

Our Responsibility in the Care of Drug Users. Blame the Victim or Cure the Victim?

Nuestra responsabilidad en la atención de personas con consumo de drogas: ¿Culpar a la víctima o curar a la víctima?

“The approach to public health starts with science and evidence, and these clearly indicate that drug use can be prevented, drug use disorders can be treated and that drug dependence that contributes to crime can be diminished. People with drug dependence can be helped and returned to productive roles in society.”

MARGARET CHAN

Director-General of WHO

Opening speech, WHO Assembly (04/19/2016)

INTRODUCTION

From April 19 to 21 of this year, the 193 State members met again at the United Nations General Assembly Special Session (UNGASS) after almost 20 years of the last session in 1998, to address the social policy challenge affecting millions of lives –what the UN has called “the world’s drug problem”.

This challenge is significant, because the political answers to drug problems have a negative effect on human lives and human rights and contradict the public health approaches based upon science and evidence, as Margaret Chan emphasizes in the epigraph. As noticed by the former UN General Secretary Kofi Annan: “Drugs have destroyed many people, but wrong policies have destroyed much more”.

The last 1998 UNGASS about drugs met under the motto “a world free of drugs –we can do it!” and strongly recommended a control policy based on the idea of elimination or banning of all use, production and traffic of illegal drugs. This idea is embodied in the national laws of many countries.

This statement interpreted the global basic drug control procedure treaty, which fully ratified the 1961 “Single Convention on Narcotic Drugs” which declared in its preamble that drug control is chiefly motivated by the interest in “the health and welfare of humanity”. None of these international agreements, however, refers to the negative consequences for health produced by the drive to ban drugs. Time has already elapsed to review the impact on health of these drug policies. It is no longer acceptable to admit the disconnection between the policy of drug control and health results based on credible evidence.

What does this health summit leave? Firstly, as assumed, “the integrity of the consensus was kept sealed...Second, that this consensus does not necessarily imply homogeneity. In general, one of the most recurrent strategies to guarantee the support of different actors in multilateral negotiations is related to the incorporation of phrases such as “as appropriate”, “according to national legislation” or “with full consideration for the sovereignty of States”. And thanks to these expressions, it was possible to unify the positions of countries with very dissimilar positions, as those of Southeastern Asia, China, Russia or Japan, promoting essentially punitive policies, with those of Portugal or Uruguay, for example, more prone to the launch of regulation strategies and damage reduction. Third, this “diplomatized” plurality shows on one side, discouraging aspects, and on the other, sheds some light of hope...

This situation entails an additional factor that contributes to disappointment: the latent contradictions between what countries express and what they really do inside their borders”. (1)

Tokatlian also agrees that the 2016 UNGASS was characterized “by minor and specific amendments within the framework of a possible opening to certain alternative and selective measures at a national level but not at a collective or global level. This approach wasted the opportunity of giving a more ambitious step.

The final document reflects this... In addition, it establishes that States have “sufficient flexibility to formulate and apply national policies regarding drugs according to their priorities and needs.”

In brief, no significant progress was made towards disabling proscriptio... though certain openings are eventually expected, in “compliance with arrangements in the three international drug inspection treaties”, to try localized and specific experiments in a regulatory direction.” (2)

In two Latin American countries, Mexico and Colombia, where the so-called “war against drugs” was most intensely fought, their presidents pronounced themselves against this policy. Enrique Peña Nieto (Mexico) expressed that “the so-called war against drugs has not inhibited the production, traffic or con-

sumption of drugs worldwide” and asked to advance “in a new international understanding”. In turn, Juan Manuel Santos (Colombia) said: “I am not proposing legalization. I am proposing that we change the approach, the priorities. Because we have been engaged more than 40 years in this war against drugs and have not won it.”

PRESENTING THE PROBLEM

As Ernesto López writes: “for a while the world has been discussing the possibility of a change in orientation, due to the absence of positive results of the ‘war-like’ alternative and due to the high individual, social, economic and political costs it has implied.

Different to the banning and punitive policy, that goes after consumers as well as producers and dealers, sheltering the development of an illegal market which, because of its illegality is a source of numerous violent episodes and ever growing corruptions, turning into a long standing war -obviously the description does not end here-, another paradigm has been developing.

