






Regional Overview

2.7 Oceania



Oceania

Table 2.7.1: Epidemiology of HIV and viral hepatitis, and harm reduction responses in Oceania

Country/territory with reported injecting drug use	People who inject drugs	HIV prevalence among people who inject drugs (%)	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)	Harm reduction response		
					NSP ^b 	OST ^c 	DCR ^a 
Australia	93,000 (67,800-118,200) ^{(1)d}	1.7% ⁽²⁾	54 ⁽²⁾	4 ⁽²⁾	✓3,000+	✓2,589 ⁽³⁾ (B, M)	✓1 ⁽⁴⁾
Fiji	nk	nk	nk	nk	✗	✗	✗
New Zealand	12,840 ⁽⁵⁾	0.2% ⁽⁶⁾	50 ^{(7)e}	nk	✓192+	✓	✗
Papua New Guinea	nk	nk	nk	nk	✗	✗	✗
Samoa	nk	nk	nk	nk	✗	✗	✗
Timor Leste	53 ⁽⁸⁾	nk	nk	nk	✗	✗	✗

nk = not known

^a DCR is a drug consumption room (please refer to chapter for details), also referred to as a safer injection facility.

^b This includes all operational NSP sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers.

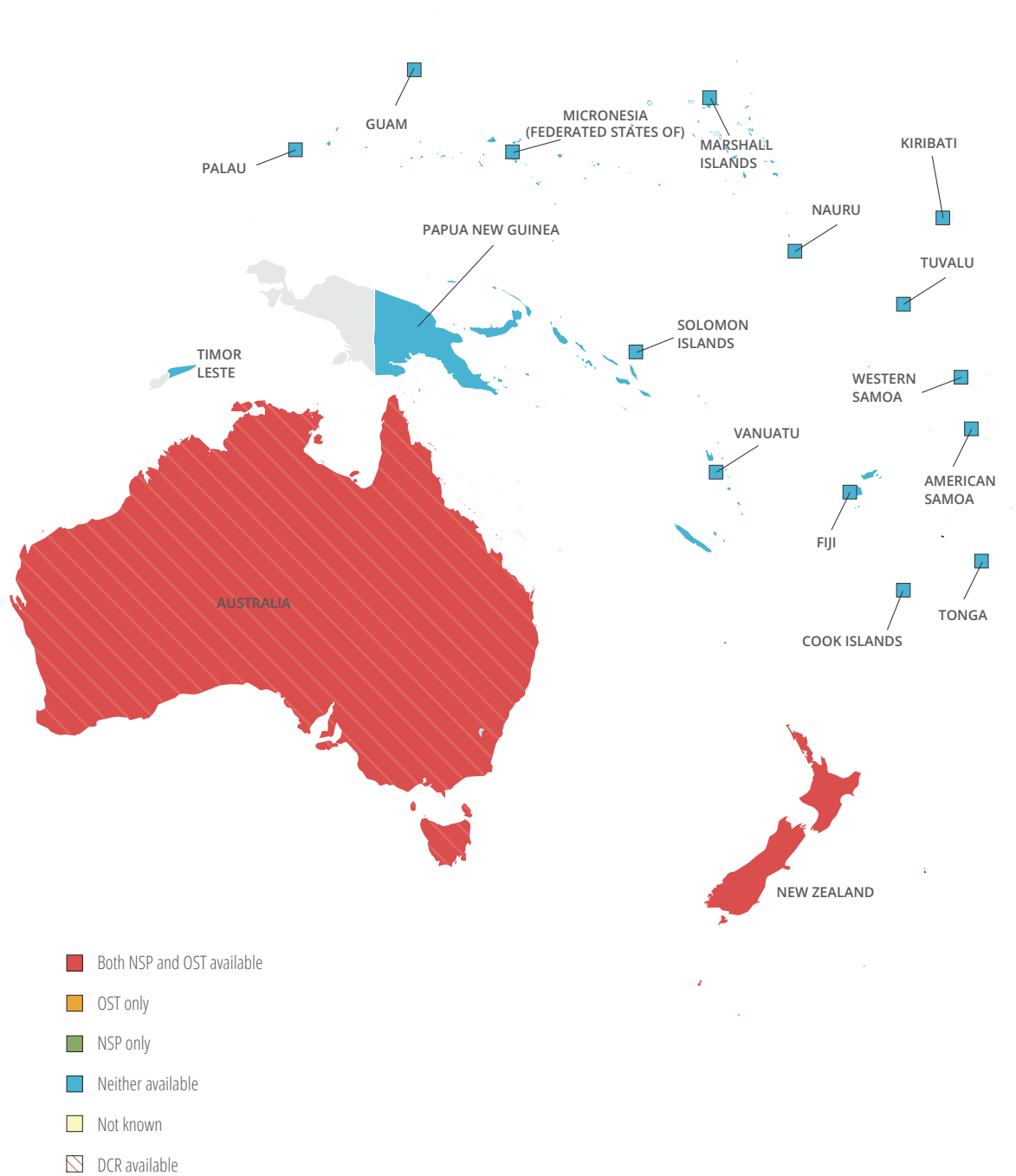
^c (M) = methadone, (B) = buprenorphine, (O) = any other form (including morphine and codeine).

