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The material practices and social dimensions of community care among people who use, produce, and supply image and performance enhancing drugs

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ABSTRACT

Background: People who use image and performance-enhancing drugs (IPEDs) face intersecting challenges, including legal constraints, stigma, and inadequate healthcare support, which perpetuate health risks. Peer-led harm reduction practices emerge as vital alternatives, fostering trust, sharing ethnopharmacological knowledge, and addressing gaps left by formal systems. This study explored how care and connoisseurship are enacted within IPED communities, emphasizing peer roles in navigating risks, enhancing safety, and reshaping care practices through collective expertise.

Methods: Semi-structured interviews with four men explored IPED manufacture, supply, and harm reduction practices. Using a Science and Technology Studies-informed case approach, analysis foregrounded relational and socio-material dynamics, challenging deficit-based narratives and offering insights into how community care is enacted through peer-led harm reduction and what this could mean for policy development.

Results: People who use IPEDs transition from consumption to production and supply as a response to inadequate mainstream healthcare and systemic barriers. Participants highlighted tensions with socio-legal and medical frameworks, navigating these barriers through collective connoisseurship. By fostering relational practices of community care, they ensured quality, safety, and informed use, challenging traditional harm discourses and emphasizing the social and material interplay shaping safer-use strategies.

Conclusions: The community collectively demonstrate a commitment to community-driven care, contrasting sharply with their experiences of formal healthcare. Our analysis directs more careful consideration to the potential for rethinking health interventions to align with community-led approaches that emphasize autonomy, peer support, and relational care.

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Introduction

For people who use image and performance enhancing drugs (IPEDs) in many Western countries, consumption of these substances non-medically is fraught with various legal constraints (Coomber et al. 2014; Piatkowski, Gibbs, et al. 2024), strict prescription requirements (Handelsman 2013, 2020), limited accessibility (van Beek and Chronister 2015; Harvey et al. 2019; Turnock and Mulrooney 2023), and social stigma (Kimergård and McVeigh 2014; McVeigh and Bates 2022; Cox et al. 2024). These intersecting systemic and structural constraints contribute to putting peoples' health at risk, arguably exacerbating health harms. People who use IPEDs who do seek IPED-specific care consistently report identical therapeutic barriers (Fraser et al. 2020), where stigma is consistently foregrounded (Richardson and Antonopoulos 2019). This reluctance is mirrored by the health workforce's lack of preparedness and poor educational training in addressing IPED-related issues (Dunn et al. 2023). As a result, healthcare systems often fail to adequately engage with people who use IPEDs, perpetuating stigma and limiting access to support and care (Seear et al. 2015; Fraser et al. 2020).

This gap reinforces the importance of peer-led initiatives, where knowledge sharing and harm reduction practices bridge the divide left by institutional neglect (Marshall et al. 2015). Scholars have argued that peer-based care is particularly valuable in settings where formal healthcare services are viewed with mistrust, as peers provide culturally appropriate and nonjudgmental support (Chang et al. 2021; Francia et al. 2023). The role of peers in harm reduction has been extensively recognized in alcohol and other drug contexts, where peer engagement increases trust and access to services (Conway et al. 2021; Silano et al. 2022). Peer-led harm reduction approaches offer an alternative to traditional healthcare models by focusing on the lived-living expertise

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of people who use drugs (Piatkowski, Seear, et al. 2024). In these contexts, peers are not only providers of material resources but also facilitators of social and emotional support, reducing barriers created by stigma and inadequate health workforce training.

