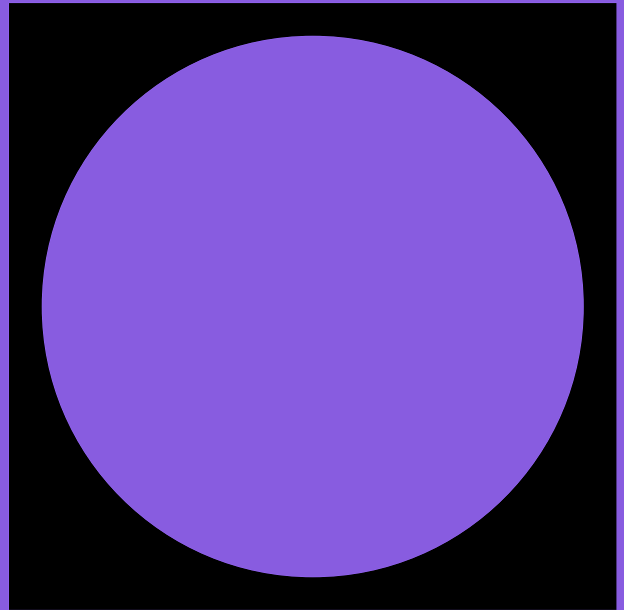
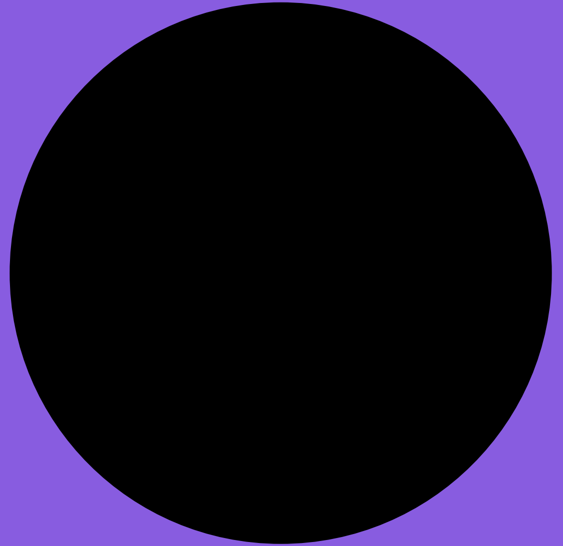
REGIONAL OVERVIEW: OCEANIA





