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Research paper

Injection risk norms and practices among migrant Puerto Rican people who inject drugs in New York City: The limits of acculturation theory

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ABSTRACT

Background: Among people who inject drugs (PWID) in New York City (NYC), racial minorities are disproportionately infected with HIV and hepatitis C (HCV). Prior research has shown that PWID who started injecting drugs in Puerto Rico (P.R.) tend to maintain the risky injection behaviors learned there. This study identifies the P.R.-native norms supporting the continued injection risk behavior of migrant Puerto Rican PWID in NYC to inform a culturally appropriate risk-reduction intervention.

Methods: 40 migrant Puerto Rican PWID were recruited in NYC for a longitudinal qualitative study. The sample was stratified to include 20 migrants with < 3 years in NYC and 20 migrants with > 3-6 years in NYC. Time-location sampling was used to curb possible network bias in recruitment. Over 12 months, migrants completed semi-structured interviews at baseline, monthly follow-ups, and study exit. Analyses were guided by grounded theory.

Results: Most participants (90%) reported having had chronic HCV, and 22.5% reported being HIV-positive. Syringe- and cooker-/cotton-sharing were widespread in both P.R. and NYC. The ubiquitous practice of cleaning used syringes by "water-rinsing and air-blowing" was guided by a normative belief, learned in P.R., that "water and air kill HIV." Sterile syringe use was not a priority. HCV was not a concern. P.R.-native abstinence-only narratives discouraged opioid agonist treatment (OAT) enrollment among recent migrants (≤3 years). Experiences with drug dealers, prison-power groups, and injection doctors ("Gancheros") in P.R. influenced migrants' injection risk behavior in NYC. Those who were Gancheros in P.R. continued working as Gancheros in NYC.

Conclusions: Injection risks make migrant Puerto Rican PWID in NYC vulnerable to HIV/HCV. Harm reduction programs should pay closer attention to the rationales behind these injection risks. A risk-reduction intervention that incorporates the Ganchero figure may be a credible way to help migrants reduce injection risk and accept OAT and syringe exchange programs (SEP).

Introduction

As the national opioid and overdose crises surge, New York City (NYC) remains a key player in the United States' (U.S.) urban drug scene. The Bronx, the poorest of the 5 NYC counties, has the highest number of overdose deaths, and the largest number of Puerto Ricans (Centro, Center for Puerto Rican Studies, 2016; Paone, Nolan, Tuazon, & Blachman-Forshay, 2017). Among Latinxs in NYC, Puerto Ricans are at highest risk for opioid overdose, accounting for 67% of all overdose deaths from 2000 to 2015 (Greer et al., 2017). Although HIV incidence and prevalence among people who inject drugs (PWID) in NYC are at historical lows (0.1/100 PY and 10%, respectively) (Des Jarlais, Kerr, Carrieri, Feelemyer, & Arasteh, 2016), racial minorities continue to be disproportionately infected with HIV among PWID (Des Jarlais et al., 2017). Among racial minorities, migrant Puerto Rican PWID remain vulnerable to HIV/AIDS and hepatitis C (HCV) (Deren, Gelpí-Acosta, Albizu, Gonzalez, & Des Jarlais, 2014; Gelpí-Acosta, Hagan, Jenness, Wendel, & Neaigus, 2011; Gelpí-Acosta et al., 2016). Reliable HIV and HCV prevalence estimates for migrant Puerto Rican PWID in NYC do not exist. Yet, when compared to U.S.-born PWID, one study found

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higher HIV prevalence among migrants (Gelpí-Acosta et al., 2011), and another suggested that HIV infection may occur after the migration event (Gelpí-Acosta et al., 2016). Also, while HCV prevalence among PWID in NYC is estimated to be 67% (Neaigus et al., 2017), it may exceed 90% among migrant Puerto Rican PWID (Gelpí-Acosta et al., 2016).

The vulnerability of migrant Puerto Rican PWID in NYC is rooted in socio-structural conditions in Puerto Rico (P.R.), where many initiated injection drug use. PWID in P.R. lack access to opioid agonist treatment (OAT, i.e., methadone or buprenorphine) and HCV treatment (Abadie, Welch-Lazoritz, Khan, & Dombrowski, 2017; Abadie et al., 2018). Also, there are only 5 inadequately funded syringe exchange programs (SEPs) in P.R. (Des Jarlais et al., 2015). These structural barriers to PWID health make P.R. a ripe context for injection risk behaviors such as syringe sharing. Furthermore, the pervasiveness of injection drug use throughout P.R.'s prison system promotes injection risks (Rodríguez-Díaz et al., 2011).

The economic and political crises in P.R. (Morales, 2017), combined with gross mishandling of Hurricane María (Klein, 2018), continue to forcibly displace thousands of Puerto Ricans to the mainland U.S. (Meléndez & Hinojosa, 2017). Deep austerity measures disproportionately affecting the poor have ensued, and some have equated the local government's economic agenda to a "shock doctrine"—using the collective trauma (financial and natural disasters) to advance a neoliberal agenda (Klein, 2018). Since the financial crisis of 2008, the displacement of Puerto Ricans to the U.S. has surpassed the great migration of the 1950s (Velázquez Estrada, 2018). Among the displaced, many are PWID.

Culture and HIV

Despite U.S. citizenship, migrant Puerto Rican PWID have manifest cultural differences (Spanish-monolingual, etc.) when compared to U.S.-born PWID (Gelpí-Acosta et al., 2011; Gelpí-Acosta et al., 2016). In P.R., structural determinants of injection risk (e.g., limited SEP and OAT, injection drug use in prisons) are linked to risky injection norms and behaviors among the local PWID population (Andía, Deren, Robles, Kang, & Colón, 2008; Andía et al., 2001). In contrast, NYC has many drug treatment programs, SEPs and HIV/HCV treatment providers. Comparative studies of PWID from P.R. and PWID from NYC are conclusive: injection risk behaviors (e.g., injection frequency, shooting gallery use, and syringe sharing) are higher among PWID in P.R., and among PWID who migrated from P.R. to NYC (Colón et al., 2006; Deren et al., 2003; Deren, Kang, Colón, & Robles, 2007a; Deren, Kang, Colón, & Robles, 2007b). Moreover, migrant Puerto Rican PWID sustain injection risk behaviors over time (Gelpí-Acosta et al., 2011; Gelpí-Acosta et al., 2016). In this paper, we present findings from our study of the P.R.-specific cultural norms associated with migrants' post-migration injection risks.