Without conforming yet a systematic doctrinarian corpus, it states that the war strategy is inappropriate, that special importance should be provided to persons, reducing the factors that turn them vulnerable, that the decriminalization of drug consumption should be open to debate and to the examination of tangible experiences carried out in different countries; that adequate health, education, employment, youth and human rights policies should be developed; that a damage-reducing strategy is valuable; and that there are no immediate solutions but that mid- and long-term initiatives should be deployed placing people as priority, among other important topics.” (3)

THE CURRENT ISSUE

The 2015 annual report of the United Nations Office on Drugs and Crime (UNODC) concluded that, from an estimated 246 million people that consumed drugs in the last year, 27 million (around 11%) experienced problems with the use of drugs, defined as dependency or ailments due to drug abuse, and that approximately 400,000 of them die each year.

Moreover, use of injected drugs represents around 30% of new HIV infections outside Sub-Saharan Africa.

Violence and drug proscription

In the 2012 Global Burden of Disease, aggression for all types of violent assaults grew nearly 18.4%, as cause of global mortality between 1990 and 2013. (4) The most affected region was Latin America, where this is among the first 5 causes of death in 15 countries.

Violence related to drugs is associated with the purpose of armed criminal groups of protecting their illegal market, often against the armed police, and military and paramilitary forces.

Occasionally, the severe repression measures of drug policy may increase violence when the rupture of a criminal network leads rival bands to intensify their efforts to capture the territory of weakened groups. Mexico, Central America and South America have suffered an enormous and persistent load of violence associated to the transit of illegal drugs, including “massacres, attacks by hired assassins and cases of people tortured to death” (OAS).

According to UNODC, 30% of murders can be explained by “groups and organized criminal bands” in America, specially Central and South America, dwarfing the percentages of other regions.

Poor women and girls hired as messengers and smugglers experience forced rapes and have no assistance resources. Brutal murders of poor women and girls are used to terrify communities or rival bands.

This violence produces the displacement of populations in Mexico and Central America, similar to the ones in regions at war. It is estimated that 1.65 million (2%) of the Mexican population has been ousted by violence or the risk of violence between 2001 and 2011. (5)

Homicides in Mexico

The fatal decision of Felipe Calderón’s administration in Mexico in 2006 of using military forces in civilian areas to fight drug dealers marked the onset of an epidemic of violence in many parts of the country, also extending to Central America.

During the 2008-2010 period men’s life expectancy was reduced by 5 years in the State of Chihuahua -one of the States more strongly affected by drug violence. (6)

Since 2006, there was a substantial increase in the number of murders, which was highly significant and notable after a long tendency to its decline. No other country in Latin America –and few worldwide- has experienced such fast increase in such short time.

The rate of murders in Mexico is 11/100,000 inhabitants, 2.5 times higher than in the United States in 2014, and highly affected areas may reach up to 80/100,000. (7)

After 2006, criminals incarcerated for drugs had 3.6 times chance of being interrogated by military forces ($p=0.0001$) and 1.6 times of having been beaten or tortured in prisons ($p=0.0001$)

“The penetration of all aspects of society by drug-trafficking organizations in Mexico, Colombia and several countries of Central America may corrupt everything, from elections and local services to sport and recreational teams.”

The annual income of Mexican drug cartels is estimated in US\$ 2,000 million for cannabis and US\$ 2,400 million for cocaine. (5)

In Colombia, it is estimated that were it not for the cocaine market, the rate of murders in 2008 would have been 27/100,000 inhabitants, instead of 37/100,000. (4)

Violence and health impact of crop eradication

In the Andes, the important consequence on health of crop eradication is the terrible violence that occurs in Mexico and Central America; drug dealers, forced out of Mexico, have been part of the mortal violence in this region.