THE GLOBAL STATE
OF HARM REDUCTION 2022

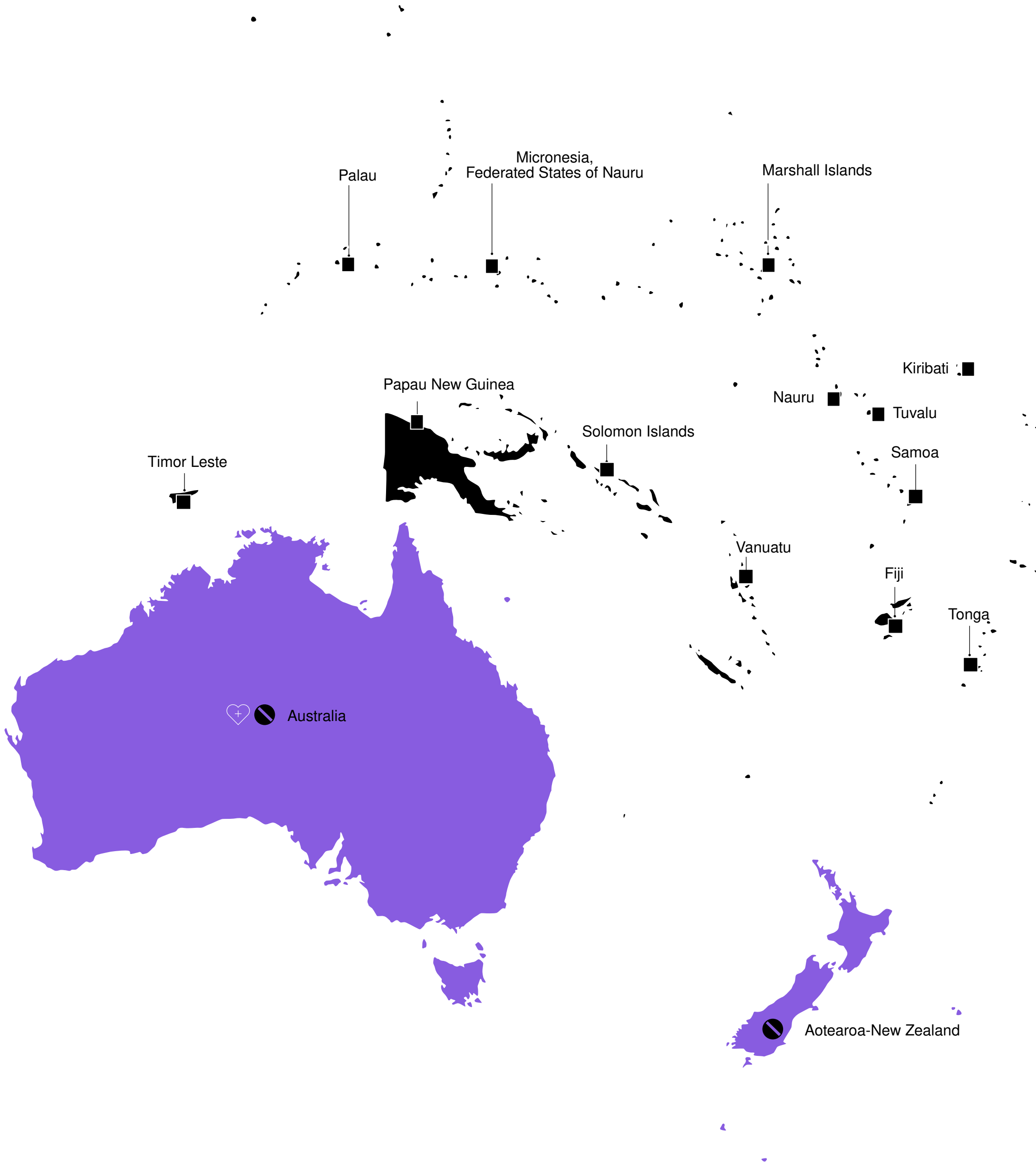
HARM REDUCTION INTERNATIONAL

TABLE 8 EPIDEMIOLOGY OF HIV AND VIRAL HEPATITIS, AND HARM REDUCTION RESPONSES IN OCEANIA

Country/territory	People who inject drugs[a]	HIV prevalence among people who inject drugs (%)[a]	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)[a]	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)[a]	Harm reduction responses[b]				
					NSP[c]	OAT[d]	Peer distribution of naloxone[e]	DCR[f]	Safer smoking equipment[g]
Aotearoa-New Zealand	22,500	0.1	71	2.8	✓ >200[2]	✓ M B[3]	✓[3]	✗	✗
Australia	98,500	1.3	53	3.9	✓ 4,218[4]	✓ M B[5]	✓	✓ 2	✗
Federated States of Micronesia	nd	nd	nd	nd	✗	✗	✗	✗	✗
Fiji	nd	nd	nd	nd	✗	✗	✗	✗	✗
Kiribati	nd	nd	nd	nd	✗	✗	✗	✗	✗
Marshall Islands	nd	nd	nd	nd	✗	✗	✗	✗	✗
Nauru	nd	nd	nd	nd	✗	✗	✗	✗	✗
Palau	nd	nd	nd	nd	✗	✗	✗	✗	✗
Papua New Guinea	nd	nd	nd	nd	✗	✗	✗	✗	✗
Samoa	nd	nd	nd	nd	✗	✗	✗	✗	✗
Solomon Islands	nd	nd	nd	nd	✗	✗	✗	✗	✗
Timor Leste	<500	nd	nd	nd	✗	✗	✗	✗	✗
Tonga	nd	nd	nd	nd	✗	✗	✗	✗	✗
Tuvalu	nd	nd	nd	nd	✗	✗	✗	✗	✗
Vanuatu	nd	nd	nd	nd	✗	✗	✗	✗	✗

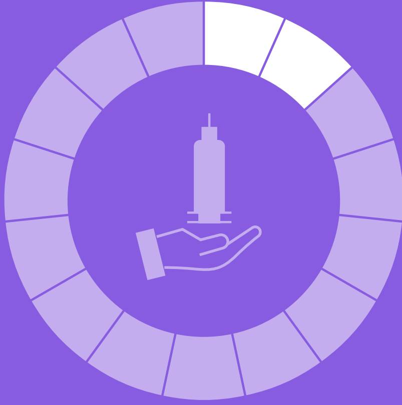
a Unless otherwise stated, data is from Degenhardt et al (under review).[1]
b Data sourced in Global State of Harm Reduction survey responses, unless otherwise stated.
c At least one needle and syringe programme operational in the country or territory, and the number of programmes (where data is available)
d At least one opioid agonist therapy programme operational in the country or territory, and the medications available for therapy. B=buprenorphine, M=methadone.
e At least one naloxone distribution programme that engages people who use drugs (peers) in the distribution of naloxone and naloxone training, and facilitates secondary distribution of naloxone between peers.
f At least one drug consumption room (also known as safe consumption sites among other names) operational in the country or territory, and the number of facilities.
g At least one programme in the country or territory distributing safer smoking equipment to people who use drugs.

