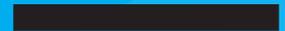


# 2.6 OCEANIA



AUSTRALIA  
FIJI  
KIRIBATI  
MARSHALL ISLANDS  
MICRONESIA, FEDERATED STATES OF  
NAURU  
NEW ZEALAND  
PALAU  
PAPUA NEW GUINEA  
SAMOA  
SOLOMON ISLANDS  
TIMOR LESTE  
TONGA  
TUVALU  
VANUATU

TABLE 2.6.1:

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

Country/ territory with reported injecting drug use <sup>1</sup>	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 <sup>2</sup>	OAT <sup>3</sup>	Peer distribution of naloxone	DCRs <sup>4</sup>
<b>Australia</b>	75,178 <sup>5(2)</sup>	2.3 <sup>3)</sup>	45 <sup>4)</sup>	4.0 <sup>5)</sup>	✓(4,182) <sup>6(2)</sup>	✓(2,940) <sup>7</sup> (B,M) <sup>6)</sup>	✓ <sup>7,8)</sup>	✓2
<b>Federated States of Micronesia</b>	nk	nk	nk	nk	x	x	x	x
<b>Fiji</b>	nk	nk	nk	nk	x	x	x	x
<b>Kiribati</b>	nk	nk	nk	nk	x	x	x	x
<b>Marshall Islands</b>	nk	nk	nk	nk	x	x	x	x
<b>New Zealand</b>	18,000 <sup>8(10)</sup>	0.2 <sup>10)</sup>	58 <sup>9(10)</sup>	nk	✓(185) <sup>10(11)</sup>	✓(B,M) <sup>11,12)</sup>	✓ <sup>11(9)</sup>	x
<b>Palau</b>	nk	nk	nk	nk	x	x	x	x
<b>Papua New Guinea</b>	nk	nk	nk	nk	x	x	x	x
<b>Samoa</b>	nk	nk	nk	nk	x	x	x	x
<b>Solomon Islands</b>	nk	nk	nk	nk	x	x	x	x
<b>Timor Leste</b>	nk	nk	nk	nk	x	x	x	x
<b>Tonga</b>	nk	nk	nk	nk	x	x	x	x
<b>Vanuatu</b>	nk	nk	nk	nk	x	x	x	x

nk = not known

1 Countries with reported injecting drug use according to Larney et al 2017. The study found no reports of injecting drug use in Nauru or Tuvalu.

2 All operational needle and syringe exchange programme (NSP) sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers. (P) = pharmacy availability.

3 Opioid agonist therapy (OAT), including methadone (M), buprenorphine (B) and any other form (O) such as morphine and codeine.

4 Drug consumption rooms, also known as supervised injecting sites.

5 Estimated for the 2018/19 years based on the method described by Kwon et al in 2019.<sup>[1]</sup>

6 2,836 pharmacies, 98 primary, 908 secondary sites and 340 syringe dispensing machines.

7 This refers to the number of dosing points in the country. 89% of opioid pharmacotherapy dosing points were pharmacies.

8 This number would be an upper limit, with recent analysis suggesting a figure close to 12,000<sup>[9]</sup>

9 This figure is based on 2013 prevalence data and likely under-reports exposure, as the cohort most likely to have been exposed will have aged, with age being a proxy for length of injecting career, and the latter correlated with increased exposure as career lengthens.<sup>[11]</sup>

10 163 pharmacies and alternative outlets, and 22 peer-based NSPs (includes two mobile services).

11 Commenced May 2020. Available through some peer-based NEXs and drug treatment services.

MAP 2.6.1:

