



PROMOTING SECONDARY EXCHANGE: opportunities to advance public health

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Executive Summary

Secondary exchange is an important but underemphasized component of HIV and hepatitis C prevention for injection drug users (IDUs). Secondary exchange refers to a range of formal and informal practices through which syringe exchange participants redistribute sterile syringes to peers within social and drug-using networks. Despite their remarkable success in disease prevention, syringe exchange programs (SEPs) directly reach between 5-10% of active injection drug users. With changing communities, gentrification, and shifting drug trends, it is clear that public health policies must respond by promoting practices that reach the most at-risk communities. Secondary exchange therefore facilitates access to sterile syringes for a far greater number of drug users. Syringe exchange programs and policy-makers should develop policies, programs, and strategies that aggressively encourage secondary exchange. Furthermore, secondary exchange can be harnessed to disseminate accurate risk reduction and disease prevention information, encourage health-promoting social norms and behavioral change, and recruit members of drug using social networks into higher-threshold services and interventions. This report includes a set of recommendations intended to facilitate, expand, and capitalize on secondary exchange.

Recommendations

- Revise local, state, and program policies to maximize the public health benefits of secondary exchange. Syringe exchange regulations and policies should shift away from the one-for-one exchange paradigm and strive to ensure that exchange participants obtain adequate numbers of syringes for themselves and their peer networks. Changing policies and procedures that require caps on the number of syringes received by participants and implementing explicit strategies and campaigns to encourage and support secondary exchange will increase the number of sterile syringes available to injectors and promote community health.
- Develop new models that engage secondary exchangers to enable social network interventions including HIV, hepatitis C, and overdose prevention, as well as recruitment to higher-threshold services (i.e., HIV and STD testing, hepatitis A & B vaccination, etc.).
- Design gender-specific approaches to engage female recipients of secondary exchange. Promote and support women peer educators trained on risk reduction for women IDUs.

- Explore strategies to ‘incentivize’ secondary exchange, including efforts to a) recognize the work of secondary exchangers within programs, b) convene special meetings, events, or trainings for secondary exchangers, and c) compensate secondary exchangers for achieving specified outreach and/or education objectives within their networks.
- Develop strategies to harness the role of secondary exchangers to increase the flow of information to programs. Secondary exchangers provide valuable information concerning drug trends, law enforcement practices, and overdose rates and response patterns. Programs should also devise simple measures and estimates of the extent and reach of secondary exchange conducted by participants, either as periodic surveys or on-going data collection.

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- Establish greater safe disposal options for secondary exchange providers and recipients; such options include distributing individual fit-packs, providing education on needlestick injuries, and establishing community safe disposal kiosks.
- Policies should promote safe disposal and education among secondary exchangers but not require secondary exchangers to collect used syringes to return at SEPs. Policies must recognize that a) IDUs employ a range of valid and safe strategies to dispose of used syringes, and b) requiring secondary exchangers to return syringes used by others may increase their risk of infection through needlestick injuries.

- Syringe exchange programs, local health clinics, and community based organizations should pilot low-threshold models that train secondary exchangers as peer educators. To be effective, these models should require the minimum amount of training and documentation necessary and provide substantial flexibility to programs and participants.

Background

Syringe access programs are one of the most effective methods of disease prevention among injection drug users. Over a decade’s worth of scientific research concludes that syringe exchange programs play an essential role in reducing the spread of blood-borne illnesses such as HIV and hepatitis B and C.¹ Research consistently demonstrates that syringe exchange programs and over-the-counter pharmacy sales of syringes are valuable public health interventions that target ‘hard to reach’ populations of injection drug users, providing a ‘bridge’ to medical, mental health, and addiction treatment. Yet, despite documented efficacy and the positive health benefits associated with participation in a syringe exchange program, their implementation is not widespread.

