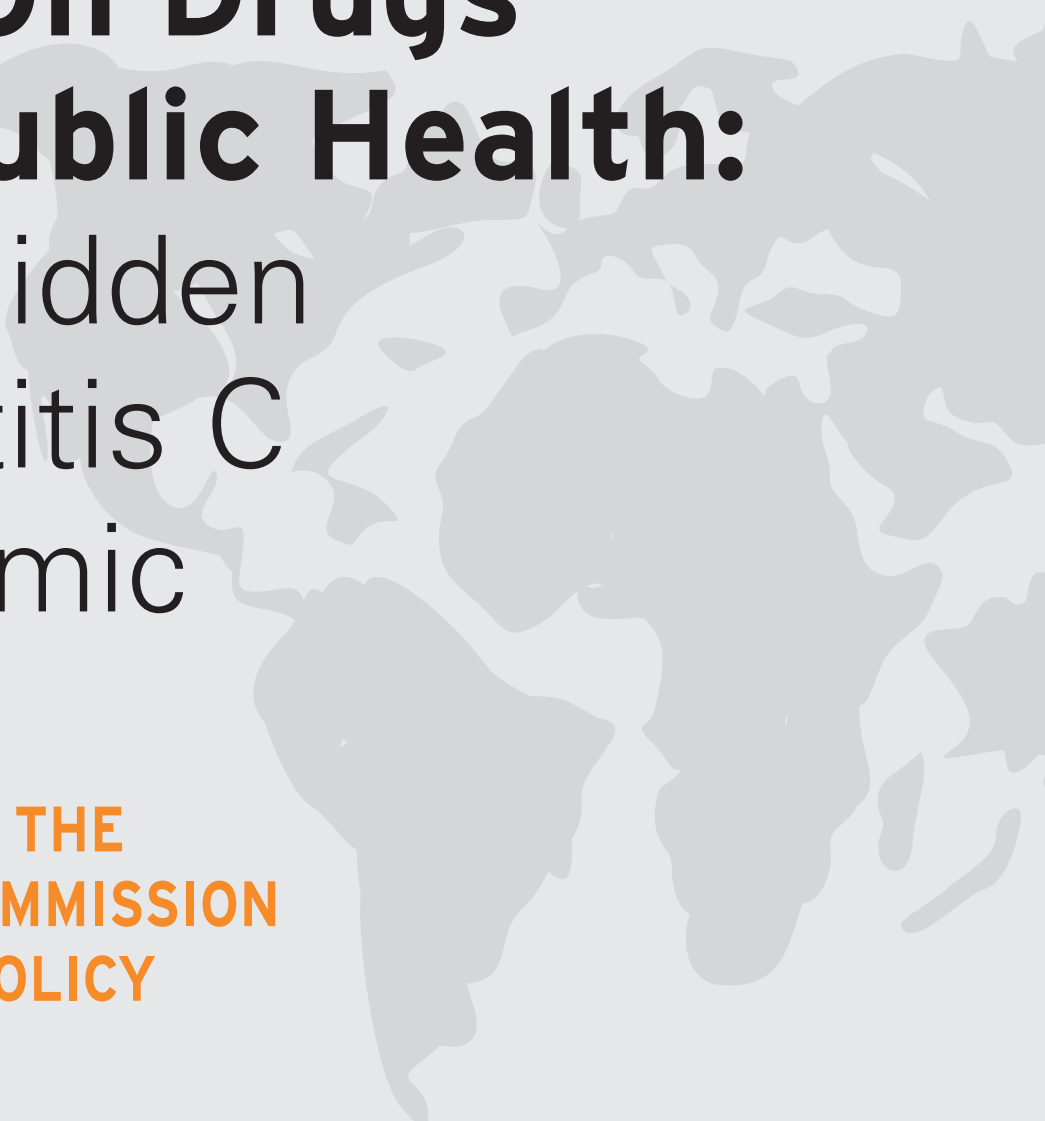


The Negative Impact Of The War On Drugs On Public Health: The Hidden Hepatitis C Epidemic



**REPORT OF THE
GLOBAL COMMISSION
ON DRUG POLICY**



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Upper left: The hidden hepatitis C epidemic is often overlooked by politicians and the general public. Civil society actions play a key role in raising awareness, as seen in this photo where a hepatitis C patient is surrounded by international and national media in Ukraine.

Photo by Denis Dyadin // courtesy of Ukrainian Community Advisory Board (UCAB)

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Hepatitis C is a highly prevalent chronic viral infection which poses major public health, economic and social crises, particularly in low and middle income countries. The global hepatitis C epidemic has been described by the World Health Organization as a ‘viral time bomb’, yet continues to receive little attention. Access to preventative services is far too low, while diagnosis and treatment are prohibitively expensive and remain inaccessible for most people in need. Public awareness and political will with regard to hepatitis C are also too low, and national hepatitis surveillance is often non-existent.

The hepatitis C virus is highly infectious and is easily transmitted through blood-to-blood contact. It therefore disproportionately impacts upon people who inject drugs: of the 16 million people who inject drugs around the world, an estimated 10 million are living with hepatitis C. In some of the countries with the harshest drug policies, the majority of people who inject drugs are living with hepatitis C – more than 90 percent in places such as Thailand and parts of the Russian Federation.

The hepatitis C virus causes debilitating and fatal disease in around a quarter of those who are chronically infected, and is an increasing cause of premature death among people who inject drugs. Globally, most HIV-infected people who inject drugs are also living with a hepatitis C infection. Harm reduction services – such as the provision of sterile needles and syringes and opioid substitution therapy – can effectively prevent hepatitis C transmission among people who inject drugs, provided they are accessible and delivered at the required scale.

Instead of investing in effective prevention and treatment programmes to achieve the required coverage, governments continue to waste billions of dollars each year on arresting and punishing drug users – a gross misallocation of limited resources that could be more efficiently used for public health and preventive approaches. At the same time, repressive drug policies have fuelled the stigmatisation, discrimination and mass incarceration of people who use drugs. As a result, there are very few countries that have reported significant declines in new infections of hepatitis C among this population. This failure of governments to prevent and control hepatitis disease has great significance for future costs to health and welfare budgets in many countries.

In 2012 the Global Commission on Drug Policy released a report that outlined how the ‘war on drugs’ is driving the HIV epidemic among people who use drugs. The present report focuses on hepatitis C as it represents another massive and deadly epidemic for this population. It provides a brief overview of the hepatitis C virus, before exploring how the ‘war on drugs’ and repressive drug policies are failing to drive transmission down.

The silence about the harms of repressive drug policies has been broken – they are ineffective, violate basic human rights, generate violence, and expose individuals and communities to unnecessary risks. Hepatitis C is one of these harms – yet it is both preventable and curable when public health is the focus of the drug response. Now is the time to reform.

MAIN RECOMMENDATIONS

1. Governments should publicly acknowledge the importance of the hepatitis C epidemic and its significant human, economic and social costs, particularly among people who use drugs.
2. Governments must acknowledge that drug policy approaches dominated by strict law enforcement practices perpetuate the spread of hepatitis C (as well as HIV and other health harms). They do this by exacerbating the social marginalisation faced by people who use drugs, and by undermining their access to essential harm reduction and treatment services.
3. Governments should therefore reform existing drug policies - ending the criminalisation and mass incarceration of people who use drugs, and the forced treatment of drug dependence.
4. Governments must immediately redirect resources away from the 'war on drugs' and into public health approaches that maximise hepatitis C prevention and care, developed with the involvement of, the most affected communities.
5. Drug policy effectiveness should be measured by indicators that have real meaning for affected communities, such as reduced rates of HIV and hepatitis transmission and mortality, increased service coverage and access, reduced drug market violence, reduced human rights violations, and reduced incarceration.
6. Governments must remove any legal or de facto restrictions on the provision of sterile injection equipment and other harm reduction services, as well as opioid substitution therapy, in line with World Health Organisation guidance. It is critical that these services are delivered at the scale required to impact upon hepatitis C transmission - both in the community but also in prisons and other closed settings.
7. Governments should ensure that people who use drugs are not excluded from treatment programmes, by establishing national hepatitis C strategies and action plans with the input of civil society, affected communities, and actors from across the HIV, public health, social policy, drug control and criminal justice sectors.
8. Governments must improve the quality and availability of data on hepatitis C, strengthening surveillance systems and better evaluating prevention and control programmes. This will, in turn, help to raise political and public awareness of the epidemic.
9. Governments should enhance their efforts to reduce the costs of new and existing hepatitis C medicines - including through negotiations with pharmaceutical companies to ensure greater treatment access for all those in need. Governments, international bodies and civil society organisations should seek to replicate the successful reduction in HIV treatment costs around the world, including the use of patent law flexibilities to make them more accessible.
10. The Global Commission calls upon the United Nations to demonstrate the necessary leadership and commitment to promote better national responses and achieve the reforms listed above.
11. Act urgently: The 'war on drugs' has failed, and significant public health harms can be averted if action is taken now.