AVAILABILITY OF HARM REDUCTION SERVICES

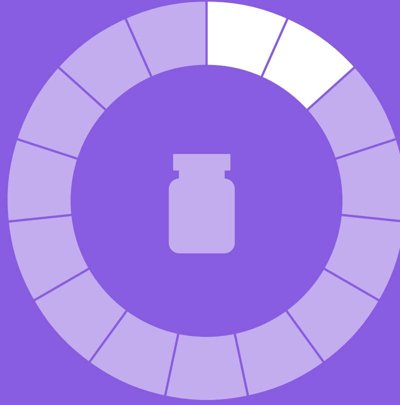


- Both NSP and OAT available
- OAT only
- NSP only
- Neither available
- Not known
- Peer-distribution of naloxone
- DCR available

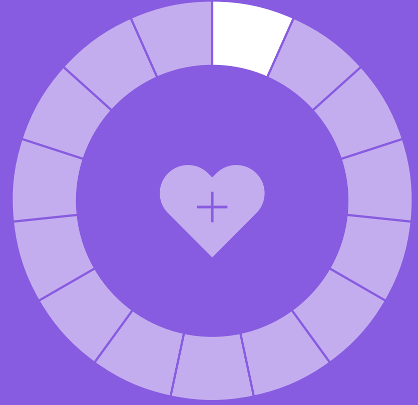
NSPs, OAT AND DCRs SINCE 2020



2 countries (13%) in Oceania provide **needle and syringe programmes** (no change from 2020)

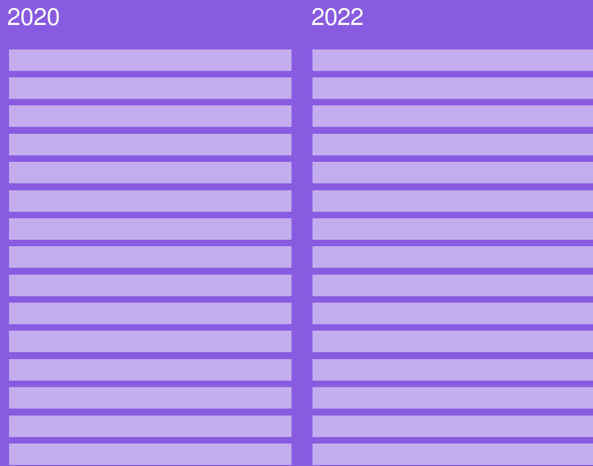


2 countries (13%) in Oceania provide **opioid agonist therapy** (no change from 2020)

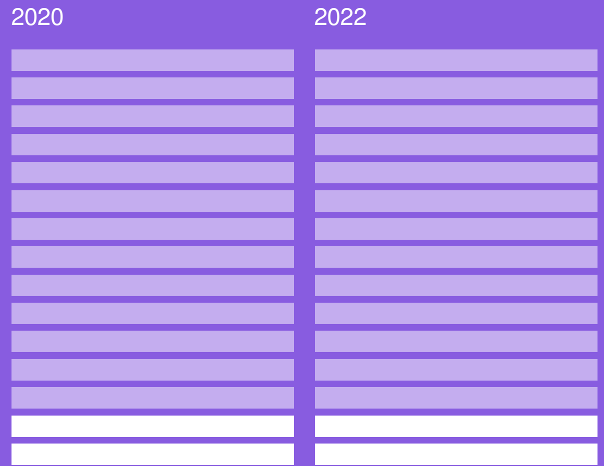


1 country (7%) in Oceania provides **drug consumptions rooms** (no change from 2020)

HARM REDUCTION IN PRISONS



No country in Oceania provides **needle and syringe programmes** in prisons (no change from 2020)



2 countries in Oceania provide **opioid agonist therapy** in prisons (no change from 2020)

MĀORI PEOPLE AND ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE FACE A DISPROPORTIONATE BURDEN OF DRUG-RELATED HARMS

REGIONAL OVERVIEW

AUTHORS:
MICHALA KOWALSKI

INTRODUCTION

There have been a few major developments in harm reduction in Oceania since 2020. In Aotearoa-New Zealand, the government formalised drug checking services and supported the roll out of take-home naloxone. Both Aotearoa-New Zealand and Australia expanded distribution of safer injecting equipment and naloxone via postal services. The COVID-19 pandemic continued to have an impact, notably creating a window of opportunity to advance harm reduction priorities long advocated for by people who use drugs and harm reduction networks. The COVID-19 pandemic disrupted and restricted access to existing services in some cases.[6,7] In Australia, this appears to have stabilised by 2021, with 80% of needle and syringe programme (NSP) clients surveyed reporting that their access to safe injecting equipment was unchanged from early 2020.[8] In 2021, uptake of COVID-19 vaccination among people who inject drugs in Australia was significantly lower than uptake among other people. Research found that women who inject drugs and people who reported daily or more frequent injection were significantly less likely to be vaccinated.[9]

DATA

Data availability in the region remains mixed. In the Pacific Islands Countries and Territories of the Federated States of Micronesia, Fiji, Kiribati, Marshall Islands, Papua New Guinea, Samoa, Solomon Islands, Timor Leste, the Kingdom of Tonga, and Vanuatu, data remains poor.[10,11] Governments do not release reliable numbers regarding population sizes of people who use drugs and injecting behaviours, and there is no indication that any types of formal harm reduction programmes exist in these countries.[11]