People who use IPEDs are known to possess unique ethnopharmacological knowledge (Monaghan 1999, 2002; Underwood 2017; Piatkowski and Cox 2024), cultivated not only from lived-living experience but through immersion in a broader community of shared experiences and practices. These practices involve not just the acquisition and application of pharmacological knowledge but also active engagement in peer support, mentoring, and the development of harm reduction strategies tailored to IPED use (Henning and Andreasson 2022; Piatkowski, Gibbs, et al. 2024). By sharing insights into usage strategies and side effect management, people who use IPEDs collectively navigate risks and promote safer practices within their networks. These different practices encompass community-driven initiatives (Henning and Andreasson 2022; Piatkowski et al. 2022, 2025; Turnock et al. 2023; Piatkowski and Cox 2024) which include peer distribution of equipment and knowledge. For people who use IPEDs, peers similarly navigate complex health and social landscapes, fostering networks of care that extend beyond individual consumption to encompass production, supply, and broader community wellbeing (Henning and Andreasson 2022; Piatkowski, Vigorous, et al. 2024). These networks challenge the binary and static nature of 'user' and 'supplier,' instead highlighting the fluid and relational nature of roles within IPED communities (Piatkowski and Cox 2024). Peer networks also redefine care in ways that counteract the punitive and stigmatizing narratives that are often shaped by and reflected in IPED use. Rather than relying solely on biomedical frameworks, these networks emphasize a collective approach to health (Moore et al. 2020; Nourse et al. 2024), where harm reduction practices are co-produced within social and affective relationships. For instance, peers often serve as intermediaries between people and systems, advocating for access to safer products and providing guidance on use practices grounded in both experiential and scientific knowledge (Piatkowski, Vigorous, et al. 2024; Piatkowski, Cox, et al. 2024).

This dynamic positions peers as crucial agents in the harm reduction landscape, advocating for safer consumption practices while addressing broader structural inequities in healthcare provision. By situating IPED-related care within the broader harm reduction literature, we highlight the significance of peer roles in reshaping health outcomes. These initiatives challenge conventional healthcare limitations and demonstrate the transformative potential of community-driven care in navigating drug use complexities.

Approach

This study draws on Science and Technology Studies (STS), particularly the concepts of *care* and *connoisseurship*, to explore the practices and social networks surrounding IPED use. Our analysis examines the social networks and interpersonal relations of care within harm reduction among communities of people who use IPEDs, emphasizing care as enacted through connoisseurship and the shared expertise cultivated within these communities. We draw on STS scholars John Law (2002) and Annemarie Mol (1999). Law's (2002) work underscores that research practices do not merely reveal preexisting realities but actively construct the worlds they examine. He argues that the methods, tools, and frameworks we employ are not neutral; they generate and shape the social and material relationships that come *into being* during the research process. This perspective implies that our research is not simply descriptive, but also constitutive; we are part of the process that brings these relational dynamics into focus. By acknowledging the generative role of our research practices, we assume responsibility for the realities we help create, attending to the intricate interplay among people, substances, and technologies. This perspective has proven valuable in alcohol and drug research (see Fraser and Seear 2011; Fraser 2013; Farrugia et al. 2021), offering insights into care as a situated and relational practice (Puig de La Bellacasa 2017; Dennis and Farrugia 2017; Duff 2015, Duncan et al. 2021). Mol (2008) conceptualizes care as a 'logic of care,' contrasting with the goal-driven, individualistic 'logic of choice.' Care is relational and emerges through interactions between humans, technologies, and societal structures, focusing on the particularities of practice rather than abstract principles. Puig de La Bellacasa (2017) extends this view, framing care as both an ethical and political act that shapes and is shaped by the worlds in which it unfolds. These insights are central to understanding harm reduction practices, as they highlight how care is co-produced with the knowledge and interventions, we, as researchers, help create. By focusing on care as a relational and process-oriented practice, our approach explores how harm reduction and peer support are conceptualized and enacted within communities of people who use IPEDs.

By valuing and placing emphasis on the lived-living experiences of people engaged in IPED consumption, manufacture, and supply, we emphasize how relational and material practices of care can enhance both the production of more contextually relevant biomedical knowledge and the development of effective harm reduction strategies. This aligns closely with an approach to peer-led harm reduction taken among IPED communities, where peoples embodied and situated knowledge plays a pivotal role in navigating risks and shaping care practices. Recognizing that IPED consumers often grant greater trust to peers than people in medical or governmental organizations (Fraser et al. 2020), we argue for the importance of engaging with the community through collective and distributed knowledge as a relational and situated practice of care. Suzanne Fraser and colleagues (2020), drawing on Isabelle Stengers, refer to this as collective knowledge as 'connoisseurship,' where engagement with drugs goes beyond simply 'consuming' them, to involve a deep, critical understanding of both the risks and benefits, which in turn allows for fine-tuning consumption practices over time. However, while Fraser and colleagues (2020) work has focused on this in relation to IPED consumption, we aim to extend this inquiry to encompass the broader practices of production and supply, acknowledging that people who use