Defined as a process whereby over time, immigrants adopt the attitudes, values, and beliefs of the host country, "acculturation" is a common framework used in the study of immigrant health (Thomson & Hoffman-Goetz, 2009). For many Latinx immigrants in the U.S., negative health outcomes like HIV infection (Strathdee et al., 2008) and substance misuse (Borges et al., 2011) are linked to greater acculturation – a phenomenon known as the "Latinx paradox" (Abraído-Lanza, Chao, & Flórez, 2005). Latinx immigrants also face acculturative stress from experiencing poverty and discrimination in the U.S. (Araújo Dawson, 2009). Immigrant-only social networks can soothe this stress via "enculturation" – the conservation of native cultural elements (Alegria, 2009).

Interestingly, migrant Puerto Rican PWID appear to be an outlier group within the broader Latinx immigrant population in the U.S. For them acculturation may be HIV-protective (Kang, Deren, Mino, & Cortes, 2009), partly because the U.S. localities to which they migrate have ampler access to disease prevention services than P.R., and because they typically migrate with previously established drug problems. In fact, the case of migrant Puerto Rican PWID challenges the applicability of the "Latinx paradox" to all Latinx immigrant groups (and to all health outcomes), serving as a cautionary tale against the oversimplification of the Latinx experience in the U.S. Furthermore, as a theoretical framework, acculturation is limited for it tends to simplify as merely "cultural" processes that are also fueled by sociopolitical and economic contexts. In spite of these limitations, understanding the influence of injection norms learned in two different environments requires addressing the concept of acculturation as this is a dominant paradigm within public health for understanding the processes by which the health behaviors of migrant/immigrant groups change post-migration.

To lessen migrant Puerto Rican PWID's vulnerability to HIV/HCV and overdose, we must identify the P.R.-native risk norms behind their sustained post-migration injection risks. Understanding these risk norms will lay a necessary foundation for the development of culturally appropriate risk-reduction interventions. In this paper, we present data to help explain why migrant Puerto Rican PWID's injection risks persist post-migration despite their improved access to drug-related services in NYC.

Methods

Overview

From 2017–2018, we conducted a longitudinal qualitative study with a group of 40 Puerto Rican migrant PWID in the Bronx, where studies show they reside (Gelpí-Acosta et al., 2011; Gelpí-Acosta et al., 2016). An aim was to identify the P.R.-native norms behind their injection risks in NYC. Our study was approved by the Institutional Review Boards of National Development and Research Institutes and New York University.

Participants

Because we sought to capture P.R.-native injection norms and their development in NYC's unique environment, we recruited migrants with only one migration event to the U.S. Participants were also required to have injected drugs in P.R. for at least one year (before migrating), and to have engaged at least once in paraphernalia sharing in P.R. They also had to be adults (18+) who spoke Spanish and/or English.

Recruitment

We employed a combination of purposive sampling (PS) and time-location sampling (TLS) to recruit the sample. PS is used to expand existing knowledge of a population and allowed us to recruit a select group of migrants with the characteristics that are the subject matter of our scientific inquiry (Patton, 2001). To capture the relevance of time after migration for P.R.-native injection risks and norms, our sampling frame consisted of 20 migrants with up to 3 years in NYC (recent migrants), and 20 migrants with > 3 but up to 6 years in NYC (longer-term migrants). This framework stems from data showing higher injection risks among recent Puerto Rican migrants as compared to their longer-term (3+ years) counterparts (Gelpí-Acosta et al., 2011; Gelpí-Acosta et al., 2016). Since our study is exploratory, we limited the time after migration of the longer-term group to 6 years to help ensure accurate recollections of P.R.-based practices.

To populate the sampling frame, we employed TLS, and structured recruitment by a randomized selection of days, times, and locations (Magnani, Sabin, Saidel, & Heckathorn, 2005). Prior to recruitment, for 2 months we conducted observations of venues migrants frequented in the Bronx. These observations led to the creation of a "venue universe" with the times, days and locations where migrants can be found. To curb network bias, the venue universe contained 26 venues across 4

Bronx neighborhoods. Within the 2.37 square mile area our venue universe covered, we identified venues delivering services to PWID (i.e., methadone programs, SEPs, food pantries, HIV and HCV clinics, and housing programs). We also identified 5 public drug spots (venues where illicit drugs can be purchased), many public drug injection sites (parks and street alleys), and businesses where PWID open doors for patrons and panhandle.

Consent and compensation

Participants' written informed consent was secured prior to baseline interviews. Study procedures including monthly follow-ups, and an exit interview were explained during consent sessions. We used unique pseudonyms for each participant to protect confidentiality. Participants received $30 for each interview, and $10 for each monthly follow-up.

Data collection

At baseline, we conducted semi-structured interviews using an interview guide focused on the following domains: 1) sociodemographics; 2) formative years; 3) drug use history; 4) environments where drug use occurred, including access to prevention services; 5) injection norms learned in PR; 6) reasons for risky injection in P.R. and in NYC; 7) reasons for migration; 8) experiences with prevention services in NYC and 9) barriers and facilitators of risk reduction. We also collected "locator" information with participants' contact information to facilitate follow-ups. After baseline, we conducted semi-structured monthly face-to-face follow-ups, and asked participants to provide updates on behavioral risks and utilization of HIV and HCV prevention, testing and treatment services, etc.

Exit interviews took place 12 months after baseline and used a semi-structured guide. Exit interviews focused on changes in: 1) injection behaviors (since baseline); 2) influences on injection cessation, maintenance, and reduction or maintenance of injection risks; 3) risk networks; 4) experiences with prevention services (e.g., SEP & OAT and HIV/HCV treatment and testing); and 5) barriers and facilitators of change in risk injection norms.

All interviews and follow-ups were conducted in Spanish or English by the Principal Investigator (PI) or the Research Assistant (RA) in public parks within the venue universe, in locations where privacy could be maintained. Interviews were audio-recorded and then transcribed verbatim by the RA. Interviews conducted in Spanish were translated into English by the PI.

Analyses

Analyses focused on P.R.-native risk behaviors and norms, differences between recent and longer-term migrants, and behavioral/normative changes over time. Interviews transcripts were entered in MAXQDA12, software that facilitates the analysis of qualitative data. Guided by a grounded theory approach (Glaser & Strauss, 1967), we attributed the status of "code" to a wealth of participant-originated terminologies related to their native risk behaviors and risk norms. After the PI coded 12 transcripts, she met with 3 additional experienced coders to perform validity and reliability checks of those transcripts. A unified code-list followed and was further examined by 4 coders to insure inter-coder reliability. Two coders proceeded to code the remaining transcripts.