HEPATITIS C AMONG PEOPLE WHO USE DRUGS

There are an estimated 16 million people who inject drugs around the world,¹ and around 10 million of them are affected by hepatitis C.² This epidemic is growing rapidly in many regions of the world, driven by ineffective and repressive drug policies and posing major economic and social threats to countries. The hepatitis C virus is transmitted through blood-to-blood contact. It can be prevented among people who use drugs when proven harm reduction interventions (such as the provision of sterile needles and syringes) are delivered at the required scale. Hepatitis C is also curable, yet very few people are able to access treatment due to its prohibitive costs. For people who use drugs, access to prevention or treatment are further decreased by criminalisation, imprisonment and systematic discrimination – including reluctance from some health care providers to offer treatment.

Epidemiology

Hepatitis C is more than three times more prevalent among people who inject drugs than HIV.^{1,2} The largest numbers of hepatitis C infections among this population are reported in East and Southeast Asia (2.6 million people), and in Eastern Europe (2.3 million people). The three countries with the highest hepatitis C burden among people who inject drugs are China (1.6 million people), the Russian Federation (1.3 million people) and the USA (1.5 million people).²

Sharing needles and syringes to inject drugs is the the most common risk factor for contracting the hepatitis C virus.

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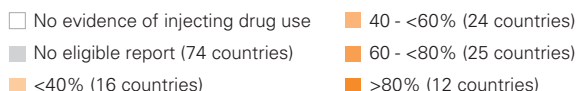
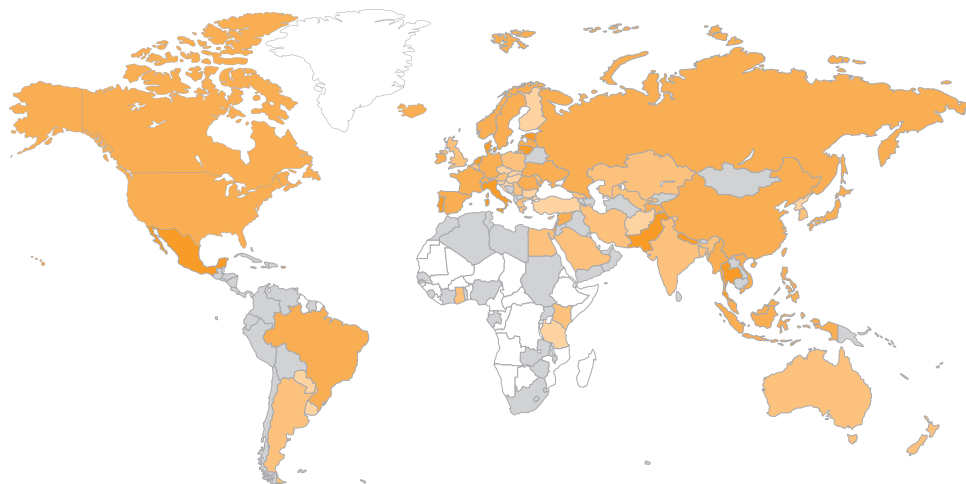
In most countries, more than half the people who inject drugs are living with hepatitis C.^{3,4} Infection rates are particularly high in many countries whose drug policies and law enforcement practices restrict access to sterile needles and syringes. In Thailand and parts of the Russian Federation, for example, up to 90 percent of people who inject drugs have tested positive for hepatitis C.⁵ The rate of new hepatitis C infections among people who inject drugs is often above 10 percent per year⁶ – but can be substantially higher in some countries: in a study from the USA, more than half of those who recently started injecting were infected.⁷

Crucially, the true size of this epidemic is likely underestimated as most countries have insufficient surveillance data.^{8,9} Increased efforts to build comprehensive, coordinated surveillance systems to monitor hepatitis infections are needed as a foundation for the scale-up of effective prevention and control services.¹⁰



FIGURE 1.
THE PREVALENCE
OF HEPATITIS C
ANTIBODIES AMONG
PEOPLE WHO
INJECT DRUGS²

Note: The prevalence data in this map provide cumulative information on infections over the last decades. High prevalence rates on this map therefore may not indicate high rates of new infections. Data on new hepatitis C infections (also known as 'incidence') is unavailable in most countries.



HOW THE INCARCERATION OF PEOPLE WHO USE DRUGS FUELS THE HEPATITIS C EPIDEMIC

One major consequence of the 'war on drugs' is the wide-scale incarceration of people who use drugs. At the same time, injecting drug use in prisons remains widespread. The absence of sterile injecting (and tattooing) equipment, and the lack of opioid substitution treatment and hepatitis services in most prisons and pre-trial detention settings¹¹ makes incarceration an independent risk factor for hepatitis C infection among people who use drugs.¹²

In many countries, hepatitis C is more common in prisons than in the general population.¹³ As a result, the provision of testing and treatment to prisoners has been shown to be a cost-effective strategy.¹⁴ The provision of sterile injecting equipment, opioid substitution therapy and drug treatment in all closed settings is also recommended by the World Health Organization. Contrary to common beliefs, it has been shown that needle and syringe distribution in closed settings has no negative impact on the security of prison staff,

and (as in community settings) it does not increase injecting drug use.^{15,16} A recent survey in Scotland found lower rates of hepatitis C infection among prisoners who inject drugs than in the community - linked to the wide-scale availability and high coverage of opioid substitution therapy inside prisons.¹⁷

The USA has one of the world's largest prison populations for drug offences, and the level of hepatitis C infection amongst US prisoners is substantially higher than in the general population: between 12 and 35 percent of prison inmates are infected with hepatitis C, compared to between 1 and 2 percent of the general population. Despite the evidence of effectiveness, the US Center for Disease Control and Prevention (CDC) does not recommend needle and syringe programmes in prisons,¹⁸ and the coverage of hepatitis C testing and treatment in US prisons is poor.^{19,20}

Transmission

The risk of contracting hepatitis C when sharing injection equipment is significantly higher than for HIV due to the hepatitis C virus's greater infectivity.²¹ This fact, together with the high prevalence of hepatitis C, explains why this particular epidemic spreads so fast among people who inject drugs. The hepatitis C virus survives for a significant period of time outside the body – in needles and syringes,²² but also in other injecting equipment such as filters and water used for injections.²³ This may also partially explain why new hepatitis C infections are not decreasing as fast as new HIV infections in some countries that have established harm reduction programmes. The coverage of these programmes needs to be much higher in most countries in order to impact upon hepatitis C transmission: even if people who inject drugs use sterile equipment the majority of times, just a few high-risk injections per year can sustain the epidemic.²⁴ This scale-up requires strong political commitment and supportive policies, including the shift of resources away from the 'war on drugs' and into public health approaches.

In higher income countries, injecting drug use has been the primary mode of hepatitis C transmission for several decades – accounting for between 50 and 80 percent of all new hepatitis C infections.²⁵ Due to its high potential for transmission, it has also been hypothesised that the hepatitis C virus could be spread by sharing non-injection drug use equipment such as straws and pipes,²⁶ while non-sterile tattooing and piercing practices can also lead to infections. Contaminated medical equipment and blood transfusions may also account for significant numbers of infections in countries with weak health infrastructures and blood testing capacities.

Mortality and Morbidity

Hepatitis C is the world's leading cause of liver disease: for 80 percent of those living with the virus, their infection takes a chronic course.²⁷ The virus causes fatal liver disease in around a quarter of those with chronic infections. However, hepatitis C infections can present no, or only mild, symptoms for several years – so the majority of people are not aware of their condition (hence the virus's label as the "silent epidemic"²⁸). In many cases, chronic hepatitis C infections remain undetected until advanced liver damage has occurred.