IPEDs often take on multiple ‘connoisseur’ roles within their communities with production and supply of IPEDs being two of these (Brennan et al. 2018; Turnock et al. 2023). Through this lens, connoisseurship becomes integral to care practices, not as a top-down imposition of universal authority but as a distributed, collaborative process that bridges community expertise and scientific knowledge (see Piatkowski, Gibbs, et al. 2024). This approach disrupts traditional hierarchies of knowledge and calls for a reframing of whose insights are considered valid, ultimately advancing harm reduction practices that are both meaningful and effective. Therefore, we aim to unpack the locally situated forms of care that arise within the networks of people who consume, produce, and supply IPEDs.

Methods

Sampling and recruitment

Recruitment for this study involved targeted outreach to individuals within the lead author’s networks in Australia, specifically focusing on identifying and engaging with IPED manufacturers and suppliers. The lead author leveraged longstanding connections and trust built over years of engagement as a peer researcher, which facilitated access to this notoriously hard-to-reach population. The participants were initially contacted by the lead author, and upon expressing interest, were provided with the study documentation and information electronically. This process was facilitated through encrypted messaging platforms, which the participants’ felt comfortable using and facilitated confidentiality in the communication process. The study received ethical approval from the University research ethics committee (Approval: 2023/781). To acknowledge participants time and expertise, each were reimbursed with a $40 AUD voucher as a token of appreciation for their involvement in the study.

The participant accounts which underpin the analysis for this study comprise four individuals with diverse roles in IPED manufacture and supply. Carlos, a 28-year-old male, had been using IPEDs for five years and was actively engaged as a competitive powerlifter. Waylon, a 32-year-old male, identified as a noncompetitive bodybuilder and reported that he was using AAS (testosterone enanthate, 250 mg p/wk) continuously (“year-round”). George, a 33-year-old male, had used IPEDs for over a decade but at the time of the study reported using testosterone replacement under prescription (testosterone enanthate 125 mg p/wk). He was also involved as a competitive powerlifter. Lastly, Ivan, a 39-year-old male, was a competitive bodybuilder who used AAS continuously without a prescription. All participants had previously supplied, or were supplying, IPEDs at the time of this study. Carlos, Waylon, and Ivan had manufactured or, were presently, manufacturing IPEDs at the time of this research.

Materials and data collection

Data were collected through semi-structured interviews. Before beginning the interview process, participants provided verbal consent. Example interview questions included: How did you get involved in the supply of IPEDs? What challenges do you face in distributing IPEDs? How do you ensure the quality and consistency of the products you supply? What are your views on the current state of regulations and law enforcement efforts concerning IPEDs? Participants were invited to take part in a one-on-one interview or in small groups if they felt comfortable. This format was sought in an effort to acknowledge the dynamics that shape participants’ preferences and comfort levels in this field. For instance, Carlos and Waylon, who shared a preexisting relationship, opted for a group interview format due to their established familiarity and mutual reassurance. Given the legal sensitivities surrounding the discussion of illicit IPEDs in Australia (Piatkowski, Gibbs, et al. 2024), particularly regarding supply and trafficking, the preference for a group setting can be understood within this context. Conversely, George and Ivan, who held no prior relationship, expressed comfort with individual interviews, likely influenced by their knowledge of the lead author’s research approach and his commitment to uphold strict ethical principles, including participant confidentiality. These formats ultimately enriched the depth and authenticity of the data collected. While interviews followed a pre-determined and set interview schedule, the lead author adapted his questions when interviewees revealed something of particular interest. These interviews took place online, where recordings were transcribed automatically and then crossed checked for errors.

