



Research paper

“We get by with a little help from our friends”: Small-scale informal and large-scale formal peer distribution networks of sterile injecting equipment in Australia



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ARTICLE INFO

Article history:

Received 7 September 2015

Received in revised form 5 April 2016

Accepted 6 April 2016

Keywords:

Bloodborne virus

Injecting drug use

Secondary syringe exchange

Peer distribution

Needle and Syringe Program

Australia

ABSTRACT

Background: In Australia, sterile needles and syringes are distributed to people who inject drugs (PWID) through formal services for the purposes of preventing blood borne viruses (BBV). Peer distribution involves people acquiring needles from formal services and redistributing them to others. This paper investigates the dynamics of the distribution of sterile injecting equipment among networks of people who inject drugs in four sites in New South Wales (NSW), Australia.

Methods: Qualitative data exploring the practice of peer distribution were collected through in-depth, semi-structured interviews and participatory social network mapping. These interviews explored injecting equipment demand, access to services, relationship pathways through which peer distribution occurred, an estimate of the size of the different peer distribution roles and participants' understanding of the illegality of peer distribution in NSW.

Results: Data were collected from 32 participants, and 31 (98%) reported participating in peer distribution in the months prior to interview. Of those 31 participants, five reported large-scale formal distribution, with an estimated volume of 34,970 needles and syringes annually. Twenty-two participated in reciprocal exchange, where equipment was distributed and received on an informal basis that appeared dependent on context and circumstance and four participants reported recipient peer distribution as their only access to sterile injecting equipment. Most ($n = 27$) were unaware that it was illegal to distribute injecting equipment to their peers.

Conclusion: Peer distribution was almost ubiquitous amongst the PWID participating in the study, and although five participants reported taking part in the highly organised, large-scale distribution of injecting equipment for altruistic reasons, peer distribution was more commonly reported to take place in small networks of friends and/or partners for reasons of convenience. The law regarding the illegality of peer distribution needs to change so that NSPs can capitalise on peer distribution to increase the options available to PWID and to acknowledge PWID as essential harm reduction agents in the prevention of BBVs.

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Introduction

Access to sterile injecting equipment is broadly recognised as critical to achieving effective blood-borne virus prevention among people who inject drugs (PWID) (Australian Government Department of Health and Ageing, 2010b; World Health Organisation, 2012a, 2012b). In most settings which recognise this, access to sterile equipment is provided through Needle and Syringe

Programs (NSPs), whilst other more informal distribution routes, such as those occurring within the networks of PWID, are ignored in current models of harm reduction in Australia.

NSPs are identified as an essential and instrumental component of harm reduction (WHO, UNAIDS, & UNICEF, 2009; World Health Organisation, 2012b; World Health Organization, 2012). The first formal NSP in Australia began operation in NSW in 1986 (Wodak et al., 2012) and at the time of writing, Australia has the third largest network of NSPs globally (Kwon et al., 2012). The state of NSW has the largest number of formal services in Australia, where injecting equipment is distributed through 346 NSPs, 488 community-based pharmacies, 141 syringe vending machines and 46 internal

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dispensing chutes (NSW Department of Health, 2013). Despite this level of distribution, there have been calls to increase, or even double, sterile syringe supply to prevent future hepatitis C transmission (Kwon, Iversen, Maher, Law, & Wilson, 2009).

Although NSW, and Australia, have had a long history with formal NSPs (Madden & Wodak, 2014), it is important to note a wide variation in population-level (or geographic) coverage, particularly as NSPs were not comprehensively or universally delivered across NSW or Australia (Mathers et al., 2010). In addition, the use of NSPs by PWID is influenced by a broader range of personal, institutional and structural factors, including a lack of awareness about services, limited hours of service operation, inconvenient service location, fear of police and stigma (Jones, Pickering, Sumnall, McVeigh, & Bellis, 2010; Treloar & Cao, 2005). These factors, in turn, influence individual-level coverage, that is, the extent to which PWID have access to adequate amounts of equipment. In a recent Australian study, it was highlighted that one in five NSP attendees reported insufficient coverage of sterile injecting equipment for all injections (Iversen, Topp, Wand, & Maher, 2012). In addition to coverage issues, NSPs are reported to reach a very particular client base, characterised as predominantly Anglo-Australian men with a median history of injecting of over ten years, and a preference for injecting heroin (The Kirby Institute, 2014). The typical client profile of NSP clients is not believed to include those 60% of PWID who are identified as occasional users (Razali et al., 2007). Although coverage is identified as critical, other studies have not found an independent relationship between inadequate syringe coverage and receptive equipment sharing in Australia (Bryant, Paquette, & Wilson, 2012b) and the UK (Craine et al., 2010).