The risk of liver cirrhosis and liver cancer increases with age and will progress quicker in the presence of high alcohol intake, HIV infection, illicit drug use and the long-term use of psychiatric medications. As a result, people who use drugs and who are living with hepatitis C have a particularly heightened risk of liver cirrhosis, liver cancer and liver-related death.^{29,30}

Hepatitis C is an increasing cause of early deaths among people who inject drugs.³¹ Between 1999 and 2007, more people in the USA died from hepatitis C than from HIV.³² Between the age of 45 and 50, the risk of developing liver cirrhosis rises sharply in hepatitis C-infected people who inject drugs.³⁰ The global burden of advanced hepatitis C-related liver disease is growing, and will continue to grow among people who use drugs – with clear implications for public health and public spending. Hepatitis C is a global public health crisis: the World Health Organization has referred to it as 'the viral time bomb'.³³

HIV/HEPATITIS C CO-INFECTION

Approximately 3 million people who inject drugs are living with HIV, and most of these individuals are also living with hepatitis C infections.³⁴ In China, the Russian Federation and Vietnam, for example, co-infection rates among HIV-infected people who inject drugs are estimated to be more than 90 percent.³⁵ Since the vast majority of co-infected individuals are people who inject drugs,³⁶ the twin epidemics of HIV and hepatitis C are fuelled by policies that increase risk, impede access to prevention services, and drive vulnerable people away from health services. Importantly, preventive efforts delivered at the scale needed to prevent hepatitis C transmission among people who inject drugs will also be able to prevent HIV transmission.

Hepatitis C disease progression, survival outcomes and treatment success are all negatively influenced by HIV co-infection.³⁷ At the same time, treatment uptake remains unacceptably low for co-infected individuals, even those who are receiving HIV care³⁸ - yet hepatitis C treatment has been shown to increase adherence to HIV treatment among this population.³⁹ In addition, very few people who use drugs have been enrolled into clinical trials on HIV and hepatitis C co-infection treatment, and this needs to be urgently rectified in order to further improve treatment outcomes for these individuals.

HEPATITIS B

Hepatitis B is another viral infection and, like hepatitis C, it is transmitted primarily through blood-to-blood contact. The routes of transmission for hepatitis B are broader: including from mother to child, person to person in early childhood, unsafe medical procedures, and higher-risk sexual practices, as well as the sharing of contaminated equipment by people who inject drugs. In adults, the chance of developing a chronic infection is less than 5 percent.

TESTING FOR HEPATITIS C

People at risk of hepatitis C infection should be regularly tested to determine if they are contagious or in need of treatment. However, the number of undiagnosed cases is estimated to be very high: between 50 and 90 percent of people living with hepatitis C may be unaware of their infection.^{49,50} In countries with repressive drug laws, hepatitis C testing rates among people who use drugs are often even lower^{10,51} - largely due to stigmatisation in health care settings, fear of arrest, or the unavailability of treatment and testing.

The diagnosis of hepatitis C is carried out in two steps:

1. A blood spot or saliva sample is tested for hepatitis C antibodies: if this test is positive, then the person has been in contact with the virus at some stage of their life.
2. A viral load test then looks for hepatitis C virus in the blood, and whether or not there is a chronic infection present and a person is contagious (in approximately 20 percent of cases the infection spontaneously resolves and no further action is required).

In order to improve hepatitis C awareness, each test should be conducted alongside information and counselling about how the virus is transmitted and how it can be prevented.

Worldwide, 1.2 million people who inject drugs are estimated to have chronic hepatitis B.² A safe, inexpensive and effective vaccination is available but the systematic discrimination and criminalisation of this population means that the availability and uptake of the hepatitis B vaccination remains poor.

Preventing Hepatitis C

In 2012 the World Health Organization issued 'Guidance on the Prevention of Viral Hepatitis B and C among People Who Inject Drugs', which is based on a six-part framework of human rights, access to health care, access to justice, the acceptability of services to people who use drugs, health literacy and integrated service provision. The Guidance further endorses the evidence-based package of harm reduction interventions for the fight against hepatitis B and C, HIV and tuberculosis – including needle and syringe programmes and opioid substitution therapy (both of which are also effective in preventing HIV transmission), targeted education, and the prevention, diagnosis and treatment of viral hepatitis.²⁸

As there is currently no vaccine against hepatitis C, the provision of sterile injecting equipment (both needles and syringes, but also other items such as filters, water and cookers) and opioid substitution therapy are the primary prevention measures that can disrupt the dominant route of transmission among people who inject drugs.^{40,41,42,43} However, the coverage of these interventions needs to be much higher in the majority of countries. As such, countries with low (or no) coverage of these interventions should primarily concentrate on their urgent scale-up.⁴⁴

Crucially, because of the scale of coverage required and similar routes of transmission, effective Hepatitis C prevention is also effective HIV prevention among people who inject drugs.

However, substantial reductions in hepatitis C transmission are unlikely to be achieved through these two interventions alone⁴⁵ – the rapid scale up antiviral treatment is also required.⁴⁶ As in the field of HIV, the topic of 'treatment as prevention' has also gained recent attention for hepatitis C: by scaling up treatment access the rate of transmission will be reduced as fewer individuals will be carrying active hepatitis C infections. Supervised drug consumption facilities, peer-based interventions, individual behavioural interventions, and voluntary testing and counselling are further evidence-based measures that have been shown to reduce injecting risk behaviour.⁴⁷

The effective delivery of evidence-based preventive measures will reduce hepatitis C infections, saving lives and money. The 'war on drugs' represents a major barrier to these interventions – resulting instead in increased stigma and fear, increased sharing of injecting equipment, increased infections, and reduced access to health care.^{48,13,16}



Treatment of Hepatitis C

Hepatitis C is a curable disease, but very few people who use drugs are allowed to access treatment.^{51,52,53,54,55} Evidence-based national guidelines for the management of hepatitis C are urgently needed in many countries to dispel the myths about treatment prospects for people who use drugs. For example, some health care providers continue to incorrectly assert that people who use drugs cannot manage the side effects of treatment, and that they will become re-infected with hepatitis C after treatment. Research has demonstrated that people who inject drugs can have treatment success rates that are similar to other patients.¹⁷ Some studies also have shown that re-infection rates after treatment can be low. Treating people who inject drugs can be especially cost-effective because of the greater public health benefits achieved through averting future infections.⁴ As with countless other factors such as housing status, alcohol use or mental health, drug use should never automatically exclude an individual from treatment. Instead, decisions must be made based on individual assessments.⁵⁶

If treatment access remains low, there will be a rising number of people who use drugs who develop advanced or fatal liver disease. On the other hand, scaling-up treatment will have a major impact on the prevalence of the disease – curing individuals who may have otherwise spread the virus, including people who continue to use drugs or who are at risk of relapse.⁴⁶ As such, this is a highly cost-effective public health policy, especially when compared to offering no treatment or treating only those who do not inject drugs.⁵⁷

Left: Harm reduction activities among people who inject drugs: needle and syringe programmes and opioid substitution therapy in Ukraine.

Photos by Efrek Lukatskiy & Natalia Kravchuk // courtesy of the International HIV/AIDS Alliance in Ukraine

CURRENT AND FUTURE HEPATITIS C TREATMENTS

The standard hepatitis C treatment is a dual combination of 'pegylated interferon' (one injection per week) and ribavirin (one to three tablets, twice a day), although the exact treatment protocol will depend which genotype of the virus a person has. Depending on a range of factors, the duration of treatment varies from 12 to 72 weeks. These treatment regimens are challenging for all patients due to their side effects and the sheer length of treatment, but these issues can be managed through good clinical care.

There are several new hepatitis C medicines in the development pipeline, with results from trials suggesting that more effective and better tolerated regimens should become available in the next few years. These treatment regimens will have the advantage of being tablet-only and not containing interferon. They will have fewer side effects and will require shorter treatment durations - making them easier to use. With these new medicines available, it has been claimed that hepatitis C could eventually be eliminated.⁵⁸

International recommendations for the management of hepatitis C among people who inject drugs are being developed by the World Health Organization and the International Network on Hepatitis care in Substance Users (INHSU).⁵⁶ These will serve as a foundation for more specific guidelines to be adapted for the needs and contexts of individual countries.

