An explorative study on how Needle Exchange Programme service users construct health

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Abstract

Needle Exchange Programmes (NEPs) are a social initiative, where people who inject drugs (PWID) are able to access sterile injecting equipment and safely dispose of used needles. NEPs use harm reduction principles to reduce the poor health outcomes that can result from practices such as needle sharing and reusing. There is an assumption that PWID do not care about their health, which is linked to neoliberal ideas of health and morality regarding individual choices and their health. There is some evidence that shows, contrary to popular belief, PWID do care about their health. The current research project had two aims: firstly, to understand how Needle Exchange Program (NEP) users construct their health; and, secondly, to explore how, according to service users, the NEP contributes to service users' overall health.

Participants were six service users of an Aotearoa New Zealand, South Island NEP outlet store. All participants identified as Pākehā/NZ European, and five identified as male, with one participant not disclosing their gender. Interviews were conducted on the premise of a South Island NEP outlet store. Reflexive Thematic Analysis was used to analyse the transcribed interviews and three themes were produced:1) PWID constructions of health and health practices; 2) Social factors and health; and 3) The NEPs contribution to health. Participants overwhelmingly felt that health was an individual responsibility, in accordance with neoliberal beliefs, and they engaged in daily practices, such as mindful nutrition consumption, to maintain a good health citizen status. Participants also framed their injecting drug use as a positive health behaviour which benefited their health maintenance. Despite describing health as an individual responsibility, participants still acknowledged external factors as impacting their health. The experience of stigma negatively affected participants through creating

barriers to health access, whereas important relationships contributed positively to their health. Finally, the NEP was a significant contributor to the health of participants, through enabling positive physical health, and through the relational support provided.

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GLOSSARY

AIDS: Acquired Immunodeficiency Syndrome

A-NZ: Aotearoa New Zealand

AOD: Alcohol and Other Drugs

BBV: Blood Borne Virus

CHP: Critical Health Psychology

Hep B & C: Hepatitis B and C

HIV: Human Immunodeficiency Virus

NEP: Needle Exchange Programme

NSEP: Needle and Syringe Exchange Programme

NSP: Needle and Syringe Exchange Programme

NZNEP: New Zealand Needle Exchange Programme

OST: Opioid Substitution Treatment

PIEDS: Performance and Image Enhancing Drugs

PWID: People Who Inject Drugs

RTA: Reflexive Thematic Analysis

TA: Thematic Analysis

CHAPTER ONE: OVERVIEW

1.1 Introduction

Needle exchange programmes (NEPs), also known as needle and syringe exchange programmes (NSEP/NSP), are a social service where injecting drug users can access sterile injecting equipment and dispose of used needles (New Zealand Needle Exchange, 2020). NEPs aim to reduce the negative health consequences of injecting drugs that result from practices, such as, needle reuse and sharing (New Zealand Needle Exchange, 2020). The habit of needle reuse and sharing is a known form of transmission for communicable disease and blood borne viruses (BBVs), specifically HIV/AIDS and Hepatitis B and C (Magura et al., 1989; Treloar et al., 2016).

This chapter examines the past literature regarding people who inject drugs (PWID), their health and the impact of NEPs on PWIDs health. To do this, I will firstly explore the history of the NEP globally, before bringing it back to Aotearoa New Zealand (A-NZ). I will then review the harm reduction model, which is the model NEPs use to inform their practice. Following which, an assessment of the effectiveness of NEPs will be completed, before reviewing a 2021 report of the cost-effectiveness of NEPs in A-NZ. The chapter will then move into an exploration of contemporary views of health, before diving into research regarding PWID and their health. This will cover past literature that examines pathways that effect PWIDs health and conceptualisations held about the health of PWID. Finally, I will move to the present study and clarify the aims of the research project.

1.2 The Needle Exchange Programme History

1.2.1 The Global History of the Needle Exchange Programme

NEPs were first introduced in the early 1980s, in the Netherlands, and many countries in the world, including in Aotearoa New Zealand (A-NZ), soon followed suit (Harris 2021; Kemp & Aitken, 2004; Macmaster & Womack, 2002; Van Santen et al., 2021; Vlahov et al., 2001). In 1984, the world's first needle exchange programme (NEP) was set up in Amsterdam by the Junkie Union (Macmaster & Womack, 2002; Vlahov et al., 2001). This was in response to the main pharmacy in Amsterdam discontinuing sales of sterile injecting equipment (due to consumer pressure) and the potential outbreak of Hepatitis B among PWID the lack of access of such sterile equipment would cause (Macmaster & Womack, 2002; Van Santen et al., 2021; Vlahov et al., 2001). The Junkie Union proposed the distribution of sterile needles and syringes around Amsterdam to the Public Health Service of Amsterdam (PHSA) (Van Santen et al., 2021). This was unchartered territory and a concern of implementation to PHSA was the risk of used needles being discarded on the public streets (Van Santen et al., 2021). An agreement between the Junkie Union and PHSA was reached that used needles and syringes would be exchanged for sterile equipment and, thus, the first needle exchange programme was borne (Van Santen et al., 2021).

Whilst Amsterdam was creating this innovative model, the world was growing more concerned with the spread of AIDS. PWID were identified in the early 1980s as a high-risk group for the contracting AIDS (Macmaster & Womack, 2002; Vlahov et al., 2001). Throughout the early-mid 1980s, the NEP as an intervention for injecting related health complications was being discussed at public health conferences and the idea to use NEPs to prevent the spread of AIDS was starting to make its way to government

officials around the world (Lane et al., 2000). In 1986, the United Kingdom started to pilot NEPs in cities throughout England and Scotland (Van Santen et al., 2021). In 1988, the first NEP in the United States of America (USA) was opened in Tacoma (Lane et al., 2000). However, it was 1992 before a NEP was established in a major American city, with New York City being the first to do so (Harris, 2021). By 1993, there were at least 37 NEPs in 27 cities across the USA (Lane et al., 2000). In Australia, the state of New South Wales decided to provide low-cost equipment to PWID in the mid-80s (Harris, 2021; Kemp & Aitken, 2004). Other Australian states followed suit in the coming years, with Victoria creating a NEP in 1988 (Harris, 2021).

1.2.2 Needle Exchange History in Aotearoa New Zealand

In the Aotearoa New Zealand (A-NZ) context, activists and advocates had been mobilised from the mid-1980s, in response to the growing numbers of HIV/AIDS cases (New Zealand Needle Exchange, 2020). The PWID community banded together with the LGBTQIA community and concerned medical professionals to create an alliance that took actionable steps to prevent the spread of the disease (Kemp & Aitken, 2004; New Zealand Needle Exchange, 2020). Pharmacists in Auckland and Christchurch supported efforts by illegally providing sterile injecting equipment to the PWID community (Harris, 2021; New Zealand Needle Exchange, 2020).

In 1987, the A-NZ government decided to enact legislation which would enable the provision of a state-sponsored NEP across the country (Harris, 2021; Kemp & Aitken, 2004; New Zealand Needle Exchange, 2020). With this decision, A-NZ became the first country in the world to fund a nation-wide NEP (Harris, 2021; New Zealand Needle Exchange, 2020). The government's choice to create a legal nationwide NEP was

underpinned by the activism from the community, the concern of the AIDS epidemic and a push from the Australian states beginning to roll out NEPs (Harris, 2021; Kemp & Aitken, 2004).

To enact this legislation, an order-in-council created the regulations about who, how and where needles and syringes could be distributed (Kemp & Aitken, 2004). The order-in-council also covered issues around the cost and safe disposal of used injecting equipment (Kemp & Aitken, 2004). By May 1988, the NEP was ready for implementation in New Zealand (Kemp & Aitken, 2004; New Zealand Needle Exchange, 2020).

The New Zealand Needle was unusual from its inception for two main reasons: First, a decision was made for PWID to cover the full costs of the equipment and, secondly, a peer-based approach was adopted from the beginning (Harris, 2021; Kemp & Aitken, 2004). PWID were to purchase the needles and syringes in the form of a ten-pack, for $10NZD which reduced to $7NZD if used equipment was brought in to be returned (Harris, 2021; Kemp & Aitken, 2004). Disposal costs were to be covered by funding from the state (Harris, 2021).

The peer-based approach was not a conscious decision from the government but rather groups were formed as charitable trusts that had the ability to respond to government need (Harris, 2021; Kemp & Aitken, 2004). An AIDS taskforce set out to establish peer-based organisations in the main cities, that were equipped with the capacity to become NEP outlets (Kemp & Aitken, 2004). In 1988, the Auckland Drug Information Outreach (ADIO), Wellington Injecting Drug Education (WIDE), Christchurch Intravenous Drug Users Resource Group (CIVDURG) and the Dunedin Intravenous Organisation (DIVO) were all established as PWID groups that had the capacity to

collaborate with pharmacies to act as outlets for purchase and disposal of injecting equipment (Harris, 2021; Kemp & Aitken, 2004).

In the first year of the NEP, 90% of the needle and syringe distribution was done through community pharmacies that were participating in the NEP (Kemp & Aitken, 2004). By 1993, this had reduced to 65%, with the peer-based organisations accounting for the other 35% (Kemp & Aitken, 2004). Around this time, the peer-based groups began to purchase injecting equipment directly from pharmacy wholesalers and recruiting community pharmacies to be outlets for them, supplying them with the equipment and dealing with the disposal of returns (Kemp & Aitken, 2004). The actions from the peer-based organisations shifted the nature of the NEP in A-NZ and by June 1996, the PWID groups were accounting for 56% of orders of needles and syringes from the wholesalers (Kemp & Aitken, 2004).

In 1995, the Ministry of Health agreed to the establishment of the New Zealand Needle Exchange, an organisation to represent the peer-based organisations and co-ordinate delivery of the NEP (Kemp & Aitken, 2004). Heading into 1996, a Wellington organisation, the Drugs and Health Development Project (DHDP), decided to trial a 1-for-1 exchange service, where PWID could get a free needle for returning a used needle (Kemp & Aitken, 2004). This was due to the number of PWID who could not access sterile equipment because of the cost. For example, some clients were in serious debt as a result of credit arrangements made to be able to buy sterile needle and syringes (Kemp & Aitken, 2004). This was despite the practices set up by the Director-General of Health requiring service users to only pay the cover amount of sterile equipment (Kemp & Aitken, 2004). The Ministry of Health eventually sent a letter to DHDP requiring the

cessation of the provision of free sterile equipment (Kemp & Aitken, 2004). The organisation sought legal counsel as to whether the Ministry had power under the legislation to require this from the organisation, which ultimately favoured the DHDP and by then the other peer-based organisations had begun implementing 1-for-1 exchanges, giving more strength to the DHDP's case (Kemp & Aitken, 2004). By 2004, the 1-for-1 exchange system was officially implemented in the New Zealand Needle Exchange (Harris, 2021).

In the twenty years since 2004, the New Zealand Needle Exchange has expanded beyond being a service that provides sterile injecting equipment and safe needle disposal. They now offer medical advice, free educational resources that cover safe injecting practices depending on the drug of choice, and avenues to obtaining extra support if desired by service users (Keen & Weston, 2021). Furthermore, community nurses and doctors use these service spaces to provide consultation to PWID (Keen & Weston, 2021).

Over the past thirty or so years, the New Zealand Needle Exchange has continually been separated from drug treatment services (Harris, 2021). This aligns with the harm reduction principles that the NEP in A-NZ follows, promoting safe injecting practices over abstention. The New Zealand Needle Exchange Programme (NZNEP) is touted to be one of the most successful public health initiatives (see 'Effectiveness of NEPs' section) and one of the first working examples of the harm reduction model (New Zealand Needle Exchange, 2020).

The most recent data on the prevalence of injecting drug use in A-NZ is from 2007/2008, which found approximately 1.3% of the population have recreationally

injected drugs, with 0.3% injecting in the 12 months previously (Ministry of Health – Manatū Hauora, 2010; Potter et al., 2025). As this data is from almost twenty years ago, the prevalence of injecting drug use in A-NZ in 2026 is unknown. The most recent data we have to understand who injecting drug users in A-NZ are, is the NZNEPs demographic report from 2022. The report found service users of the NEP were mainly NZ European/Pākehā (76.1%), aged between 35 – 49 (45%) and the majority were methamphetamine users (45%) (Yu et al., 2022).

1.3 Harm Reduction

NEPs are all based on a harm reduction approach. Stated simply, harm reduction is a pragmatic approach to drug use that focuses on reducing negative consequences of use, as opposed to abstention (Single, 1995). In the context of NEPs, the provision of sterile injecting equipment and a safe place to dispose of used needles aims to reduce the practice of needle sharing, which is a known vehicle to spread disease and BBVs. In contrast to abstentionism which seeks to decrease the prevalence of drug use, harm reduction seeks to reduce the side effects associated with illicit drug use (Harm Reduction Coalition Aotearoa, 2024; Marlatt, 1996; Riley & O'Hare, 2000). Harm reduction realises that abstinence from drugs is not realistic for all individuals and creates a hierarchy of goals whereby users achieve immediate and realistic goals to reach risk free use, or abstinence if they so desire (Marlatt, 1996; Riley & O'Hare, 2000).

Harm reduction aims to identify the consequences of drug use, which can be conceptualised as three main types of consequence (health, social and economic) which occur at three different levels (individual, community and societal) (Riley & O'Hare, 2000). As drug use is political and moralised, the assertion of benefits or

negatives is subjective to individual belief (Riley & O'Hare, 2000). However, a harm reduction framework allows for the identification of consequence and an evaluation of policies that deal with the harms identified (Harm Reduction Coalition Aotearoa, 2004; Marlatt, 1996; Riley & O'Hare, 2000).

How harm reduction is implemented depends on the socio-cultural and historical context of the area in which it is being promoted (Basto & Strathdee, 2000). In A-NZ, harm reduction follows the following seven key principles (Aotearoa Harm Reduction Coalition, 2024; Riley & O'Hare, 2000):

- Pragmatism – some drug use is inevitable and normal in a society. It could even be of benefit to some people. Thus, reducing the harms resulting from drug use is more viable than eliminating drug use.
- Humanistic Values – individuals are autonomous and ultimately it is their decision to continue to use, and these decisions should not subject them to punishment or coercion.
- Dignity – counselling principles are promoted, including; no moral judgement being made regarding use or non-use, respect for the individual, no hidden agendas, self-determination, empowerment and education.
- Risk Reduction – drug use itself, is secondary to the risks of harms that come from use. The priority is to decrease the harm to the user. If absention from drugs is the goal of the person, this is supported provided this is self-determined.
- Interconnected – successful interventions focus on overall wellbeing, quality of life and community impact, rather than cessation of drugs.

- Evidence Based Interventions – the strategies of harm reduction are practices that have data, lived experience, person-centred approaches and scientific evidence to support them.
- Community Engagement – lived experience of drug use is at the forefront of every policy, “nothing about us, without us”.

1.4 The Effectiveness of NEPs

The utilisation of harm reduction to address the negative health consequences of injecting drug use has been an effective and successful intervention (Single, 1995; Wilson et al., 2015). Specifically, since the inception of NEPs, over 40 years ago, the evidence has overwhelmingly shown these services to be effective interventions to reduce the transmission of disease, such as HIV/AIDs (Single, 1995; Wilson et al., 2015).

1.4.1 HIV/AIDs and NEP

Many NEPs were set up as a response to the AIDs epidemic and the effectiveness of this reaction has been assessed multiple times, with the majority of the literature showing that NEPs are effective in reducing the incidence of HIV/AIDs in the PWID population (Strathdee & Vlahov, 2001; Wilson et al., 2015).

Hurley, Jolley and Kaldor (1997) took data from multiple cities around the world. They investigated HIV incidence rates in 52 cities without NEPs and compared this data to 29 cities with established NEP (Hurley, Jolley & Kaldor, 1997). The results found that in cities without NEP, rates of HIV increased by 5.9% annually, compared with a decrease of 5.8% annually, in the cities with NEPs (Hurley, Jolley & Kaldor, 1997).

This is consistent with Strathdee and Vlahov’s (2001) review and Fernandes et al.’s (2017) meta-analysis. Strathdee and Vlahov (2001) found that NEPs were

associated with decreased risk-taking behaviours, such as needle sharing and frequent injecting, behaviours known to be vehicles of HIV/AIDs transmission. Both Strathdee and Vlahov (2001) and Fernandes et al., (2017) found overall that studies show a decrease in HIV/AIDs infection rates when NEPs have been introduced.

1.4.2 Hepatitis B and C and NEP

The evidence of NEPs reducing BBVs, specifically Hepatitis B and C is very mixed. Basto and Strathdee (2000); Strathdee and Vlahov (2001) and Sweeney et al. (2019) all indicate NEPs being associated with a reduction in BBVs. However, both Davis et al. (2017) and Fernandes et al., (2017) found in their meta-analyses that results for NEPs prevention of Hepatitis C, specifically, were mixed. Fernandes et al. (2017) elaborated on this and found in their analysis that when NEPs included other harm reduction initiatives (such as opiate replacement treatment), the strength the association of NEPs decreasing BBVs increased.

1.4.3 Cost-benefit analyses of NEPs

Overall, the literature suggests that NEPs are beneficial and low-cost initiatives, in which the reduction in negative health complications from drug injecting outweighs the costs involved in the establishment and maintenance of NEPs (Gold et al., 1997; Sweeney et al., 2019; Wilson et al., 2015).

Gold et al., (1997) set out to complete a cost-effectiveness analysis of their local NEP in the prevention of HIV infection. They conservatively estimated that their NEP will prevent 24 cases of HIV infection over five years, which translated into healthcare system savings of $1.3 million CAD after the NEP costs are covered (Gold et al., 1997).

