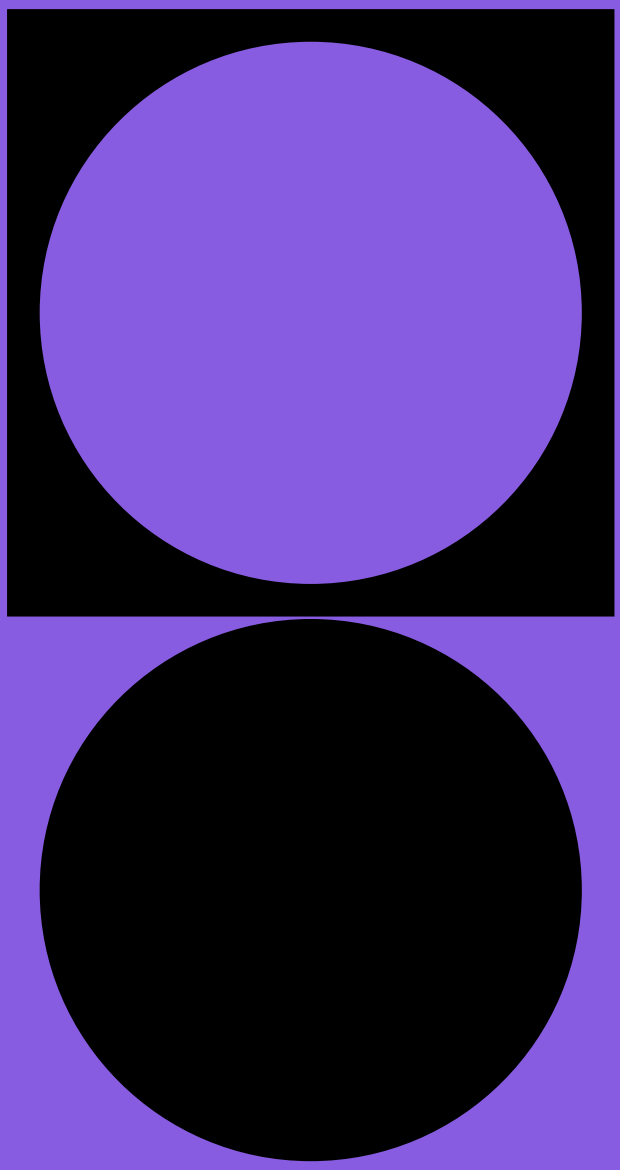
REGIONAL OVERVIEW: OCEANIA



THE GLOBAL STATE
OF HARM REDUCTION 2024

HARM REDUCTION INTERNATIONAL

AUTHOR OF OCEANIA REGIONAL OVERVIEW: **John Gobeil**

John Gobeil is the CEO of the Australian Injecting and Illicit Drug Users League (AVIL), the national peak organisation focused on advancing the health and human rights of people with living or lived experience of drug use. They have worked in several frontline and leadership roles for renowned community-led organisations through the years, as well as many local drop-in centres, successfully improving programming and service delivery for the community, building organisational capacity and increasing sustainability. John draws from personal lived and living experience of discrimination, marginalisation and stigma as a neurodivergent LGBTQI+, people who use drugs peer and CALD (culturally and linguistically diverse person) migrant.

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

Country/territory	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 responses				
					NSP[a]	OAT[b]	Peer distribution of naloxone[c]	DCR[d]	Safer smoking equipment[e]
Aotearoa New Zealand	nd[f]	0.1	53	2.8	✓ 227	✓ M B N	✓	×	×
Australia	98,500[g]	2.1	32	2.2	✓ 4442	✓ M B N	✓	✓ 2	×
Federated States of Micronesia	nd	nd	nd	nd	nd	nd	nd	nd	nd
Fiji	nd	nd	nd	nd	nd	nd	nd	nd	nd
Kiribati	nd	nd	nd	nd	nd	nd	nd	nd	nd
Marshall Islands	nd	nd	nd	nd	nd	nd	nd	nd	nd
Nauru	nd	nd	nd	nd	nd	nd	nd	nd	nd
Palau	nd	nd	nd	nd	nd	nd	nd	nd	nd
Papua New Guinea	nd	nd	nd	nd	nd	nd	nd	nd	nd
Samoa	nd	nd	nd	nd	nd	nd	nd	nd	nd
Solomon Islands	nd	nd	nd	nd	nd	nd	nd	nd	nd
Timor Leste	nd	nd	nd	nd	nd	nd	nd	nd	nd
Tonga	nd	nd	nd	nd	nd	nd	nd	nd	nd
Tuvalu	nd	nd	nd	nd	nd	nd	nd	nd	nd
Vanuatu	nd	nd	nd	nd	nd	nd	nd	nd	nd