Data analysis

Interview transcripts were organized and coded using NVivo (QSR, v12). Our analysis adopted an STS inspired case approach, informed by Mol and Law’s (2002) argument that the value of cases lies not in their representativeness but in their ability to sensitize us to previously unexamined events, practices, and possibilities. Rather than aiming to generalize themes, we explore the specificities of the practices, relationships, and socio-material dynamics revealed in the four participant accounts. This type of case approach is well-established in STS scholarship on drug consumption (e.g. Farrugia et al. 2019, 2022; Fraser et al. 2022). These case approaches do not claim representativeness but seek to foreground the complexities and contingencies of the participants’ practices. We position each case as a site for exploring the relational and material dynamics of peer-led harm reduction in the context of IPED manufacture and supply. Through this, we illuminate how the participants’ agency, expertise, and lived-living experiences challenge deficit-based representations of people who consume IPEDs, offering alternative pathways for reimagining harm reduction practices and policy frameworks.

Findings and discussion

Our analysis examines three distinct cases of IPED manufacture and supply, highlighting the ways in which care is realized through a complex network of relationships. Together, these cases reveal how harm reduction and care practices are shaped by a broader interplay of social and material forces. We begin with case one, where George spoke about the tensions for IPED consumers when considering how they manage health and harm given the broader socio-legal landscape they exist in.

George: Negotiating health and harm boundaries

George offered a considered evaluation of the health effects associated with IPEDs, asserting that while these drugs can have negative impacts on peoples' lives and relationships, these consequences are deemed to be less severe compared to other illicit substances.

> In terms of the [harms], you know it can destroy people's lives and relationships and stuff, but definitely by far not to the same degree as on the other drugs. Much less significant […] Medicinal uses and there's tons more research now supporting the idea for using it [testosterone] as you age. So, there's things to support health. And at the same time, people have choices, and if you want to take them [IPEDs], then you should be able to.

George's assessment positions harm as relative rather than absolute, suggesting that the biomedical framing of IPED risks does not align with his lived-living experience or that of the community. In doing so, he reworks the dominant harm discourse, integrating both medical research and experiential knowledge to redefine what constitutes acceptable risk and legitimate substance use. His comments highlight a shift from viewing IPEDs solely through a lens of harm to considering their medicinal potential and the right to personal choice (see Fomiatti et al. 2023). This is important when considering how IPED-using communities actively contest and reshape medical discourse, foregrounding their own expertise in managing health. George further articulated his critique of the regulatory landscape:

> The current landscape, regulations in terms of steroids and performance enhancing drugs in Australia um, it's horrible. It's too harsh because people who legitimately need help, have a very hard, very difficult time doing so. I'm like I'm pro-choice for anything you wanna do, just like any other, any other drug. For some people, it's not their fault and they need help. Why should they be jailed for something that you know that might need medical help for?

What he described well, is the entanglement of social practices and healthcare when it comes to IPED consumption, building on Berridge's (1997) work on medico-penal approaches. Here, George makes explicit how legal and medical structures do not just fail to provide care but actively obstruct it, creating conditions where people must navigate health decisions in isolation. His frustration reflects a broader harm reduction issue: the exclusion of IPED consumers from mainstream healthcare reinforces informal networks of care and knowledge-sharing as an alternative. This dynamic illustrates how harm reduction is not just about reducing physiological risks but also about challenging structural barriers that prevent access to legitimate care.

Building on these tensions, George envisioned what could be. He suggested the potential for intertwined personal experiences within the healthcare system.

> If a doctor can help you along the way and provide safe use for personal reasons … Even if they [medical professionals] can't supply, at least be open to helping us with supervision, you know, no one is helping us. I think even just from a health perspective and people who want help, need help, and for such a drug that isn't really under the same banner as every other drug.

George's call for a more adaptable approach underscores how scientific knowledge and individual practices could interact to shape the discourse on IPED use, chiming somewhat with Fraser et al. (2020) vision. This call acknowledges and supports IPED use, not just as pathology, but as an informed and personal choice, demonstrates how care is being redefined by those excluded from traditional medical frameworks. Rather than accepting medical gatekeeping, he argues for a system that meets users where they are, offering oversight and harm reduction rather than punishment. As he noted, the difficulty of accessing legitimate help for people who want to use these substances responsibly, coupled with a lack of medical support for those facing health complications, shapes the choices individuals make. Faced with these constraints, George enacted his own form of harm reduction: sourcing and supplying IPEDs within his community.