The benefits of NEPs for both on individual health and savings for the healthcare system are further backed up by Sweeney et al.'s (2019) analysis of the cost-effectiveness of NEPs in the United Kingdom. Sweeney et al. (2019) completed an analysis on the cost-effectiveness of NEPs on Hepatitis C transmission, finding that not only were NEPs a low-cost intervention that reduced Hepatitis C transmission, but they were also cost saving in some settings.

Wilson et al. (2015) found that NEPs also provide a higher quality of life for PWID, alongside the physical health benefits. Their analysis looked at several forms of harm reduction, including NEPs, and each form had significant strengths in the reduction of harm with minimal costs (Wilson et al., 2015). Their findings support the cost-effectiveness of NEPs, and they suggest that scaling up harm reduction initiatives will yield high investment return through the reduction of health-related complications for PWID (Wilson et al., 2015).

The benefits of NEPs do not just include physical health benefits to PWID, they also extend to wider society (Strathdee & Vlahov, 2001). It has been shown that NEPs do not contribute to high-risk needle sharing networks, they do not increase drug use, nor do they increase crime in the areas they are established (Strathdee & Vlahov, 2001). They also decrease the number of needles discarded on streets and in public areas (Strathdee & Vlahov, 2001)

1.5 Aotearoa New Zealand 2021 Report

In A-NZ, a report on the cost-effectiveness of the national NEP was published in 2021. Keen and Weston (2021) found multiple benefits of the New Zealand Needle Exchange. This includes reductions in the transmission of HIV, hepatitis C and hepatitis

B, synonymous with previous research and the findings discussed above (Keen & Weston, 2021). The addition of further harm reduction initiatives, such as hepatitis C testing and community nurse consultation gives PWID more awareness of their infection status and reduces the risk of further infection spread (Keen & Weston, 2021). The New Zealand Needle Exchange also provides education and educational resources around safe injecting practices for the users' drug of choice, helping to reduce risk of skin and soft tissue infections (Keen & Weston, 2021). Recently, with the opioid overdose epidemic around the world, due to drugs being laced with fentanyl, the New Zealand Needle Exchange has started to provide naloxone (an opioid reversal agent) to service users (Keen & Weston, 2021). This helps to reduce the number of fatal overdoses (Keen & Weston, 2021). The New Zealand Needle Exchange has also been shown to be significant in improving mental health outcomes for PWID, with findings from Hay et al. (2017) showing lower rates of depression and anxiety, greater life satisfaction and increased health related information exchange for PWID who used the NEP over those who accessed equipment from pharmacies (Keen & Weston, 2021).

When weighing up these benefits versus the costs of the New Zealand Needle Exchange, Keen and Weston (2021) calculated the benefits as the reduction of burden on the A-NZ healthcare system compared to the costs to run the New Zealand Needle Exchange. They calculated the benefits at approximately $39.9 million NZD saved, compared to approximately $6 million NZD in costs. This equals to approximately $6.79 in savings, for every $1 of cost (Keen & Weston, 2021).

1.6 Conceptions of health in contemporary society

Western contemporary society health conceptions are informed by neoliberal, capitalist ideology (Cheek, 2008; Riley et al., 2025b). The dominant culture in Western countries is individualistic, whereby, the needs of the individual are given preference over the collective (Black & Huygens, 2021; Levy & Waitoki, 2021). The individualistic nature of western societies aligns well with neoliberal capitalism. Neoliberal and capitalist societies value productivity, and desire citizens who understand themselves to be rational, coherent and autonomous decision makers (Riley et al., 2025b). This understanding of the self cultivates citizens who believe they have control over their future, view themselves as projects that require self-monitoring and improvement through appropriate consumption and who begrudge dependency of the state (Riley et al., 2025b).

This perspective impacts how health is conceptualised. Neoliberal understandings place health as the responsibility of the individual, that is, the individual is responsible for making decisions that benefit their health (Crawford, 1980; Cheek; 2008; Lyons & Chamberlain, 2017). This perspective is known as healthism and it is laden with moralistic connotations around health, which ultimately leads to victim blaming (Lyons & Chamberlain, 2017). When behaviours are framed as individual choices, when engaging in a behaviour that is deemed negative for your health (i.e., using drugs) you are seen as a 'bad health citizen' – as the behaviour you chose to engage in makes you a burden on the state (Lyons & Chamberlain, 2017). This lens removes the environmental, social and relational contexts for understanding an individual's health (Riley et al., 2025b). Through doing this, it shifts the onus of health from the structural and institutional powers at play, and gives these powers a reason to

deny social, environmental and relational initiatives for health (Lyons & Chamberlain, 2017; Riley et al., 2025b).

1.7 People Who Inject Drugs and health

It has been well established that NEPs are highly effective interventions in reducing negative physical health consequences for PWID (Keen & Weston, 2021; Single, 1995; Strathdee & Vlahov, 2001; Wilson et al., 2015). Less investigated is how NEP service users perceive health. The predominant assumption in wider society, regarding PWID and their perceptions on health, is that PWID do not care about their health (Olsen et al., 2012). This assumption is related to the moral judgement wider society imposes on drug use and individual responsibility to complete health behaviours that benefit health (Fong et al., 2021; Olsen et al., 2012). In contrast, the literature suggests that PWID are health conscious and, rather, that it is the stigma they face in the healthcare system that acts as a barrier to PWID achieving health (Drumm et al., 2005; Dutere et al., 2001; Olsen et al., 2012).

1.7.1 PWID and stigma

PWID face lots of stigma which impacts health, through a myriad of different pathways. Stigma can become discrimination when the stigma is a sign of low moral status in the eyes of wider society (Couto e Cruz et al., 2018). Evidence shows that when PWID experience discrimination, they are more likely to have worse overall health and wellbeing (Couto e Cruz et al., 2018). The risk of adverse health outcomes increases when the frequency of discrimination experiences increases (Couto e Cruz et al., 2018).

Previous literature shows that PWID experience stigma in healthcare settings and from medical providers, due to beliefs that PWID can choose to not use drugs and through not using drugs their health issues would disappear (Fong et al., 2021; Paquette et al., 2018). It has been found that when compared to other conditions that are perceived to be out of the individuals' control (such as diabetes and depression) the attitude of healthcare workers towards drug users is more negative and the regard for drug users is lower (Fong et al., 2021). Furthermore, healthcare workers perceive drug users as being challenging and potentially unsafe (Fong et al., 2021).

The experience of this stigma impacts on how PWID access healthcare and how PWID engage in medical treatment (Austin et al., 2022; Fong et al., 2021; Paquette et al., 2018). PWID are less likely to access healthcare services when needed because of the stigma they experience in those settings (Austin et al., 2022; Paquette et al., 2018). Interactions with healthcare providers, often leave PWID feeling intense shame around their drug use and feeling unheard and ignored (Austin et al., 2022). As the stigma from healthcare workers includes a belief that drug use is a choice, PWID often find that providers will coerce and try to control their drug use over treating other conditions (Austin et al., 2022). PWID feel pressure from their healthcare providers to abstain from drug use in order to be perceived as worthy of care, with PWID having experiences where non-users had their care prioritised over them (Austin et al., 2022; Paquette et al., 2018). These experiences impact how and when PWID access healthcare, with many avoiding seeking help regarding their health until it has reached a state of urgency (Austin et al., 2022; Paquette et al., 2018). Hoadley et al. (2021) found that women who inject drugs and were on community parole were more inclined to seek health support from the emergency department of hospitals once their health status was seriously

declining, as opposed to addressing the issue early, as a means to avoid experiencing as much stigma as possible around their drug use status.

The societal stigma and discrimination experienced by PWID also impacts decisions to use evidence-based treatments for their addiction. Opioid substitution treatment, also known as methadone programmes, are effective interventions to help PWID abstain from heroin use (Wilson et al., 2015). However, society at large does not view this programme as a treatment for PWID, instead there is a stigma that users are just replacing one drug with another (Paquette et al., 2018).

1.7.2 PWID and Internalised Stigma

The stigma produced by wider society about PWID can often be so pervasive, that over time, PWID internalise the stereotypical beliefs held by society and begin to accept them as the truth (Paquette et al., 2018; Von Hippel et al., 2018). Through the internalisation of the discrimination experienced by PWID, their health is negatively affected (Paquette et al., 2018; Von Hippel et al., 2018).

Self-stigma is associated with increased risky injecting behaviours and less health seeking (Paquette et al., 2018; Von Hippel et al., 2018). Von Hippel et al. (2018) found that PWID who experienced explicit internalised stigma were less comfortable accessing NEPs and had poorer psychosocial functioning.

1.7.3 PWID and perception of health risk

There is some evidence that PWIDs perception of vulnerability influence the level of risky and unsafe behaviours that they engage with (Bonar & Bohnert, 2016; Houlding & Davidson, 2003; Von Hippel et al., 2018). If PWID believe they are less likely to obtain or transmit disease (such as HIV) then they are less likely to use condoms during sexual

intercourse (Houlding & Davidson, 2003). Bonar and Bohnert (2016) had similar findings with perceived susceptibility to overdose influencing the use of safe injecting practices. Likewise, Von Hippel et al., (2018), found that the more implicitly positive PWID were regarding drug use, the more likely they were to engage in needle sharing and avoid health treatments.

1.7.4 PWID and health maintenance

Engagement in behaviours that are associated with negative health behaviours is not just isolated to PWID, often the general public does not follow health advice (Olsen et al., 2012). However, because drug use is laden with negative moral connotations (especially injecting drug use), wider society assume that PWID are not health conscious (Drumm et al., 2005; Olsen et al., 2012). However, there is some evidence challenging this assumption, albeit it is limited. Dutere et al. (2001) found that the health behaviours of drug users were closely aligned with the practices of the general public. Whilst some users did engage in risky behaviours, there were a significant amount who were conscious of ensuring they engage in positive health behaviours, such as vitamin supplementation (Dutere et al., 2001). This was also represented in Drumm et al. (2005), where interviews with drug users found that users were actively involved in the management of their health. Participants described making positive health choices around food consumption, exercise, sex and managing drug use (Drumm et al., 2005). Olsen et al. (2012) discussed health consciousness with women who inject drugs and found that the women were actively engaging in positive lifestyle choices. This research challenges the notion that PWID engage in only 'unhealthy' behaviours and are not concerned with their overall health.

1.7.5 Health as lower on the priority scale

Whilst research shows that drug users are conscious of their health, much like other members of society, their engagement in positive health practices is contextualised by cultural, economic, social and political factors. Olsen et al. (2012) found many of their participants (women who inject drugs) would place their health lower on the list of priorities. They were conscious of the activities that could help their health yet were likely to forego this to address their most urgent needs, such as housing or food (Olsen et al., 2012). This was also found by Austin et al. (2022) with their findings showing that health was deprioritised to put out the most urgent fires. Hoadley et al. (2021) extended these findings to the preference of PWID to use acute care medical services over addressing health earlier with general practice healthcare. Food and housing often came up as daily needs that felt more pressing to address for PWID (Hoadley et al., 2021; Olsen et al., 2012).

1.8 The Present Study

Evidence shows that NEPs are cost-effective tools, that reduce the risk of needle-sharing behaviours and, in turn, reduce the risk of PWID obtaining communicable diseases and BBVs (Gold et al., 1997; Hurley et al.,1997; Keen & Weston, 2021; Strathdee & Vlahov, 2001; Sweeney et al., 2019; Wilson et al., 2015). Despite the government funded provision of NEPs within A-NZ, and the emphasis on harm reduction as advocated by the NEPs, PWID are still heavily stigmatised by wider society (Gibson & Hutton, 2021; Rijnink et al., 2022). The discrimination experienced by PWID acts a barrier to health, with the stigma being linked to poor health outcomes and is a related to the assumption that drug use is a personal choice (Couto e Cruz et al., 2018; Fong et al., 2021; Olsen et al., 2012). There is a further assumption that PWID do

not care about their health, which is linked to ideas about morality, individual choice and health (Olsen et al, 2012). Yet, the from the limited research, it is evident that PWID do care about their health, however, they often have to prioritise other needs before their health (Austin et al., 2022; Drumm et al., 2005; Dutere et al., 2001; Hoadley et al., 2021; Olsen et al., 2012).

Given the above, it can be argued that despite the assumptions made about PWID by wider society, service users of NEPs are health conscious. Within A-NZ, research has shown that NEPs have become more than just places to obtain equipment that reduces risks of health complications, they are spaces of support that are beneficial to the health of PWID and provide safe zones to seek health-related information from peers (Clarke et al., 2016; Hay et al., 2017).

Despite research showing that NEPs users seek to reduce health risks and search for answers to health-related queries, there has been limited research about their perspectives on health. They are a population that is under consulted in research (Salazar et al., 2021). Mobilising the PWID community to participate in research can identify critical issues and produce better outcomes for such individuals (Salazar et al., 2021). Through understanding the perspectives of PWID around health, the assumptions of wider society and neoliberal ideals of healthism may potentially be challenged and disrupted.

1.9 Research Aims

Consequently, the proposed research has two main aims. Firstly, it aims to understand how Needle Exchange Program (NEP) users construct their health.

Secondly, it seeks to explore how, according to service users, the NEP contributes to service users' overall health.

CHAPTER TWO: RESEARCH METHODOLOGY

2.1 Theoretical Framework

The current research was conducted from a critical health psychology (CHP) perspective and was underpinned by a social constructionist epistemological framework.

2.1.1 Critical Health Psychology

Health psychology, as a field, was developed in the 1960s and 1970s, and became was recognised as an official discipline of psychology in the late 1970s (Lyons & Chamberlain, 2017). The aim of the health psychology discipline was to integrate psychological knowledge into four health-related areas: 1) promoting and maintaining health; 2) preventing and treating illness; 3) identifying causal and diagnostic correlates of health and illness; and 4) improving the health-care system and health policy formation (Lyons & Chamberlain, 2017).

Traditionally, health psychologists have focused on the first area, with attention being place on individual lifestyle choices and changing individual's behaviour to maximise beneficial health outcomes in our society (Lyons & Chamberlain, 2017). This aligns well with the ideological beliefs, held by Western neoliberal societies, where health is seen as an individual responsibility – an idea known as healthism (Cheek, 2008; Crawford, 1980; Hui, 2022; Lyons & Chamberlain, 2017; Morison & Gibson, 2025; Riley et al., 2025b). The idea that health is the responsibility of the autonomous individual, comes with the reinforcement of the idea of health being a moral obligation ((Cheek, 2008; Crawford, 1980; Hui, 2022; Lyons & Chamberlain, 2017; Morison & Gibson, 2025; Riley et al., 2025b). A moral citizen will maintain good health through

positive (or health-enhancing) behavioural choices, and those who engage in negative health behaviours are responsible for any consequential illness (Cheek, 2008; Crawford, 1980; Hui, 2022; Lyons & Chamberlain, 2017; Morison & Gibson, 2025; Riley et al., 2025b).

One such negative health behaviour is drug use, with wider society often viewing those who use drugs as not health conscious, despite the general public also being unlikely to follow health advice (Drumm et al., 2005; Olsen et al., 2012). The broader factors involved in drug use are often overlooked and ignored, with it being seen as an individual choice that a person can chose to stop engaging in at anytime (Nepustil & Swim, 2022). CHP challenges the assumptions that health is the responsibility of the individual. Instead, it is concerned with context, power and social justice – where power is examined in how it facilitates or prevents health (Lyons & Chamberlain, 2017; Riley et al., 2025b).

2.1.2 Social Constructionism

Underpinning this research and the CHP perspective being brought to the current project is a social constructionist epistemology. Social constructionism is an epistemology that suggests that knowledge is not one single, universal truth, but rather that multiple understandings can coexist at once (Burr & Dick, 2017). This is opposed to the positivist framework where universal science is touted as truth, yet ignores the nuanced social and cultural factors that shape human behaviour (Lyons & Chamberlain, 2017). Social constructionism poses that how we perceive the world is a product of language and the socio-historical period we live in (Burr & Dick, 2017). Language used in everyday settings produces discourse – which may be understood as

sets of meaning-making ideas (Burr & Dick, 2017). What differentiates discourse from just language is the power it has to influence our behaviour (Burr & Dick, 2017).

Social constructionism as an epistemological framework ties in well with CHP perspectives. How we make meaning of our health is based in the prominent discourses of our society. The discourse of healthism influences us to partake in 'good health behaviours' and to blame ourselves for any ill health, even though research continually shows the impact of social issues (such as poverty) on worse health outcomes. Social constructionism also allows for the exploration of alternative understandings of health, through the examination of marginalised discourses that provide points of resistance to the dominant discourse.

2.2 Research Design

The current research project used a qualitative study design. The research was concerned with the meaning-making processes that NEP service users undertake to understand health and wellbeing, as well as exploring their everyday lived experience of health. There were two aims to the research: Firstly, to understand how Needle Exchange Program (NEP) users construct their health; and, secondly, to explore how, according to service users, the NEP contributes to service users' overall health.

2.3 Data Collection

2.3.1 Participants

Participants were six service users of a NEP outlet store, based in the South Island of Aotearoa New Zealand, run by DISC Trust. Their ages ranged between 36 – 65, with five participants identifying as male, and one participant who did not wish to disclose their gender. All participants identified as NZ European/Pākehā. The substance

use disclosed were individualised, but the substances identified were Ritalin, Methadone, Amphetamine, Heroin, Steroids and Peptides.

The number of participants was determined through the use of the 'Information Power' model developed by Malterud et al. (2016). According to this model, the greater the information power a sample holds, the lower the number of participants necessary. This model determines sample size through the consideration of five dimensions: 1) study aim, 2) sample specificity, 3) use of established theory, 4) quality of dialogue, and 5) analysis strategy.