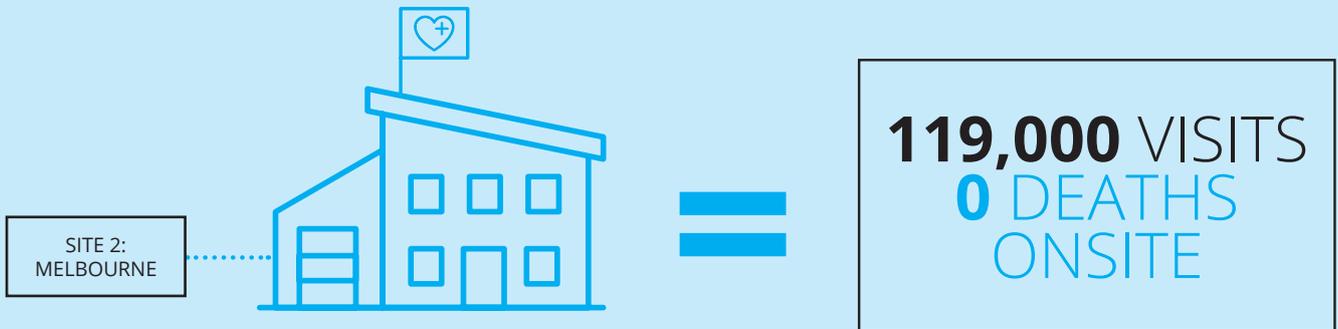
Availability of harm reduction services



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

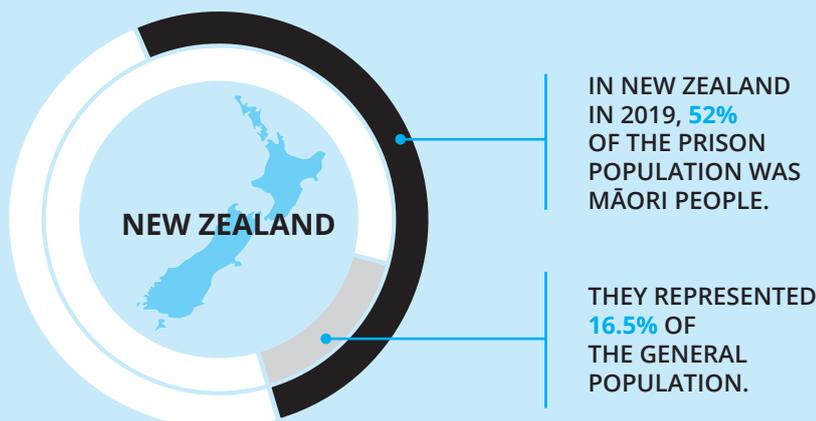
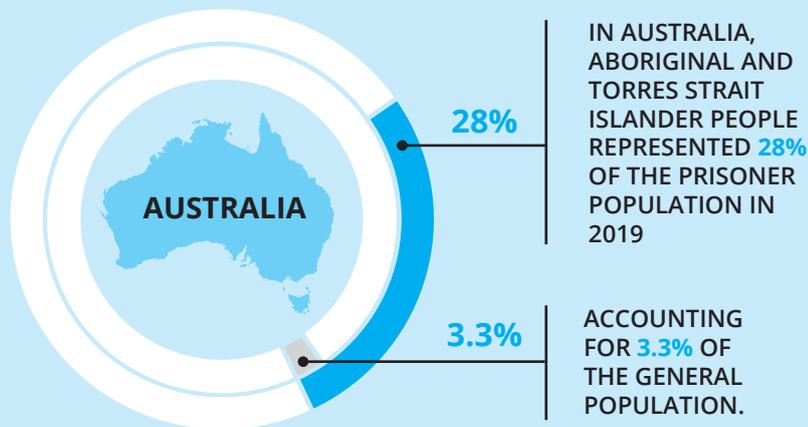
## 2.6 Harm reduction in Oceania

### OVERDOSE, OVERDOSE RESPONSE AND DRUG CONSUMPTION ROOMS (DCRS)



THE SECOND DCR OPENED IN 2018 IN MELBOURNE FOR A TWO-YEAR TRIAL PERIOD, ENDING IN 2020. AN INDEPENDENT EXPERT PANEL CONDUCTED A REVIEW OF THE PROGRAMME BASED ON THE FIRST 18 MONTHS OF OPERATION, AND FOUND THAT THE DCR HAD SUCCESSFULLY REDUCED HARMS FOR SERVICE USERS, WITH MORE THAN 119,000 VISITS IN THE FIRST 18 MONTHS, AND NO OVERDOSE DEATHS ONSITE.

### HARM REDUCTION IN PRISONS



*The proportion of NSP clients reporting an Aboriginal and/or Torres Strait Islander background in Australia increased significantly over the past five years, from 14% in 2015 to 22% in 2019.*



# 1. Overview

Author: *Robert Csak*  
Harm Reduction  
International



There are significant numbers of people who inject drugs in Australia and New Zealand, but there appear to be few in the rest of the region, with no evidence of injecting drug use in Fiji, Marshall Islands, Nauru, Papua New Guinea, Samoa, Solomon Islands, Tonga or Tuvalu.<sup>[13-20]</sup> While there are a wide range of harm reduction services available in Australia and New Zealand, there is no new evidence for any such services anywhere else in the region since the *Global State of Harm Reduction 2018*. The highly variable data, in terms of availability and quality, across the region remains a key limitation in collating an overall picture of the state of harm reduction in Oceania.

All Australian states and territories operate needle and syringe programmes (NSPs), with a small increase in the number of NSPs operating in the country since 2018.<sup>[2]</sup> Various NSP service models exist in Australia, including primary and secondary outlets, mobile and outreach services, syringe vending machines, and peer-led models.<sup>[21]</sup> New Zealand has a national state-sponsored peer-based NSP, which consists of 185 facilities.<sup>[11,22]</sup> Though New Zealand is among countries with high prevalence of injecting drug use, the prevalence of HIV among people who inject drugs is low,<sup>[23]</sup> which can be attributed to the early introduction of NSPs in the country.<sup>[24]</sup> The number of opioid agonist therapy (OAT) clients in Australia has remained stable since 2018, though there is a trend of an ageing cohort in OAT.<sup>[25]</sup> An important characteristic in OAT provision in Australia is the slow but continuous shift towards a higher proportion of dosing occurring at community pharmacies rather than specialist OAT facilities. There is an increasing trend in the number of people receiving OAT in New Zealand,<sup>[26]</sup> where initiation time has decreased in the past few years.<sup>[26]</sup> Unfair treatment and stigma and discrimination towards people who inject drugs or are attending OAT programmes are evident in both countries,<sup>[7,27]</sup> and further barriers to access exist for certain communities. In Australia, access to NSPs is suboptimal for young people and Indigenous people, and in New Zealand, people who inject performance and image-enhancing substances are underserved and the needs of Māori (Indigenous New Zealanders) are not appropriately met.<sup>[11]</sup>

A recent analysis of adolescent health behaviour in six Pacific Island countries and territories (Cook Islands, Kiribati, Samoa, Solomon Islands, Tonga and Tuvalu) found higher lifetime prevalence of amphetamine use than previous studies, though the prevalence rates varied greatly between countries.<sup>[28]</sup> The two most popular stimulants in Australia are cocaine and MDMA,<sup>[29]</sup> while cocaine is less prevalent in New Zealand than amphetamines and MDMA.<sup>[30]</sup> An important harm reduction response to amphetamine-type stimulants (ATS) and new psychoactive substances (NPS) use in Australia and New Zealand is drug checking (also known as pill testing), which has been available in festival settings since 2014 in New Zealand,<sup>[31-33]</sup> and two pilot programmes have been implemented over the past two years in Australia.<sup>[7,34-36]</sup>