> I needed something for personal use … Once I found some one [to supply] … I found them, made sure they were good [quality product] … Then a few people wanted, you know, [and] I had a supply …. I had close friends that needed some. In the initial part of me dealing there was a lot of that expansion, because you were selling to, you know, new users, gym users, [not just] friends.

His decision to supply others was not simply economic; it was an extension of the care practices he believed were absent from formal institutions. By sourcing high-quality products and distributing them within a trusted network, he sought to reduce harm in ways the existing healthcare and regulatory system failed to do. Rather than seeing informal supply as inherently risky or criminal, George's actions highlight peer-led harm reduction as a response to structural neglect. Barriers to healthcare pushed him into an informal network that became a parallel care structure, meeting both his needs and those of his peers by ensuring access to quality substances in a precarious market.

Ivan: Connoisseurship beyond consumption

In the previous section, we explored how the balance between health and harm in the context of IPED use is complicated by a hostile and fragmented socio-legal landscape, where people who use these drugs are often left to navigate the risks of consumption with limited support. In contrast, Ivan's narrative illustrates the evolution from consumer to manufacturer and supplier, highlighting how the development of his connoisseurship, emerges as a practical strategy for mitigating harm and enhancing care within the community. In his early experiences as a consumer, Ivan acquired detailed technical and experiential knowledge that provided the foundational skills necessary to transition into manufacturing. Within his community, Ivan noted the presence of both informal bro-science and rigorously vetted, peer-reviewed research. This duality, accessible through both in-person interactions and social media, enabled him to selectively integrate high-quality advice into his decision-making process.

> As a community the word is out there. There's bro science being peddled and there's actual you know, research with peer reviewed studies and whatnot that can be cited. And both in person and on social media you've got really good people, like, you know, experts in their field who are able to give you free advice on your all ranges of health that applies to steroid use as well. There are obviously fuckheads out there that you're not gonna listen to, but if you can pick and choose as maturely, I guess responsibly, well that's what I did. I used a range of educational opportunities to make better choices.

Ivan's transition from consumer to manufacturer was driven by economic and quality concerns. He remarked:

> I got involved…. I think it [the steroid market] is pretty broken and quality wasn't what it could have been. In Australia, you're paying a fortune for something that's been processed and the process of cooking it, it's very basic, so if I could pay a dollar for a gram of testosterone powder or less from China, why wouldn't I pay it? I think it was bloody, close to $200 for a bottle [of testosterone] which has got 2 1/2 grams in it. Back then I… really it was hard to afford and hard to justify. So that's probably where I started, so I probably just started cooking [manufacturing] for myself, and then other people wanted some and things grew from there.

This shift not only represented a pragmatic response to market inefficiencies but also signaled a move toward self-reliance and collective care, ensuring that quality products were available as a harm reduction measure for the broader community. In a follow-up discussion, Ivan emphasized that the lack of open communication in traditional settings necessitated a reliance on trust-building and informal networks:

> Interviewer: Do you wanna just give me a bit of context around and that all sort of happened?
>
> Ivan: Nobody talked about it openly. Everybody just lied. You could look around the gym and you know, the only real way to talk to anybody who was involved in anything was to build trust. Also, from there, talking on the Internet and on bodybuilding forums helped, so that's kind of where everything I knew and learned grew from. Anybody I was involved with was as knowledgeable or more knowledgeable than myself.

This narrative underscores how the social dynamics of secrecy and trust not only create barriers to open discussion but also serve as catalysts for harm reduction. By cultivating relationships built on trust, Ivan and his peers were able to share both technical manufacturing knowledge and practical safety practices, thereby collectively mitigating the risks associated with IPED use. The collective practices extended beyond mere consumption, encompassing the technical, social, and safety dimensions of IPED manufacture and supply. Ivan described how he leveraged the collective repository of knowledge, gathered from forums (see Lamb et al. 2024) and in-person interactions, to guide his first '*cook*':

> I had obviously the information I got from those forums and online. But I also met people, and they helped talk me through the [cooking] process. They basically talked me through my first cook [steroid production]. I read up what I needed to and made a plan […] ordered what I needed and […] then I said "Hey can you walk me through this, this is what I know and this is what I'm thinking of doing". And that really helped.

