort.** This individual was subsequently "busted" (*lo narcaron*) soon after enrollment and was unable to attend any of the sessions. When this individual was removed from calculations (as an outlier), the mean number of substances was more reasonable at 2.25 substances, similar to 2.00 for the second cohort and 2.27 substances for the third cohort and 1.07 substances for the final cohort.

Neither alcohol nor marijuana appeared disproportionately among any of the four cohorts over the first half or second half of the project. There appeared to be a high number of heroin users among the second and third cohorts, consistent with injection behavior reported by the participants. Methamphetamine use appeared slightly higher (more reported users) in the final half of the project than the first half of the project.

Reported cocaine use was relatively minimal across the entire project. It is not known whether cocaine users were injectors, given that those who reported injection behavior also reported "using" heroin. *Interestingly, all but one of six participants reporting methadone use also reported using heroin in the previous 90 days.* Not too surprisingly, there was a fair amount of pill use, although we are still analyzing the data to try and determine whether these were "distributed" or "sold" in relation to work or whether these pills were for after-work recreational use. Most of the pills were heroin substitutes (like Darvon) but some (like Valium) were not.

Still, those migrant workers who reported methamphetamine use had used cocaine prior to their initiation into methamphetamine use. In our sample, methamphetamine users tended to be younger and included women users. Methamphetamine was indicated as one way to get more energy, to work longer and to be able to bend over more. The project data would support with some degree of reliability that as one comes from more central and southern regions of Mexico, there was a tendency to see more heroin and cocaine users. The closer to the United States-Mexico border the workers identified themselves as coming from, methamphetamine use was more popular. Those that identified as being from one or more of the indigenous groups, heroin and marijuana tended to be the drugs of choice.

2) Cultural/Personal Characteristics of Migrant Farm Workers:

Migrant farm workers all share several important characteristics that demonstrate continuity historically in terms of them being identified as a vastly under served population. Most migrant workers are foreign born with most in the Yuma County area from various parts of Mexico, Guatemala and El Salvador. The majority of workers do not speak English, have limited formal education and are not literate in any language.

Access to health care is limited, because many work in the agricultural industries where employers do not typically provide health insurance and, as recent immigrants, they are excluded

from federal safety net programs such as Medicaid. In addition migrant workers along the border, if they seek medical attention, tend to utilize health care networks in Mexico due to traditional values and/or affordability. Mobility, language, illiteracy and traditional customs all present significant barriers to substance abuse prevention efforts and culturally and linguistically appropriate efforts are not available.

Also characteristic of much of this population is that the myth of machismo, the religious proscription against certain preventive activities and cultural taboos often prevent migrant workers from adopting health practices which would protect them from substance misuse, HIV/AIDS, STIs and many other health problems.

Also, among these populations, there is a tendency to find many individuals who do not work the full growing seasons. For example, the data from our piloting of Safety Counts showed that 16 persons reported employment during the period of participation in the project (38.1%). A greater proportion were employed for the first half than the second half of the project; eight of 15 for the first two month reported they were employed (53.3%) and eight of 27 participants for the latter half of the project reported they were employed (29.6%).

Border Health Foundation Recommendation:

When looking at migrant workers as a potential population to implement Safety Counts, community-based organizations must take into consideration such employment patterns. As we were able to demonstrate with recruitment, participation levels, the nature of employment and the periods of employment will affect retention efforts.

The Border Health Foundation would strongly encourage those agencies contemplating adapting Safety Counts fully understand what types of work is being done, how many agricultural growing seasons are involved, what are the lengths of these seasons and how many are unemployed considerable periods of time. The success of follow-ups is completely contingent upon knowing these trends.

For agricultural workers especially, an awareness of the different growing seasons will have a direct impact upon your recruitment, retention and follow-up activities. Knowing which growing season is likely to have the greatest numbers of drug users and also the greatest number of potential participants

Border Health Foundation Recommendation:

Although there is a certain amount of general feeling among migrant workers of their similarities as migrant workers, there are numerous differences that must be considered when implementing and adapting Safety Counts. While many are from Mexico, they come from many diverse cultural regions of Mexico.

Those from Michoacan, for example, are different in drug using patterns and other factors from those from Sonora. Community-based organizations must become totally aware of the different cultures that could find their way into regions where Safety Counts could be implemented. You

cannot assume that just because they are from Mexico, everyone understands Spanish at the same level and that they share "affinities" in terms of culture and language.

The Border Health Foundation saw many migrant workers who could not understand a word of Spanish. They spoke one or more Native American languages (with Mixtec being predominant in our pilot area). Other languages could include Zapotec, Yaqui, Chatino, Tarascan, Cora-Huichol and numerous Mayan languages from Guatemala.

Agency staff must make allowances for such exigencies. For example, we found that our Power Point presentations could be adapted to meet the needs of non-Spanish-speaking participants through the use of pictures and other devices instead of Spanish language. The Foundation found that Power Point displays were especially good in keeping and enhancing interest--especially among male participants who tended to allow their minds wander off a little. Comic books are also good. Develop some fotonovelas to broaden the base of keeping participants from varied ethnic backgrounds interested.

3) Rationale for Safety Counts:

The social, cultural, political, legal, ecological, historical and economic interactions of the United States-Mexico border create daunting challenges for dealing with problems of substance abuse--especially among migrant workers. Efforts to address substance misuse-related health problems like HIV transmission have been largely ineffective and uncoordinated.

Injection and non-injection drug use is a growing problem on the United States-Mexico border. Recent ethnographic research by Dr. Anderson (much of this funded by NIDA) and others has shown that it could be as high as 11-12% of the total population in many of the borderland areas--of which migrant workers comprise a substantial number of these percentages. Because of its shared borders with California and Mexico, Yuma County (the pilot target site) is a historic drug-staging area for heroin, cocaine and most recently high volumes of methamphetamine trafficking and distribution. The Pilot site of Somerton, Arizona is less than 10 miles across the Colorado River from the Mexican City of San Luis Rio Colorado, which is the point of export for large-scale drug trafficking en route to Arizona, California and points beyond.

What makes this situation even more dangerous is that there is so little known of the "nexus" of intersecting social norms that are interwoven within the migrant workers drug-using population's cultural norms and values into which an identified migrant worker "culture of drugs" has begun to play and important role.

Complicating matters is the fact that the poverty levels both in Mexico and Southwest Arizona have fueled increased drug trafficking throughout the area which is affecting the communities of both countries' border regions with a "drug spill-over" effect. Drugs are thus highly available at extra-low prices in the region.

This spill-over effect has created an extensive informal economy (that has come to include human trafficking and male forced labor) which in some areas is stronger than the local "legal" formal economy. This has had a significant impact on the local economic, political, legal, health

and social services infrastructures of smaller remote rural areas on both sides of the border. In fact, one key cultural consultant told Anderson in previous research when asked why he became involved in these illicit informal networks, he responded, "It is just another way to make a living in an area where there are no jobs". "Who really pays attention anyway?--"No one in my community".

Therefore, the Border Health Foundation contended that Safety Counts would be an ideal evidence-based prevention intervention to test among migrant workers along the border. It had not been tested with these populations in the past and because they are economically disadvantaged, many of who identify themselves as drug users (also from specific ethnic groups from Mexico, Guatemala, El Salvador, etc.) and the fact that many are inextricably involved with the drug networks in the region, Safety Counts would be an ideal prevention intervention to pilot test.

In addition, the Foundation believed that Safety Counts was an excellent prevention intervention to pilot because it could help fill in the pieces of the broader border picture by providing urgently needed baseline data on the risk levels of migrant workers, what segments of this population is especially at-risk for drug use, what cultural elements among the migrant worker social networks act as barriers in limiting risk behaviors and/or prevent them from being recruited into evidence-based prevention interventions like Safety Counts. The Border Health Foundation believes that it was well-suited and situated to assist the Centers for Disease Control and Prevention to successfully implement and complete this pilot because of working with migrant workers in over 60 types of prevention programs over the last 22 years.

Despite minimal research on the efficaciousness of substance abuse and HIV prevention interventions targeting networks (often hidden) of migrant worker injection and non-injection drug users, what little evidence that exists has shown that effective interventions can be adapted to meet the needs of migrant workers. Still, there remain huge gaps in the contextual knowledge needed to develop appropriate evidence-based prevention strategies for predominantly Spanish-speaking migrant workers.

Despite the fact that Safety Counts was originally developed by Dr. Fen Rhodes as a four-month intervention, it does have core elements and certain key characteristics that still provide ample opportunities to allow us to look at culture and social environment and how these factors affect social processes which in turn drive injection and non-injection drug use among social networks of migrant workers.

Somerton, Arizona was chosen as the target site because the area has a unique combination of characteristics crucial in obtaining the data necessary to address critical questions in substance abuse prevention. The area has a large migrant worker population and increasing injection and non-injection drug use (especially methamphetamine). In addition, the Border Health Foundation has been operating prevention-related programming utilizing the promotora model in the area for the past 22 years. It is this type of prolonged engagement with the target community that is important for the testing of Safety Counts.

B) Agency Resource Assessment:

1) Budget:

The Border Health Foundation has created a substantial reserve and GA accounts over the 22 years of operation. When Centers for Disease Control and Prevention asked the Foundation to pilot test Safety Counts among migrant workers, the organization was in a good position to pay for the pilot testing itself out of these accounts. The total cost for the pilot period was approximately \$25,000.

2) Appropriate Staff:

At the core of the Border Health Foundation's approach for Safety Counts was a team of dedicated, skilled and bilingual/bicultural outreach or community health workers called promotoras (one of which was a former migrant worker). The promotora approach has proven to be especially culturally competent to address and solve issues surrounding health disparities and in accessing hard-to-reach populations like migrant farm workers.