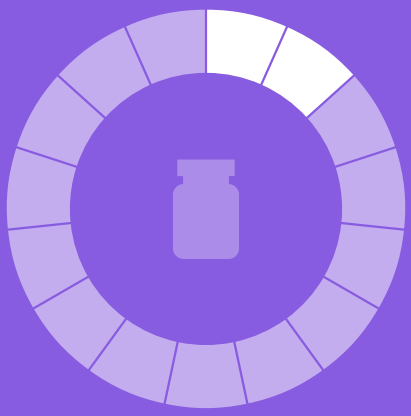
a At least one needle and syringe programme operational in the country or territory, and the number of programmes (where data is available).
b At least one opioid agonist therapy programme operational in the country or territory, and the medications available for therapy. B=buprenorphine, H=heroin, M=methadone, N=Naloxone.
c 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.
d At least one drug consumption room (DCR) (also known as safe consumption sites among other names) operational in the country or territory, and the number of facilities.
e At least one programme in the country or territory distributing safer smoking equipment to people who use drugs.
f nd = no data
g Civil society actors believe this to be an underestimate.

AVAILABILITY OF HARM REDUCTION SERVICES

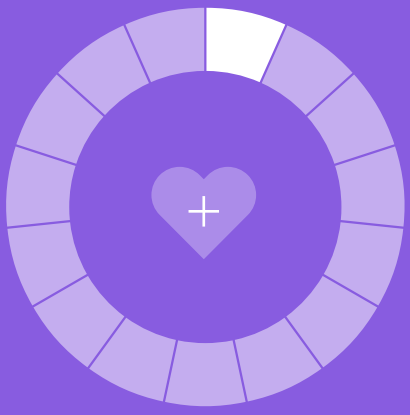
- Both NSP and OAT available
- OAT only
- NSP only
- Neither available
- Not known
- Peer-distribution of naloxone
- DCR available

NSP, OAT, DCRs AND SAFER SMOKING KITS

2 countries (13.33%) in Oceania provide **needle and syringe programmes** (no change from 2022)



2 countries (13.33%) in Oceania provide **opioid agonist therapy** (no change from 2022)



1 country in Oceania provides **drug consumptions rooms** (no change from 2022)

There is no country in Oceania that provides **safer smoking kits**

KEY ISSUE

DIVERSE LANDSCAPE, CONSISTENT CRIMINALISATION

The Oceania region comprises a combination of high-and low-income countries such as Australia, Aotearoa New Zealand, Fiji, Papua New Guinea and Tonga.

Although many countries in the region are small, each country has unique cultural, linguistic, political and social landscapes, alongside differing histories, locations and economic development,[1,2] which impact the availability and use of drugs in each context. However, all countries in Oceania criminalise and stigmatise people who use drugs.

Countries in the region show variable commitments to harm reduction. Australia and Aotearoa New Zealand are recognised for pioneering the implementation of harm reduction and HIV prevention services for people who use drugs. There is a relatively good understanding of the ways drugs are used in both countries, and national needle and syringe programmes (NSP) have been implemented in Australia and Aotearoa New Zealand since 1986 and 1988, respectively.[3,4]

Far less is known about drug use in many other Oceania countries. In the last decade, the increase in drug trafficking routes between Asia and the

Americas to Australia and Aotearoa New Zealand has resulted in an increase in drug seizures, including cocaine, ketamine and methamphetamine, and the availability and use of these drugs in countries such as Papua New Guinea and Fiji.[5,6] However, information and data relating to patterns of drug use and the availability of harm reduction in these countries is limited, and there is little demonstrated commitment to implementing health, human rights and harm reduction policies and services for people who use drugs.[7]

While Australia and Aotearoa New Zealand are recognised as harm reduction leaders, no country in the region has legalised or decriminalised drug use entirely. The only place in Oceania where some decriminalisation has happened is the Australian Capital Territory, which decriminalised small amounts of drugs for personal use in October 2023.[a,8]

Due in part to consistent criminalisation, social and systemic stigma and discrimination against people who use drugs is rampant.[9] People who use drugs continue to be harmed by laws and regulations, and even the agencies that are designed to protect them.[10,11] This inequitable treatment has prevented policymakers and governments across the region from prioritising and developing lifesaving harm reduction interventions, especially those that are peer-led.[12,13]