Awareness and Stigma

Low awareness about hepatitis C – among the general population, policy makers, people who use drugs and health care professionals – remains a significant barrier to efficiently responding to this growing epidemic.⁶³ Knowledge about hepatitis C and the harms of undetected and untreated infections is poor, even for individuals living with the virus.^{64,65} For example, a recent study among people who inject drugs in Thailand revealed that two thirds of respondents did not seek hepatitis C testing because they had “never heard” of the virus.⁵⁰ Reasons for this poor awareness include the lack of immediate symptoms, the slow progression of the disease, low political will to tackle the epidemic, the stigmatisation of people who use drugs, the lack of support for people living with hepatitis C, and the reliance on repressive drug control responses that prevent people who use drugs from accessing care and support. For many people who inject drugs, hepatitis C is almost viewed as a harm that cannot be avoided.

When people who use drugs are living with hepatitis C, they can suffer a double stigma which deters them from testing, treatment and care, as well as from disclosing their hepatitis C status or injecting drug use to medical professionals.⁶⁶ Addressing these issues is therefore a core part of an effective response to the hepatitis C epidemic among people who use drugs.

Over time, hepatitis C has become increasingly associated with injecting drug use due to a global reduction in transmissions through medical practices and blood transfusions. There is therefore noticeably less sympathy for some people living with hepatitis C. This is associated with widespread perceptions of drug dependence as a weakness of character, a lack of responsibility or moral strength, or a ‘social evil’, rather than as a chronic relapsing disease. Where the ‘war on drugs’ is being fought, repressive drug policies and the mass incarceration of people who use drugs are exacerbating these misconceptions.

HEPATITIS C IN LITHUANIA

In Lithuania, more than 90 percent of people who inject drugs are living with the hepatitis C virus,² and everyone receiving opioid substitution treatment is tested and referred to treatment if needed. The number of patients enrolled into hepatitis C treatment in this middle-income country has increased by 26 percent between 2008 and 2011. Hepatitis C diagnostics and treatment are covered for those with mandatory health insurance,⁵⁹ but ‘pegylated interferon’ remains one of the government’s most costly medicines (the price of treatment decreased by only 3 percent between 2007 and 2011). However, people who inject drugs often do not have valid health insurance, are not aware of their hepatitis C status, and do not have access to either opioid substitution therapy or hepatitis C treatment.

While Lithuania is a leading country in Eastern Europe in terms of the provision of hepatitis C treatment, only 5 percent of those in need have been reached in recent years.^{59,60} The country’s response to the epidemic is being hindered by the low coverage of harm reduction interventions and an unfavourable policy environment for people who use drugs. There are nine needle and syringe programmes in Lithuania (funded primarily by local government), and 19 institutions offering opioid substitution therapy.⁶¹ Yet the coverage of these preventive measures is insufficient: an average of 37 needles is distributed each year per person who injects drugs,⁶² and other injecting equipment (such as filters and water) is not provided. There are also key gaps at the national level in terms of hepatitis C testing and surveillance.

THE FINANCIAL BURDEN OF HEPATITIS C

The World Health Organization has referred to hepatitis C as a 'viral time bomb' due to the global human, social and economic costs that the epidemic threatens to inflict.³³ In order to respond effectively and urgently to this threat, governments need to scale-up both prevention and treatment, especially for people who use drugs. This will require drug policy reform to create more enabling environments for public health approaches, the redirection of resources away from the 'war on drugs' and into health services, and widespread efforts to reduce the costs of treatment.

Around the world, the high cost of hepatitis C treatment is having a devastating effect on its availability for people who use drugs. The manufacturers of the two patented forms of 'pegylated interferon' (Roche and Merck) charge different prices in different countries: the same medication can range in cost from US\$ 2,000 to US\$ 20,000 per treatment course of treatment.⁶⁷ These patents are due to expire in the next two to four years. Hepatitis C diagnosis is relatively expensive too – with viral load tests costing between US\$ 100 and US\$ 200 as they require specialist laboratory capacities.

Yet hepatitis C has not received the widespread attention and international pressure – from governments, international donors, the United Nations and others – that has helped to dramatically reduce the price of antiretroviral therapy for HIV.⁶⁸ Recent calls have been made for the World Health Organization to include hepatitis C treatments in their list of essential medicines, and also for UNITAID to include hepatitis C in its new four-year strategy in the hope that the organisation can replicate its significant impact in making HIV and tuberculosis treatments more affordable and accessible.⁶⁹

At the national level, treatment costs can be immediately reduced through active negotiations with pharmaceutical companies, alongside pressure from civil society and international organisations, to help lower prices and make treatment more accessible (including safe and effective generic versions of pegylated interferon).⁷⁰

Even at current prices, however, hepatitis C treatment is cost-effective from a public health perspective due to the significant costs of treating liver disease caused by chronic, untreated infections. In the USA, for example, the one-off cost of hepatitis C treatment (between US\$ 16,300 and US\$ 32,700) is far exceeded by the cost of treating liver cancer (at an average of US\$ 44,200 per year).⁷⁴

With regards to the new hepatitis C medicines in the development pipeline, their use will be severely limited if they are not affordable for low and middle income countries. If negotiations with pharmaceutical companies do not lead to sufficient reductions in prices, countries should turn to the flexibilities that are permitted for public health emergencies as part of the World Trade Organization's Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS).⁷⁵ These include the issue of compulsory licenses for the import or production of cheaper generic or 'biosimilar' versions of these medicines, despite them being under patent.

Reducing the costs of existing and future hepatitis treatments should be an urgent priority for all national and international authorities.

ADVOCATING FOR MORE, CHEAPER TREATMENT: THE EXAMPLE OF UKRAINE

Civil society organisations have advocated successfully for lower treatment prices and greater government commitments: for example, in Ukraine but also in India and Thailand. In Ukraine around 1 million people are living with hepatitis C, with more than 90 percent of people who inject drugs living with the virus. Similar to the situation faced by most other countries around the world, this means that the government cannot hope to meet the treatment need at current prices. As with many countries around the world, Ukraine still does not have an approved National Hepatitis Program or treatment protocol, and there are no official statistics collected about the virus.

In response, civil society groups such as the International HIV/AIDS Alliance in Ukraine have reached an agreement with the Global Fund to Fight AIDS, Tuberculosis and Malaria to fund treatment for people

who inject drugs - to be delivered alongside opioid substitution therapy and HIV treatments.⁷¹ The price for these treatments has been halved during negotiations with pharmaceutical companies.

Civil society organisations in Ukraine have also played an important role in raising public awareness about hepatitis C, mobilising partners and communities, and facilitating dialogue between the government and the pharmaceutical industry. As a result, the Ukrainian President has instructed the government to find funds for hepatitis C treatment⁷² and the government has adopted a national viral hepatitis programme.⁷³



In April 2013, people living with hepatitis C and civil society groups including the Ukrainian Community Advisory Board (UCAB) demonstrated in front of the Cabinet of Ministers - one of many actions to get the government's attention. This time their demands to approve a national hepatitis C programme and fund hepatitis C treatment and other essential healthcare have been heard at least partially - the programme was approved soon afterward.

Photo by Andriy Andrushkiv // courtesy of All-Ukrainian Network of People Living with HIV and Ukrainian Community Advisory Board (UCAB)

HEPATITIS C AND THE 'WAR ON DRUGS'

The 'war on drugs' was made famous by US President Nixon more than 40 years ago, and has come to refer to a punitive, repressive law enforcement approach that takes a "zero tolerance" approach to drugs and seeks to achieve a drug-free world.⁷⁶ This approach goes beyond the intention of current international drug policy treaties, which recognise concern for "the health and welfare of mankind" and allow for alternatives to criminalisation of drug users.⁷⁷ The 'war on drugs' places people who use drugs within a criminal, rather than a public health, frame. With huge resources being invested in law enforcement around the world, this has translated into a war on people who use drugs and other vulnerable groups.