The promotora approach is a goal-oriented process (highly relevant to Safety Counts) that promotes the empowerment of community members in order to address stigma and gain access to services. Each of our promotoras on this pilot fostered the decision-making autonomy of high-risk migrant workers, while supporting the acquisition and continuity of appropriate services.

The outreach strategies that the Safety Counts promotoras utilized included: 1) outreach designed to assess substance abuse and social service needs of marginalized at-risk migrant workers; 2) locating the venues where targeted high-risk migrant workers congregated and accessing these locations to engage high-risk workers; 3) dispensing education and risk reduction kits at these sites; 4) recruiting drug-using migrant workers into Safety Counts; 5) emphasizing a systematic process linking, coordinating, facilitating, empowering, advocating, monitoring service and identifying services for high-risk migrant workers; 6) addressing gaps in services which may be filled through community based organizations linked in a network; and 7) facilitation of access to, and coordination of a range of social and health services which are not usually available through a single agency.

There are certain advantages of hiring promotoras/lay health community workers from the communities in implementing local-level prevention interventions like Safety Counts. These include: (a) to ensure the cultural sensitivity of the prevention intervention; (b) to facilitate rapport with the target group members; (c) to enhance program legitimacy among target group members; (d) to translate technical materials into readily understood concepts; (e) to increase target group concerns about substance abuse and/or other public health concerns; (f) to achieve a better understanding of shared norms, values and perspectives for identifying viable risk reduction strategies; (g) to gain access to the high-risk migrant worker populations' social networks to monitor the adoption and maintenance of risk reduction measures; and (h) to improve follow-up capabilities for reinforcing behavior changes as a result of their knowledge of and relationships to other networks.

The Border Health Foundation ensures that all services they provide are culturally sensitive and relevant by employing Mexican/Mexican promotoras and other program personnel. These individuals are normally long-time residents of the area they are working in. These individuals are totally conversant with the regional borderland culture and language use. This includes being able to provide services in English and the regional varieties of Spanish that form a complex spectrum of language competencies in the border region. This includes a widespread code-switching language variety, the technical term for what was thought to be a switching back and forth between two languages.

Border Health Foundation Recommendation:

Whatever type of outreach model any particular agency has used in its prevention work, the Foundation recommends here that any agency contemplating implementing and adapting Safety Counts certain additional criteria are used in hiring outreach staff especially. Each organization must carefully choose their outreach staff especially based on criteria of strong communication skills; assertiveness; perceptive interpersonal skills; responsible/goal-oriented; easily trained on evidence-based technical concepts; a working understanding of what to look for with substance abusers; appropriate assessment skills; creative service acquisition skills; have knowledge of and contact with available services in their respective communities; appropriate boundary assessment skills; and be a resident of the target community.

Border Health Foundation Recommendation:

If you have one team of two community workers, at least one must be a former migrant worker. Each team of two workers must possess this element. The Border Health Foundation learned from its pilot test that gender plays a minimal if any role in accessing and recruiting potential participants. The key here is that one worker must be a former migrant worker. Such a strategy will provide any implementing agency with credibility within the migrant community and shorten efforts to get the program running considerably.

Border Health Foundation Recommendation:

The Border Health Foundation would also recommend if at all possible, recruiting and hiring a former drug user. However, it is not necessarily imperative if you have a former migrant worker on staff.

Border Health Foundation Recommendation:

Community-based organizations considering implementing and adapting Safety Counts among predominantly Spanish-speaking migrant workers must ensure that their staff is able to operate within regional and culture-specific conventions of politeness that normally are explicitly addressed with regard to/in the context of risk, as well as region- and culture-specific gender-role expectations.

3) Training of Staff:

Given the time frame (roughly four months) that the pilot was to be conducted, a quasi-ethnographic approach was used by the promotoras. Initially, the promotoras received an overview of Safety Counts from Dr. Anderson and one of the Foundation's Senior Researchers (Dr. Keith Bletzer). Within 10 days of actual implementation of the pilot, the promotoras received a formal training from a "certified" Safety Counts Trainer. The promotoras were then trained by Anderson and Bletzer on some of the basic do's and don'ts of participant observation. Instruction was provided on what to look for with camp- and field-centered outreach, informal interviewing techniques, how to gain entry and access to high-risk migrant workers, and how to write detailed descriptive notes, logs and diaries. All field notes were provided to Anderson and Bletzer each week for review and analysis.

All staff for the project--outreach personnel and other staff- must receive on-going training in a variety of areas to allow for the successful implementation and adaptation of Safety Counts.

Border Health Foundation Recommendation:

Agencies should train all current and potential Safety Counts staff as a minimum in the following areas:

- *Ethnographic Methods.*
- *Informal and Formal Outreach Strategies.*
- *Informal Interviewing Techniques.*
- *How to Effectively Assess for Substance Abuse/Misuse.*
- *Individual and Group Counseling Techniques.*
- *Current Trends in Substance Abuse-Related Prevention Research.*
- *Effective Follow-Up Strategies.*
- *Effective Recruitment and Retention Strategies.*
- *Accurate Record Keeping/Documentation.*
- *Issues Surrounding Confidentiality and Informed Consent.*
- *Ethical Dilemmas in Working with Active Drug Users.*
- *What are Social Networks, How they are Constructed and What to look for in Accessing Them.*
- *Group Facilitation Skills.*
- *Cultural Competency.*
- *Logic Modeling.*
- *Behavioral Theories.*

Border Health Foundation Recommendation:

It is absolutely imperative that organizations keep another staff-related issue in mind before actual implementation and adaptation of Safety Counts. If it is not possible to hire at least one

former substance user, it is absolutely imperative to fully train all staff on addiction, characteristics of drug users and what to look for when conducting outreach and recruitment.

This includes how to better identify and access drug-using networks. The individual and group sessions will also require such knowledge.

Border Health Foundation Recommendation:

*A minimum of quarterly training updates need to be provided **to all staff on recent trends in substance abuse prevention-related topics.***

Border Health Foundation Recommendation:

All staff must be trained on the role of evaluation in the implementation and adaptation of Safety Counts. This includes the maintaining of good case files and documentation.

4) Sufficient Linkages and Access to Migrant Worker Drug Users:

Again, the Border Health Foundation has maintained such linkages and access for over 20 years. In addition, all Foundation researchers have extensive ties with such populations by virtue of their research over the years. With the thousands of migrant workers that come into Yuma County and adjacent Imperial Valley in California, there will always be an adequate number of migrant worker drug users to have enough (even with over sampling) participants to complete Safety Counts.

5) Agency Ability to Commit Additional Time and Staff Resources to Adapt Safety Counts:

The Border Health Foundation was able to do this as been mentioned before. Promotoras, current Focus Area Two staff (including Mr. Ricky Wascher-Tavares), Dr. Anderson, Foundation CEO Mr. Albert Moreno, Financial Officer Mrs. Maribel Najjar and Senior Researcher Dr. Bletzer all played important roles in the pilot testing of Safety Counts in Yuma County, Arizona.

Border Health Foundation Recommendation:

The Border Health Foundation here would strongly urge that agencies who want to implement and adapt Safety Counts among migrant workers keep one very key factor in mind. Do not attempt to implement this program over just a four-month period. Sufficient staff and organization resources must be available to allow for prolonged engagement. Recruitment will improve significantly if you can enroll participants in cohorts and where enough time elapses to allow word of Safety Counts to filter out into the camps, fields and migrant worker social networks.

The Border Health Foundation Safety Counts staff discovered that no matter how well the promotoras were trained or known in the region, the message about Safety Counts was most effective when it came from the migrant workers themselves in their own words within their known networks.

6) Part II of Safety Counts Program Manual: See Following Discussions.

C) Formative Research and Evaluation:

1) Literature Review:

It was the primary role of the Border Health Foundation Researchers to review all relevant literature relating to the implementation and pilot testing of Safety Counts. In addition, Dr. Anderson and Dr. Bletzer have extensive field research with these and other borderland populations which allowed for effectively supplementing the training of staff. In fact, it was by virtue of working closely with Centers for Disease Control Science Application Team and our Program Consultant and having access to such research that made it clear to Anderson and others at the Foundation that Safety Counts would indeed be a good prevention intervention to test among migrant workers.

2) Obtaining Information from Experts in the Fields of HIV Prevention and Drug Use:

Again, Border Health Foundation research staff and CEO have considerable professional networks with scholars from several universities, Research Centers (like NDRI) and prevention specialists in a variety of disciplines across the United States and Mexico to allow for such a free exchange of ideas on migrant workers, drug using networks and what prevention interventions would most likely be most successful with them.

3) Conduct Structured Interviews and Focus Groups With Local Drug Users:

The Foundation was well-prepared to undertake Centers for Disease Control's request to pilot test Safety Counts among migrant workers in Yuma County. Both Dr. Anderson and Dr. Bletzer have done considerable ethnographic and social epidemiological work on drug use patterns among many populations of users along the border and throughout other areas of the United States. In addition, the Foundation was awarded a year earlier a SAMHSA-funded HIV Planning Grant for Yuma County (Project Director was Anderson).

Much of the data that we were to use as part of our rationale for pilot testing Safety Counts came from this project. Several research strategies were used to obtain the baseline data we would need to implement Safety Counts. These included: (a) epidemiological/social profiles; (b) participant observation; (c) cultural inventories; (d) cultural consultant interviews; (e) life histories; (f) focus groups; (g) network analysis and; (h) decision-tree modeling.

Border Health Foundation Recommendation:

For those agencies that may be contemplating implementing and adapting Safety Counts for migrant workers, the Border Health Foundation would recommend that beyond the usual methods of acquiring necessary baseline data (e.g., focus groups and cultural consultant interviews) every effort in terms of staff time and resources be applied in completing a cultural inventory or two.