^d Civil society believe this figure to be an underestimate as there is no distinction given between regular, frequent and occasional people who inject drugs.

^e The updated figure from the World Drug Report notes this has increased to 57%, however due to the sample size (n=700) figures have been taken from 2014 report.



Map 2.7.1: Availability of needle and syringe programmes (NSP) and opioid substitution therapy (OST)



Harm reduction in Oceania

Overview

The regional prevalence of injecting drug use in Oceania is limited to data from Australia, New Zealand and Timor Leste (please see Table 2.7.1). Since the 2014 edition of the *Global State*, there has been little new research into drug use or drug related harms undertaken in the Pacific Island countries and territories (PICTs).^f This remains a concern due to the reporting of injecting drug use, and the lack of harm reduction programmes in this region.⁽⁴⁾ Injecting drug use is not thought to be common within the PICTs,⁽⁹⁾ yet there appears to be a marked increase in the use of amphetamine-type stimulants (ATS).⁽⁹⁾ The most recent UNAIDS report to emerge from Fiji states only one case of HIV infection occurred through injecting drug use in 2014.⁽¹⁰⁾

Approximately 105,893 people inject drugs in Australia, New Zealand and Timor Leste combined. The use of heroin reportedly declined in Australia between 2010-2013.⁽¹¹⁾ However, there has been a small increase in HIV prevalence among people who inject drugs from 1.2% in 2014,⁽¹²⁾ to 1.7% in 2015.⁽¹³⁾ Although harm reduction initiatives have been well-established in Australia, there are still reportedly significant disparities in service provision among Indigenous Australians.⁽²⁾ Injecting drug use is less prevalent than other drug use among this population, yet there is a high incidence of unsafe injecting practices,⁽¹⁴⁾ and higher rates of HIV infection associated with injecting drug use.⁽¹⁵⁾

In both New Zealand and Australia severe side effects and low success rates of hepatitis C treatment had previously formed a significant barrier for people who inject and/or use drugs. Yet the availability of a free hepatitis C treatment using direct-acting antivirals in Australia since February/March 2016 has seen a rapid increase in the numbers of people seeking treatment.⁽¹⁶⁾ In New Zealand, uptake of testing and treatment for hepatitis C among people who use drugs remains extremely low, and there is an urgent need to amend the way hepatitis C is diagnosed and treated in the country.⁽¹⁷⁾

The rise of stimulant use in Australia

Stimulant use, although increasing in Australia, is estimated to have remained relatively stable in New Zealand, with approximately 26,000 people reporting use of amphetamine-type stimulants (ATS) in the past year.⁽¹⁸⁾ In Australia, however, findings from the Kirby Institute show a marked rise in methamphetamine use between 2010 and 2014, with methamphetamine reported as the last drug injected by one-third of respondents in the Australian Needle and Syringe Program Survey (ANSPS) in 2014.⁽¹³⁾ More than 200,000 people are reported to be using crystalline methamphetamine (commonly known as 'ice') in Australia, an increase of 100,000 since last reported in 2007.⁽¹⁹⁾ National data indicate that methamphetamine injection has increased significantly from 27% in 2011, to 36% in 2014, overtaking heroin as the most commonly injected drug in the country.⁽²⁰⁾ In 2015, it continued to be the most commonly injected drug in the majority of jurisdictions, including New South Wales (32%), Queensland (34%), South Australia (53%), Tasmania (42%), and Western Australia (45%).⁽²⁰⁾ Crystal methamphetamine is also believed to be one of the most commonly injected drugs among gay and bisexual men living in Sydney.⁽²¹⁾