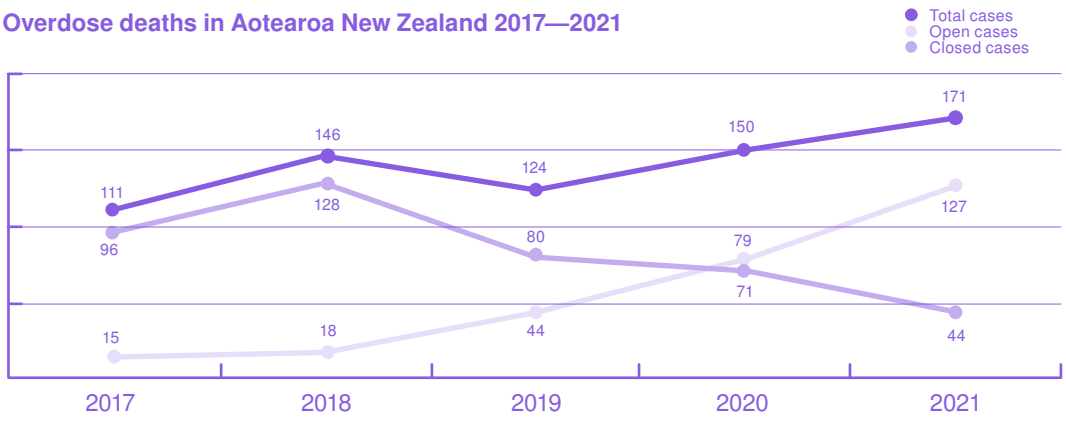
Even in Australia and Aotearoa New Zealand, investment and support for harm reduction is declining.

a Amounts that are decriminalised for use are limited to 1.5g of methamphetamine, 1.5g of MDMA, 1.5g of cocaine, 1g of heroin, 1.5g of psilocybin (dry or wet), 0.001g of LSD, 50g of dried cannabis and 150g of wet cannabis.

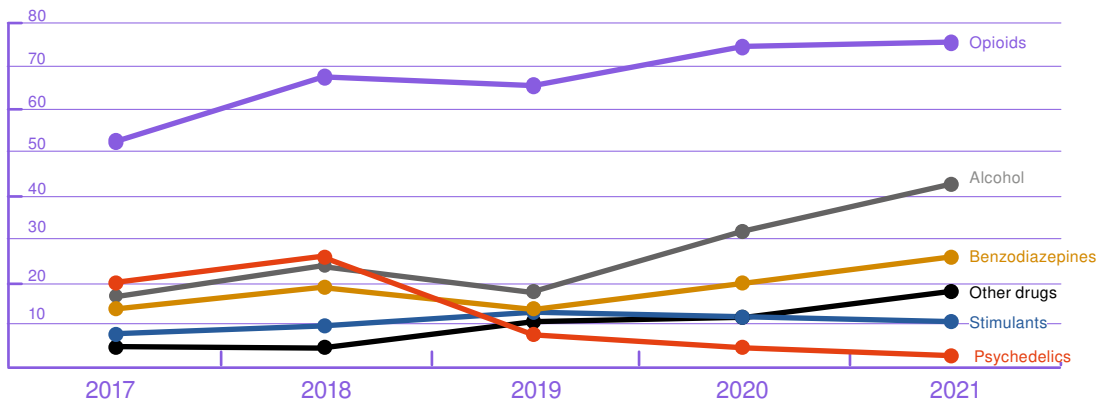
In Australia, funding for harm reduction has decreased over time compared to funding to address drug supply and demand reduction.[14]

In both countries, drug-related overdoses increase each year, and more people than ever are dying every day from overdoses.[15] In Aotearoa New Zealand, the most recent coronial data identified 702 overdose deaths between 2017 and 2021. Across this five-year period, cases rose by 54%. In comparison, the population of people who use drugs increased by just 6%.[16,17] Recent data from Australia also shows an alarming increase in the number of drug-related deaths, with 2,356 deaths reported in 2022; 79 more than in 2021.[18,19] The impacts of criminalisation, aggressive law enforcement and related stigmatisation prevents people who use drugs from accessing essential services and seeking help, resulting in preventable illnesses and deaths, while drug laws, regulations and the lack of resources hinder the delivery of crucial peer-based harm reduction services and support.[20,21]

Overdose deaths in Aotearoa New Zealand 2017—2021



Overdose deaths in Aotearoa New Zealand by substance 2017—2021



“Due in part to consistent criminalisation, social and systemic stigma and discrimination against people who use drugs is rampant. People who use drugs continue to be harmed by laws and regulations, and even the agencies that are designed to protect them. This inequitable treatment has prevented policymakers and governments across the region from prioritising and developing lifesaving harm reduction interventions, especially peer-led harm reduction.”

