EASL Policy Statement:
Drug use and the global hepatitis C elimination goal

Introduction

People who inject drugs (PWID) are one of the driving forces of the hepatitis C virus (HCV) epidemic in the Western world and wider and account for the majority of new cases of HCV infection in high income countries (1). Globally, 8.5% of all HCV infections occur among persons aged 15-64 years who injected drugs within the last 12 months (2). In Europe, of the two million HCV-infected PWID, 1.5 million live in the Eastern Europe (2). In 2015, estimated 16% of all people living with viremic HCV infection in the European Union and Norway were PWID (3). In the last decade, the mortality due to untreated HCV infection has been increasing, particularly due to late presentation of infected PWID. In those over 50 years of age, death from liver disease is as equally common as death from overdose (4). In this context drugs are understood to be illicit substances.

Treatment with direct acting antivirals (DAA) works very well in PWID and evidence already exists that broad accessibility to DAA can lower the HCV prevalence among PWID (5, 6). This has led United Nations member states to include viral hepatitis as a target of the Sustainable Development Goals, and the World Health Organization (WHO) to set HCV elimination as the goal of its first Global Health Sector Strategy on Eliminating Viral Hepatitis as a public health threat by 2030 (7).

Management of hepatitis C in people who inject drugs

Besides hepatitis C treatment, in order to reduce hepatitis C incidence and prevalence among PWID and reach the WHO 2030 elimination goal, access to interventions such as low-threshold needle and syringe exchange programmes, as well as opioid substitution therapy

(OST) are essential (8). OST has proven to be effective for the prevention of both HCV and HIV infections. Combination of OST and high-coverage needle and syringe exchange programmes can reduce HCV incidence by more than 70%. The evaluation framework for the Global Health Sector Strategy provides clear targets to countries regarding the scale of provision of these measures (7).

In 2009, WHO, the United Nations Office on Drugs and Crime (UNODC) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) defined a package of nine interventions for PWID, which includes access to sterile injecting equipment, OST, and information as well as education on harm reduction (9).

Despite the evidence and recommendations from WHO, the European Association for the Study of the Liver (EASL) and other distinguished associations, testing and treatment for hepatitis C among PWID globally remain suboptimal, and comprehensive harm reduction services are not in place for most PWID worldwide (10). In 2017, among the 179 countries and territories where injecting drug use has been reported, only 86 (48%) have implemented OST and 93 (52%) have adopted needle and syringe exchange programmes (11).

Furthermore, the regional and national hepatitis care varies substantially and is often below WHO targets, with less than 1% of PWID living in countries with high provision of both services. However, even if those services do exist, PWID face many difficulties in accessing a hepatitis C continuum of care that includes prevention, testing and treatment. They are either per se excluded from treatment by means of restrictive guidelines, have poor access to health services, or suffer from universal stigmatization when disclosing their status as drug users (12). As a result, the hepatitis C epidemic continues to grow among PWID (1).

The drug use policies across Europe

Increasing evidence shows that policies and laws prohibiting illegal drug use represent a central role in shaping health outcomes among PWID. Regarding a human immunodeficiency virus (HIV) infection, a systematic review of 106 peer-reviewed articles has shown that the

majority of them, i.e. 85 (80%) suggested drug criminalisation having a negative effect on HIV prevention and treatment (13). This negative effect of criminalisation was particularly evident in relation to decreased needle and syringe distribution, increased syringe sharing, and an increased burden of HIV among PWID.

Similarly, in HCV-infected PWID, the lack of appropriate access to hepatitis C care is predominantly driven by political resistance to harm reduction services, as well as laws and policies which criminalize drug use, drug possession and PWID themselves (14-16). In many ways, drug use policy is a direct barrier to achieving the goal of HCV elimination because of its impact on access to harm reduction services and HCV treatment:

- prohibiting the possession of drug paraphernalia hinders harm reduction service delivery and uptake;
- many national laws impose severe custodial sentences for minor, non-violent drug offenses, such as drug use and possession;
- PWID are frequently imprisoned or detained, without access to prevention and other harm reduction services, and often forced to interrupt ongoing HCV treatment;
- policies that criminalize drug use reinforce stigmatization and discrimination of PWID.

While most European countries have laws that criminalize the possession and distribution of drugs, their policies differ regarding offences and penalties (17). Even in countries that have integrated harm reduction into their routine public health services, the criminalization of drug use has remained official law, not only driving PWID away from prevention and care services due to the fear of being arrested, but also instilling a fear of helping PWID, in case they are treated as accomplices of criminal offenders.

A time to change a drug use policy

The international legal framework on drug control is provided by three United Nations conventions (18). However, in the last decade there has been an increasing debate over a

change in policy for non-medical drugs. The terminology covering this particular area is not very precise; however, the following distinctions seem to be of crucial importance: decriminalisation, depenalisation, legislation and regulation (19).

In order to provide an enabling environment for PWID to access hepatitis C testing and treatment, a change in drug use policies is needed which can address the barriers that hinder harm reduction services from reaching those that need them. For that purpose, implementation of public health and human rights-oriented drug policies would be more appropriate than enforcing criminal sanctions against people who use drugs.