Peer distribution is a community-driven practice of individual PWID collecting sterile injecting equipment from an authorised source and distributing this equipment within their networks. By locating the distribution of injecting equipment within existing relationships, more opportunities for sterile injecting equipment distribution to occur “naturally” are reported (Snead et al., 2003), as well as the ability to reach larger networks of PWID and geographic areas than traditional distribution programs (Broadhead et al., 1998). This reach is also reported to provide access to populations of PWID that cannot, or will not, access current NSPs, such as women, young people, and people in regional areas (Anderson, Clancy, Flynn, Kral, & Bluthenthal, 2003; Broadhead et al., 1998; Stopka, 2006; Voytek, Sherman, & Junge, 2003). The cost-effectiveness of peer distribution has been widely acknowledged (Anderson et al., 2003; Bryant & Hopwood, 2009; Irwin, Karchevsky, Heimer, & Badrieva, 2006; Lorvick et al., 2006; Tyndall et al., 2002), as this form of distribution is voluntary and therefore involves no added staffing costs to a service (Stopka, 2006; Valente, Foreman, Junge, & Vlahov, 1998).

Peer distribution as a common and informal practice is extensively reported in the international literature, particularly the US, where it is reported that 28–75% of NSP attendees participate in peer distribution (Huo, Bailey, Hershow, & Ouellet, 2005; Kuyper et al., 2006; Lorvick et al., 2006; Murphy, Kelley, & Lune, 2004; Valente et al., 1998; Wood et al., 2003). Importantly, the distribution of sterile injecting equipment reported in these settings was believed to have reached those people most at risk (Wood et al., 2003), particularly those new to injecting, where a person's social network may be the only access point for sterile injecting equipment (Craine et al., 2010). The size of peer distribution in the US context is diverse, with some PWID collecting and distributing small amounts of injecting equipment; whilst other PWID have reported large, formalised distribution networks of sterile injecting equipment that may operate as quasi-NSPs, including established hours, clients, procedures, and the provision of educational information about the risks of injecting drug use (Benyo, 2006; Kuyper et al., 2006).

In Australia, peer distribution is prohibited as only authorised services, and the nominated people within these services, are legally permitted to distribute sterile injecting equipment (Legal and Discrimination Working Party of MACBBVS, 2013; NSW Government, 1985). The literature reporting on peer distribution in Australia is best described as scant; however, the findings across those few studies suggest peer distribution is a common activity with 32–38% of respondents from the Australian NSP survey (Iversen & Maher, 2013) and 40% of respondents from a pharmacy survey in South-East Sydney reporting the distribution of needles and syringes in the past month (Bryant & Hopwood, 2009). Peer distribution among pharmacy attendees was typically small scale, where people would collect a small number of syringes from the pharmacy (median 10 at last visit) and distribute a small number of needles and syringes [about 4]. This practice occurred in small networks and did not appear formalised or highly organised. Similar to the international literature, people who distributed equipment “were significantly more likely to tell others about some specific pieces of information, including where to get ancillary injecting equipment, where to get tested for hepatitis C, and how to get treatment for drug use” (Fisher, Wilson, & Bryant, 2013, p. 1). However, it must be noted that people who access injecting equipment from pharmacies in NSW may have to pay for equipment which may result in different patterns of peer distribution compared with people who obtain their injecting equipment free from publicly funded NSPs.

Across this literature, peer distribution is reported to occur regardless of the type of NSP program, service level distribution policy or whether peer distribution was an illegal practice (Lorvick et al., 2006). Motivations for participating in peer distribution appear altruistic and driven by a moral economy to prevent others from catching disease (Benyo, 2006; Snead et al., 2003) and PWID express a sense of pride in their involvement in an informal health intervention role (Fisher et al., 2013). As there is little known about PWID who participate in peer distribution in NSW, particularly those attending NSP where equipment is distributed for free and without restrictions on the volume that can be collected at any one time, this study aimed to fill the gap in the literature.

Methods

The data presented in this article are drawn from a larger doctoral project, which explored responses to hepatitis C risk and prevention among four networks of Australians who inject drugs. Participants were recruited to the larger study from four study sites in NSW. Staff of a NSP in each site assisted with the referral of a key individual who then referred members of their social network to the study in the geographic areas known as Newcastle (assisted by a youth-based Secondary NSP); South-West Sydney (assisted by a primary NSP in South-East Sydney as this area did not have an operational NSP); South-East Sydney (assisted by an inner-city primary NSP) and the North Coast (assisted by a secondary regional NSP). Primary NSPs are stand-alone services with dedicated staff. Secondary NSPs are operated by other health and community services (such as sexual health, community health or youth services) in which staff are not specifically trained in relation to BBV prevention or drug user health and social needs. Although peer distribution is the focus of this article, and interview questions directly explored this practice, it should be noted that inclusion criteria for recruitment to this study did not include involvement with peer distribution.

All study participants took part in semi-structured face-to-face interviews (all conducted by JN), in various locations across NSW (such as parks and private spaces within NSPs) which ranged between thirty minutes and two hours in duration. All interviews were recorded, transcribed verbatim and checked for accuracy. All

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