Results

Of 40 migrants completing the baseline interview, 20 were recent and 20 were longer-term. Monthly follow-ups were conducted with 35 (87.5%) and exit interviews with 34 (85%). Results are presented in three sections: (A) Sociodemographics, (B) Puerto Rico data (drug treatment, prisons and drug dealers), and (C) New York City data (migration and harm reduction access).

Table 1
Sociodemographics Migrant Puerto Rican PWID in NYC, by Risk Group (n = 40).

	Recent Number (%)	Longer-term Number (%)	TOTAL Number (%)
Age			
18 – 29	3 (15.0)	0 (0.0)	3 (7.5)
30 – 39	11 (55.0)	8 (40.0)	19 (47.5)
40 – 49	4 (20.0)	11 (55.0)	15 (37.5)
50 +	2 (10.0)	1 (5.0)	3 (7.5)
Gender			
Male	19 (95.0)	16 (80.0)	35 (87.5)
Female	0 (0.0)	4 (20.0)	4 (10.0)
TG	1 (5.0)	0 (0.0)	1 (2.5)
Education			
< HS	7 (35.0)	11 (55.0)	18 (45.0)
HS	10 (50.0)	7 (35.0)	17 (42.5)
> HS	3 (15.0)	2 (10.0)	5 (12.5)
Housing			
Homeless	16 (80.0)	6 (30.0)	22 (55.0)
3/4 House	1 (5.0)	2 (10.0)	3 (7.5)
Stable	2 (10.0)	4 (20.0)	6 (15.0)
Room Rental	1 (5.0)	4 (20.0)	5 (12.5)
SRO	0 (0.0)	4 (20.0)	4 (10.0)
Income generating activities			
Legal	11 (55.0)	10 (50.0)	21 (52.5)
Illegal	16 (80.0)	16 (80.0)	32 (80.0)
Panhandle/Opening doors	9 (45.0)	10 (50.0)	19 (47.5)
Ganchero*	3 (15.0)	4 (20.0)	7 (18.0)
Illicit drugs used			
Heroin injection	0 (0.0)	1 (5.0)	1 (2.5)
Speedball injection	20 (100.0)	19 (95.0)	39 (97.5)
K2 (smoked)**	11 (55.0)	9 (45.0)	29 (61.0)
Opioid Agonist Treatment			
In Tx	6 (30.0)	12 (60.0)	18 (45.0)
No Tx	14 (70.0)	8 (40.0)	22 (55.0)
HIV/HCV status			
HCV + in PR	16 (80.0)	20 (100.0)	36 (90.0)
HCV cured in NYC	2 (10.0)	6 (30.0)	8 (20.0)
HCV reinfected in NYC	1 (5.0)	5 (25.0)	6 (15.0)
HIV + in PR	0 (0.0)	8 (40.0)	8 (20.0)
HIV + in NYC	1 (5.0)	0 (0.0)	1 (2.5)

* A Ganchero is an injection specialist who gets paid for his injection services.

** Only 33 were asked about K2.

Sociodemographics

Most participants were males (88%) in their 30 s (48%) and 40 s (38%), and only 10% were females (Table 1). Of these, 45% did not complete High School (HS), 42.5% finished HS, and 12.5% had some college. All except 3 were Spanish-monolingual. Many were homeless (55%), and 73% of these were recent migrants. With 93% of the sample residing in the Bronx, many made a living through off-the-books legal means (recycling, cleaning grocery stores, construction) (50%). Yet, most (78%) also resorted to illegal means to make a living (e.g., dealing drugs, selling $2 "swipes" at subway stations after tampering with MTA cards to get additional rides from a single-ride card, and shoplifting). Additionally, 45% panhandled and opened doors to patrons of numerous businesses. Seven (18%) also made a living as "Gancheros" (vein-finding experts who get paid with drugs for their injection services). Except for a female who only injected heroin, all injected speedballs (a mix of cocaine and heroin), and many (61%) smoked the synthetic cannabinoid K2.

Of 9 HIV-positive migrants, 8 were infected in P.R. (longer-term) and one in NYC (recent). As many as 36 (90%) had had chronic HCV infection, and most cite syringe sharing in Puerto Rican prisons as the

likely source. Eight had been successfully treated for HCV in NYC, and 6 of these reported re-infection (5 longer-term).

Puerto Rico

All participants had started to inject drugs in P.R. Most cited ubiquitous injection drug use in their native communities and coping with family trauma (mainly sexual abuse) as reasons for injection drug use initiation (average age = 16). Most (61%) were from the San Juan area (33%) or from the island's West coast (28%). None reported steady SEP access in P.R. Instead, regular syringe sources were pharmacies, neighborhood diabetics, and "shooting galleries." Typically, a shooting gallery in P.R. has a manager who enforces behavioral norms:

> Ricky (recent) – A shooting gallery norm is that you can't have firearms in there.
>
> Interviewer- Are there managers?
>
> Ricky- Yes, and you must pay him $1 for using the space. Pay with a few drops [syringe units from the drug solution] and if you don't have a syringe, there is a Ganchero.
>
> Interviewer- A Ganchero?
>
> Ricky – That's when you don't have a syringe, he has new syringes and he will inject you. He knows how to get [inject] you. If you have 25 [units] of heroin and cocaine, you give him 5. That's his. After you get straight, you must leave the shooting [gallery]. You can't stay there unless you are going to continue consuming. Each time you use a bag in a shooting [gallery], you must give the manager $1.

Others explained how shooting gallery managers are paid with drug solution, for they collect the units drawn from multiple patrons in "empty insulin bottles." Managers use these on themselves or sell them to patrons. Everyone in this study injected drugs in shooting galleries in P.R.

Drug treatment

While 5% reported access to OAT (methadone) in P.R., access was not steady. The drug treatment program most accessible in P.R. was Hogar Crea (a faith-based, abstinence-only residential program), which 50% of the sample had attended. Although many liked the structure Hogar Crea offered (i.e., housing, daily house tasks, meals, religious messages, and support groups), others described how they were humiliated by program staff. Mateo, a recent migrant explained that when caught smoking cigarettes, he had to wear a necklace made of cigarettes for days to display his "disrespect to the population." Others mentioned that when someone "relapsed" to heroin, they would be viciously berated in support groups as weak "tecatos" ("drug users"). Additionally, if caught masturbating, residents had to wear a bracelet with 2 bells and explain to visiting family members the reason for it.