A "cultural inventory" is basically a qualitative strategy and is an on-going assessment of "cultural artifacts" that comprise physical and sociocultural structures of a community. For instance, such factors like where bars and other venues that may cater to drug-using migrant workers and their sexual partners are geographically located in relation to where public parks and schools are situated are considered important facts. Places that are known for harboring illegal drugs are another relevant factor, along with places where sex workers congregate.

Before implementing Safety Counts it would be advisable to continuously note various aspects of the community as well as linkages with the wider region. Data specific to socioeconomic conditions of the community with special attention to drug/alcohol distribution and sales should be analyzed. A cultural inventory will help any agency identify the different groups of drug users (including social networks and where they congregate); where to conduct outreach; the optimal times to conduct outreach activities; and groups of individuals within the community that could assist with the implementation of Safety Counts.

Border Health Foundation Recommendation:

In addition, to the Cultural Inventory or other community assessments, the Foundation would strongly encourage agencies to conduct a situational ("gap") analysis of existing social and health agencies that may serve migrant workers to determine the gaps in service provision and to ascertain those areas where the prevention intervention can be adapted so as not to duplicate services.

Border Health Foundation Recommendation:

An Advisory Board is a must and it must have substantial migrant worker representation (and at least one who was a former drug user).

D) Adaptation of Intervention Activities:

b. Program Enrollment Session:

- (1) Introduction: Adaptation not Applicable.
 - (2) Eligibility Check: Adaptability Not Applicable.
 - (3) Completion of Program Enrollment Form
- (a) Demographic and Personal Information:

Interesting Finding:

For residential arrangements of the participant sample, there were no data collected specifically on this facet of their lives outside of the Enrollment Forms (because of the nervousness of the part of some participants). Several addresses on the Enrollment Forms were the same. *This suggests to the Foundation that those who became acquainted with the project were likely to*

encourage participation of "friends." This actually benefited future recruitment efforts by the promotoras.

Interesting Finding:

Parents by far were the most commonly reported contact person for participants (13 of 28 or 46.4%) followed by friends (*amigos*) at 21.4% (6 of 28). *What is important here for consideration of recruitment and retention purposes is that it was not known to what extent the person named as "contact" was in fact living in the same household as the participant or was providing living space to the participant.*

Previously we reported that there were basically two periods over the four-month span of the pilot that we divided the program up into. These two periods were March-April and May-June. These two periods correspond to the seasonal division of labor in Yuma County, whereby most agricultural workers, the population from whom we drew our sample, work intensely in perishable crops up to the final weeks of April.

At that time, as the migrant season begins, many travel to areas of Arizona outside Yuma County or to other states in pursuit of farm labor. Some may seek jobs outside agriculture but eventually return at a later date to agricultural labor whether they return back to Yuma or elsewhere in Arizona or another state along the border. A few workers remain in Yuma County for a short season of melons; of these few, most spend their time irregularly employed and unemployed.

It is imperative that we note this factor here because it will influence in many ways how adaptation must evolve from the Introduction all the way through the four-month program.

Border Health Foundation Recommendation (Program Enrollment Form):

For those agencies that may be thinking about implementing and adapting Safety Counts for migrant workers, it is probably advisable to extend the Enrollment Session from 55 minutes to 70-80 minutes. This is because there will be considerable confusion with most groups of drug-using migrant workers especially with the Risk Reduction Interview.

In terms of the Program Enrollment Form, most agencies will find it beneficial to expand the questions to take into consideration Race/Ethnicity. As I mentioned earlier, many individuals from Mexico especially will identify with more than one group (Mexican/Mixtec for example). In addition, it would be wise to add a question on where an individual was from in Mexico or other country. This will have major ramifications for the group sessions, individual counseling session and social events.

This not to say that you need to have a supplemental form developed. In fact, the Border Health Foundation would recommend that this information is asked as part of the overall interactive process of eliciting the required information. Staff should be trained in probing in a non-threatening manner to get this data. Once the staff member has acquired this data, make notations "in a subtle way" in the margins of the form. Migrant workers are a suspicious group

to begin with and you do not want to have to fill out in front of them any more paperwork than is absolutely necessary.

It should be mentioned here that there were instances of confusion when working with participants on this form. Many of the "scientific" names for the drugs were not known to the participants. Just as in urban street environments, where there are local terms used for these drugs, the same holds true for many migrant workers. Dr. Anderson and Dr. Bletzer attempted to instruct project staff on what these drugs were and what some of the "slang" or street names could be. This is still not enough because migrant workers still have different names for many of these substances.

Considerable time must be spent in training staff on what are some of common terms for many of the drugs listed on the Enrollment Form. Very few drug users in either rural or urban environments will identify them with the scientific names. This is especially true for younger drug users among the migrant worker population. Also, agencies contemplating implementing and adapting Safety Counts among migrant workers must always keep in the back of their minds that many (if not most) of these workers will be illiterate in any language and not likely be able to related to scientific terms for drugs.

Community-based organizations must provide training to their outreach staff on ethnographic techniques like participant observation and informal interviewing techniques. The Foundation would strongly encourage that time be spent in developing a "dictionary of drug terminology" that migrant workers in their area utilize in identifying specific drugs. This can be done as part of their overall outreach and recruitment activities and by informal interviews. This will go a long way in getting "buy-in" from potential participants in showing that you are aware of their unique needs, while at the same time remove much of the inconsistencies in responses that could add more time completing the form. The Border Health Foundation has been working on such a dictionary for the border and it highly recommended.

In addition, having a former migrant worker on staff, a former drug user or both could also assist with this process. Just telling participants that some of the drugs may not pertain to them is not enough if they really do and they do not understand what they are because of being called something else among their using networks.

(4) Description and Overview of Safety Counts:

(a) Emphasize the Particular Subgroup

The Foundation learned that the two promotoras were not equally as effective with this part of the Enrollment Session. The one who was from Somerton, Arizona and not a migrant worker was not as effective in having potential participants listen closely to the overview. The female who was a former migrant worker had much more success in keeping participants interested. She was able to explain how Safety Counts was exclusively designed for migrant workers like themselves in the style of language used by this population.

The other promotora speaks fluent Spanish, but it was not the Spanish many of the migrant workers used to communicate among themselves. So, while the promotoras fully understood the importance of providing the overview to emphasize that Safety Counts is for migrant workers just like themselves, this had greater weight in terms of being believed by the former migrant worker.

Another avenue that the Foundation's staff attempted was to stress to the participants that their status as migrant workers is unique to them and that Safety Counts could, in fact, meet those unique needs as it related to drug-use--while the participants could help the Border Health Foundation even better understand their needs. Again, this is why the 55 minutes recommended for the Program Enrollment Session is so short.

Migrant workers need more time to become trustful before they would move into the next phases of the prevention intervention. You have to "get" them at this stage or retention would become an issue. It is important to emphasize here that we are not advocating changing anything in terms of those topics that must be covered, we are instead alluding to the fact that more time could be needed and more probing required to get "buy-in" from a very suspicious population.

Border Health Foundation Recommendation (We Stress This Point Many Times Throughout This Report!):

At least one member of the Safety Counts team must be a former migrant worker. This individual will have the greatest impact early in the intervention's implementation. This individual will be able to interact during the Program Enrollment phase to keep potential participants interested in continuing with the program. This is not to say that the other promotora was ineffective. On the contrary, she was able to provide the other sessions in an interactive fashion to keep participants interested. But, this was after they were drawn in by the former migrant worker.

(5) Completion of Risk Reduction Interview:

(a) Risk Reduction Interview:

The Border Health Foundation does not adhere to the belief that this should be changed. However, there were some interesting dilemmas that surfaced during this part of the Enrollment Period. After the first few participants, it became clear to Dr. Anderson, Dr. Bletzer and staff that based on a wide range of entries on the forms (one could say "highly personalized"), considerable attention needed to be paid to working with participants on the Personal Risk Reduction Checklist.

Border Health Foundation Recommendation:

As part of the "formal" training on Safety Counts, greater time should be allotted by the Trainer on the Personal Risk Reduction Checklist--especially for migrant workers. This section needs to be highly interactive and the staff must be able to allow it to flow because of the chance it could become "bogged down" on definitions and so on. Again, because migrant workers are uneasy

with "outsiders", if this section is not handled in an interactive exchange the "buy-in" will not be there and retention rates will be low.

Staff must be fully conversant with the key terms and behaviors mentioned on the Checklist and they must appear that they know what they are talking about before the migrant workers will take them seriously. Staff must really be instructed on how to do this correctly.

In terms of analysis of the data based upon participant response to the Checklist, no difference was evident in the amount of attention paid to either sexual risk taking (condom use, number of partners, etc.) or substance use risk (cleaning needles, reducing drug use, etc.). All the possible choices filled the pages of the Checklist. Mostly these were Not Applicable and Yes/No with very few forms having "somewhat." Checklists that had the most entries were filled primarily with participant choices of Yes/No. These inclined toward having more "yes" responses, at a ratio of two ("Yes") to one ("No").

Since the Checklist serves as the baseline information for participant risk reduction cross-check (two progress reports as Follow-Up), it is interesting to note here that "no" responses were used more for that portion of individual entries dealing with project plans ("I have a plan...") and reported progress ("I feel good about my progress...").

For some reason (and we are still looking at the data here), the item covering "one partner" was chosen more often than other items for sexual risk taking, *whereas items for substance use risk taking appear to be more evenly distributed among individual items on the Checklist.* This is obviously an important finding, but we are not sure what to make of it at this point. It could be due to the fact that migrant workers are known among themselves in such a small community and it is considered "safer" not to mention too many sexual partners because of possible negative consequences if word got out. Clearly, the fact that participants all knew who used drugs and what, was considered less of a threat to those migrant worker participants at this stage of Safety Counts.