Dimension one explains that the more specific the study aims, the smaller the number of participants required, as it is easier to get information relating to the aims (Malterud et al, 2016). For this research project, the study aims were broad, thus the number of participants required was potentially needing to be larger. However, upon consideration of the final four dimensions, only a small sample size was necessary to hold greater information power.

Dimension two refers to the specificity of the sample, with Malterud et al. (2016) stating the more specific a sample, the smaller the number of participants needed to garner sufficient information power. As the current research had a very purposive sample (PWID who use my local NEP outlet store service), the need for a greater number of participants was lessened. Similarly for dimension three, Malterud et al. (2016) argue that having an established framework underlying the research provides a foundation for the conclusions drawn in the research and, consequently, a smaller sample would allow for sufficient information power. As the theoretical background for

this project is CHP, a very well-established psychological perspective, information power was derived from a smaller number of participants.

The final two dimensions of quality of dialogue and analysis strategy were continually assessed over the course of data collection and analysis. During the data collection stage, all but one interview took over an hour to complete and the transcriptions were rich with detail. The analysis and analytical method require an in-depth review of data, and thus, Malterud et al. (2016) suggest that fewer participants are required, with more information power being drawn from an in-depth analysis of the data.

Overall, the research only required a smaller sample of participants. This was continually assessed over the course of data collection, with discussions with my supervisor around the dimensions presented. Six participants, based on the dimensions above, were enough to draw provide sufficient information power for the purposes of this research.

2.3.2 Recruitment

With the permission of DISC Trust (the South Island NEP contract providers) (refer to appendix A), I recruited participants through a South Island NEP outlet store, run by the Trust. The staff of the store approached their service users with an invitation to participate in the research project. Participants were people who inject drugs, who access the service of my local NEP. To access the service, individuals must be over the age of 18, thus, participants of this research had to be over 18 years old. If an individual was visibly under the influence of drugs, they were excluded, due to the ethical issues surrounding their ability to fully consent.

The store staff were asked to approach potential participants and provide them with an information sheet (refer to appendix C) for two reasons. Firstly, PWID are a vulnerable community and building trust takes time. They have often been excluded from research and are mistrusting of the healthcare system and professionals (Austin et al., 2022; Fong et al., 2021; Paquette et al., 2018; Salazar et al., 2021). Furthermore, the PWID have already developed a strong rapport with the outlet staff and through staff being the ones to approach them, the hope was that participants were more likely to believe that they could trust the research project and researcher. Secondly, as the NEP has a peer-based approach, and the staff regularly interact with service users, they have a better understanding of the competency levels of the participants. The staff are better able to judge whether service users are visibly under the influence of drugs, compared to me, a researcher that is not involved in the drug community.

Originally, the plan was for potential participants to contact me through an email created specifically for the purposes of the research project; PWIDHealth@gmail.com. Through sending an email, it would signify their interest and willingness to participate in the research presented. Upon commencement of the recruitment process, it was flagged to me by the staff of the NEP outlet, that many potential participants were more inclined to provide their number for me to contact them. This resulted in the purchase of a $5 SIM card, to contact the service users who had willingly left their number upon receiving an invitation to participate.

The initial text message sent to participants was as follows:

Hi X,

Y from the South Island NEP outlet store gave me your number as they said you were keen to participate in my research project!

I am very grateful for your interest.

I just want to touch base with you, and begin working out when we might be able to meet up!

I will be doing interviews on Tuesday's and Wednesday's at the South Island NEP outlet store office. Is there a day out of these two, and a time that works best for you?

Thank you so much, I look forward to talking to you.

-Zoe.

Those who were interested in participating would respond by text and we would organise a date and time for an interview. Those who did not respond were sent a follow up message after a week. If there was still no response, I did not press further and took that as an indication that they were no longer interested.

After three weeks of staff recruitment, there was only three people who indicated their interest. To further the number of participants, I went into the outlet for a couple of hours, twice a week, to reach out to service users personally. With the times I went to the outlet being quiet, I had a discussion with the manager about what times would be busiest to come in and approach potential participants. I had discussions with the staff and manager about who they felt would be ideal to approach. When I was physically at the outlet, staff would be the ones to introduce to potential participants, and then I could talk to service users from there. I would provide the service users with an information sheet and explain what the research project was and what it entailed for

those who wished to participate. If they expressed their desire to participate, we discussed an option for communication, to potentially set up an interview. Either they would provide me with their phone number and I would follow up with them using the format of the initial text message above, or I gave them the number of the purchased SIM, for them to reach out to me, if they wished to engage.

The recruitment process begun mid-May and the first interview was conducted on the last week of May. I officially ended recruitment the last week of July, and the last interviews were held the first week of August.

2.3.3 Interviews

Semi-structured interviews were utilised for data collection, with the interviews lasting between 50 minutes to 2 hours. Before beginning the interview, both verbal and written consent were obtained. Confidentiality and its limitations were discussed, with participants explicitly being told my obligations to break confidentiality if details of harm to themselves or others were shared, alongside explicit explanations around where and who they obtain illicit substances from. Participants were also told that they could stop the interview at any point, and I would immediately switch off the recording, for any reason. They were also informed they could fully withdraw their participation from the research without reason anytime during the interview and for up to a month after the interview was held.

All interviews were recorded on a digital voice recorder hired from Massey University. Participants were made aware that the interviews will be recorded and consent was obtained to begin recording.

During the interview, the following questions were discussed, as well as any further questions that arose from the discussion:

- What does health mean to you?
- What does wellbeing mean to you?
- What strategies do you include in your self-care of your health and wellbeing?
- How does the needle exchange fit into your health?
- What assumptions have you found others in the wider community tend to make about your health?
- Have you found these assumptions have an impact on your health? If so, in what ways?
- What sources do you use for health information?
- Can you tell me a bit more about these sources and what they offer you?
- What is your opinion on the healthcare system in this country?
- What are your relationships to 'front-line' health providers, i.e., pharmacies, general practitioners, emergency doctors?
- Do you feel that your environment impacts your health maintenance? If so, could you elaborate on what ways?
- Is there anything important that we have not discussed that you would like to raise?

These questions were based on the research aims and the background research I had completed for this project. They were designed to be open ended, to prompt further

discussions and elicit more questions regarding topics I had not come across or thought to include.

Each participant was given the opportunity to review their transcript, with most opting for a small summary sheet on my key takeaways from the interview, to be provided once the research is completed. Two participants were keen to review their transcript and provide edits. They signed an authority to release transcript form and once the transcript was accurate to the audio, it was printed off and placed in an envelope for participants to pick up at the South Island outlet store.

After the first four interviews had been conducted, the news about a change of the NEP contract provider in the South Island broke. After 35 years of needle exchange service provision to the South Island, the DISC Trust, who operated the NEP outlet store I was recruiting and conducting interviews at, lost the contract. Thus, the last two interviews were completed with this major change at the forefront of mind. At the time of the last two interviews, the NEP service users were unaware of what the future of provisioning looked like and how this would affect their access to sterile injecting equipment.

2.4 Data Analysis

2.4.1 Reflexive Thematic Analysis

For the purpose of this research, I opted to use Reflexive Thematic Analysis (RTA) to analyse the data. Thematic Analysis (TA) is an analytical method where patterns within a qualitative dataset are recognised, interpreted and reported on through the process of coding (Braun & Clarke, 2022). The patterns developed become themes, which are the ultimate analytical purpose of the method (Braun & Clarke, 2022). TA is flexible and

there are multiple approaches to conducting TA, RTA being one of them (Braun & Clarke, 2019; 2021; 2022; Byrne, 2022). RTA understands that the researcher is actively involved with the production of knowledge, with the final findings being considered the researchers interpretive analysis of the data (Braun & Clarke, 2019; 2021; 2022; Byrne, 2022). RTA encourages the researcher to continually examine their beliefs, positionality, assumptions and interactions throughout all stages of data analysis (Braun & Clarke, 2022).

RTA as a methodology aligns well with the epistemology underpinning this research project, social constructionism. Social constructionism purports that there is no one single universal truth, and that meaning-making is produced through the socio-historical and cultural context live in (Burr & Dick, 2017; Braun & Clarke, 2022). Language is viewed as a tool which is used to influence and understand our everyday lives from the lens of social constructionism (Burr & Dick, 2017; Braun & Clarke, 2022). Language produces discourses that are utilised for meaning making (Burr & Dick, 2017; Braun & Clarke, 2022). Both RTA and social constructionism embrace the researcher's influence and subjectivity on the research (Burr & Dick, 2017; Braun & Clarke, 2022). RTA allows for exploration of the patterns of meaning making that exist in the current socio-historical period we live in.

With the social constructionist underpinnings, the analysis was also partly informed by discursive analysis (DA), as how language functions to influence identity and behaviour was considered, which is a core tenet of DA (Hayfield et al., 2019; Terry & Braun, 2016; Wiggins, 2017). I initially was concerned about delving into language, beyond just its meaning making properties, but through discussions with my supervisor,

it was pointed out that RTA and discursive analysis can work together to create a breadth of work that contains depth (Hayfield et al., 2019; Terry & Braun, 2016).

RTA has six phases as outlined by Braun and Clarke (2022):

1. Familiarisation
2. Coding
3. Generating initial themes
4. Developing and reviewing themes
5. Refining, defining and naming themes
6. Writing up.

The phases are not designed to be linear or step by step. Instead, the process requires movement between the phases, that are back and forth, moving between multiple stages at different periods of time (Braun & Clarke, 2022). For this research, I would be generating initial theme with one data set and the knowledge produced from that would be taken into the coding of another data set, and vice versa. It was a fluid process, that adapted over the course of the research.

2.4.2 Stage 1: Familiarisation

Familiarisation requires an immersion into the data, gaining a deep knowledge about what is within the data, alongside critically engaging with the data content (Braun & Clarke, 2022).

All interviews were conducted with a voice recording device. The raw data was uploaded to Otter.ai, a transcription software, which completed the initial transcription.

From there, I edited the transcripts whilst listening to the audio of the interviews to ensure accuracy. This process had to be repeated a few times for each interview, as the interviews were between 50 minutes and 2 hours long. Pseudonyms were chosen by participants and were added to the transcriptions in the editing process. This process allowed me to gain a deeper understanding of the data content. During this process, I would write in my reflexive journal key ideas that I derived from the data.

Six interviews in total were completed, with each participant being given the opportunity to review their transcript if they wished. Although two participants took this up, neither provided any edits.

2.4.3 Stage 2: Generating Initial Codes

Coding is a process of systematically working through each data item and the entire data set, tagging sections of data that are relevant to the research question (Braun & Clarke, 2022).

The edited transcripts were uploaded onto word documents once I was satisfied the transcriptions were accurate and true to the participants words. From there, I went through each interview, line by line, and made notes using the comment button on parts I thought were interesting and that were relevant to the research aims. The ideas I had begun to ponder during the transcription period were influential in how I interpreted the data sets and in my coding. I sent some of my initial codes for my supervisor for some peer revision. He would give feedback and some of his own interpretations of the data, which in turn influenced my next stages of analysis.

2.4.4 Stage 3: Constructing Themes

Generating initial themes involves exploring the coded data sections and clustering them where there is similarity (Braun & Clarke, 2022). For this stage, I started out by taking the codes from all the interviews and using an online mind map service and clustered like codes and began to name groups of similar codes. I found I was struggling with the online format, so I printed off all the codes and begun clustering them physically. From this, I created a word document and took the strongest initial themes and wrote definitions about the potential themes. I had approximately four overall themes with 14 subthemes that fell under them. I sent these to my supervisor who provided feedback and his interpretations.

2.4.5 Stage 4: Reviewing Themes

Developing and reviewing the themes is about reviewing the clusters and exploring whether there are better patterns to be developed (Braun & Clarke, 2022). For this stage, I found mind mapping to be the most helpful way to refine my themes. I completed a mind map in my reflexive journal with all the themes. Lines connected themes with similar underlying ideas. I used the maps to explore themes that could become one big theme and figure out what could be subthemes. I made multiple iterations of the maps, rearranging how the potential themes linked with other themes, trying a new way of connection each time.

2.4.6 Stage 5: Refining and Naming Themes

For the fifth phase, refinement is key and through the development of theme names, the phase begins to figure out the structure and flow of the analysis (Braun & Clarke, 2022). The previous stages laid the groundwork for the refinement of the

themes. I started to piece together the narrative of the analysis, through the mind maps I had done previously. I utilised flow charts to lay out how the story of the research might be weaved. I decided which themes were the most relevant and the strongest in the way they told the story of the research and participants. Different names were tried out, with some feedback from my supervisor helping to determine what worked well for the content of the theme.

2.4.7 Writing Up

Writing up requires deep refining analytical work to bring the whole story of the analysis together (Braun & Clarke, 2022). This stage was the longest and required the most in depth reflection during the process. Multiple analyses drafts were completed, with many being sent to my supervisor for feedback. He helped me navigate what I wanted to say, by ensuring the write up was clarified and cohesive.

Reflexive practice was also utilised throughout the entire research process, as well as alongside the six phases of analysis, which is discussed below in section 2.5.7 Reflexivity and Positionality.

2.4.8 Quality Control

As qualitative research leans into subjectivity, we cannot address reliability and validity in the same way that positivist researchers do (Shenton, 2004). To counteract the concerns of qualitative research's trustworthiness, four criteria were established to ensure that qualitative research is trustworthy:

1. Credibility
2. Transferability
3. Dependability

4. Confirmability (Shenton, 2004; Nowell et al., 2017).

The credibility of study is determined by how recognisable the experience of the participants is when readers are confronted with it (Nowell et al., 2017). To meet the criteria of credibility, I used a well-established method for analysis, provided participants numerous opportunities to withdraw from the research to help ensure honesty in the interviews, I had frequent debriefing sessions with my supervisor, and I kept a reflective commentary of the whole research process through my reflexive journal. Prior to the research beginning, I had already established a familiarity with the culture of the participants and the NEP, as I completed a student placement at my local NEP outlet. The placement was for my foundational course work and through completing it at my local NEP, the idea for this research project was formed. Some participants I had already interacted with previously, during the placement, so there was an established rapport with them. The placement also gave me an insight into the NEP and how the organisation of DISC Trust supported PWID.

Other inclusions to establish credibility were peer scrutiny of the research, through my supervisor providing feedback during every stage of the project process. Member checking through access to transcripts. Only two participants engaged in reading their transcript and neither provided any edits. I provided detailed descriptions of the NEP, its history and effectiveness, as well as of previous research on PWID and their health. The previous research was examined, and the findings of this research project were congruent with the past literature.

The transferability of the research refers to its generalisability, and this is achieved in qualitative research through the in-depth analysis of the findings (Nowell et al., 2017). I

aimed to provide descriptions that were detailed and rich to show the applicability of the research to other contexts. I included the organisation which the study was based on, the inclusion and exclusion criteria of the study, the number of participants and how the decision on the sample number was made, the method of data collection was described in depth including the length of sessions and the time period in which the data was collected (Shenton, 2004). These were included to enhance the transferability and transparency of the research, however, as the researcher, I am unable to say whether it is transferable, as that is ultimately up to the reader (Shenton, 2004).

Nowell et al., (2017) address dependability by ensuring that research is transparent, and decisions are well documented and justified. Through providing a detailed methodology section, documenting the entire process of the research, dependability is addressed. The decisions I made have been documented and justifications provided. I provided an in depth and detailed methodology section, that included the research design, its implementation, the minutiae details of data gathering and analysis.

Once the previous three criteria have been addressed, confirmability can be established (Nowell et al., 2017). Confirmability also asks that the researcher demonstrate how the interpretations have been reached (Nowell et al., 2017). I took a data-oriented approach to an "audit trail" for this research (Shenton, 2004). The dataset led to the formation of the recommendations and findings contrived (Shenton, 2004). The "audit trail" enables the reader to determine whether the constructs produced from the data are acceptable.

The practice of reflexivity is also essential to meet the criteria of trustworthy qualitative research (Nowell et al., 2017). The final interpretations were subject to my

own assumptions and beliefs. The were informed by the context and background knowledge I had. Through my reflexive journal and supervision, I was able to identify my positionality and the assumptions I was bringing to the research. The decisions made were considered in the context and the methodological limitations.

2.5 Ethical Considerations

2.5.1 Ethical Approval Process

The start of this research began by consulting with my supervisor to determine that a High-Risk Application with Massey University Ohu Matatika 1. Ohu Matatika 1 is Massey University's Human Ethics committee with particular expertise in health, nutrition and exercise (Massey University, 2026). The first submission was assessed by the committee on March 11th, 2025. On the 27th of March, the research was given provisional acceptance, to be fully accepted with a few amendments. After the changes required being addressed, I resubmitted on the 8th of April. Human Ethics Application: 4000030165 was approved on the 01/05/2025 (see Appendix B)

2.5.2 Informed Consent and Autonomy

To ensure informed consent, participants were given an information sheet to read (see appendix C) and decide if they wished to participate in the research. I also talked them through the information sheet, highlighting specific points such as rights to withdraw, before starting the interviews. I also sought verbal and written consent (see appendix D) before beginning the interview.

There was a consideration of participants' autonomy, specifically regarding the assurance of the comprehension of participants. As participants are individuals who use drugs that can potentially alter their minds, NEP staff were asked to be the first to

approach potential participants and were the first to greet participants as they entered the premise. As it is a peer based and led organisation, the staff have a better ability to recognise signs of participants being on drugs than I.

2.5.3 Anonymity and Privacy

Since the interviews were held onsite of the NEP, the staff knew which clients were participating in the research. Thus, I made sure to anonymise the interview data whilst transcribing, through using pseudonyms and removing identifying information. This way staff will not know which participant said which words, and the privacy of the participants is respected.