Not only does there appear to be a rise in the use of ATS and, in particular, an increase in crystal methamphetamine injecting in Australia, but there is also a rise in polydrug use.⁽²²⁾ This calls for an adapted harm reduction approach, as opioid substitution therapy (OST) is only indicated as a treatment for opioid drug use.⁽²³⁾ In response to the growth of ATS use, the politically conservative Australian government commissioned a report on 'ice'.⁽¹⁹⁾ Although the report recommends a move away from law enforcement to local area focused health responses to ice use, it fails to mention harm reduction,⁽⁴⁾ which came as a profound disappointment to some civil society groups.^(4, 24)

At present there is little solid evidence relating to pharmacological treatment for amphetamine use.⁽²⁵⁾ However, harm reduction for people who use amphetamines follows the same fundamental principles as harm reduction for people who use opioids.⁽²⁵⁾

^f The PICTs comprise 22 countries and territories subdivided into Micronesia, Polynesia and Melanesia. They are American Samoa, Cook Islands, Federated States of Micronesia, Fiji, French Polynesia, Guam, Kiribati, Marshall Islands, Nauru, New Caledonia, Niue, Northern Mariana Islands, Palau, Papua New Guinea, Pitcairn Islands, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu, Vanuatu, and Wallis and Futuna.



Developments in harm reduction implementation

Needle and syringe programmes (NSPs)

It is estimated that approximately 10,000 people make use of NSP services in New Zealand, with 3 million new needles distributed each year.⁽⁶⁾ NSPs operate via 21 primary sites and approximately 170 pharmacies providing needles and syringes. These high coverage rates make HIV rates among people who inject drugs remain consistently low. In Australia, NSPs have been in place for many years and there are over 3,000 NSP outlets in operation, including mobile outreach services and vending machines.⁽⁴⁾

A scientific paper from Australia published in 2009 argued that sterile injecting equipment was limited by supply rather than demand, and estimated that needle and syringe distribution needed to double in order to reduce the annual incidence of hepatitis C virus infections in particular.⁽²⁶⁾ In response to this paper, the New South Wales Ministry of Health removed limits to the amount of equipment supplied when visiting a service, and people who inject drugs in this state can now access as many syringes as they require.^(27, 28) A further development in NSPs in Australia has been the ability of peers to legally provide injecting equipment in the Australian Capital Territory, Tasmania, the Northern Territory, and New South Wales.^(4, 28) Although there have been improvements in policy relating to NSPs, the ANSPS found that the prevalence of people re-using needles and syringes (including reuse of one's own syringes) in ranged from 21-25% between 2011 and 2015,⁽²⁰⁾ indicating the need to undertake more focused efforts to reduce this practice.⁽²⁸⁾

As previously noted in past editions of the *Global State*, there is a disparity of service provision among indigenous communities and indigenous people who inject drugs continue to be underrepresented in NSP services.⁽⁴⁾ Findings from the ANSPS show that the number of people from an Indigenous background accessing NSPs is increasing, from 5% in 1995, to 14% in 2014.⁽¹³⁾ However, between 2010 and 2014, 16% of all HIV diagnoses among Aboriginal and Torres Strait Islander people is attributed to unsafe injecting drug use, highlighting the urgent need for targeted harm reduction responses for these populations.⁽²⁾

While NSPs continue to operate across the country in many jurisdictions in Australia, some barriers to access remain, including limited after-hours service availability,

geographic access and stigma and discrimination experienced by some people who inject drugs when accessing harm reduction services.⁽²⁰⁾

Opioid substitution therapy (OST)

In 2015, there were 2,589 outlets providing OST in Australia covering 48,522 clients. OST provision has seen an increase of 564 sites in Australia since the *Global State* reported in 2014,⁽²⁹⁾ while the number of people receiving OST nationally has nearly doubled - from 1.3 to 2.1 per 1,000 population - since 1998.⁽³⁰⁾ The vast majority (88%) of OST in Australia is dispensed from pharmacies.⁽²⁹⁾ The ratio of clients per OST prescriber, however, decreased from 23 in 2013,⁽³¹⁾ to 19 in 2015.⁽²⁹⁾ Although there has been a scaling-up of OST provision in the country, the cost continues to be extremely prohibitive for people who use opioids, and has yet to be addressed. While the drug is provided free, dispensing fees are charged by participating pharmacies, meaning people who receive doses are charged between AU\$7 and AU\$10 every day.⁽⁴⁾ Similarly to NSP provision, Indigenous people continue to be underrepresented in OST services.⁽³⁾