Despite these humiliating experiences, some justify this approach. Bonita, one of 4 females (all longer-term) in the sample, was on buprenorphine maintenance treatment. She explained the differences between Hogar Crea and OAT:

> Bonita- In methadone and Suboxone you just go, take your medication, and leave. Crea is an in-patient [program], and a completely different philosophy. They use humiliation and punishment… not here, what they want to do here is treatment, to replace a drug with another to get you out of trouble. Crea wants you to get clean, period. No methadone, no Suboxone.
>
> Interviewer- What kind of structure do migrants need in NYC to help them quit drugs?
>
> Bonita- That is an individual journey, you understand? Crea is a good option, but it's up to the individual. However, Crea is something we know well, and we might feel more comfortable with it. It's true they humiliate you, and they do horrible things, but that's what we need, that's what we are used to. Boricuas [Puerto Ricans] are used to being treated roughly, we don't pay attention otherwise.

Mía, a longer-term migrant who was on methadone, made similar remarks:

> Interviewer – Does Hogar Crea work?
>
> Mía- They do, definitively. The thing is, you must have the desire to change. It's all about the mentality you have when you do it, but Crea definitively works.
>
> Interviewer- What exactly is about that model that works?
>
> Mía- Look, there is always the good group and the bad group. If you throw a good apple where there are rotten ones, what do you think will happen?
>
> Interviewer- It'll rot too…
>
> Mía- Yes. Crea works, but it depends on how you work it. What you want to do, focus on where you want to go. Understand?
>
> Interviewer – How do you compare methadone to Crea?
>
> Mía- Oh no, nothing. There is no comparison. None. Here [in NYC] you have something that helps you, with that vice you have, a substitute that helps prevent withdrawal pains. But in Crea you must do it "a capella." [without OAT] If you submit to it, Crea will work.

There is respect for the abstinence-only model among study migrants, and an emphasis on the individual's role in achieving positive treatment outcomes. Many found the experience too humiliating and left these programs; however, this did not equate to an abandonment of their endorsement of the abstinence-only philosophy.

Prisons & power groups

Ninety percent of participants spent time in Puerto Rican prisons, mostly for non-violent drug charges, where they injected drugs, shared injection paraphernalia, and engaged in the local syringe-cleaning practice of "water-rinsing and blowing air" (i.e., remove the plunger from the barrel of a syringe, blow air from the mouth through the barrel, and then rinse the barrel and plunger with water or bleach, if available) to kill HIV. Almost all who were infected with HCV (88%) or HIV (20%) reported getting infected in Puerto Rico. Outside of prison, 75% also engaged in the water-rinsing and air-blowing practice: an island-wide norm.

> Interviewer- In P.R., how do injection risks compare between inside and outside prison?
>
> Pedrito (longer-term) - I'd say in prison the risk is 90% higher.
>
> Interviewer- How do drugs get in?
>
> Pedrito- Guards and family members
>
> Interviewer – Were there leaders in your prison? Ñetas or Los 27?
>
> Pedrito – 27
>
> Interviewer- So was it riskier in prison?
>
> Pedrito- Definitively, there were times there was only one syringe for a cellblock of 48!
>
> Interviewer- 48 people injecting with one syringe?
>
> Pedrito- Yes. But I think that's what saved me from getting infected. I would not wash my syringe 1, 2 or 3 times. I'd wash it 5, 6, 7, 8 times if I had to… avoid getting infected. And I'd take the plunger out and blow air through it, understand?

Interviewer- Bleach?

Pedrito- Generally, yes

Interviewer- Not always?

Pedrito- If there was no bleach, water-rinsing many times and blowing air through it.

Pedrito did end-up getting HIV/HCV co-infected in P.R., but he learned about it after his prison term in Guayama. The fact is, he is not sure where these infections occurred.

Also, in P.R. prisons, a Ganchero was often present on their cell-block.

Interviewer – Were there Gancheros in prison?

Ricky (recent) - Yes, always. The prison Ganchero gets 2 drops, 2 units. 2 drops of each bag. You get straight, and you immediately leave the cell (in prison) or the shooting [gallery] (outside prison). The difference is that on the streets, in the drug spot, if you don't have [anyone] who can sell you a syringe, there is a Ganchero who owns brand new syringes. You must give him 5 drops, 5 units for the full-service.

Interviewer – So, in prison its 2 drops and 5 drops outside?

Ricky – Outside it's 5 drops. It's 5 but you are guaranteed a brand-new syringe, and he gets you really quick because he knows so much, more than a doctor.

Interviewer- So this Ganchero is very important in P.R.?

Ricky- Of course! He must be there, he is the one who knows how to get [inject] you.

Interviewer- Wouldn't you be an expert yourself after so many years injecting drugs?

Ricky – Desperation. When you have "la cura" [heroin] on you, you get nervous, you are about to get straight and your veins all the sudden aren't there, and move around, and you try and you can't get it… you need a Ganchero.

In prison, the Ganchero secured syringes (or made syringes using commissary artifacts such as ear-pumps for suction, or metal spring bars from wristwatches), water, bleach and cookers, injected all PWID in the cellblock and cleaned the syringe (usually with bleach from the commissary) after each injection. The Ganchero was appointed by the leader of prison-power groups Ñetas (the largest), Los 25, or Los 27. These groups, particularly the Ñetas, have a strong history of prisoners' rights advocacy, and control the drugs that run through Puerto Rican prisons.

Interviewer – So what do Ñetas do in prison?

Mateo (recent) – We run prisons in P.R.

Interviewer- But I've heard Los 27 are strong

Mateo – They only have 2 prisons: Guayama, and Guayama 1000. That's it. They can't live in other prisons.

Interviewer – So I heard the Ñetas forbid selling "horse anesthesia" [Xylazine]?

Mateo – Those who sell that on the streets, when they go inside, they will pay for their violation. You can only sell the drugs we approve. We will sit you down in the center of the room and we are going to address all the rules you've broken.

Interviewer- Ñetas do that?

Mateo – Yup, if you are wrong, and come inside for raping a girl or whatever, you are going to get what you deserve.

Interviewer- A beat-down?

Mateo – Yes, even death. And if you are a snitch, you'll be shred to pieces.