In 2005, the drug policy branch of OAS, the “Inter American Commission for the Control of Drug Abuse (IACCCA) analyzed the effect of glyphosate herbicide on health and the environment in Colombia, and concluded that there was no significant risk for human health associated with its aerial spraying. (8) The study was very criticized by the civilian society, with thousands of health problem complaints associated with fumigation, which was not taken into account by the IACCCA researchers. In 2008, Ecuador made a presentation at the International Court of Justice, claiming that Ecuadorians who lived in the border with Colombia were suffering from diseases due to glyphosate spraying, including burning pain, eye rash, skin ulcers, bowel bleeding and even death, specially affecting children. Ecuador requested Colombia to limit fumigation, at least 10 km away from its border. The case ended in 2013, before the International Court of Justice made its final hearings. It is reported that Colombia provided compensation for damage to people and farm cattle and agreed to a buffer zone without fumigation near the border.

In 2015, the WHO International Agency for Cancer Research reviewed animal and human studies and classified glyphosate as “potentially carcinogenic for human beings”, a classification used “when there is limited evidence of carcinogenesis in humans and sufficient evidence of carcinogenesis in experimental animals.” (9)

The screening of millions of individuals by the University of los Andes shows that aerial fumigation was significantly associated, in this large sample, with an increased incidence of dermatological and respiratory symptoms 15 days after being exposed to the herbicide, and also with spontaneous abortions. One standard deviation of increase in aerial fumigation was associated with 10-15% increase in miscarriages among women exposed to the herbicide during pregnancy. (10) Putting an end to more than 20 years of practice, in May 2015, the Colombian government decided to stop aerial spraying on coca crops, because farmers complained that in addition to affecting food crops, the food for animal offspring, which they depend on as a source of income or for direct consumption, it also contaminated water sources. (11)

Increase of HIV, hepatitis C and tuberculosis infections: the neglect of proven solutions

The reduction of sexually transmitted HIV is evident and known worldwide, but HIV transmitted by drug injection, with unsterilized devices, continues forcing the increase in its incidence in many regions, including Eastern Europe and Central Asia, despite the

availability of interventions already known to stop it. A global decline of 35% in HIV infection occurred between 2000 and 2014, but it increased 30% in Asian populations, where unsafe drug injections are responsible for 65% of the new accrued cases. (12)

Regarding hepatitis C virus (HCV), WHO estimated that 2 out of 3 individuals who inject drugs worldwide are living with the virus, a much higher proportion than the estimated 13% living with HIV. The frequency of co-infections between HIV and/or HCV is estimated in 90%.

The risk of tuberculosis is 30 times higher in people living with HIV. People with HIV who inject drugs are 2 to 6 times more likely to develop tuberculosis than people with HIV who do not inject drugs. In turn, tuberculosis is the most important cause of death among patients who live with HIV, causing 1 of every 4 deaths according to WHO.

“Multidrug-resistant tuberculosis” threatens to undermine the progress in the control of this disease in many parts of the world.

Available proven effective tools

Needles Syringe Programmes (NSP)

WHO has found that easy exchange of used for sterile devices significantly reduces HIV transmission and does not increase the frequency of injections or the initiation of drug use in people.

A meta-analysis showed 58% reduction of HIV, though there are still doubts about the quality of some studies and the difficulty of discriminating the NSP effect from other associated services. (13)

The effectiveness of randomized clinical trials for hepatitis C transmission is more unclear. The results are more effective when health coverage is high and closer to the initiation of drug injection.

Opiate Substitution Treatment (OST)

This treatment has 2 functions: it stabilizes the life of addicts, with the concomitant benefits this entails, and prevents HIV and HCV infection, because when it is effective the substitution by “methadone” or “buprenorphine” eliminates the injection. The OST has the longest and most successful clinical experience in treatment and risk reduction. Many countries have legal and practical restrictions for the use of OST with methadone.

In a meta-analysis performed in 2012 in Europe, North America and Asia, methadone reduced HIV risk by 54%. (14)

A revision of reviews performed in 2014 shows strong evidence for the prevention of HIV, especially when the dose of opioid agonists is adequate. (15)

Observational studies carried out in the United States, Ukraine, Canada and Australia show substantial reductions of hepatitis C. Analysis models suggest that the greater the coverage the higher the reduction.

With these tools, several countries of Western Europe have almost banished HIV transmission.

HIV, hepatitis C and tuberculosis infection treatment

All HIV- infected persons should be treated. The antiretroviral therapy (ART) can suppress “viremia” and decrease transmission.