Border Health Foundation Recommendation:

Staff must be trained well to take note of issues such as this. The development of the goal-setting stage must take these differences into account. Issues surrounding sexual behaviors are clearly less likely to be answered "honestly" in rural migrant worker settings. Because everyone knows who is using drugs and what they are using, getting "honest" responses is much more likely.

Inconsistencies occurred minimally between data on the Checklist and other data supplied by the participants on other Safety Counts forms. Two instances appeared where another form had no reported injection behavior, but the Checklist indicated that the participant planned to make their injection practices safer, and there was another instance of inconsistency for entries on the Checklist for sexual risk taking (NA on Checklist for practices in which a participant had reported engagement over the previous 90 days). The only two instances of a specific alternative from risky sex were entries for "Not Sexually Active over the Past 90 Days" and "Abstinence" for separate participants.

Border Health Foundation Recommendation:

Many of the above inconsistencies occurred early in the project. They became much reduced as the second through fourth cohorts were completed. It is important that staff be trained on how to ask questions consistently in the same order to all participants. Through such consistency in how questions and discussions are framed you will reduce such problems.

A few Checklists had missing information. Seven forms were filled totally Not Applicable; three were for substance use risks and four for sexual risk taking (four of the seven were from the final cohort). Nearly twice that amount had been completed with most of the risk items listed as Not Applicable. Some for example, had entries for "one partner" with the remaining risk items listed as Not Applicable; some had entries for "one partner" with items checked on condom use; and several had items checked for the last two on HIV and Hepatitis Counseling and Testing, whether or not they had other items checked.

One Checklist had the first page blank (first cohort) and one Checklist had the last page blank (third cohort). A few Checklists had items crossed-out with other choices as "corrected" responses. Again, what this could be arguing for is that more than 55 minutes is really needed for the Program Enrollment Session. All-in-all, these few examples of inconsistencies did not detract from the number of participants that completed Safety Counts.

(6) Referral for HIV Testing and Other Needs:

(a) Providing Referrals and Community Linkages:

As could be expected, this is one of the strong points of the Border Health Foundation in its 22 years of operation. The organization has extensive experience in developing coalitions and service provider collaborations.

Border Health Foundation Recommendation:

Due to the characteristics of a highly mobile and often time transitory population, agencies must be in position to make referrals broad-based enough in terms of potential services and which can be made at any time during Safety Counts. Procedures for providing transportation to those requesting services must be part of any Implementation Plan. Referrals should be provided to such services as: HIV and Viral Hepatitis Testing and Counseling; Screening for STDs; Low-Income Housing; Food Banks/Pantries; Domestic Violence; Reproductive Health Services; Substance Abuse Treatment Facilities; Mental Health Services; Legal Services for Recent Immigrant Drug Users and Their Sexual Partners; Support Groups; Homeless Shelters; and Prevention Case Management.

The way that the Foundation approaches the idea of referrals and community linkages through a community mobilization design and if referrals for specific services are required or requested by participants in any of its programs (including Safety Counts), these are made to an appropriate service. In other words, when making a specific referral or when responding to a specific request

from a participant, the promotora or other staff member will carefully consider the most appropriate service provider for the participant. Close attention is always paid to the participant's culture, language, and unique status as a migrant worker, gender, sexual orientation, age and educational/developmental levels.

Border Health Foundation Recommendation:

Community-based organizations planning to implement and adapt Safety Counts for migrant workers should develop a Referral Resource Guide (to be up-dated on a regular basis) to be used with program participants and for walk-in traffic into the agency's office. At a minimum this Guide should include a contact person at the referring agency, hours of operation, what they offer and when they offer it.

This is important because through the process of networking, outreach and recruitment Safety Counts staff will be better informed of common barriers that may arise that could work against completing the referral (which could also have negative repercussions vis-à-vis retention in the total program if you cannot demonstrate how well-linked you are in the community in a migrant worker participant's eyes). Only when such barriers are fully identified, appropriate techniques can be implemented to address these barriers. *Every effort must be made to match the referral with participant's stated needs which will greatly enhance the likelihood that the referral will be completed.*

Normally, the Foundation provides the participant with a contact person at the organization in which the referral is made. All Border Health Foundation staff is fully knowledgeable of what the organization has to offer and when it is offered. All such information is maintained in a Referral Resource Guide and other literature kept at the Field Offices. Networking with local agencies is sufficient enough to allow for more than one referral option if necessary. In those cases where a migrant worker would be nervous about contacting the provider directly, the promotora or other staff will make the initial contact on behalf of the participant.

Staff must be properly trained to understand that no information should be shared with the contacted agency for any reason unless the participant gives his/her signed consent to do so.

With respect to migrant worker populations (especially those who are predominantly Spanish-speaking), there are several reasons why a participant could be nervous to call a referral agency on his/her own. One of the main barriers that must be addressed here is the fact that on the United States-Mexico border, the family or social support systems are the processes through which problems are resolved and coping mechanisms are developed. To go outside the family or social support network entails a process involving a trusted "other" that is identified as being credible by the family.

Border Health Foundation Recommendation:

Community-based organizations working with migrant workers and Safety Counts could actually work with participants to assist staff members with getting other migrant workers to utilize

referral services for HIV and viral Hepatitis testing (and other services). Migrant workers have strong social support networks beyond the family because many travel to work without their families present. Many remain in Mexico or other places. Once agency staff gets total "buy-in" from participants, these social support mechanisms can be evoked to assist each other in accessing referral services--even going together instead of individually. Such individuals would be that trusted "other". This also will serve the purpose of keeping everything interactive and allow participants to participate at a different level.

This is important because a residual effect of the family or social support system is the propensity of migrant worker families to distrust any kind of mental health/substance abuse system due to feelings of shame and also of fears of having the situation as being viewed as a failure of the family or support system. This factor is important for all agencies working with migrant workers in terms of Safety Counts because this lack of understanding/education can act as a barrier in seeking help and in engaging in individual and group sessions.

Border Health Foundation Recommendation:

It might be a good idea for community-based organizations to develop their own local-level substance abuse and/or HIV/AIDS hotline if none exists. This would be a confidential telephone service that will provide information, support and referral to anonymous callers who might be migrant workers.

It should be mentioned here that the linkages between the Border Health Foundation and local organizations enables us to standardize our promotora approach while contributing to capacity building efforts. For the purposes of Safety Counts, this is important for any success among the target population. This is due to the fact promotoras fostered the decision-making/goal-setting autonomy of migrant worker drug users, while supporting the acquisition and continuity of appropriate services.

Safety Counts in rural areas where migrant workers may be found in large numbers will only work if agency staff is involved in a participatory community mobilization model based on a bottom-up local-level capacity building hierarchy that builds on individual stakeholders to create a promotora/outreach network that binds community workers and community-based organizations in community-wide efforts.

There must be a process in place that allows for stressing individual participation by community members, broad representation of local interests and respected "stakeholders". A determination of needs, goals and objectives will be formulated in close partnership with community members. In this sense the Foundation's community workers serve as powerful cultural brokers and gatekeepers in mitigating barriers that could limit recruitment of migrant workers into Safety Counts and into other services.

(7) Closing: Adaptation not applicable here.

(8) Participation Documentation: Adaptation not applicable here.

c) Group Session 1:

(1) Introduction:

The Border Health Foundation Safety Counts staff did not attempt to change either sequence or content of this section. However, we did find that for the initial cohorts, getting them to pay attention throughout the Introduction was often difficult. Here, it is important to have a migrant worker staff member to get the participant's to take personal ownership (for them) of Safety Counts immediately and what it could do for them in helping to reduce risk behaviors. *Each of the five topics must be presented in such a way to have relevance to each participant.*

Border Health Foundation Recommendation:

It is imperative during the Program Enrollment period that the staff takes a closer look at how each migrant worker self-identifies and from where they are from. Even though migrant workers have their own social support and own drug-using networks that provide some degree of support (i.e. protection and internal social control), they still come from different areas, possibly speak languages other than Spanish and are of great cultural diversity.

Agencies must consider within what is required to present alternatives of delivery that give the impression of being "individualized" to each worker, while still being able to address them in a group format. Each cohort may require a different approach in how the message is delivered because participants in this group may come from different areas, have different ways of expressing themselves, have different levels of awareness in terms of risk, etc.

In terms of stimulating a sense of group cohesion, we found that sometimes it was a good idea to use one or two of the most vocal participants in the group to play an active role in assisting the staff with the introduction--without making the session too long. For example, when the Brief Facts about HIV and Viral Hepatitis discussion transpired, one of the promotoras would ask one of these participants to summarize what was said in the language the group would relate to.

Another possible strategy to think about (which would be relevant for the other Core Elements of Safety Counts as well) is to develop a wide range of supporting educational materials that could be dispensed at the session for future reference. These could be carried in their pockets and pulled out during their breaks in the fields or at their residence, etc. Several possibilities could be considered here. These would include fotonovelas, comic books, informative brochures/fact sheets that address migrant worker risk reduction concerns in a language and cultural style familiar to them, etc.

While Foundation staff did not have this in their budget, new materials could not be developed. However, we found that some of the comic books and fotonovelas developed in the past that dealt with substance abuse and HIV were of interest to all of the participants. The Foundation would strongly recommend that budgetary arrangements be made to incorporate this strategy into Safety Counts.

(2) Am I at Risk?:

The percentage of Worksheets completed for one or the other Group Session and/or Individual Counseling Session (#1, #2) corresponded to the proportion of clients who participated in each of these respective activities for the first three cohorts, but there was inconsistency in completion for the second Worksheet for the final cohort, where the percentages differed.