Currently, there is an HIV epidemic in Papua New Guinea,[12] and viral hepatitis prevalence is high in Papua New Guinea, Fiji and Kiribati[13], although injecting drug use is not indicated as a factor in either epidemic.[12–14] There are also reports of growing methamphetamine use in the Kingdom of Tonga and Marshall Islands, partly as a result of drug trafficking routes passing through the region.[15,16] Despite this being an indication that providing safer smoking equipment may be necessary, no such programmes exist. The Joint United Nations Programme on HIV/AIDS (UNAIDS)' *Unified Budget, Results and Accountability Framework workplan for 2022 to 2023* includes provision for funding harm reduction programmes in Fiji.[17]

Data from Aotearoa-New Zealand and Australia is better, with reliable estimates of the prevalence of injecting drug use,[18] prevalence of HIV and hepatitis in people who inject drugs,[6,19,20] and the implementation of both formal and informal harm reduction programmes.

DRUG CHECKING

In 2022, Aotearoa-New Zealand made its informal drug checking services an official programme.[21] New legislation has enabled the licensing of four drug checking programmes, including a mix of mobile

and fixed sites, in Auckland, Christchurch, Dunedin and Wellington.[7] Australia's first fixed site drug checking service opened its doors on 18 July 2022 in Canberra.[22] It is currently operating as a six-month pilot[22] (for more information, please see the thematic section on formalising drug checking in the region).

COVID-19

In Aotearoa-New Zealand, take-home naloxone was rolled out for the first time following COVID-19-related lockdowns, provided onsite at harm reduction services.[7,23] As changes were made to the provision of OAT programmes to enable more flexibility, including take-home doses, some OAT service providers had concerns that clients might be at greater risk of overdose.[7] To reduce this risk, the federal government enabled OAT service providers to provide naloxone with take-home OAT doses (i.e. multi-day doses, where clients self-administer).[7] At their discretion, select service providers made naloxone and needle and syringe services available to peer networks to disperse to clients.[7] At present, the provision of naloxone in Aotearoa-New Zealand remains ad hoc, and it is unclear if or when it will be formalised.[7,24,25]

Following a process that began before the COVID-19 pandemic, in July 2022 the Australian government began the roll out a four-year programme of take-home naloxone across the country.[26] Through this new model, currently operational in participating pharmacies, naloxone will be available free of charge without a prescription and dispersed through peer networks, community and hospital-based pharmacies, alcohol and drug treatment centres, NSPs and custodial release programmes.[26] This programme formalises and expands on the pilot take-home naloxone programme the Australian government operated from December 2019 to June 2022 in three states (New South Wales, South Australia and Western Australia).[27]

Since 2020, in response to the COVID-19 pandemic, OAT delivery in both Aotearoa-New Zealand and Australia has placed greater emphasis on reduced in-person supervision, which has resulted in an increase in take-home doses.[7,28] But this has not been rolled out as a uniform measure, and in Australia many clients are back on supervised daily dosing regimens.[29] In Aotearoa-New Zealand, a few select clients who have been 'deemed stable' by their OAT service providers have been able to continue with take-home OAT, reducing the burden of supervision.[7] Another change to the delivery of OAT in Australia is an increase in the prescription of depot buprenorphine[28] (a long-acting injectable formulation of buprenorphine[30]), especially within the prison system.[29] Long-acting injectables can provide people in community settings with more flexibility in their lives, as it removes the logistical burden of attending a clinic for daily dosing and the constant reminder that they are on OAT.[29] However, some harm reduction advocates are concerned that this model of care is over-developed in Australia's prisons and under-developed in community settings.[29] This mismatch between the model of OAT provided in prison and the model of OAT provided in the community has led to a situation in which people are struggling to find a doctor to continue prescribing long-acting injectables upon release from prison.[29] There is limited information available on the choices offered, practices associated with prescribing long-acting buprenorphine to people in prison, and the preferences of people in prison. Broadly, there is a shortage of OAT prescribers, which affects accessibility throughout Australia.[31]

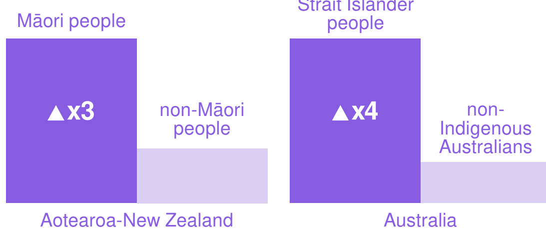
"In July 2022, the Australian government began the roll out a four-year programme of take-home naloxone across the country. Through this new model, currently operational in participating pharmacies, naloxone will be available free of charge without a prescription and dispersed through peer networks, community and hospital-based pharmacies, alcohol and drug treatment centres, NSPs and custodial release programmes."