2.5.4 Coercion and Avoidance of Harm

Since staff will be passing on the invitation to participate in the study, we discussed issues of coercion. To ensure no coercion is used, I had a meeting with staff laying out expectations for how to best approach participants. I also went through consent with participants via the consent form and through seeking verbal consent at the beginning of each interview.

To avoid harm, specifically, to ensure safety for both the client and me as the researcher, interviews were held on the premise of my local NEP. The premise is a neutral space that many service users see as a safety zone. Holding the interviews there will allow participants to feel more comfortable, and as I am not an employee of NEP outlet, I will never be left on my own there. Any emotional harm created through the interviews was to be addressed by following the NEP outlets protocols to ensure I was looking after their clientele. No instances of emotional harm were expressed during the interviews.

PWID are already a vulnerable population so whilst analysing the data and writing the report, the language I used was carefully chosen as to not perpetuate any stigma and cause further harm to any individuals or groups.

2.5.5 Cultural Considerations

Dr Pita King agreed to provide cultural consultation for this research project. I had a zoom meeting with him before submitting my ethics application, to discuss how I would display cultural competency and safety as a Pākehā researcher. He provided some valuable insight into how I could display the principles of partnership, protection and participation for potential Māori participants.

My commitment to Te Tiriti o Waitangi as Tangata Tiriti was ongoing and involved responsive and reflexive practice. Through being responsive to the individual needs of participants, a partnership within the research context will be formed. Building the rapport and continuing engagement through conversation allowed me to respond to the needs of participants, without using blanket strategies that may not be appropriate for everyone. Participants have the right to read and edit the transcripts of their interview, and this was offered. In line with being responsive to participants, I offered a one-page synopsis of the key takeaways from the research to be distributed after the research is completed. I did not want to assume that everyone wanted to participate in reading their transcript and providing edits, so the synopsis provided a more accessible way for individuals to participate in the research. Finally, through being reflexive about my own worldview and cultural beliefs, I decentred myself as a researcher and I aimed to protect participants from a power dynamic where the researcher is centred as 'the expert'. Everyone makes sense of the world in their own way, based on their upbringing

and culture, this research is focused on understanding the health beliefs of a community that I am not a part of. Thus, I shall remove myself from being positioned as an expert.

Māori participants were to be engaged with in a manner that was responsive to the individual. Tikanga protocols were to be followed, where appropriate. Conversations around comfortability and needs were to be had before interview. As relationships are significantly important in Māori culture, taking the time to build rapport with participants was to be prioritised. Ultimately, none of the individuals who volunteered to participate in the research identified as Māori.

2.5.6 Reflexivity and Positionality

Reflexivity is an active and dynamic practice where researchers consciously address their subjectivity and its influence on the research (Braun & Clarke, 2022; Olmos-Vega et al., 2023). The goal of reflexive practice in this research is not to neutralise the subjective understandings of the researcher, but to rather acknowledge and address how subjectivity and context influence the research process (Olmos-Vega et al., 2023).

Throughout the course of the project I utilised a reflexive journal, discussions with my supervisor and other students, and peer revision as practices to reflect on the research. The journal was my main form of reflection. For each interview it was used to make notes, and immediately after the interviews it would contain my initial thoughts. I would send these to my supervisor, and we would discuss these in our fortnightly zoom meetings. The journal was also used to reflect on each stage of the research process, documenting the struggles, the wins and the ideas produced.

I am a young, white, middle-class female. These positions come with an immense privilege regarding social status and the amount of ease I can function within society. I am not a member of the PWID community; thus, I came to the researcher as an outsider to the community. My previous experience completing a student placement at my local NEP outlet gave me some knowledge of the experiences of the PWID community, as well as allowed me to build rapport with some potential participants and the staff. However, being an outsider, I was at a disadvantage in not having knowledge around the health practices of PWID, but this did mean I could bring a sense of curiosity to each individual participant and their understanding of health.

I am more privileged than I am marginalised, with no tangible experiences of ever being discriminated against because of my social positioning. Thus, my worldview is trusting and largely positive, with no concerns of financial insecurity and discrimination affecting me. I have over time, developed a strong sense of social justice, which I believe I gained from interacting with diverse groups of people and from following the academic pathway of psychology. Interactions with others time and time again challenge assumptions and remind us, that we are all humans seeking a healthy and fulfilling life.

My first interaction with the PWID was when I was working at a pharmacy which was a part of the NEP contract with pharmacies. Members of the PWID community would bring their used equipment in a small container and would dispose of them in a biohazard bin. They would then get another container with 10 needles and syringes. At the time, I did not fully comprehend the assumptions I held towards them. Other staff members at the pharmacy would sanitise their hands after PWID would enter and

encouraged me to do so as well. I did not realise how much these interactions informed the way I would judge the community prior to completing a placement at my local NEP. The placement at the NEP broadened my context and challenged the ideas I held about the health of PWID.

In terms of the research process, the hardest challenge I faced was deconstructing my positivist training in psychology and allowing my subjective interpretations to influence the research. This was discussed multiple times with my supervisor, at many stages of the research project. It was inhibiting me from accessing the depth needed to level up the research. The feedback from my supervisor reminded me that the knowledge I was inputting from my interpretations were coming from my background experiences and socio-historical context. I was not searching for one objective truth, instead it was one reality in a world made up of multiple individual realities.

CHAPTER THREE: DATA ANALYSIS

3.1 Chapter Overview

As detailed in the methodology chapter, how participants understand health and how the NEP contributed to their health, were topics discussed with participants during the interviews. The analysis of the interviews produced the following three themes: (1) PWID constructions of health and health practices; (2) Social factors and health; and (3) The contributions of the NZNEP to health. Within each theme there are nuances and intricacies that will be explored as subthemes that fall under the umbrella of the overall theme.

Theme	Subthemes
PWID constructions of health and health practices	1) Health as an individual responsibility 2) Nutrition for health 3) Injecting drug use as a health strategy
Social Factors and Health	1) Community stigma and health 2) Discrimination in healthcare settings 3) The Importance of relationships to health
The contributions of the NZNEP to health	1) Physical health benefits 2) The NEP – More than just a needle exchange

Table 3.1 Overall themes and subsequent subthemes

3.2 Theme 1: PWID constructions of health and health practices

PWID are not viewed as healthy individuals in society, and there is a perpetuating belief that PWID have no regard for their health, especially in comparison to wider society (Olsen et al., 2012). Contrary to this belief, past research has found that PWID

are conscious about their health and will engage in active management of their health (Drumm et al., 2005; Dutere et al., 2001; Olsen et al., 2012). This is also true of this analysis, with this theme exploring how participants construct their health, their beliefs regarding health and how they conceptualise their drug use as part of their health. Three subthemes will be discussed: Health as an individual responsibility; Nutrition for health; and Injecting drug use as a health strategy.

3.2.1 "I just think it's really good, people taking responsibility for their own health": Health as an individual responsibility

Throughout the majority of the conversations with participants of this research project, there was both explicit and implicit positioning of health as the responsibility of the individual. Many participants constructed their health as their responsibility. For example, Donald stated the following:

> *...it doesn't matter if the doctor frustrates me anymore because I take responsibility for my own, my own health.*

> *...I just think it's really good people taking responsibility for their own health.*

Donald understands his health as being under his control. He states that the onus of health is on the individual, and that when others also conceptualise their health as their responsibility that it is "really good". This belief about health being a personal responsibility is more covertly expressed by SS:

> *Yeah, I don't see a GP so much, I tend to say, I mean, I think that indicates I do a pretty good job of maintaining my wellness...*

SS suggests that through his actions, he stays healthy, implying that he is responsible for the good health outcomes he experiences. Spud asserted this idea by stating how his actions concerning his health are a choice that he made and is responsible for:

> *Sometimes, what it comes down to is you've got to look at your life sometimes and decide, am I gonna snap out of it and start doing what's good for me, or am I gonna keep doing this? And who cares about the consequence?*

These three extracts provide different snapshots of the same idea: health as an individual responsibility. Health conceptualised as a personal responsibility finds its most current and fundamental expression in healthism, an approach to health emerging from neoliberal ideology (Cheek, 2008, Crawford, 1980; Lyons & Chamberlain, 2017; Riley et al., 2025b). Neoliberal and capitalist societies hold an individualistic worldview and seek to produce citizens who believe themselves to be in control of their future, resent reliance on the state, engage in persistent self-monitoring, and regard themselves as a project which can continually be improved through appropriate consumption (Beck, 1992; Giddens, 1991; Kelly, 2006; Riley et al., 2025b; Rose, 1998). Healthism insinuates maintaining health is achievable through engaging in appropriate behaviours and choices, and depicts the self as profoundly separate from relational, social and environmental contexts (Riley et al., 2025b). Through placing the responsibility of health outcomes on the individual, it falls on the person to engage in behaviours that are beneficial to health, and if illness occurs, this is understood as due to lack of positive action by the individual (Lyons & Chamberlain, 2017; Morison & Gibson, 2025). This ideology removes health responsibilities from social structure and

the agendas and actions of those in power, and places it firmly with the individual (Lyons & Chamberlain, 2017; Riley et al., 2025b). Thus, health becomes a moral obligation for the citizens of neoliberal societies (Lyons & Chamberlain, 2017).

3.2.2 "Just eating proper food": Nutrition for health

As discussed above, healthism implies that health is controllable by taking personal responsibility and is achievable through taking appropriate actions (Riley et al., 2025b). Appropriate actions are regarded as lifestyle choices, and there are certain behaviours that neoliberal societies view as beneficial to one's health. These behaviours (i.e., physical activity, eating well, cessation of smoking and limiting alcohol) are framed as a choice, where people can either choose to do them and aid their health, or choose not to do them and not look after themselves (Blaxter, 1997; Cook & Wood, 2021). Five out of six participants spoke at length about how they used their eating habits to achieve health. How participants understood dietary habits to impact health was varied. Steve and Spud made sense of their diet through a mindful consumer identity:

> *But body health and like, food consumptions and all of that, I think, is a part of being healthy …I was not much of a drinker, but I did a lot of drugs. But then I sort of decided not to. Then is when I started worrying about the sort of things that I'm putting into my body, like food and all of that sort of stuff. So, it all matters.* (Spud)

> *Just eating proper food. I mean, a lot of people that do drugs choose to do drugs, not food. So, I mean, I'm eating properly and living.* (Spud)

Food. We eat properly. We eat good meals. My housemate does most of the cooking, but I'll cook. And yeah, we don't eat shit foods. Cupboards are always full …so food wise, we eat, quite well (Steve)

Their descriptions display a conscientiousness about what they are "putting into" their bodies. Food is framed as dichotomous – it is either "good" or bad ("shit"). With good food being seen as healthy and better for you, and bad food as unhealthy. Understanding the ritual of eating through a mindful consumer lens reinforces healthism values. The act of being mindful about what enters their body through their diet encourages constant self-surveillance and by labelling food in a dichotomous way, individuals feel a sense of control around their health, as they understand that eating "proper" food contributes to the betterment of the self directly. Donald was also explicit in how he mindfully consumed food, with the avoidance of bad foods being key to his health maintenance:

Even, even just avoiding, like, the 42 different chemicals in your loaf of bread for breakfast every morning, like, I, I used to eat hand ground, handmade sourdough, like loaves from the bakery. Now, I got my own starter, 100 year old starter from Europe, like and bought my own organic flour and stuff, because I just don't, I don't want to eat that shit on the daily. If I do, I'll eat it. When I have a choice, I'll go over there and eat my junk …So I don't know, eliminating poisons out of your diet, the daily poisons. (Donald)

Donald also characterises his diet from a mindful consumer lens, being conscious to avoid the "chemicals", "shit" and "poisons" that are seen to contribute to poor health. Again, Donald, like Spud and Steve, engages in the healthism related

practice of self-surveillance, through his avoidance of bad food. However, this extract does display a contradiction between Donald's understanding of health, and the sense of control that healthism posits individuals have over their health. Through stating "when I have a choice", Donald implies that there is not always a choice to avoid food that is viewed as bad for health. This challenges the idea that health is achievable through a series of right/good decisions from a rational, autonomous individual – the core ideology that underpins healthism.

Exploration with participants regarding what foods are included in the category of "good" resulted in an emphasis on homemade meals, as stated by Steve and SS:

> *Well for tea, we have something like chicken, vegetables, you know, the staple, meat type meals. We make our own pizzas. Have pizza night. Yep, we do that. We make spring rolls. Make our own spring rolls. So, we do quite a lot, a different range of so many different things. For lunch, I like to have tuna on toast, so, you know, that sort of thing. So, that's a sort of healthy food. Got bananas and fruit (Steve)*

> *... really nice breads, and vegetables... And like, stew is fantastic way to keep, you know, it's like a chicken, it's good stuff. And, yeah, yes, staying well. And so, your, your awareness of physical health that's got to adjust to the seasons. You know, winter needs to be robust. Yeah, you don't want to fall under the wheel and wind up with, you know, some type of chesty, coldly fluey thing ... it can mean I need stew, you know, and I need to eat nice steak and potatoes and salad.* (SS)

To stay healthy and physically well, Steve and SS position wholefoods and homemade meals as the best form of dietary consumption. Homemade meals provide

a sense of control around what food/ingredients are consumed, aligning with the values of healthism regarding appropriate consumption and self-surveillance. SS also mentions having an awareness of physical health over the seasons, the implication being that food consumption through the seasons needs to adjust and what you consume during those time impacts health directly.

Whilst the previous extracts have constructed diet and nutrition for health through the lens of being a mindful consumer, George understood dietary habits for health through the lens of eating to refuel:

> *don't say I eat well, but I do eat. You know, you have meals like you have, like a dinner, like a good dinner... especially when you've been on the shit for days on end, bananas are a good one. You eat a couple of bananas, and you just feel everything coming back...*
>
> *...I'm a bad, I'm a mad lolly fanatic, so I do eat a lot of them. I think that helps as well. But you gotta be careful because of the sugar and stuff like that. But you're still putting stuff in your stomach. See, it's when, I used to say to people, you'd say them after a couple of days and they look like, absolutely dragged out and ask "when's the last time you ate,?" and they're like, "oh I don't know", and they're like, "oh I feel like shit." That's why you feel like shit, because you're not eating, you're every day, your body is just getting stripped of everything. You've got to refuel work, you know.*

The notion of food as a fuel source for our bodies reminded me of the way endurance athletes utilise food. Athletes push their body to physical extremes and food is a way to supply their body with more energy to keep moving (Bytomski, 2017).

Athletes place their bodies under extreme stress, and food brings stability to their health, as it provides energy for consumption doing their highly physical task (Bytomski, 2017). This understanding frames food as an instrument for achieving a stable health status. From a nutritional perspective, food consumption does provide energy for our bodies (Cornil, Gomez & Vasiljevic, 2020). This perspective aligns with the belief that health is a stable state, as postulated through healthism – when a person has a stable health status, they are more productive members of society, the ideal citizen of neoliberal and capitalist contexts (Riley et al., 2025b). George characterises his health as pursuing a stable, homeostasis that is achieved through food consumption when the homeostasis is out of balance after intensive drug use.

These extracts provide descriptions of a couple of different ways that diet can be conceptualised as impacting health. For mindful consumers, who use homemade meals as a means to control what they put into their bodies, diet is a tangible way to display their appropriate consumption, constant surveillance of themselves, and therefore, their moral worthiness as health citizens in a neoliberal context. In neoliberal ideology, different health-related behaviours are positioned as morally commendable or reprehensible (Lyons & Chamberlain, 2017). Through the framing of these behaviours as choices, those who complete actions in line with positive health behaviours are seen as "good health citizens" (Cheek, 2008; Lyons & Chamberlain, 2017; Riley et al., 2025b). Through completing positive health behaviours, individuals are seen as decreasing their chances of being a burden on the state – if the individual is not taking care of their health through these actions, then they are more likely to become ill (Lyons & Chamberlain, 2017; Morison & Gibson, 2025). As a health valuing culture, moral obligations are placed on engaging in behaviours that are viewed as 'healthy', and to be

identified as a good citizen, you must demonstrate that you chose these behaviours (Crawford, 2006; Riley et al., 2025b).

By participants describing practices that view food and nutrition through a dichotomous lens, they exert their personal responsibility regarding their health. The concept of food as being either “good” or “bad” for you, is a dominant discourse in society (Oakes, 2004). Food being labelled this way implies that particular foods are better for health. From a nutritional science perspective, however, this is frequently not the case (Oakes, 2004). The reputation of food is often rooted in beliefs that have been perpetuated through generations, rather than based on nutritional content (Oakes, 2004). The labelling of food also places a moral obligation on individuals to control what they ingest, as consumption becomes a personal responsibility (Silchenko & Askegaard, 2020).

Labelling and categorising food is a way of atomising what we eat and reduces food consumption to a pathway to sustain physical health, excluding other dimensions of food consumption such as social connection and pleasure. Through describing practices of eating “good” food, surveying what they eat through homemade meals and removing “shit” food from their diet, the participants are actively demonstrating how they are good health citizens, as they are making the right choices. However, the limitations around choice noted by Donald challenges the notions of healthism around diet being simply a controllable lifestyle choice. It calls into question the idea that the individual has the ability to have full power over their health, and implies there are structural, social and external factors that contribute to health (Morison & Gibson, 2025; Riley et al., 2025a).

In his extracts, George, implies that health is an achievable state of balance, that requires putting fuel into his body when it has been depleted of energy through drug use. Through describing his utilisation of diet in this way, he parallels the understanding that athletes and sports nutritionists have regarding food consumption (Bytomski, 2017; Cornil, Gomez & Vasiljevic, 2020). Health is seen as a balance between stress on the body and food consumption for energy (Bytomski, 2017; Cornil, Gomez & Vasiljevic, 2020). George's characterisation of diet for health in this way appears to alleviate the negative health effects of his drug use and frames health as achievable whilst using substances, as long as the individual replenishes their energy with diet.