Australia is among the few countries on track globally to reach the hepatitis C elimination goal by 2030.<sup>[37]</sup> People have had universal access to hepatitis C direct-acting antivirals (DAAs) since 2016, with access to further DAA treatment if they become re-infected.<sup>[3,7]</sup> Prison-based access is a particular priority; the therapeutic cost of DAAs for people in prison is covered by the Australian government.<sup>[38]</sup> A study among hepatitis C-positive people who inject drugs recommended expanding community-based programmes and peer support to ensure that people who inject drugs take up hepatitis C treatment in sufficient numbers to drive elimination.<sup>[39]</sup> A significant development in New Zealand is that DAA treatment became publicly funded and it is now available at no cost to patients.<sup>[11,40]</sup> The public funding of DAA has improved access to hepatitis C treatment for people who inject drugs, as they are the focus of testing and treatment measures.<sup>[11]</sup> Low HIV prevalence is a historic characteristic in both countries. A recent analysis found that the prevalence rate among people who inject drugs was below 2.3% in all survey years between 1995-2019 in Australia.<sup>[3]</sup> A study examining new HIV cases between 1996-2018 in New Zealand found that on average two HIV diagnoses (less than 3%) per year could be attributed to injecting drug use over the study period.<sup>[24]</sup> The successful prevention of an HIV epidemic is attributed to the early implementation of NSPs and the sustained harm reduction response.<sup>[24,41]</sup>

## Data availability in Oceania

A key limitation in assessing the state of harm reduction in Oceania, is the highly variable data across the region. The data collection systems in Australia are of high quality: regular systematic data collection and analysis are available on drug use in the general population,<sup>[29]</sup> among people who inject drugs;<sup>[42]</sup> NSP implementation<sup>[2]</sup> and national strategies<sup>[43]</sup> are monitored regularly; pilot programmes are evaluated;<sup>[36,44]</sup> analyses on long-term trends are published,<sup>[3]</sup> while the national drug user network also conducts studies complementing the government's and academics' perspectives.<sup>[27]</sup> At the same time estimates on injecting use or the prevalence of blood-borne viruses among people who inject drugs are not available in any Pacific Island countries and territories,<sup>[10]</sup> and drug use or harm reduction in general is hardly mentioned in reports to international agencies.<sup>[45]</sup> While data on drug use and harm reduction is widely available in Australia and New Zealand, which contain 73% of the population of the region,<sup>[10]</sup> the lack of information on the Pacific Island countries and territories constitutes a significant data gap in the global state of harm reduction.

To bridge the gap, international agencies could focus on countries in the region with relatively bigger populations: adding estimates on the number of people who use drugs in Fiji, Papua New Guinea and Solomon Island would increase UNODC data coverage to 96% of people in the region. Furthermore, it would be worth considering alternative methodologies to questionnaires sent to ministries, where governments' country reports based on available quantitative data are complemented by qualitative data involving civil society organisations, professionals and other stakeholders. Methodologies are available to create mixed method surveys that can fill the gap in quantitative information while providing timely, quality data.<sup>[46]</sup>

Data gaps can be identified in Australia and New Zealand, even though these countries have a great deal of research on drug use, prevalence of blood-borne diseases and coverage of services. Analysis on drug-related government expenditure is an area where evidence is lacking. The latest analysis available on government spending examined decade-old data in Australia, and eight-year-old data in New Zealand.<sup>[47,48]</sup> These countries implement evidence-based drug policy, include harm reduction in their national drug strategies, and also involve peers in government consultations.

Adding government spending analysis to their toolkit would improve the evidence base and could inform decision makers and advocacy groups to better target public resources.



*Estimates on injecting use or the prevalence of blood-borne viruses among people who inject drugs are not available in any Pacific Island countries and territories,<sup>[10]</sup> and drug use or harm reduction in general is hardly mentioned in reports to international agencies.<sup>[45]</sup>*

# 1. Developments in harm reduction implementation



## 2.1

### NEEDLE AND SYRINGE PROGRAMMES (NSPs)

According to national reports submitted by the respective ministries of health to the Joint United Nations Programme on HIV/AIDS (UNAIDS), there is no evidence of injecting drug use in Fiji, Marshall Islands, Nauru, Papua New Guinea, Samoa, Solomon Islands, Tonga or Tuvalu.<sup>[13–20]</sup> However, Australia and New Zealand are home to a substantial number of people who inject drugs, and these are the two countries in the region with long running NSP services.

According to the Australian NSP survey, the most commonly injected drugs in the country are methamphetamine (49% reported injecting it in 2019, up from 36% in 2015), and heroin (27% reported injecting in 2019, decreased from 31% in 2015).<sup>[3,4,49]</sup> Over the last decade, there has been a continuous shift in the drug last injected; the proportion of people who injected heroin declined, while the prevalence of methamphetamine doubled over the period 2010 to 2019.<sup>[3]</sup> All Australian states and territories operate NSPs, with a total of 4,182 in operation in the country, a 15% increase since 2018.<sup>[2]</sup> The country's network services have different types of NSPs. The majority (two-thirds), is based in pharmacies, and there are 98 primary<sup>12</sup> and 908 secondary<sup>13</sup> NSPs.<sup>[2]</sup> The number of syringe dispensing machines (vending machines that dispense syringes for free or at a nominal cost) almost tripled from 118 in 2008 to 340 in 2019, with 17 new machines since the *Global State of Harm Reduction* last reported in 2018.<sup>[2]</sup> Outreach programmes and peer distribution are also part of the NSP services in Australia.<sup>[21,52]</sup> The majority of primary and pharmacy NSPs are located in major cities, while secondary NSPs and syringe dispensing machines are mainly located outside of major cities.<sup>[2]</sup> The number of distributed syringes steadily increased over the last decade, with 52.5 million syringes distributed in 2018/19. This translates to 698 syringes per person who injects drugs, reaching far beyond the World Health Organization (WHO) targets<sup>14</sup> on syringe distribution.<sup>[2,53,54]</sup> The main developments in NSP implementation since the last report are the increased integration of take-home naloxone programmes,<sup>[8]</sup> and the increased availability of hepatitis treatment at NSPs in Australia.<sup>[7]</sup>