In New Zealand, current levels of OST provision are unclear, but in 2009 it was estimated that approximately 4,600 people were receiving OST, predominantly in the form of methadone.⁽³²⁾ One of the main barriers to OST uptake is the banning of OST for those who are found to be continuing to use illicit drugs. Urine analysis is commonplace, with people removed from OST treatment if their urine is found to contain illicit drugs.⁽³³⁾ There can also be up to a six-month wait in New Zealand to accessing OST services.⁽³³⁾ However, civil society report that OST is now available through NGO services.⁽¹⁷⁾

Viral hepatitis

Historically, Australia has one of the best examples of harm reduction globally, however, the prevalence of antibodies to hepatitis C virus among people who inject drugs only declined from 60% in 1995 to 53/54% in all years between 2010-2014.⁽¹³⁾ This highlights the need for greater accessibility of hepatitis C treatment for people who use drugs, as well as better coverage of NSPs and other prevention services. High prevalences of lifetime hepatitis C diagnostic screening, ranging from 83% to 88%, were illustrated in a recent study with just over half (54%) of respondents having had a hepatitis C test in the previous 12 months in 2015.⁽²⁰⁾

In March 2016, the Australian government made direct-acting antiviral treatments for hepatitis C available

free of charge without restriction relating to drug use or disease stage – only the second country in the world to do so.⁽³⁴⁾ The availability of these new treatments through the Pharmaceutical Benefits Scheme (PBS) is a significant positive step forwards, and is seen as a potential means to substantially reduce the growing burden of disease and interrupt ongoing transmission.⁽⁴⁾

Findings from a report published in September 2016 indicate that since the new treatments became available in March 2016, an estimated 26,360 people initiated treatment, compared with 7,296 in 2015.⁽¹⁶⁾ However, it is not known what proportion of those accessing these treatments are current or former people who inject drugs.

In New Zealand, the provision for hepatitis C testing and treatment for people who inject drugs remains extremely low. It is clear from the steady rate of hepatitis C among people who inject drugs in the country that an urgent change in treatment provision is necessary.

Tuberculosis (TB)

Tuberculosis (TB) continues to remain extremely low in both Australia and New Zealand, with six cases per 100,000 people in Australia⁽³⁵⁾ and seven cases per 100,000 people in New Zealand.⁽³⁵⁾

Although TB is covered to some extent in harm reduction policies in New Zealand, there is no evidence to suggest it is increasing among people who inject drugs.⁽³³⁾ This finding is echoed in Australia, although there is little information on rates of TB infection among people who inject drugs both in the country and surrounding PICTs.

Antiretroviral therapy (ART)

The prevalence of HIV among people who inject drugs in Australia and New Zealand has remained consistently low (please see Table 2.7.1). However, the proportion of Aboriginal Australians who have acquired HIV through unsafe injecting drug use is 13% higher than among non-Aboriginal people exposed to HIV through injecting drug use.⁽²⁾ Self-testing HIV screening kits are being increasingly used in Australia,⁽³⁶⁾ although more likely among men who have sex with men than among people who inject drugs. While access to HIV testing and treatment is available in the PICTs, it is unclear how many people who inject/use drugs receive treatment.

Harm reduction in prisons

Apart from Australia, data on harm reduction in prisons in the region continues to be scarce. In Australia, drug

offences currently represent the second most common criminal offence, with a 17% increase in sentences for drug offences registered in 2015 alone.⁽³⁷⁾ As a result, people who inject drugs comprise a large proportion of the country's prison population (approximately 50% in 2011)⁽³⁸⁾ and injecting drug use continues to take place in prison settings. A recent study on the prison economy of needles and syringes in New South Wales found that out of 30 prisoners from 12 different prisons, six reported injecting at a frequency of less than monthly, three more frequently than monthly, three more than weekly, three daily and five more than daily.⁽³⁹⁾ The most commonly injected drug is amphetamine, with the most recent national prison entrants' survey showing 59% of prisoners reporting it as the last drug injected.⁽⁴⁰⁾

The region of Australasia[§] has been identified as having the second highest prevalence of HCV in prisons in the world after Asia.⁽⁴¹⁾ In Australian prisons, HCV prevalence has been found to be up to 38%⁽⁴²⁾ whereas HIV prevalence continues to be almost zero.⁽³⁸⁾ While there is very little data on the PICTs, a study undertaken in Fiji looking at a sample of prisoners post-release found that HIV prevalence was 1%, similar to that of the general population.⁽⁴³⁾ Although none of the participants involved in the study reported ever injecting drugs, one-third did not use condoms with casual sex partners, stating that this was due to a lack of availability.⁽⁴³⁾ Condom provision is also reportedly inadequate in prisons in Australia and New Zealand, with varying availability depending on the prison.^(4, 33)