3.2.3 Injecting Drug Use as a Health Strategy

A salient topic noted in many interviews, was how participants positioned their injecting drug use in relation to their health. Four of the participants framed injecting drugs as an integral part of their health and wellness. This framing was highly associated with the type of drug they were injecting. For Donald, a Performance and Image Enhancing Drugs (PIEDs) user, his injecting drug use is viewed through an optimisation lens:

> *Zoe Knudsen: Would you consider the, some the injecting, all this like protocol that you follow is a part of your health, self-care? Like you are, you're doing it to take care of your health*
>
> *Donald: 100%*
>
> *Zoe Knudsen: Yeah, and you're getting added benefits of like optimizing?*
>
> *Donald: The optimizing is the health benefit*

...so all of it's biohacking. You're biologically trying to make your body as best as you can. (Donald)

By injecting PIEDs, Donald understands that he is not only taking care of his health, but that he is optimising his health. JJ also sees their drug use (opioids and methadone) as beneficial for their health, and frames drug use as a prescription:

...So I've found a prescription, basically. Is the key to safe, well being (while) using Substance, using medication of your choice.

... when I stopped being clean and relapsed, my life improved.

...if I were a Swiss person I would have gone and lived in Switzerland in order to get heroin everyday from a needle clinic because I know that I might feel better in my life with opiates because I've got such a high underlying level of anxiety on the daily... opiates are hands down for me the most powerful and least harmful anti-anxiolytic that's ever been, you know, discovered, or is there.

JJ positions their injecting drug use as a medication they chose to cope with their day-to-day mental health struggles. Donald and JJ both drew a parallel to those who are dependent on prescription medications to their injecting drug use:

It's like me going over to a diabetic and giving them a hard time. They're trying to optimize their blood sugar levels. I'm trying to optimize my hormone levels. (Donald)

...So they don't want any cost to be responsible for turning someone into a drug dependent. But insulin people, people that use insulin are dependent on it. Many

medications, heart medications, so many things that are integral to health and well being are okay, yet substance addictions, addictions is at the clinic. (JJ)

Donald and JJ discuss how those dependent on prescription medications are seen as taking care of their health, and they view their injecting drug use in a similar way. They both specifically mention diabetics and insulin. Diabetes medication can include the need to inject insulin to stabilise blood sugar levels, as diabetes is a disease where the individual does not produce enough insulin to regulate their blood sugars (Diabetes New Zealand, n.d.). The use of needles and injecting for diabetes management is widely accepted by society. By drawing comparisons to an accepted form of injection use, it is easier to view illicit substance use as an integral part of health for the participants.

Donald and JJ's understanding of injecting drug use for their health appear to align with the ideas raised by Chatwin and Alexander in their 2024 article, "Virtuous drug use in the neoliberal age". They suggest that neoliberalism can inform the construction of drug use as a rational decision, as individuals are choosing to seek personal happiness (Chatwin & Alexander, 2024). When viewed through the lens of self-enhancement, drug use could be considered virtuous and aligns with healthism, as a rational, autonomous individual is making a decision in pursuit of the betterment of their health (Chatwin & Alexander, 2024). For both participants, they view their drug use as a choice for their own self-enhancement. Donald engages PIEDs for physical health enhancement, whereas JJ utilises opioids and methadone for his mental health enhancement.

Steve and Spud also viewed their drug use through the lens of betterment of health. Steve positions his injecting drug use as a way to cope with physical chronic pain:

> *Yep. I went from, just, went from, from codeine to methadone, and even the methadone, it works, it helps, helps a lot. But I'll never get rid of the pain completely. It just sort of subdues the pain for a little while and helps me get through my day pretty much.*

Through injecting methadone, Steve indicates feeling more able to manage his chronic pain on a daily basis, which helps him to function in life. Spud was the final participant to frame his drug use as a health strategy. He also injected methadone, and he understood this action to be beneficial to his health as it provided him with stability:

> *I've stabilized. I've got my methadone program, and I've been on it for a while now, you know, so it was the best thing I could have done for myself.*
>
> *...because with methadone, right? At least for what it's worth, I only shoot it up three times a week. Okay, because I pick up my takeaways on Monday, Wednesday and Friday. So, I have that, so I don't spend the week, you know, chasing drugs and doing this and doing that. So, I've got, I just, I do that in my room, no one sees it, and then I live my life, you know, sort of thing.*

The notion of stability being key to health was commonly discussed with participants who were engaged in the Opioid Substitution Treatment (OST) programme. Health is achieved through stability, and methadone was viewed as a tool to create a

stable foundation. Aiming for balance is a value of healthism, and requires constant surveillance, and control of behaviours (Cheek, 2008; Crawford, 1980; Lowe, 2024).

These extracts all frame injecting drug use as beneficial for the health of the participants. Making sense of drug use in this way justifies the continuation of the behaviour and shapes the action as a positive health behaviour. Through conceptualising their substance use this way, PWID are still taking responsibility for their health, whilst aligning themselves with the neoliberal ideology of health. Through establishing illicit injecting drug use as a health strategy, it gives PWID a level of autonomy regarding their health. For participants, injecting drugs is then a way of taking responsibility for their health. Shaping their use through this lens provides the PWID with a rationale for continuing their use, despite how wider society sees injecting drug users. With a health landscape that urges individuals to be responsible for their health, it is understandable that participants feel that drug use provides some control over health.

Donald and JJ both describe themselves as autonomous and rational decision makers, who use substances to enhance their health. Neoliberal societies value the individual who continually works on self-betterment, and thus, provides a way to conceptualise drug use as a positive health behaviour. For Steve and Spud, methadone is an instrument that provides stable health, which allows them to function as members of society. Productive citizens are moral citizens in neoliberal societies, and to be productive, individuals are required to have stable health (Lowe, 2024; Riley et al., 2025b). Through injecting methadone, Steve and Spud are enabled to become productive citizens and therefore moral health citizens.

Healthism promotes an optimistic view of health, one in which an individual has control over their health (Crawford, 2006; Riley et al., 2025b). Health is hailed as a stable state, which is achievable through taking personal responsibility, engaging in 'healthy' lifestyle and behavioural choices, performing continuous self-monitoring, seeing the self as a project and resenting reliance on the state (Lowe, 2024; Riley et al., 2025b). This understanding of health becomes tied up with an individuals' identity as a good person – that is, your health status is an indication of whether you are a good citizen and therefore, morally, a good person (Cheek, 2008; Lyons & Chamberlain, 2017; Riley et al., 2025b). This theme demonstrates how PWID reject the identity society imposes on them as an injecting drug user and instead position themselves as good health citizens who take personal responsibility for their health. Healthism holds power that is productive, diffuse and disciplinary (Riley et al., 2025b), that is, it has amassed cultural acceptance (productive), it is pervasive and dispersed across multiple agents (diffuse), and it has shaped people's meaning making of health (disciplinary) (Riley et al., 2025b). Healthism has integrated into the lives of PWID and moved beyond meaning making to daily rituals. Through diet and mindful consumption, values of healthism are reinforced. Participants are seeking to improve their health through what that consume and engage in self-surveillance through monitoring their diet. By conceptualising their injecting drug use as a health strategy, it changes the status of a negative health behaviour to a positive health behaviour that aligns with their constructions of health as a personal responsibility. They are engaging in self-enhancement, a trait of a good health citizen by neoliberal ideals. Participants also sought stability, a notion which requires constant surveillance of the self.

3.3 Social Factors and Health

Whilst participants' descriptions of their health practices demonstrated an assumption that they are individuals responsible for their health, they also reference external factors in relation to their health. Research indicates that social factors are important to health (Cohen, 2004; Umberson & Karaz Montez, 2010). The reference to external factors impacting the health of participants, challenges the understanding of health from a neoliberal perspective (Riley et al., 2025b). Healthism reduces health to an individual responsibility and conceals the systemic structural and power issues that influence health outcomes (Cheek, 2008; Crawford, 1980; Lyons & Chamberlain, 2017; Riley et al., 2025b). By acknowledging that there are social factors that impact their health, participants contradict neoliberal understandings of health. Three subthemes will be addressed in relation to this theme: 1) Community stigma and health; 2) Discrimination in healthcare settings; and 3) The importance of relationships to health.

3.3.1 Community stigma and health

Past research shows that the experience of stigma and discrimination can negatively impact the health of PWID (Couto e Cruz et al., 2018). All participants shared experiences where they had been discriminated against and experienced stigma. A perception of PWID held by the general public, that participants had experienced was the characterisation of PWID as being dirty and contagious (Earnshaw et al., 2012):

> *100% so like these people, my friends, are 'dirty fucking steroid gym rats', if there's even such a thing, I don't know anybody that's like that* (Donald)

> *We used to get syringes from the chemist, and they'd look us up and down like we were the dirtiest, filthiest piece of shits in town. It was horrible, because I was*

not that dirty, filthy junkie that everybody's stigma relates to, you know. It's horrible (Steve)

Maybe that you might be, like, contagious because you're injecting drug user, or certainly, you know, like, not untouchable, but don't, you know, don't talk too long to him. But maybe more, just certainly for needle use. "Oh, he might have something", you know, a little bit of that. And it might not be specified by the people that they're responding in that way, but it's a little bit like that, or "I might catch that". And "Oh, you look like you're struggling maybe with drug use, so I can't, I can't help you, I used to talk to you, but talk to you now, like, good luck. I don't know anything about that, therefore I'm frightened" ...Yep, so disease like, and there's a bit of shock value in needles, blood, maybe an obvious perception of, "you don't seem to be showering every morning or brushing your hair every night". Yeah. So dirty, sick, these things are not expressed, but it may be felt in that way (SS).

This perception frames PWID as unhygienic and riddled with disease that is communicable (Lawless et al., 1996). The underlying assumption is that those who inject drugs are unhealthy and spread illness, which is a result of their own choices and therefore, a moral failing on their behalf (Lawless et al., 1996). As expressed by Steve and Donald, this stigma does not align with how they conceptualise themselves and their health. Another way participants have experienced stigma, is through the attribution of their behaviours as being due to their substance use, as explained by JJ:

They think that, they are, because to explain my behaviour to themselves, they have to just come back to substance. And it's not true. And my upsetness is seen

as, with, with testosterone, I was super, so upset, I walked in the hospital smoking cigarette. And I wasn't, I couldn't, wouldn't, yet to get testosterone. So "he's roid raging" never, he doesn't even have any roids...

...If I'm angry, I'm high, if I'm happy, I'm high, I'm just not a person anymore. It dehumanizes you. You cease to exist. Any health problem you have is all due to pointy finger, pointing meth, trailing pipe, you know, like really hard work, and it just makes you not like, I mean, makes you understand society and feel sorry for it, but it doesn't make you feel like you want to be a part of it.

JJ describes having his behaviour and emotional reactions attributed to his drug use as dehumanising. This understanding of PWID ostracises individuals (Sumnall et al., 2021), as shown by how JJ says "*...makes you understand society and feel sorry for it, but it doesn't make you feel like you want to be a part of it.*" Similarly, Steve argued that the wider population ignored the stories of users, and instead just focused on the fact that he uses drugs:

And for the wider population of people, they've got no understanding of, especially like me, being a drug addict. But I'm a drug addict not because I like drugs, it's because the doctors got me prescribed on drugs which was needed, and it's gone from one to the other and escalated, until I ended up on the methadone...

...People aren't really interested in your story, most people, they just more interested in the facts. You know. "You're a drug addict." And that's it, there's nothing around it, "why are you a drug addict? How is this affected?" Like you're doing. Very rarely, do people really care.

All of these experiences of stigma have marginalised PWID from the wider community, a process which has hurt the health and wellbeing of participants, as explained by SS:

> *So, I've suffered recently from feeling a lot of shame and a lot of rejection or integrated with a loss of some degree, of status and personal possessions. Presently riding a little push bike and, and some other stuff like that, really was quite, not hurtful in a bad way, but an awareness that it was quite disconnected from the community, and it didn't accept the and so with struggles and troubles and turmoil, it'll effect, your self-esteem, obviously, and, and also out of employment, you know.*

There is evidence that being isolated socially and from community is strongly correlated with mortality (Cacioppo & Cacioppo, 2014; House et al., 2000; Umberson & Karas Montez, 2010). PWID are more likely to have worse health and wellbeing when they experience discrimination and the risk of ill health increases with the frequency of stigmatisation experienced (Couto e Cruz et al., 2018). Community stigma also creates a barrier to accessing Alcohol and Other Drug (AOD) services, as substance users are concerned that they could be recognised when seeking these services (Simmonds & Coomber, 2009). This stigma also impacts whether they use treatments available from addiction services, as certain treatments (such as OST are viewed as replacing one drug for another (Paquette et al., 2018). Spud discussed how he internalised the stigma from the community about AOD, which pushed him away from the service:

> *Yeah, because, but I didn't want to be associated with AOD centre, because of that ... as soon as you do associate yourself with them and you join up with their*

programs, you become a known drug seeker in the community. You know. Yeah, yeah. Well, I felt that anyway.

The experiences explored above show that participants experience discrimination in an array of ways, and this impacts how they view themselves and their health. The experience of stigma keeps PWID from accessing services in fear of being marginalised within their community and altering how those around them view them. Stigma keeps PWID positioned as outsiders and impacts their identity and self-esteem (Cama et al., 2016; Paquette et al., 2018; Von Hippel et al., 2018). Although participants indicated that they do not view themselves in the way the wider community does, it is hard for them to not internalise the portrayals that circulate in the social conversations around them (Cama et al., 2016; Paquette et al., 2018; Von Hippel et al., 2018).

This contradicts the assumption that health is only impacted through personal choices and lifestyle behaviours (Lyons & Chamberlain, 2017; Riley et al., 2025b). How the wider community seemingly perceives PWID is informed by healthism, as the underlying assumption from all the types of stigma described is that injecting drug use is a moral failing of individuals who engage in such behaviour (Fong et al., 2021; Paquette et al., 2018). Healthism creates a disconnect between PWID and their community, despite evidence from this current project and past research indicating that PWID see health as their responsibility and engage in practices that denote positive health behaviours (Drumm et al., 2005; Dutere et al., 2001; Olsen et al., 2012). Through the community viewing injecting drug users as bad health citizens, who are unproductive members of society, barriers are created for PWID to become involved in the community, and their health is ultimately impacted by such experiences. Neoliberal

ideas regarding health as a lifestyle choice is a powerful tool that keeps groups marginalised from society, without the broader context being considered.

3.3.2 Discrimination in healthcare settings

A common experience described by participants was of experiencing discrimination in healthcare settings. PWID have been found to be labelled as drug seekers by healthcare providers and that in turn impacts how and whether they access help for their health when they need to (Austin et al., 2022; Fong et al., 2021; Paquette et al., 2018). JJ discussed how their experiences with healthcare providers left them feeling demoralised and, ultimately, led them to paying for private healthcare:

> *...access to health care is just totally it's a closed door for me. Because I have such a terror of being traumatized again. And, I mean, I've heard of people, you know, fentanyl people with opiate habits to walk, to not go to hospital and have a to, they'd rather have a limb fall off than go to hospital. Now, that's extreme, because they don't want the shame and the stigma anymore. They've had it from their family. They've already been cast out. Lost everything...*

> *...it's just really, with healthcare, you know, trying to get help ... By the time they get round to me, I'm paying privately for assessment. You know that... They just, they, you know, it's just, it really pisses me off, because what I went through, the cost me a lot, and, and it's just prescription, you know, and the whole sort of idea "we know best", you know, you're just a, the drug seeker shit really fucks you up.*

JJ shared how the stigma in healthcare settings has not only affected them and stopped them from accessing health, but also their friends. JJ also mentions how being labelled a drug seeker created a barrier for them in the public healthcare sector and

how they ultimately had to seek help at a cost. Steve discussed how it was hurtful to be viewed as a drug seeker, especially when he was genuinely experiencing constant pain due to past illness and injury. He felt disbelieved, something that other participants also mentioned:

> *...it's horrible, because I've never been a hard user. I never touched heroin. I've never done anything really, really hard. I went from codeine, from the doctors, to methadone, from AOD. And the only reason I went to AOD was because doctors wouldn't help me. They keep calling me a drug seeker. "Oh, you're not in pain. There's nothing wrong with you. Get out." And I used to get that all the time, even though I had a steel pin from here to here, steel plates in my kneecaps and a steel plate in my ankle, and they were "No, no, you're fine. Go away."*

Steve has a significant history of physical injury, that being tangible evidence as to why he would be in pain, yet in his experience, healthcare professionals dismiss his feelings, as they regarded him as seeking drugs. Spud shared an experience where he was refused treatment from a GP, who explicitly labelled him a "junkie", with the implication he was drug seeking:

> *A lot of them don't mate. I've had a doctor kick me out. He refused to see me...And all is I actually asked him, right, was because he was filling in for my doctor. Okay, so I need to repeat prescription for my medication, that my doctor was prescribing me, and he refused. He refused, and I ended up having a full on argument with him. Just about got in a fight with him...*
>
> *Spud:... It was his opinion on a drug-, he thought I was just a junkie. That was the answer, that's it.*

Zoe Knudsen: Did he explicitly say this, or did he..?

Spud: Yeah, right to my face. That's why we just about went at it man, it wasn't good

... I don't understand what his issue was, mate, all is I asked us for him to, do what you do, you know, and it was his job. He was filling in, because my doctor wasn't there. "Would you like to see another doctor?" I went, Okay! Silly me. Mate, "I'm not giving you those". That was pretty much the way it went. "Get out".