The Global Commission on Drug Policy has previously outlined how this approach has failed to reduce the supply or use of drugs,⁷⁶ as well as several ways in which the 'war on drugs' has driven the HIV pandemic among people who use drugs:

- Stigma and fear of arrest drive people who use drugs away from essential health services.
- Health care systems limit access to care for people who use drugs, for example by setting arbitrary requirements around abstinence from drug use.
- Restrictions on the provision of sterile needles and syringes results in increased rates of equipment sharing, exacerbated in many situations by the use of needle and syringe possession by police as evidence of criminal activity.
- Prohibitions or restrictions on opioid substitution therapy and other evidence-based treatments result in avoidable harms.
- The mass incarceration of this population places individuals in high-risk environments such as prisons and other closed settings.
- At the same time, the lack of prevention measures in prison leads to avoidable virus outbreaks among people who use drugs.
- Limited public funds continue to be wasted on harmful and ineffective drug law enforcement efforts instead of being invested in proven prevention and treatment strategies.⁷⁸

Each one of these factors is also driving hepatitis C transmission among people who use drugs. Indeed, as hepatitis C is more prevalent and contagious, the negative effects of drug policies are even more severe for this epidemic – further evidence that the 'war on drugs' has failed and serves only to generate harm while demonising and isolating those who are at risk. Hepatitis C among people who use drugs is preventable and treatable, but requires urgent drug policy reform. This chapter explores some of the specific ways in which the 'war on drugs' fuels the hepatitis C epidemic, and the ways in which governments need to react.

Political Ignorance of the Hepatitis C Epidemic

The global hepatitis C pandemic continues to receive only a fraction of the attention, resources and commitment that its size and deadly consequences merit. Global access to hepatitis C treatment is far too low for people who use drugs, particularly in Eastern Europe, Central Asia, and Asia where the epidemic is at its worst among this population.

Although public awareness is increasing, most governments around the world continue to overlook this important area of public health and the impacts of repressive drug policies. Population-based hepatitis surveillance is weak, and political efforts to secure effective prevention and affordable treatment lag far behind those for HIV. Existing harm reduction approaches need to be optimised and expanded in order to tackle hepatitis C – yet even among the leading harm reduction donors, hepatitis C is marginalised as a public health issue.

Fear of Police and Stigma Drive Risks

Those who operate and profit from the multi-billion dollar illicit drug market often remain out of the reach of law enforcement efforts. Instead, the 'war on drugs' persecutes people who use drugs and others from the lower levels of the drug trade. These individuals remain the easiest targets for law enforcement officers, whose performance is often evaluated based on arrest figures and who may seek to supplement income through bribes and extortion.

The emphasis on law enforcement leads to widespread fear of arrest and police harassment, but does not reduce drug use or demand. It simply serves to elevate the risks of hepatitis C and other preventable harms. The main outcome is that people who use drugs are driven away from essential public health services. For example, drug services are often targeted by police officers looking to quickly identify and harass people. This is particularly the case where laws prohibit the possession of needles and syringes, or where these items are used as evidence of criminal acts. People who use drugs may be unable or unwilling to access HIV or hepatitis prevention services, and instead will use potentially contaminated equipment.

The 'war on drugs' also promotes the stigmatisation and discrimination of people who use drugs in a wide range of settings. For example, the 'United Nations Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment' has reported that abuses faced by people who use drugs in health care settings "may cross a threshold of mistreatment that is tantamount to torture or cruel, inhuman or degrading treatment or punishment".⁷⁹ In many settings, people who use drugs are treated with suspicion and mistrust, and it is wrongly assumed that they will not succeed in their treatment unless they are abstinent from drugs.

Mass Incarceration Fuels Transmission

The failed 'war on drugs' has resulted in the mass incarceration of people who use drugs and other vulnerable individuals. As described earlier in this report, prisons are notoriously high-risk settings for the spread of HIV and hepatitis.⁸⁰ Opioid substitution therapy and antiretroviral therapy are routinely denied to people in closed settings, as are evidence-based prevention tools including sterile injecting equipment and condoms. The issues are further exacerbated in compulsory detention centres for people who use drugs, which remain in operation as "treatment" in numerous countries despite widespread concerns about human rights.⁸¹

Drugs remain widely available in prisons across the world, despite official denial of this fact by authorities. At the same time, there is often no access to harm reduction services. Of the 158 countries that have reported injecting drug use, just 10 provide needle and syringe programmes in prisons while only 41 countries

provide prison-based opioid substitution therapy.³ The failure to provide services in closed settings impacts upon hepatitis treatment retention and success from the time of arrest. Governments should urgently develop policies to promote the health of people who use drugs inside custodial settings. At the same time, governments should scale-up policy alternatives to incarceration, including the decriminalisation of drug use and drug possession for personal use.

Repressive Policies Prevent Service Access

Many governments continue to prioritise punitive drug policies that impede the scale-up and coverage of harm reduction services for people who use drugs. Despite the wealth of evidence and technical guidance available to demonstrate the effectiveness and feasibility of harm reduction services, their global coverage is far too low. For example, needle and syringe programmes remain unavailable in more than 70 countries and territories where injecting drug use has been reported.³ The Russian Federation also continues to prohibit medicines used for opioid substitution therapy (methadone and buprenorphine), denying this proven intervention to more than 1.8 million people who inject drugs and with no signs of this position being reconsidered.

Even when services are provided for people who use drugs, the constant threat of arrest and police harassment can impede adherence. Where hepatitis care is available to the general population, people who use drugs often face stigma and discrimination and are unable to access treatment. Care services are rarely adapted to their needs, despite the fact that people who use drugs can be successfully engaged in integrated, community based settings.⁸² Efforts to make services more user-friendly will increase uptake and engagement, which in turn will provide significant benefits in terms of hepatitis C prevention and averted disease burdens. However, the few targeted programmes for people who use drugs are often limited to small-scale 'perpetual pilots' that are dependent on external donors, as opposed to widely accessible, systematic initiatives. Governments need to invest more in efforts to prevent public health harms such as hepatitis C, rather than waste resources on repressive policies – which at best are ineffective, and at worst are exacerbating harms.

PUBLIC HEALTH APPROACHES CAN SUPPRESS HARM: WHERE THEY ARE IGNORED, THE EPIDEMIC IS OUT OF CONTROL

When drug policies are in line with public health goals, rather than striving in vain for a drug-free society, they can protect against hepatitis C transmission. Hepatitis C is preventable and curable – with evidence showing that people who use drugs are just as able to successfully complete treatment as other individuals.⁸³

We now have examples of successful, health-based national programmes increasing awareness and consequently improving hepatitis C detection and treatment,^{49,84} such as the example from Scotland highlighted below. Studies have repeatedly demonstrated that public health and harm reduction approaches do not increase rates of drug use. Rather, they can reduce rates of drug use by creating enabling environments in which people can access health and drug dependence services without judgement or discrimination.

Despite the evidence, many governments continue to pursue counterproductive and ultimately futile efforts to eradicate the drug market. Drugs remain as affordable and widely available as ever. At the same time, our

understanding of the negative consequences of the ‘war on drugs’ continues to expand. Mass incarceration and punitive approaches prevent people who use drugs from accessing potentially lifesaving services, while the stigma, discrimination and abuses which these individuals face create high-risk environments for the transmission of hepatitis.

The silence about the harms produced by the ‘war on drugs’ has been broken, and there is now clear momentum toward reform as governments and the public begin to objectively critique existing policies and practices.⁸⁵ There are a range of approaches and interventions available that have been proven to work, and these need to be scaled-up and further evaluated as a matter of urgency in order to reduce the negative impacts of punitive drug law enforcement.

Action is needed now.

Detention is used as drug ‘treatment’ in Phnom Penh, Cambodia. This image is a still from the film ‘Violence Is Not The Solution’, used in the Campaign to Stop Torture in Health Care.

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BEST PRACTICE: THE NATIONAL HEPATITIS C ACTION PLAN IN SCOTLAND⁸⁶

Evidence-based national hepatitis C strategies have the potential to reduce the financial and societal burden of the epidemic. The Hepatitis C Action Plan for Scotland is an impressive example of a national strategy that has successfully focused on people who use drugs. Within a period of six years, hepatitis C testing, prevention and treatment have all been improved.