In places where there is great HIV transmission linked to unsafe injections, denial of treatment to HIV positive persons using drugs, ensures HIV risk in their injection and sex mates and violates the rights of all the people involved. However, drug users are systematically excluded from Labor Risk Insurance (LRI) in many parts of the world. (5)

Labor Risk Insurance coverage is high in Europe, North America and Australia, but this is not the same everywhere; for example, a review performed in 2014 shows that both in China and Malaysia, less than 5% of HIV-infected drug users have access to treatment, and in Russia only 1%. (16) The 2014 Joint United Nations Programme on HIV/AIDS (UNAIDS) report declares that in Africa it is even less than 1%.

Since 2010, direct action antivirals are available for hepatitis C with a much higher cost than “interferon therapy”. The price of new generation medicines for hepatitis C should be reduced, so that drug users can benefit from this treatment, taking the example of significant price reductions for HIV medicines.

In the 2013 WHO Bulletin, experts stated that it was important to avoid the role of “punitive drug policies and laws enhancing the tuberculosis epidemics in drug users”.

The treatment of tuberculosis should not be considered isolated from other infections. HIV, hepatitis C and tuberculosis services should be integrated and respond with low threshold to drug users. The reality of these services is out of reach for drug users worldwide.

Condoms, supervised injections and pre-exposure prophylaxis programs

Programs and Education on the use of condoms are necessary, as there are many studies showing the association between drug use during sexual activity with lower use of condoms, resulting in high prevalence of HIV and other sexually transmitted infections.

There are Supervised Injection Sites in various European countries, Canada and Australia where people can legally inject themselves illegal drugs behind closed doors (and sometimes inhale) under medical supervision, obtain clean injection devices, be referred to OST programs and receive preventive education on HIV and overdose. They try to decrease damage, not only of HIV transmission, but also mortality and other adverse results of overdose, and in turn reduce the use of unsafe syringes.

A meta-analysis showed a reduction of 69% in syringe-sharing with the use of “supervised injection sites” and in addition these measures save costs. (17)

Pre-prophylaxis with tenofovir, an important measure of prevention, has often excluded people using drugs. A randomized clinical trial in Bangkok showed the effect of prevention both for men and women who inject drugs. (18)

THE ASSOCIATION OF INCARCERATION WITH DRUGS AND HEALTH

In 2014, 21% of incarcerated subjects worldwide were convicted for drug offenses (UNODC). Drug possession for personal use was, by far, the most common crime (83% of drug offenses).

Thus, extended deprivation of freedom is exercised almost exclusively on subjects considered non-violent, which includes those who use drugs, drug possession only for personal use and selling of small amounts.

The over-representation of subjects who use drugs in prisons, and the lack of essential care and support while they are in State custody, is among the most devastating health legacies of the drug prohibition policy. In addition, there is no evidence that incarceration is an effective deterrent to drug use, either in prison or later. A long-term cohort study, “Vancouver Injection Drug User Study” (VIDUS), (19) revealed that recent incarceration was negatively associated with cessation of drug injection.

The latest information from selected countries shows that the proportion of subjects incarcerated for drug crime is 57% in Mexico, 49% in the United States (federal), 33% in Argentina, 24.8% in Brazil, 23, 8% in Peru and 17% in Colombia. And among women 80% in Mexico, 68.4% in Peru, 68.2% in Argentina, 59.4% in the United States (federal), and 53.9% in Brazil.

Although it is clear that in the drug market more men than women are involved in drug use, possession and sale, a higher proportion of women are in prison due to sentences related with drugs in almost all countries with available data.

Almost 30% of women accused of drug offenses in Argentina in 2013, have been detained without trial for 1-2 years and about 12% for more than 2 years. (20)

In the United States, drug arrest in women (mostly for possession), has doubled between 1990 and 2006 (from 400/100,000 to about 800/100,000).

There is also discrimination between the poorer population and massive drug-related incarceration. In the United States it is associated with the racial component; among men aged 30-34 years (2011), 1 in 13 African Americans were in prison, compared with 1 in 36 Hispanic Americans and 1 in 90 white Americans, even when drug prevalence is similar in all three populations. Therefore, the possibility of being in prison at some point in life is 32% in African-Americans, 17% in Hispanic Americans and 6% in white men.