Social, legal, and political constraints deter the development of syringe access programs, resulting in limited access to—and circulation of—sterile syringes in many communities. Recent research suggests that while the total number of syringes exchanged is on the rise, the number of syringe exchange programs has decreased slightly.² Logistical barriers and finite resources suggest that, even under the most optimistic scenarios, SEPs will never directly reach more than a fraction of IDUs. A practice known as ‘secondary and satellite exchange’ is a supplementary method to increase the number of sterile syringes in circulation and reach injection drug users who are unable or unwilling to attend a syringe exchange program.³

Secondary exchange is a broad term encompassing practices that range from semi-formal arrangements among a stable peer network which one member serves as ‘designated exchanger’ for the group to more informal patterns where exchangers provide, loan, or sell syringes to peers on an as needed basis. Strategies to promote secondary distribution and exchange offer a complementary approach to increase syringe access, disseminate health promotion and disease prevention messages, and engage more IDUs.

This report intends to:

1. Explore the dynamics of secondary exchange
2. Outline advantages and shortcomings associated with secondary exchange
3. Propose recommendations to diversify models of syringe access in order to capitalize on the practice of secondary exchange

Secondary Exchange: scope and practice

Based on a recent nationwide survey of syringe exchange programs, 90% of programs encourage secondary exchange and the vast majority of IDUs supply syringes to others.⁴ In a California research study, approximately 75% of SEP participants reported engaging in secondary exchange. Studies also document the extent to which secondary exchange increases the number of sterile syringes in circulation. A research study in Chicago found that 22% of the 40,000 syringe exchange visits involved secondary exchange; these transactions accounted for over half of all syringes exchanged at that program.⁵ Most often, secondary exchange takes place through peer networks where an IDU participating in a syringe exchange program supplies sterile syringes (and often injection equipment such as cookers, cotton, and alcohol pads) to friends, family members, lovers, and/or associates.⁶

Research demonstrates that syringe exchange programs are successful in reaching predominantly male, long-time drug injectors; however, studies suggest that SEPs are less effective in reaching younger injectors, women, and new drug users.⁷ When compared to primary SEP participants, recipients of secondary exchange are more likely to be younger and newer to injection drug use than their counterpart SEP participants. In addition, more women participate in secondary exchange, most often, with an IDU partner.⁸ These 'hidden' groups of IDUs are under-represented at SEPs but often participate in secondary exchange and receive syringes through peer and partner networks.

Motivations to participate in secondary exchange: providers and recipients

IDUs engage in secondary exchange as 'provider' and/or 'recipient' for different reasons. For providers, the primary motivation to supply sterile syringes is altruistic; qualitative research studies found that the driving force behind secondary exchange is a strong desire to help others.⁹ IDUs who were recipients in secondary exchanges reported that convenience was the primary factor in receiving syringes through peer networks rather than through

SEPs. Research suggests that IDUs are more likely to acquire syringes through secondary exchange when access to SEPs is limited.¹⁰ The location of a SEP is significant because IDUs required to travel longer distances to access programs report fear of police harassment as a major factor in participating in secondary exchange.

Reasons cited by injection drug users as disincentives for participation in a syringe exchange program include:

- Fear of targeting by law enforcement
- Privacy concerns (not wanting to be identified publicly as an IDU)
- Inconvenient or inaccessible hours or location of SEPs
- Employment schedule conflicts with hours of exchange

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- Lack of consistent transportation
- Disability (including disease, injury, and mental illness)
- Homelessness or transient housing (lack of safe place to store syringes)
- Alternative access to syringes (through dealers)
- Drug lifestyle (desire to limit use)
- Legal status (probationer, parolee, fear of outstanding warrants)

Secondary Exchange: advantages and disadvantages

Research investigating the health benefits of secondary and satellite exchange found that both practices are valuable means of increasing

sterile syringe circulation, especially among high-risk groups. Secondary exchangers engage the groups most at risk for drug-related harm including women, younger injectors and new IDUs—many of whom do not regularly participate in SEPs. While secondary exchange is effective in distributing sterile syringes to non-SEP users, research suggests that health promotion benefits and disease prevention messages are diminished during these encounters. Studies of injection-related risks among primary SEP users, secondary exchange recipients, and drug users not utilizing these services found mixed results. In some instances, individual risk behaviors were significantly higher among IDUs who did not attend a SEP or receive syringes through secondary exchange.¹¹ However, other research documented similar levels of risky injection behavior among secondary exchange recipients and non-secondary exchange IDUs. A qualitative study in California found that secondary exchange providers replicated myths about HIV transmission and did not deter users from sharing injection equipment or other high-risk practices.