New Zealand was the first country in the world to have a national state-sponsored needle and syringe programme

(New Zealand Needle Exchange Programme, NZNEP), and a peer-based model has been a defining feature of the country-wide network, which consists of 163 pharmacies and alternative outlets, and 22 peer-based programmes (including two mobile services).<sup>[11,22]</sup> NSPs in New Zealand distributed 3.75 million syringes in 2018,<sup>[55]</sup> providing moderate coverage of a minimum of 200 syringes per person who injects drugs in a year.<sup>[11]</sup> Since 2018, access to hepatitis C testing in NSPs has been expanded and it is now available across the NSPs in New Zealand, not just at the three services with an on-site health clinic.<sup>[11]</sup> Furthermore, as a response to the COVID-19 pandemic, an online NSP store was launched in 2020; following the introduction of nationwide COVID-19 measures, the online shop helped to ensure access to sterile injecting equipment.<sup>[11]</sup>

Though NSPs are widely available both in Australia and in New Zealand, there are barriers to access. The Australian Injecting & Illicit Drug Users League (AIVL) reported unfair treatment and stigma and discrimination towards people who inject drugs when accessing injecting equipment in hospitals and pharmacies.<sup>[27]</sup> In New Zealand, the cost of injecting equipment could be a barrier as only a limited range of syringes is available for free under the one-for-one exchange scheme,<sup>15</sup> and all other harm reduction commodities have to be purchased.<sup>[11]</sup> Geographical barriers also exist in the country. The NZNEP operates only two mobile services, leaving a number of areas underserved by the programme.<sup>[11]</sup> Insufficient geographical coverage is a problem in Australia too: many locations are missing syringe dispensing machines, and the number and location of NSPs are also insufficient,<sup>[7]</sup> while coverage varies within capital cities.<sup>[56]</sup> Barriers to access exist for certain communities in both countries. In Australia, access to NSPs is suboptimal for young people and Aboriginal and Torres Strait Islander people because many feel uncomfortable about approaching the mainstream face-to-face NSPs, and limited targeted programmes are available in the country for these populations.<sup>[7]</sup> Two groups were identified in New Zealand where access to NSPs is insufficient: there is some anecdotal evidence that people who inject performance- and image-enhancing substances are underserved and have little exposure to harm reduction services, and the needs of Māori people are not appropriately met, though data is lacking in this area.<sup>[11]</sup>

<sup>12</sup> Primary NSPs are integrated into broader health services – and offer broader support for people who inject drugs (PWID) e.g. referrals to other health and welfare services, nurses assisting with injecting-based injuries, vein care etc.<sup>[21,50]</sup>

<sup>13</sup> According to the Australian NSP National Minimum Data Collection Data Dictionary, secondary NSP refers to NSPs operating within existing health or community services with staff that are not solely dedicated to the provision of services to PWID.<sup>[51]</sup>

<sup>14</sup> According to the WHO indicator, NSP coverage is high if NSPs in a country distribute more than 200 syringes per person who injects drugs per year, though the WHO hepatitis strategy calls for 300 syringes per person who injects drugs per year by 2030.<sup>[53,54]</sup>

<sup>15</sup> One-for-one exchange scheme means that sterile syringes are available free of charge in exchange for the return of used equipment on a one-for-one basis: one sterile syringe for one unsterile syringe.

## Health inequalities among Indigenous peoples in Oceania

Indigenous peoples in Oceania, specifically Aboriginal and Torres Strait Islander people in Australia and the Māori population in New Zealand, are disproportionately affected by the harms of drug use, and consistently experience worse health outcomes than other ethnic groups in the region.<sup>[102-104]</sup> This inequality has persisted since the arrival of European settlers and the beginning of colonialism,<sup>[105]</sup> with newly imposed health care systems focusing primarily to serve those of European descent.<sup>[102]</sup>

Structural inequalities negatively impact the health of Indigenous people both in Australia and New Zealand. In New Zealand, such factors include social deprivation, poverty, the quality of housing and household crowding, which could contribute to inequalities in rates of most infectious diseases – COVID-19 included.<sup>[106]</sup> Furthermore, Māori people consistently experience barriers when accessing health services, from discriminatory behaviour and inadequate information provision to practical barriers like costs and travel challenges, resulting in Māori people disengaging or actively avoiding health services.<sup>[102]</sup> Factors contributing to worse health outcomes in Aboriginal and Torres Strait Islander people include higher prevalence of low household incomes, unemployment, food insecurity, poorer housing and lower level of education compared to the non-Indigenous population.<sup>[103,107]</sup> The lack of accessibility to culturally appropriate health services is also apparent.<sup>[107]</sup> Though there are government-funded Indigenous-specific primary health care services in Australia, the low rate in specialist service use reflects difficulties in accessing these services for many Aboriginal and Torres Strait Islander people.<sup>[108]</sup> It has been recognised in New Zealand that Māori people have specific health needs, and the Māori Health Strategy was adopted in 2014.<sup>[109]</sup> However, racism and discrimination across the health system was raised as a key issue when the Māori Health Action Plan 2020–2025 was developed.<sup>[110,111]</sup>

Inequalities are reflected in higher burden of drug-related infectious diseases, for example hepatitis C prevalence is higher among Aboriginal and Torres Strait Islander people who inject drugs compared to non-Indigenous people who inject drugs.<sup>[3,112]</sup> However, research in Australia found that factors associated with hepatitis C infection were the same for Indigenous and non-Indigenous people who inject drugs - imprisonment, sharing injecting equipment in prison - but the extent