In 2013, there were about half a million arrests in New York City, due to penalties for cannabis offences, mostly in young subjects.

Drug arrest was similar according to the racial

component in 1980; it quickly separates and keeps 2 to 3 times higher in the black population, despite cannabis use is less than in the white population. (5)

Incarcerations in response to drug use have a profound effect on the welfare of relatives, children and partner of subjects in prison for drug-related crimes.

In a poll conducted in 2014 in Mexican prisons (21), where visitors are mostly women, over 30% of them declared that due to the spouse or relative imprisonment they had had to get a job or an additional job, but, on the other hand, 41% had lost their jobs and over 18% had been forced to leave their homes. Spouses of subjects in prison were also disproportionately affected by a number of health problems, including high blood pressure and depression.

Incarceration for drugs and the emergence of infectious diseases

A United Nations Agency estimated that the prevalence of HIV infection, other sexually transmitted infections, hepatitis C and B, and tuberculosis is 2 to 10 times higher in prisons than in the community.

In Argentina, for example, subjects living with tuberculosis and with a history of incarceration are 6 times more likely to have HIV and 18 times more likely to have hepatitis C than the general population.

HIV in prison: Compared to the general population, it was 15 times higher in Ukraine, 10 in Argentina, and 2.4 in South Africa and the United States.

Hepatitis-C transmission in prison: in a 2013 review of 39 countries, 26% of subjects with a history of drug injection had positive tests (women 32%, men 24%).

Tuberculosis in prison: Overcrowding, poor sanitation, inadequate ventilation, high HIV prevalence and inadequate basic services, are the factors that contribute to tuberculosis transmission in prisons.

In 2010, WHO estimated that in European regions (including Eastern Europe) the relative risk of tuberculosis in prison was 145 times higher than in the community. And hence, 1 of every 11 to 16 cases occurs in prison.

Prison services for infectious diseases and drug dependence

An international regulation says that subjects in prison are entitled to the health service level offered to the community in its jurisdiction.

Both UNODC and WHO recommend a set of measures to assess HIV prevention, care and support for subjects in prison, including NSP and OST and also for hepatitis C. But to achieve these measures is a real challenge.

Among the 80 countries providing OST to the community, only 43 countries offered OST in at least one of its prisons during 2014. For example, OST is generally absent in the United States prisons, but it is available in most Canadian prisons.

HIV treatment with antiretroviral drugs in the 5 countries with more use of drug injection after the

United States, that is, Russia, China, Malaysia, Vietnam and Ukraine (2011-2014) was very scarce in the community and absent in prisons.

Hepatitis-C diagnosis and treatment is even rarer in many countries.

“In different scenarios that include Zambia, Namibia, India, Argentina, Brazil and Thailand, there is a slow growing commitment of HIV care with social barriers and of the health systems.” (5)

Regarding tuberculosis, WHO and UNODC recommend active search of cases, systematic testing to all who are in their custody, monitoring of respiratory symptoms, information to health control authority, isoniazid preventive therapy to subjects with HIV in prison, treatment for tuberculosis and continuation of care in the community if the course of treatment is longer than the sentence, and provision of HIV testing in those who are positive for tuberculosis.

The various treatment options, such as low-intensity advice, therapeutic community interventions, detoxification by various methods, Anonymous Narcotics based upon abstinence, and session groups adding OST-NSP are still extremely rare (only provided by 8 countries, mostly in Western Europe).

Continuity of care is critical after release from prison, since discontinuation of treatment is probable and has serious health consequences.

Death by overdose and drug policy

Drug overdose is an urgent priority in the drug policy and risk reduction effort. Overdose may be lethal or leave neurological sequelae due to hypoxia.

According to a systematic review of 2013, (22) overdose is the leading cause of death in subjects who inject drugs. In 2014, WHO estimated that 69,000 subjects worldwide die annually from opioid overdose. In the United States, overdose accounts for 3.4% of deaths among subjects aged 15-39 years.

Naloxone: It is an opioid antagonist that can reverse the clinical manifestations of overdose. The “naloxone injection” administered by the police, emergency medical groups and organizations, reverses many thousands of deaths.