Interviewer- Talking to police or correctional officers?

Mateo – Both. To talk to correctional officers, you must bring a "presente"

Interviewer- A what?

Mateo – A witness. Prison is entirely Ñeta. We must give you permission to use drugs, we have norms. We the drug users created that organization, to advocate for inmates' rights. There were a lot of abuses before Carlos "La Sombra," our founder.

Interestingly, just like Hogar Crea, prison-power groups address, often violently, rule breakers. Of the 21 participants who shared their power group affiliation, 11 were Ñeta and 10 were either from Los 25 or Los 27. Participants explained that in P.R., it is in the drug users' best interest to join a prison-power group, for these provide protection from enemies inside prison, provide heroin, and are very vocal about prisoners' rights. Participants respect their power group leaders and observe their rules to secure order and safety.

Bichotes: street rulers

Outside prison, Ñetas and Los 27 are not the powerful figures they are inside. Yet, sustained affiliation provides protection from members of opposing power groups, for retaliation is guaranteed in the likely occurrence of the perpetrator's eventual imprisonment. Outside prison, participants explained that "Bichotes" (intrinsically territorial, heavily armed, and often violent drug dealers who are also community caregivers) control the drug spots, their communities, and even PWID's injection behaviors.

Bebo (longer-term)- Bichotes made it a rule to give "la cura" early in the mornings to all the addicts of the "caseríos" [housing projects], who'd wait in line, because they are the ones who help the Bichote run his drug spot, get the Bichote's food during the day, among other tasks.

Interviewer- I see. Did everyone inject on the streets like here in NY?

Bebo- Oh no, no. If there is no shooting gallery in the caserío, the Bichote will rent an apartment and will get an addict to manage it. You can't do that there.

Interviewer – Is there a rule against it?

Bebo- Yes. If you inject on the streets, and they get you, they will beat you up. Also, you can't throw used syringes on the streets. There is also a rule that, when you get out of prison, and you bring the Bichote your prison release papers, the Bichote will give you 1 and 1 [one heroin and one cocaine] or 2 and 1 [2 heroin and one cocaine], plus the money for the plane ticket [if you must leave the island], or he will take you to your home, or rent a car from some junkie by giving him a couple of bags in exchange for taking you home, and if you don't have money to buy your mom a gift, he will give you money to buy something for her. A pound of bread, whatever.

Interviewer- So he takes care of you upon release from prison? Why? He's losing drugs, time, money…

Bebo- Yes, but he's helping alleviate the pain from all that time imprisoned. In appreciation for your silence, for not snitching. For being a warrior.

Throughout the island, Bichotes have a set of norms everyone had to observe: 1) never inject drugs in front of children or the elderly (out of respect); 2) never inject drugs near the drug spot (calls for police

trouble); and 3) never throw used needles on the streets (to protect kids). Engaging in any of these behaviors guarantees a serious "beat-down," and even death. Also, Bichotes assign PWID to "managerial" roles of their communities' shooting galleries, often securing the venue as well. Bichotes are the most powerful figures on the island's drug scene, and participants were simultaneously terrified of and grateful to them. Terrified of the imminent threat of violence, and grateful because Bichotes often offer a "morning bag" to their everyday clients, and with gifts and money "take care" of the families of those who do not snitch.

New York City

Migration and the new context

Participants' top three reasons for migrating were to leave drug use behind (68%), to be with family (22.5%), and to escape trouble with Bichotes and/or law enforcement (12.5%). Among recent migrants, 5 went directly to a secular residential drug treatment program that recruits PWID on the island (through municipal administrations and Christian communities), and one to a Christian drug treatment program. Among longer-term migrants, 5 went to Christian programs.

Both types of programs offered immediate Medicaid and food stamps enrollment, and inpatient drug treatment using OAT or abstinence-only, prayer-based therapy (Christian programs). Participants repeatedly mentioned a recruiter who promised housing upon completion of the residential drug treatment program's 28 days. Of the 5 individuals who arrived directly from P.R. to that program, all were unable to comply with program rules (i.e., abstinence) leading to disenrollment. The promise of housing also evaporated, and at least one migrant was left on the streets during the 2014–2015 Winter season.

At the time of this study, most participants were enmeshed in poverty. Those who were homeless (55%) managed to get to sleep around 2–3 am, on the sidewalks of the southern Bronx (underneath cardboard), only to wake up just before 5am, when street noises resurface as people head to work and school. They started their days accordingly and resumed their income-generating activities: panhandling; opening doors; drug dealing; collecting and redeeming recyclables; and shoplifting. These activities led to frequent encounters with law enforcement, with 82% having been stopped and/or arrested at least once during the study's 12-month follow up period. Moreover, 75% had been in jail or prison in the U.S. at least once since migration. Unlike in P.R. prisons, none had injected drugs in NY prisons or jails.

Despite these circumstances, all participants planned to stay in NYC. In NYC, their anonymity allowed them to do as they pleased without their beloved mothers being adversely affected. In NYC, they were also safer from Bichotes or law enforcement than in P.R., and, while all agreed that NYC has lower-quality heroin than P.R., the ease with which they could make money in NYC offset that drawback. They also injected more frequently than they had in P.R. Eight of the 20 recent migrants injected ≥10 times/day, compared to only 4 of the 20 longer-term migrants. During our yearlong presence in the field, we called 911 three times for suspected opioid overdoses, and witnessed many overdose reversals by paramedics within the study's recruitment area. Finally, 10 migrants (5 recent, 5 longer-term) overdosed at least once during this time, and, in each case, an SEP worker was responsible for saving the participant's life with naloxone. Despite access to naloxone free-of-charge from local SEPs, none of the participants carried naloxone.

SEP and opioid agonist treatment access

Unlike in P.R., migrants accessed SEPs regularly in NYC. In the Bronx, one SEP is open for at least 8 hours 6 days a week, and another 2 SEPs operate at comparable schedules. SEP utilization is high across the two sub-groups, with 11 recent and 10 longer-term migrants accessing an SEP 6 days a week on average. Also, all 7 active Gancheros in the sample obtained their sterile supplies at these SEPs. Enhancing this access is the common policy among NYC SEPs of distributing syringes "by the box" (100 ct./box) upon request, which allowed Gancheros to have healthy supplies of sterile syringes in their worn-out "mochilas" (backpacks), and use new, sterile syringes with their clients. Their regular use of SEP may be a steppingstone in the development of safer injection norms.