*Social determinants of health have a demonstrable effect on the harms associated with drug use. Addressing structural inequalities and implementing harm reduction services tailored to Indigenous peoples' needs, practices and conceptualisations of health are pivotal to decrease the prevalence of blood-borne viruses and drug-related harms.*

of exposure to these factors differed.<sup>[112]</sup> In particular, incarceration rates are higher for Indigenous people in both countries.<sup>[113,114]</sup> In Australia, Aboriginal and Torres Strait Islander people represented 28% of the prisoner population in 2019, while accounting for 3.3% of the general population.<sup>[113]</sup> In New Zealand in 2019, 52% of the prison population was Māori people, while they represented 16.5% of the general population.<sup>[114,115]</sup>

Prevalence of drug use in general is also higher among Indigenous peoples. In New Zealand, Māori people are more likely to have used cannabis and amphetamines in the past year than non-Māori people<sup>[26]</sup> and, in Australia, last year prevalence of cannabis is 1.9 times higher, while last year prevalence of amphetamines is 2.3 times higher among Aboriginal and Torres Strait Islander Australians than non-Indigenous Australians.<sup>[116]</sup> Also, the proportion of NSP clients reporting an Aboriginal and/or Torres Strait Islander background in Australia increased significantly over the past five years, from 14% in 2015 to 22% in 2019.<sup>[3]</sup>

Social determinants of health have a demonstrable effect on the harms associated with drug use. Addressing structural inequalities and implementing harm reduction services tailored to Indigenous peoples' needs, practices and conceptualisations of health are pivotal to decrease the prevalence of blood-borne viruses and drug-related harms.



## 2.2 OPIOID AGONIST THERAPY (OAT)

The number of OAT clients in Australia has remained stable since 2018. On a snapshot day in June 2019, 50,945 people in Australia were receiving OAT (a 2% increase from 49,762 in 2017), two-thirds of these were male and 10% identified as Aboriginal or Torres Strait Islander, and the majority (61%) of OAT clients received methadone (17% received buprenorphine and 23% received buprenorphine-naloxone).<sup>[25]</sup> A recent development is that depot buprenorphine (a slow release, long-acting version of buprenorphine) has been introduced in Australia and became available from April 2020.<sup>[7,57]</sup> There is a trend of an ageing cohort in OAT over the past decade in Australia, the proportion of clients aged 60 and over has increased, while the proportion of clients under 30 has declined since 2010.<sup>[25]</sup> Reports attribute aging in the OAT population to three factors: methadone being available in Australia for more than 40 years, OAT reducing the risk of premature death, and clients seeking OAT for the first time at an older age.<sup>[25]</sup> On the snapshot day in 2019, there were 3,395 authorised prescribers of OAT, a 33% increase since 2015.<sup>[25]</sup> Between 2015 and 2019, the ratio of clients per prescriber decreased to 16; though, nationally, prescribers working in correctional facilities had an average of 36 clients. An important characteristic in OAT provision in Australia is the slow but continuous shift towards a higher proportion of dosing occurring at community pharmacies rather than specialist OAT facilities.<sup>[7]</sup> Though OAT coverage is sufficient in Australia, costs remained a barrier to access as clients have to pay dispensing fees at pharmacies of up to AUD 75 (USD 54) per week.<sup>[7,34,58,59]</sup> Although access to take-home OAT has improved slightly with COVID-19 (see COVID-19 chapter p.33),<sup>[60,61]</sup> there is also a need for greater access to take-home OAT.<sup>[7,34]</sup> Furthermore, actual and perceived stigmatisation of OAT clients is still an issue in the country.<sup>[7,34]</sup>

Methadone, buprenorphine and slow-release morphine tablets are available for OAT in New Zealand, and are mostly consumed orally and daily.<sup>[62,63]</sup> There is an increasing trend in the number of people receiving OAT in New Zealand, 5,573 people were on OAT in 2018 compared to 5,158 in 2013.<sup>[26]</sup> OAT initiation time has decreased in the past few years, with 75% of new clients starting OAT within four weeks of initial consultation with a provider in 2019 compared to 50% in 2013.<sup>[26]</sup> A recent report found that stigma and discriminatory behaviour by healthcare workers

are a common issue for OAT clients in New Zealand. Stigma could impact the quality and type of medical treatment for other health issues given to people who receive OAT, for example reluctance to prescribe pharmacological pain treatment because of suspicion about drug-seeking behaviour.<sup>[63]</sup> Stigma creates a serious barrier in access as it could prevent people who receive OAT from accessing treatment, and also dissuades general practitioners from prescribing OAT.<sup>[63]</sup>



## 2.3 AMPHETAMINE-TYPE STIMULANTS (ATS) AND NEW PSYCHOACTIVE SUBSTANCES (NPS)

A recent analysis of adolescent health behaviour in six Pacific Island countries and territories (Cook Islands, Kiribati, Samoa, Solomon Islands, Tonga and Tuvalu) found higher lifetime prevalence of amphetamine use than previous studies, though the prevalence rates varied greatly between countries, ranging from 2.7% in Cook Islands to 34.6% in Samoa.<sup>[16,28]</sup>