Buprenorphine: It may be particularly useful in preventing overdose in some populations.

Injection sites supervised by medical staff, allow assistance in case of overdose. In 2011, in Vancouver, death as a result of overdose decreased by 35% in 2 years around areas with supervised injection. And there is no evidence of drug initiation, more frequent injections or increased crime.

Access to drug addiction treatment

There is no monitoring of access to rehabilitation and treatment quality standards in subjects who use drugs.

The 2015 UN report on the availability of drug addiction treatment in different countries shows, for example, that in America OST is low, less than 20% in

only two countries, similar to opioid antagonist treatment; however, 80% of those who need treatment for drug abuse live in low- and middle-income countries.

Drug addiction treatment is more effective with the support of other social services such as: stable housing, food assistance, employment support, all seldom used measures.

Women are particularly at disadvantage; in many places women with babies lose custody if they do not undergo treatment or are registered in drug records. Legally, in some countries, mothers who use drugs are not considered suitable to have custody over their children.

Around 40 prominent doctors and scientists from the United States and Europe declared that “to demonize pregnant women creates a situation where punishment rather than support is the predominant response, and it will inevitably lead to discourage women from seeking care.”

Seventy-five percent of the world population, that is 5,500 million subjects, has no access to controlled drugs for post-operative or severe pain. For example, 92% of morphine is used in countries that account for 17% of the world population, the vast majority in developed countries.

REJECTING CRIMINALIZATION OF MINOR OFFENCES AND EXPANDING HEALTH SERVICES.

Some examples

Portugal: The democratic opening of the 70s brought, in the 80s, a flow of illicit drugs that they were ill-prepared to face. HIV infection associated to drug injections rapidly propagated, drug dependence became a major public issue and the most aggressive policies seemed unable to stop drug use.

In 1998, a “multisectorial committee of experts” was summoned by the Portuguese government. The process culminated in a law, released in 2000 and implemented in 2001, that eliminated criminal penalties for the use and possession of all drugs. Individual use was liberally defined as the amount needed for 10-day use. Infringements could not be punished with prison and were not attached to the criminal record.

Larger-scale crimes, such as trafficking and sale of large quantities of drugs, maintained their penalties. Juvenile offenders were invited, but not required, to meet in “deterrence committees” -groups of health and social sector professionals- that offered the possibility of being voluntarily referred to services attempting to determine if they could handle the problematic use of drugs. HIV prevention services (including OST and NSP) were substantially expanded, as well as the services that offered treatment for drug dependence other than OST.

New transmission of HIV decreased from almost 800 cases in 2003 to less than 100 cases in 2012. It is difficult to isolate the results of the non-criminalization policy from the wide application of social and health services. Today, the use of cannabis is one of

the lowest in the European states. Last year, possession of “amphetamines” in Portugal was low, similar to that of other countries.

Switzerland: at the end of the 80s the country had the scourge of heroin injection and rapid growth of HIV related to drug use. The police tried a geographical confinement, grouping subjects who injected drugs in a public park in Zurich, which became known as the “needle park”.

It implemented one of the most effective applications of HIV prevention services in history. The country became a pioneer in “supervised injection sites” in its largest cities, and quickly helped reduce overdose deaths and public injection.

As in Portugal, there was a dramatic drop in HIV infections related to drug injection, and the decrease was sustained for a long period.

The Swiss experience consistently showed good results linked to the program, reducing the use of illicit drugs, crime and mortality.

Czech Republic: In the late 80s it emerged from a long period of Soviet occupation, when HIV infection and drug injection were growing in Europe. They were visionaries when they made investments to establish HIV prevention services. The recently independent country established individual use as an administrative rather than a criminal offense.

In 1998, it switched to criminalizing drug consumption, and after a long debate, it was replaced in 2010 by a law that did not criminalize its use and possession.

European Union: A 2015 review showed that European Union countries have instituted a range of practices at the time of arrest that reduces criminal penalty for minor drug offenses. They also have the highest coverage of OST and NSP of any region and most countries have coverage of ART for subjects who inject drugs.