Yet, this process quickly meets resistance for some participants argued that SEPs promote drug use. Melvin (recent) used SEPs about 3 times a week:

> Interviewer- There are no SEPs in Las Piedras, P.R. How does SEP access feel in NYC?
>
> Melvin – It feels good because they help you. We don't have this in P.R. And it's all free of charge! The problem is that since they give you everything, now you only have to get the money for "la cura."
>
> Interviewer – Are you saying access is bad?
>
> Melvin – It incites use, that's how I see it, inciting to use more heroin.
>
> Interviewer- But you know they are trying to help you remain HIV-, right?
>
> Melvin – Yes and that is a good thing, but on the other end… that's how I see it.

Melvin was not alone in this opinion. Joselito (longer-term) from Vega Alta, P.R., went further.

> Joselito- They serve you everything here in a golden platter. They make it so easy for you to get these services. Like right now, I found you, and you are going to pay me for my time. It's so easy to make money here. In P.R., it's not like that.
>
> Interviewer – And why is this a problem?
>
> Joselito- Because you are making it too easy for the Boricua.
>
> Interviewer - How?
>
> Joselito- And all these SEP programs…
>
> Interviewer- They are trying to help prevent diseases…
>
> Joselito- I understand you do it with that in mind. But for us, well you are just making it easier for us to continue doing drugs. It's a joke.

While all participants appreciated the public health rationale behind SEP, the ample availability and low-threshold way these services are offered was misread by some as promoting drug use.

Similar to SEP, participants had ample access to OAT in NYC (unlike in P.R.). Forty-five percent of participants regularly used OAT. Like SEP, OAT access may be a steppingstone in the development of safer injection norms. Yet, OAT faces more resistance than SEP, for it was more commonly accessed by longer-term migrants (60% versus 30% among recent migrants). Unsurprisingly, longer-term migrants injected less frequently than their recent counterparts and attributed this to OAT. However, a common perception across risk groups was that to be on OAT is not synonymous with being "clean" [abstinent]. Whilst 68% of the sample cited "to access drug treatment" as a main reason for migrating to NYC, what many meant by "drug treatment" was abstinence-based residential programs. Hence, their perceptions of SEP and OAT remain influenced by the P.R.-hegemonic faith-based treatment approach. This influence of religion over a community's negative perceptions of harm reduction can be found elsewhere in the U.S. (Szott, 2018).

Water-rinsing & air-blowing

Despite access to SEP, migrants across risk groups perpetuated the syringe-cleaning technique of "water-rinsing, air-blowing" they learned in P.R.

Ricky (recent) – Yes, sure, we do that over here too. We get the plunger out of the barrel and [makes blowing sound] because they say oxygen kills AIDS. We know that so we always do it here too.

Interviewer- Did you do that in P.R.?

Ricky – Yes, I learned it over there and I always do it here.

Ramón (recent) from La Perla, San Juan, is the youngest at age 22 and self-reports being HIV and HCV negative. He added:

Ramón – They'd wash it [the syringe] with water to get rid of the blood. As soon as they no longer see the blood, they thought of it as safe and clean: "I can't get sick because there is no blood there." They do it here too. I've seen it happen.

Interviewer- What about blowing air?

Ramón – That too. I think the bacteria is still there, you know? But not them. And if the person has Hep C then the bacteria could still be there. They really think that getting rid of the blood will do. I see them do it here all the time. I don't understand when they could just come here [the SEP] every day and get new syringes.

Although Ramón did not disclose it, during our yearlong fieldwork we observed him engaging in this behavior too, while publicly injecting. Across the two risk groups, 60% (n = 24) admitted to engaging in receptive and/or distributive syringe sharing (after water-rinsing and air-blowing) at least once during the 12 months of observations. Yet, our observations provided data suggesting that this practice is more prevalent than admitted. Of those who disclosed engaging in this practice, 13 of 24 were longer-term migrants.

Laziness and desperation

In addition, 16 of 24 said they'd rather not walk to a SEP (to get sterile syringes) from any of the drug spots (3–10 blocks away) out of "laziness" and "desperation." Melvin (recent), who self-reported being HIV-negative, explained:

They share because they choose to, they are lazy. They don't want to walk over there to the SEP. The priority is "curarse" [to get straight]. When you are sick, you are not going to walk all the way there [to the SEP]. Gimme' yours [syringe] because I'm not going down there. When you are a junkie and are sick, you don't care if the other is sick [HIV] or not… you water-rinse and blow air, and that's safe enough. This is something that is normal. I even remember once in P.R., I injected a shot that had someone else's blood!

Indeed, this is normative. Mía (longer-term), who is living with HIV, provided additional testament to this.

The other day, I was walking with my husband and we were going to go inject behind the bushes over there [points to public injection spot in a local park] and found this guy who asked us for syringes. I told him we only had ours, and he replied, "I'll go with you and when you are done, I will borrow it." We said, go to the truck over there [SEP van], they'll give you syringes. We will wait for you here. He said, "Nah, I'm not going there! When you are done, I'll borrow it."

Mía later explained she disclosed her HIV status to this individual, but that did not change his mind. Interestingly, migrants call HIV "el perro," [the dog] and ask other migrants before sharing "¿tú estas mordío?" [are you bitten? (by the dog)] They are not interested in being "bitten by the dog." Yet, across risk groups, there was profound trust in the water-rinsing and air-blowing process they learned in prisons and shooting galleries in P.R. Also, if sterile syringes are not readily available, "desperation and laziness" lead to water-rinsing and air-blowing.

"Caballo," cleaning the cooker, and HCV

Except for one person, all participants reported sharing cookers in "Caballo" sessions (2 PWID pool monies to purchase and inject drugs together) multiple times a day, and regardless of HCV/HIV status. Unlike with water-rinsing and air-blowing, all readily admitted to this behavior.

Interviewer- Describe the "Caballo."

Ricky (recent) – That's easy. Here I have $3. How much do you have? "Ah… $2.50″ Ok, let's go to "rebuliar" (slang term for off-the-books money-making), and when we get the money [for heroin and cocaine] we'll make a Caballo. And we'll determine if its "abrazo" [literally 'hug,' but refers to a 50% split of the cooked drug, regardless of who secured which drug]. With the 2 bags, we make 40 units [of drug solution] and we go half and half [20/20].