The two-phase Action Plan was launched in 2006, and aimed to involve all stakeholders to build a strong governance structure. It explicitly acknowledged that people who inject drugs were the main group at risk of hepatitis C in the country, and focused the available resources accordingly. Key outcomes include:

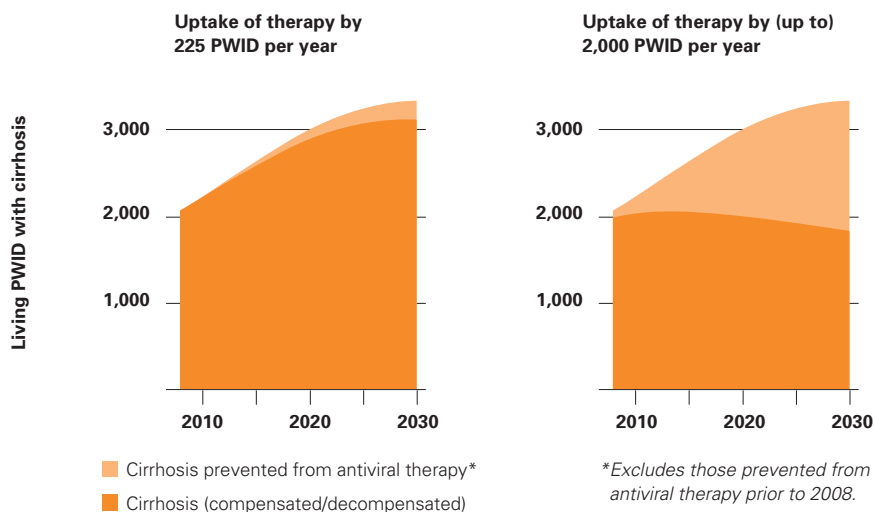
- A four-fold to six-fold increase in the provision of sterile injecting equipment, including needles, syringes, filters and spoons.
- An increase in the number of people tested for hepatitis C, mainly in prisons and drug services.

- Increased awareness of hepatitis C due to a wide range of initiatives to promote testing.
- A doubling of the number of people receiving hepatitis C treatment following the development of clinical services - including a large number of people who inject drugs.
- An eight-fold increase in the number of prisoners receiving hepatitis C treatment.
- A clear downward trend in the number of recent hepatitis C infections.

As the Scottish Action Plan continues to be implemented and evaluated, further improvements in hepatitis C care and outcomes for people who use drugs are anticipated. For example, mathematical modelling has been used to predict the impact of hepatitis C treatment uptake on the number of liver cirrhosis and liver disease cases in Scotland. As the graph below shows, providing hepatitis C treatment to 2,000 people who inject drugs each year will prevent more than 1,000 cases of liver cirrhosis by 2030.⁸⁷

FIGURE 2.

Modelled number of people who inject drugs (PWID) with cirrhosis in Scotland by different uptake rates of hepatitis c treatment, 2008-2030⁸⁸



REFERENCES

- 1 Mathers BM, Degenhardt L, Phillips B, et al (2008). Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review. *Lancet*; 372(9651): 1733-1745.
- 2 Nelson PK, Mathers BM, Cowie B, et al (2011). Global epidemiology of hepatitis B and hepatitis C in people who inject drugs: results of systematic reviews. *Lancet*; 378(9791): 571-583.
- 3 Harm Reduction International (2012). The global state of harm reduction 2012: towards an integrated response. Available from: <http://www.ihra.net/global-state-of-harm-reduction-2012>
- 4 Vickerman P, Hickman M, May M, et al (2010). Can hepatitis C virus prevalence be used as a measure of injection-related human immunodeficiency virus risk in populations of injecting drug users?: an ecological analysis. *Addiction*; 105(2): 311-318.
- 5 Rhodes T, Platt L, Judd A, et al (2005). Hepatitis C virus infection, HIV co-infection, and associated risk among injecting drug users in Togliatti, Russia. *Int J STD AIDS*; 16(11): 749-754.
- 6 MacDonald M, Crofts N, Kaldor J (1996). Transmission of hepatitis C virus: rates, routes, and cofactors. *Epidemiol Rev*; 18(2): 137-148.
- 7 Garfein RS, Vlahov D, Galai N, et al (1996). Viral infections in short term injecting drug users: the prevalence of hepatitis C, hepatitis B, human immunodeficiency and human T-lymphotropic viruses. *Am J Public Health*; 86: 655-661.
- 8 World Hepatitis Alliance (2008). The World Hepatitis Atlas: completing the data map.
- 9 ECDC and EMCDDA (2011). Prevention and control of infectious diseases among people who inject drugs. Stockholm: ECDC and EMCDDA.
- 10 Hagan LM, Schinazi RF (2013). Best strategies for global HCV eradication. *Liver Int*; 33 Suppl 1: 68-79.
- 11 Jurgens R, Ball A, Verster A (2009). Interventions to reduce HIV transmission related to injecting drug use in prison. *Lancet Infect Dis*; 9(1): 57-66.
- 12 Falster K, Kaldor JM, Maher L (2009). Hepatitis C virus acquisition among injecting drug users: a cohort analysis of a national repeated cross-sectional survey of needle and syringe program attendees in Australia, 1995-2004. *J Urban Health*; 86(1): 106-118.
- 13 Sarang A, Rhodes T, Sheon N, Page K (2010). Policing drug users in Russia: risk, fear, and structural violence. *Subst Use Misuse*; 45(6): 813-864.
- 14 Sutton AJ, Edmunds WJ, Gill ON (2006). Estimating the cost-effectiveness of detecting cases of chronic hepatitis C infection on reception into prison. *BMC Public Health*; 6: 170.
- 15 Hunt DR, Saab S (2009). Viral hepatitis in incarcerated adults: a medical and public health concern. *Am J Gastroenterol*; 104(4): 1024-1031.
- 16 Friedman SR, Kippax SC, Phaswana-Mafuya N, et al (2006). Emerging future issues in HIV/AIDS social research. *AIDS*; 20(7): 959-965.
- 17 Hellard M, Sacks-Davis R, Gold J (2009). Hepatitis C treatment for injection drug users: a review of the available evidence. *Clin Infect Dis*; 49(4): 561-573.
- 18 Weinbaum C, Lyerla R, Margolis HS (2003). Prevention and control of infections with hepatitis viruses in correctional settings. *MMWR Recomm Rep*; 52 (RR-1): 1-36.
- 19 Tan JA, Joseph TA, Saab S (2008). Treating hepatitis C in the prison population is cost-saving. *Hepatology*; 48(5): 1387-1395.
- 20 Rice JP, Burnett D, Tsotsis H, et al (2012). Comparison of hepatitis C virus treatment between incarcerated and community patients. *Hepatology*; 56(4): 1252-1260.
- 21 Sepkowitz KA (1996). Occupationally acquired infections in health care workers. *Ann Intern Med*; 125(11): 917-928.
- 22 Painsil E, He H, Peters C, et al (2010). Survival of hepatitis C virus in syringes: implication for transmission among injection drug users. *J Infect Dis*; 202(7): 984-990.
- 23 Doerrbecker J, Behrendt P, Mateu-Gelabert P, et al (2013). Transmission of hepatitis C virus among people who inject drugs: viral stability and association with drug preparation equipment. *J Infect Dis*; 207(2): 281-287.
- 24 Vickerman P, Martin N, Turner K, Hickman M (2012). Can needle and syringe programmes and opiate substitution therapy achieve substantial reductions in hepatitis C virus prevalence?: model projections for different epidemic settings. *Addiction*; 107(11): 1984-1995.
- 25 Shepard CW, Finelli L, Alter MJ (2005). Global epidemiology of hepatitis C virus infection. *Lancet Infect Dis*; 5: 558-567.
- 26 Scheinmann R, Hagan H, Lelutiu-Weinberger C, et al (2007). Non-injection drug use and hepatitis C virus: a systematic review. *Drug Alcohol Depend*; 89(1): 1-12.
- 27 Te HS, Jensen DM (2010). Epidemiology of hepatitis B and C viruses: a global overview. *Clin Liver Dis*; 14(1): 1-21, vii.
- 28 World Health Organization (2012). Guidance on prevention of viral hepatitis B and C among people who inject drugs. Available from: <http://www.who.int/hiv/pub/guidelines/hepatitis>
- 29 Thein HH, Yi Q, Dore GJ, Krahn MD (2008). Estimation of stage-specific fibrosis progression rates in chronic hepatitis C virus infection: a meta-analysis and meta-regression. *Hepatology*; 48(2): 418-431.
- 30 Grebely J, Raffa JD, Lai C, et al (2011). Impact of hepatitis C virus infection on all-cause and liver-related mortality in a large community-based cohort of inner city residents. *J Viral Hepat*; 18(1): 32-41.
- 31 Gibson A, Randall D, Degenhardt L (2011). The increasing mortality burden of liver disease among opioid-dependent people: cohort study. *Addiction*; 106(12): 2186-2192.
- 32 Ly KN, Xing J, Klevens RM, et al (2012). The increasing burden of mortality from viral hepatitis in the United States between 1999 and 2007. *Ann Intern Med*; 156(4): 271-278.
- 33 Canadian HIV/AIDS Legal Network, et al (2008). "Viral time bomb": health and human rights challenges in addressing hepatitis C in Canada. Available from: www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=2016
- 34 Cook C, Kanaef N (2008). The global state of harm reduction: mapping the response to drug-related HIV and hepatitis C epidemics. Available from: <http://www.ihra.net/contents/551>

