**FACT SHEET #3:**

**Syringe Exchange Delivery Models**

SEP’s use many different models to exchange syringes. Some exchanges use exclusively one model; others use several. Which model a program uses depends on a number of factors including cost, staff/volunteer availability, geographic context (e.g. urban vs. rural), and political climate. Using multiple models can increase access to injectors and help decrease transmission of HIV and Hepatitis C.

**Storefront/Fixed** A building houses the syringe exchange. This could be a storefront, an office, or other similar space.

**Strengths:**
- Shelter from street-based activities/safe space.
- Protection from the weather.
- Room for other services such as medical care, referrals, psychosocial.
- Out of view of local residents, businesses.
- Privacy for exchange participants.

**Limitations:**
- Participants have to come to you.
- Limited hours of operation.
- Higher overhead and upkeep.
- Can become the focus of community opposition.
- Difficult to adjust to changes in the drug scene, neighborhood development.

**Mobile/Street Based** Vehicle based exchange; driving to already established exchange sites. In urban areas, foot or bike-based mobile exchange.

**Strengths:**
- Flexibility if the drug scene or neighborhood changes.
- Easier negotiations with larger community if they know you are not a permanent fixture.
- Informal and low threshold if actually on the sidewalk or in a park.
- Reaches harder to reach IDUs.

**Limitations:**
- Harder to deliver ancillary services than with a fixed site.
- Inclement weather can dissuade participants from coming to exchange.
- Van involves higher overhead because of insurance, upkeep, driver, etc.

**Home Delivery/Urban** Delivering injection supplies to where a person lives (or another agreed upon site) in the city, such as SRO rooms, scattered site housing, shooting galleries. Can happen on a regular schedule, or by appointment via cell phone or pager.

**Strengths:**
- Safer for participants.
- Potential for large exchanges.

**Limitations:**
- Participant needs to be at home.
- Invasion of privacy.

**Home Delivery Rural** Provision of services where a person lives in the country or the suburbs. This is often done by word of mouth once the initial contact is made. Also done by ap-

**Strengths:**
- Same as Urban

**Limitations:**
- Can involve a lot of driving, resulting in high overhead.
**FACT SHEET #3:**

**Syringe Exchange Delivery Models**

*continued*

**Integrating into pre-existing structure:** An organization adds syringe exchange into their on-going services.

**Strengths:**
- Pre-existing organizational infrastructure and client base.
- Multiple ways of getting syringes to participants, depending on the type of services provided by the agency.

**Limitations:**
- Staff is often resistant to new programs & new ideas, especially if the agency follows a traditional abstinence approach.

**Peer-based Exchange** Also called secondary or satellite exchange. Participants exchange with their peers after being supplied by the syringe-access program. Can easily be combined with home delivery.

- Peer knowledge of drugs, drug use, and the local drug scene.
- Increases access to new syringes for socially isolated injectors who do not access services such as syringe exchange.

- Cost of training and supervision of peers.
- Possible conflicting identities as peer worker and IDU community member.

**Collaboration** Partner agencies that provide other type of services in the community (e.g. social, shelter, youth, etc.) but also provide SEP services at their site on behalf of the parent SEP.

- May attract different groups of IDUs than parent exchange.
- Increase accessibility in terms of location, time, culture and age group.
- May offset operational and human resource costs from the parent SEP to the satellite site.

- Difficult to enforce NEP policies on satellite sites.
- Staff turnover at satellite may require frequent training of staff by parent SEP.