Most migrants look forward to drug-darkened cottons (from sustained use) for there is "a guaranteed shot" in it. They make sure to keep their used cookers (with the cotton inside) moist by placing them in tiny clear plastic Ziploc bags. That moist cooker and cotton, with its daylong-use residue, was used in the mornings with a shot of water (5 units) to take the edge off one's morning sickness. For most, it's effective.

When we probed around HCV risks, participants expressed a lack of concern, and made statements such as, "We all have it," "that's normal among us," and "that really doesn't make you sick, like HIV." Even Gancheros, who otherwise tend to avoid sharing injection paraphernalia for they are typically well-equipped, revere the drug-darkened cooker/cotton. Willie (recent), a popular Ganchero, explained,

Remember, that's where they [clients] leave my pay [in the cooker]. You just saw how I did him, and that's how he pays me. Payment is in the cooker.

We interviewed Willie inside a building where he uses vacant office space as his Ganchero premises. He has a backpack full of syringes, and the building's "super" allows him to use the space. Willie explained that a shared cooker is an intrinsic part of the Ganchero's payment, and he later explained that he lends his cooker to non-clients, to increase the residue in it, and guarantee that free shot for the morning sickness.

Because most participants are HCV infected, we offered them HCV treatment opportunities. During the 12 months of observations, there were 2 active studies recruiting HCV-infected PWID for HCV treatment and offering financial compensation. While migrants expressed interest, only 2 participated. At the end of the fieldwork period, one participant had been cured [Bonita].

Discussion

In NYC, migrant Puerto Rican PWID who started injecting drugs in Puerto Rico have ample access to disease prevention services that they lacked in P.R. Across risk groups, SEP use was normalized, and longer-term migrants made regular use of OAT. These are health-promoting practices that are helping some prevent disease transmission, and clearly saving the lives of many, judging by the volume of overdose reversals at local SEPs. Yet there are clear limits to these health-promoting practices.

Migrants actively preserve injection risk behaviors and norms acquired in P.R., including: 1) water-rinsing & air-blowing; 2) Caballo sessions; 3) used cooker/cotton fetishization, and 4) HCV normalization. While migrant PWID's higher levels of syringe sharing relative to U.S.-born PWID have been documented (Deren et al., 2007a), the present study identified a critical risk norm governing this behavior: the belief that air and water kill HIV and the associated practice of cleaning syringes by water-rinsing and air-blowing. Although these run counter to the standard gospel of harm reduction (e.g., one sterile syringe for every shot), there is some empirical evidence supporting this belief and practice. In their ethnographic work describing the injection practices of PWID, Ciccarone and Bourgois (2003) argue the practice of water-

rinsing injection equipment may have played an HIV-protective role among black tar heroin users in the U.S. Also, laboratory tests have shown that water-rinsing may be effective in ridding a used syringe from HIV (Abdala, Gleghorn, Carney, & Heimer, 2001), although these are not conclusive (Gaughwin, Gowans, Ali, & Burrell, 1991). For those in this study, it seems that after having engaged in water-rinsing and air-blowing for years, their maintenance of an HIV-negative status might serve as confirmation that this practice works and trump NYC-normative harm reduction narratives that dismiss it as not evidence-based.

Importantly, our findings highlight the limitations of the acculturation model for understanding the health-related behavior of migrant/immigrant groups. This binary framework cannot adequately explain the complex processes by which these migrants negotiate the intersection of normative injection practices and logics of their home environment (PR) with those of their host environment (NYC). Acculturation theory would suggest that, after migration to the U.S., Puerto Rican PWID would either retain the (riskier) injection norms and practices learned in P.R. or, alternatively, adopt the (less risky) injection norms and practices of NYC (heavily influenced by the logic of harm reduction and the ampler availability of OAT and SEP). However, our data show that this would be an oversimplification of their reality. These migrants strategically adopt some new drug-related behaviors in NYC (i.e., pragmatic use of OAT and SEP) while concurrently rejecting some of the accepted wisdom underlying these services (e.g., self-blaming for continued drug use and viewing SEP as perpetuating addiction) and retain certain norms and practices characteristic of their home environment (e.g., water-rinsing and air-blowing). This suggests that cultural norms and practices, even within the domain of injection drug use, are not monolithic entities to be rejected, retained or adopted in toto, but rather the product of ongoing processes of negotiation.

Migrants' SEP use makes for an excellent example of these negotiation processes. While prevalent, SEP use is mainly an ex post facto event. Their daily activities revolve around securing as many injection sessions as possible. They wake up very early, clean their still-moist, heavily used cookers to curb morning sickness, and begin to engage in income-generating activities. SEP attendance will only take place after they have secured that first speedball injection, after they have engaged in a Caballo session, after they have shared a heavily-used cooker with their Caballo running partner, and after they cleaned a previously used syringe by water-rinsing and air-blowing. Although often within a 2-3-minute walk, the SEP is simply too out of the way from the location where their most intrinsic needs can be met: the drug spots. Their use of non-sterile injection equipment is explained by the fact that HCV is not a major concern for them, and water-rinsing and air-blowing renders syringe-sharing "safe enough" to prevent HIV (a major concern for them). Hence, they do not perceive a compelling need to change their behavior.

Moreover, many are severe in their critique of OAT and refuse to utilize it. While their ambivalence towards SEP does not prevent them from using it, ambivalence towards OAT curtails access among recent migrants. For the latter, the abstinence-only model constitutes "real" drug treatment, and methadone is "just another drug." This disdain of OAT stems from the predominantly evangelist drug treatment infrastructure in P.R. (Hansen, 2005), as promoted by Hogar Crea and other programs. Yet, this influence of religion over negative perceptions of SEP and OAT is not unique to migrant Puerto Rican PWID, for religion often plays a deciding role over other communities in the U.S. that today continue to reject SEP based on moral grounds (Szott, 2018). For their influence over perceptions of OAT, religious approaches to drug treatment are associated with the very high injection frequency (and risks) of recent migrants in this study. Because these migrants use speedballs, a drug combination associated with higher injection frequency (Colón et al., 2001), OAT use could help curb injection frequency and risks (Deren, Kang, Colón, & Robles, 2007b). Hence, their moral approach to OAT augments their disease vulnerability.