... Yeah, so they push you. They either say, go to AOD, or they'll call you straight up a drug seeker. I'm out, was honestly, I never went doctors to try and keep my drugs. I got my drugs other places, you know, I got my drugs off for people that went to the doctors and got, know what I mean.

... I never tried to get drugs out of my doctor. I only asked my doctor for drugs that were to help manage my addictions. That's all I've ever asked for. I've never asked the doctor for benzos or anything like that. So, I don't know why he did it. Well, I do know.

This incident that Spud described is an example of the overt discrimination PWID can experience in healthcare settings. Through this stigma, barriers to healthcare access are created. PWID are less likely to seek help for their health when needed, due to how their past experiences facing stigma have impacted their overall wellbeing (Austin et al., 2022; Fong et al., 2021; Paquette et al., 2018). The participants' encounters in healthcare settings aligns with the findings of previous research, with access to healthcare and engagement in medical treatment being affected because of the stigma they experience (Austin et al., 2022; Fong et al., 2021; Paquette et al., 2018).

Having experienced explicit and implicit discrimination from the general population and from healthcare providers, it seems understandable that PWID will come to view their health as their own responsibility. Through healthcare providers stigmatising them and their behaviour, it is easier to not access health services and instead focus on the things they can control that appear to maintain their health. Perhaps the expression of healthism that participants postulate is less of an underlying belief of carrying personal responsibility for their health and instead a response to the structural barriers they have encountered due to their drug user status.

Healthcare professionals understanding of PWID is informed by the socio-cultural context that shapes our knowledge (Baum, 2015; Morison & Gibson, 2025; Pickren, 2019). The biomedical model of health disregards social, environmental and broader issues that contribute to health, and reduces health to a matter of only the physical (Morison & Gibson, 2025). This model reinforces the idea that individuals have autonomy over their health, through their personal choices, thus, healthism aligns well with the biomedical model (Morison & Gibson, 2025). The lack of attention to the impact of behavioural, psychological and social factors on health resulted in dissatisfaction with the biomedical model, with the subsequent development of the biopsychosocial model (Engel, 1977; Morison & Gibson, 2025; Schramme, 2013). The biopsychosocial model is what currently informs mainstream understandings of health. However, critics of the model postulate that although it includes 'psychosocial' in the name, in practice, it essentially remains the same as the biomedical model (Crossley, 2000; Lyons & Chamberlain, 2006; Morison & Gibson, 2025; Stam, 2014). The biopsychosocial model continues to align with individualistic ideas, and health psychology from this perspective focuses on changing individual behaviour, rather than

addressing the broader contextual factors that interplay with health (Horrocks & Johnson, 2014; Lyons & Chamberlain, 2017; Morison & Gibson, 2025). Thus, the biopsychosocial model continues to perpetuate neoliberal ideas, and healthcare providers see PWID as immoral individuals who are choosing to engage in negative behaviours.

3.3.3 The importance of relationships to health

In the discussions regarding relationships and health with participants, they indicated that trusted relationships were integral to their health. The way these relationships influenced and impact the health of participants were varied. For JJ, they had a friend who they regarded as physically aiding their health, by being a chosen barrier to the number of drugs they consume:

> *I have a friend, a best friend, who's holds my script of Ritalin. So I, it's a well being. I go and see them every day to have my thing, because I know if I get my whole script, I will, I will use it in half the time, and not good for me, for my well being. It's just about harm minimization for me, its about knowing my limitations and going, "that's how much".*

JJ goes further to explain that it is not just the physical benefits that they receive from this relationship, but a deeper social connection that gave them reason to leave their house:

> *...in the in the process of didi [obtaining drugs from friend], there's, there's other good things come out. I'm out. I'm outside my house. I'm not at home, and being a hermit, being agoraphobic, which I am, I'm agoraphobic and schizo, schizotypal. And it's, yeah, right, okay, well, it just gets me going. And my*

partners, I've been like, motor function I don't have, but I run on other people's motors, and they'll get me to going.

Spud also felt that his relationships were key to his health, and he experienced this through wanting to improve his health for his relationship with his daughter. As well as protecting her from any potential disease or virus he had:

...it definitely is. You know, you're right with that, definitely. And even the hepatitis, right, when I first met with my daughter, I told her I had it, okay, and that was really a driving factor in me getting rid of it, was being around her and all that sort of stuff. Just protecting the people around me and that sort of stuff, because it is contagious, and you can give it to people when easy, it's easier than people think.

Spud indicated that the connection with his daughter was the most important relationship in his life, and prompted him to take action, such as quitting smoking and stabilising his life through being on the OST programme, in the pursuit of better health outcomes.

Spud: ...But yeah. She was like, "What are you moving down for?", I was like, so I can be down, you know, by you, and we just, our relationships grown.
Zoe Knudsen: Oh that's so lovely.

Spud: Yeah, I'm glad I waited. I am, I really am.
Zoe: And you can just see the strength of that relationship from what you've said and how it's affected your physical health through wanting to sort out the hep C

and making sure that you're not smoking, and then also your, just, wellbeing in general.

Spud: Yeah, yeah, that's right, yeah. It's been a journey, mate. But we all have our own journey in some ways. We do.

Strong connections sometimes provided a way to health through intervening in the participants' lives and encouraging them to have a few days without injecting – as was explained by George:

They said, "No, no more. You're having a break." And they would literally just cut me off. And I couldn't get shitty at them, because they're not doing it to play God or anything. I know they're doing it for, because they're my mate, and they, just like, you need a break. You have a few days off.

As seen through thee extracts, social relationships can tangibly contribute to the health of an individual through a myriad of pathways. There is well established research that there is a strong correlation between social isolation and mortality (Cacioppo & Cacioppo, 2014; House et al., 2000; Umberson & Karas Montez, 2010). Research also shows that having supportive and trusted relationships lead to better health outcomes (Argyle, 1992; Cohen, 2004; Seeman, 1996; Suls, 1982). For participants, their trusted relationships were immensely supportive of their health, whether by creating physical barriers to their injecting drug use or through encouraging them to maintain their health. Pettersen et al. (2019) found that relationships were integral for those who were no longer using drugs. Those who had strong and supportive relationships were more likely to maintain stability in their life, and were less likely to relapse and begin using substances again (Pettersen et al., 2019). Similarly, Gogineni et al. (2001) found that for

intravenous injecting methadone users, those who had a social network that provided them with emotional support were less likely to share needles and more likely to maintain stability whilst using the OST/methadone programme. Spud's experience is consistent with this research, as he described his relationship with his daughter as being pivotal to his health.

Living in A-NZ, we are influenced by the Western societal norms which inform our everyday understandings. Western societies are individualistic, and as I have already established, place the responsibility of health outcomes onto the individual (Cheek; 2008; Lyons & Chamberlain, 2017; Morison & Gibson, 2025; Riley et al., 2025b). Yet broader social factors and social relationships are evidenced to be integral to health outcomes. The fact that participants in the current research acknowledge the impact of social factors on their health, directly challenges the assumptions of healthism that individuals are responsible for their health. Health outcomes are not only informed by the behaviours and lifestyle choices of the individual, but also by wider external factors, such as the social relationships of the individual.

The theme explored above shows that the stigma faced by PWID can be traced to the underlying assumptions of healthism, which assert that continued drug use is a choice made by the individual, and that their health issues would disappear, if they choose to not engage in the action. The biopsychosocial model of health informs healthcare practices, yet it does not address the structural and wider issues in any tangible way (Crossley, 2000; Lyons & Chamberlain, 2006; Morison & Gibson, 2025; Stam, 2014). The experiences of participants show the impact of social relationships on

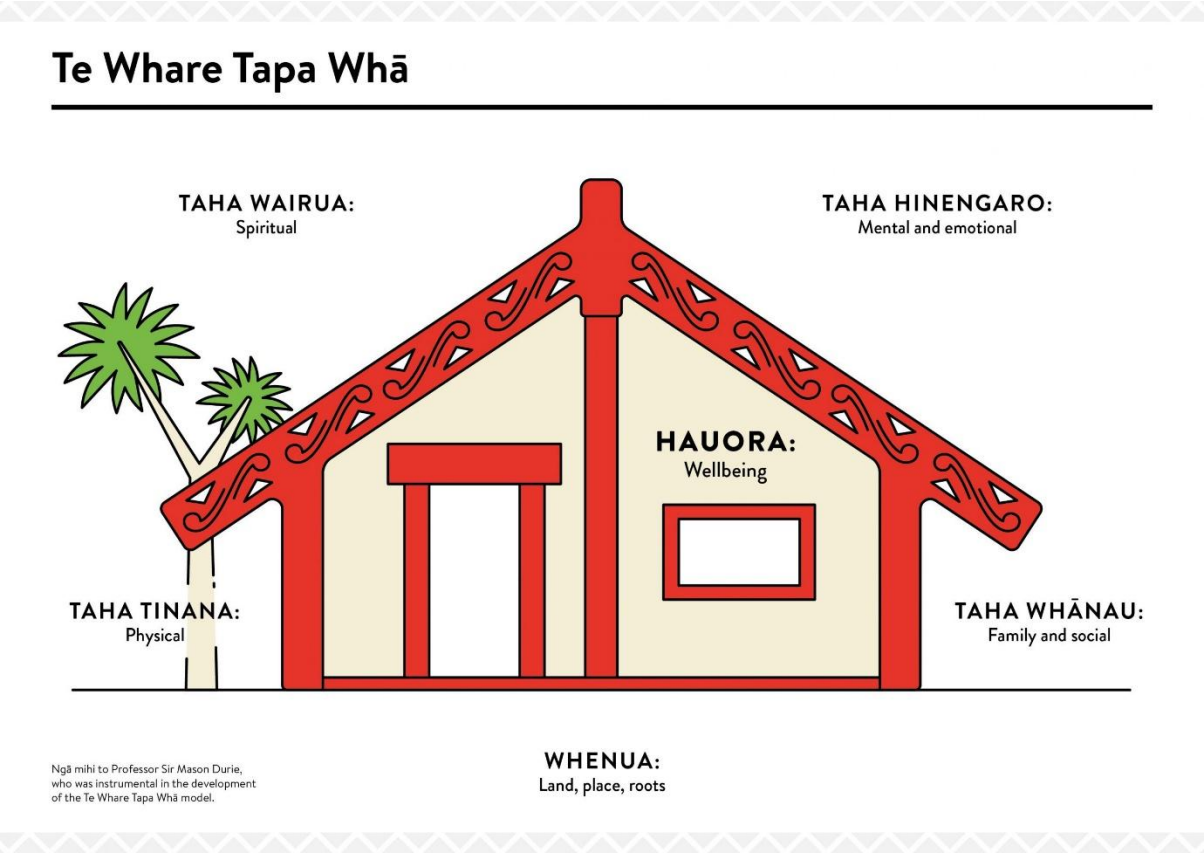
health - stigma in community and healthcare settings created barriers to addressing their health and trusted relationships influenced their health in beneficial ways.

An approach to health for PWID (and wider society) that is relational and considerate of the interconnection between broader factors involved in health would be beneficial. In A-NZ, our indigenous population already regards health in a holistic and relational way (Brittain & Kora, 2025). Māori models of health consider individual health across multiple dimensions and examine the relationship between these dimensions and within the wider environment and context (Brittain & Kora, 2025). Dimensions that are considered in Māori health models include physical (tinana), mental/emotional (hinengaro), social (whānau) and spiritual (wairua) health (Brittain & Kora, 2025). These are all tied to the connection Māori have with the whenua (land) and their wider environment (Brittain & Kora, 2025). Indigenous knowledge has largely been left out of mainstream conversations, due to Western colonisation enforcing the concept of one universal truth, that is superior to other streams of knowledge (Brittain & Kora, 2025; Morison & Gibson, 2025). Māori models of health challenge the neoliberal perspective of health and the inclusion of broader dimensions are a great example of another approach to health that would be of benefit to PWID.

One such Māori model of health that has been applied to addictions treatment is Sir Mason Durie's Te Whare Tapa Whā model (see figure 3.3). This framework encompasses four dimensions for health; taha tinana – physical health, taha hinengaro – mental health, taha whānau – social health and taha wairua – spiritual health (Durie, 2004; Huriwai, McClintock & McClintock, 2022; Rochford, 2004). Te Whare Tapa Whā depicts a traditional wharenui, with the foundations of the whare being the four

dimensions for health (Durie, 2004; Rochford, 2004). If one dimension is broken, or falling, then all the other dimensions are impacted (Durie, 2004; Rochford, 2004). This depiction expressions how health is based on multiple factors that are all interconnected (Durie, 2004; Rochford, 2004).

Figure 3.3. Te Whare Tapa Whā



Note. From *Spirituality and awe* [Illustration], by All Right?, 2019 (https://www.allright.org.nz/articles/spirituality-and-awe)

Hua Oranga is a Māori mental health outcome measure that incorporates Te Whare Tapa Wha and encourages an approach to treatment that involves partnership, by goals being negotiated between the individual and those implementing the measure (Huriwai, McClintock & McClintock, 2022).

MOKO Māori Mental Health Services, Whitiki Maurea, the Mental Health and Addiction Services of the Waitemata District Health Board who presented a case study of Hua Oranga being used in practice (Huriwai, McClintock & McClintock, 2022). An individual (known as BG) was involuntarily committed based on the Mental Health Act, due to psychosis, paranoia and increased drug use (cannabis) (Huriwai, McClintock & McClintock, 2022). Through being introduced to a program that focused on Te Whare Tapa Whā, BG experienced positive changes, something his close relationships also commented on (Huriwai, McClintock & McClintock, 2022). Hua Oranga gained the perspectives of BG, his whānau and his treatment team to promote collaboration between all invested parties (Huriwai, McClintock & McClintock, 2022). The measure found that BG had improved significantly because of the Māori health framework, and he stated that he was able to quit using cannabis because of his involvement with the programme implemented for treatment (Huriwai, McClintock & McClintock, 2022).

3.4 The Needle Exchange Programme's contribution to health

The NEP has a significant history in A-NZ, and all participants were fervent in their expression of gratitude for the service. Historically, the NEP was developed in response to the HIV/AIDs epidemic (Harris 2021; Kemp & Aitken, 2004; Macmaster & Womack, 2002; Van Santen et al., 2021; Vlahov et al., 2001) and has continued with the goal to reduce the transmission of BBVs such as Hepatitis B and C (Basto & Strathdee, 2000; Strathdee & Vlahov, 2001; Sweeney et al., 2019). Using the harm reduction models, NEPs aim to prevent injecting drug use related physical harms, through the implementation of a non-judgemental space that educates about safe injecting practices, provides sterile equipment and a way to dispose of used equipment (Harris 2021; Kemp & Aitken, 2004; Macmaster & Womack, 2002; Riley & O'Hare, 2000; Single,

1995; Van Santen et al., 2021; Vlahov et al., 2001). Many analyses of the cost-effectiveness of NEPs around the world have been completed (Gold et al., 1997; Sweeney et al., 2019; Wilson et al., 2015), including in A-NZ, with a 2021 report finding that for every NZ$1 spent, there was a saving in healthcare spending of approximately NZ$6 (Keen & Weston, 2021). These reports revolved around the physical health benefits of NEPs for the PWID community. There is also some research that shows that NEPs are beneficial to wider society and the mental health of PWID (Keen & Weston, 2021; Strathdee & Vlahov, 2001; Wilson et al., 2015). When discussing the NEP with participants, conversations revolved around two major points: 1) The physical health benefits of using the service, and 2) the NEP being more than just a needle exchange.

3.4.1 Physical Health Benefits

> *I love this place... I'm grateful for this place, that it's here, grateful for the stuff they provide, grateful for the service.* (Donald)

All participants expressed how much they valued the NEP for the provision of its sterile equipment:

> *Well, it's good because you've got clean stuff. That's, that's what you want, like, you know, I've been in this thing where you've had to use your same one for a bit like, you know, because I couldn't get any or stuff like this.* (George)

> *Well, I get clean needles. I don't, never have to, ever, ever use a needle that's not 100% clean and safe, which is, that's amazing, really. When I first started using, it was hard to find them, right?* (Spud)

The access to so, the present system is free. We're talking about it as if that is the case, there's no reference to before? The availability of clean injecting equipment is enormously, enormously supportive of personal, each individual user's personal health, but I can only speak for me, is enormously supportive of maintaining their health. (SS)

A lot better, because I'm not using dirty needles (Steve)

For some participants, they experienced times where access to sterile equipment was limited and resulted in poor health outcomes for them. Spud contracted the hepatitis C virus during a time of limited availability to sterile needles:

We used to have to go and buy them in Lower Hutt. We'd pay $10, you get a round canister and have your, there'd 10 of them in it. But I mean, that didn't last long when you know, people were using, and there was a lot of it. People using other people's, because we didn't really know much about hepatitis C either. So, there's a whole generation of people that got it...

That is now. It's amazing now. I did it, and I managed to get rid of the hepatitis virus ... So, I managed to improve that ... I mean what it's worth, because of things like the needle exchange, I never, ever have to worry about that sort of thing again, you know. So, they are a good thing. For the whole of New Zealand, you know.