Vancouver (Canada): During the mid-90s there was an epidemic of HIV infection among drug injection users in Downtown Eastside of Vancouver, 18.6/100 subjects/year in 1996-97. In 1997, a “health emergency” was declared. In 15 years the use of methadone increased and NSP were decentralized to all local clinics. Large reductions in syringe sharing and HIV were observed over time. The third step was use of ART and support, with decline in median viral load and reduced HIV infections.

HIV infection fell from 18.6/100 subjects/year in 1997 to less than 0.38/100 subjects/year in 2008. (23)

Harm reduction in drug crop production:

International drug control historically rested on South American and Southeastern and Southwestern Asian countries to cut the supply of coca leaves, opium poppy and cannabis, rather than in consumer countries to reduce demand.

The focus on the eradication of these crops implies militarization and war, a “war against drugs”, despite

the strong growth of production and use of synthetic drugs, which now dominates drug supply and consumption.

In Bolivia, President Evo Morales withdrew, in an unprecedented move, his ratification of the 1961 Convention on Narcotic Drugs, and sought permission to re-access, with a formal condition, to the traditional use of the coca leaf. Only 15 countries (out of the 61 required) objected and Bolivia imposed the criterion that coca and cocaine are not the same. With the strong acknowledgement of the need for a legal market of coca leaf, the government of Bolivia established a scheme whereby some coca farmers are allowed to grow coca for legal uses on a fixed area of land (1 cato: about 1.600 m²). This resulted in a significant reduction in the growth of coca for illicit markets which in turn reduced violence much more than the results of forced eradication efforts.

CONCLUSIONS

Policies intended to ban or greatly suppress drugs present an apparent paradox. They are launched as political decisions that are necessary to preserve public health and safety, but nonetheless contribute, directly or indirectly, to lethal violence, disease, discrimination, forced labor, and injustice, and fundamentally they undermine subjects' right to health. "...but on the basis of the evidence identified and analyzed by the Commission it is concluded that drug prohibition harms far outweigh the benefits." (5)

Violence, associated both to the market of illicit drugs and the police, including military and paramilitary forces, is a deeply traumatic violation of the right to health. The cost of incarceration of an enormous number of subjects -men, women and children- for minor non-violent crimes, largely disorganizes society.

The misuse of the criminal justice system to discriminate against the poor and racial and ethnic minorities is unacceptable. The cost of infectious diseases has become more common, more severe and more difficult to handle due to the practices of law enforcement and mass incarceration, despite these diseases and even death are completely avoidable.

Death from overdose, which is preventable, affects the most marginalized subjects in society. The eradication of crops used in drug production is harmful to the community, families and the environment. And there is the not manifested suffering of millions, whose pain cannot be alleviated by effective analgesics for fear of drug diversion for illegal uses.

"We agree with the UNAIDS-Lancet Commission conclusion that too many countries are allowing subjects who inject drugs to die, before removing the barriers, including laws and drug policies, that stand in the way of services that save lives."(5)

A policy of balanced drug has been overlooked and even European countries that no longer criminalize the use and possession of minor drugs, that have extensive services to reduce risk and secure access to

ART for subjects who use drugs, have not lifted the prohibition completely; drugs are still illegal in those countries.

We must think if the number of individuals with access to varied and complete drug treatments, the frequency of deaths from overdose and the access to welfare programs do not tell us more about drug policy than the simple and unoriginal number of arrests, provided by state information, when it exists.

Health professionals in all countries are urged to be informed and involved in discussions on drug policies at all levels, so that their voices are heard.