The level of consistency in completion of other forms in the participant folders *decreased* rather than increased as the project progressed through time. There were 14 items on the forms that had missing information for the first cohort (n=9 persons), eleven items missing information for the second cohort (n=6 persons), 25 items missing information for the third cohort (n=15 persons) and 40m items missing information for the fourth and final cohort (n=12 persons).

As rates, these would be 1.56 items missing information per person for the first cohort, 1.83 items missing per person for the second cohort, 1.67 items missing per person for the third cohort and 3.33 items missing per person for the final cohort (as already suggested competing activities for staff were taking place at the time of the final cohort). However, these missing items for the first three cohorts did not negatively impact any arguments that Safety Counts would not work for migrant workers. **Instead, these indicate areas where the wording on the items and consistency in asking for them must be considered.**

The most consistent entries were 100% completion for Locale (all but three were Somerton, Arizona) and Sex (gender--assuming no transposed identification), including one person identified as Transgender Male and one woman identified as Lesbian, followed by Currently Employed (four items missing across 42 persons), Age (ten items missing across 42 persons) and Current Contact Person (fourteen items missing across 42 persons).

Greater difficulty in completing forms was experienced for items intended to capture information on risk behavior. There was a high level of consistency for collecting data on whether the intervention participants had taken the HIV test and/or taken one of several available Hepatitis tests (100% consistency in completing each respective item, including a few instances of client "does not know month", "does not know month or year" or client "does not know at all"). Generally speaking, there was greater detail (like naming month) when the test was taken in the previous 12 months. The accuracy of these risk behavior data assumes that clients knew whether a test they took was in fact an HIV Test or Hepatitis Test or another unrelated blood test.

Border Health Foundation Recommendation:

*It might be useful to consider probe questioning for the above items. Again, this would entail providing staff with not only training on Safety Counts, but also some in-house ancillary training on informal interviewing techniques and how to "probe". This is made even more important by the fact that Yuma County participants who (according to their files) had one Hepatitis Test apparently had them all. **Centers for Disease Control must be made aware here that this is extremely unlikely, considering the variation in transmission routes across the five types of Hepatitis (three common, two rare).***

The next most consistent item was for information on condom use according to type of sex (14 items missing among 126 possible entries or an excellent 88.9% completion rate--11.1% non-completion), followed by "injected in past three months" (six items were missing among 42 possible entries or a good 88.9% completion [four of six were for final cohort]). These questions may also require some probing, as there was a fairly high rate of anal sex reported, where nearly all of these instances also included reports of vaginal and oral sex.

Border Health Foundation Recommendation:

While we did not change the content of the Worksheet 1 here, we still might consider changing the order in which the questions are asked--or more specifically change the order of the sections. It is possible we could eliminate or drastically reduce some of the inconsistent answers we get from the participants across the four cohorts. We would not be deleting any questions, nor would we be changing the content. Instead, we change the order to allow for more probing to elicit more consistent responses. This is also because some of the data would indicate that many migrant workers do not think in a totally linear fashion, much like some like some who self-identify as Native American.

It is important here for the Border Health Foundation to stress to Centers for Disease Control regarding migrant workers that high levels of disclosure on anal sex are usually considered "suspect" no matter what the risk context for data collected at point of first contact. So, for future efforts in implementing and adapting Safety Counts for migrant workers, some consideration to these questions must be considered in light of our experiences with migrant workers both prior to and during the pilot testing of Safety Counts.

Finally, there was a drop in consistency for those items in which staff elicited data from participants on other forms of risk activity, when they were asked to specify whether in the previous three months they had engaged in needle transfer ("shared") or whether their sexual partners had engaged in needle transfer (33 missing items among a possible 84 entries or 60.7% completion rate--39.3% non-completion [again less consistency at the end of the project with 14 of 33 missing items appearing over entries for the final cohort]).

Border Health Foundation Recommendation:

Notwithstanding the emphasis in Safety Counts on injection risk community-based organizations wanting to use Safety Counts for migrant workers must pay equally close attention to these items. This is because each item requires an entry (even if the participant "does not know"), to assure that the data are attributing the appropriate behavior to each participant.

It may be necessary within the scope of training on Safety Counts that some attention be devoted to the intricacies of these risk behaviors, that when one is present, there are further requirements in data entry on additional levels of risk. For Safety Counts, for example, a partner may in fact place the participant at greater risk than the individual practices of that participant.

(3) Stages of Change--How We Change Our Behavior:

(a) No additional adaptation necessary.

(4) Learning from Risk Reduction Stories:

(a) While the format in Appendix C of the Manual were adhered to in developing the Risk Reduction Stories, the Foundation staff did encounter some initial difficulties in enlisting individuals to tape or write them down. Initially, it was nearly impossible to get migrant workers themselves to agree to allow staff to either tape or have them write out their stories in their language. Our first story was from a former male migrant worker who had used drugs over a period of several years before he stopped.

This can be expected until the project staff gets out into the fields and is fully known enough to allow those from the actual migrant worker drug-using networks pass the word along by word-of-mouth. It might be a good idea here to video tape several stories at once from migrant workers and up-date them on a regular basis when new workers come into the region. Once the program was known, it was easier to recruit actual current workers into the activity of doing Role Model Stories.

Border Health Foundation Recommendation:

Our staff did not get to develop an actual Role Model Story from a current farm worker because of time constraints--another reason why an agency does not just want to implement Safety Counts immediately, but may want to ease into it. There is considerable preparation to do. We would recommend that several Role Model Stories be developed. They should include both male and female participants as well as past users and current users. Past and current users who provide their stories should also reflect the use of different drugs, because a methamphetamine user who is young may not mirror the needs and stimulate the interest of an older heroin user. Furthermore, we strongly urge that geographical and cultural diversity characteristic of migrant worker populations also are represented within the Role Model Stories.

(5) The Importance of Social Support:

(a) We do not have anything to add to this section.

(6) Where Do I Stand in Reducing My Risks?:

(a) Much of what we would recommend here can be found in Section (2) above. The suggestion to read out loud the questions before the participants fill them out is basically sound. However, instead of the facilitator reading them all, it might be fruitful to consider having one of the participants (do not put any one ill-at-ease here because of the chance that no one can read) read some of them as well to the group. We found that those individuals who were "recognized leaders" and assisted keeping the more vocal members of the group in line were good candidates for this role. By the mere fact that they were able to maintain order so the session could evolve, indicates that they were individuals who the others trusted.

There could be one stumbling block, however, with the part on "Decreasing/Managing my drug use" and attempting to incorporate ways in which this could be done for specific drugs has the great potential for real problems. However, with only four months to complete the pilot, the Foundation staff could not really develop any potential recommendation for this aspect.

Border Health Foundation Recommendation:

As mentioned above, an agency must be really careful in how they approach this section of Safety Counts. For example, trying to demonstrate ways a participant could manage his/her drug use through discussions on how this works for specific drugs could be a disaster. It is absolutely imperative, that staff is fully aware of the physiological and psychological effects of specific drugs, what they are composed of and what they are called among the participants.

Here the Foundation would argue for supplementary in-house training be provided to staff apart from training on Safety Counts. If this does not occur any potential benefits from such discussions could have irreparable consequences for participants if they can not impart the correct information.

(7) Closing:

(a) Adaptation not applicable.

(8) Participation Documentation:

(a) Adaptation not applicable.

(9) Staff Debriefing:

(a) Adaptation not applicable.

d) Group Session 2:

(1) Introduction:

(a) **Look Up Ice Breaker**

(2) Developing Risk Reduction Goals:

(a) See Discussion Below.

(3) Identifying First Steps Toward Goals:

(a) See Discussion Below.

(4) Overcoming Barriers to Behavior Change:

(a) For Steps 2-4, the Border Health Foundation would make an inclusive recommendation. We have mentioned in several places in this report that implementing and adapting Safety Counts is really more than a four-month process. Agencies should carefully plan to conduct several activities prior to commencing outreach, recruitment and the Enrollment Session.

While Steps 2 through 4 do not require any adaptation per se, the Foundation would highly suggest that community-based organizations wanting to work with migrant workers strongly consider conducting some sort of community assessment. There are several quantitative and qualitative techniques that could be used for this purpose. Closed and Open-Ended Surveys are good to start with to get a feel about potential risk and protective factors in the community, both in terms of the general community, but also for migrant workers specifically. Once it has been decided to embark upon completing such a process, it is a good idea to select a sample of 5-10 migrant workers to conduct cultural consultant interviews with. A Focus Group or two with migrant workers (with 6-8 participants) is also a good strategy.

By asking the correct questions for these data gathering strategies, you will be better to provide some valuable information to allow agency staff to become better informed about what types of risk reduction activities could best be utilized in meeting the needs of migrant workers. It is advisable that community-based organizations budget for incentives to potential participants of these activities. In addition, a timeline must be established to complete acquiring this information so as to allow staff to become better familiar with risk reduction strategies as these pertain to Safety Counts prior to its implementation. Staff must be able to give the perception of being informed about migrant worker needs in these areas before the Group Session 2 activities can be completely successful.

(5) Learning from Risk Reduction Stories:

(a) No additional adaptation necessary and the Border Health Foundation has nothing more to add here.

(6) Finding Social Support:

(a) No additional adaptation necessary.

(7) Closing:

(a) No further adaptation necessary.

(8) Participation Documentation:

(a) Adaptation not applicable.

(9) Staff Debriefing:

(a) Adaptation not applicable.

e) Individual Counseling Session:

(1) Introduction

(a) No adaptation required in terms of sequence and content.

(2) Review and Refine Persona Goal Card:

(a) No adaptation required and we had no problem with this one.