According to the latest general population survey in Australia, the two most popular stimulants in the country are cocaine and ecstasy.<sup>[29,17]</sup> Cocaine has become more popular in Australia since 2016, with both lifetime prevalence (11.2%) and last year prevalence (4.2%) of cocaine use having increased, while last year use increased across all age groups, and the frequency of use also increased among people who used cocaine.<sup>[29]</sup> Recent ecstasy use in the country increased between 2016 and 2019; in 2019 12.5% reported lifetime use, and 3% reported last year use of ecstasy.<sup>[29]</sup> People living in the wealthier areas in Australia continued to be more than twice as likely as those in the least wealthy areas to use ecstasy.<sup>[29]</sup> The declining trend in methamphetamine and amphetamine use has continued since 2018, and it is still driven mainly by a decline in use among people in their 20s; in 2019, 5.8% of adult population reported lifetime use of methamphetamine and amphetamine, and 1.3% reported last year use.<sup>[29]</sup> An estimated 50% of people who used methamphetamine and amphetamine used it mainly in crystal form, which is linked with more frequent use. Similarly, 47% of people who used crystal methamphetamine as their main form use it monthly or more often.<sup>[29]</sup>

<sup>16</sup> Lifetime prevalence rate of amphetamine use in the remaining four countries: Kiribati 4.1%, Solomon Islands 14.9%, Tonga 6.2%, Tuvalu 3.6%

<sup>17</sup> In the 2019 National Drug Strategy Household Survey questionnaire, "ecstasy" was the general term for substances containing MDMA as an active ingredient. See <https://www.aihw.gov.au/getmedia/5dc5a9f9-a877-4637-9aa5-b1b066c2adce/aihw-phe-270-2019-NDSHS-questionnaire.pdf.aspx>

The prevalence of last year amphetamine and methamphetamine use was 1% in 2018/19 in the adult population in New Zealand, an increase from 0.7% in 2017/18.<sup>[64]</sup> Though amphetamine and methamphetamine use is relatively low in the country, methamphetamine use is concentrated in some communities. Wastewater testing by the police showed four times higher methamphetamine use per capita in the northernmost part of New Zealand as compared to the southernmost part.<sup>18[26,30]</sup> MDMA use is on the rise in the country; it was the second most commonly detected drug in wastewater testing, and seizures have increased in the past years.<sup>[26,30]</sup> Reports attributed the increased MDMA use to increased availability as the supply from overseas grew and ecstasy pills became more affordable, while dose and purity also increased over the past years.<sup>[26,30]</sup> According to the police, wastewater testing for cocaine is less prevalent in New Zealand than for amphetamines and MDMA.<sup>[30]</sup>

More than 70 deaths were connected to synthetic cannabinoids between 2017 and 2019.<sup>[26]</sup> However, death rates decreased at the end of 2019. Reports attribute this decline to steadily decreasing police and border seizures of synthetic substances, and the type of synthetic cannabinoids available in the market being less toxic.<sup>[26]</sup> At the beginning of 2020, New Zealand launched an early warning system to help identify drug-related risk situations by collecting information through a standardised analysis process including street national data sets, street sample testing, and information from civil society organisations working on the ground.<sup>[65,66]</sup> Some Australian jurisdictions have established informal information sharing groups as local early warning systems,<sup>[67]</sup> with a model for a national early warning system soon to be tested for feasibility.<sup>[68,69]</sup>

An important harm reduction response to ATS and NPS use in the region is drug checking (also known as pill testing). In New Zealand, KnowYourStuffNZ has operated a free pill testing service at music festivals since 2014 and, in 2019, the organisation in partnership with the New Zealand Drug Foundation implemented a fixed site pilot pill testing service in Wellington.<sup>[31-33]</sup> The organisation considered the pilot programme successful, and the number of clients and tested substances increased steadily over the six month pilot period.<sup>[32]</sup> Both at festivals and at the fixed site testing programme the majority of substances tested was MDMA, and most clients said that they would not take a substance if it turned out not to be what they expected.

<sup>[31,32]</sup> In the festival scene, the trends showed an increase in the proportion of substances that were what they were expected to be: in 2016/17, only 68% of substances tested consistently with what they were supposed to be, compared to 87% in 2018/19. An increase of high-dose ecstasy pills was a concern in the year of reporting.<sup>[31]</sup>

All but one of Australia's nine state and territorial governments officially oppose drug checking.<sup>[7]</sup> However, there have been two trials of pill testing at music festivals in the Australian Capital Territory (Canberra) over the last two years<sup>[7,34-36]</sup> and, on 20 August 2020, the government of the Australian Capital Territory announced a plan to extend drug checking, and implement a weekly fixed site drug checking service in Canberra towards the end of 2020.<sup>[7,70]</sup> The evaluation of the pilot programmes concluded that the trials were successful, provided valuable information on drug availability in Canberra, and produced positive results in terms of participants' harm reduction knowledge and practices.<sup>[35,36]</sup> After the successful 2018 Canberra pilot, the policy debate significantly increased on drug checking, and an analysis of the debate in New South Wales concluded that despite the fact that advocates and the opponents shared the same goal (to save lives), a productive debate on the issue has to address underlying differences in values on drug use and agency of young people. While opponents viewed drugs as inherently bad and thought young people require protection from their poor choices, advocates viewed drug use as a reality and thought young people can make informed decisions based on the information drug checking could provide.<sup>[71]</sup>



## 2.4 OVERDOSE, OVERDOSE RESPONSE AND DRUG CONSUMPTION ROOMS (DCRs)

There are two drug consumption rooms (DCRs) in the region, both in Australia where they are known as medically supervised injection facilities. The DCR in Sydney has been operating since May 2001.<sup>[72]</sup> The second DCR opened in 2018 in Melbourne for a two-year trial period, ending in 2020. An independent expert panel conducted a review of the programme based on the first 18 months of operation,<sup>[44]</sup> and found that the DCR had successfully reduced harms for service clients, with more than 119,000