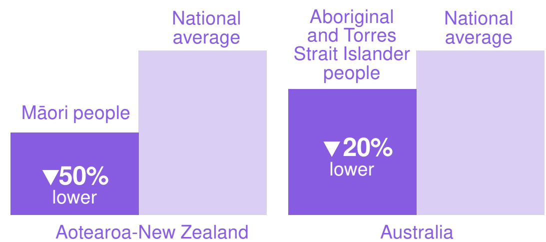
INEQUITABLE OUTCOMES

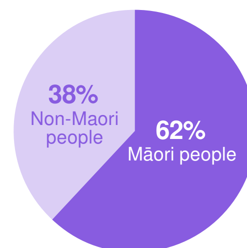
Inequitable outcomes of current drug policies and drug use are pervasive in Aotearoa-New Zealand and Australia. Despite longstanding government recognition of the disproportionate burden of drug-related harms faced by Māori people in Aotearoa-New Zealand[32] and Aboriginal and Torres Strait Islander peoples in Australia[33], very little has changed since 2020. This disparity in outcomes includes:

- **Drug-related deaths:** Māori people are three times more likely to die from drug use than non-Māori people in Aotearoa-New Zealand,[34] and Indigenous Australians are four times more likely to die from drug use than non-Indigenous Australians.[35]
- **COVID-19 vaccination rates:** Māori people receiving services for drugs or alcohol had a vaccination rate that was half the national average in 2021,[34] for and the Aboriginal and Torres Strait Islander people vaccination rate was 20-30% lower than the national average vaccination rate in Australia in 2021.[36]
- **Higher and rising hepatitis C prevalence** among Aboriginal and Torres Strait Islander people in Australia; whereas hepatitis C prevalence is dropping among the general population.[37]
- **Incarceration rates:** 62% of people sentenced to prison on drug possession offences were Māori,[34] and Aboriginal and Torres Strait Islander people's rate of imprisonment is 13.3 times higher than the non-Indigenous imprisonment rate in Australia.[38]

Data indicates that, in practice, Aboriginal and Torres Strait Islander peoples[39] and Māori people[40] have been excluded from the benefits of drug law reforms that granted police discretionary powers over whether to press charges for possession of cannabis in Australia and Aotearoa-New Zealand. Culturally safe and appropriate harm reduction services are needed for Aboriginal and Torres Strait Islander people in Australia,[41] and Māori people in Aotearoa-New Zealand.[25,34] Advocates have called for extensive drug law reforms that are inclusive of Indigenous communities.[34,42,43]







POLICY DEVELOPMENTS

There have been small gains in drug law reform in Australia since 2020. In the Australian Capital Territory (ACT), cannabis was decriminalised (sometimes referred to as 'limited legalisation') for personal use, possession and minimal domestic cultivation in January 2020.[31,44] On 9 June 2022, in response to a parliamentary inquiry, the ACT government endorsed a private member's bill to decriminalise possession and use of small amounts of amphetamine, cannabis, cocaine, heroin, LSD, MDMA, methamphetamine and psilocybin.[45] The bill was passed in October 2022 and will come into effect in October 2023.

Setbacks include defeat in a referendum on cannabis legalisation in Aotearoa-New Zealand in 2020.[46] In Australia, the private insurance company that provided public liability insurance for on-site drug checking at festivals in ACT rescinded its coverage in April 2022.[47]

LOOKING AHEAD

There are three processes underway in the region that are likely to have an effect on harm reduction and drug policy. In Aotearoa-New Zealand, the harm reduction community is awaiting the full findings of the review of the 2019 changes to the Misuse of Drugs Act,[48] which were expected to be released in August 2021.[49] In Australia, advocates await the Department of Health's review of opiate dependence medicines, which includes an examination of the barriers to access and future models of care.[50] In New South Wales, Australia's most populous state, the government is yet to respond to the Special Commission of Inquiry into the Drug 'Ice' (methamphetamine).[51] In January 2020, the commission made 109 recommendations, including the decriminalisation of all drugs, the establishment of additional DCRs that include smoking facilities, and removing prohibitions on access to these facilities for young people and pregnant people.[52]

Current priorities for harm reduction advocacy in Aotearoa-New Zealand and Australia include decriminalisation and law reform,[24,24,41,53–55] roll out of naloxone in Aotearoa-New Zealand,[7] broader and more equitable NSP coverage,[25] including in prisons,[53] increasing access to healthcare for people who use drugs,[24,25,55] expanding drug checking services[7,55] and reforming OAT services,[41,56] including injectable OAT and the removal of dispensing fees.[7]