- 35 International Harm Reduction Association (2010). The global state of harm reduction: key issues for broadening the response. Available from: www.ihra.net/contents/535
- 36 Thomas DL, Leoutsakas D, Zabransky T, Kumar MS (2011). Hepatitis C in HIV-infected individuals: cure and control, right now. *J Int AIDS Soc*; 14: 22.
- 37 Taylor LE, Swan T, Mayer KH (2012). HIV coinfection with hepatitis C virus: evolving epidemiology and treatment paradigms. *Clin Infect Dis*; 55 Suppl 1: S33-S42.
- 38 Grebely J, Oser M, Taylor LE, Dore GJ (2013). Breaking down the barriers to hepatitis C virus (HCV) treatment among individuals with HCV/HIV coinfection: action required at the system, provider, and patient levels. *J Infect Dis*; 207 Suppl 1: S19-S25.
- 39 Roux P, Fugon L, Winnock M, et al (2012). Positive impact of hepatitis C virus (HCV) treatment on antiretroviral treatment adherence in human immunodeficiency virus-HCV coinfecting patients: one more argument for expanded access to HCV treatment for injecting drug users. *Addiction*; 107(1): 152-159.
- 40 Hagan H, Thiede H, Des Jarlais DC (2005). HIV/hepatitis C virus co-infection in drug users: risk behavior and prevention. *AIDS*; 19 Suppl 3: S199-S207.
- 41 Thiede H, Hagan H, Murrill CS (2000). Methadone treatment and HIV and hepatitis B and C risk reduction among injectors in the Seattle area. *J Urban Health*; 77(3): 331-345.
- 42 Turner KM, Hutchinson S, Vickerman P, et al (2011). The impact of needle and syringe provision and opiate substitution therapy on the incidence of hepatitis C virus in injecting drug users: pooling of UK evidence. *Addiction*; 106(11): 1978-1988.
- 43 Van Den BC, Smit C, Van BG, et al (2007). Full participation in harm reduction programmes is associated with decreased risk for human immunodeficiency virus and hepatitis C virus: evidence from the Amsterdam Cohort Studies among drug users. *Addiction*; 102(9): 1454-1462.
- 44 Vickerman P, Martin NK, Hickman M (2013). Could low dead-space syringes really reduce HIV transmission to low levels? *Int J Drug Policy*; 24(1): 8-14.
- 45 Vickerman P, Martin N, Turner K, Hickman M (2012). Can needle and syringe programmes and opiate substitution therapy achieve substantial reductions in hepatitis C virus prevalence? Model projections for different epidemic settings. *Addiction*; 107(11): 1984-1995.
- 46 Martin NK, Vickerman P, Foster GR, et al (2011). Can antiviral therapy for hepatitis C reduce the prevalence of HCV among injecting drug user populations?: a modeling analysis of its prevention utility. *J Hepatol*; 54(6): 1137-1144.
- 47 Degenhardt L, Mathers B, Vickerman P, et al (2010). Prevention of HIV infection for people who inject drugs: why individual, structural, and combination approaches are needed. *Lancet*; 376(9737): 285-301.
- 48 Rhodes T, Mikhailova L, Sarang A, et al (2003). Situational factors influencing drug injecting, risk reduction and syringe exchange in Togliatti City, Russian Federation: a qualitative study of micro risk environment. *Soc Sci Med*; 57(1): 39-54.
- 49 Hagan LM, Schinazi RF (2013). Best strategies for global HCV eradication. *Liver Int*; 33 Suppl 1: 68-79.
- 50 Hatzakis A, Wait S, Bruix J, et al (2011). The state of hepatitis B and C in Europe: report from the hepatitis B and C summit conference. *J Viral Hepat*; 18 Suppl 1: 1-16.
- 51 Lindenburg CE, Lambers FA, Urbanus AT, et al (2011). Hepatitis C testing and treatment among active drug users in Amsterdam: results from the DUTCH-C project. *Eur J Gastroenterol Hepatol*; 23(1): 23-31.
- 52 Mehta SH, Genberg BL, Astemborski J, et al (2008). Limited uptake of hepatitis C treatment among injection drug users. *J Community Health*; 33(3): 126-133.
- 53 Grebely J, Petoumenos K, Matthews GV, et al (2010). Factors associated with uptake of treatment for recent hepatitis C virus infection in a predominantly injecting drug user cohort: The ATACH Study. *Drug Alcohol Depend*; 107(2-3): 244-249.
- 54 Grebely J, Raffa JD, Lai C, et al (2009). Low uptake of treatment for hepatitis C virus infection in a large community-based study of inner city residents. *J Viral Hepat*; 16(5): 352-358.
- 55 Strathdee SA, Latka M, Campbell J, et al (2005). Factors associated with interest in initiating treatment for hepatitis C Virus (HCV) infection among young HCV-infected injection drug users. *Clin Infect Dis*; 40 Suppl 5: S304-S312.
- 56 Robaey G, Grebely J, Mauss S, et al (2013). Recommendations for the management of hepatitis C virus infection among people who inject drugs. *Clin Infect Dis*; in press.
- 57 Martin NK, Vickerman P, Miners A, et al (2012). Cost-effectiveness of hepatitis C virus antiviral treatment for injection drug user populations. *Hepatology*; 55(1): 49-57.
- 58 Martin NK, Vickerman P, Grebely J, et al (2013). HCV treatment for prevention among people who inject drugs: modeling treatment scale-up in the age of directacting antivirals. *Hepatology*; in press.
- 59 Minister of Health of the Republic of Lithuania (2008). Order of Minister of Health of the Republic of Lithuania on the approval of the description of the procedure of diagnostic and treatment of chronic HCV with reimbursable medicines. Report Number V-613.
- 60 Liakina V, Valantinas J (2012). Anti-HCV prevalence in the general population of Lithuania. *Med Sci Monit*; 18(3): PH28-35.
- 61 Lithuanian Drug, Tobacco and Alcohol Control Department (2012). Annual report.
- 62 Mathers BM, Degenhardt L, Ali H, et al (2010). HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage. *Lancet*; 375(9719): 1014-1028.
- 63 National Institute for Health and Clinical Excellence (2012). Hepatitis B and C: ways to promote and offer testing to people at risk of infection. Available from: <http://publications.nice.org.uk/hepatitis-b-and-c-ways-to-promote-and-offer-testing-to-people-at-increased-risk-of-infection-ph43>
- 64 Ng MH, Chou JY, Chang TJ, et al (2013). High prevalence but low awareness of hepatitis C virus infection among heroin users who received methadone maintenance therapy in Taiwan. *Addict Behav*; 38(4): 2089-2093.
- 65 Treloar C, Rhodes T (2009). The lived experience of hepatitis C and its treatment among injecting drug users: qualitative synthesis. *Qual Health Res*; 19(9): 1321-1334.