Women

Studies consistently illustrate that women who inject drugs are much more likely engage in practices that place them at high risk for disease. Women are more likely to have an IDU sex partner and also more apt to trade sex for money or drugs.¹² Findings from a Baltimore study reported that women who engaged in secondary exchange were significantly more likely to become infected with HIV than their male IDU counterparts.¹³ Researchers suggested that interconnected drug and sexual partnerships created a heightened risk environment.

The role of peer networks: opportunities for intervention

Secondary exchange is embedded in existing social networks and functions alongside peer education.¹⁴ These networks can be informal arrangements, taking place during drug sales or use. According to a recent qualitative research study, secondary exchange also takes place formally, operating as a quasi-syringe exchange program with established hours, clients, procedures, and educational information. Secondary exchange providers operate within peer networks that have limited or non-existent contact with SEPs. Therefore, these providers serve as advocates who share and disseminate risk reduction information as peer educators. Although participation in a syringe exchange program is associated with a reduction of syringe sharing, it does not result in cessation of all syringe sharing. Research from a study at a Baltimore syringe exchange

program showed that 78.3% of SEP participants reported sharing with a close friend. The study found that IDUs engage in selective risk taking – only sharing syringes with close friends or people with whom they had strong ties in their peer networks. Risk taking was not random; IDUs were less likely to share syringes with strangers or weaker-known associates. This was particularly true for women, who are more likely to share syringes with close friends or partners.

Researchers noted that when networks are relatively closed, with low disease prevalence rates among the group, the IDU is ‘protected’ or insulated from outside exposure. However, researchers also found that there is significant turnover within close-friend networks; the role of ‘close-friend’ changes over time.¹⁵ For syringe exchange programs and secondary exchange models, these findings represent an opportunity to tailor disease prevention messages and provide targeted counseling on syringe sharing and risk behavior in the context of close friendships, partnerships, and peer networks.

An innovative peer model recently established in Russia developed formal secondary exchange methods to counteract the overwhelming operational barriers (such as oppressive law enforcement tactics) to reach Russia’s largely ‘hidden’ IDU population. To offset these profound legal and law enforcement obstacles, advocates created an alternative SEP model that employed peer educators and actively recruited IDUs to promote secondary exchange. Since its inception, Project Renewal’s secondary exchange model is utilized more than the primary SEP program at both the fixed and mobile sites.¹⁶

Promoting secondary exchange: policy and public health goals

Research demonstrates that the most effective disease prevention occurs when IDUs receive both sterile syringes and risk reduction messages during SEP transactions and encounters with staff. IDUs who visit SEPs consistently, exchange syringes for personal use, have access to ancillary social services and sustained engagement with

harm reduction staff, have the lowest likelihood of HIV transmission, because they receive both sterile syringes and messages which influence individual behavioral change. Against the backdrop of limited resources and structural barriers to expand syringe access—as well as overall changing drug use trends—secondary exchange can enhance public health by increasing sterile syringe circulation in the IDU community.¹⁷ By using more formal peer education with SEP participants who perform secondary exchange, SEPs can capitalize on access to non-SEP-using IDUs and enhance their capacity to promote risk reduction strategies.

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3. Secondary exchange refers to the practice whereby a participant at a syringe exchange program receives more syringes than needed for their personal use and re-distributes sterile syringes among their peer networks and associates. Whereas satellite exchange refers to the practice of distributing large quantities of sterile syringes (through shipping or delivering) to locations that do not have syringe exchange programs (or very limited SEPs). The most notable difference in these practices is that secondary exchange often occurs among known associates and peers, and satellite exchange happens outside a personal network in a given community when syringes are distributed at a distance from the original exchanger. Both practices are quasi-legal based on state or local policies.
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