As explained by Spud, the NEPs provision of equipment not only prevents physical ill health through BBVs and disease but also calms fears PWID have around picking up diseases, because they are secure in the knowledge the equipment is sterile

and freely accessible. George discussed how access to sharp needles was beneficial to his skin health:

> *I have bashed my arms and they have looked terrible, and stuff, and a lot of it comes down to not using clean needles every time, like the more you use it, the same one, it's harder on your skin as well, you know. So a nice, sharp one goes through. You can hide, you know, and it heals quick, but you keep using old one and creates a sore, it creates sickness, blunt, you know. So you're forcing it through more and stuff like this.*

George highlights how sharp needles are integral to skin maintenance for PWID. The provision of sharp and unused needles from the NEP enables PWID to protect their skin from potential infection more easily and readily. In regard to physical health, SS also emphasised how the immediate effects from injecting reusing unclean equipment can be detrimental:

> *The effect of using unclean or rewash gear are really quite pronounced. People might not be able to identify specifically getting what in injecting circles is called 'dirty shot', where you've got something unclean or, or, you know, a re-washed fit, you're never going to get all the biological components of the blood that has been in there out. Or, you know, dust on, wherever you're preparing a little spoon and splashing it there. I mean, I'm splashed up, and I'll get the filter and wipe it all up. And I haven't cleaned that table for first possibly, so using old injecting equipment, you can have not be a dirty, because a dirty, within about a minute and a half, you'll realize, "oh, fuck, I've got a dirty", and your whole body will go into like a bit of a vibrating, sickly shock. Some people vomit… But even so, my*

point was, even if you don't have a dirty from using equipment, you can, yeah, it can affect you.

Participants understood the needle exchange and the access to free, sterile equipment as overwhelmingly beneficial to their physical health. Both George and SS mentioned that having free access to the equipment from the exchange was necessary for benefitting physical health:

> *...it is really good and free, yeah, you know, that makes it even better, because a lot of the times people don't have money, they would just use an old one or something like this. They'll just go and do it, you know* (George)

> *Yeah, I believe you had sicker people without the being free. People just, yeah, using the fit, washing it straight away, because they're going to use it again, but that, you know, you can't get rid of all the biological components. So, it's sitting there, fester, you know, not festering, but not ideal to be used again. And yet, people are doing that because they don't have spare cash for needles till pay day and they have to use for the next three days. So, it's going to be wash needles and reuse wheel filters and stuff like that. Reuse wheel filters are real bad. They should be one use, but they were two bucks. So, you're not, barely got your needles as often would be with rippling. It's ideal you have wheel filters, 'cause of the chalky elements. But if you've got your drugs and you paid five bucks for 10 needles, no wheel filters, and that's, that's rugged, that that impacts your veins with the build up of chalk deposits from Ritalin, really, quite quick* (SS)

All participants regarded the NEP as beneficial to their physical health, which is supported by previous research. The implementation of NEPs reduces the transmission

rates of HIV/AIDS and BBVs, as well as reducing the risk of skin infections (Al-Dabbagh & Maaita, 2023; Basto & Strathdee, 2000; Fernandes et al., 2017; Hurley et al.,1997; Single, 1995; Strathdee & Vlahov, 2001; Wilson et al., 2015). As previously established, PWID are concerned about their health (Fong et al., 2021; Olsen et al., 2012) and the provision of equipment from NEPs eases their worries about their physical health. The use and accessing of needles (and more) from NEPs are an act of self-care for PWID. The NEP is part of their health strategies, as they understand that through re-using or sharing dirty needles, they risk their health. Many participants shared how they had been injecting before the service was free, and they anecdotally found that there was more illness due to lack of access to sterile equipment. Through the service being free to access, participants felt that physical health was greatly improved.

NEPs are an effective environmental space that encourages better physical health for PWID. Whilst neoliberal ideology advocates for citizens to view their health as their personal responsibility and to not rely on the state (Cheek, 2008; Crawford, 1980; Lyons & Chamberlain, 2017; Riley et al., 2025b), the NEP is a social intervention that the state does fund and has had positive results overall – which has included saving the government money through the healthcare system (Keen & Weston, 2021). It shows that social and environmental contexts are influential in our health, despite the overwhelming wider understanding that individuals are in control of their health (Cheek, 2008; Crawford, 1980; Lyons & Chamberlain, 2017; Riley et al., 2025b). The existence and the considerable benefits of the NEP makes the argument for more social and environmental policies to be implemented to ensure better health outcomes in A-NZ.

3.4.2 The NEP: "It's not just the needle exchange"

For many of the participants, the implementation of peer-based organisations managing the NEP contributed positively to their health and view of themselves significantly. The NEP has become more than just a sterile injecting equipment provider, with the outlets becoming an educational and safe space for the PWID community. The lack of judgement from the staff of the NEP (some who are also injecting drug users), provides PWID with a sense of safety and compassion:

> *I love it because it's, it goes against, you know, human beings that run and they don't you don't feel judged, and that's super good, because the other, everywhere else is, you feel like you're going to be, but it's not … yeah, the needle exchange is great, because it's sort of, it's human, it's sort of supporting your thing that the rest of society pointed would just "nup, you're fucked". I'm telling you, you know, they're not, they're actually, as you could say, they're not encouraging you to use, you know, IV, but its compassionate, I think, it's just compassionate. It's harm minimisation, it's humane, it's support* (JJ)

The NEP plays a role in the understanding of health for participants. As JJ points out, in previous experiences in healthcare settings they have felt dismissed and dehumanised because of their drug user status. Whereas at the NEP, they provide harm minimisation by being compassionate and humanising PWID. Similarly, SS felt the NEP enhanced his mental health, through providing an alternate way to view himself as an injecting drug user, that contradicts how he is viewed by society:

> *You're integrating with the fact that you're an intravenous drug user and it's not a toxic environment. These are tools that enable you to feel more normal and more*

well, you know. Here's the yellow bottle for dirty fits. We're not scummy junkies. Uses clean water, clean you know, it really raises the standard and raises the status of how you feel.

For SS, the NEP enables him to feel "normal" by providing the tools to keep his environment hygienic and healthy, that is, through the provision of a used needles disposal container. The picture society paints of PWID are of dirty and unhygienic people, who cannot control their urges to use substances (Earnshaw et al., 2012). For SS, the NEP has helped him to disprove this identity and given him another lens through which to view his use.

Steve recounted times where he was only able to access needles through the pharmacy:

I felt like I was dirt, was the way I felt when I walked in there. I didn't want to buy needles, it was just the worst thing you could do. Just go into a chemist and ask for a needle, and it was horrible.

This experience was a stark contrast to the NEP, and Steve mentions the treatment he received when going to NEP outlets felt safe and respectful:

But the needle exchange has been awesome, you know, there's so many services just, it's not just the needle exchange. There's so much more here too. Yeah, so it's a good place to come and to know that you're respected and not rejected.

NEPs provide PWID with an alternative way to view themselves and their health. Previous research by Treloar et al. (2016) found that NEPs provide service users with a sense of social legitimacy. For a group who are constantly mistrusted by the

community, NEPs build relationships with PWID and humanise them. The NEP was a safe space for participants, who had previously felt rejected when taking up space in other places. The compassion and lack of judgement provided by the NEP aligns with the principles of harm reduction, specifically, the principle of humanistic values (Riley & O'Hare, 2000). The NEPs and harm reduction seek to create a judgement free environment and look to meet service users "where they are at" (Riley & O'Hare, 2000). They are pragmatic and understand that drugs, are always going to be around in society, so rather than prohibition, they aim to reduce the physical harms experienced (Riley & O'Hare, 2000). From participants accounts, it also seems that NEPs can help with mental and social health experiences. The NEPs challenge the views and understandings of PWID that society presents and treats the PWID with dignity and respect.

Harm reduction has no doubt brought a lot of benefits to the health of PWID, especially in A-NZ. However, there seems to be a tension for me, within the principles of harm reduction. The environmental spaces that are created and the social intervention aspect of the NEP, resonates with collectivism and provides an understanding of health that addresses the impacts of the wider factors at play in regard to health. The fact that the A-NZ NEP is peer-based and that its origins were 'for PWID by PWID' strengthens the relational aspect of the NEP and that health is a holistic experience. Yet, harm reduction constructs the individual as a rational, autonomous decision maker (Riley & O'Hare, 2000), which is a construction of the self that neoliberal ideology promotes (Lyons & Chamberlain, 2017; Riley et al., 2025b). Viewing PWID as autonomous decision makers is meant to be empowering, however, it also runs the risk of further perpetuating that it is a rational choice to use drugs, and that PWID can/should just choose to stop the

action of injecting drugs. There is therefore some contradiction between the values of harm reduction and how it is implemented. This is not to say that harm reduction cannot evolve and there is already some integration of harm reduction principles with indigenous understandings of health to be found (Levine et al., 2021; Morin et al., 2022).

Levine et al. (2021) developed and evaluated an indigenous harm reduction framework. The “Not just Naloxone” programme based in British Columbia, Canada, was developed in response to the increase in fatal overdoses amongst First Nations people in Canada (Levine et al., 2021). The First Nations Health Authority created an indigenized harm reduction approach, which was taught to trainees, who then took their knowledge out into the communities (Levine et al., 2021). The trainees taught the indigenous harm reduction programme to First Nations people and communities, and upon evaluation found that the communities’ attitudes to harm reduction changed to be more positive (Levine et al., 2021).

Morin et al., (2022), were based in northern Ontario in Canada, and evaluated a program integrating indigenous healing practices with harm reduction. A framework known as the Indigenous Healing and Seeking Safety (IHSS) model was implemented in a residential addiction treatment program (Morin et al., 2022). Overall, they found that through the inclusion of the IHSS model in the program, clients were more likely to see the program to completion (Morin et al., 2022).

CHAPTER FOUR: CONCLUSION

4.1 Chapter Overview

This research project was borne out of having my personal assumptions challenged, when I completed a placement project at my local NEP. I prided myself on being open minded yet found myself surprised when a service user told me about the green smoothies and ginger health shots he took every day. It was the first time that I realised how I had assumed PWID were not health conscious. This appears to be an assumption that is rife within the wider community, with society deeming PWID as a group who do not care about their health (Drumm et al., 2005; Olsen et al., 2012). Investigations into how PWID conceptualise their health are far and few between, with PWID oftentimes being left out of research about them (Salazar et al., 2021). Thus, this research project sought to understand PWIDs conceptions of health.

Alongside the health understandings of PWID, I was also interested in how the NEP was seen to contribute to the health of service users. The NEP is a unique social service initiative, which in A-NZ started from grassroot community activism (Harris, 2021; Kemp & Aitken, 2004; New Zealand Needle Exchange, 2020). It has been shown that NEPs are effective in the prevention of physical health ailments, such as BBVs and communicable diseases (Keen & Weston, 2021; Single, 1995; Strathdee & Vlahov, 2001; Wilson et al., 2015), however, there is limited research on how service users view the NEPs contributions to their health. All of this resulted in the two aims for the project: Firstly, to understand how NEP users construct their health. Secondly, to explore how, according to service users, the NEP contributes to service users' overall health.

In this closing chapter, I will explore the findings from the analysis and their relevance to the overall aims of the project. Firstly, I will summarise the findings from the analysis, before discussing their implications. As with all research, the limitations experienced will be addressed. From there, the implications and limitations will be used to indicate possible routes for future research. Finally, I will make my concluding remarks regarding the project.

4.2 Summary of Findings

Three themes emerged from my analysis of the interviews with participants: 1) PWID constructions of health and health practices; 2) Social factors and health; and 3) the Needle Exchange Programme's contribution to health.

4.2.1 PWID constructions of health and health practices

Theme One encapsulates how participants construct their health and the daily practices they engaged in to align with this understanding. Participants overwhelmingly understood health as a personal responsibility. Health as an individual responsibility is the core ideological conception of healthism (Cheek, 2008; Crawford, 1980; Lyons & Chamberlain, 2017; Riley et al., 2025b). Participants engaged with this understanding by using nutrition for health and by conceptualising their injecting drug use as a health care strategy. Healthism positions individuals as either good or bad health citizens, with PWID typically being viewed as bad health citizens (Drumm et al., 2005; Lyons & Chamberlain, 2017; Olsen et al., 2012; Riley et al., 2025b). Participants do not identify themselves as poor health citizens and engage in behaviours that are considered positive to health, such as nutrition to demonstrate their status as good health citizens.

Participants were mindful consumers of food, who viewed homemade meals as the best for them. Meals being homemade exerts control over what they consume, demonstrating how participants exercise appropriate consumption and surveillance of the self, to actively manage their health. Food was labelled as “good” or “bad” by participants, which again, displays how they are moral health citizens (Oakes, 2004; Silchenko & Askegaard, 2020). Consumption of foods that are seen as “good” was a high priority for participants, as then they are seen to be making the “right” choices for their health. There was some contradiction to this understanding, with Donald challenging the notion of choice when it comes to nutrition. Through Donald stating, “when I have the choice”, it questions the idea that health is the responsibility of the individual. This highlights the idea that the dichotomy between good/bad and wrong/right when it comes to health, may not be controllable, and there are underlying social, structural and institutional powers that impact health (Morison & Gibson, 2025; Riley et al., 2025a).

Another way nutrition was utilised for health, was through the lens of food stabilising health after heavy drug use. It was seen as a way to refuel the body, an understanding that is parallel to how athletes often view and use nutrition (Bytomski, 2017; Cornil, Gomez & Vasiljevic, 2020). Food becomes a tool to return the body to homeostatic balance, an indicator of health, following the depletion of the body’s energy (Bytomski, 2017; Cornil et al., 2020; Lowe, 2024). This suggests that health is an achievable goal whilst using drugs, but requires using nutrition and diet to bring energy levels back to a stable state.

Participants aligned their injecting drug use with their health, by viewing it as a strategy that is included in their active management as health. Through conceptualising injecting drug use as a health strategy, it changes the view of the behaviour to one that aligns with their identities as good health citizens and is a demonstration of their taking responsibility for their health. Chatwin and Alexander (2024) suggest that neoliberalism can construct drug use as a tool for health, if it is being used for self-enhancement and personal happiness. This notion rings true for my interpretation of two participants, JJ and Donald. How their drug use contributes to their health was individualised and associated with the drugs they were injecting. For Donald, a PIEDs user, his injecting was utilised for physical health, whereas, for JJ, an opioids user, his injecting was utilised for his mental health.

Injecting drug use was also framed as a tool for stability and balanced health. For Spud and Steve, two methadone users, they injected to function in society as stable, healthy individuals. Through achieving stability they demonstrate their morality, as productive members of society are those with stable health and are highly valued in neoliberal capitalistic societies.

4.2.2 Social factors and health

Theme Two entails the many references made to the social factors participants considered as impacting their health. Experiences of direct and felt stigma were shared by many participants. The wider community were described as characterising PWID as unhygienic and as attributing any perception of heightened emotions to participants being high on drugs. Participants spoke of feeling marginalised by the community and that they internalised some of the stigma felt. This was regarded as creating barriers to

health, through affecting mental health, self-esteem and access to healthcare. Community stigma felt by participants ostracised them from social connection, creating feelings of isolation. Being socially isolated from communities is strongly associated with mortality (Cacioppo & Cacioppo, 2014; House et al., 2000; Umberson & Karas Montez, 2010). Perceived views from the community regarding organisations such as AOD were inhibiting factors in participants seeking help for their addiction. Participants felt that becoming associated with AOD would place a drug seeker label on them in the community, and past research also suggests that OST is viewed as replacing one drug for another by wider society, thus placing a barrier on healthcare access for participants (Paquette et al., 2018; Simmonds & Coomber, 2009).

Experiences of stigma in healthcare settings were also shared by participants, this impacting their access to healthcare for participants. PWID are less likely to seek help based on past experiences with healthcare professionals (Austin et al., 2022; Fong et al., 2021; Paquette et al., 2018). Participants also discussed their occasional struggle to seek help, as they did not wish to experience being judged by healthcare providers. When viewing participants understanding of health through the lens of the discrimination they have felt, it seems that viewing their health as their own responsibility could be a protective factor to the structural barriers they have experienced in healthcare settings. By exerting control over their health, they can focus on actionable steps that are viewed as positive behaviours to maintain health, rather than having to access health through institutions that demean them.

Healthcare settings are largely informed by the biopsychosocial model of health (Crossley, 2000; Lyons & Chamberlain, 2006; Morison & Gibson, 2025; Stam, 2014). This

model is seen as addressing the wider contextual psychological and social factors, alongside the biological factors that impact health (Crossley, 2000; Lyons & Chamberlain, 2006; Morison & Gibson, 2025; Stam, 2014). Yet critics of the model, maintain that the model gives preference to the biological factors and remains essentially the biomedical model (Crossley, 2000; Lyons & Chamberlain, 2006; Morison & Gibson, 2025; Stam, 2014). The biopsychosocial model of health aligns with individualistic and neoliberal views of health, with health psychology from this perspective focusing on individual behaviour change, rather than addressing the wider contextual factors (Morison & Gibson, 2025). Understanding health from this model continues to perpetuate the idea that individuals are in control of their health through the actions they choose to undertake (Lyons & Chamberlain, 2006; Morison & Gibson, 2025). Thus, healthcare providers view PWID as individuals who can choose to achieve health through stopping their engagement in injecting drug use.

In contrast, participants also spoke about to the health benefits they felt, due to having trusted relationships. Trusted relationships varied in how they were utilised by participants. In some instances, trusted others intervened by encouraging a participant to take a few days before injecting drugs again. In another instance, a relationship between a participant and his daughter, motivated him to pursue better health. Theme Two captures a more relational understanding of health, which contradicts the first theme, where participants constructed their health as their own individual responsibility. There is research that shows supportive relationships are immensely impactful and lead to better health outcomes (Argyle, 1992; Cohen, 2004; Seeman, 1996; Suls, 1982). Strong relationships have been shown to be beneficial to those with addiction, with an individual who has supportive networks around them being less likely

to relapse (Pettersen et al., 2019). Gogineni et al. (2001) found that injecting methadone users with a strong network for emotional support were more likely to engage in safe injecting practices and maintain balanced health on the OST programme.