- 66 Paterson BL, Backmund M, Hirsch G, Yim C (2007). The depiction of stigmatization in research about hepatitis C. *Int J Drug Policy*; 18(5): 364-373.
- 67 Ford N, Singh K, Cooke GS, et al (2012). Expanding access to treatment for hepatitis C in resource-limited settings: lessons from HIV/AIDS. *Clinical Infectious Diseases*; 54: 1465-1472.
- 68 Ocheret D, Bikmukhametov D, Sultangaziev A, Matuzaite E (2013). Current situation regarding access to hepatitis C treatment in Eastern Europe and Central Asia. Available from: http://www.harm-reduction.org/images/stories/News_PDF_2013/hep_c_policy_brief_update_en.pdf
- 69 von Schoen-Angerer T, Cohn J, Swan T, Piot P (2013). UNITAID can address HCV/HIV co-infection. *Lancet*; 381(9867): 628.
- 70 Hoover J (2009). Shining a light on a hidden epidemic: why and how civil society advocates can support the expansion of hepatitis C treatment in Eastern Europe and Central Asia. Available from: <http://www.opensocietyfoundations.org/reports/shining-light-hidden-epidemic>
- 71 International HIV/AIDS Alliance in Ukraine (2013). The Alliance plans to provide treatment of viral hepatitis C for 50 HIV-positive SMT [substitution maintenance therapy] patients. Available from: http://www.aidsalliance.org.ua/ru/news/pdf/03_2013/GF_VHC_eng.pdf
- 72 Order of the President of Ukraine of 28 December 2012 On Issues Regarding Prevention of Spread of Epidemics of Tuberculosis, HIV/AIDS and Viral Hepatitis.
- 73 Department of Information and Public Communication of the Cabinet of Ministers of Ukraine (2013). Prime Minister has completed his task to adopt a targeted programme on prevention and treatment of viral hepatitis. 29.04.2013 [in Ukrainian]. Available from: http://www.kmu.gov.ua/control/uk/publish/article?art_id=246305333&cat_id=244276429
- 74 Liu S, Cipriano LE, Holodniy M, et al (2012). New protease inhibitors for the treatment of chronic hepatitis C: a cost-effectiveness analysis. *Ann Intern Med*; 156(4): 279-290.
- 75 World Trade Organization (2006). TRIPS and pharmaceutical patents. Available from: www.wto.org/english/tratop_e/trips_e/tripsfactsheet_pharma_2006_e.pdf
- 76 Global Commission on Drug Policy (2011). War on drugs. Available from: <http://www.globalcommissionondrugs.org/reports/>
- 77 United Nations (1972). Single Convention on Narcotic Drugs, 1961: as amended by the 1972 Protocol amending the Single Convention on Narcotic Drugs, 1961.
- 78 Global Commission on Drug Policy (2012). The war on drugs and HIV/AIDS: how the criminalization of drug use fuels the global pandemic. Available from: <http://www.globalcommissionondrugs.org/reports/>
- 79 United Nations (2013). Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez. Available from: http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf
- 80 Friedland G (2010). Infectious disease comorbidities adversely affecting substance users with HIV: hepatitis C and tuberculosis. *J Acquir Immune Defic Syndr*; 55 Suppl 1: S37-S42.
- 81 United Nations (2012). Joint statement: compulsory drug detention and rehabilitation centres. Available from: http://www.unaids.org/en/media/unaids/contentassets/documents/document/2012/JC2310_Joint%20Statement6March12FINAL_en.pdf
- 82 Wilkinson M, Crawford V, Tippet A, et al (2009). Community-based treatment for chronic hepatitis C in drug users: high rates of compliance with therapy despite ongoing drug use. *Aliment Pharmacol Ther*; 29(1): 29-37.
- 83 Dimova RB, Zeremski M, Jacobson IM, et al (2012). Determinants of hepatitis C virus treatment completion and efficacy in drug users assessed by meta-analysis. *Clin Infect Dis*; 56(6): 806-816.
- 84 Delarocque-Astagneau E, Meffre C, Dubois F, et al (2010). The impact of the prevention programme of hepatitis C over more than a decade: the French experience. *J Viral Hepat*; 17(6): 435-443.
- 85 <http://supportdontpunish.org/>
- 86 Health Protection Agency (2011). Hepatitis C in the UK: 2011 report. Available from: http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1309969906418
- 87 Economist Intelligence Unit (2012). The silent pandemic: tackling hepatitis C with policy innovation. Available from: http://www.janssen-emea.com/sites/default/files/The%20Silent%20Pandemic%20-%20Tackling%20Hepatitis%20C%20with%20Policy%20Innovation%20FINAL_0.PDF
- 88 Hutchinson SJ, Weir A, Bird SM, Goldberg DJ (2008). Modelling the impact of antiviral therapy on the future health and economic burden of chronic hepatitis C in Scotland. *J Hepatology*; 48 (Suppl 2): S297.

RECOMMENDATIONS OF THE GLOBAL COMMISSION ON DRUG POLICY REPORT "WAR ON DRUGS"

1. Break the taboo. Pursue an open debate and promote policies that effectively reduce consumption, and that prevent and reduce harms related to drug use and drug control policies. Increase investment in research and analysis into the impact of different policies and programs.
2. Replace the criminalization and punishment of people who use drugs with the offer of health and treatment services to those who need them.
3. Encourage experimentation by governments with models of legal regulation of drugs (with cannabis, for example) that are designed to undermine the power of organized crime and safeguard the health and security of their citizens.
4. Establish better metrics, indicators and goals to measure progress.
5. Challenge, rather than reinforce, common misconceptions about drug markets, drug use and drug dependence.
6. Countries that continue to invest mostly in a law enforcement approach (despite the evidence) should focus their repressive actions on violent organized crime and drug traffickers, in order to reduce the harms associated with the illicit drug market.
7. Promote alternative sentences for small-scale and first-time drug dealers.
8. Invest more resources in evidence-based prevention, with a special focus on youth.
9. Offer a wide and easily accessible range of options for treatment and care for drug dependence, including substitution and heroin-assisted treatment, with special attention to those most at risk, including those in prisons and other custodial settings.
10. The United Nations system must provide leadership in the reform of global drug policy. This means promoting an effective approach based on evidence, supporting countries to develop drug policies that suit their context and meet their needs, and ensuring coherence among various UN agencies, policies and conventions.
11. Act urgently: The war on drugs has failed, and policies need to change now.

RECOMMENDATIONS OF THE GLOBAL COMMISSION ON DRUG POLICY REPORT "THE WAR ON DRUGS AND HIV/AIDS"

The following action must be taken by national leaders and the United Nations Secretary General, as well as the United Nations Office on Drugs and Crime, UNAIDS and the Commission on Narcotic Drugs:

1. Acknowledge and address the causal links between the war on drugs and the spread of HIV/AIDS, drug market violence and other health (e.g. hepatitis C) and social harms.
2. Respond to the fact that HIV risk behavior resulting from repressive drug control policies and under-funding of evidence based approaches is the main issue driving the HIV epidemic in many regions of the world.
3. Push national governments to halt the practice of arresting and imprisoning people who use drugs but do no harm to others.
4. Replace ineffective measures focused on the criminalization and punishment of people who use drugs with evidence based and rights-affirming interventions proven to meaningfully reduce the negative individual and community consequences of drug use.
5. Countries that under-utilize proven public health measures should immediately scale up evidence-based strategies to reduce HIV infection and protect the health of persons who use drugs, including sterile syringe distribution and other safer injecting programs. Failure to take these steps is criminal.
6. The public and private sectors should invest in an easily accessible range of evidence-based options for the treatment and care for drug dependence, including substitution and heroin-assisted treatment. These strategies reduce disease and death, and also limit the size and harmful consequences of drug markets by reducing the overall demand for drugs.
7. All authorities - from the municipal to international levels - must recognize the clear failure of the war on drugs to meaningfully reduce drug supply and, in doing so, move away from conventional measures of drug law enforcement "success" (e.g. arrests, seizures, convictions), which do not translate into positive effects in communities.
8. Measure drug policy success by indicators that have real meaning in communities such as reduced rates of transmission of HIV and other infectious diseases (e.g. hepatitis C), fewer overdose deaths, reduced drug market violence, fewer individuals incarcerated and lowered rates of problematic substance abuse.
9. Call for public health bodies within the United Nations system to lead the response to drug use and related harms and to promote evidence-based responses. Other bodies, including the International Narcotics Control Board, should be subjected to independent external review to ensure the policies they promote do not worsen community health and safety.
10. Act urgently: The war on drugs has failed, and millions of new HIV infections and AIDS deaths can be averted if action is taken now.

GLOBAL COMMISSION ON DRUG POLICY

The purpose of the Global Commission on Drug Policy is to bring to the international level an informed, science-based discussion about humane and effective ways to reduce the harm caused by drugs to people and societies.

GOALS

- Review the basic assumptions, effectiveness and consequences of the 'war on drugs' approach
- Evaluate the risks and benefits of different national responses to the drug problem
- Develop actionable, evidence-based recommendations for constructive legal and policy reform



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