This collaborative process was not only a technical learning experience but also a form of collective care, ensuring that manufacturing practices adhered to safety protocols and reduced harm within the community. Furthermore, the collective knowledge Ivan accessed included crucial safety protocols that transcended the technical aspects of steroid production. He recounted the social and relational practices that were integral to maintaining operational security:

> Absolutely never talk inside a car. Don't talk inside a house. Don't talk over the phone. Use encrypted phones […] Was told to everything done in cash, wouldn't use bank accounts or 'pay ID' [bank transfer] like people do these days. No trail. I was told, and didn't cook with or in front of other people or anything like that.

These guidelines illustrate how community-shared practices serve both to protect individuals from legal repercussions and to function as a harm reduction strategy, ensuring safety throughout the supply chain. Ivan's development of connoisseurship underscores the importance of collaborative learning and adaptive safety measures in contexts where formal support structures are absent. His expertise was built not only through personal experience but also through dynamic exchanges of ethnopharmacological knowledge, enabling his transition from consumer to manufacturer.

Ivan's experience demonstrates that the fusion of technical expertise and trust-based networking does more than facilitate clandestine production, it actively creates a form of local care. By relying on community-sourced knowledge and mutually agreed-upon safety practices, Ivan and his peers constructed a protective framework that mitigates risks and supports wellbeing. This locally situated care, embedded in everyday interactions and collective problem-solving, serves as a vital counterbalance to formal healthcare structures that often neglect the nuanced needs of IPED consumers as indicated by George previously.

Carlos and Waylon: Relational practices in community care through supply

Our final case builds the concept of collective connoisseurship into a relational practice of community care. Carlos and Waylon, both consumers, manufactures, and suppliers of IPEDs, illustrated how they are a source of mutual support and harm reduction within their community, providing services of care for community members. In their interview, they reflected on how their practices transcend the isolated actions of consumption and manufacturing and are instead embedded in relational dynamics that support the broader community. Carlos emphasized that his primary goal was not profit but ensuring a reliable product for those who need it, such as competitive powerlifters and bodybuilders:

> Carlos: But my intention was never just to try and make as much money as I could or anything like that. It was always to provide a good quality product to not only myself, but the people who need it the most… a majority of my clients are competitive powerlifters or bodybuilders, and they need that product for that specific reason.

Waylon echoed this sentiment, highlighting a cautious approach to meeting the needs of people in the community:

> Waylon: As Carlos said, the intention was never to get rich fast or anything like that. I just wanna keep things small and quality [high]. And as I said, like if I go to use something I just pull it off the shelf of what I've made for everyone else. We don't wanna get caught. We don't wanna get too big, but we still need to find a way to get that product out there to people that need it.

As Carlos explained further, the value of his role lies not only in the production of IPEDs but also in ensuring the quality and safety of the substances being consumed within their network. He emphasized the importance of community involvement in maintaining standards, highlighting how these relational practices foster both care and accountability:

> Carlos: I find enjoyment in being able to produce my own product that I know is clean. So, I think the community stepping in and making sure that there is a level of cleanliness and making sure that the product that we're getting is correct is important.

For Waylon, the act of supplying IPEDs was not just about selling a product to attain capital but to offer a service that includes guidance, support and health protecting. He reframed his role not solely as a supplier but as a source of advice, highlighting the ethical balancing act between personal involvement and providing care. As Waylon explained

> Waylon: It's more provided as a service, which is, you know, still underground and like any sort of business that's hard, you know, navigating how to how to do something both, you know, ethically as well as you know making an income or like, you know or having a personal, you know, you know, stake in you're selling. But I'm reframing more from helping people with that as much as the service, more just providing advice.

Considered in this way, the quality and safety of IPEDs are deeply intertwined with the social dynamics and affective engagements of both producers and consumers, reflecting how material practices and relational interactions co-construct the experience of IPED use and harm reduction community care. Carlos and Waylon's engagement with customers also reflected a broader network of interactions that shape and support safer use models:

> Carlos: I'm happy to have a discussion with some customers about, you know, proper use or safer use models and things like that. If they've got any questions, I'm more than happy to answer them.