4.2.3 The NEPs contributions to health

The third theme addresses the contributions of the NEP to the health of participants. Participants described the benefits to their physical health resulting from having access to the NEP. Some have previously experienced Hep C and by knowing they can access sterile equipment, their concerns regarding the potential to catch the BBV again, have reduced. Accessing sterile equipment from the NEP has become a way to exercise self-care for participants, it is a strategy used to maintain their physical health. The NEP is a social service, that has become an environment through the outlet stores, that enables good physical health. This acknowledgement from participants regarding how beneficial the NEP is to their physical health, demonstrates that health is impacted by social and environmental contexts, despite the pervasive belief that individuals should take responsibility for their health (Cheek, 2008; Lyons & Chamberlain, 2017; Morison & Gibson, 2025; Riley et al., 2025a; Riley et al., 2025b). Previous literature presents evidence supporting the benefits of the NEP around the world (Gold et al., 1997; Keen & Weston, 2021; Sweeney et al., 2019; Wilson et al., 2015). These findings suggest that social and environmental policies when implemented are highly beneficial to health, and policies designed around these factors should be implemented in A-NZ to enable better health outcomes.

For the participants, the NEP was more than just a needle exchange programme. The trusted relationships they built with staff, the lack of judgement felt, and the

genuine respect they experienced from staff were identified as integral to their wellbeing. This positions the NEP as a healthcare setting with positive experiences in such a setting becoming integral to the participants identities as health citizens. The NEP provided them with a way of viewing themselves that countered the more stigmatised viewpoints they encountered in other, especially public and medical, settings. The NEP as a place provides an environment where they could view themselves as citizens who care about health. The way the participants describe the respect they receive from staff of the NEP appear to demonstrate humanistic values and the idea of "meeting the person where they are at" that underpin harm reduction (Riley & O'Hare, 2000). Harm reduction aims to treat people with respect and dignity, and is pragmatic in its understanding of substance use, acknowledging that drugs will always be around and will always be used for many different reasons (Riley & O'Hare, 2000). The experiences participants have had with the NEP, appear to have been of benefit to the social and mental health of participants.

4.3 Implications of Research

This research aimed to understand; 1) how NEP service users constructed health and 2) how the NEP contributed to the health of service users, from their perspective. Through the analysis, I found that service users construct health through a neoliberal lens, demonstrating an understanding that they are personally responsible for their health. However, when delving into broader factors associated with health, participants described how they understood social factors as contributing to their health, contradicting the neoliberal ideology perpetuated and understood by participants.

Participants positioned themselves as autonomous, rational beings, who make decisions and engage in actions that benefit their health. However, they also refer to the relational side of health, contradicting the dominant influence of healthism. Participants gave examples of how they personally had their health impacted for the better by their trusted relationships. They also described how the social stigma they felt from the wider community and within healthcare settings created structural barriers to health. This included feelings of isolation, feeling ostracised and struggling to access healthcare. This implies that despite healthism being a pervasive ideology, adopting a more relational approach to health is beneficial. Effectively addressing the structural barriers and discrimination towards PWID, will allow them to broaden their understanding of health. Considering the social factors described that negatively impacted the health of participants, once can argue that the statements and practices they shared that align with healthism can be better understood as a response to these factors. By viewing health as a personal responsibility it feels empowering to individuals, particularly those who have been sidelined and marginalised by public opinion and health institutions. It gives them a sense of control, by placing the onus of their health on themselves, especially after experiencing times where their health has been out of their control.

The NEP was discussed as greatly being greatly beneficial to the participants health, through preventing poor physical health and by supporting participants in their mental and social health. The implications of this research could be used to further address the inequities of health experienced by PWID and inform provision of services for PWID. The contributions the NEP has made to the health of participants from their perspective is a testament to how social initiatives and environmental contexts can

positively impact health. How the NEP provides its services is largely relational, with staff building rapport and trust with service users. The NEP started from collectivist origins, being for community and by community, with the implementation of government funding broadening the services that the NEP could provide to service users (Harris, 2021; Keen & Weston, 2021). This research supports the continued funding of the NEP, as well as advocating for the implementation of health policies that includes meaningful consideration of social and environmental contexts.

There is, however, a slight tension for me, with the principles of harm reduction and how I understand health. It is regarding the principle of autonomy. I understand how it is designed to empower individuals, who have been previously disenfranchised and had their autonomy regarding their health undermined, however, viewing an individual as an autonomous and rational decision maker, is a core tenet of healthism. The implication here being that this principle may continue to perpetuate beliefs that individuals are choosing to inject drugs and therefore are failing morally.

4.4 Limitations

4.4.1 Diversity of Participants

As with any project, this research project has several limitations. Foremost, is the lack of diversity of participants. No women agreed to participate, there were no Māori participants, nor were there any participants that identified as any ethnicity outside of Pākehā/NZ European. Historically, healthcare and psychological services have not been kind to women and Māori, leading to a deep sense of distrust towards health professionals of any type (Graham & Masters-Awatere, 2020; Thompson & Blake, 2020). Alongside this, female PWID are smaller in number and also less trusting of

unfamiliar people (Gibson & Hutton, 2021). This is the same for Māori NEP service users; in the South Island of A-NZ there are less Māori injecting drug users, at least who use the NEP (Yu et al., 2022). The collective harm that has happened to Māori over our short A-NZ history, especially in relation to health, has been profound (Graham & Masters-Awatere, 2020). The Māori worldview (Te Ao Māori) is highly relational (Forster, 2022) thus relationships and rapport would have to be built over time with Māori participants and may be part of the reason why they did not engage in the research.

4.4.2 Participant Interest in the Topic

Another limitation is that the research topic may have appealed to NEP service users who are already interested in health. Through being an individualistic culture, where neoliberal ideals are dominant, A-NZ is also a health valuing culture (Crawford, 2006). Participants were well versed in their health understandings and discussed the many ways in which they actively manage their health. Thus, the research may only reflect the perspectives of a particular subset of NEP service users.

As this is a qualitative research project, the aim was never to find one universal truth but rather to explore the meaning making and to understand the experiences of a particular group of service users in a particular context. The insights produced from this context could be transferred to other contexts deemed to be similar by other researchers and service providers. However, given the specificity of this group of participants, caution is required in transferring the results to other NEP service users.

4.4.3 Participant Experience with the NEP

The final limitation is that all PWID who agreed to participate were passionate about their appreciation for the NEP. Not one participant had a bad word to say about

this service. This could signal how well established the rapport development processes of the NEP are. However, it is also likely that the those who are grateful for the services provided by the NEP agreed to participate based on the content of the topic. As above, this impacts the transferability of the research findings, as only a specific subset of the NEP service users was interviewed and had their transcriptions analysed.

4.5 Recommendations for Future Research

From the findings and limitations of this research, I would make the following recommendations in relation to future research. Firstly, exploring the understandings of PWID who identify as women and are of other ethnicities. With the historical mistreatment of women and those who are not of white, European descent, in healthcare settings (Graham & Masters-Awatere, 2020; Thompson & Blake, 2020), gaining their perspectives and understandings of health in this particular context is of importance. As A-NZ is a bicultural state, the understandings of Māori PWID are particularly important to explore, to uphold our obligations as Tangata Tiriti. This may provide greater credibility to the current project's findings and facilitate transference to other contexts.

As above, the exploration of the perspectives of PWID who either do not use the NEP or are not so appreciative of the NEP is recommended. Again, through gaining their constructions of health, the applicability of the current research project's finding's is increased. Having this perspective would also help to inform how NEP provision could broaden to achieve harm reduction for all individuals who inject drugs.

Education regarding PWID and their constructions of health for healthcare professionals is recommended, alongside an approach to healthcare that focuses on

the wider contextual influences on health, such as Te Whare Tapa Whā. So much of the stigma described by participants was experienced within the healthcare system and from professionals. The approach to health used by healthcare providers is the biopsychosocial model, which critics suggest does not truly assess the wider factors at play (Morison & Gibson, 2025). This understanding to health continues to perpetuate the ideas expressed through healthism, and thus, continues the cycle of discrimination experienced by PWID. Trusted relationships are hugely beneficial to health, and this extends to the therapeutic relationship between patient and provider (Argyle, 1992; Cohen, 2004; Seeman, 1996; Suls, 1982; Thomas, 2007). Through providing education to healthcare professionals, the hope is that they would become more open-minded to the experiences of PWID and build rapport with PWID, rather than shun them from the system.

I also recommend the exploration and implementation of relational and holistic approaches to health for the NEP. The NEPs positive contributions to their health were common points made by all the participants. Thus, the harm reduction model applied to the NZNEP, and has largely been beneficial, as shown by participants discussing how it has contributed to their health. The model does hold some tension, in terms of its principles regarding autonomy and its community driven, almost collectivist, origins. Understanding the individual as a rational, coherent, autonomous decision maker, aligns with neoliberal ideas of health, yet is a principle of harm reduction. It is designed to be empowering for the PWID, who often have their autonomy regarding their health compromised by discrimination and stigma. However, it could also perpetuate the idea that PWID can choose to stop taking drugs at any given time, and that they are therefore actively deciding to be bad health citizens and a burden on the state. Through the

implementation of models of health like Te Whare Tapa Whā, the NEP will be able to broaden its provisions and serve more of the PWID population. Harm reduction and indigenous models of health can integrate and are beneficial, as shown through First Nations harm reduction initiatives in Canada (Levine et al., 2021; Morin et al., 2022). Implementing Māori models of health in our A-NZ NEP, alongside the harm reduction ethos could have the potential to increase the benefits already provided by the programme.

4.6 Conclusion

Overall, participants construct their health from a neoliberal perspective, with understandings that revolve around health being a personal responsibility. Despite this perspective being at the forefront of their constructions, when delving deeper, participants describe social factors that they see as having been instrumental in their health for worse or for better. Community and healthcare discrimination created barriers to their healthcare access. However, trusted relationships were integral to better health outcomes for participants. From the experiences shared, it is understandable that PWID could turn to a more individualistic understanding of health, as it provides control in an uncertain world, especially where professionals meant to help you ostracise you. Thus, the importance of NEPs cannot be stressed enough for participants, as it is a setting that does not judge service users, no matter how they present when they enter an outlet store. The NEP has been beneficial to these participants and has contributed to their physical health and overall wellbeing. The NEP and staff became a trusted relationship for participants and allowed them to view themselves and their health in an alternative way, one that often contrasts with experiences of views of the wider society. Having this knowledge shows that a holistic

approach to health, with a focus on the relational aspects of health would be beneficial. Using models of health, such as Te Whare Tapa Whā, more substantially introduces the wider context into understanding an individual's health and counters the victim blaming practices that healthism perpetuates.

To conclude the research, I want to reflect on the time I had my assumption challenged, which I mentioned at the beginning of this chapter. Through listening to the person explaining to me their health rituals, I had a reality check about the lens through which I viewed health. Health is not a dichotomous, black and white, good or bad, state that an individual is in. Health is broad and interconnected with multiple facets in life. Through taking this understanding and approaching health in a holistic way, everyone benefits, especially those marginalised by society, such as PWID.

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Appendix A: DISC Trust Letter of Support

New Zealand Needle Exchange Programme
Te Waipounamu | DISC

20 February 2025

To the Massey University Human Ethics Committee,

Kia ora,

I am writing on behalf of Drug Injecting Services in Canterbury (DISC) Trust to express our full support for Zoe Knudsen completing her master's research project through our organisation. DISC Trust is Aotearoa's leading harm reduction service providing harm reduction equipment, drug checking, hepatitis C screening and treatment, general health screening and vaccination programmes for People Who Inject Drugs (PWID) and People Who Use Drugs (PWUD). We also partner with the University of Otago Medical School to deliver harm reduction training to medical students in both Ōtepoti and Ōtautahi.

We support Zoe to complete her recruitment efforts through our Nelson based service. Our Nelson service is one of seven static services delivering harm reduction advice and support within Te Waipounamu, all of which operate under the DISC Trust.

We also have a space in our Nelson premises, where we welcome Zoe to hold her interviews.

We look forward to seeing the outcome of Zoe's research.

Ngā mihi nui

Philippa Jones

Executive Director

DISC Trust

PO Box 22478 |10 Washington Way | Sydenham |Christchurch
www.nznep.org.nz

Appendix B: Ethical Approval

TE KUNENGA KI PŪREHUROA | MASSEY UNIVERSITY
UNIVERSITY OF NEW ZEALAND

1/05/2025

Dear: Zoe Knudsen

Re: Ethics Application - OM1 25/10 - An explorative study on how Needle Exchange Programme service users construct health

Thank you for the above application that was considered by the Massey University Human Ethics Committee:

Ohu Matatika 1 at their meeting held on **Tuesday, 11 March 2025**

On behalf of the Committee I am pleased to advise you that the ethics of your application are approved.

Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Professor Tracy Riley,
Acting Chair, Research Ethics Chair's Committee

Appendix C: Information Sheet

Participant information form

An explorative study on how Needle Exchange Programme service users construct health

You are being invited to take part in a study on how needle exchange programme users understand their health. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and ask me if there is anything that is not clear or if you would like more information. Thank you for reading this.

What is the purpose of the project?

As a requirement of obtaining my master's degree in Health Psychology, I am to complete a research project. For my research project I am interested in interviewing users of the needle exchange programme about their views on health and wellbeing. The interview will be used for the purposes of my master's thesis project.

Do I have to take part?

Taking part in this research is entirely voluntary. If you do not want to take part, please say so. If you decide to take part, you will be given this information sheet to keep (and be asked to sign a consent form). If you decide to take part you can change your mind at any time and withdraw from the study up until one month after the interview, without giving a reason. After one month, withdrawing your interview transcription will no longer be possible, as once the data has been analysed, it cannot be withdrawn.

What will happen to me if I take part?

You will be interviewed for approximately 1-2 hours on the topic of health in a private office at NICHE, at a time that is during NICHE open hours. The types of questions you will be asked will be about health and wellbeing. If there are any questions that you do not wish to answer, you do not have to. The interview will be recorded as I will be transcribing the discussion for analysis purposes.

What are the possible disadvantages and risks of taking part?

There are minimal risks associated with this study, and it is hoped that you enjoy taking part. Sometimes talking about even everyday situations can bring up emotional memories. If this occurs for you, I will ask if you want to stop the interview. If in the course of participating in this interview you think that you would like some support, then I will provide a list of services that are accessible for support. We hope you find this an enjoyable experience, but if you have cause for complaint, you are invited to contact my supervisor, Clifford Van Ommen: C.VanOmmen@massey.ac.nz

Will my taking part in this project be kept confidential?

All personal information relating to you (e.g., email address, mobile phone number) will be kept confidential. Consent forms will be scanned and sent to my supervisor where he will store them

in a locked cabinet that only he has access to. The original signed forms will be destroyed once scanned and the scanned forms will be destroyed after a five-year period.

The transcript from the interview will go through a de-identification process. Where you will be given a pseudonym, and any identifying information will be removed. For example, if you say something that might give away your identity (e.g., where you live), then this information will also be removed.

We will conduct the interview in a private office space on the NICHE premise. The interview will be recorded on a digital voice recorder. Immediately after the interview, the audio file will be transferred to a password protected device and uploaded to the password protected Massey University OneDrive. The audio will be transferred to a secure transcribing software, where it will be deidentified during the transcription process. Once the transcription process is completed, the recording will be deleted. Any quotes used from your interview will have gone through the de-identification process before being reported in my thesis. You will also have the opportunity to review your transcript after the process.

What happens immediately after the interview?

I will have a debrief with you about how you found the interview and you will have the opportunity to ask further questions regarding the study should you wish to do so. You will also be given a koha, in the form of a $40 shopping voucher, to thank you for your time and sharing your stories.

Who has reviewed the project?

This project has been reviewed and approved by the Massey University Human Ethics Ohu Matatika 1, Application OM1 25/10. If you have any concerns about the conduct of this research, please contact the Chairperson, Massey University Human Ethics Ohu Matatika 1, email humanethics1@massey.ac.nz.

Contact for further information on the project.

Researcher - Zoe Knudsen, email: PWIDHealth@gmail.com

Supervisor - Clifford Van Ommen, email: C.VanOmmen@massey.ac.nz

If in the course of participating in the study, you feel you would like to talk to somebody in a therapeutic way the following services might be useful.

The Male Room: 03 548 0403 or email: info@maleroom.co.nz

Nelson Women's Refuge: 0800 16 33 44 or **admin@whakaturefuge.org.nz**

Community Mental Health Nelson Marlborough: 0800 776 364

Lifelinc: 03 548 2400

Lifeline: Call 0800 543 354 or Text 4357

Appendix D: Consent Form

Principle Investigator: Zoe Knudsen

An explorative study on how Needle Exchange Programme service users construct health

I have read and understand the Information Sheet. I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study. I understand participation is voluntary and that I may withdraw from participating in the study at any time. I understand that if I do not consent to my interview content being used, I have one month from the date of recording to redact the data. I understand that consent includes agreeing to have my anonymized data used in the researchers' project.

	Initial Showing Consent
I confirm that I have read and understand the information sheet for the project in which I have been asked to take part and have had the opportunity to ask questions.	
I understand that my participation is voluntary and that I am free to withdraw at any time during the interview without giving any reason.	
I understand that that I am free to withdraw my data without giving any reason until 1 month after my interview.	
I understand that the interview will be recorded and that the audio file will be stored securely and only listened to by the Investigator signed below.	
I understand that my responses will be deidentified in the interview transcript, and will be seen by markers / examiners of the master's thesis.	
I understand that all personal data about me will be kept confidential.	
I agree to take part in the above research project.	

I, …… (**Participant's** full name) hereby volunteer to participate in the above named study.

Signed **(participant) …….. ……..** Date.....

I, …… (**Investigator's** full name) certify that the details of this procedure have been fully explained and described in writing to the person named above.

Signed (investigator) ..... **Date**……