<sup>18</sup> New Zealand has 12 police districts, nine in the North Island and three in the South Island. Northland district is the northernmost, Southern district is the southernmost. See: <https://www.police.govt.nz/about-us/structure/police-districts>

visits in the first 18 months, and no overdose deaths onsite.<sup>[44]</sup> Furthermore, the DCR provided access to other health and support services to people who used the service, and the report concluded that the provision of complex services (NSPs, infectious disease testing, counselling of HIV and hepatitis C, and treatment of hepatitis C) at the DCR is beneficial, for example more than a third of people screened tested positive for hepatitis C and a quarter had begun treatment.<sup>[44]</sup> Following the recommendations of the review panel, in June 2020, the local government announced the extension of the trial for another three years, and the opening of Melbourne's second DCR.<sup>[34,44,73,74]</sup> Establishing a DCR is an ongoing issue in the Australian Capital Territory, where the government funded a feasibility study in 2020 to examine the possibility of implementing a DCR in the territory.<sup>[75]</sup> Establishing DCRs in New Zealand is not currently debated as the main barriers to implementation are the lack of political will and the costs of such facilities.<sup>[11]</sup>

**Naloxone (including the intranasal form)<sup>[76]</sup> is available in all states and territories in Australia with a prescription or over the counter from a pharmacy,** though people have to pay for it,<sup>[7,8]</sup> and cost is a barrier to access.<sup>[77]</sup> However, there is a movement towards community-based distribution of naloxone with a national government trial of take-home naloxone (THN) which began in 2019 and will run until 2021. Naloxone is available free of charge (and without a prescription) under the THN pilot in three states: New South Wales, South Australia and Western Australia.<sup>[7,34,78]</sup> During the pilot period, THN is available in community and hospital-based pharmacies, alcohol and other drug treatment centres, NSPs, custodial release programmes and at general practitioner clinics.<sup>[78]</sup> THN programmes are available through 66 NSPs in the country, and 40% of primary NSPs and 3% of secondary NSPs have programmes to facilitate access to THN.<sup>[2]</sup>

Naloxone kits are available at NSPs in New Zealand, though there has not been universal uptake of this approach, and it is not part of the New Zealand Needle Exchange Programme service provision.<sup>[11]</sup> However, during the COVID-19 pandemic the government funded access to naloxone kits at NSPs.



## 2.5 HIV AND ANTIRETROVIRAL THERAPY (ART)

HIV prevalence among people who inject drugs remains low in the region, estimated at 2.3% in Australia and 0.2% in New Zealand.<sup>[3,10,11]</sup> Low HIV prevalence is an historic characteristic in both countries. A recent analysis found that the HIV prevalence rate among people who inject drugs was below 2.3% in all survey years between 1995-2019 in Australia, and has been stable over the past five years.<sup>[3]</sup> A study examining new HIV cases between 1996-2018 in New Zealand found that new HIV diagnoses among people who inject drugs remained very low, on average two (less than 3%) per year could be attributed to injecting drug use over the study period.<sup>[24]</sup> The low prevalence rates among people who inject drugs in New Zealand is attributed to the early introduction of NSPs, the peer-led approach in NSP implementation, and the sustained harm reduction response in the country.<sup>[24,41]</sup>

Drug use is not the major mode of HIV transmission in these countries. In Australia, injecting drug use was reported for 3% of new HIV cases in the country,<sup>[5]</sup> and injecting drug use accounts for a small fraction of HIV transmission in New Zealand: in 2019 only one locally acquired case was attributed to injecting drug use in the country.<sup>[24,79]</sup> HIV prevalence has a similar pattern in Australia: injecting drug use is not the main mode of transmission, men who have sex with men have a much higher risk of acquiring HIV.<sup>[5]</sup> HIV prevalence was 32% in 2019 among the subpopulation of people who inject drugs and reported being men who have sex with men.<sup>[3]</sup> According to the national NSP survey data, the HIV prevalence rate among Aboriginal and Torres Strait Islander respondents was stable between 2014 to 2018. However, it was higher among this population compared to other respondents (3.6% and 1.1% respectively in 2018).<sup>[4]</sup> This difference could be attributed to several factors (inadequate implementation of prevention strategies such as treatment as prevention and pre-exposure prophylaxis; higher proportion of undiagnosed HIV cases in the population; higher HIV incidence in the Aboriginal and Torres Strait Islander population attributed to injecting drug use than in the non-Indigenous population)<sup>[5,80]</sup> though structural factors contributing to overall worse health outcomes among Indigenous populations also have to be considered (see Box 2 on p.152).

ART and pre-exposure and post-exposure prophylaxis<sup>19</sup> are widely available in both Australia and New Zealand.<sup>[81-84]</sup> Among the Australian NSP survey respondents who reported they were living with HIV, 88% reported they were on ART.<sup>[3]</sup>



## 2.6 HARM REDUCTION IN PRISONS

Prison is a high risk setting where harm reduction interventions are of key importance. In Australia, people in prison with a history of injecting drug use are a key population for hepatitis C elimination. Hepatitis C prevalence is high among prison entrants in both men (24%) and women (28%).<sup>[5]</sup> Furthermore, in 2019, half of NSP survey respondents reported a lifetime history of incarceration,<sup>[3]</sup> and hepatitis C prevalence was higher among respondents reporting recent imprisonment compared to those who did not.<sup>[4]</sup> NSP clients in New Zealand have similar characteristics; data derived from the most recent NZNEP client survey indicates that imprisonment is the most powerful predictor of hepatitis C serostatus, and that 43% of respondents had been imprisoned at some time in their lives.<sup>[11,85]</sup>