SPOTLIGHT

DRUG CHECKING IN AOTEAROA-NEW ZEALAND

Aotearoa-New Zealand started on the path to formalising drug checking in 2020.[57] This process has formalised services that have been in existence since 2015, when providers began offering informal drug checking services at festivals without legal backing.[58] While a licensing scheme was developed, the country's Director-General of Health was empowered to appoint drug checking service providers on a temporary basis.[57] The formal licensing scheme was introduced in April 2022.[21] Licence terms are for a maximum of three years, and includes stipulation about approved testing methods.[57] To date, four organisations hold licenses to deliver drug checking programmes.[57] These are KnowYourStuffNZ, NZ Drug Foundation, New Zealand Needle Exchange Programme (NZNEP) and the Institute of Environmental Science and Research (EST).[57] These programmes include on site services,[7,24,25] fixed site services,[7,24,25] pop up clinics,[7] mobile services,[24] and a mail-in service for cannabis.[25] Services are funded by the government[7,24] and delivered by community-led organisations.[7,24,25] Peers are meaningfully involved in planning and implementing services.[7,24,25]

However, the programme is still in its infancy,[25] and coverage is insufficient. Most people who need a drug checking programme do not have access to one.[7,24,25] The COVID-19 pandemic response restricted services' ability to run drug checking and had a negative impact on the provision of harm reduction.[7] Moreover, equipment is limited.[24] At the time of writing, there are only four FT-IR spectrometers available for drug checking in Aotearoa-New Zealand.[7] Services are generally available at festivals or in the community on a time limited basis; for example, for three hours on a Tuesday night at a specific location.[7] Service availability is also limited outside of cities.[24] The service is also yet to garner widespread support from the general population.[25]

Organisation	Equipment	Model of Service
KnowYourStuffNZ	Reagents and FT-IR Spectroscopy[58]	On site and fixed site clinics
NZ Drug Foundation	Reagents and FT-IR Spectroscopy[61]	Pop up clinics and fixed site clinics[60]
NZNEP	Reagents and FT-IR Spectroscopy[60]	Fixed site clinics[60]
ESR	Forensic lab	Fixed site confir-matory testing[57,60,62]

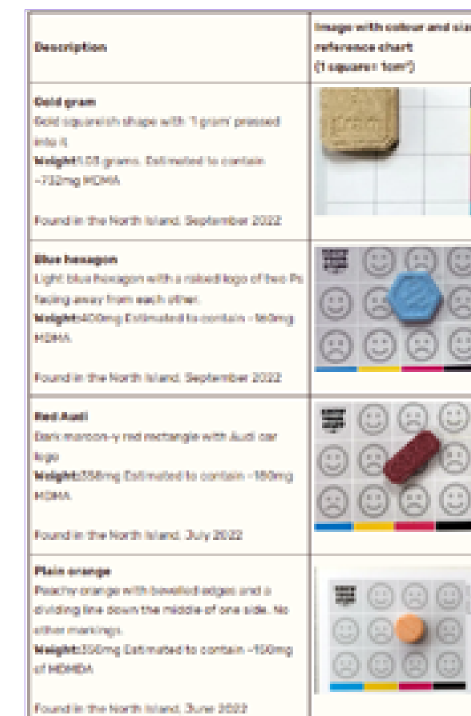
Harm reduction services are currently advocating for drug checking to be made permanently available at community-based outlets, in a similar manner to the local NSPs.[7] Ideally, these services will be located with needle and syringe provider outlets.[7] Drug checking services advertise that drugs, such as MDMA, ketamine, cocaine, methamphetamine, LSD, pharmaceuticals, supplements and other drugs used to enhance performance or image, can all be checked with current processes.[63] Services have also released results from testing during the summer of 2020/2021 to raise awareness among people who use drugs of the true contents of substances sold as MDMA.[63]

In Australia, formal drug checking programmes have operated on a provisional basis. Two on-site drug checking pilots ran in 2018 and 2019,[64] and the ACT government is currently trialling a six-month, fixed-site drug checking service.[22] This service is located within an established harm reduction needle and syringe provider outlet.[29] Results released from the first month of testing indicate that the service has tested samples of ketamine, MDMA, heroin, methamphetamine, cocaine, MDA (3,4-methylenedioxyamphetamine) and a range of psychedelics.[65] All three drug checking pilots have been peer-led, with peer groups working together as part of a consortium of specialists on both the design and implementation of the services.[29]

However, the Australian path to formalisation faced some setbacks in 2022. A third on-site drug checking pilot was cancelled at the last minute in April after a private insurance company rescinded public liability insurance for the service.[47] There is concern among advocates and providers that the insurer's decision will have implications for other drug checking pilots that are in development.[29,66] Of note is the fact that restrictions introduced to mitigate the spread of COVID-19 resulted in the suspension of the festival season for two years. This meant that effective advocacy windows to call for more extensive roll-outs of drug checking services were limited in 2020 and 2021.[67]

While people who use drugs, advocates, harm reduction organisations and specialists wait for legislative change in Australia, many harm reduction services engage with bottom-up, peer-led strategies to provide (informal) drug checking.[55] As drug checking equipment is legal in Australia, this bottom-up approach involves the distribution of reagent testing kits and fentanyl testing kits at multiple harm reduction service outlets.[55,68] But this operating model does not ensure accurate interpretation of results,[55,68] and the approach to distribution does not necessarily ensure a person receives tailored information and advice. However, these approaches do respond to the significant demand for formalised drug checking services[55,68] and may pave the way for these services to be formal recognised in the future.