> Waylon: It's becoming more common and, as Carlos said earlier, just talking to customers and making sure that they have the right tools to do things properly, like, we have people message us all day everyday asking questions… it is good that they're asking all these questions and trying to do things properly and learn.

Carlos's willingness to discuss use and Waylon's observation of increased inquiries highlight how, collectively, community members actively participate in knowledge exchange and care practices. Their integration of health advice into IPED consumption and supply practices highlights how these elements coalesce to foster a supportive environment prioritizing wellbeing and 'safer' use. This process involves negotiating and redefining norms around safer usage, which challenges the stigma associated with IPED use and our current understanding of it. Expanding our ways of understanding these dynamics helps to make this form of community care more visible. It also reveals the way these interactions create and legitimize practices within IPED communities, moving beyond traditional stigmatizing and pathologising frameworks and contributing to a more supportive and inclusive approach to harm reduction.

Conclusions

The exploration of community care among IPED consumers underscores the significance of recognizing and supporting self-organized practices within marginalized groups. These practices not only offer crucial health benefits but also cultivate a sense of community and mutual aid that is frequently absent in mainstream services. By engaging with the social and political dynamics of IPED consumption, this analysis reveals how community care is actively constructed through interactions among people who use, produce, and supply. Their practices highlight the social and affective dimensions of care, demonstrating how community-led initiatives can challenge and reshape dominant narratives around IPEDs. This process of care involves not only the provision of products but also the active dissemination of health information and support for self-regulation, thereby counteracting the stigma often associated with IPED use. Instead, our findings illustrate a new approach toward considering IPEDs and health outcomes, highlighting the autonomy and self-regulation exercised by community members. The practices and experiences of our participants, thus, offer a counter-narrative to dominant discourses on drug use and harm, not merely resisting these narratives but actively shaping them through autonomy, self-regulation, and collective support. The narratives enact an ethics of community care (Duff 2015; Rhodes et al. 2017), where affected communities took proactive measures to mitigate harm in the absence of adequate health support.

In essence, the construction of popularized views of IPEDs (James and Wynn 2022; Dowsett et al. 2023; Nourse et al. 2024), and the persistent endeavors to depict them as hazardous substances, starkly contrasts with the network relations shaping these drugs as therapeutic aids or providing potential for human enhancement. There is a need for public health initiatives to incorporate the insights and practices of the community, acknowledging their expertise and autonomy (Fraser et al. 2020; Underwood 2025). This could involve developing more flexible and programs that respect the agency of people who use IPEDs. This includes recognizing the value of peer networks and integrating them into formal health care strategies. We need more collaboration with community groups to co-create care models that are respectful and responsive to the needs of IPED-using communities. Acknowledging the resourcefulness and resilience of people who use IPEDs challenges the stigma and marginalization they often face, paving the way for more respectful and empowering approaches to health and wellbeing. This shift in perspective is crucial for developing health policies that genuinely address the needs and aspirations of all community members.

Several limitations must be acknowledged in this study. Firstly, the sample is predominantly composed of people from specific social and economic backgrounds, which may not fully represent the diverse experiences of all IPED producers and suppliers. The discourse of care and harm reduction within this community is influenced by the marginalization of people who use IPEDs within legal, medical, and popular frameworks, and often functions as part of a business or marketing strategy. Thus, while participants may genuinely care about their clients' wellbeing, these expressions of care are inherently tied to the commercial realities of their practices, making their dual roles dynamic, intertwined, and subject to temporal change.

This study underscores the significance of community-led care in the context of IPED use, illustrating how people who use, produce, and supply these substances actively shape harm reduction practices beyond traditional healthcare models. By foregrounding peer networks and lived-living expertise, our findings challenge dominant narratives that position IPED use solely as a public health risk, instead revealing the agency, knowledge, and self-regulation embedded in these communities. Recognizing and integrating these forms of expertise into public health and policy is critical. Rather than marginalizing these practices, health strategies must engage with them to co-develop more responsive and culturally appropriate care models, which includes supporting peer-led initiatives. Future research should further explore how peer-led initiatives influence healthcare and the social dynamics of stigma, inclusion, and empowerment. Expanding this knowledge base will not only inform better interventions but also help reimagine care in ways that value the expertise of people who use IPEDs.

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