OST, antiretroviral therapy, as well as diagnostics and treatment for HIV, HCV and TB, however, are reported to be available to prisoners in both countries.^(4, 33)

In Australia, OST can be initiated during incarceration if clinically directed, but measures are also in place to ensure continuity of OST for prisoners who were prescribed it prior to incarceration. While there is no data on coverage of OST in prisons at the national level, in the state of New South Wales, which houses one-third of the country's prisoners, coverage has been estimated at 43%.⁽⁴⁴⁾

NSPs are still not available in prisons in New Zealand and Australia, despite high rates of HCV and unsafe injecting reported in the latter.⁽⁴⁾ In Australia, a recent study found that prisoners were paying AU\$100-AU\$150 on average, and up to AU\$350, for one sterile needle/syringe, demonstrating the inherent value of sterile injecting equipment in prisons.⁽³⁹⁾ The study also found that there were far more blood-borne virus risks related to the informal prison needle/syringe economy than there were opportunities to mitigate these risks, and

[§] Australasia, a region of Oceania, is comprised of Australia, New Zealand, the Island of New Guinea and the neighbouring islands in the Pacific Ocean.



concluded that provision of NSPs would greatly reduce the risk of disease transmission, as well as violence between inmates.⁽³⁹⁾ Although the ACT government has committed to an NSP trial at the Alexander Maconochie Centre (AMC) in Canberra, Australia, it continues to meet with fervent opposition from the Community and Public Sector Union (CPSU). Following years of deadlock on this issue, an NSP Working Group was appointed in 2015 and tasked with developing a prison NSP model that could be safely and effectively implemented in the prison.⁽⁴⁵⁾ Unfortunately, the prisons officers union recently rejected the proposed model by majority vote,⁽⁴⁵⁾ and now a new model will be developed and voted on.

Overdose

In Australia, deaths due to accidental overdose grew by 61% between 2004 and 2014, with a 14% rise between 2013 and 2014 alone.⁽⁴⁶⁾ Aboriginal people have been particularly affected by this epidemic, with accidental fatal drug overdoses per capita among this population increasing by 141% between 2004 and 2014 (from 3.9 to 9.4 per 100,000) in the five jurisdictions with Aboriginal data.⁽⁴⁶⁾ In the same time period, an increase of 45% was recorded among non-Aboriginal people.⁽⁴⁶⁾

In 2014, the *Global State* reported the implementation of pilot naloxone programmes for people who use drugs in four states (Australian Capital Territory, Western Australia, Victoria, and New South Wales), with evaluations showing a high degree of success.⁽⁴⁷⁾ Since these pilots, naloxone has been co-scheduled by the Therapeutic Goods Administration (TGA) as a Schedule 3 and 4 drug, meaning it can be accessed without a prescription from a pharmacist, and the introduction of take-home naloxone has occurred in numerous jurisdictions in the country.^(4, 28) Many of the programmes introduced receive government support, however, they are very small scale and there has been little broader uptake by general practitioners and other medical professionals.⁽⁴⁾ An on-going issue, despite the scheduling amendments to naloxone, is the necessity for a prescribing doctor or pharmacist to be involved, especially if clients on health care cards are to receive the drug at cost. Naloxone is available for purchase at a pharmacy but may cost upwards of AU\$40 for a single dose, although for those on a health care card and with a doctor's prescription, the cost is approximately AU\$6.⁽⁴⁾

Australia has a medically supervised injecting centre (also known as a DCR – please see Table 2.7.1), which provides sterile injecting equipment alongside a range of additional services for people who inject drugs. This

service has been found to significantly reduce calls to ambulance-attended opioid-related overdoses in the small area of Sydney where it is located.⁽⁴⁸⁾ However, demands for additional supervised injecting facilities and the introduction of inhalation as an additional route of administration within DCRs have been met with limited to little or no support from the government.⁽⁴⁾

In New Zealand, no overdose prevention programmes exist in the form of naloxone distribution among peers. However, civil society report that this is being discussed as an initiative.⁽¹⁷⁾ At present, overdose is handled through drug helplines and emergency services.⁽³³⁾ In the PICTs, information on overdose and prevention is unknown.