(3) Review and Refine First Step:

(a) No adaptation needed and we did not find it necessary to do so.

(4) Ensure Social Support:

(a) No additional adaptation necessary and we had no problems with this part of Safety Counts.

(5) Assess Referral Needs and Make Referrals:

(a) See discussions above. Referrals were made at every stage of the pilot.

(6) Review Future Program Participation:

(a) Adaptation not applicable.

(7) Closing:

(a) Adaptation not applicable.

(8) Participation Documentation:

(a) Adaptation not applicable.

f) Social Events:

(1) Greeting and Introduction:

(a) All recommended steps were followed for this section. However, again we found that if the former migrant worker on our Safety Counts staff did the Greeting and Introduction it was much more effective in terms of the activities that were to follow and in keeping the participants in the right frame of mind to continue with the prevention intervention and to stimulate their drug-using peers to enroll as participants in future cohorts.

Still, there were some very interesting developments with respect to the Social Events that require addressing for future implementation and adaptation of Safety Counts for migrant workers. Because of the nature of the seasonal work of these individuals, there were considerable problems in holding two Social Events for this population. It was not anticipated to be a problem when we piloted the prevention intervention, but the Border Health Foundation can advise future agencies that scheduling difficulties will arise for this Core Element of Safety Counts.

More than any other Core Element of the prevention intervention, completing the Social Events will have the greatest impact in determining whether the participants will complete all steps of Safety Counts. This is reflected in the fact that 15 of the total 42 participants (35.7%) completed all sessions of Safety Counts. **Those that did not complete all steps, it was the timing of the two Social Events that provide to be most problematic.** Still, this number is rather impressive when it is considered that there were a lot of issues to iron out as the pilot evolved. Considering the fact that the Foundation was under time and financial restraints to get the project off the ground for a four-month intervention demonstrates that the number that completed the prevention intervention is indeed good.

The Border Health Foundation has proven that Safety Counts is relevant for migrant workers and have identified most (if not all) of the potential barriers in its implementation and adaptation. As was mentioned earlier in this final report, no agency should contemplate utilizing Safety Counts for migrant workers unless considerable effort is made prior to its implementation in preparing for the potential barriers to be encountered with this most difficult population. Issues surrounding prolonged engagement, conducting community assessments and other activities should be considered.

For this population, we would strongly recommend that some time (up to 60 days) be spent in laying the groundwork for its successful implementation and adaptation. Interestingly, there appeared to be no distinction between men and women in completing the sessions. The Social Events, along with follow-up contacts are the most difficult to achieve with Safety Counts for this population, but it is by no means impossible with a little flexibility and ingenuity. Also, the final cohort (melon season) really had the highest percentage of those who did not complete all of the sessions for some of the reasons outlined earlier.

Border Health Foundation Recommendation:

While the Safety Counts Manual specifies that there should be two Social Events to be held monthly toward the end of the month, with migrant workers, this timeline will probably not work over the long haul over several waves of cohorts. We are not advocating eliminating one of the Events. On the contrary, they were shown to be quite successful for those participants that completed all sessions of Safety Counts. Due to the length of some of the growing seasons and the mobility of migrant workers, we would strongly encourage future agencies to remain flexible here. It could be the situation where the Safety Counts Social Events must be scheduled closer together to ensure that all Core Elements are met and migrants attend all of the sessions.

(2) Program-Related Entertainment Activity:

(a) Initially, this was a challenging task in keeping the migrant worker participants interested, engaged and interactive. There are several possibilities that will work here. Based upon the Foundation's *Entre Familia* (Strengthening Families) project funded by SAMHSA, our staff developed some activities that could have some relevance for Safety Counts in terms of shared cultural characteristics.

For example, there are drug-friendly messages in mainstream U. S. popular culture English language music (including hip hop and rap) widely popular among young adults along the border. Many adults (including migrant workers) also listen to or at least often exposed to the very popular Spanish language drug-running *corridos* which have become ubiquitous in the United States-Mexico border environment.

The songs receive considerable air time on regional radio stations on both sides of the border and many people buy the CDs. These songs openly extol the not-so-covert prestige the underground drug trafficking and using cultures enjoy among some sectors of the region--including migrant workers. A number of songs recommend taking a particular drug (e.g., taking Cocaine makes me able to drink longer and harder with my friends"). Many songs have reference to heroin as "la fina", implying *categoría* (high status, high quality).

Because these songs are listened to by both male and female migrant workers, Social Events can include some entertainment activity surrounding these *corridos*. Staff can play them during the Event and then elicit migrant worker inputs on what these songs mean to them in terms of how they could work against (or even support) the risk reduction goals of the participants. You can turn the Entertainment into literally a Media Literacy Campaign of sorts and critique these songs in order to find those messages the group feels are cultural barriers to risk reduction and that can in some manner be incorporated in some fashion into harm reduction goals.

The Border Health Foundation has also used other activities for entertainment with its other prevention intervention projects addressing the needs of migrant workers. As another potential illustration, an activity that takes the educational/developmental needs of migrants into consideration is to act out the theme of the Safety Counts Social Events using puppets.

This may seem like a children's activity, but our experiences in the past have shown that it is a good way to keep the level of interest among adults high as well. In many ways, such an activity serves the same purpose as the comic books or *fotonovela* formats, but here the participants take an active interactive role in putting what they are trying to achieve in terms of risk reduction into "play".

Depending on where the migrant workers derive from, another activity associated with children in Mexico and along the border can also be adapted for the use among adult migrant workers as well. Piñatas might be a good adaptation to incorporate that has some cultural relevance to many of the participants. But, instead of the normally enclosed candies, the piñata could contain small pieces of paper with Safety Counts risk reduction themes written on them. As we have found, the participants would go for the pieces of paper as they would with candy; then each would have to

explain to their peers/social support participants what they had learned to date about the topic they drew. You can also use balloons and pop them for the topics contained in side on pieces of paper.

The balloon-bursting activity is widely used at Mexican weddings today along with borderland baby showers. Here, each participant could select a balloon with a small piece of paper inside. One-by-one, around a circle of participants, each person could sit on their balloon and pop it. They then would retrieve the paper message and read the message out loud to the rest of the group attending the Social Event.

At baby showers, the paper often instructs the participants to perform some ludicrous pantomime or to read an off-color remark (popular/common with migrant workers) and the person must respond. Whatever, activities are chosen for the Social Event, the aim of the Border Health Foundation is to stress to agencies contemplating implementing and adapting Safety Counts for migrant workers, all staff must be aware of the cultural diversity that migrant worker populations often exhibit--**and it is imperative that the Social Events address this diversity in some manner.**

Entertainment activities must evoke well-known cultural symbols common to this population in administering Safety Counts Social Events. It is most important to emphasize here that the above are only examples that were used by the Foundation in its 22 years of working with migrant worker populations. Whatever strategy a new organization adopts must remain flexible and innovative, while at the same time have cultural relevance to keep participants interested in completing both Social Events.

Another activity that was used in the past with migrant workers for Social Events (time permitting) is making baskets or some other "culturally relevant" item. Such an activity is good for those migrant workers that have Native American roots from Mexico and Guatemala. These baskets could depict cultural themes common to where they came from as well as risk reduction themes learned in Safety Counts. Again, such activities will keep interest high while addressing the cultural sensitivity issues peculiar to migrant workers. Obviously, this type of activity could only be done over two Social Events given the time requirements of this activity.

(3) Meal:

(a) Adaptation not applicable here.

(4) Risk Reduction Activity:

(a) No additional adaptation necessary.

(5) Drawing for Grand Prize:

(a) Adaptation not applicable.

(6) Dessert and Closing:

(a) The Foundation staff followed the Manual on this fully in terms of the closing statement. We have nothing further to add here.

(7) Participation Documentation:

(a) Adaptation not applicable.

(8) Staff Debriefing:

(a) Adaptation not applicable.

g) Follow-Up Contacts:

(1) Approach and Greeting: **See Section on Recruitment/Retention.**

(2) Verify and Validate Client's Goal and Progress:

(a) Adaptation not applicable.

(3) Plan the Next Step:

(a) No further adaptation necessary.

(4) Help Client Identify and Overcome Barriers to Achieving Next Step:

(a) No additional adaptation required.

(5) Social Support Check-In:

(a) No additional adaptation required.

(6) Closing:

(a) Adaptation not applicable.

(7) Participation Documentation:

(a) Adaptation not applicable:

(8) Staff Debriefing:

(a) Adaptation not applicable.

E) Developing a Recruitment and Retention Plan:

Obviously, for the four-month pilot the Border Health Foundation did not have the necessary time to develop a formal Recruitment and Retention Plan. However, our experiences with this population have provided us with experience in terms of identifying potential barriers for implementing Safety Counts among migrant workers. As I mentioned earlier, there are two areas (Core Elements) that must be addressed in the Recruitment and Retention Plan. These are follow-ups and the two Social Events.

While 15 of the 42 participants completed all sessions, 27 initial participants could not be relocated to do more than one follow-up. Nearly all were found for the first follow-up. The fact that participants may often be relocated or reassigned to other field sites must be considered in your Plan in some fashion. In addition, it must be taken into consideration that if you schedule your follow-ups too late in the evening after every one is off work, you will find some migrant workers who do not want to be bothered because they are too tired. This is especially the case if the weather was overly hot that day (it can get up to 127 degrees).

For agencies thinking about adapting Safety Counts for migrant workers in their respective regions, much outreach and recruitment could be conducted in what are often defined as "base camps" where some families will remain the year round. If those base camps exist (they do not everywhere), consider trying to recruit as many participants as possible from these areas.