Decriminalisation of drug use in relation to hepatitis C elimination

There is no universal agreement on the definition of decriminalisation of drug use. According to the definition of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), decriminalisation comprises removal of a conduct or activity from the sphere of criminal law (19). Prohibition remains the rule, but sanctions for use no longer fall within the framework of criminal law.

In the context of eliminating HCV infection, the decriminalisation of drug use in PWID means the decriminalisation of the consumption, purchase and possession of or personal consumption of plants, substances or preparations, not exceeding the amount for individual consumption during a certain period of time. Such decriminalisation of personal consumption restores the right to health and social reintegration of a drug user. However, decriminalisation by itself brings about only a reduction in punishment and not a public health response. To reach the desired goal, both decriminalisation and integrated interventions that include HCV testing and treatment should be implemented so that individual drug users can access centres of assistance regardless their drug consumption. Combining decriminalisation of drug use and integrated interventions reflects a humanistic approach, pragmatic and focused on protecting public health, thus establishing a basis for a comprehensive system of quality management.

Rehabilitative measures of treating, educating or reintegrating drug users as alternatives to punishment are based on the options provided by the international drug control legal framework (20). Alternatives to punishment are nowadays established in the laws of several European countries and are available to varying degrees. According to the study from 2016, all European Union member states reported having at least one alternative to coercive sanctions available, and most had more than one (21). For problematic PWID (the high-risk injectors with a recurrent drug use causing actual personal and social harms), rehabilitative measures applied by the criminal justice systems in Europe are usually oriented towards treatment of drug addiction and its consequences or post-treatment interventions, whereas for non-problem PWID (whose drug use patterns are associated with a lower level of harm), they are more oriented towards education (22).

The success of these measures depends partly on the degree to which they are accurately targeted to specific objectives and specific users. Unfortunately, they are often carried out without robust monitoring or evaluation, despite the fact that in the long run such an information can be used to improve the efficiency and effectiveness of the program. But even if the resulting evidence is not strong, the key to success seems to be having a range of interventions available that can be matched appropriately to the needs of individuals with different types and levels of drug problems.

A good practice example

Growing recognition of the need for evidence-based drug policy change has led the WHO, the United Nations Agencies and other distinguished institutions to recommend the decriminalisation of minor, non-violent drug offenses, and a strengthening of health-oriented alternatives to criminal sanctions (14, 23-30). According to the International Drug Policy Consortium (IDPC) report from January 2020 there were 29 countries and 49 jurisdictions across the world that have adopted some form of decriminalisation for drug use and possession for personal use (31).

Portugal became the first country in the world to decriminalise minor drug offences (32). In 2000, due to losing the fight against drug overdose deaths and the rising prevalence of HIV/AIDS, the country started an experiment to decriminalise use and possession for personal use of all drugs and putting the focus on a public health approach to illegal drug use and on treating addiction. The need for harm reduction responses was systematically assessed and activities were scaled up where needed.

In practice, the drug strategy in Portugal removed the threat of criminal punishment to encourage the most problematic PWID into treatment (33). This involved decriminalisation of use-related offences, making them administrative offences, and establishing 'commissions for the dissuasion of drug abuse' (CDT) to deal with the offenders. They present as multidisciplinary panels including a lawyer, a medical doctor and a social worker and operate under the auspices of the Ministry of Health. All drug users, either experimental users or dependent ones, disclosed by the police are sent to a CDT. Based on the case assessment, the CDT hears every offender and rules on the offence, aiming to treat any addiction and rehabilitate the person using the most appropriate interventions.

Contrarily to predictions, the Portuguese decriminalisation did not lead to major increase in drug use. Moreover, evidence indicates reductions in problematic drug use, drug-related harms and criminal justice overcrowding (34). The rate of PWID among the general population aged 15 to 64 decreased from 2.3-6.4 per 1000 population in 2000 to 1.5-3.0 per 1000 population in 2005 (35). A decrease was noted also in the number of deaths related to drug use (from 131 in 2001 to 20 in 2008). The number of newly notified HIV diagnoses related to drug addiction also decreased, from 1430 in 2000 to 352 in 2008. The prevalence of drug users with HIV among those who started treatment in 2000 and in 2008 was 14% and 9%, respectively. The latest data from 2017 show that only 2.2% of the new HIV infections are connected to injected drug use (36).

To summarise, twenty years after its implementation, the change in Portuguese drug use policy has proven very successful with significant public health benefits, such as having one of the steepest declines in the number of newly diagnosed HIV infections among PWID and a

low number of drug-related deaths, while drug use and dependence have not skyrocketed, as opponents of the legal changes had predicted.

Conclusions

In order to achieve the 2030 WHO viral hepatitis elimination goals, EASL recommends that all barriers to the uptake of the continuum of care by PWID need to be removed by changing policies and discrimination that hinder access, including the criminalisation of minor, non-violent drug offences and to adopt an approach based on public health promotion, respect for human rights and evidence.

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