Policy development for harm reduction

Harm reduction has been a key pillar of successive Australian National Drug Strategies for over 20 years. Harm reduction is mentioned within various national policies and strategies including: the Seventh National HIV Strategy 2014-2017;⁽⁴⁹⁾ the Fourth National Hepatitis C Strategy 2014-2017;⁽⁵⁰⁾ the Second National Hepatitis B Strategy 2014-2017;⁽⁵¹⁾ the Fourth National Aboriginal and Torres Strait Islander Blood-Borne Viruses and Sexually Transmissible Infections Strategy 2014-2017;⁽⁵²⁾ and the National Drug Strategy 2010-2015.⁽⁵³⁾ However, it has been observed that Australia's political commitment to harm reduction is waning.^(4, 54) Australia made no reference to harm reduction in their statements at both the United Nations General Assembly Special Session (UNGASS) on drugs or the Commission on Narcotic Drugs (CND) meetings held in April 2016 and March 2016 respectively. New Zealand, however, did endorse harm reduction during their UNGASS statement. Despite previously being a world leader in harm reduction, civil society groups now lament the lack of progress and regression in Australian drug policy.⁽⁴⁾

Civil society and advocacy developments for harm reduction

In Australia, civil society organisations continue to play a key role in the harm reduction response for people who inject and use drugs. In September 2014 the Alcohol and Other Drugs (AOD) Peaks Network was formed, providing a conduit for access to services in all jurisdictions of Australia, including harm reduction services.⁽⁵⁵⁾ Unharm was established in New South

Wales in 2014 to promote safe environments at parties where drugs may be used, and to promote realistic and positive alternatives to the stigmatisation of illicit drug use.⁽⁵⁶⁾ Drug Policy Australia was also established in 2014, to promote new approaches to minimise the health risks and other harms associated with both licit and illicit drugs in the country.⁽⁵⁷⁾

Harm Reduction Australia was set up in late 2015 to represent the concerns of people working in the drug sector or concerned about drug policy in Australia. Harm Reduction Australia focuses solely on advocacy and is self-funded by members.⁽⁴⁾ A National Naloxone Reference Group was established to provide structure and mode of delivery to existing naloxone programmes, map successes in implementation, look into the issues and challenges in implementation, evaluate the programmes, explore opportunities for expansion and engage professionals and community members.⁽⁵⁸⁾

The work of peer-based organisations continues in most jurisdictions, yet too often their funding is under pressure from government budgets that struggle to meet the demand of the sector.⁽⁴⁾ The Australian Injecting and Illicit Drug Users League (AIVL), has played an integral role in ensuring that harm reduction and policy reform issues are heard through their involvement on government committees.⁽⁴⁷⁾ In 2015, AIVL successfully retained its funding after funding threats and continues to conduct research and programming on stigma and discrimination towards people who use drugs.⁽⁵⁹⁾

In 2005, the Pacific Drug and Alcohol Research Network was established and met regularly since its inception, but ceased to operate in 2011.^(9,4) Further research is needed for the development and provision of harm reduction services in the PICTs as the evidence base

for these services has not yet been established. Currently many countries in the PICTs send people to New Zealand or Australia for drug and alcohol harm reduction interventions,⁽⁹⁾ which is an infeasible long-term option that highlights the necessity for further work to be undertaken in this part of the region.

In New Zealand, civil society organisations provide the majority of advocacy activities for people who inject drugs.⁽³³⁾ Two primary organisations in the country are the New Zealand Needle Exchange Program, and the New Zealand Drug Foundation.⁽¹⁷⁾ In the PICTs, although there is a Pacific Drugs and Alcohol Research Network (PDARN), the last meeting was held in August 2011. There has been a small increase in research in these territories, but further data gathering and advocacy should be undertaken regarding harm reduction approaches to drug use, particularly with the increase in ATS.

Funding developments for harm reduction

Financial support for harm reduction in Australia has predominantly been provided by the government. However, funding for harm reduction remains at low levels, estimated to be as low as 2%, when compared to law enforcement, and treatment and prevention of drug budgets.⁽⁴⁾ Funding for harm reduction has not increased over the years, despite the rise in injecting drug use among people who use ATS, and it is likely to be proportionally lower in the future.⁽⁴⁾

In New Zealand, harm reduction activities are government funded, yet similarly to Australia, funding is limited and more is required to scale-up services.⁽¹⁷⁾

Australian government spend on drugs⁽⁶⁰⁾

Policy domain	AU\$ million	Percentage
Prevention	156.8	9.2%
Treatment	361.8	21.3%
Harm Reduction	36.1	2.1%
Law Enforcement	1123.3	66%
Other	23.1	1.4%
TOTAL	1,701.1	100%



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