There are some other interesting patterns that may have to be considered in other parts of the United States as well (outside the United States.-Mexico borderlands). There is an interesting pattern that exists for the Somerton area and is normally exhibited during the summer months more so than earlier in the year.

Many fathers will leave early (even before the last melon season) without the family on their California migration. Some mothers and their children would follow him in about May or early June. They would join up in an area where as many as 5 families would be living at the same time in the same house where all of them have chipped in for purposes of paying the rent. Then the mothers and children return to Somerton when school is about to start and the fathers join them later.

Another interesting pattern is that some of the children are often left in Somerton by themselves while their mothers and fathers do the summer migration cycle. Usually, a 14 or 15 year old adolescent will remain behind, often to be in charge of younger siblings. A grandmother or other relative may go by to check on them maybe once every two weeks, or the parents may call them about once every two weeks to see how they are doing.

One reason why the children are left behind like this and not taken on the migration routes is that in some of the agricultural labor camps, families are not allowed. They are for single men only. Furthermore, in such camps, there is prostitution, drinking, drugs and violence. When fights do occur, agricultural knives are used as weapons. People have known to get killed. This is the primary reason why families that do travel the migrant routes rent houses or garages together and why other families leave their children in Somerton.

Border Health Foundation Recommendation:

The reason why the above factors have been mentioned here is to alert future agencies on Safety Counts among migrant workers, such issues (and many others) must be considered when doing outreach and recruitment. Each region will have its own patterns of mobility, etc. These patterns must be known completely before agency staff will have any success with implementing and adapting Safety Counts for migrant workers.

All Retention and Recruitment Plans must have certain "core" elements to take all potential barriers into consideration. Some of these core elements must include:

(1) Agency staff must be comfortable in obtaining as much information as humanly possible on the cultural characteristics, language characteristics, mobility patters, etc. of migrant workers if they are to be your target population for Safety Counts.

(2) Oftentimes recruitment and retention efforts will provide confused health or risk reduction messages. This is because new staff especially may not be initially totally familiar with what sort of messages are most effective for what type of setting or environment. All agency Safety Counts personnel staff must be familiar with the settings they may conducting outreach in or what is the nature of their linkages with other agencies (for referral purposes) in order to be sure that the messages they present with respect to Safety Counts.

(3) With respect to referral services, it is imperative that recruitment into Safety Counts takes into consideration referrals specific to the prevention intervention itself.

(4) Even though it is not required for Safety Counts per se, the Border Health Foundation would argue that it is a good idea that each Safety Counts staff member track the participant through the referral process to monitor whether they complete the referral or not. There may have been unforeseen barriers in completing the referral, or it could have been simply that the participant felt the staff member was not particularly concerned with his/her well-being beyond completing the Safety Counts sessions. To help with retention purposes and recruitment, it is recommended that monitoring the total progress of the participant through the referral process and not just with the goal-setting activities of Safety Counts.

(5) All Recruitment and Retention Plans must establish minimal standards for Outreach, Recruitment, Making Referrals and Retention. These will need to be expanded and adapted at a later date once the participants and Safety Counts staff becomes more familiar with implementation and adaptation efforts. This will include revising outreach and recruitment venues and even actual strategies to enhance recruitment and retention later on. This Plan must have well-defined strategies for conducting the follow-ups as part of the overall strategies.

While it is possible to conduct recruitment through outreach alone as is indicated by the steps in Safety Counts, we would strongly encourage that all recruitment and retention efforts also entail some recruitment through existing referral service agencies. This is especially the case if these agencies are known to work well with the organization implementing and adapting Safety

Counts and who are also known among migrant workers in being especially sensitive to their myriad of challenging needs.

The Border Health Foundation also utilized recruitment from one of our other existing programs (Abstinence Only) and this appeared to be successful for many of the initial participants. The migrant workers like this particular program and by extension they thought Safety Counts would also be right for them. While recruitment through outreach alone will be successful over the initial stages of the prevention intervention will be more successful through successive cohorts of participants if we combine recruitment through outreach with recruitment through existing referral networks with the community who are known to be able to meet the needs of migrant workers. This process will only enhance the retention efforts.

One of the "ethnographic" strategies that will be helpful as part a community assessment process is that of the Cultural Inventory. This technique has been mentioned earlier and will not be elaborated upon here. It is really a good way to determine and fully become knowledgeable of the venues where migrant workers congregate, work and socialize within their drug-using networks. Also, by doing this you can determine the specific characteristics of your target population which is imperative for adapting the way you present the risk reduction messages of Safety Counts.

Again, this point is extremely relevant for agencies who want to implement and adapt Safety Counts. Prolonged engagement is imperative as it relates to its use with migrant workers. More time must be allotted to "preparation" work. The Foundation would recommend that a minimum of 60 days be scheduled before full implementation.

There must be some sort of social/cultural profile of the migrant worker populations located in different regions of the country. This will allow outreach or community workers plan their strategies more effectively in recruiting participants and for conduction follow-ups and referrals. This will greatly enhance (or improve recruitment and retention efforts).

As part of this social/cultural profile, staff must fully aware of the most appropriate venues from which to recruit from; the optimal times to conduct outreach and recruitment; and other relevant information. This will allow all agency staff involved with Safety Counts to be flexible and innovative in their work. We found that you had to vary the days of the week and the hours for recruitment purposes because on some days, the workers may not be in the same fields as they were when the initial contacts were made.

This was especially the case for Yuma County during the four months we conducted the pilot because there were two growing seasons back to back and both were relatively short in duration. These factors also pertain to follow-ups and the monitoring of referral activities (even though this is not required--we still highly recommend some monitoring activity).

As I mentioned earlier in this report, it is absolutely imperative that agencies implementing and adapting Safety Counts for migrant worker populations, ensure that at least one staff member (preferably an outreach/community worker) be a former migrant worker. For established agencies like the Border Health Foundation, who have worked with migrant populations over a

long period of time this is established practice anyway. However, there may be other organizations out there who will be working with these populations for the first time. As a result, they may not be totally aware of this need.

Outreach staff does not necessarily need to be males for this high-risk group. We have had many prevention-related projects where our promotoras have been predominantly females with little problems during outreach and recruitment activities. This is partly because the promotora model is known from the regions from which many of the migrant workers derive, and normally the promotoras in these areas are highly respected women who were born and raised in the communities they served. It might be wise to have at least one staff member who was a former drug user as well. This would lend itself to even greater legitimacy among drug-using migrant workers--although such an employee did not turn out to be an urgent need for the pilot.

Border Health Foundation Recommendation:

At least one Safety Counts staff member must be a former migrant worker. If this does not happen, then outreach and recruitment efforts could run into some major snags. Still, this is not enough. The Foundation would strongly encourage at a minimum that all Safety Counts staff receive additional in-house training in the following (beyond being formally trained on Safety Counts itself):

- *The Relationship of Successful Outreach and Recruitment from a Scientific Context.*
- *Staff Must be Trained on Understanding and on How to Recognize Drug-Related Dependency.*
- *Staff Must be Provided Training on How to Comprehend the Relationships Between Migrant Worker Self Perceptions of Their Cultures, Disease and Wellness in the Context of Being At-Risk to use Drugs.*
- *Some Basic Training on Some of the Simpler and Basic Ethnographic Techniques Would be Useful.*
- *Training on the Various Approaches to Successful Outreach and Recruitment among Other Populations Would go a Long Way in Allowing New Staff to Better Develop Additional Strategies that may be Unique to Accessing Migrant Workers.*
- *This Would Include a Brief Introduction on the History and "Philosophy" of Outreach. This Introduction Should Specifically Address Outreach in its Role of Preventing HIV/AIDS, Successful Recruitment, Follow-Ups, and Referrals.*
- *Provide Some Insights into Migrant Workers Specifically as Such Knowledge Would Pertain to the Daily Lives of Substance-Abusing Migrant Workers.*
- *Training on Cultural Competency to Take into Account the Great Diversity of Cultures that the Migrant Worker Populations Represent.*
- *Individual Counseling and Group Facilitation Skill Training is Highly Recommended.*
- *Additional Training on the Role and Importance of Evaluation.*
- *Training on What the Various Drugs on the Enrollment Form are called (in Non-Scientific Language) by These Populations in any Respective Potential Target*

Region. This is Where Having a Former Migrant Worker on Staff Could Help if it is not Possible to Have a Former Drug User as well.

Another strategy that should be included (if possible given any potential budgetary restraints) is to incorporate a program entailing the use of secondary incentives. This would help with recruitment and retention efforts in a major way. Secondary incentives would be offered to "seed" participants to refer other migrant workers to the Safety Counts program. This could be done in a variety of contexts.

For example, this is where some remedial training on ethnographic techniques could be beneficial. As many people know, ethnography is sensitive to inconsistencies between how people describe themselves in the "ideal" and how they actually behave for "real", at the same time that it can provide qualitative data to improve quantitative (for evaluation purposes in Safety Counts) and to develop interpretive models of drug community interactions.

I, as a Principal and Co-Investigator on several drug-related NIDA grants, have found that at any educational/developmental levels outreach staff can be trained on basic ethnographic procedures as part of their overall duties on projects similar to the prevention intervention goals of Safety Counts. This would include some basic knowledge on participant observation, interviewing techniques and network analysis to name just a few.

I firmly believe that by providing such training before actual implementation and adaptation of Safety Counts would go a long way in improving the obvious problems associated with recruitment and retention of migrant worker participants in Safety Counts. Because the type of ethnography I am advocating for here would simply be that such techniques or knowledge would assume (i.e. questions on how, why and where) certain social actions may become migrant worker cultural realities that can affect migrants decision to initiate and maintain drug use.