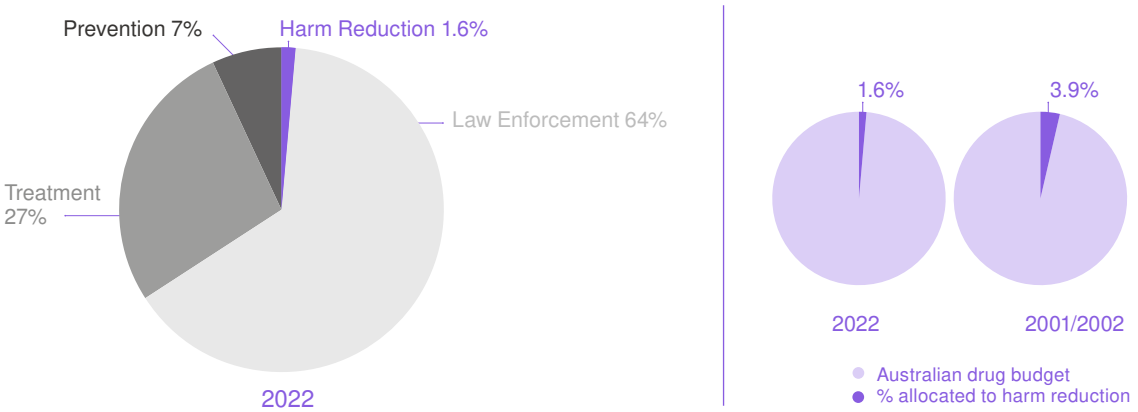
KEY ISSUE

INSUFFICIENT INVESTMENT IN AND SUPPORT FOR HARM REDUCTION

Aotearoa New Zealand and Australia have multiple harm reduction programmes,[22,23,24] including festival-based harm reduction, take-home naloxone and peer distribution, NSPs, OAT, drug checking, medically supervised injecting centres (two in Australia only) and peer-led drug user organisations.[25,26] In Australia, between 2022 and 2024, dispensing fees for opioid agonist therapy (OAT) have finally been funded by the Commonwealth Government to uphold equitable access to OAT and human rights.[27,28] The Queensland government in Australia implemented its first permanent drug checking fixed site and successfully trialled its first multi-day festival drug checking service.[29,30] The New South Wales government implemented its first drug checking service at the Sydney Medically Supervised Injecting Centre.[31] The Victorian government made the Melbourne Medically Supervised Injecting Room permanent,[32] and also announced it would run a drug checking trial with mobile and fixed sites.[33] These changes mean Australia is slowly aligning with Aotearoa New Zealand which legalised drug checking in 2020 and made it permanent under a 2021 law.

But while the governments of Australia and Aotearoa New Zealand fund a range of harm reduction services, including peer-based harm reduction responses, investment remains insufficient. This is despite over 30 years of proven efficacy, impact and cost-effectiveness of these services.[34] A recent report revealed that only 1.6% of the total Australian 'drug budget' for 2021/22 was spent on harm reduction while 64.3% was spent on law enforcement for drug control, 27.4% on treatment and 6.7% on drug use.[35]

Australia's drug budget



Beyond Australia and Aotearoa New Zealand, other countries in Oceania have either very limited or no harm reduction programmes, and peer-based harm reduction services are unavailable.

For some low-income countries in the region, expanding drug trafficking routes[36,37] has increased the use of stimulants, including injection use, which has heightened the risk of HIV[38] and hepatitis C[39] infection among people who use drugs. The lack of comprehensive harm reduction programmes means that some countries are vulnerable to HIV and hepatitis C epidemics. Most communities in the region are affected by low resourcing, lack of health infrastructure and limited community experience of blood-borne virus and harm reduction programmes, peer support and education.

There remains a need to develop and expand harm reduction programmes in the region to provide adequate coverage to support the diverse community of people who use drugs and effectively ensure community-led monitoring of services.[40,41,42] There is an urgent need for dedicated funding to ensure that harm reduction programmes are available and accessible in all countries and territories in Oceania.

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