Migrants 'abstinence-only' and 'water and air kill HIV' beliefs run counter to the standard gospel of harm reduction, which insists OAT is the only evidence-based drug treatment intervention and that a sterile syringe must be used for every shot. Harm reduction services (SEP & OAT) are not adequately acknowledging these gray areas. Cocaine (and speedballs) injectors are uniquely vulnerable to HIV, and SEP access alone might not suffice to prevent HIV (Archibald et al., 1998; Tyndall et al., 2003). Standard harm reduction messages also fail to adequately address the difficulty/burden a homeless cocaine injector would have in using a sterile syringe for every shot. This critique to harm reduction is not new (Bourgois & Schonberg, 2009). In a way, harm reduction denies the validity of these migrants' lived experiences which likely alienates them from more effective disease and overdose prevention.

Augmenting these complex phenomena, migrants' widely perceived lower quality of heroin and cocaine in NYC (compared to P.R.) could be fueling their sense of "desperation," and hence injection frequency and risks. Also, the absence of Bichotes controlling the drug scene in NYC is important. In P.R., migrants were used to observing the rules Bichotes imposed. Their respect stemmed from fear of violence and also from the care they experienced from Bichotes (gifted morning bags, gifted their mothers, and nurtured respect for their communities by prohibiting public injection). Lacking this parental figure in NYC, migrants' behavior devolved accordingly with routine episodes of public injection and discarding used syringes in public areas. In NYC, migrants also lack the authority figures prison power groups represented in P.R. While migrants are not injecting drugs while incarcerated in NYS/NYC, an undoubtedly positive health event, the absence of these behaviorally influential power groups could be further enhancing their unruliness. Thus, migrant Puerto Rican PWID in NYC lack the few sources of legitimate authority that once helped them curb unruly injection drug use. The only native figure who did not disappear with migration is the Ganchero.

All 7 Gancheros explained they have more resources in NYC than in P.R. This is a positive thing. Because drug quality in NYC is experienced as significantly lower than in P.R., many reported injecting more frequently (than they did in PR) to achieve the high they are used to. When factoring in that their preferred drug is speedballs, which deteriorates veins faster than heroin-only injections (Loyd-Smith et al., 2008), we surmise that the need for Gancheros will remain strong within this community, as healthy veins become increasingly harder to find. The Ganchero figure then emerges as a possible way out of risk for migrants, for he is a figure migrants relate to, and one who organically displays aptitudes for safer injection practices.

Limitations

Given the exploratory nature of this study, relatively small sample size and lack of probabilistic sampling, findings from this study may not be representative of the migrant Puerto Rican PWID population in NYC. However, the rigorous recruitment approach – in particular, the use of time-location sampling techniques to populate our purposive sampling frame – helped to insure geographic and PWID network variance in the sample and may increase the generalizability of the results. Another limitation is that much data stems from self-report and as such should be viewed with caution. However, the use of observational and longitudinal data to triangulate participants' self-reports bolsters the validity of the findings.

Conclusions

Migrant Puerto Rican PWID in NYC maintain several high-risk injection practices learned in Puerto Rico, specifically in the maintenance of the normative belief that "air and water kill HIV" that, in turn, fosters the ubiquitous reliance on water-rinsing and air-blowing as a syringe-cleaning technique. Also, Caballo sessions and cooker-sharing are as common in NYC as they were in P.R. and trigger little concern for HIV/

HCV. While SEP use is normative, sterile syringe use is not a priority. Furthermore, P.R.-based faith-based drug treatment narratives remain normative, and inform migrants pronounced ambivalence towards SEP and OAT. While increased access to harm reduction services in NYC is a positive event, migrants' negotiations of the normative injection practices and logics learned in P.R. with those of NYC render the acculturation framework impractical to understand the rationales underlying their risks.

Clearly, mere access to SEP, OAT and naloxone does not suffice to eliminate migrants' disease and overdose risks. Harm reduction programs could engage migrants to: 1) target the belief that air and water kill HIV (to reduce the water-rinsing, and air-blowing practice); 2) discuss evidence-based rationales behind SEP and OAT, 3) educate around HCV transmission and pathogenesis (to address cooker/cotton fetishization), and 4) address the unique disease and overdose vulnerabilities of homeless speedball injectors. Indeed, this may be an opportunity for harm reduction programs to engage the communities they serve in a revitalizing dialogue of their service needs.

Finally, a risk reduction intervention for migrants could attempt to include the Ganchero figure to: 1) help migrants prioritize injection safety, 2) promote evidence-based HIV/HCV prevention behaviors while accommodating their competing priorities and daily routines, and 3) help migrants regain control over their injection practices (e.g., not inject in public, not dispose of used syringes in public areas) without requiring a threatening authority (e.g. Bichotes).

Conflict of interest statement

The authors declare no conflict of interest.

CRediT authorship contribution statement

C. Gelpí-Acosta: Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Resources, Software, Supervision, Validation, Visualization, Writing - original draft. **H. Guarino:** Formal analysis, Investigation, Methodology, Validation, Writing - review & editing. **E. Benoit:** Formal analysis, Investigation, Writing - review & editing. **S. Deren:** Formal analysis, Investigation, Writing - review & editing. **E.R. Pouget:** Investigation, Writing - review & editing. **A. Rodríguez:** Data curation, Formal analysis, Writing - review & editing.

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Glossary

Abrazo: Literally, "hug." Yet, for migrant Puerto Rican PWID in NYC it means sharing equal amount (50/50) of the drug substance (typically speedballs) regardless of who pooled more money.
Bichote: A person who supervises and controls the drug trade in a specific neighborhood of Puerto Rico.
Boricua: Puerto Rican.
Caserío: Commonly used name for government-assisted housing in Puerto Rico.
Curarse: Literally, "heal." To use heroin to feel better.
Caballo: Literally, "horse." Yet, for migrant Puerto Rican PWID in NYC it means to pool monies to buy drugs (typically, 2 PWID).
El perro: Literally, "the dog." Yet, for migrant Puerto Rican PWID in NYC it refers to HIV.
Ganchero: The syringe man. A person with injection supplies who exchanges his vein-finding expertise for drugs or money.
Hogar Crea: A widely available faith and abstinence-based program for people who use drugs in Puerto Rico.
La cura: Literally, "the cure." Yet, for migrant Puerto Rican PWID in NYC it means heroin.
Los 27: A prison-based power group in Puerto Rico.
Los 25: A prison-based power group in Puerto Rico.
Ñetas: A prison-based power group in Puerto Rico. Known as the largest and most powerful of prison power groups.
Rebuliar: A slang term referring to off-the books (including illegal) money-making activities.
Tecato: A pejorative adjective commonly used in Puerto Rico to refer to people who use drugs.