With respect to the payment of secondary incentives to individuals (where each "seed" participant would receive monetary compensation for each migrant worker recruited into Safety Counts), the process should follow some of the basic ideas associated with one or a combination of several types of network analysis. The best way to look at this is think of it as a combination of chain or snowball sampling with ego-centric networks (with alter connections). Any outreach worker can be taught the steps in conducting Random Walks (or "Walk Alongs"). Through outreach and/or participant observation, staff could identify potential "focal actors" who are knowledgeable of the drug-using migrant worker populations.

I would recommend that 5-10 individuals would be enough to assist with recruitment into Safety Counts. Each of these focal actors will be the "seed" participants and be asked to name as many individuals (taking agency budgetary constraints into consideration) as possible, where to locate them, optimal times to locate them, etc.

For every one of these potential contacts actually enrolled in Safety Counts, the "seed" participants would be paid a certain amount and for every participant that completes all Sessions they would be paid an additional amount. You have to be careful here in that what you would pay these "recruiters" is not more than those who complete Safety Counts. Word may get out

into the migrant worker communities and you will be back to where you started if you were having problems with recruitment and retention to begin with.

It is the belief here that by employing such a simple strategy where actual migrant workers recruiting other migrant workers will bring a high level of legitimacy for Safety Counts and the agency implementing and adapting this important evidence-based prevention intervention. **Furthermore, a Random Walk approach where you attempt to recruit "seed" participants and other potential participants for Safety Counts is particularly effective prior to actual implementation, in allowing for greater visibility and in minimizing community curiosity on one's purpose in high-risk areas where migrant workers congregate or work.**

Border Health Foundation Recommendation:

Beyond thinking about implementing a program of secondary incentives, agencies should also consider "stepping-up" the amount of incentives for each Session completed by the actual participants in Safety Counts. In other words, you would start off with a lower-level incentive and increase it through each phase of the prevention intervention. Obviously, an organization's budget must be able to absorb this, but with effective planning it can be done.

Sampling Strategies:

Up to this point sampling issues have been avoided. It was mentioned earlier that we did not utilize any sampling strategies for the pilot test. This was because we only had 4 months in which to complete Safety Counts and training of staff was limited to formal instruction on Safety Counts and on some basic ethnographic techniques like participant observation, interviewing techniques and so on.

For new agencies contemplating implementing and adapting Safety Counts to their respective migrant worker populations, there is another issue that must be considered. This is staff must have some ability to understand the nature of sampling strategies that could improve their outreach, recruitment and retention activities.

This is another good reason why no agency should plan to implement this prevention intervention without some preliminary preparation (minimum of 60 days). It has been mentioned many times that prolonged engagement is a necessary prerequisite for the successful implementation of Safety Counts among migrant populations.

Using ethnography again as an example, ethnographic investigations among drug users ("hidden populations") can normally locate suitable numbers for analysis through chain referral and other sampling strategies. Still, this does not always allow researchers to make inferences from their sample to hidden populations as a whole. With respect to recruitment and retention into Safety Counts, I would argue that the same situation could present itself.

Border Health Foundation Recommendation:

We would argue that chain referral/snowball sampling would work in general in those situations where recruitment and retention have not emerged as a problem. However, where such problems begin to present themselves (and it did early in our pilot testing), we would recommend combining chain referral sampling with the use of secondary incentives with "seed" participants to help with an agency's efforts here.

This would really work with ego-centric networks we have found to be relevant for migrant worker populations and through Random Walks during outreach to identify potential focal actors among the migrant workers and use his/her network ties to assist with recruitment.

I would contend here that simple random sampling (equal probability sampling), stratified random sampling and purposive sampling could work in some situations-especially if there is only one growing season and if the migrant workers are in some other occupation than agriculture and are in a location for longer periods of time (i.e. where base communities could exist). However, I would not recommend these sampling techniques as stand alone strategies. I would combine and/or adapt them with snowball/ chain referral, Random Walks and ego-centric network techniques combined with secondary incentives.

Finally, if you are dealing with longer working seasons, agencies that lack staff to implement the above sampling designs could "get by" with some adaptation of purposive sampling where you identify the substance-abusing migrant worker populations based on characteristics they have in common. You need to really be careful here. The only characteristics they may have in common are that they are migrant workers and they use drugs. We have mentioned that there is great cultural and language diversity of these populations. Therefore, it is the belief here that Purposive sampling, in and of itself, really is not suitable for these types of issues.

Whatever sampling strategy an agency decides to adopt/adapt, the Foundation learned from the pilot test, that it is extremely wise to consider over sampling by around 8% during the recruitment of the initial cohorts of participants. This will better ensure that you have adequate numbers of participants completing the follow-ups and Social Events. We have mentioned that these are the two programmatic areas of Safety Counts that became most problematic for us in terms of retention. Once the program evolves through additional waves of cohorts, over sampling by 5% would probably adequate.

With respect to follow-ups, we encountered similar problems with Safety Counts as we have with other Border Health Foundation prevention programs. This is a highly transitory and mobile population which plays havoc with required follow-ups for any program. **We found that it is a good idea to do a follow-up within just a few days of each session.** While, we are not arguing to reduce the number of follow-ups, we are arguing that it would good to consider "bunching them" up a little more to assure better retention and in the re-locating of participants.

Final General Recommendations/Suggestions:

For the final discussion of this report the Border Health Foundations would like to add a few more things to look for in terms of what we found to work with the pilot test. These really do not fit well into the sub divisions above so we will add them as additional suggestions that could work for other agencies in the future.

- **This suggestion bears repeating. Do not attempt to implement this program over just a four-month period. Prolonged engagement in some form is an absolute must. Recruitment and retention will improve substantially if you can enroll participants in cohorts and where enough time elapses to allow word of Safety Counts to filter out into the fields, camps and using/social networks of migrant workers. We found that no matter how well the promotoras are trained or known in Yuma County, the message about Safety Counts is most effective when it comes from the migrant workers themselves in their own words/language and within their own known networks.**
- **An Advisory Board is a must and this body must have migrant worker and substance abuser representation.**
- **Power Point presentations are especially good in keeping and enhancing interest--especially among males who have a tendency to look around the prevention intervention setting a lot. In addition, among indigenous speakers like Mixtec, Zapotec, Chatino, Tarascan, Cora-Huichol, Yaqui, Otomi, etc. who may have some ability in Spanish, Power Point can be utilized and adapted with a minimum of words to have relevance and interest to them as well.**
- **For Spanish-speaking migrant workers, agencies should think about creating educationally/developmentally informational materials to supplement the Safety Counts Sessions. Especially effective here would be fotonovelas. We have found that comic books are also quite good in keeping interest. All such activities could help recruitment and retention immeasurably.**
- **A strong referral network is a must--especially with Health Departments, Clinics, etc. that do confidential HIV and Hepatitis testing. For example, our staff was asked repeatedly if the Foundation did HIV testing. As a result, the Foundation worked out an agreement with the Yuma County Health Department to have their mobile van available at some of our outreach, recruitment and follow-up activities to do the HIV testing.**
- **Risk reduction kits were extremely popular with all of the participants. Agencies should plan to begin early in putting these together. These kits are also good for adding the fotonovelas and comic books as a total prevention intervention "package".**

- **Although field/camp-centered outreach and recruitment is good over the long run through several cohorts, agency staff must always remain flexible and adaptable and regularly vary the hours and days of outreach to venues where workers congregate and be fully aware of when these venues change. This is a highly mobile population and what works with one cohort will not work with succeeding cohorts.**
- **Because in some regions along the border and in other regions where migrant workers may be found, the growing seasons may be shorter than others (and there might be more than one growing season in some regions), for follow-up purposes, adaptations in timelines may need to be made or adjusted. It is not a good idea to shorten the recommended time for each phase/activity/core element, but the individual counseling sessions, the group sessions, social events and follow-ups may have to be bunched more together if you want to have a high retention rate. For example, instead of having one social event toward the end of the month, you may have to schedule two--especially if you have successive waves of cohorts.**
- **Transportation will be needed for the participants to access referral services.**
- **Agency staff will have to be flexible and innovative on where to conduct the various sessions. We even did one in a garage with the door down so that no one knew the workers were there in the residence of a former migrant worker (one who was known and trusted by Safety Counts participants). Conducting the sessions in low-income housing areas is also a good location.**
- **Safety Counts sessions in apartments or low-income housing complexes were most successful in getting people to return for the next activity. This was because the migrant workers see these locations as "safe havens" where the police do not patrol as much and ask too many questions. It is known that Yuma County police do not like to spend too much time at these venues because they areas where much drug-related violence occurs.**
- **Capacity building assistance to other community-based organizations must remain an on-going goal of all agency staff in their respective communities. Such organizations could assist each other with the implementation and adaptation of Safety Counts to ensure that even larger numbers of this high-risk population are served. Some of these agencies should be represented on the Community Advisory Board.**

Final Comments:

In summary, the above discussion will hopefully be informative for the Centers for Disease Control and Prevention in helping to address adaptation issues of Safety Counts among migrant workers. The Border Health Foundation has been able to generate volumes of data from this four-month pilot--probably even more than we even could anticipate heading into this exciting opportunity. We firmly believe that the barriers that future agencies will encounter are fairly well detailed in this report and what types of strategies the Border Health Foundation staff used to address some of these.

There is no doubt in our minds that Safety Counts can be successfully adapted to meet the needs of high-risk migrant worker populations. This is because Safety Counts can be "personalized" for these groups and the duration of four-months is especially well-suited for this mobile and sometimes transitory population. However, The Border Health Foundation would strongly recommend that no attempts be made by any agency to implement and adapt the prevention intervention before a minimum of 60 day preliminary preparation is done. This would include being involved with activities that will allow for prolonged engagement in the communities and venues frequented by migrant workers.