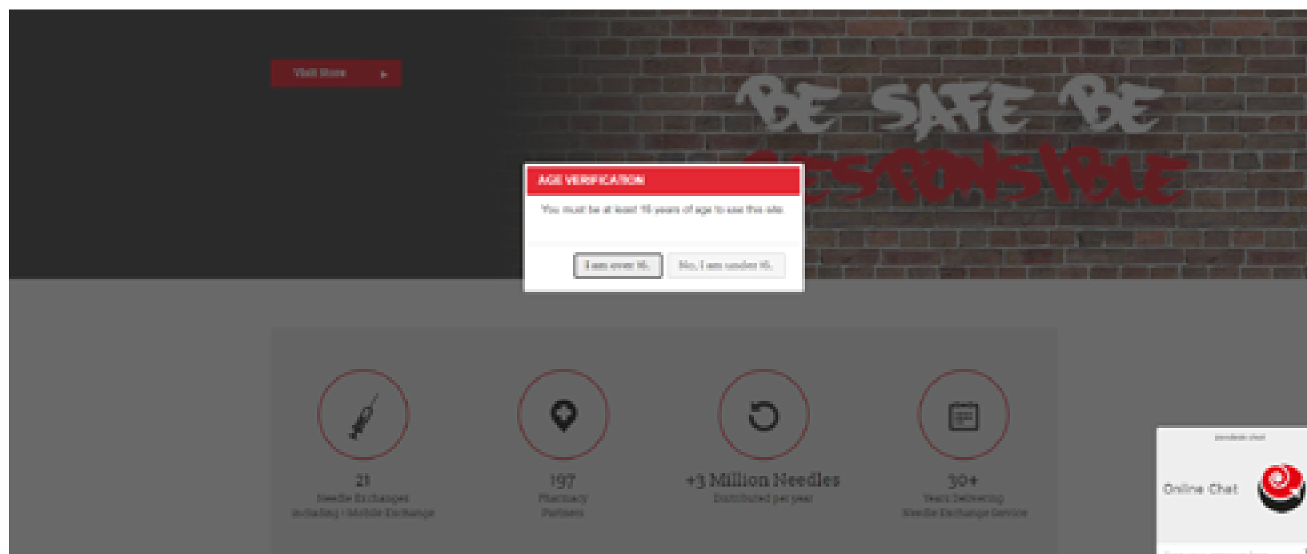
Alongside formal and informal drug checking services in Aotearoa-New Zealand and Australia, harm reduction services[69] and government health departments[70,71] in both countries have established early warning systems for drugs.[24,66] These systems are able to send out alerts and notifications about both dangerous adulterants (substances that are added to drugs) and the potency of drugs that are currently in circulation. These early warning systems demonstrate the potential reach of drug checking services that go beyond their individual clients[72] to reduce potential harms for the broader community.

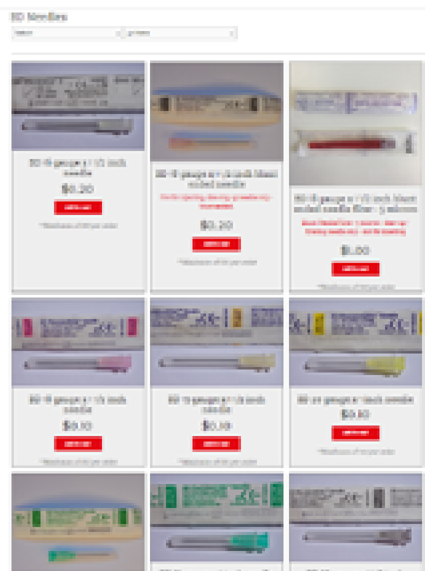


Description	Image with colour and size reference chart (1 square = 1cm²)
Gold gram Gold squareish shape with '1 gram' pressed into it. **Weight:** 1.05 grams. Estimated to contain ~732mg MDMA. Found in the North Island, September 2022	
Blue hexagon Light blue hexagon with a raised logo of two Ps facing away from each other. **Weight:** 400mg. Estimated to contain ~160mg MDMA. Found in the North Island, September 2022	
Red Audi Dark maroon-y red rectangle with Audi car logo. **Weight:** 358mg. Estimated to contain ~180mg MDMA. Found in the North Island, July 2022	
Plain orange Peachy orange with bevelled edges and a dividing line down the middle of one side. No other markings. **Weight:** 350mg. Estimated to contain ~100mg of MDMDA. Found in the North Island, June 2022	