Dr. Hernán C. Doval^{MTSAC}

Director of the Argentine Journal of Cardiology

REFERENCES

1. Comini N, López Chorne J. En la ONU, los Estados juegan a doble estándar. *Diario Clarín* 08/05/2016.
2. www.opendemocracy.net/democraciaabierta/juan-gabriel-tokatlian/ungass-2016-de-la-oportunidad-al-oportunismo.
3. López E. Otras perspectivas a los enfoques beligerantes. *Diario Clarín* 08/05/2016.
4. GBD 2013 Mortality and Cause of Death Collaborators. Global, regional and national sex-age specific all-cause and cause-specific mortality for 240 causes of death, 1990-2013. a systematic analysis of the Global Burden of Disease Study 2013. *Lancet* 2015;59:1403-32.
5. Csete J, Kamarulzaman A, Kazatchkine M, Altice F, Balicki M, Buxton J, et al. Public health and international drug policy. *Lancet* 2016;387:1427-80. <http://doi.org/bdp2>
6. Gonzalez-Perez GJ, Vega-Lopez MG, Cabrera-Pivaral CE. Impact of homicide on male life expectancy in Mexico. *Pan Am J Public Health* 2012;32:335-42.
7. Espinosa V, Rubin DB. Did the military intervention in the Mexican drug war increase violence? *Am Statistician* 2015;69:17-27. <http://doi.org/bhs5>
8. Solomon KR, Anadón A, Cerdeira AL, Marshall J, Sanin L-H. Environmental and human health assessment of the aerial spray program for coca and poppy control in Colombia. Prepared for the Inter-American Drug Abuse Control Commission section of Organization of American States, Washington, DC: Organization of American States, 2005.
9. International Agency for Research on Cancer. IARC monographs on the evaluation of carcinogenic risks to human: preamble. Lyon: International Agency for Research on Cancer, 2006.
10. Camacho A, Mejía D. The health consequences of aerial spraying of illicit crops: the case of Colombia (working paper 408) Washington DC: Center for Global Development, 2015.
11. Menendez A. Ecuador-Colombia settlement wont' end spraying. <http://www.ipsnews.net/2013/10/ecuador-colombia-settlement-wont-end-spraying/>
12. UNAIDS How AIDS changed everything. Geneva: UNAIDS, 2015.
13. Aspinall EJ, Nambiar D, Goldberg DJ, Hickman M, Weir A, Van Velzen E, et al. Are needle and syringe programmes associated with a reduction in HIV transmission among people who inject drugs: a systematic review and meta-analysis. *Int J Epidemiol.* 2014;43:235-48. <http://doi.org/bhs6>
14. MacArthur GJ, Minozzi S, Martin N, Vickerman P, Deren S, Brueneau J, et al. Opiate substitution treatment and HIV transmission in people who inject drugs: systematic review and meta-analysis. *BMJ.* 2012 Oct 3;345:e5945. <http://doi.org/bhs7>
15. MacArthur GJ, van Velzen E, Palmateer N, y col. Interventions to prevent HIV and hepatitis c in people who inject drugs: a review of reviews to assess evidence of effectiveness. *Int J Drug Policy* 2014;25:34-62. <http://doi.org/bhs8>

16. Degenhardt L, Mathers BM, Wirtz AL, Wolfe D, Kamarulzaman A, Carrieri MP, et al. What has been achieved in HIV prevention, treatment and care for people who inject drugs, 2010-2012? A review of the six highest burden countries. *Int J Drug Policy*. 2014;25:53-60. <http://doi.org/bhs9>
17. Milloy MJ, Wood E. Emerging role of supervised injecting facilities in human immunodeficiency virus prevention. *Addiction* 2009;104:620-1. <http://doi.org/br79gj>
18. Choopanya K, Marti M, Suntharasamai P, for the Bangkok Tenofovir Study Group. Antiretroviral prophylaxis for HIV infection in injecting drug users in Bangkok, Thailand (the Bangkok Tenofovir Study): a randomized, double blind, placebo-controlled phase 3 trial. *Lancet* 2013;381:2083-90. <http://doi.org/f2kbr3>
19. DeBeck K, Kerr T, Li K, Montaner J, Wood E. Incarceration and drug use pattern among a cohort of injection drug users. *Addiction* 2009;104:69-76. <http://doi.org/cqwph4>
20. Organization of American States Inter-American Commission of Women. Women and drugs in Americas: a policy working paper. Washington DC: Inter-American Commission of Women, 2014.
21. Perez Correa C, Azeola E. Resultados de la primera encuesta realizada en los Centros Federales de Readaptación Social. México City: CIDE 2012.
22. Mathers BM, Degenhardt L, Bucello C, Lemon J, Wiessing L, Hickman M. Mortality among people who injecting drugs: a systematic review and meta-analysis. *Bull World Health Organ* 2013;91:102-23. <http://doi.org/bhtc>
23. Urban Health Research Initiative. Drug situation in Vancouver. Vancouver Urban Health Research Initiative, 2009.