Despite NSPs being established services in Australia and New Zealand, with good coverage in community settings, NSPs are not available in any prison in the region.<sup>[7,11,34]</sup> Implementing NSPs in prisons was considered in the development of the National Hepatitis C Action Plan in New Zealand,<sup>[11]</sup> though the action plan has not yet been published.<sup>[86]</sup> Without appropriate access to sterile injecting equipment, injecting drug use in prison poses serious health risks; according to a study by AIVL, syringes in prison settings are reused an estimated 100 times.<sup>[27]</sup> This is a major concern, as 32% of recently imprisoned NSP clients reported injecting in prison in Australia.<sup>[3]</sup> These are consistent with the results of a recent longitudinal study of injecting risk behaviours in Australian prisons, where they found that, following entry into prison, the proportion of people who reported injecting drug use decreased, but among those who did inject drugs, syringe sharing increased.<sup>[87]</sup>

OAT is available in prisons in both Australia and New Zealand, however access is more limited than in the general population.<sup>[7,34,88]</sup> In New Zealand, OAT is only available to prisoners who had initiated OAT prior to incarceration (except in one prison where OAT can be initiated).<sup>[89]</sup> In Australia, OAT can and frequently is newly initiated within prison;<sup>[7]</sup> a total of 3,588 clients received OAT in prisons on a given day in 2019 (7% of all OAT clients in the country).<sup>[25]</sup> The availability of OAT can vary considerably between prisons in different states and territories. Out of the 101 OAT prescribers in correctional facilities in Australia, 48 were located in New South Wales, whereas just three were in Queensland.<sup>[25]</sup> Clients of OAT prescribers in correctional facilities in 2019 were younger than clients of public or private prescribers, and there were more males among them: nine out of ten OAT clients in correctional facilities were male, compared to twice as many males as females at public and private prescribers.<sup>[25]</sup>



*In Australia, OAT can and frequently is newly initiated within prison; a total of 3,588 clients received OAT in prisons on a given day in 2019 (7% of all OAT clients in the country)*

<sup>19</sup> Pre-exposure prophylaxis is a course of medication that can reduce the chances of HIV infection before exposure to the virus. Post-exposure prophylaxis is a preventive medical treatment started after possible exposure to HIV in order to prevent the infection from occurring.

### 3. Policy developments for harm reduction

The Australian and New Zealand governments remain supportive of harm reduction interventions both within their countries and internationally, for example through support for harm reduction at the UN Commission on Narcotic Drugs.<sup>[7,90,91]</sup> Harm reduction forms one of the three pillars of Australia's National Drug Strategy 2017-2026 (alongside demand reduction and supply reduction), and is included in the most recent national drug strategy annual report as an approach that is integral to the national response to drug use.<sup>[92,93]</sup> New Zealand's National Drug Policy 2015-2020 also explicitly supports harm reduction and a people-centred system of interventions.<sup>[94]</sup> No evidence has been found of policy documents declaring explicit support for harm reduction in the region outside these two countries.

In November 2018, the Australian government publicly released five national blood-borne virus (BBV) and sexually transmissible infection (STI) strategies for 2018-2022.<sup>[7,95]</sup> While the National STI Strategy does not contain explicit reference to harm reduction, the National HIV Strategy, the National Hepatitis C Strategy, the National Hepatitis B Strategy and the National Aboriginal and Torres Strait Islander BBV and STI Strategy include harm reduction in the guiding principles, and increasing access to NSPs and facilitation of peer-based harm reduction initiatives are included among the priority areas of action.<sup>[95-99]</sup>

There were some changes in the legal environment in the region. Australia's National Drug Strategy annual report highlighted that the New South Wales Police Force has announced a trial of drug Criminal Infringement Notices<sup>20</sup> for minor possession offences at music festivals as part of a harm reduction approach.<sup>[92]</sup> In August 2019, New Zealand's drug laws were updated to emphasize a health-based approach to personal drug use. In the case of personal possession and use of drugs, police must determine whether a health-centred or therapeutic approach would be more beneficial to the public interest than prosecution.<sup>[26,100]</sup>

### 4. Funding developments for harm reduction

In both New Zealand and Australia, much investment in harm reduction services and advocacy comes from national and state governments.<sup>[7,11]</sup> In Australia, a commitment to harm reduction investment is included in the National Drug Strategy.<sup>[93]</sup> However, it is estimated that the majority of funding allocated in the strategy goes to law enforcement,<sup>[7]</sup> while THN and OAT are not fully funded, and funding for traditional harm reduction services and drug checking is insufficient.<sup>[21]</sup> The last analysis of drug-related expenditure in Australia was in 2009/10 and no such analysis has been made since then.<sup>[34,47]</sup> Although funding for harm reduction is stable in Australia, the level of funding is insufficient.<sup>[7,34]</sup> Harm reduction organisations are generally funded to provide services, but there is a lack of funding to engage in policy work and advocacy.<sup>[7]</sup> Funding also limits the expansion of NSPs,<sup>[7,34]</sup> for example AIVL recommendations include extended services for outer suburbs where there are no primary NSPs, outreach services in communities with dispersed populations, and greater funding flexibility in general to establish operating hours that align with community needs or provide a broader range of equipment that matches the community's pattern of usage.<sup>[27]</sup>

In New Zealand, harm reduction in general is closely aligned with the Ministry of Health, which provides the Secretariat for New Zealand's National Drug Policy, and the NZNEP.<sup>[11]</sup> As with all government-funded programmes in the country, service provision is limited by the allocation of resources, a problem not limited to harm reduction.<sup>[11]</sup> Since 2018, the government of New Zealand has on several occasions introduced extra funds to address emerging trends in drug use. To address the acute drug harms related to synthetic cannabinoid receptor agonists, the government announced a dedicated NZD 8.6 million (USD 5.7 million) acute drug harm discretionary fund at the end of 2018 to support community responses.<sup>[101]</sup> Furthermore, in 2020, a NZD 32 million (USD 21.3 million) investment was announced for District Health Boards to strengthen their existing alcohol and drug specialist services.<sup>[11]</sup>

20 Criminal Infringement Notices are 'on-the spot' fines<sup>[7,34]</sup> for certain minor offences.

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