SPOTLIGHT

ONLINE HARM REDUCTION IN OCEANIA





The COVID-19 pandemic created an opportunity for increased digitisation of harm reduction services in Aotearoa-New Zealand and Australia. Peer-led harm reduction organisations[73–75] responded rapidly to lockdowns by turning to online delivery of education[41,73,76] and distribution of sterile injecting equipment via post.[7,41,76] Equipment was mailed to clients via post, including provisions for safe disposal of used equipment.[76] Not only did this pivot to remote distribution of services increase accessibility for clients during COVID-19 restrictions in general,[7] it improved accessibility to harm reduction for rural and remote clients and people who inject drugs other than opioids,[7] and removed some of the points of friction that clients routinely experience while accessing safe injecting equipment (such as travel distance and time commitments).[54,76]

Both Aotearoa-New Zealand and Australia introduced strict lockdown conditions in response to the COVID-19 pandemic in March 2020[77,78] and phased through alternating levels of restrictions throughout 2021.[78,79] Restrictions on mobility and gatherings were lifted in Aotearoa-New Zealand and Australia at the end of 2021.[78,79] Although needle and syringe providers were classified as an essential health service,[25] some outlets restricted their hours of operation.[7] A small number of pharmacy outlets withdrew from the New Zealand Needle Exchange Programme, citing the extra demands placed on them by lockdowns and vaccination programmes.[7] In Australia, 12% of respondents to the 2020 Australian Needle Syringe Program Survey reported that it was more difficult to access equipment during the COVID-19 pandemic.[6]

Notwithstanding the disruption caused by the COVID-19 pandemic, NSP coverage in Australia is classified as high, and NSP coverage in Aotearoa-New Zealand is classified as moderate, according to World Health Organization standards.[18,80] Civil society organisations report that coverage is relatively good in the major cities during daytime hours.[24,29] However, both countries have gaps in NSP coverage in regional and rural areas,[24,29] and after-hours in the cities.[29] Clients resort to filling these gaps with bottom-up strategies, including reusing equipment[54] and sharing equipment, both of which present a greater risk of health harms.[6] The 2020 Australian Needle Syringe Program Survey found that one in six (16%) respondents had shared someone else's injecting equipment in the last month.[6]

At times, the ways NSPs operate in Aotearoa-New Zealand and Australia can be cumbersome and stigmatising. Some services require people to return used equipment to access new equipment.[54] This requirement creates a logistical challenge for some,[54] and increases people's chances of being detected by law enforcement.[29] Clients report that they avoid using after-hours NSPs based in hospitals due to experiencing stigmatising encounters at these services.[29] People have also reported avoiding NSP outlets that are located in OAT sites in both Aotearoa-New Zealand and Australia.[7,29] This is because some OAT programmes take a punitive approach to clients injecting their OAT.[7] According to reports from Aotearoa-New Zealand, clients who are found to be injecting OAT are forced to attend supervised dosing (instead of continuing with take-away doses).[7] Providing these services digitally and by post can overcome these barriers.

As entire sectors transitioned to working online, peer-led harm reduction organisations enhanced their websites[41] and built online shops.[7] Online service integration and distribution models of services differ from one organisation to the next. Some services offer online education, take-home naloxone and sterile injecting equipment free of charge.[73] Others charge a small fee to access sterile injecting equipment.[74,75] Order processing and shipping can take a few days,[73] meaning that this model of access is not on-demand. Civil society organisations report that clients' responses to their online service have been positive.[7]

While the pivot to digitised delivery of harm reduction services has increased accessibility for some people,[7,41,76] it has made services less accessible for others.[7] One concern is that online services will result in clients having fewer points of contact with harm reduction service providers. According to the 2021 *National Data Report on the Needle Syringe Program National Minimum Data Collection*, two in five service interactions at primary NSP outlets involved the provision of health education.[18] One in ten service interactions involved a referral to other harm reduction and healthcare services, either within the service or to an external provider.[18] There may be a need for increased integration of the services that are available online to provide a digital equivalent to the 'no-wrong door' policy that organisations are trying to implement in the physical environment.

To date, the digitisation of some harm reduction services in Aotearoa-New Zealand and Australia has continued, despite the lifting of COVID-19-related restrictions. Peer-led harm reduction organisations have led the way, developing innovative models to provide education, naloxone and safe injecting equipment to clients. The digitisation of services has had a positive effect on the provision of harm reduction; increasing access to services for those located in regional and rural areas, while reducing the barriers people who use drugs face when trying to access harm reduction services.

1 Degenhardt L, Webb P, Colledge-Frisby S, Ireland J, Wheeler A, Ottaviano S, et al. (under review), 'A global systematic review of the epidemiology of people who inject drugs: Prevalence, sociodemographic characteristics, risk environments and injecting-related harm, *Lancet Glob Health*.
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5. Australian Institute of Health and Welfare (2022), *National Opioid Pharmacotherapy Statistics Annual Data Collection*.
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